



October 2023

Molina Healthcare

Medicaid

**Preferred Drug List
(Formulary)/
Lista de Medicamentos
Preferidos
(Formulario)**



Discrimination is against the law

Molina Healthcare (Molina) follows the law. We treat all people equally.

We do not discriminate against anyone based on:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion

We provide free help and services to people with disabilities. We want you to be able to communicate with us easily.

We offer:

- Qualified sign language interpreters.
- Written information in many formats. These may include:
 - Large print
 - Audio
 - Accessible electronic formats
 - Other formats

We also provide free language services to people whose first language is not English. We offer:

- Qualified interpreters
- Information that is written in other languages

Contact us at (800) 424-4518 (TTY/TDD: 711) if you need any of these services.

The AlertLine offers confidential and anonymous reporting without fear of retaliation. If you believe there have been instances of non-compliance, potential fraud, waste or abuse or have experienced discrimination, you may file a report by calling the Molina AlertLine at (866) 606-3889 or online at <https://molinahealthcare.alertline.com>

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You may do this online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Or you may do this by mail or phone:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

(800) 368-1019

TDD: (800) 537-7697

Complaint forms are available online. You may find them at <http://www.hhs.gov/ocr/office/file/index.html>.

Help in other languages

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 424-4518 (TTY/TDD: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어지원서비스를 무료로 이용하실 수 있습니다.

(800) 424-4518 (TTY/TDD: 711) 번으로 전화해 주십시오.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số

(800) 424-4518 (TTY/TDD: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (TTY/TDD: 711)

(800) 424-4518.

Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان، اتصل برقم (1-800-424-4518) رقم هاتف الصم والبكم: (711) -قم هاتف الصم والبكم: .

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa (800) 424-4518 (TTY/TDD: 711).

Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات راهنمای زبان به صورت رایگان برای شما در دسترس است. با شماره 4518-424 (800) TTY/TDD (تعماریه ونه ته بینوایان 711)); تعماریه ونه ته بینوایان تماس بگیرید

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ማከተለው ቁጥር ይደውሉ

Urdu

دعیمان دین: اگر آپ اردو بولتے ہیں تو مشق زبان کی مدد والی خل ما شت دستیاب ہیں۔ (711 بلس --800-424 TTY/TDD) 4518: میڈ لین۔ پیکریں کال۔

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 424-4518 (ATS: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. ЗВОНИТЕ (800) 424-4518 (Телетайп: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

(800) 424-4518 (TTY/TDD: 711) पर काल करे।

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer (800) 424-4518 (TTY/TDD: 711).

Bengali

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পা রেখবা। উপল আছা ফোন করুন।

(800) 424-4518 (TTY/TDD: 711).

Bassa

Dè dè nià kɛ dyédé gbo: ɔ juú ké m̀ Bàsò ɔ-wùdù-po-nyò juú ní, níí, à wudu kà kò do po-poó bé in m̀ gbo kpáa. Đá (800) 424-4518 (TTY/TDD: 711).

CONTENTS/CONTENIDO

(10/01/2023)

FORMULARY GUIDE (ENGLISH)

INTRODUCTION

We are pleased to provide the *2023 Molina Healthcare (Molina) Preferred Drug List (Formulary)* as a useful reference and informational tool. This guide can help medical providers select clinically appropriate and cost-effective products for their patients.

The drugs in this guide have been reviewed by a Pharmacy and Therapeutics (P&T) Committee and are approved before being included. This guide reflects current medical practice as of the date of review.

The information in this guide is provided solely for the benefit of medical providers. We do not guarantee accuracy of such information. This guide is not intended to be comprehensive in nature. All the information in the guide is provided as a reference for drug therapy selection.

This guide is subject to state-specific regulations and rules, including, but not limited to, those about generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

Molina is not responsible for the actions or omissions of any medical provider based on information in this guide. The medical provider should check the drug manufacturer's product literature or standard references for more detailed information.

PREFACE

This guide is organized by sections. Each section is divided by therapeutic drug class by type.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

We use the services of a Pharmacy and Therapeutics Committee ("P&T Committee") to approve safe and clinically effective drug therapies. The P&T Committee is an advisory body of clinical professionals. The P&T Committee's voting members include physicians and pharmacists who all have a broad background of clinical and academic expertise on prescription drugs. Voting members of the P&T Committee must disclose any financial relationship or conflicts of interest with any pharmaceutical manufacturers.

DRUG LIST PRODUCT DESCRIPTIONS

To help you understand which specific strengths and dosage forms are covered, some general guidelines are noted below.

- The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., LIPITOR). Generic drugs are listed in lowercase italics (e.g., atorvastatin).

- The second column (labeled Drug Tier) will list what tier the drug is placed on in the Drug Formulary.
- The third column (Requirements/Limits) contains any special requirements for coverage of your drug.
- If the OTC and prescription versions of the product are covered, then both are listed.
- Extended-release and delayed-release products require their own entry.
- Dosage forms will be consistent with the category and use where listed.

GENERIC SUBSTITUTION

Generic substitution is when your pharmacy may dispense a generic version instead of a prescribed brand-name product. In this guide, lowercase italicized type means a generic version is available. In most instances, if there's a generic product available, the brand-name version will become non-formulary. The generic product will be covered instead of the brand-name version. However, this guide is subject to state specific regulations and rules for generic substitution and mandatory generic rules apply where appropriate.

Prescription generic drugs are:

- Usually priced lower than their brand-name equivalents
- Approved by the U.S. Food and Drug Administration for safety and effectiveness. They are manufactured under the same strict standards that apply to brand-name drugs
- Tested in humans to make sure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter how safe and effective they are
- Manufactured in the same strength and dosage form as the brand-name drugs

When a generic drug is substituted for a brand-name drug, the generic should be just as safe and effective as the brand-name drug (therapeutic equivalence).

PLAN DESIGN

- This guide represents Molina and Virginia Medicaid's Common Core Formulary. Generic medications are typically available at the lowest cost. Brand-name medications usually cost more than generic versions. Medications not on the list will usually cost the most.

This guide lists drugs in the following manner:

Preferred Drugs

Non-Preferred Drugs

The medications listed in this guide are covered by Molina as represented. Molina covers certain medications on the list if utilization management criteria are met (i.e., Step Therapy, Prior Authorization, Quantity Limits, etc.). Molina will review requests for such medications outside of their listed criteria for medical necessity. If a medication is not listed, you may request a formulary exception for coverage. We will review medical necessity or formulary exception requests based on

drug-specific prior authorization criteria or standard non-formulary prescription request criteria. Log into molinahealthcare.com to check coverage.

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Molina Drug Formulary may be approved when medically necessary and when formulary options have proven not to work. When this happens, the physician may fax a completed drug prior authorization form to Molina at (844) 278-5731. You can find these forms at molinahealthcare.com. We will not consider trials of pharmaceutical samples as rationale for approving a prior authorization request.

PRIOR AUTHORIZATION HELPFUL HINTS

For the quickest response possible from Molina's pharmacy department, please provide relevant information with the Prior Authorization request.

The following are examples:

Class of Medication/Diagnosis	Requested Clinical Information
Cholesterol Lowering	Lipid Panel, Cardiovascular risk factors
Diabetes	A1c Report
Non-Formulary/Non-Preferred Medication	Medication Log and/or Progress Notes documenting previous use of Formulary medications

EXCLUDED SERVICES

Please note that certain medications are excluded. These include, but are not limited to:

- Drugs used for anorexia or weight gain
- Drugs used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered
- Drugs which have been recalled
- Experimental drugs or non-FDA-approved drugs
- Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program

NOTICE

The information contained in this guide is proprietary. The information may not be copied in whole or in part without written permission. ©2023. All rights reserved.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers.

FORMULARY UPDATES

Please review the formulary changes which pertain to the pharmacy benefit. If you have questions, contact Molina Member Services. We're available Monday through Friday from 8 a.m. to 8 p.m. local time at (800) 424-4518 (TTY: 711).

Key			
AGE=Age Limit	CL=Closed Class Medication	MED=Max 90 mg Morphine Equivalent Dose Per Day	OTC= Over the Counter
PA=Prior Authorization	PA, QL=Quantity Limit is applied after Prior Authorization approval	QL=Quantity Limit	SP=Specialty Drugs
ST=Step Therapy			

Date Effective	Product Name	Change	Notes
10/1/2023	CLINDACIN 1% FOAM	Add to formulary, non-preferred	
10/1/2023	DAPSONE 7.5% GEL PUMP	Add to formulary, non-preferred	
10/1/2023	BELBUCA 150 MCG FILM	Add to formulary, non-preferred	
10/1/2023	BELBUCA 750 MCG FILM	Add to formulary, non-preferred	
10/1/2023	BELBUCA 900 MCG FILM	Add to formulary, non-preferred	
10/1/2023	BELBUCA 75 MCG FILM	Add to formulary, non-preferred	
10/1/2023	BELBUCA 600 MCG FILM	Add to formulary, non-preferred	
10/1/2023	BELBUCA 450 MCG FILM	Add to formulary, non-preferred	
10/1/2023	BELBUCA 300 MCG FILM	Add to formulary, non-preferred	
10/1/2023	TESTOSTERONE 30 MG/1.5 ML PUMP	Add to formulary, non-preferred	
10/1/2023	RAGWITEK SUBLINGUAL TABLET	Add to formulary, non-preferred	
10/1/2023	ODACTRA 12 SQ-HDM SL TABLET	Add to formulary, non-preferred	
10/1/2023	GRASTEK 2,800 BAU SL TABLET	Add to formulary, non-preferred	
10/1/2023	VANCOMYCIN 25 MG/ML SOLUTION	Add to formulary, non-preferred	
10/1/2023	VANCOMYCIN 50 MG/ML SOLUTION	Add to formulary, non-preferred	
10/1/2023	VENLAFAXINE HCL ER 150 MG TAB	Add to formulary, non-preferred	
10/1/2023	VENLAFAXINE HCL ER 225 MG TAB	Add to formulary, non-preferred	
10/1/2023	VENLAFAXINE HCL ER 75 MG TAB	Add to formulary, non-preferred	
10/1/2023	VILAZODONE HCL 10 MG TABLET	Add to formulary, non-preferred	
10/1/2023	VILAZODONE HCL 20 MG TABLET	Add to formulary, non-preferred	
10/1/2023	VILAZODONE HCL 40 MG TABLET	Add to formulary, non-preferred	
10/1/2023	GRANISETRON HCL 1 MG TABLET	Add to formulary, non-preferred	

10/1/2023	POSACONAZOLE 200 MG/5 ML SUSP	Add to formulary, non-preferred	
10/1/2023	POSACONAZOLE DR 100 MG TABLET	Add to formulary, non-preferred	
10/1/2023	ORAVIG 50 MG BUCCAL TABLET	Add to formulary, non-preferred	
10/1/2023	MICONAZOLE NITRATE 2% SOLUTION	Add to formulary, non-preferred	
10/1/2023	FEBUXOSTAT 40 MG TABLET	Add to formulary, non-preferred	
10/1/2023	FEBUXOSTAT 80 MG TABLET	Add to formulary, non-preferred	
10/1/2023	GLOPERBA 0.6 MG/5 ML SOLUTION	Add to formulary, non-preferred	
10/1/2023	VERAPAMIL ER PM 100 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	ISRADIPINE 5 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	ISRADIPINE 2.5 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	TUXARIN ER 8-54.3 MG TABLET	Add to formulary, non-preferred	
10/1/2023	AUVI-Q 0.15 MG AUTO-INJECTOR	Add to formulary, non-preferred	
10/1/2023	AUVI-Q 0.1 MG AUTO-INJECTOR	Add to formulary, non-preferred	
10/1/2023	RETACRIT 20,000 UNIT/2 ML VIAL	Add to formulary, non-preferred	
10/1/2023	BISMUTH-METRO-TETR 140-125-125	Add to formulary, non-preferred	
10/1/2023	CIMETIDINE 300 MG/5 ML SOLN	Add to formulary, non-preferred	
10/1/2023	METFORMIN ER 500 MG GASTRC-TB	Add to formulary, non-preferred	
10/1/2023	METFORMIN ER 1,000 MG GASTR-TB	Add to formulary, non-preferred	
10/1/2023	ZILEUTON ER 600 MG TABLET	Add to formulary, non-preferred	
10/1/2023	COLESEVELAM HCL 3.75 G PACKET	Add to formulary, non-preferred	
10/1/2023	ATORVALIQ 20 MG/5 ML SUSP	Add to formulary, non-preferred	
10/1/2023	DULOXETINE HCL DR 40 MG CAP	Add to formulary, non-preferred	
10/1/2023	PIROXICAM 20 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	AZASITE 1% EYE DROPS	Add to formulary, non-preferred	
10/1/2023	BROMFENAC SODIUM 0.09% EYE DRP	Add to formulary, non-preferred	
10/1/2023	NEVANAC 0.1% EYE DROP	Add to formulary, non-preferred	
10/1/2023	DORZOLAMIDE-TIMOLOL 2%-0.5%	Add to formulary, non-preferred	
10/1/2023	COSOPT PF EYE DROPS	Add to formulary, non-preferred	
10/1/2023	COSOPT EYE DROPS	Add to formulary, non-preferred	
10/1/2023	BETIMOL 0.25% EYE DROPS	Add to formulary, non-preferred	
10/1/2023	BETIMOL 0.5% EYE DROPS	Add to formulary, non-preferred	
10/1/2023	BETOPTIC S 0.25% EYE DROP	Add to formulary, non-preferred	
10/1/2023	LIQREV 10 MG/ML ORAL SUSP	Add to formulary, non-preferred	
10/1/2023	KONVOMEPEP 2-84 MG/ML ORAL SUSP	Add to formulary, non-preferred	
10/1/2023	TASIMELTEON 20 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	RAMELTEON 8 MG TABLET	Add to formulary, non-preferred	
10/1/2023	QUAZEPAM 15 MG TABLET	Add to formulary, non-preferred	
10/1/2023	DORAL 15 MG TABLET	Add to formulary, non-preferred	
10/1/2023	METAXALONE 400 MG TABLET	Add to formulary, non-preferred	
10/1/2023	BACLOFEN 25 MG/5 ML SUSPENSION	Add to formulary, non-preferred	
10/1/2023	ORPHENGESIC FORTE 50-770-60 MG	Add to formulary, non-preferred	
10/1/2023	BUDESONIDE 2 MG RECTAL FOAM	Add to formulary, non-preferred	
10/1/2023	DEPAKOTE DR 250 MG TABLET	Add to formulary, non-preferred	
10/1/2023	EPRONTIA 25 MG/ML SOLUTION	Add to formulary, non-preferred	
10/1/2023	RUFINAMIDE 200 MG TABLET	Add to formulary, non-preferred	

10/1/2023	RUFINAMIDE 40 MG/ML SUSPENSION	Add to formulary, non-preferred	
10/1/2023	RUFINAMIDE 400 MG TABLET	Add to formulary, non-preferred	
10/1/2023	SYMPAZAN 10 MG FILM	Add to formulary, non-preferred	
10/1/2023	SYMPAZAN 20 MG FILM	Add to formulary, non-preferred	
10/1/2023	SYMPAZAN 5 MG FILM	Add to formulary, non-preferred	
10/1/2023	TOPIRAMATE ER 100 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	TOPIRAMATE ER 25 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	TOPIRAMATE ER 50 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	ZAVZPRET 10 MG NASAL SPRAY	Add to formulary, non-preferred	
10/1/2023	ABILIFY ASIMTUFII 720 MG/2.4ML	Add to formulary, non-preferred	
10/1/2023	ABILIFY ASIMTUFII 960 MG/3.2ML	Add to formulary, non-preferred	
10/1/2023	ADASUVE 10 MG INHALATION POWDR	Add to formulary, non-preferred	
10/1/2023	ARIPIRAZOLE 1 MG/ML SOLUTION	Add to formulary, non-preferred	
10/1/2023	ZIPRASIDONE 20 MG/ML VIAL	Add to formulary, non-preferred	
10/1/2023	ROFLUMILAST 250 MCG TABLET	Add to formulary, non-preferred	
10/1/2023	ARCALYST 220 MG VIAL	Add to formulary, non-preferred	
10/1/2023	ZEGALOGUE 0.6 MG/0.6ML AUTOINJ	Add to formulary, non-preferred	
10/1/2023	ZEGALOGUE 0.6 MG/0.6 ML SYRING	Add to formulary, non-preferred	
10/1/2023	FLUTICASONE-SALMETEROL 230-21	Add to formulary, non-preferred	
10/1/2023	FLUTICASONE-SALMETEROL 115-21	Add to formulary, non-preferred	
10/1/2023	FLUTICASONE-SALMETEROL 45-21	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIIO 4,000 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIIO 250 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIIO 2,000 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIIO 500 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIIO 1,000 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIIO 3,000 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	GILENYA 0.25 MG CAPSULE	Add to formulary, non-preferred	
10/1/2023	TERIFLUNOMIDE 14 MG TABLET	Add to formulary, non-preferred	
10/1/2023	TERIFLUNOMIDE 7 MG TABLET	Add to formulary, non-preferred	
10/1/2023	TYSABRI 300 MG/15 ML VIAL	Add to formulary, non-preferred	
10/1/2023	HYDROXYPROGEST 1,250 MG/5 ML	Add to formulary, non-preferred	
10/1/2023	HYDROXYPROGEST 250 MG/ML VIAL	Add to formulary, non-preferred	
10/1/2023	DEXTROAMP-AMPHET ER 10 MG CAP	Add to formulary, non-preferred	
10/1/2023	DEXTROAMP-AMPHET ER 15 MG CAP	Add to formulary, non-preferred	
10/1/2023	DEXTROAMP-AMPHET ER 20 MG CAP	Add to formulary, non-preferred	
10/1/2023	DEXTROAMP-AMPHET ER 25 MG CAP	Add to formulary, non-preferred	
10/1/2023	DEXTROAMP-AMPHET ER 30 MG CAP	Add to formulary, non-preferred	

10/1/2023	DEXTROAMP-AMPHET ER 5 MG CAP	Add to formulary, non-preferred	
10/1/2023	METHYLPHENIDATE 10 MG/9HR PTCH	Add to formulary, non-preferred	
10/1/2023	METHYLPHENIDATE 15 MG/9HR PTCH	Add to formulary, non-preferred	
10/1/2023	METHYLPHENIDATE 20 MG/9HR PTCH	Add to formulary, non-preferred	
10/1/2023	METHYLPHENIDATE 30 MG/9HR PTCH	Add to formulary, non-preferred	
10/1/2023	TM-TOLNAFTATE 1% LIQUID	Update to non-preferred	
10/1/2023	LANSOPRAZOL-AMOXICIL-CLARITHRO	Update to non-preferred	
10/1/2023	METRONIDAZOLE TOP 1% GEL PUMP	Update to non-preferred	
10/1/2023	LACOSAMIDE 100 MG/10 ML CUP	Update to non-preferred	
10/1/2023	LACOSAMIDE 150 MG/15 ML CUP	Update to non-preferred	
10/1/2023	LACOSAMIDE 200 MG/20 ML CUP	Update to non-preferred	
10/1/2023	LACOSAMIDE 50 MG/5 ML CUP	Update to non-preferred	
10/1/2023	HYDROXYPROGESTERONE 1.25 G/5ML	Update to non-preferred	
10/1/2023	MEMANTINE HCL 10 MG TABLET	Add to formulary, preferred	
10/1/2023	MEMANTINE HCL 5 MG TABLET	Add to formulary, preferred	
10/1/2023	ENALAPRIL MALEATE 5 MG TABLET	Add to formulary, preferred	
10/1/2023	ENALAPRIL MALEATE 10 MG TAB	Add to formulary, preferred	
10/1/2023	ENALAPRIL MALEATE 20 MG TAB	Add to formulary, preferred	
10/1/2023	ENALAPRIL MALEATE 2.5 MG TAB	Add to formulary, preferred	
10/1/2023	LISINOPRIL 20 MG TABLET	Add to formulary, preferred	
10/1/2023	LISINOPRIL 5 MG TABLET	Add to formulary, preferred	
10/1/2023	LISINOPRIL 40 MG TABLET	Add to formulary, preferred	
10/1/2023	LISINOPRIL 30 MG TABLET	Add to formulary, preferred	
10/1/2023	LISINOPRIL 2.5 MG TABLET	Add to formulary, preferred	
10/1/2023	LISINOPRIL 10 MG TABLET	Add to formulary, preferred	
10/1/2023	LOSARTAN POTASSIUM 100 MG TAB	Add to formulary, preferred	
10/1/2023	LOSARTAN POTASSIUM 50 MG TAB	Add to formulary, preferred	
10/1/2023	LOSARTAN POTASSIUM 25 MG TAB	Add to formulary, preferred	
10/1/2023	DESVENLAFAXINE SUCCNT ER 100MG	Add to formulary, preferred	
10/1/2023	DESVENLAFAXINE SUCCNT ER 50 MG	Add to formulary, preferred	
10/1/2023	VENLAFAXINE HCL ER 37.5 MG CAP	Add to formulary, preferred	
10/1/2023	VENLAFAXINE HCL ER 75 MG CAP	Add to formulary, preferred	
10/1/2023	ESCITALOPRAM 5 MG TABLET	Add to formulary, preferred	
10/1/2023	ESCITALOPRAM 10 MG TABLET	Add to formulary, preferred	
10/1/2023	ESCITALOPRAM 20 MG TABLET	Add to formulary, preferred	
10/1/2023	SERTRALINE HCL 50 MG TABLET	Add to formulary, preferred	
10/1/2023	SERTRALINE HCL 25 MG TABLET	Add to formulary, preferred	
10/1/2023	SERTRALINE HCL 100 MG TABLET	Add to formulary, preferred	
10/1/2023	MECLIZINE 25 MG TABLET	Add to formulary, preferred	
10/1/2023	PROMETHAZINE 12.5 MG SUPPOS	Add to formulary, preferred	
10/1/2023	PROMETHAZINE 25 MG	Add to formulary, preferred	

	SUPPOSITORY		
10/1/2023	SM CHILD ALL DAY ALLER 1 MG/ML	Add to formulary, preferred	
10/1/2023	GUANFACINE 1 MG TABLET	Add to formulary, preferred	
10/1/2023	CLONIDINE HCL 0.2 MG TABLET	Add to formulary, preferred	
10/1/2023	CLONIDINE HCL 0.1 MG TABLET	Add to formulary, preferred	
10/1/2023	CLONIDINE HCL 0.3 MG TABLET	Add to formulary, preferred	
10/1/2023	ALLOPURINOL 100 MG TABLET	Add to formulary, preferred	
10/1/2023	ALLOPURINOL 300 MG TABLET	Add to formulary, preferred	
10/1/2023	COLCHICINE 0.6 MG TABLET	Add to formulary, preferred	
10/1/2023	SUMATRIPTAN 6 MG/0.5 ML INJECT	Add to formulary, preferred	
10/1/2023	SUMATRIPTAN 6 MG/0.5ML AUTOINJ	Add to formulary, preferred	
10/1/2023	OSELTAMIVIR PHOS 30 MG CAPSULE	Add to formulary, preferred	
10/1/2023	OSELTAMIVIR PHOS 45 MG CAPSULE	Add to formulary, preferred	
10/1/2023	ACYCLOVIR 200 MG/5 ML SUSP	Add to formulary, preferred	
10/1/2023	METOPROLOL SUCC ER 25 MG TAB	Add to formulary, preferred	
10/1/2023	METOPROLOL SUCC ER 200 MG TAB	Add to formulary, preferred	
10/1/2023	METOPROLOL SUCC ER 100 MG TAB	Add to formulary, preferred	
10/1/2023	METOPROLOL SUCC ER 50 MG TAB	Add to formulary, preferred	
10/1/2023	OXYBUTYNIN CL ER 15 MG TABLET	Add to formulary, preferred	
10/1/2023	OXYBUTYNIN CL ER 5 MG TABLET	Add to formulary, preferred	
10/1/2023	OXYBUTYNIN CL ER 10 MG TABLET	Add to formulary, preferred	
10/1/2023	OXYBUTYNIN 2.5 MG TABLET	Add to formulary, preferred	
10/1/2023	ALFUZOSIN HCL ER 10 MG TABLET	Add to formulary, preferred	
10/1/2023	FINASTERIDE 5 MG TABLET	Add to formulary, preferred	
10/1/2023	FELODIPINE ER 2.5 MG TABLET	Add to formulary, preferred	
10/1/2023	FELODIPINE ER 10 MG TABLET	Add to formulary, preferred	
10/1/2023	FELODIPINE ER 5 MG TABLET	Add to formulary, preferred	
10/1/2023	CIPROFLOXACIN HCL 500 MG TAB	Add to formulary, preferred	
10/1/2023	LUBIPROSTONE 24 MCG CAPSULE	Add to formulary, preferred	
10/1/2023	LUBIPROSTONE 8 MCG CAPSULE	Add to formulary, preferred	
10/1/2023	DEXAMETHASONE 4 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISOLONE 15 MG/5 ML SOLN	Add to formulary, preferred	
10/1/2023	PREDNISOLONE SOD PH 25 MG/5 ML	Add to formulary, preferred	
10/1/2023	PREDNISON 2.5 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISON 20 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISON 10 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISON 5 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISON 50 MG TABLET	Add to formulary, preferred	
10/1/2023	ACID REDUCER 20 MG TABLET	Add to formulary, preferred	
10/1/2023	PIOGLITAZONE HCL 45 MG TABLET	Add to formulary, preferred	
10/1/2023	METFORMIN HCL 1,000 MG TABLET	Add to formulary, preferred	
10/1/2023	METFORMIN HCL 500 MG TABLET	Add to formulary, preferred	
10/1/2023	GLIMEPIRIDE 4 MG TABLET	Add to formulary, preferred	
10/1/2023	GLIMEPIRIDE 2 MG TABLET	Add to formulary, preferred	
10/1/2023	GLIMEPIRIDE 1 MG TABLET	Add to formulary, preferred	

10/1/2023	MONTELUKAST SOD 10 MG TABLET	Add to formulary, preferred	
10/1/2023	FENOFIBRATE 145 MG TABLET	Add to formulary, preferred	
10/1/2023	CHOLESTYRAMINE POWDER	Add to formulary, preferred	
10/1/2023	EZETIMIBE 10 MG TABLET	Add to formulary, preferred	
10/1/2023	ROSUVASTATIN CALCIUM 5 MG TAB	Add to formulary, preferred	
10/1/2023	ROSUVASTATIN CALCIUM 10 MG TAB	Add to formulary, preferred	
10/1/2023	DULOXETINE HCL DR 30 MG CAP	Add to formulary, preferred	
10/1/2023	DULOXETINE HCL DR 20 MG CAP	Add to formulary, preferred	
10/1/2023	DULOXETINE HCL DR 60 MG CAP	Add to formulary, preferred	
10/1/2023	PREGABALIN 25 MG CAPSULE	Add to formulary, preferred	
10/1/2023	PREGABALIN 100 MG CAPSULE	Add to formulary, preferred	
10/1/2023	PREGABALIN 50 MG CAPSULE	Add to formulary, preferred	
10/1/2023	PREGABALIN 150 MG CAPSULE	Add to formulary, preferred	
10/1/2023	PREGABALIN 225 MG CAPSULE	Add to formulary, preferred	
10/1/2023	PREGABALIN 300 MG CAPSULE	Add to formulary, preferred	
10/1/2023	PREGABALIN 200 MG CAPSULE	Add to formulary, preferred	
10/1/2023	PREGABALIN 75 MG CAPSULE	Add to formulary, preferred	
10/1/2023	GABAPENTIN 100 MG CAPSULE	Add to formulary, preferred	
10/1/2023	GABAPENTIN 300 MG CAPSULE	Add to formulary, preferred	
10/1/2023	DICLOFENAC EPOLAMINE 1.3% PTCH	Add to formulary, preferred	
10/1/2023	CHILDREN IBUPROFEN 100 MG/5 ML	Add to formulary, preferred	
10/1/2023	DICLOFENAC SOD DR 25 MG TAB	Add to formulary, preferred	
10/1/2023	DICLOFENAC SOD DR 50 MG TAB	Add to formulary, preferred	
10/1/2023	DICLOFENAC SOD DR 75 MG TAB	Add to formulary, preferred	
10/1/2023	TOBRADEX EYE DROPS	Add to formulary, preferred	
10/1/2023	TIMOLOL MALEATE 0.5% EYE DROP	Add to formulary, preferred	
10/1/2023	TIMOLOL 0.5% GEL-SOLUTION	Add to formulary, preferred	
10/1/2023	TIMOLOL 0.25% GEL-SOLUTION	Add to formulary, preferred	
10/1/2023	CALCIUM ACETATE 667 MG TABLET	Add to formulary, preferred	
10/1/2023	DANTROLENE SODIUM 50 MG CAP	Add to formulary, preferred	
10/1/2023	DANTROLENE SODIUM 100 MG CAP	Add to formulary, preferred	
10/1/2023	DANTROLENE SODIUM 25 MG CAP	Add to formulary, preferred	
10/1/2023	CLOBETASOL 0.05% SOLUTION	Add to formulary, preferred	
10/1/2023	ENOXAPARIN 40 MG/0.4 ML SYR	Add to formulary, preferred	
10/1/2023	ENOXAPARIN 30 MG/0.3 ML SYR	Add to formulary, preferred	
10/1/2023	LOXAPINE 10 MG CAPSULE	Add to formulary, preferred	
10/1/2023	LOXAPINE 25 MG CAPSULE	Add to formulary, preferred	
10/1/2023	LOXAPINE 5 MG CAPSULE	Add to formulary, preferred	
10/1/2023	LOXAPINE 50 MG CAPSULE	Add to formulary, preferred	
10/1/2023	DARUNAVIR 600 MG TABLET	Add to formulary, preferred	
10/1/2023	DARUNAVIR 800 MG TABLET	Add to formulary, preferred	
10/1/2023	SUNLENCA 4- 300 MG TABLET	Add to formulary, preferred	
10/1/2023	SUNLENCA 463.5 MG/1.5 ML VIAL	Add to formulary, preferred	
10/1/2023	SUNLENCA 5- 300 MG TABLET	Add to formulary, preferred	
10/1/2023	AUSTEDO XR 24 MG TABLET	Add to formulary, preferred	

10/1/2023	AUSTEDO XR 6 MG TABLET	Add to formulary, preferred	
10/1/2023	AUSTEDO XR 12 MG TABLET	Add to formulary, preferred	
10/1/2023	OXBRYTA 300 MG TABLET	Add to formulary, preferred	
10/1/2023	DEXTROAMP-AMPHETAM 12.5 MG TAB	Add to formulary, preferred	
10/1/2023	DEXTROAMP-AMPHETAM 7.5 MG TAB	Add to formulary, preferred	
10/1/2023	DEXTROAMP-AMPHETAMIN 10 MG TAB	Add to formulary, preferred	
10/1/2023	DEXTROAMP-AMPHETAMIN 15 MG TAB	Add to formulary, preferred	
10/1/2023	DEXTROAMP-AMPHETAMIN 20 MG TAB	Add to formulary, preferred	
10/1/2023	DEXTROAMP-AMPHETAMIN 30 MG TAB	Add to formulary, preferred	
10/1/2023	DEXTROAMP-AMPHETAMINE 5 MG TAB	Add to formulary, preferred	
10/1/2023	DEXTROAMP-AMPHETAMINE 10 MG TAB	Add to formulary, preferred	
10/1/2023	METRONIDAZOLE TOPICAL 0.75% GL	Update to preferred	
10/1/2023	ZENZEDI 15 MG TABLET	Update to preferred	
10/1/2023	ZENZEDI 20 MG TABLET	Update to preferred	
10/1/2023	ZENZEDI 30 MG TABLET	Update to preferred	
10/1/2023	Voxelotor Tab 300 MG	Add PA	
10/1/2023	Timothy Grass Pollen Allergen Ext SL Tab 2800 BAU	Add QL	1 per day
10/1/2023	Epinephrine Solution Auto-injector 0.1 MG/0.1ML	Add QL	12 per 365 days
10/1/2023	Deutetrabenazine Tab ER 24HR 24 MG	Add QL	4 per day
10/1/2023	Deutetrabenazine Tab ER 24HR 6 MG	Add QL	4 per day
10/1/2023	Deutetrabenazine Tab ER 24HR 12 MG	Add QL	4 per day
10/1/2023	Midazolam Nasal Spray Soln 5 MG/0.1 ML	Add QL	10 per 24 days
10/1/2023	Risperidone Microspheres For IM Extended Rel Susp 25 MG	Add QL	2 per 22 days
10/1/2023	Risperidone Microspheres For IM Extended Rel Susp 37.5 MG	Add QL	2 per 22 days
10/1/2023	Risperidone Microspheres For IM Extended Rel Susp 50 MG	Add QL	2 per 22 days
10/1/2023	Semaglutide Soln Pen-inj 0.25 or 0.5 MG/DOSE (2 MG/3ML)	Add QL	3mL per 22 days
10/1/2023	Dulaglutide Soln Pen-injector 3 MG/0.5ML	Add QL	2mL per 22 days
10/1/2023	Dulaglutide Soln Pen-injector 4.5 MG/0.5ML	Add QL	2mL per 22 days
10/1/2023	Alendronate Sodium Tab 5 MG	Remove QL	
10/1/2023	Ivermectin Cream 1%	Remove QL	
10/1/2023	Cabotegravir 400 MG/2ML & Rilpivirine 600 MG/2ML IM Susp ER	Update QL	12mL per 67 days

10/1/2023	Short Ragweed Pollen Allergen Extract SL Tab 12 Amb a 1-U	Age Limit	Min age 5
10/1/2023	*Dust Mite Mixed Ext SL Tab 12 SQ-HDM***	Age Limit	Min age 18
10/1/2023	Timothy Grass Pollen Allergen Ext SL Tab 2800 BAU	Age Limit	Min age 5
10/1/2023	Codeine Phos-Chlorpheniramine Maleate Tab ER 12HR 54.3-8 MG	Age Limit	Min age 6
10/1/2023	Sildenafil Citrate Oral Susp 10 MG/ML	Age Limit	Min age 18
10/1/2023	Zavegepant HCl Nasal Spray 10 MG/ACT	Age Limit	Min age 18
10/1/2023	Aripiprazole IM ER Susp Prefilled Syringe 720 MG/2.4ML	Age Limit	Min age 18
10/1/2023	Aripiprazole IM ER Susp Prefilled Syringe 960 MG/3.2ML	Age Limit	Min age 18
10/1/2023	Lenacapavir Sodium Tab Therapy Pack 4 x 300 MG	Age Limit	Min age 18
10/1/2023	Lenacapavir Sodium Subcutaneous Soln 463.5 MG/1.5ML	Age Limit	Min age 18
10/1/2023	Lenacapavir Sodium Tab Therapy Pack 5 x 300 MG	Age Limit	Min age 18
10/1/2023	Deutetrabenazine Tab ER 24HR 24 MG	Age Limit	Min age 18
10/1/2023	Deutetrabenazine Tab ER 24HR 6 MG	Age Limit	Min age 18
10/1/2023	Deutetrabenazine Tab ER 24HR 12 MG	Age Limit	Min age 18
10/1/2023	Fingolimod HCl Cap 0.25 MG (Base Equiv)	Age Limit	Min age 10
10/1/2023	Voxelotor Tab 300 MG	Age Limit	Min age 12
10/1/2023	Fenfluramine HCl Oral Soln 2.2 MG/ML	Remove Age Limit	
10/1/2023	Elbasvir-Grazoprevir Tab 50-100 MG	Remove Age Limit	
10/1/2023	Ombitas-Paritapre-Riton & Dasab Tab Pak 12.5-75-50 & 250 MG	Remove Age Limit	
10/1/2023	Sofosbuvir Tab 200 MG	Remove Age Limit	
10/1/2023	Sofosbuvir-Velpatasvir-Voxilaprevir Tab 400-100-100 MG	Remove Age Limit	
10/1/2023	Sofosbuvir Tab 400 MG	Remove Age Limit	
10/1/2023	Sofosbuvir Pellet Pack 200 MG	Remove Age Limit	
10/1/2023	Sofosbuvir Pellet Pack 150 MG	Remove Age Limit	
10/1/2023	Lixisenatide Pen-inj Starter Kit 10 MCG/0.2ML & 20 MCG/0.2ML	Remove Age Limit	
10/1/2023	Lixisenatide Soln Pen-injector 20 MCG/0.2ML (100 MCG/ML)	Remove Age Limit	
10/1/2023	Exenatide Extended Release Susp Auto-Injector 2 MG/0.85ML	Remove Age Limit	
10/1/2023	Exenatide Soln Pen-injector 10 MCG/0.04ML	Remove Age Limit	
10/1/2023	Exenatide Soln Pen-injector 5 MCG/0.02ML	Remove Age Limit	
10/1/2023	Pramlintide Acetate Pen-inj 2700	Remove Age Limit	

	MCG/2.7ML (1000 MCG/ML)		
10/1/2023	Pramlintide Acetate Pen-inj 1500 MCG/1.5ML (1000 MCG/ML)	Remove Age Limit	
10/1/2023	Dulaglutide Soln Pen-injector 0.75 MG/0.5ML	Remove Age Limit	
10/1/2023	Dulaglutide Soln Pen-injector 1.5 MG/0.5ML	Remove Age Limit	

LEGEND

AGE	Age Limit
CL	Closed Class Medication
MED	Max 90 mg Morphine Equivalent Dose per day
OTC	Over-the-counter, covered benefit with a prescription
PA	Prior Authorization
PA, QL	Quantity Limit is applied after Prior Authorization approval
QL	Quantity Limit
SP	Specialty Drug
ST	Step Therapy
<i>lowercase</i>	Indicates generic availability
UPPERCASE	Indicates brand availability

GUÍA DE FORMULARIO (ESPAÑOL)

INTRODUCCIÓN

Nos complace proporcionar *Lista de Medicamentos Preferidos de [Molina Healthcare (Molina)] [2023] (Formulario)* como una herramienta de referencia e información útil. Esta guía puede ayudar a los proveedores médicos a seleccionar productos clínicamente apropiados y rentables para sus pacientes.

Los medicamentos que se indican en esta guía fueron revisados por un Comité de Farmacia y Terapéutica (P&T, *Pharmacy and Therapeutics*) y están aprobados antes de su inclusión. Esta guía refleja la práctica médica actual a la fecha de revisión.

La información en esta guía se proporciona únicamente para el beneficio de los proveedores médicos. No garantizamos la exactitud de dicha información. Esta guía no fue hecha con un propósito integral. Toda la información de esta guía se proporciona como referencia para la selección de la terapia con medicamentos.

Esta guía está sujeta a normas y reglamentos específicos del estado, incluidos, entre otros, aquellos relacionados con la sustitución genérica, los programas de sustancias de administración controlada, la preferencia de marcas y los genéricos obligatorios cuando corresponda.

[Molina] no asume la responsabilidad por las acciones u omisiones de cualquier proveedor médico en función de la información contenida en esta guía. El proveedor médico debe revisar la documentación del producto provista por el fabricante del medicamento o las referencias estándar para obtener información más detallada.

PREFACIO

Esta guía está organizada en secciones. Cada sección se divide según la clase terapéutica del fármaco, por tipo.

COMITÉ DE FARMACIA Y TERAPÉUTICA (P&T)

Utilizamos los servicios de un Comité de Farmacia y Terapéutica (P&T) para aprobar tratamientos con medicamentos seguros y clínicamente eficaces. El Comité de P&T es un organismo asesor de profesionales clínicos. Entre los miembros votantes del Comité de P&T, se encuentran médicos y farmacéuticos, los cuales tienen una amplia experiencia clínica y académica en medicamentos recetados. Los miembros votantes del Comité de P&T deben divulgar cualquier relación financiera o conflicto de intereses con cualquier fabricante farmacéutico.

DESCRIPCIONES DE LOS PRODUCTOS DE LA LISTA DE MEDICAMENTOS

Para ayudar a entender cuáles son las fortalezas específicas y las formas de dosificación cubiertas, algunas pautas generales se describen a continuación.

- En la primera columna del cuadro se indica el nombre del medicamento. Los medicamentos de marca están en letra mayúscula (p. ej., LIPITOR). Los medicamentos genéricos se indican en letra minúscula en cursiva (p. ej., atorvastatin).
- En la segunda columna (categoría de medicamento etiquetado) se indica en qué categoría se ubica el medicamento en el formulario.
- La tercera columna (Requisitos/Límites) contiene cualquier requisito especial para la cobertura de su medicamento.
- Si las versiones de productos de venta libre (OTC, *Over The Counter*) y las versiones de productos con receta médica están cubiertas, se indican ambas.
- Los productos de liberación prolongada y de liberación retardada requieren su propia entrada.
- Las formas de dosificación serán coherentes con la categoría y el uso en que se clasificaron.

SUSTITUCIÓN GENÉRICA

La sustitución genérica es cuando su farmacia puede administrar una versión genérica en lugar de un producto de marca recetado. En esta guía, la letra minúscula en cursiva significa que hay una versión genérica disponible. En la mayoría de los casos, si hay un producto genérico disponible, la versión de marca registrada no tendrá formulario. El producto genérico estará cubierto en lugar de la versión de marca registrada. Sin embargo, esta guía está sujeta a regulaciones y normas específicas del estado sobre la sustitución genérica y se aplican normas genéricas obligatorias si corresponde.

Los medicamentos genéricos con receta médica cuentan con las siguientes características:

- Normalmente, tienen un precio menor que sus equivalentes de marca.
- Están aprobados por la Administración de Alimentos y Medicamentos de los EE. UU. en términos de seguridad y eficacia. Se fabrican bajo las mismas normas estrictas que se aplican a medicamentos de marca.
- Se probaron en humanos para garantizar que el genérico sea absorbido en el torrente sanguíneo en una tasa y extensión similares en comparación con el medicamento de marca (bioequivalencia). Los genéricos pueden ser diferentes de los de la marca en cuanto a tamaño, color e ingredientes inactivos, pero esto no altera lo efectivos ni seguros que son.
- Se fabrican con la misma concentración y dosificación que los medicamentos de marca.

Cuando un medicamento genérico es sustituido por un medicamento de marca, el medicamento genérico debe ser igual de efectivo y seguro que el medicamento de marca (equivalencia terapéutica).

DISEÑO DE PLANES

Esta guía representa el Formulario Básico Común de [Molina] y Virginia Medicaid. Los medicamentos que se presentan en el documento pueden tener un costo variable para el miembro del plan. Los medicamentos genéricos suelen estar disponibles al menor precio. Los medicamentos de marca, por lo general, serán más caros que las versiones genéricas. Los medicamentos que no están presentes en la lista suelen tener el mayor precio.

En esta guía se indican los medicamentos de la siguiente manera:

Categoría 1: Medicamentos Genéricos Preferidos

Categoría 2: Medicamentos de Marca Preferidos

Categoría 3: Medicamentos de Marca no Preferidos: Los medicamentos que no aparecen en el documento se consideran como “No Preferidos”

Los medicamentos que aparecen en esta guía están cubiertos por [Molina] según lo que se representa. [Molina] cubra algunos medicamentos de la lista si se cumplen los criterios de administración de utilización (es decir, terapia progresiva, autorización previa, límites de cantidad, etc.). [Molina] revisará las solicitudes de dichos medicamentos que estén fuera de los criterios enumerados se revisarán según la necesidad médica. Si un medicamento no aparece, puede solicitar una excepción de formulario para la cobertura. Revisaremos las solicitudes de necesidad médica o de excepción de formulario en función de los criterios de autorización previos específicos para el medicamento o los criterios estándar de solicitud de receta médica no convencional. Inicie sesión en [molinahealthcare.com] para revisar la cobertura.

PROCEDIMIENTO DE SOLICITUD DE AUTORIZACIÓN PREVIA

Las recetas de medicamentos que requieren aprobación previa o para medicamentos que no están incluidos en el Formulario de Medicamentos de [Molina] pueden ser aprobadas cuando son médicamente necesarias y cuando se haya demostrado que las alternativas del formulario no funcionan. Cuando esto ocurra, su proveedor puede enviar por fax un formulario completado de autorización previa de medicamentos a [Molina] al [(844) 278-5731]. Puede encontrar estos formularios en [molinahealthcare.com]. No consideraremos los ensayos de muestras farmacéuticas como justificativos para la aprobación de una solicitud de autorización previa.

CONSEJOS ÚTILES DE AUTORIZACIÓN PREVIA

Para la respuesta más rápida posible del Departamento de Farmacia de [Molina], proporcione la información pertinente con la solicitud de autorización previa.

Observe los siguientes ejemplos:

Clase de medicamento o diagnóstico	Información clínica solicitada
Reducción de colesterol	Perfil lipídico, factores de riesgo cardiovasculares
Diabetes	Resultados de prueba de A1c
Medicamento no preferido/fuera del formulario	Los Registros de Medicamentos o Notas de Progreso en los cuales se documente que el medicamento del formulario se utilizó con anterioridad

SERVICIOS EXCLUIDOS

Tenga en cuenta que algunos medicamentos están excluidos. Estos incluyen, entre otros:

- Medicamentos contra la anorexia, pérdida de peso o aumento de peso.
- Medicamentos para promover la fertilidad.
- Medicamentos para fines cosméticos o el crecimiento del cabello.
- Medicamentos para el tratamiento de disfunción sexual o eréctil; a menos que dichos medicamentos se utilicen para tratar una afección distinta de la disfunción eréctil; para la que los medicamentos estén aprobados por la FDA.
- Todos los medicamentos DESI (*Drug Efficacy Study Implementation*, Implementación del Estudio de la Eficacia de los Medicamentos) que, según la definición de la FDA, no tengan el nivel requerido de eficacia. Recetas de compuestos, lo que incluye medicamentos DESI no cubiertos.
- Medicamentos que se hayan retirado del Mercado.
- Medicamentos experimentales o no aprobados por la FDA.
- Cualquier medicamento de venta bajo receta archivada que se comercialice por un fabricante no perteneciente al Programa de Devolución de Medicamentos de Medicaid.

AVISO

La información contenida en esta guía es patentada. La información no se puede copiar en su totalidad o en parte sin el permiso por escrito. ©2023. Todos los derechos reservados.

Este documento contiene referencias a medicamentos con receta que son marcas comerciales o marcas comerciales registradas de fabricantes farmacéuticos.

ACTUALIZACIONES DEL FORMULARIO

Revise los cambios de formulario que pertenecen al beneficio de farmacia. Si tiene preguntas, comuníquese con el Departamento de Servicios para Miembros de [Molina]. Atendemos de lunes a viernes, de 8:00 a.m. a 8:00 p.m., hora local en (800) 424-4518 (TTY: 711).

Siglas			
AGE=Límite de edad	CL= Medicamentos de Clase Cerrada	MED=Dosis equivalente de morfina de 90 mg como máximo por día	OTC=Over-the-Counter
PA=Autorización previa	PA, QL=Límite de cantidad que se aplica después de la aprobación de la Autorización Previa	QL=Límite de Cantidad	SP=Medicamento de especialidad
ST=Terapia progresiva			

Fecha Efectiva	Nombre del Producto	Cambiar	Notas
10/1/2023	CLINDACIN 1% FOAM	Agregar al formulario, no preferido	
10/1/2023	DAPSONE 7.5% GEL PUMP	Agregar al formulario, no preferido	
10/1/2023	BELBUCA 150 MCG FILM	Agregar al formulario, no preferido	
10/1/2023	BELBUCA 750 MCG FILM	Agregar al formulario, no preferido	
10/1/2023	BELBUCA 900 MCG FILM	Agregar al formulario, no preferido	
10/1/2023	BELBUCA 75 MCG FILM	Agregar al formulario, no preferido	
10/1/2023	BELBUCA 600 MCG FILM	Agregar al formulario, no preferido	
10/1/2023	BELBUCA 450 MCG FILM	Agregar al formulario, no preferido	
10/1/2023	BELBUCA 300 MCG FILM	Agregar al formulario, no preferido	
10/1/2023	TESTOSTERONE 30 MG/1.5 ML PUMP	Agregar al formulario, no preferido	
10/1/2023	RAGWITEK SUBLINGUAL TABLET	Agregar al formulario, no preferido	
10/1/2023	ODACTRA 12 SQ-HDM SL TABLET	Agregar al formulario, no preferido	
10/1/2023	GRASTEK 2,800 BAU SL TABLET	Agregar al formulario, no preferido	
10/1/2023	VANCOMYCIN 25 MG/ML SOLUTION	Agregar al formulario, no preferido	
10/1/2023	VANCOMYCIN 50 MG/ML SOLUTION	Agregar al formulario, no preferido	
10/1/2023	VENLAFAXINE HCL ER 150 MG TAB	Agregar al formulario, no preferido	
10/1/2023	VENLAFAXINE HCL ER 225 MG TAB	Agregar al formulario, no preferido	
10/1/2023	VENLAFAXINE HCL ER 75 MG TAB	Agregar al formulario, no preferido	
10/1/2023	VILAZODONE HCL 10 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	VILAZODONE HCL 20 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	VILAZODONE HCL 40 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	GRANISETRON HCL 1 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	POSACONAZOLE 200 MG/5 ML SUSP	Agregar al formulario, no preferido	
10/1/2023	POSACONAZOLE DR 100 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	ORAVIG 50 MG BUCCAL TABLET	Agregar al formulario, no preferido	
10/1/2023	MICONAZOLE NITRATE 2% SOLUTION	Agregar al formulario, no preferido	
10/1/2023	FEBUXOSTAT 40 MG TABLET	Agregar al formulario, no preferido	

10/1/2023	FEBUXOSTAT 80 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	GLOPERBA 0.6 MG/5 ML SOLUTION	Agregar al formulario, no preferido	
10/1/2023	VERAPAMIL ER PM 100 MG CAPSULE	Agregar al formulario, no preferido	
10/1/2023	ISRADIPINE 5 MG CAPSULE	Agregar al formulario, no preferido	
10/1/2023	ISRADIPINE 2.5 MG CAPSULE	Agregar al formulario, no preferido	
10/1/2023	TUXARIN ER 8-54.3 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	AUVI-Q 0.15 MG AUTO-INJECTOR	Agregar al formulario, no preferido	
10/1/2023	AUVI-Q 0.1 MG AUTO-INJECTOR	Agregar al formulario, no preferido	
10/1/2023	RETACRIT 20,000 UNIT/2 ML VIAL	Agregar al formulario, no preferido	
10/1/2023	BISMUTH-METRO-TETR 140-125-125	Agregar al formulario, no preferido	
10/1/2023	CIMETIDINE 300 MG/5 ML SOLN	Agregar al formulario, no preferido	
10/1/2023	METFORMIN ER 500 MG GASTRC-TB	Agregar al formulario, no preferido	
10/1/2023	METFORMIN ER 1,000 MG GASTR-TB	Agregar al formulario, no preferido	
10/1/2023	ZILEUTON ER 600 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	COLESEVELAM HCL 3.75 G PACKET	Agregar al formulario, no preferido	
10/1/2023	ATORVALIQ 20 MG/5 ML SUSP	Agregar al formulario, no preferido	
10/1/2023	DULOXETINE HCL DR 40 MG CAP	Agregar al formulario, no preferido	
10/1/2023	PIROXICAM 20 MG CAPSULE	Agregar al formulario, no preferido	
10/1/2023	AZASITE 1% EYE DROPS	Agregar al formulario, no preferido	
10/1/2023	BROMFENAC SODIUM 0.09% EYE DRP	Agregar al formulario, no preferido	
10/1/2023	NEVANAC 0.1% EYE DROP	Agregar al formulario, no preferido	
10/1/2023	DORZOLAMIDE-TIMOLOL 2%-0.5%	Agregar al formulario, no preferido	
10/1/2023	COSOPT PF EYE DROPS	Agregar al formulario, no preferido	
10/1/2023	COSOPT EYE DROPS	Agregar al formulario, no preferido	
10/1/2023	BETIMOL 0.25% EYE DROPS	Agregar al formulario, no preferido	
10/1/2023	BETIMOL 0.5% EYE DROPS	Agregar al formulario, no preferido	
10/1/2023	BETOPTIC S 0.25% EYE DROP	Agregar al formulario, no preferido	
10/1/2023	LIQREV 10 MG/ML ORAL SUSP	Agregar al formulario, no preferido	
10/1/2023	KONVOMEPEP 2-84 MG/ML ORAL SUSP	Agregar al formulario, no preferido	
10/1/2023	TASIMELTEON 20 MG CAPSULE	Agregar al formulario, no preferido	
10/1/2023	RAMELTEON 8 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	QUAZEPAM 15 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	DORAL 15 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	METAXALONE 400 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	BACLOFEN 25 MG/5 ML SUSPENSION	Agregar al formulario, no preferido	
10/1/2023	ORPHENGESIC FORTE 50-770-60 MG	Agregar al formulario, no preferido	
10/1/2023	BUDESONIDE 2 MG RECTAL FOAM	Agregar al formulario, no preferido	
10/1/2023	DEPAKOTE DR 250 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	EPRONTIA 25 MG/ML SOLUTION	Agregar al formulario, no preferido	
10/1/2023	RUFINAMIDE 200 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	RUFINAMIDE 40 MG/ML SUSPENSION	Agregar al formulario, no preferido	
10/1/2023	RUFINAMIDE 400 MG TABLET	Agregar al formulario, no preferido	
10/1/2023	SYMPAZAN 10 MG FILM	Agregar al formulario, no preferido	
10/1/2023	SYMPAZAN 20 MG FILM	Agregar al formulario, no preferido	

10/1/2023	SYMPAZAN 5 MG FILM	Agregar al formulario, nopreferido	
10/1/2023	TOPIRAMATE ER 100 MG CAPSULE	Agregar al formulario, nopreferido	
10/1/2023	TOPIRAMATE ER 25 MG CAPSULE	Agregar al formulario, nopreferido	
10/1/2023	TOPIRAMATE ER 50 MG CAPSULE	Agregar al formulario, nopreferido	
10/1/2023	ZAVZPRET 10 MG NASAL SPRAY	Agregar al formulario, nopreferido	
10/1/2023	ABILIFY ASIMTUFII 720 MG/2.4ML	Agregar al formulario, nopreferido	
10/1/2023	ABILIFY ASIMTUFII 960 MG/3.2ML	Agregar al formulario, nopreferido	
10/1/2023	ADASUVE 10 MG INHALATION POWDR	Agregar al formulario, nopreferido	
10/1/2023	ARIPIRAZOLE 1 MG/ML SOLUTION	Agregar al formulario, nopreferido	
10/1/2023	ZIPRASIDONE 20 MG/ML VIAL	Agregar al formulario, nopreferido	
10/1/2023	ROFLUMILAST 250 MCG TABLET	Agregar al formulario, nopreferido	
10/1/2023	ARCALYST 220 MG VIAL	Agregar al formulario, nopreferido	
10/1/2023	ZEGALOGUE 0.6 MG/0.6ML AUTOINJ	Agregar al formulario, nopreferido	
10/1/2023	ZEGALOGUE 0.6 MG/0.6 ML SYRING	Agregar al formulario, nopreferido	
10/1/2023	FLUTICASONE-SALMETEROL 230-21	Agregar al formulario, nopreferido	
10/1/2023	FLUTICASONE-SALMETEROL 115-21	Agregar al formulario, nopreferido	
10/1/2023	FLUTICASONE-SALMETEROL 45-21	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIII 4,000 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIII 250 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIII 2,000 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIII 500 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIII 1,000 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIII 3,000 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	GILENYA 0.25 MG CAPSULE	Agregar al formulario, nopreferido	
10/1/2023	TERIFLUNOMIDE 14 MG TABLET	Agregar al formulario, nopreferido	
10/1/2023	TERIFLUNOMIDE 7 MG TABLET	Agregar al formulario, nopreferido	
10/1/2023	TYSABRI 300 MG/15 ML VIAL	Agregar al formulario, nopreferido	
10/1/2023	HYDROXYPROGEST 1,250 MG/5 ML	Agregar al formulario, nopreferido	
10/1/2023	HYDROXYPROGEST 250 MG/ML VIAL	Agregar al formulario, nopreferido	
10/1/2023	DEXTROAMP-AMPHET ER 10 MG CAP	Agregar al formulario, nopreferido	
10/1/2023	DEXTROAMP-AMPHET ER 15 MG CAP	Agregar al formulario, nopreferido	
10/1/2023	DEXTROAMP-AMPHET ER 20 MG CAP	Agregar al formulario, nopreferido	
10/1/2023	DEXTROAMP-AMPHET ER 25 MG CAP	Agregar al formulario, nopreferido	
10/1/2023	DEXTROAMP-AMPHET ER 30 MG CAP	Agregar al formulario, nopreferido	
10/1/2023	DEXTROAMP-AMPHET ER 5 MG CAP	Agregar al formulario, nopreferido	
10/1/2023	METHYLPHENIDATE 10 MG/9HR PTCH	Agregar al formulario, nopreferido	
10/1/2023	METHYLPHENIDATE 15 MG/9HR PTCH	Agregar al formulario, nopreferido	

10/1/2023	METHYLPHENIDATE 20 MG/9HR PTCH	Agregar al formulario, nopreferido	
10/1/2023	METHYLPHENIDATE 30 MG/9HR PTCH	Agregar al formulario, nopreferido	
10/1/2023	TM-TOLNAFTATE 1% LIQUID	Actualización para nopreferido	
10/1/2023	LANSOPRAZOL-AMOXICIL-CLARITHRO	Actualización para nopreferido	
10/1/2023	METRONIDAZOLE TOP 1% GEL PUMP	Actualización para nopreferido	
10/1/2023	LACOSAMIDE 100 MG/10 ML CUP	Actualización para nopreferido	
10/1/2023	LACOSAMIDE 150 MG/15 ML CUP	Actualización para nopreferido	
10/1/2023	LACOSAMIDE 200 MG/20 ML CUP	Actualización para nopreferido	
10/1/2023	LACOSAMIDE 50 MG/5 ML CUP	Actualización para nopreferido	
10/1/2023	HYDROXYPROGESTERONE 1.25 G/5ML	Actualización para nopreferido	
10/1/2023	MEMANTINE HCL 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	MEMANTINE HCL 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	ENALAPRIL MALEATE 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	ENALAPRIL MALEATE 10 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	ENALAPRIL MALEATE 20 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	ENALAPRIL MALEATE 2.5 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	LISINOPRIL 20 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	LISINOPRIL 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	LISINOPRIL 40 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	LISINOPRIL 30 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	LISINOPRIL 2.5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	LISINOPRIL 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	LOSARTAN POTASSIUM 100 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	LOSARTAN POTASSIUM 50 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	LOSARTAN POTASSIUM 25 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DESVENLAFAXINE SUCCNT ER 100MG	Agregar al formulario, privilegiado	
10/1/2023	DESVENLAFAXINE SUCCNT ER 50 MG	Agregar al formulario, privilegiado	
10/1/2023	VENLAFAXINE HCL ER 37.5 MG CAP	Agregar al formulario, privilegiado	
10/1/2023	VENLAFAXINE HCL ER 75 MG CAP	Agregar al formulario, privilegiado	
10/1/2023	ESCITALOPRAM 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	ESCITALOPRAM 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	ESCITALOPRAM 20 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	SERTRALINE HCL 50 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	SERTRALINE HCL 25 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	SERTRALINE HCL 100 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	MECLIZINE 25 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PROMETHAZINE 12.5 MG SUPPOS	Agregar al formulario, privilegiado	
10/1/2023	PROMETHAZINE 25 MG SUPPOSITORY	Agregar al formulario, privilegiado	
10/1/2023	SM CHILD ALL DAY ALLER 1 MG/ML	Agregar al formulario, privilegiado	
10/1/2023	GUANFACINE 1 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	CLONIDINE HCL 0.2 MG TABLET	Agregar al formulario, privilegiado	

10/1/2023	CLONIDINE HCL 0.1 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	CLONIDINE HCL 0.3 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	ALLOPURINOL 100 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	ALLOPURINOL 300 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	COLCHICINE 0.6 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	SUMATRIPTAN 6 MG/0.5 ML INJECT	Agregar al formulario, privilegiado	
10/1/2023	SUMATRIPTAN 6 MG/0.5ML AUTOINJ	Agregar al formulario, privilegiado	
10/1/2023	OSELTAMIVIR PHOS 30 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	OSELTAMIVIR PHOS 45 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	ACYCLOVIR 200 MG/5 ML SUSP	Agregar al formulario, privilegiado	
10/1/2023	METOPROLOL SUCC ER 25 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	METOPROLOL SUCC ER 200 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	METOPROLOL SUCC ER 100 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	METOPROLOL SUCC ER 50 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	OXYBUTYNIN CL ER 15 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	OXYBUTYNIN CL ER 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	OXYBUTYNIN CL ER 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	OXYBUTYNIN 2.5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	ALFUZOSIN HCL ER 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	FINASTERIDE 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	FELODIPINE ER 2.5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	FELODIPINE ER 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	FELODIPINE ER 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	CIPROFLOXACIN HCL 500 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	LUBIPROSTONE 24 MCG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	LUBIPROSTONE 8 MCG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	DEXAMETHASONE 4 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISOLONE 15 MG/5 ML SOLN	Agregar al formulario, privilegiado	
10/1/2023	PREDNISOLONE SOD PH 25 MG/5 ML	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONONE 2.5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONONE 20 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONONE 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONONE 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONONE 50 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	ACID REDUCER 20 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PIOGLITAZONE HCL 45 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	METFORMIN HCL 1,000 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	METFORMIN HCL 500 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	GLIMEPIRIDE 4 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	GLIMEPIRIDE 2 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	GLIMEPIRIDE 1 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	MONTELUKAST SOD 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	FENOFIBRATE 145 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	CHOLESTYRAMINE POWDER	Agregar al formulario, privilegiado	
10/1/2023	EZETIMIBE 10 MG TABLET	Agregar al formulario, privilegiado	

10/1/2023	ROSUVASTATIN CALCIUM 5 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	ROSUVASTATIN CALCIUM 10 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DULOXETINE HCL DR 30 MG CAP	Agregar al formulario, privilegiado	
10/1/2023	DULOXETINE HCL DR 20 MG CAP	Agregar al formulario, privilegiado	
10/1/2023	DULOXETINE HCL DR 60 MG CAP	Agregar al formulario, privilegiado	
10/1/2023	PREGABALIN 25 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	PREGABALIN 100 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	PREGABALIN 50 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	PREGABALIN 150 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	PREGABALIN 225 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	PREGABALIN 300 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	PREGABALIN 200 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	PREGABALIN 75 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	GABAPENTIN 100 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	GABAPENTIN 300 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	DICLOFENAC EPOLAMINE 1.3% PTCH	Agregar al formulario, privilegiado	
10/1/2023	CHILDREN IBUPROFEN 100 MG/5 ML	Agregar al formulario, privilegiado	
10/1/2023	DICLOFENAC SOD DR 25 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DICLOFENAC SOD DR 50 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DICLOFENAC SOD DR 75 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	TOBRADEX EYE DROPS	Agregar al formulario, privilegiado	
10/1/2023	TIMOLOL MALEATE 0.5% EYE DROP	Agregar al formulario, privilegiado	
10/1/2023	TIMOLOL 0.5% GEL-SOLUTION	Agregar al formulario, privilegiado	
10/1/2023	TIMOLOL 0.25% GEL-SOLUTION	Agregar al formulario, privilegiado	
10/1/2023	CALCIUM ACETATE 667 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	DANTROLENE SODIUM 50 MG CAP	Agregar al formulario, privilegiado	
10/1/2023	DANTROLENE SODIUM 100 MG CAP	Agregar al formulario, privilegiado	
10/1/2023	DANTROLENE SODIUM 25 MG CAP	Agregar al formulario, privilegiado	
10/1/2023	CLOBETASOL 0.05% SOLUTION	Agregar al formulario, privilegiado	
10/1/2023	ENOXAPARIN 40 MG/0.4 ML SYR	Agregar al formulario, privilegiado	
10/1/2023	ENOXAPARIN 30 MG/0.3 ML SYR	Agregar al formulario, privilegiado	
10/1/2023	LOXAPINE 10 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	LOXAPINE 25 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	LOXAPINE 5 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	LOXAPINE 50 MG CAPSULE	Agregar al formulario, privilegiado	
10/1/2023	DARUNAVIR 600 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	DARUNAVIR 800 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	SUNLENCA 4- 300 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	SUNLENCA 463.5 MG/1.5 ML VIAL	Agregar al formulario, privilegiado	
10/1/2023	SUNLENCA 5- 300 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	AUSTEDO XR 24 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	AUSTEDO XR 6 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	AUSTEDO XR 12 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	OXBRYTA 300 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	DEXTROAMP-AMPHETAM 12.5 MG	Agregar al formulario, privilegiado	

	TAB		
10/1/2023	DEXTROAMP-AMPHETAM 7.5 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DEXTROAMP-AMPHETAMIN 10 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DEXTROAMP-AMPHETAMIN 15 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DEXTROAMP-AMPHETAMIN 20 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DEXTROAMP-AMPHETAMIN 30 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DEXTROAMP-AMPHETAMINE 5 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	DEXTROAMPHETAMINE 10 MG TAB	Agregar al formulario, privilegiado	
10/1/2023	METRONIDAZOLE TOPICAL 0.75% GL	Actualización para privilegiado	
10/1/2023	ZENZEDI 15 MG TABLET	Actualización para privilegiado	
10/1/2023	ZENZEDI 20 MG TABLET	Actualización para privilegiado	
10/1/2023	ZENZEDI 30 MG TABLET	Actualización para privilegiado	
10/1/2023	Voxelotor Tab 300 MG	Agregar PA	
10/1/2023	Timothy Grass Pollen Allergen Ext SL Tab 2800 BAU	Agregar QL	1 por día
10/1/2023	Epinephrine Solution Auto-injector 0.1 MG/0.1ML	Agregar QL	12 por 365 días
10/1/2023	Deutetrabenazine Tab ER 24HR 24 MG	Agregar QL	4 por día
10/1/2023	Deutetrabenazine Tab ER 24HR 6 MG	Agregar QL	4 por día
10/1/2023	Deutetrabenazine Tab ER 24HR 12 MG	Agregar QL	4 por día
10/1/2023	Midazolam Nasal Spray Soln 5 MG/0.1 ML	Agregar QL	10 por 24 días
10/1/2023	Risperidone Microspheres For IM Extended Rel Susp 25 MG	Agregar QL	2 por 22 días
10/1/2023	Risperidone Microspheres For IM Extended Rel Susp 37.5 MG	Agregar QL	2 por 22 días
10/1/2023	Risperidone Microspheres For IM Extended Rel Susp 50 MG	Agregar QL	2 por 22 días
10/1/2023	Semaglutide Soln Pen-inj 0.25 or 0.5 MG/DOSE (2 MG/3ML)	Agregar QL	3mL por 22 días
10/1/2023	Dulaglutide Soln Pen-injector 3 MG/0.5ML	Agregar QL	2mL por 22 días
10/1/2023	Dulaglutide Soln Pen-injector 4.5 MG/0.5ML	Agregar QL	2mL por 22 días
10/1/2023	Alendronate Sodium Tab 5 MG	Eliminar QL	
10/1/2023	Ivermectin Cream 1%	Eliminar QL	
10/1/2023	Cabotegravir 400 MG/2ML & Rilpivirine 600 MG/2ML IM Susp ER	Actualizar QL	12mL por 67 días
10/1/2023	Short Ragweed Pollen Allergen Extract SL Tab 12 Amb a 1-U	Limite de edad	Edad mínima 5
10/1/2023	*Dust Mite Mixed Ext SL Tab 12 SQ-HDM***	Limite de edad	Edad mínima 18

10/1/2023	Timothy Grass Pollen Allergen Ext SL Tab 2800 BAU	Limite de edad	Edad mínima 5
10/1/2023	Codeine Phos-Chlorpheniramine Maleate Tab ER 12HR 54.3-8 MG	Limite de edad	Edad mínima 6
10/1/2023	Sildenafil Citrate Oral Susp 10 MG/ML	Limite de edad	Edad mínima 18
10/1/2023	Zavegepant HCl Nasal Spray 10 MG/ACT	Limite de edad	Edad mínima 18
10/1/2023	Aripiprazole IM ER Susp Prefilled Syringe 720 MG/2.4ML	Limite de edad	Edad mínima 18
10/1/2023	Aripiprazole IM ER Susp Prefilled Syringe 960 MG/3.2ML	Limite de edad	Edad mínima 18
10/1/2023	Lenacapavir Sodium Tab Therapy Pack 4 x 300 MG	Limite de edad	Edad mínima 18
10/1/2023	Lenacapavir Sodium Subcutaneous Soln 463.5 MG/1.5ML	Limite de edad	Edad mínima 18
10/1/2023	Lenacapavir Sodium Tab Therapy Pack 5 x 300 MG	Limite de edad	Edad mínima 18
10/1/2023	Deutetrabenazine Tab ER 24HR 24 MG	Limite de edad	Edad mínima 18
10/1/2023	Deutetrabenazine Tab ER 24HR 6 MG	Limite de edad	Edad mínima 18
10/1/2023	Deutetrabenazine Tab ER 24HR 12 MG	Limite de edad	Edad mínima 18
10/1/2023	Fingolimod HCl Cap 0.25 MG (Base Equiv)	Limite de edad	Edad mínima 10
10/1/2023	Voxelotor Tab 300 MG	Limite de edad	Edad mínima 12
10/1/2023	Fenfluramine HCl Oral Soln 2.2 MG/ML	Eliminar Limite de edad	
10/1/2023	Elbasvir-Grazoprevir Tab 50-100 MG	Eliminar Limite de edad	
10/1/2023	Ombitas-Paritapre-Riton & Dasab Tab Pak 12.5-75-50 & 250 MG	Eliminar Limite de edad	
10/1/2023	Sofosbuvir Tab 200 MG	Eliminar Limite de edad	
10/1/2023	Sofosbuvir-Velpatasvir-Voxilaprevir Tab 400-100-100 MG	Eliminar Limite de edad	
10/1/2023	Sofosbuvir Tab 400 MG	Eliminar Limite de edad	
10/1/2023	Sofosbuvir Pellet Pack 200 MG	Eliminar Limite de edad	
10/1/2023	Sofosbuvir Pellet Pack 150 MG	Eliminar Limite de edad	
10/1/2023	Lixisenatide Pen-inj Starter Kit 10 MCG/0.2ML & 20 MCG/0.2ML	Eliminar Limite de edad	
10/1/2023	Lixisenatide Soln Pen-injector 20 MCG/0.2ML (100 MCG/ML)	Eliminar Limite de edad	
10/1/2023	Exenatide Extended Release Susp Auto-Injector 2 MG/0.85ML	Eliminar Limite de edad	
10/1/2023	Exenatide Soln Pen-injector 10 MCG/0.04ML	Eliminar Limite de edad	
10/1/2023	Exenatide Soln Pen-injector 5 MCG/0.02ML	Eliminar Limite de edad	
10/1/2023	Pramlintide Acetate Pen-inj 2700 MCG/2.7ML (1000 MCG/ML)	Eliminar Limite de edad	
10/1/2023	Pramlintide Acetate Pen-inj 1500 MCG/1.5ML (1000 MCG/ML)	Eliminar Limite de edad	
10/1/2023	Dulaglutide Soln Pen-injector 0.75	Eliminar Limite de edad	

	MG/0.5ML		
10/1/2023	Dulaglutide Soln Pen-injector 1.5 MG/0.5ML	Eliminar Limite de edad	

LEYENDA

AGE	Límite de edad
CL	Medicamentos de Clase Cerrada
MED	Dosis equivalente de morfina de 90 mg como máximo por día
OTC	Medicamento de venta libre, beneficio cubierto con una receta médica
PA	Autorización previa
PA, QL	Límite de cantidad que se aplica después de la aprobación de la Autorización Previa
QL	Límite de Cantidad
SP	Medicamento de especialidad
ST	Terapia progresiva
<i>minúscula</i>	Indica disponibilidad genérica
MAYÚSCULA	Indica disponibilidad de la marca

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Drug Name	Formulary Status	Requirements/Limits
ACNE AGENTS, TOPICAL [OPEN CLASS]		
ACANYA GEL 1.2-2.5 % EXTERNAL (<i>clindamycin phos-benzoyl perox</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>acne medication 10 gel 10 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>acne medication 10 lotion 10 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>acne medication 2.5 gel 2.5 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>acne medication 5 gel 5 % external (otc)</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>acne medication 5 lotion 5 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>adapalene cream 0.1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>adapalene gel 0.1 % external (otc)</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>adapalene gel 0.3 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>adapalene-benzoyl peroxide gel 0.1-2.5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>adapalene-benzoyl peroxide gel 0.3-2.5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
ALTRENO LOTION 0.05 % EXTERNAL (<i>tretinoin</i>)	Non Preferred	PA; AGE (Max 18 Years)
AMZEEQ FOAM 4 % EXTERNAL (<i>minocycline hcl micronized</i>)	Non Preferred	PA; AGE (Min 9 Years and Max 18 Years)
ARAZLO LOTION 0.045 % EXTERNAL (<i>tazarotene</i>)	Non Preferred	PA; AGE (Max 18 Years)
ATRALIN GEL 0.05 % EXTERNAL (<i>tretinoin</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur</i> (Avar Cleanser Liquid 10-5 % External)	Non Preferred	PA; AGE (Max 18 Years)
AVAR LS CLEANSER LIQUID 10-2 % EXTERNAL (<i>sulfacetamide sodium-sulfur</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur</i> (Avar-E Emollient Cream 10-5 % External)	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur</i> (Avar-E Green Cream 10-5 % External)	Non Preferred	PA; AGE (Max 18 Years)
AVAR-E LS CREAM 10-2 % EXTERNAL (<i>sulfacetamide sodium-sulfur</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin</i> (Avita Cream 0.025 % External)	Non Preferred	PA; AGE (Max 18 Years)
BENZAMYCIN GEL 5-3 % EXTERNAL (<i>benzoyl peroxide-erythromycin</i>)	Non Preferred	PA; AGE (Max 18 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
BENZEFOAM FOAM 5.3 % EXTERNAL (OTC) (<i>benzoyl peroxide</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>benzoyl peroxide gel 10 % external (otc)</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>benzoyl peroxide gel 2.5 % external (otc)</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>benzoyl peroxide gel 5 % external (otc)</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>benzoyl peroxide wash liquid 10 % external (otc)</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>benzoyl peroxide wash liquid 5 % external (otc)</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>benzoyl peroxide-erythromycin gel 5-3 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>bp 10-1 emulsion 10-1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>bp cleansing wash emulsion 10-4 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>bpo foaming cloths 6 % external (otc)</i>	Non Preferred	PA; AGE (Max 18 Years)
CLEOCIN-T LOTION 1 % EXTERNAL (<i>clindamycin phosphate</i>)	Non Preferred	PA; AGE (Max 18 Years)
CLINDACIN ETZ KIT 1 % EXTERNAL (<i>clindamycin phos & cleanser</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate</i> (Clindacin Etz Swab 1 % External)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>clindamycin phosphate</i> (Clindacin Foam 1 % External)	Non Preferred	PA; AGE (Max 18 Years)
CLINDACIN PAC KIT 1 % EXTERNAL (<i>clindamycin phos & cleanser</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate</i> (Clindacin-P Swab 1 % External)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
CLINDAGEL GEL 1 % EXTERNAL (<i>clindamycin phosphate</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phos-benzoyl perox gel 1.2-2.5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phos-benzoyl perox gel 1.2-5 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>clindamycin phos-benzoyl perox gel 1-5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate foam 1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate gel 1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>clindamycin phosphate lotion 1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>clindamycin phosphate solution 1 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>clindamycin phosphate swab 1 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>clindamycin-tretinoin gel 1.2-0.025 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>dapsone gel 5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>dapsone gel 7.5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
DERMACINRX ATRIX ANTIBAC WASH LIQUID 2 % EXTERNAL (<i>salicylic acid</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>ery pad 2 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
ERYGEL GEL 2 % EXTERNAL (<i>erythromycin</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>erythromycin gel 2 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>erythromycin solution 2 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
FABIOR FOAM 0.1 % EXTERNAL (<i>tazarotene</i>)	Non Preferred	PA; AGE (Min 12 Years and Max 18 Years)
<i>clindamycin-benzoyl per (refr)</i> (Neuac Gel 1.2-5 % External)	Non Preferred	PA; AGE (Max 18 Years)
ONEXTON GEL 1.2-3.75 % EXTERNAL (<i>clindamycin phosphobenzoyl perox</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS CREAM 10 % EXTERNAL (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS LOTION 9.8 % EXTERNAL (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS SHAMPOO 10 % EXTERNAL (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS WASH GEL 10 % EXTERNAL (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS WASH LIQUID 10 % EXTERNAL (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
OVACE WASH LIQUID 10 % EXTERNAL (<i>sulfacetamide sodium</i>)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A CREAM 0.025 % EXTERNAL (<i>tretinoin</i>)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
RETIN-A CREAM 0.05 % EXTERNAL (<i>tretinoin</i>)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
RETIN-A CREAM 0.1 % EXTERNAL (<i>tretinoin</i>)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
RETIN-A GEL 0.01 % EXTERNAL (<i>tretinoin</i>)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
RETIN-A GEL 0.025 % EXTERNAL (<i>tretinoin</i>)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
RETIN-A MICRO GEL 0.04 % EXTERNAL (<i>tretinoin microsphere</i>)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO GEL 0.1 % EXTERNAL (<i>tretinoin microsphere</i>)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO PUMP GEL 0.04 % EXTERNAL (<i>tretinoin microsphere</i>)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO PUMP GEL 0.06 % EXTERNAL (<i>tretinoin microsphere</i>)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO PUMP GEL 0.08 % EXTERNAL (<i>tretinoin microsphere</i>)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO PUMP GEL 0.1 % EXTERNAL (<i>tretinoin microsphere</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>sodium sulfacetamide shampoo 10 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sodium sulfacetamide wash liquid 10 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sss 10-5 cream 10-5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sss 10-5 foam 10-5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium (acne) lotion 10 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium (cleans) gel 10 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium liquid 10 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur cream 10-2 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur cream 10-5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur liquid 10-2 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur liquid 10-5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur liquid 9.8-4.8 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur liquid 9-4 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur liquid 9-4.5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur lotion 10-5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur pad 10-4 % external</i>	Non Preferred	PA; AGE (Max 18 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
<i>sulfacetamide sodium-sulfur suspension 10-5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sodium-sulfur suspension 8-4 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide sod-sulfur wash liquid 9-4.5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>sulfacetamide-sulfur in urea emulsion 10-5 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN KIT 9-4.5 % EXTERNAL (<i>sulfacetamide-sulfur-cleanser</i>)	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN WASH LIQUID 9-4.5 % EXTERNAL (<i>sulfacetamide sodium-sulfur</i>)	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN XLT KIT 9-4.5 % EXTERNAL (<i>sulfacetamide-sulfur-sunscreen</i>)	Non Preferred	PA; AGE (Max 18 Years)
SUMAXIN CP KIT 10-4 % EXTERNAL (<i>sulfacetamide-sulfur-cleanser</i>)	Non Preferred	PA; AGE (Max 18 Years)
<i>tazarotene cream 0.1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tazarotene foam 0.1 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Min 12 Years and Max 18 Years)
<i>tazarotene gel 0.05 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tazarotene gel 0.1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin cream 0.025 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>tretinoin cream 0.05 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>tretinoin cream 0.1 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>tretinoin gel 0.01 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>tretinoin gel 0.025 % external</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
<i>tretinoin gel 0.05 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin microsphere gel 0.04 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin microsphere gel 0.1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin microsphere pump gel 0.04 % external</i>	Non Preferred	PA; AGE (Max 18 Years)
<i>tretinoin microsphere pump gel 0.1 % external</i>	Non Preferred	PA; AGE (Max 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
WINLEVI CREAM 1 % EXTERNAL (<i>clascoterone</i>)	Non Preferred	PA; AGE (Min 12 Years and Max 18 Years)
ZIANA GEL 1.2-0.025 % EXTERNAL (<i>clindamycin-tretinoin</i>)	Non Preferred	PA; AGE (Max 18 Years)
ALZHEIMER'S AGENTS [OPEN CLASS]		
ADLARITY PATCH WEEKLY 10 MG/DAY TRANSDERMAL (<i>donepezil hcl</i>)	Non Preferred	PA
ADLARITY PATCH WEEKLY 5 MG/DAY TRANSDERMAL (<i>donepezil hcl</i>)	Non Preferred	PA
ARICEPT TABLET 10 MG ORAL (<i>donepezil hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ARICEPT TABLET 23 MG ORAL (<i>donepezil hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ARICEPT TABLET 5 MG ORAL (<i>donepezil hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>donepezil hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>donepezil hcl tablet 23 mg oral</i>	Preferred	Max 90-day supply per fill
<i>donepezil hcl tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>donepezil hcl tablet dispersible 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>donepezil hcl tablet dispersible 5 mg oral</i>	Preferred	Max 90-day supply per fill
EXELON PATCH 24 HOUR 13.3 MG/24HR TRANSDERMAL (<i>rivastigmine</i>)	Non Preferred	PA; Max 90-day supply per fill
EXELON PATCH 24 HOUR 4.6 MG/24HR TRANSDERMAL (<i>rivastigmine</i>)	Non Preferred	PA; Max 90-day supply per fill
EXELON PATCH 24 HOUR 9.5 MG/24HR TRANSDERMAL (<i>rivastigmine</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>galantamine hydrobromide er capsule extended release 24 hour 16 mg oral</i>	Non Preferred	PA
<i>galantamine hydrobromide er capsule extended release 24 hour 24 mg oral</i>	Non Preferred	PA
<i>galantamine hydrobromide er capsule extended release 24 hour 8 mg oral</i>	Non Preferred	PA
<i>galantamine hydrobromide solution 4 mg/ml oral</i>	Non Preferred	PA
<i>galantamine hydrobromide tablet 12 mg oral</i>	Non Preferred	PA
<i>galantamine hydrobromide tablet 4 mg oral</i>	Non Preferred	PA
<i>galantamine hydrobromide tablet 8 mg oral</i>	Non Preferred	PA
<i>memantine hcl er capsule extended release 24 hour 14 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl er capsule extended release 24 hour 21 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>memantine hcl er capsule extended release 24 hour 28 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl er capsule extended release 24 hour 7 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl solution 2 mg/ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>memantine hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>memantine hcl tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
NAMENDA TABLET 10 MG ORAL (<i>memantine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
NAMENDA TABLET 5 MG ORAL (<i>memantine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
NAMZARIC CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 & 28 -10 MG ORAL (<i>memantine hcl-donepezil hcl</i>)	Non Preferred	PA
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG ORAL (<i>memantine hcl-donepezil hcl</i>)	Non Preferred	PA
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 21-10 MG ORAL (<i>memantine hcl-donepezil hcl</i>)	Non Preferred	PA
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 28-10 MG ORAL (<i>memantine hcl-donepezil hcl</i>)	Non Preferred	PA
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR 7-10 MG ORAL (<i>memantine hcl-donepezil hcl</i>)	Non Preferred	PA
<i>rivastigmine patch 24 hour 13.3 mg/24hr transdermal</i>	Preferred	Max 90-day supply per fill
<i>rivastigmine patch 24 hour 4.6 mg/24hr transdermal</i>	Preferred	Max 90-day supply per fill
<i>rivastigmine patch 24 hour 9.5 mg/24hr transdermal</i>	Preferred	Max 90-day supply per fill
<i>rivastigmine tartrate capsule 1.5 mg oral</i>	Non Preferred	PA
<i>rivastigmine tartrate capsule 3 mg oral</i>	Non Preferred	PA
<i>rivastigmine tartrate capsule 4.5 mg oral</i>	Non Preferred	PA
<i>rivastigmine tartrate capsule 6 mg oral</i>	Non Preferred	PA
ANDROGENIC AGENTS [OPEN CLASS]		
ANDRODERM PATCH 24 HOUR 2 MG/24HR TRANSDERMAL (<i>testosterone</i>)	Preferred	AGE (Min 18 Years)
ANDRODERM PATCH 24 HOUR 4 MG/24HR TRANSDERMAL (<i>testosterone</i>)	Preferred	AGE (Min 18 Years)
ANDROGEL PUMP GEL 20.25 MG/ACT (1.62%) TRANSDERMAL (<i>testosterone</i>)	Preferred	
FORTESTA GEL 10 MG/ACT (2%) TRANSDERMAL (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
NATESTO GEL 5.5 MG/ACT NASAL (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
TESTIM GEL 50 MG/5GM (1%) TRANSDERMAL (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>testosterone gel 1.62 % transdermal</i>	Preferred	
<i>testosterone gel 10 mg/act (2%) transdermal</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>testosterone gel 12.5 mg/act (1%) transdermal</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>testosterone gel 20.25 mg/1.25gm (1.62%) transdermal</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>testosterone gel 20.25 mg/act (1.62%) transdermal</i>	Preferred	
<i>testosterone gel 25 mg/2.5gm (1%) transdermal</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>testosterone gel 40.5 mg/2.5gm (1.62%) transdermal</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>testosterone gel 50 mg/5gm (1%) transdermal</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>testosterone solution 30 mg/act transdermal</i>	Non Preferred	PA; AGE (Min 18 Years)
VOGELXO GEL 50 MG/5GM (1%) TRANSDERMAL (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
VOGELXO PUMP GEL 12.5 MG/ACT (1%) TRANSDERMAL (<i>testosterone</i>)	Non Preferred	PA; AGE (Min 18 Years)
ANTI-ALLERGENS, ORAL [OPEN CLASS]		
GRASTEK TABLET SUBLINGUAL 2800 BAU SUBLINGUAL (<i>timothy grass pollen allergen</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 5 Years)
ODACTRA TABLET SUBLINGUAL 12 SQ-HDM SUBLINGUAL (<i>dust mite mixed allergen ext</i>)	Non Preferred	PA; AGE (Min 12 Years and Max 65 Years)
ORALAIR TABLET SUBLINGUAL 300 IR SUBLINGUAL (<i>grass mix pollens allergen ext</i>)	Non Preferred	PA; AGE (Min 5 Years)
PALFORZIA (12 MG DAILY DOSE) 2 X 1 MG & 10 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (120 MG DAILY DOSE) 20 MG & 100 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (160 MG DAILY DOSE) 3 X 20 MG & 100 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (20 MG DAILY DOSE) 20 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (200 MG DAILY DOSE) 2 X 100 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (240 MG DAILY DOSE) 2 X 20 MG & 2 X 100 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (3 MG DAILY DOSE) 3 X 1 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (300 MG MAINTENANCE) PACKET 300 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)

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Drug Name	Formulary Status	Requirements/Limits
PALFORZIA (300 MG TITRATION) PACKET 300 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (40 MG DAILY DOSE) 2 X 20 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (6 MG DAILY DOSE) 6 X 1 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (80 MG DAILY DOSE) 4 X 20 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA INITIAL ESCALATION 0.5 & 1 & 1.5 & 3 & 6 MG ORAL (<i>peanut powder-dnfp</i>)	Non Preferred	PA; AGE (Min 4 Years)
RAGWITEK TABLET SUBLINGUAL 12 AMB A 1-U SUBLINGUAL (<i>short ragweed pollen ext</i>)	Non Preferred	PA; AGE (Min 5 Years)
ANTIBIOTICS, INHALED [CLOSED CLASS]		
ARIKAYCE SUSPENSION 590 MG/8.4ML INHALATION (<i>amikacin sulfate liposome</i>)	Non Preferred	PA; QL (235.2 ML per 28 days); AGE (Min 18 Years)
BETHKIS NEBULIZATION SOLUTION 300 MG/4ML INHALATION (<i>tobramycin</i>)	Preferred	QL (224 ML per 28 days); AGE (Min 6 Years)
CAYSTON SOLUTION RECONSTITUTED 75 MG INHALATION (<i>aztreonam lysine</i>)	Non Preferred	PA; QL (84 ML per 28 days); AGE (Min 7 Years)
KITABIS PAK NEBULIZATION SOLUTION 300 MG/5ML INHALATION (<i>tobramycin</i>)	Preferred	QL (280 ML per 28 days); AGE (Min 6 Years)
TOBI NEBULIZATION SOLUTION 300 MG/5ML INHALATION (<i>tobramycin</i>)	Non Preferred	PA; QL (280 ML per 28 days); AGE (Min 6 Years)
TOBI PODHALER CAPSULE 28 MG INHALATION (<i>tobramycin</i>)	Preferred	PA; QL (224 EA per 28 days); AGE (Min 6 Years)
<i>tobramycin nebulization solution 300 mg/4ml inhalation</i>	Non Preferred	PA; QL (224 ML per 28 days); AGE (Min 6 Years)
<i>tobramycin nebulization solution 300 mg/5ml inhalation</i>	Non Preferred	PA; QL (280 ML per 28 days); AGE (Min 6 Years)
<i>tobramycin nebulization solution 300 mg/5ml inhalation</i>	Preferred	QL (280 ML per 28 days); AGE (Min 6 Years)
ANTICOAGULANTS [CLOSED CLASS]		
ARIXTRA SOLUTION 10 MG/0.8ML SUBCUTANEOUS (<i>fondaparinux sodium</i>)	Non Preferred	PA
ARIXTRA SOLUTION 2.5 MG/0.5ML SUBCUTANEOUS (<i>fondaparinux sodium</i>)	Non Preferred	PA
ARIXTRA SOLUTION 5 MG/0.4ML SUBCUTANEOUS (<i>fondaparinux sodium</i>)	Non Preferred	PA
ARIXTRA SOLUTION 7.5 MG/0.6ML SUBCUTANEOUS (<i>fondaparinux sodium</i>)	Non Preferred	PA
<i>dabigatran etexilate mesylate capsule 150 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>dabigatran etexilate mesylate capsule 75 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
ELIQUIS DVT/PE STARTER PACK TABLET THERAPY PACK 5 MG ORAL (<i>apixaban</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ELIQUIS TABLET 2.5 MG ORAL (<i>apixaban</i>)	Preferred	Max 90-day supply per fill
ELIQUIS TABLET 5 MG ORAL (<i>apixaban</i>)	Preferred	Max 90-day supply per fill
<i>enoxaparin sodium solution 150 mg/ml injection</i>	Preferred	
<i>enoxaparin sodium solution 300 mg/3ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 100 mg/ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 120 mg/0.8ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 150 mg/ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 30 mg/0.3ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 40 mg/0.4ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 60 mg/0.6ml injection</i>	Preferred	
<i>enoxaparin sodium solution prefilled syringe 80 mg/0.8ml injection</i>	Preferred	
<i>fondaparinux sodium solution 10 mg/0.8ml subcutaneous</i>	Non Preferred	PA
<i>fondaparinux sodium solution 2.5 mg/0.5ml subcutaneous</i>	Non Preferred	PA
<i>fondaparinux sodium solution 5 mg/0.4ml subcutaneous</i>	Non Preferred	PA
<i>fondaparinux sodium solution 7.5 mg/0.6ml subcutaneous</i>	Non Preferred	PA
FRAGMIN SOLUTION 10000 UNIT/4ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SOLUTION 95000 UNIT/3.8ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SOLUTION PREFILLED SYRINGE 10000 UNIT/ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SOLUTION PREFILLED SYRINGE 12500 UNIT/0.5ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SOLUTION PREFILLED SYRINGE 15000 UNIT/0.6ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SOLUTION PREFILLED SYRINGE 18000 UNT/0.72ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SOLUTION PREFILLED SYRINGE 2500 UNIT/0.2ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SOLUTION PREFILLED SYRINGE 5000 UNIT/0.2ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
FRAGMIN SOLUTION PREFILLED SYRINGE 7500 UNIT/0.3ML SUBCUTANEOUS (<i>dalteparin sodium</i>)	Non Preferred	PA
<i>warfarin sodium</i> (Jantoven Tablet 1 Mg Oral)	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>warfarin sodium</i> (Jantoven Tablet 10 Mg Oral)	Preferred	Max 90-day supply per fill
<i>warfarin sodium</i> (Jantoven Tablet 2 Mg Oral)	Preferred	Max 90-day supply per fill
<i>warfarin sodium</i> (Jantoven Tablet 2.5 Mg Oral)	Preferred	Max 90-day supply per fill
<i>warfarin sodium</i> (Jantoven Tablet 3 Mg Oral)	Preferred	Max 90-day supply per fill
<i>warfarin sodium</i> (Jantoven Tablet 4 Mg Oral)	Preferred	Max 90-day supply per fill
<i>warfarin sodium</i> (Jantoven Tablet 5 Mg Oral)	Preferred	Max 90-day supply per fill
<i>warfarin sodium</i> (Jantoven Tablet 6 Mg Oral)	Preferred	Max 90-day supply per fill
<i>warfarin sodium</i> (Jantoven Tablet 7.5 Mg Oral)	Preferred	Max 90-day supply per fill
LOVENOX SOLUTION 300 MG/3ML INJECTION (<i>enoxaparin sodium</i>)	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 100 MG/ML INJECTION (<i>enoxaparin sodium</i>)	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 120 MG/0.8ML INJECTION (<i>enoxaparin sodium</i>)	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 150 MG/ML INJECTION (<i>enoxaparin sodium</i>)	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 30 MG/0.3ML INJECTION (<i>enoxaparin sodium</i>)	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 40 MG/0.4ML INJECTION (<i>enoxaparin sodium</i>)	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 60 MG/0.6ML INJECTION (<i>enoxaparin sodium</i>)	Non Preferred	PA
LOVENOX SOLUTION PREFILLED SYRINGE 80 MG/0.8ML INJECTION (<i>enoxaparin sodium</i>)	Non Preferred	PA
PRADAXA CAPSULE 110 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Preferred	Max 90-day supply per fill
PRADAXA CAPSULE 150 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Preferred	Max 90-day supply per fill
PRADAXA CAPSULE 75 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Preferred	Max 90-day supply per fill
PRADAXA PACKET 110 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Non Preferred	PA
PRADAXA PACKET 150 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Non Preferred	PA
PRADAXA PACKET 20 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Non Preferred	PA
PRADAXA PACKET 30 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Non Preferred	PA
PRADAXA PACKET 40 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Non Preferred	PA
PRADAXA PACKET 50 MG ORAL (<i>dabigatran etexilate mesylate</i>)	Non Preferred	PA
SAVAYSA TABLET 15 MG ORAL (<i>edoxaban tosylate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
SAVAYSA TABLET 30 MG ORAL (<i>edoxaban tosylate</i>)	Non Preferred	PA
SAVAYSA TABLET 60 MG ORAL (<i>edoxaban tosylate</i>)	Non Preferred	PA
<i>warfarin sodium tablet 1 mg oral</i>	Preferred	Max 90-day supply per fill
<i>warfarin sodium tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>warfarin sodium tablet 2 mg oral</i>	Preferred	Max 90-day supply per fill
<i>warfarin sodium tablet 2.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>warfarin sodium tablet 3 mg oral</i>	Preferred	Max 90-day supply per fill
<i>warfarin sodium tablet 4 mg oral</i>	Preferred	Max 90-day supply per fill
<i>warfarin sodium tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>warfarin sodium tablet 6 mg oral</i>	Preferred	Max 90-day supply per fill
<i>warfarin sodium tablet 7.5 mg oral</i>	Preferred	Max 90-day supply per fill
XARELTO STARTER PACK TABLET THERAPY PACK 15 & 20 MG ORAL (<i>rivaroxaban</i>)	Preferred	
XARELTO SUSPENSION RECONSTITUTED 1 MG/ML ORAL (<i>rivaroxaban</i>)	Preferred	Max 90-day supply per fill
XARELTO TABLET 10 MG ORAL (<i>rivaroxaban</i>)	Preferred	Max 90-day supply per fill
XARELTO TABLET 15 MG ORAL (<i>rivaroxaban</i>)	Preferred	Max 90-day supply per fill
XARELTO TABLET 2.5 MG ORAL (<i>rivaroxaban</i>)	Preferred	Max 90-day supply per fill
XARELTO TABLET 20 MG ORAL (<i>rivaroxaban</i>)	Preferred	Max 90-day supply per fill
ANTICONVULSANTS [CLOSED CLASS]		
APTIOM TABLET 200 MG ORAL (<i>eslicarbazepine acetate</i>)	Non Preferred	PA
APTIOM TABLET 400 MG ORAL (<i>eslicarbazepine acetate</i>)	Non Preferred	PA
APTIOM TABLET 600 MG ORAL (<i>eslicarbazepine acetate</i>)	Non Preferred	PA
APTIOM TABLET 800 MG ORAL (<i>eslicarbazepine acetate</i>)	Non Preferred	PA
BANZEL SUSPENSION 40 MG/ML ORAL (<i>rufinamide</i>)	Non Preferred	PA
BANZEL TABLET 200 MG ORAL (<i>rufinamide</i>)	Non Preferred	PA
BANZEL TABLET 400 MG ORAL (<i>rufinamide</i>)	Non Preferred	PA
BRIVIACT SOLUTION 10 MG/ML ORAL (<i>brivaracetam</i>)	Non Preferred	PA
BRIVIACT TABLET 10 MG ORAL (<i>brivaracetam</i>)	Non Preferred	PA
BRIVIACT TABLET 100 MG ORAL (<i>brivaracetam</i>)	Non Preferred	PA
BRIVIACT TABLET 25 MG ORAL (<i>brivaracetam</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
BRIVIACT TABLET 50 MG ORAL (<i>brivaracetam</i>)	Non Preferred	PA
BRIVIACT TABLET 75 MG ORAL (<i>brivaracetam</i>)	Non Preferred	PA
<i>carbamazepine er capsule extended release 12 hour 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbamazepine er capsule extended release 12 hour 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbamazepine er capsule extended release 12 hour 300 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbamazepine er tablet extended release 12 hour 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbamazepine er tablet extended release 12 hour 200 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbamazepine er tablet extended release 12 hour 400 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carbamazepine suspension 100 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>carbamazepine tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>carbamazepine tablet chewable 100 mg oral</i>	Preferred	Max 90-day supply per fill
CARBATROL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL (<i>carbamazepine</i>)	Preferred	Max 90-day supply per fill
CARBATROL CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL (<i>carbamazepine</i>)	Preferred	Max 90-day supply per fill
CARBATROL CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL (<i>carbamazepine</i>)	Preferred	Max 90-day supply per fill
CELONTIN CAPSULE 300 MG ORAL (<i>methsuximide</i>)	Non Preferred	PA
<i>clobazam suspension 2.5 mg/ml oral</i>	Preferred	
<i>clobazam tablet 10 mg oral</i>	Preferred	
<i>clobazam tablet 20 mg oral</i>	Preferred	
<i>clonazepam tablet 0.5 mg oral</i>	Preferred	
<i>clonazepam tablet 1 mg oral</i>	Preferred	
<i>clonazepam tablet 2 mg oral</i>	Preferred	
<i>clonazepam tablet dispersible 0.125 mg oral</i>	Non Preferred	PA
<i>clonazepam tablet dispersible 0.25 mg oral</i>	Non Preferred	PA
<i>clonazepam tablet dispersible 0.5 mg oral</i>	Non Preferred	PA
<i>clonazepam tablet dispersible 1 mg oral</i>	Non Preferred	PA
<i>clonazepam tablet dispersible 2 mg oral</i>	Non Preferred	PA
DEPAKOTE ER TABLET EXTENDED RELEASE 24 HOUR 250 MG ORAL (<i>divalproex sodium</i>)	Non Preferred	PA; Max 90-day supply per fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
DEPAKOTE ER TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL (<i>divalproex sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
DEPAKOTE SPRINKLES CAPSULE DELAYED RELEASE SPRINKLE 125 MG ORAL (<i>divalproex sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
DEPAKOTE TABLET DELAYED RELEASE 125 MG ORAL (<i>divalproex sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
DEPAKOTE TABLET DELAYED RELEASE 250 MG ORAL (<i>divalproex sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
DEPAKOTE TABLET DELAYED RELEASE 500 MG ORAL (<i>divalproex sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
DIACOMIT CAPSULE 250 MG ORAL (<i>stiripentol</i>)	Non Preferred	PA
DIACOMIT CAPSULE 500 MG ORAL (<i>stiripentol</i>)	Non Preferred	PA
DIACOMIT PACKET 250 MG ORAL (<i>stiripentol</i>)	Non Preferred	PA
DIACOMIT PACKET 500 MG ORAL (<i>stiripentol</i>)	Non Preferred	PA
DIASTAT ACUDIAL GEL 10 MG RECTAL (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DIASTAT ACUDIAL GEL 20 MG RECTAL (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DIASTAT PEDIATRIC GEL 2.5 MG RECTAL (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
<i>diazepam gel 10 mg rectal</i>	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
<i>diazepam gel 2.5 mg rectal</i>	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
<i>diazepam gel 20 mg rectal</i>	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DILANTIN CAPSULE 100 MG ORAL (<i>phenytoin sodium extended</i>)	Non Preferred	PA; Max 90-day supply per fill
DILANTIN CAPSULE 30 MG ORAL (<i>phenytoin sodium extended</i>)	Preferred	
DILANTIN INFATABS TABLET CHEWABLE 50 MG ORAL (<i>phenytoin</i>)	Non Preferred	PA; Max 90-day supply per fill
DILANTIN SUSPENSION 125 MG/5ML ORAL (<i>phenytoin</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>divalproex sodium capsule delayed release sprinkle 125 mg oral</i>	Preferred	Max 90-day supply per fill
<i>divalproex sodium er tablet extended release 24 hour 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>divalproex sodium er tablet extended release 24 hour 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>divalproex sodium tablet delayed release 125 mg oral</i>	Preferred	Max 90-day supply per fill
<i>divalproex sodium tablet delayed release 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>divalproex sodium tablet delayed release 500 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
ELEPSIA XR TABLET EXTENDED RELEASE 24 HOUR 1000 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA
ELEPSIA XR TABLET EXTENDED RELEASE 24 HOUR 1500 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA
EPIDIOLEX SOLUTION 100 MG/ML ORAL (<i>cannabidiol</i>)	Preferred	PA (Eligible for auto-PA); AGE (Min 1 Years)
<i>carbamazepine</i> (Eitol Tablet 200 Mg Oral)	Preferred	Max 90-day supply per fill
EPRONTIA SOLUTION 25 MG/ML ORAL (<i>topiramate</i>)	Non Preferred	PA
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL (<i>carbamazepine (antipsychotic)</i>)	Non Preferred	PA
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL (<i>carbamazepine (antipsychotic)</i>)	Non Preferred	PA
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL (<i>carbamazepine (antipsychotic)</i>)	Non Preferred	PA
<i>ethosuximide capsule 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ethosuximide solution 250 mg/5ml oral</i>	Preferred	AGE (Min 3 Years); Max 90-day supply per fill
<i>felbamate suspension 600 mg/5ml oral</i>	Non Preferred	PA
<i>felbamate tablet 400 mg oral</i>	Non Preferred	PA
<i>felbamate tablet 600 mg oral</i>	Non Preferred	PA
FELBATOL SUSPENSION 600 MG/5ML ORAL (<i>felbamate</i>)	Non Preferred	PA
FELBATOL TABLET 400 MG ORAL (<i>felbamate</i>)	Non Preferred	PA
FELBATOL TABLET 600 MG ORAL (<i>felbamate</i>)	Non Preferred	PA
FINTEPLA SOLUTION 2.2 MG/ML ORAL (<i>fenfluramine hcl</i>)	Non Preferred	PA; AGE (Min 2 Years)
FYCOMPA SUSPENSION 0.5 MG/ML ORAL (<i>perampanel</i>)	Non Preferred	PA
FYCOMPA TABLET 10 MG ORAL (<i>perampanel</i>)	Non Preferred	PA
FYCOMPA TABLET 12 MG ORAL (<i>perampanel</i>)	Non Preferred	PA
FYCOMPA TABLET 2 MG ORAL (<i>perampanel</i>)	Non Preferred	PA
FYCOMPA TABLET 4 MG ORAL (<i>perampanel</i>)	Non Preferred	PA
FYCOMPA TABLET 6 MG ORAL (<i>perampanel</i>)	Non Preferred	PA
FYCOMPA TABLET 8 MG ORAL (<i>perampanel</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>gabapentin capsule 100 mg oral</i>	Preferred	
<i>gabapentin capsule 300 mg oral</i>	Preferred	
KEPPRA SOLUTION 100 MG/ML ORAL (<i>levetiracetam</i>)	Non Preferred	PA; Max 90-day supply per fill
KEPPRA TABLET 1000 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA; Max 90-day supply per fill
KEPPRA TABLET 250 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA; Max 90-day supply per fill
KEPPRA TABLET 500 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA; Max 90-day supply per fill
KEPPRA TABLET 750 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA; Max 90-day supply per fill
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA; Max 90-day supply per fill
KEPPRA XR TABLET EXTENDED RELEASE 24 HOUR 750 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA; Max 90-day supply per fill
KLONOPIN TABLET 0.5 MG ORAL (<i>clonazepam</i>)	Non Preferred	PA
KLONOPIN TABLET 1 MG ORAL (<i>clonazepam</i>)	Non Preferred	PA
KLONOPIN TABLET 2 MG ORAL (<i>clonazepam</i>)	Non Preferred	PA
<i>lacosamide solution 10 mg/ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>lacosamide solution 10 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>lacosamide tablet 100 mg oral</i>	Preferred	
<i>lacosamide tablet 150 mg oral</i>	Preferred	
<i>lacosamide tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lacosamide tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
LAMICTAL ODT KIT 21 X 25 MG & 7 X 50 MG ORAL (<i>lamotrigine</i>)	Preferred	
LAMICTAL ODT KIT 25 & 50 & 100 MG ORAL (<i>lamotrigine</i>)	Preferred	
LAMICTAL ODT KIT 42 X 50 MG & 14X100 MG ORAL (<i>lamotrigine</i>)	Preferred	
LAMICTAL ODT TABLET DISPERSIBLE 100 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Maximum 90-day supply per fill
LAMICTAL ODT TABLET DISPERSIBLE 200 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Maximum 90-day supply per fill
LAMICTAL ODT TABLET DISPERSIBLE 25 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Maximum 90-day supply per fill
LAMICTAL ODT TABLET DISPERSIBLE 50 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Maximum 90-day supply per fill
LAMICTAL STARTER KIT 35 X 25 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
LAMICTAL STARTER KIT 42 X 25 MG & 7 X 100 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL STARTER KIT 84 X 25 MG & 14X100 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL TABLET 100 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL TABLET 150 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL TABLET 200 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL TABLET 25 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL TABLET CHEWABLE 25 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL TABLET CHEWABLE 5 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL XR KIT 21 X 25 MG & 7 X 50 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL XR KIT 25 & 50 & 100 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL XR KIT 50 & 100 & 200 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 250 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
LAMICTAL XR TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL (<i>lamotrigine</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine er tablet extended release 24 hour 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine kit 21 x 25 mg & 7 x 50 mg oral</i>	Non Preferred	PA
<i>lamotrigine kit 25 & 50 & 100 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>lamotrigine kit 42 x 50 mg & 14x100 mg oral</i>	Non Preferred	PA
<i>lamotrigine starter kit-blue kit 35 x 25 mg oral</i>	Non Preferred	PA
<i>lamotrigine starter kit-green kit 84 x 25 mg & 14x100 mg oral</i>	Non Preferred	PA
<i>lamotrigine starter kit-orange kit 42 x 25 mg & 7 x 100 mg oral</i>	Non Preferred	PA
<i>lamotrigine tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine tablet 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine tablet chewable 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine tablet chewable 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lamotrigine tablet dispersible 100 mg oral</i>	Preferred	Maximum 90-day supply per fill
<i>lamotrigine tablet dispersible 200 mg oral</i>	Preferred	Maximum 90-day supply per fill
<i>lamotrigine tablet dispersible 25 mg oral</i>	Preferred	Maximum 90-day supply per fill
<i>lamotrigine tablet dispersible 50 mg oral</i>	Preferred	Maximum 90-day supply per fill
<i>levetiracetam er tablet extended release 24 hour 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>levetiracetam er tablet extended release 24 hour 750 mg oral</i>	Preferred	Max 90-day supply per fill
<i>levetiracetam solution 100 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>levetiracetam tablet 1000 mg oral</i>	Preferred	Max 90-day supply per fill
<i>levetiracetam tablet 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>levetiracetam tablet 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>levetiracetam tablet 750 mg oral</i>	Preferred	Max 90-day supply per fill
<i>methsuximide capsule 300 mg oral</i>	Non Preferred	PA
MYSOLINE TABLET 250 MG ORAL (<i>primidone</i>)	Non Preferred	PA; Max 90-day supply per fill
MYSOLINE TABLET 50 MG ORAL (<i>primidone</i>)	Non Preferred	PA; Max 90-day supply per fill
NAYZILAM SOLUTION 5 MG/0.1ML NASAL (<i>midazolam (anticonvulsant)</i>)	Preferred	PA (Eligible for auto-PA); QL (10 EA per 30 days); AGE (Min 12 Years)
ONFI SUSPENSION 2.5 MG/ML ORAL (<i>clobazam</i>)	Non Preferred	PA
ONFI TABLET 10 MG ORAL (<i>clobazam</i>)	Non Preferred	PA
ONFI TABLET 20 MG ORAL (<i>clobazam</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>oxcarbazepine suspension 300 mg/5ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>oxcarbazepine tablet 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>oxcarbazepine tablet 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>oxcarbazepine tablet 600 mg oral</i>	Preferred	Max 90-day supply per fill
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL (<i>oxcarbazepine</i>)	Non Preferred	PA
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>oxcarbazepine</i>)	Non Preferred	PA
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 600 MG ORAL (<i>oxcarbazepine</i>)	Non Preferred	PA
<i>phenobarbital elixir 20 mg/5ml oral</i>	Preferred	
<i>phenobarbital tablet 100 mg oral</i>	Preferred	
<i>phenobarbital tablet 15 mg oral</i>	Preferred	
<i>phenobarbital tablet 16.2 mg oral</i>	Preferred	
<i>phenobarbital tablet 30 mg oral</i>	Preferred	
<i>phenobarbital tablet 32.4 mg oral</i>	Preferred	
<i>phenobarbital tablet 60 mg oral</i>	Preferred	
<i>phenobarbital tablet 64.8 mg oral</i>	Preferred	
<i>phenobarbital tablet 97.2 mg oral</i>	Preferred	
<i>phenytoin sodium extended (Phenytek Capsule 200 Mg Oral)</i>	Non Preferred	PA; Max 90-day supply per fill
<i>phenytoin sodium extended (Phenytek Capsule 300 Mg Oral)</i>	Non Preferred	PA; Max 90-day supply per fill
<i>phenytoin (Phenytoin Infatabs Tablet Chewable 50 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>phenytoin sodium extended capsule 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>phenytoin sodium extended capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>phenytoin sodium extended capsule 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>phenytoin suspension 100 mg/4ml oral</i>	Preferred	Max 90-day supply per fill
<i>phenytoin suspension 125 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>phenytoin tablet chewable 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pregabalin capsule 100 mg oral</i>	Preferred	
<i>pregabalin capsule 150 mg oral</i>	Preferred	
<i>pregabalin capsule 200 mg oral</i>	Preferred	
<i>pregabalin capsule 225 mg oral</i>	Preferred	
<i>pregabalin capsule 25 mg oral</i>	Preferred	
<i>pregabalin capsule 300 mg oral</i>	Preferred	
<i>pregabalin capsule 50 mg oral</i>	Preferred	
<i>pregabalin capsule 75 mg oral</i>	Preferred	
<i>primidone tablet 125 mg oral</i>	Preferred	
<i>primidone tablet 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>primidone tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 100 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 150 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 200 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 25 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
QUDEXY XR CAPSULE ER 24 HOUR SPRINKLE 50 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
<i>levetiracetam</i> (Roweepra Tablet 500 Mg Oral)	Preferred	Max 90-day supply per fill
<i>rufinamide suspension 40 mg/ml oral</i>	Non Preferred	PA
<i>rufinamide tablet 200 mg oral</i>	Non Preferred	PA
<i>rufinamide tablet 400 mg oral</i>	Non Preferred	PA
SABRIL PACKET 500 MG ORAL (<i>vigabatrin</i>)	Non Preferred	PA
SABRIL TABLET 500 MG ORAL (<i>vigabatrin</i>)	Non Preferred	PA
SPRITAM TABLET DISINTEGRATING SOLUBLE 1000 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA
SPRITAM TABLET DISINTEGRATING SOLUBLE 250 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA
SPRITAM TABLET DISINTEGRATING SOLUBLE 500 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA
SPRITAM TABLET DISINTEGRATING SOLUBLE 750 MG ORAL (<i>levetiracetam</i>)	Non Preferred	PA
<i>lamotrigine</i> (Subvenite Starter Kit-Blue Kit 35 X 25 Mg Oral)	Non Preferred	PA
<i>lamotrigine</i> (Subvenite Starter Kit-Green Kit 84 X 25 Mg & 14X100 Mg Oral)	Non Preferred	PA
<i>lamotrigine</i> (Subvenite Starter Kit-Orange Kit 42 X 25 Mg & 7 X 100 Mg Oral)	Non Preferred	PA
<i>lamotrigine</i> (Subvenite Tablet 100 Mg Oral)	Preferred	Max 90-day supply per fill
<i>lamotrigine</i> (Subvenite Tablet 150 Mg Oral)	Preferred	Max 90-day supply per fill
<i>lamotrigine</i> (Subvenite Tablet 200 Mg Oral)	Preferred	Max 90-day supply per fill
<i>lamotrigine</i> (Subvenite Tablet 25 Mg Oral)	Preferred	Max 90-day supply per fill
SYMPAZAN FILM 10 MG ORAL (<i>clobazam</i>)	Non Preferred	PA
SYMPAZAN FILM 20 MG ORAL (<i>clobazam</i>)	Non Preferred	PA
SYMPAZAN FILM 5 MG ORAL (<i>clobazam</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TEGRETOL SUSPENSION 100 MG/5ML ORAL (<i>carbamazepine</i>)	Non Preferred	PA; Max 90-day supply per fill
TEGRETOL TABLET 200 MG ORAL (<i>carbamazepine</i>)	Non Preferred	PA; Max 90-day supply per fill
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL (<i>carbamazepine</i>)	Preferred	Max 90-day supply per fill
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL (<i>carbamazepine</i>)	Preferred	Max 90-day supply per fill
TEGRETOL-XR TABLET EXTENDED RELEASE 12 HOUR 400 MG ORAL (<i>carbamazepine</i>)	Preferred	Max 90-day supply per fill
<i>tiagabine hcl tablet 12 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tiagabine hcl tablet 16 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tiagabine hcl tablet 2 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>tiagabine hcl tablet 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
TOPAMAX SPRINKLE CAPSULE SPRINKLE 15 MG ORAL (<i>topiramate</i>)	Non Preferred	PA; Max 90-day supply per fill
TOPAMAX SPRINKLE CAPSULE SPRINKLE 25 MG ORAL (<i>topiramate</i>)	Non Preferred	PA; Max 90-day supply per fill
TOPAMAX TABLET 100 MG ORAL (<i>topiramate</i>)	Non Preferred	PA; Max 90-day supply per fill
TOPAMAX TABLET 200 MG ORAL (<i>topiramate</i>)	Non Preferred	PA; Max 90-day supply per fill
TOPAMAX TABLET 25 MG ORAL (<i>topiramate</i>)	Non Preferred	PA; Max 90-day supply per fill
TOPAMAX TABLET 50 MG ORAL (<i>topiramate</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>topiramate capsule sprinkle 15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>topiramate capsule sprinkle 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>topiramate er capsule er 24 hour sprinkle 100 mg oral</i>	Non Preferred	PA
<i>topiramate er capsule er 24 hour sprinkle 150 mg oral</i>	Non Preferred	PA
<i>topiramate er capsule er 24 hour sprinkle 200 mg oral</i>	Non Preferred	PA
<i>topiramate er capsule er 24 hour sprinkle 25 mg oral</i>	Non Preferred	PA
<i>topiramate er capsule er 24 hour sprinkle 50 mg oral</i>	Non Preferred	PA
<i>topiramate er capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA
<i>topiramate er capsule extended release 24 hour 200 mg oral</i>	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>topiramate er capsule extended release 24 hour 25 mg oral</i>	Non Preferred	PA
<i>topiramate er capsule extended release 24 hour 50 mg oral</i>	Non Preferred	PA
<i>topiramate tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>topiramate tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>topiramate tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>topiramate tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
TRILEPTAL SUSPENSION 300 MG/5ML ORAL (<i>oxcarbazepine</i>)	Preferred	Max 90-day supply per fill
TRILEPTAL TABLET 150 MG ORAL (<i>oxcarbazepine</i>)	Non Preferred	PA; Max 90-day supply per fill
TRILEPTAL TABLET 300 MG ORAL (<i>oxcarbazepine</i>)	Non Preferred	PA; Max 90-day supply per fill
TRILEPTAL TABLET 600 MG ORAL (<i>oxcarbazepine</i>)	Non Preferred	PA; Max 90-day supply per fill
TROKENDI XR CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
TROKENDI XR CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
TROKENDI XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
TROKENDI XR CAPSULE EXTENDED RELEASE 24 HOUR 50 MG ORAL (<i>topiramate</i>)	Non Preferred	PA
<i>valproic acid capsule 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>valproic acid solution 250 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
VALTOCO 10 MG DOSE LIQUID 10 MG/0.1ML NASAL (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days)
VALTOCO 15 MG DOSE LIQUID THERAPY PACK 7.5 MG/0.1ML NASAL (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days)
VALTOCO 20 MG DOSE LIQUID THERAPY PACK 10 MG/0.1ML NASAL (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days)
VALTOCO 5 MG DOSE LIQUID 5 MG/0.1ML NASAL (<i>diazepam</i>)	Preferred	QL (10 EA per 30 days)
<i>vigabatrin packet 500 mg oral</i>	Non Preferred	PA
<i>vigabatrin tablet 500 mg oral</i>	Non Preferred	PA
<i>vigabatrin (Vigadrone Packet 500 Mg Oral)</i>	Non Preferred	PA
VIMPAT SOLUTION 10 MG/ML ORAL (<i>lacosamide</i>)	Non Preferred	PA; Max 90-day supply per fill
VIMPAT TABLET 100 MG ORAL (<i>lacosamide</i>)	Non Preferred	PA
VIMPAT TABLET 150 MG ORAL (<i>lacosamide</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
VIMPAT TABLET 200 MG ORAL (<i>lacosamide</i>)	Non Preferred	PA; Max 90-day supply per fill
VIMPAT TABLET 50 MG ORAL (<i>lacosamide</i>)	Non Preferred	PA; Max 90-day supply per fill
XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI TABLET 100 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI TABLET 150 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI TABLET 200 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI TABLET 50 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X 200 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X 100 MG ORAL (<i>cenobamate</i>)	Non Preferred	PA
ZARONTIN CAPSULE 250 MG ORAL (<i>ethosuximide</i>)	Non Preferred	PA; Max 90-day supply per fill
ZARONTIN SOLUTION 250 MG/5ML ORAL (<i>ethosuximide</i>)	Non Preferred	PA; AGE (Min 3 Years); Max 90-day supply per fill
ZONISADE SUSPENSION 100 MG/5ML ORAL (<i>zonisamide</i>)	Non Preferred	PA
<i>zonisamide capsule 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>zonisamide capsule 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>zonisamide capsule 50 mg oral</i>	Preferred	Max 90-day supply per fill
ZTALMY SUSPENSION 50 MG/ML ORAL (<i>ganaxolone</i>)	Non Preferred	PA; AGE (Min 2 Years)
ANTIDEPRESSANTS - OTHER [OPEN CLASS]		
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 174 MG ORAL (<i>bupropion hbr</i>)	Non Preferred	PA
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 348 MG ORAL (<i>bupropion hbr</i>)	Non Preferred	PA
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 522 MG ORAL (<i>bupropion hbr</i>)	Non Preferred	PA
AUVELITY TABLET EXTENDED RELEASE 45-105 MG ORAL (<i>dextromethorphan-bupropion</i>)	Non Preferred	PA
<i>bupropion hcl er (sr) tablet extended release 12 hour 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bupropion hcl er (sr) tablet extended release 12 hour 150 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>bupropion hcl er (sr) tablet extended release 12 hour 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bupropion hcl er (xl) tablet extended release 24 hour 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bupropion hcl er (xl) tablet extended release 24 hour 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bupropion hcl er (xl) tablet extended release 24 hour 450 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>bupropion hcl tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bupropion hcl tablet 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>desvenlafaxine er tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>desvenlafaxine er tablet extended release 24 hour 50 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>desvenlafaxine succinate er tablet extended release 24 hour 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>desvenlafaxine succinate er tablet extended release 24 hour 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>desvenlafaxine succinate er tablet extended release 24 hour 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>duloxetine hcl capsule delayed release particles 20 mg oral</i>	Preferred	
<i>duloxetine hcl capsule delayed release particles 30 mg oral</i>	Preferred	
<i>duloxetine hcl capsule delayed release particles 40 mg oral</i>	Non Preferred	PA
<i>duloxetine hcl capsule delayed release particles 60 mg oral</i>	Preferred	
EFFEXOR XR CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL (<i>venlafaxine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
EFFEXOR XR CAPSULE EXTENDED RELEASE 24 HOUR 37.5 MG ORAL (<i>venlafaxine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
EFFEXOR XR CAPSULE EXTENDED RELEASE 24 HOUR 75 MG ORAL (<i>venlafaxine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
EMSAM PATCH 24 HOUR 12 MG/24HR TRANSDERMAL (<i>selegiline</i>)	Non Preferred	PA
EMSAM PATCH 24 HOUR 6 MG/24HR TRANSDERMAL (<i>selegiline</i>)	Non Preferred	PA
EMSAM PATCH 24 HOUR 9 MG/24HR TRANSDERMAL (<i>selegiline</i>)	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (<i>levomilnacipran hcl</i>)	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (<i>levomilnacipran hcl</i>)	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL (<i>levomilnacipran hcl</i>)	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL (<i>levomilnacipran hcl</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
FETZIMA TITRATION CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL (<i>levomilnacipran hcl</i>)	Non Preferred	PA
FORFIVO XL TABLET EXTENDED RELEASE 24 HOUR 450 MG ORAL (<i>bupropion hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
MARPLAN TABLET 10 MG ORAL (<i>isocarboxazid</i>)	Non Preferred	PA
<i>mirtazapine tablet 15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet 45 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet 7.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet dispersible 15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet dispersible 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mirtazapine tablet dispersible 45 mg oral</i>	Preferred	Max 90-day supply per fill
NARDIL TABLET 15 MG ORAL (<i>phenelzine sulfate</i>)	Non Preferred	PA
<i>nefazodone hcl tablet 100 mg oral</i>	Non Preferred	PA
<i>nefazodone hcl tablet 150 mg oral</i>	Non Preferred	PA
<i>nefazodone hcl tablet 200 mg oral</i>	Non Preferred	PA
<i>nefazodone hcl tablet 250 mg oral</i>	Non Preferred	PA
<i>nefazodone hcl tablet 50 mg oral</i>	Non Preferred	PA
<i>phenelzine sulfate tablet 15 mg oral</i>	Preferred	
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL (<i>desvenlafaxine succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>desvenlafaxine succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL (<i>desvenlafaxine succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
REMERON SOLTAB TABLET DISPERSIBLE 15 MG ORAL (<i>mirtazapine</i>)	Non Preferred	PA; Max 90-day supply per fill
REMERON SOLTAB TABLET DISPERSIBLE 30 MG ORAL (<i>mirtazapine</i>)	Non Preferred	PA; Max 90-day supply per fill
REMERON SOLTAB TABLET DISPERSIBLE 45 MG ORAL (<i>mirtazapine</i>)	Non Preferred	PA; Max 90-day supply per fill
REMERON TABLET 15 MG ORAL (<i>mirtazapine</i>)	Non Preferred	PA; Max 90-day supply per fill
REMERON TABLET 30 MG ORAL (<i>mirtazapine</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>tranylcypromine sulfate tablet 10 mg oral</i>	Non Preferred	PA
<i>trazodone hcl tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>trazodone hcl tablet 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>trazodone hcl tablet 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>trazodone hcl tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
TRINTELLIX TABLET 10 MG ORAL (<i>vortioxetine hbr</i>)	Non Preferred	PA
TRINTELLIX TABLET 20 MG ORAL (<i>vortioxetine hbr</i>)	Non Preferred	PA
TRINTELLIX TABLET 5 MG ORAL (<i>vortioxetine hbr</i>)	Non Preferred	PA
<i>venlafaxine besylate er tablet extended release 24 hour 112.5 mg oral</i>	Non Preferred	PA
<i>venlafaxine hcl er capsule extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl er capsule extended release 24 hour 37.5 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>venlafaxine hcl er capsule extended release 24 hour 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>venlafaxine hcl er tablet extended release 24 hour 150 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>venlafaxine hcl er tablet extended release 24 hour 225 mg oral</i>	Non Preferred	PA
<i>venlafaxine hcl er tablet extended release 24 hour 37.5 mg oral</i>	Non Preferred	PA
<i>venlafaxine hcl er tablet extended release 24 hour 75 mg oral</i>	Non Preferred	PA
<i>venlafaxine hcl tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>venlafaxine hcl tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>venlafaxine hcl tablet 37.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>venlafaxine hcl tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>venlafaxine hcl tablet 75 mg oral</i>	Preferred	Max 90-day supply per fill
VIIBRYD STARTER PACK KIT 10 & 20 MG ORAL (<i>vilazodone hcl</i>)	Non Preferred	PA
VIIBRYD TABLET 10 MG ORAL (<i>vilazodone hcl</i>)	Preferred	Maximum 90-day supply per fill
VIIBRYD TABLET 20 MG ORAL (<i>vilazodone hcl</i>)	Preferred	Maximum 90-day supply per fill
VIIBRYD TABLET 40 MG ORAL (<i>vilazodone hcl</i>)	Preferred	Maximum 90-day supply per fill
<i>vilazodone hcl tablet 10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>vilazodone hcl tablet 10 mg oral</i>	Non Preferred	PA; Maximum 90-day supply per fill
<i>vilazodone hcl tablet 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>vilazodone hcl tablet 20 mg oral</i>	Non Preferred	PA; Maximum 90-day supply per fill
<i>vilazodone hcl tablet 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>vilazodone hcl tablet 40 mg oral</i>	Non Preferred	PA; Maximum 90-day supply per fill
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL (<i>bupropion hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 150 MG ORAL (<i>bupropion hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL (<i>bupropion hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL (<i>bupropion hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>bupropion hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ANTIDEPRESSANTS - SSRI [OPEN CLASS]		
CELEXA TABLET 10 MG ORAL (<i>citalopram hydrobromide</i>)	Non Preferred	PA; Max 90-day supply per fill
CELEXA TABLET 20 MG ORAL (<i>citalopram hydrobromide</i>)	Non Preferred	PA; Max 90-day supply per fill
CELEXA TABLET 40 MG ORAL (<i>citalopram hydrobromide</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>citalopram hydrobromide capsule 30 mg oral</i>	Non Preferred	PA
<i>citalopram hydrobromide solution 10 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>citalopram hydrobromide tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>citalopram hydrobromide tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>citalopram hydrobromide tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>escitalopram oxalate solution 5 mg/5ml oral</i>	Non Preferred	PA
<i>escitalopram oxalate tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>escitalopram oxalate tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>escitalopram oxalate tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluoxetine hcl (pmdd) tablet 10 mg oral</i>	Non Preferred	PA
<i>fluoxetine hcl (pmdd) tablet 20 mg oral</i>	Non Preferred	PA
<i>fluoxetine hcl capsule 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluoxetine hcl capsule 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluoxetine hcl capsule 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluoxetine hcl capsule delayed release 90 mg oral</i>	Non Preferred	PA
<i>fluoxetine hcl solution 20 mg/5ml oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>fluoxetine hcl tablet 10 mg oral</i>	Non Preferred	PA
<i>fluoxetine hcl tablet 20 mg oral</i>	Non Preferred	PA
<i>fluoxetine hcl tablet 60 mg oral</i>	Non Preferred	PA
<i>fluvoxamine maleate er capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA
<i>fluvoxamine maleate er capsule extended release 24 hour 150 mg oral</i>	Non Preferred	PA
<i>fluvoxamine maleate tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluvoxamine maleate tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluvoxamine maleate tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
LEXAPRO TABLET 10 MG ORAL (<i>escitalopram oxalate</i>)	Non Preferred	PA; Max 90-day supply per fill
LEXAPRO TABLET 20 MG ORAL (<i>escitalopram oxalate</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
LEXAPRO TABLET 5 MG ORAL (<i>escitalopram oxalate</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>paroxetine hcl er tablet extended release 24 hour 12.5 mg oral</i>	Non Preferred	PA
<i>paroxetine hcl er tablet extended release 24 hour 25 mg oral</i>	Non Preferred	PA
<i>paroxetine hcl er tablet extended release 24 hour 37.5 mg oral</i>	Non Preferred	PA
<i>paroxetine hcl suspension 10 mg/5ml oral</i>	Non Preferred	PA
<i>paroxetine hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>paroxetine hcl tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>paroxetine hcl tablet 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>paroxetine hcl tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>paroxetine mesylate capsule 7.5 mg oral</i>	Non Preferred	PA
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 12.5 MG ORAL (<i>paroxetine hcl</i>)	Non Preferred	PA
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>paroxetine hcl</i>)	Non Preferred	PA
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 37.5 MG ORAL (<i>paroxetine hcl</i>)	Non Preferred	PA
PAXIL SUSPENSION 10 MG/5ML ORAL (<i>paroxetine hcl</i>)	Non Preferred	PA
PAXIL TABLET 10 MG ORAL (<i>paroxetine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
PAXIL TABLET 20 MG ORAL (<i>paroxetine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
PAXIL TABLET 30 MG ORAL (<i>paroxetine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
PAXIL TABLET 40 MG ORAL (<i>paroxetine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
PROZAC CAPSULE 10 MG ORAL (<i>fluoxetine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
PROZAC CAPSULE 20 MG ORAL (<i>fluoxetine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
PROZAC CAPSULE 40 MG ORAL (<i>fluoxetine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>sertraline hcl capsule 150 mg oral</i>	Non Preferred	PA
<i>sertraline hcl capsule 200 mg oral</i>	Non Preferred	PA
<i>sertraline hcl concentrate 20 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>sertraline hcl tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sertraline hcl tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sertraline hcl tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
ZOLOFT CONCENTRATE 20 MG/ML ORAL (<i>sertraline hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ZOLOFT TABLET 100 MG ORAL (<i>sertraline hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ZOLOFT TABLET 25 MG ORAL (<i>sertraline hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ZOLOFT TABLET 50 MG ORAL (<i>sertraline hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ANTIEMETIC/ANTIVERTIGO AGENTS [OPEN CLASS]		
AKYNZEO (READY-TO-USE) SOLUTION 235-0.25 MG/20ML INTRAVENOUS (<i>fosnetupitant-palonosetron</i>)	Non Preferred	PA
AKYNZEO (TO-BE-DILUTED) SOLUTION 235-0.25 MG/20ML INTRAVENOUS (<i>fosnetupitant-palonosetron</i>)	Non Preferred	PA
AKYNZEO CAPSULE 300-0.5 MG ORAL (<i>netupitant-palonosetron</i>)	Non Preferred	PA
AKYNZEO SOLUTION RECONSTITUTED 235-0.25 MG INTRAVENOUS (<i>fosnetupitant-palonosetron</i>)	Non Preferred	PA
ANTIVERT TABLET 50 MG ORAL (<i>meclizine hcl</i>)	Non Preferred	PA
ANTIVERT TABLET CHEWABLE 25 MG ORAL (<i>meclizine hcl</i>)	Non Preferred	PA
ANZEMET TABLET 50 MG ORAL (<i>dolasetron mesylate</i>)	Non Preferred	PA; QL (10 EA per 1 Fill)
APONVIE EMULSION 32 MG/4.4ML INTRAVENOUS (<i>aprepitant</i>)	Non Preferred	PA; QL (4.4 ML per 1 Fill)
<i>aprepitant 80 & 125 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 Fill)

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Drug Name	Formulary Status	Requirements/Limits
<i>aprepitant capsule 125 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 Fill)
<i>aprepitant capsule 40 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 Fill)
<i>aprepitant capsule 80 & 125 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 Fill)
<i>aprepitant capsule 80 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 Fill)
BARHEMSYS SOLUTION 10 MG/4ML INTRAVENOUS <i>(amisulpride (antiemetic))</i>	Non Preferred	PA
BARHEMSYS SOLUTION 5 MG/2ML INTRAVENOUS <i>(amisulpride (antiemetic))</i>	Non Preferred	PA
BONJESTA TABLET EXTENDED RELEASE 20-20 MG ORAL <i>(doxylamine-pyridoxine)</i>	Non Preferred	PA; AGE (Min 18 Years)
CINVANTI EMULSION 130 MG/18ML INTRAVENOUS <i>(aprepitant)</i>	Non Preferred	PA; QL (2 ML per 1 Fill)
<i>prochlorperazine (Compro Suppository 25 Mg Rectal)</i>	Non Preferred	PA
DICLEGIS TABLET DELAYED RELEASE 10-10 MG ORAL <i>(doxylamine-pyridoxine)</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>dimenhydrinate solution 50 mg/ml injection</i>	Non Preferred	PA
<i>doxylamine-pyridoxine tablet delayed release 10-10 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
DRIMINATE TABLET 50 MG ORAL <i>(dimenhydrinate)</i>	Preferred	
<i>dronabinol capsule 10 mg oral</i>	Preferred	PA
<i>dronabinol capsule 2.5 mg oral</i>	Preferred	PA
<i>dronabinol capsule 5 mg oral</i>	Preferred	PA
EMEND CAPSULE 80 MG ORAL <i>(aprepitant)</i>	Non Preferred	PA; QL (2 EA per 1 Fill)
EMEND SOLUTION RECONSTITUTED 150 MG INTRAVENOUS <i>(fosaprepitant dimeglumine)</i>	Non Preferred	PA
EMEND SUSPENSION RECONSTITUTED 125 MG/5ML ORAL <i>(aprepitant)</i>	Non Preferred	PA
EMEND TRI-PACK CAPSULE 80 & 125 MG ORAL <i>(aprepitant)</i>	Non Preferred	PA; QL (1 EA per 1 Fill)
<i>fosaprepitant dimeglumine solution reconstituted 150 mg intravenous</i>	Non Preferred	PA
GIMOTI SOLUTION 15 MG/ACT NASAL <i>(metoclopramide hcl)</i>	Non Preferred	PA
<i>gnp motion sickness relief tablet 25 mg oral</i>	Preferred	
<i>gnp motion sickness relief tablet 50 mg oral</i>	Preferred	
<i>granisetron hcl solution 1 mg/ml intravenous</i>	Non Preferred	PA

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>granisetron hcl solution 4 mg/4ml intravenous</i>	Non Preferred	PA
<i>granisetron hcl tablet 1 mg oral</i>	Non Preferred	PA
<i>hm motion sickness tablet 50 mg oral</i>	Preferred	
MARINOL CAPSULE 2.5 MG ORAL (<i>dronabinol</i>)	Non Preferred	PA
<i>meclizine hcl tablet 12.5 mg oral (otc)</i>	Preferred	
<i>meclizine hcl tablet 12.5 mg oral (rx)</i>	Preferred	
<i>meclizine hcl tablet 25 mg oral (otc)</i>	Preferred	
<i>meclizine hcl tablet 25 mg oral (rx)</i>	Preferred	
<i>meclizine hcl tablet chewable 25 mg oral (otc)</i>	Preferred	
<i>metoclopramide hcl solution 10 mg/10ml oral</i>	Preferred	
<i>metoclopramide hcl solution 5 mg/5ml oral</i>	Preferred	
<i>metoclopramide hcl solution 5 mg/ml injection</i>	Preferred	
<i>metoclopramide hcl tablet 10 mg oral</i>	Preferred	
<i>metoclopramide hcl tablet 5 mg oral</i>	Preferred	
<i>motion sickness relief tablet 25 mg oral</i>	Preferred	
<i>motion sickness relief tablet 50 mg oral</i>	Preferred	
<i>motion-time tablet chewable 25 mg oral</i>	Preferred	
<i>ondansetron hcl solution 4 mg/2ml injection</i>	Non Preferred	PA
<i>ondansetron hcl solution 4 mg/5ml oral</i>	Preferred	
<i>ondansetron hcl solution 40 mg/20ml injection</i>	Non Preferred	PA
<i>ondansetron hcl solution prefilled syringe 4 mg/2ml injection</i>	Non Preferred	PA
<i>ondansetron hcl tablet 4 mg oral</i>	Preferred	QL (60 EA per 1 Fill)
<i>ondansetron hcl tablet 8 mg oral</i>	Preferred	QL (60 EA per 1 Fill)
<i>ondansetron tablet dispersible 4 mg oral</i>	Preferred	QL (60 EA per 1 Fill)
<i>ondansetron tablet dispersible 8 mg oral</i>	Preferred	QL (60 EA per 1 Fill)
<i>palonosetron hcl solution 0.25 mg/2ml intravenous</i>	Non Preferred	PA
<i>palonosetron hcl solution 0.25 mg/5ml intravenous</i>	Non Preferred	PA
<i>palonosetron hcl solution prefilled syringe 0.25 mg/5ml intravenous</i>	Non Preferred	PA
PHENERGAN SOLUTION 25 MG/ML INJECTION (<i>promethazine hcl</i>)	Non Preferred	PA; AGE (Min 2 Years)
PHENERGAN SOLUTION 50 MG/ML INJECTION (<i>promethazine hcl</i>)	Non Preferred	PA; AGE (Min 2 Years)
<i>prochlorperazine edisylate solution 10 mg/2ml injection</i>	Non Preferred	PA; AGE (Min 2 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>prochlorperazine maleate tablet 10 mg oral</i>	Preferred	
<i>prochlorperazine maleate tablet 5 mg oral</i>	Preferred	
<i>prochlorperazine suppository 25 mg rectal</i>	Non Preferred	PA
<i>promethazine hcl solution 25 mg/ml injection</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl solution 50 mg/ml injection</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl suppository 12.5 mg rectal</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl suppository 25 mg rectal</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl tablet 12.5 mg oral</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl tablet 25 mg oral</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl tablet 50 mg oral</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl (Promethegan Suppository 12.5 Mg Rectal)</i>	Preferred	AGE (Min 2 Years)
<i>promethazine hcl (Promethegan Suppository 25 Mg Rectal)</i>	Preferred	AGE (Min 2 Years)
PROMETHEGAN SUPPOSITORY 50 MG RECTAL (<i>promethazine hcl</i>)	Non Preferred	PA; AGE (Min 2 Years)
REGLAN TABLET 10 MG ORAL (<i>metoclopramide hcl</i>)	Non Preferred	PA
REGLAN TABLET 5 MG ORAL (<i>metoclopramide hcl</i>)	Non Preferred	PA
SANCUSO PATCH 3.1 MG/24HR TRANSDERMAL (<i>granisetron</i>)	Non Preferred	PA; QL (2 EA per 1 Fill)
<i>scopolamine patch 72 hour 1 mg/3days transdermal</i>	Non Preferred	PA
<i>sm motion sickness tablet 25 mg oral</i>	Preferred	
<i>sm motion sickness tablet 50 mg oral</i>	Preferred	
SUSTOL PREFILLED SYRINGE 10 MG/0.4ML SUBCUTANEOUS (<i>granisetron</i>)	Non Preferred	PA
TIGAN SOLUTION 100 MG/ML INTRAMUSCULAR (<i>trimethobenzamide hcl</i>)	Non Preferred	PA
TRANSDERM-SCOP PATCH 72 HOUR 1 MG/3DAYS TRANSDERMAL (<i>scopolamine base</i>)	Non Preferred	PA
<i>trimethobenzamide hcl capsule 300 mg oral</i>	Preferred	
ANTIFUNGAL TOPICAL [OPEN CLASS]		
<i>alevazol ointment 1 % external</i>	Non Preferred	PA
<i>antifungal (clotrimazole) cream 1 % external</i>	Preferred	
<i>antifungal clotrimazole cream 1 % external</i>	Preferred	
<i>antifungal cream 2 % external</i>	Preferred	
<i>antifungal powder 2 % external</i>	Non Preferred	PA
<i>athletes foot (clotrimazole) cream 1 % external</i>	Preferred	
<i>athletes foot (terbinafine) cream 1 % external</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>athletes foot powder spray aerosol powder 1 % external</i>	Non Preferred	PA
<i>athletes foot powder spray aerosol powder 2 % external</i>	Non Preferred	PA
<i>bensal hp ointment 3 % external</i>	Non Preferred	PA
<i>butenafine hcl cream 1 % external</i>	Non Preferred	PA
<i>ciclopirox (Ciclodan Solution 8 % External)</i>	Preferred	
<i>ciclopirox gel 0.77 % external</i>	Non Preferred	PA
<i>ciclopirox olamine cream 0.77 % external</i>	Non Preferred	PA
<i>ciclopirox olamine suspension 0.77 % external</i>	Non Preferred	PA
<i>ciclopirox shampoo 1 % external</i>	Non Preferred	PA
<i>ciclopirox solution 8 % external</i>	Preferred	
<i>ciclopirox treatment kit 8 % external</i>	Non Preferred	PA
<i>clotrimazole anti-fungal cream 1 % external (otc)</i>	Preferred	
<i>clotrimazole cream 1 % external (otc)</i>	Preferred	
<i>clotrimazole cream 1 % external (rx)</i>	Preferred	
<i>clotrimazole solution 1 % external (otc)</i>	Preferred	
<i>clotrimazole solution 1 % external (rx)</i>	Preferred	
<i>clotrimazole-betamethasone cream 1-0.05 % external</i>	Preferred	
<i>clotrimazole-betamethasone lotion 1-0.05 % external</i>	Non Preferred	PA
<i>econazole nitrate cream 1 % external</i>	Non Preferred	PA
<i>ERTACZO CREAM 2 % EXTERNAL (sertaconazole nitrate)</i>	Non Preferred	PA
<i>EXELDERM CREAM 1 % EXTERNAL (sulconazole nitrate)</i>	Non Preferred	PA
<i>EXELDERM SOLUTION 1 % EXTERNAL (sulconazole nitrate)</i>	Non Preferred	PA
<i>ft antifungal cream 1 % external</i>	Preferred	
<i>ft antifungal cream 2 % external</i>	Preferred	
<i>ft athletes foot (clotrimaz) cream 1 % external</i>	Preferred	
<i>ft athletes foot (terbinafine) cream 1 % external</i>	Preferred	
<i>FUNGOID TINCTURE SOLUTION 2 % EXTERNAL (miconazole nitrate)</i>	Non Preferred	PA
<i>gnp athletes foot cream 1 % external</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp miconazorb af powder 2 % external</i>	Non Preferred	PA
<i>gnp terbinafine hydrochloride cream 1 % external</i>	Preferred	
<i>gnp tolnaftate cream 1 % external</i>	Preferred	
JUBLIA SOLUTION 10 % EXTERNAL (<i>efinaconazole</i>)	Non Preferred	PA
KERYDIN SOLUTION 5 % EXTERNAL (<i>tavaborole</i>)	Non Preferred	PA
<i>ketoconazole cream 2 % external</i>	Preferred	
<i>ketoconazole foam 2 % external</i>	Non Preferred	PA
<i>ketoconazole shampoo 2 % external</i>	Preferred	
<i>ketoconazole (Ketodan Foam 2 % External)</i>	Non Preferred	PA
KETODAN KIT 2 % EXTERNAL (<i>ketoconazole-cleanser</i>)	Non Preferred	PA
LOPROX KIT 0.77 % (SUSP) EXTERNAL (<i>ciclopirox olamine-cleanser</i>)	Non Preferred	PA
LOPROX SHAMPOO 1 % EXTERNAL (<i>ciclopirox</i>)	Non Preferred	PA
LOPROX SUSPENSION 0.77 % EXTERNAL (<i>ciclopirox olamine</i>)	Non Preferred	PA
LOTRIMIN AF CREAM 1 % EXTERNAL (<i>clotrimazole</i>)	Non Preferred	PA
<i>luliconazole cream 1 % external</i>	Non Preferred	PA
LUZU CREAM 1 % EXTERNAL (<i>luliconazole</i>)	Non Preferred	PA
MENTAX CREAM 1 % EXTERNAL (<i>butenafine hcl</i>)	Non Preferred	PA
MICOMITIN SOLUTION 1 % EXTERNAL (<i>tolnaftate</i>)	Non Preferred	PA
<i>miconazole nitrate cream 2 % external (otc)</i>	Preferred	
<i>miconazole nitrate solution 2 % external</i>	Non Preferred	PA
<i>miconazole-zinc oxide-petrolat ointment 0.25-15-81.35 % external</i>	Non Preferred	PA
MICOTRIN AC CREAM 1 % EXTERNAL (<i>clotrimazole</i>)	Preferred	
MICOTRIN AL SOLUTION 1 % EXTERNAL (<i>tolnaftate</i>)	Non Preferred	PA
MICOTRIN AP POWDER 2 % EXTERNAL (<i>miconazole nitrate</i>)	Non Preferred	PA
MYCOZYL AC CREAM 1 % EXTERNAL (<i>clotrimazole</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
MYCOZYL AL SOLUTION 1 % EXTERNAL (<i>tolnaftate</i>)	Non Preferred	PA
MYCOZYL AP POWDER 2 % EXTERNAL (<i>miconazole nitrate</i>)	Non Preferred	PA
<i>naftifine hcl cream 1 % external</i>	Non Preferred	PA
<i>naftifine hcl cream 2 % external</i>	Non Preferred	PA
<i>naftifine hcl gel 2 % external</i>	Non Preferred	PA
NAFTIN GEL 1 % EXTERNAL (<i>naftifine hcl</i>)	Non Preferred	PA
NAFTIN GEL 2 % EXTERNAL (<i>naftifine hcl</i>)	Non Preferred	PA
<i>nystatin (Nyamyc Powder 100000 Unit/Gm External)</i>	Preferred	
<i>nystatin cream 100000 unit/gm external</i>	Preferred	
<i>nystatin ointment 100000 unit/gm external</i>	Preferred	
<i>nystatin powder 100000 unit/gm external</i>	Preferred	
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-% external</i>	Non Preferred	PA
<i>nystatin-triamcinolone ointment 100000-0.1 unit/gm-% external</i>	Non Preferred	PA
<i>nystatin (Nystop Powder 100000 Unit/Gm External)</i>	Preferred	
<i>oxiconazole nitrate cream 1 % external</i>	Non Preferred	PA
OXISTAT LOTION 1 % EXTERNAL (<i>oxiconazole nitrate</i>)	Non Preferred	PA
<i>qc antifungal (tolnaftate) cream 1 % external</i>	Preferred	
<i>sm antifungal clotrimazole cream 1 % external</i>	Preferred	
<i>sm antifungal miconazole cream 2 % external</i>	Preferred	
<i>sm antifungal tolnaftate cream 1 % external</i>	Preferred	
<i>sm athletes foot cream 1 % external</i>	Preferred	
<i>sulconazole nitrate cream 1 % external</i>	Non Preferred	PA
<i>sulconazole nitrate solution 1 % external</i>	Non Preferred	PA
<i>tavaborole solution 5 % external</i>	Non Preferred	PA
<i>terbinafine hcl cream 1 % external</i>	Preferred	
<i>tm-clotrimazole cream 1 % external</i>	Preferred	
<i>tm-tolnaftate lr solution 1 % external</i>	Non Preferred	PA
<i>tm-tolnaftate solution 1 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>tolnafi-al solution 1 % external</i>	Non Preferred	PA
<i>tolnaftate cream 1 % external</i>	Preferred	
<i>tolnaftate powder 1 % external</i>	Preferred	
VUSION OINTMENT 0.25-15-81.35 % EXTERNAL (<i>miconazole-zinc oxide-petrolat</i>)	Non Preferred	PA
ANTIFUNGALS, ORAL [OPEN CLASS]		
ANCOBON CAPSULE 250 MG ORAL (<i>flucytosine</i>)	Non Preferred	PA
ANCOBON CAPSULE 500 MG ORAL (<i>flucytosine</i>)	Non Preferred	PA
BREXAFEMME TABLET 150 MG ORAL (<i>ibrexafungerp citrate</i>)	Non Preferred	PA
<i>clotrimazole troche 10 mg mouth/throat</i>	Non Preferred	PA
CRESEMBA CAPSULE 186 MG ORAL (<i>isavuconazonium sulfate</i>)	Non Preferred	PA
CRESEMBA CAPSULE 74.5 MG ORAL (<i>isavuconazonium sulfate</i>)	Non Preferred	PA
DIFLUCAN SUSPENSION RECONSTITUTED 10 MG/ML ORAL (<i>fluconazole</i>)	Non Preferred	PA; Max 90-day supply per fill
DIFLUCAN SUSPENSION RECONSTITUTED 40 MG/ML ORAL (<i>fluconazole</i>)	Non Preferred	PA; Max 90-day supply per fill
DIFLUCAN TABLET 100 MG ORAL (<i>fluconazole</i>)	Non Preferred	PA; Max 90-day supply per fill
DIFLUCAN TABLET 150 MG ORAL (<i>fluconazole</i>)	Non Preferred	PA; Max 90-day supply per fill
DIFLUCAN TABLET 200 MG ORAL (<i>fluconazole</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>fluconazole suspension reconstituted 10 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>fluconazole suspension reconstituted 40 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>fluconazole tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluconazole tablet 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluconazole tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fluconazole tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>flucytosine capsule 250 mg oral</i>	Non Preferred	PA
<i>flucytosine capsule 500 mg oral</i>	Non Preferred	PA
<i>griseofulvin microsize suspension 125 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>griseofulvin microsize tablet 500 mg oral</i>	Non Preferred	PA
<i>griseofulvin ultramicrosize tablet 125 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>griseofulvin ultramicrosize tablet 250 mg oral</i>	Non Preferred	PA
<i>itraconazole capsule 100 mg oral</i>	Non Preferred	PA
<i>itraconazole solution 10 mg/ml oral</i>	Non Preferred	PA
<i>ketoconazole tablet 200 mg oral</i>	Non Preferred	PA
NOXAFIL PACKET 300 MG ORAL (<i>posaconazole</i>)	Non Preferred	PA
NOXAFIL SUSPENSION 40 MG/ML ORAL (<i>posaconazole</i>)	Non Preferred	PA
NOXAFIL TABLET DELAYED RELEASE 100 MG ORAL (<i>posaconazole</i>)	Non Preferred	PA
<i>nystatin suspension 100000 unit/ml mouth/throat</i>	Preferred	Max 90-day supply per fill
<i>nystatin tablet 500000 unit oral</i>	Preferred	Max 90-day supply per fill
ORAVIG TABLET 50 MG BUCCAL (<i>miconazole</i>)	Non Preferred	PA
<i>posaconazole suspension 40 mg/ml oral</i>	Non Preferred	PA
<i>posaconazole tablet delayed release 100 mg oral</i>	Non Preferred	PA
SPORANOX CAPSULE 100 MG ORAL (<i>itraconazole</i>)	Non Preferred	PA
SPORANOX SOLUTION 10 MG/ML ORAL (<i>itraconazole</i>)	Non Preferred	PA
<i>terbinafine hcl tablet 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>tolsura capsule 65 mg oral</i>	Non Preferred	PA
VFEND SUSPENSION RECONSTITUTED 40 MG/ML ORAL (<i>voriconazole</i>)	Non Preferred	PA
VFEND TABLET 200 MG ORAL (<i>voriconazole</i>)	Non Preferred	PA
VFEND TABLET 50 MG ORAL (<i>voriconazole</i>)	Non Preferred	PA
VIVJOA CAPSULE THERAPY PACK 150 MG ORAL (<i>oteseconazole</i>)	Non Preferred	PA
<i>voriconazole suspension reconstituted 40 mg/ml oral</i>	Non Preferred	PA
<i>voriconazole tablet 200 mg oral</i>	Non Preferred	PA
<i>voriconazole tablet 50 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ANTIHYPERTENSIVES: ANGIOTENSIN MODULATOR COMBINATIONS [OPEN CLASS]		
<i>aliskiren fumarate tablet 150 mg oral</i>	Non Preferred	PA
<i>aliskiren fumarate tablet 300 mg oral</i>	Non Preferred	PA
<i>amlodipine besy-benazepril hcl capsule 10-20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 10-40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 2.5-10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 5-10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 5-20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besy-benazepril hcl capsule 5-40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besylate-valsartan tablet 10-160 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besylate-valsartan tablet 10-320 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besylate-valsartan tablet 5-160 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besylate-valsartan tablet 5-320 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine-olmesartan tablet 10-20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine-olmesartan tablet 10-40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine-olmesartan tablet 5-20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine-olmesartan tablet 5-40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine-valsartan-hctz tablet 10-160-12.5 mg oral</i>	Non Preferred	PA
<i>amlodipine-valsartan-hctz tablet 10-160-25 mg oral</i>	Non Preferred	PA
<i>amlodipine-valsartan-hctz tablet 10-320-25 mg oral</i>	Non Preferred	PA
<i>amlodipine-valsartan-hctz tablet 5-160-12.5 mg oral</i>	Non Preferred	PA
<i>amlodipine-valsartan-hctz tablet 5-160-25 mg oral</i>	Non Preferred	PA
AZOR TABLET 10-20 MG ORAL (<i>amlodipine-olmesartan</i>)	Non Preferred	PA; Max 90-day supply per fill
AZOR TABLET 10-40 MG ORAL (<i>amlodipine-olmesartan</i>)	Non Preferred	PA; Max 90-day supply per fill
AZOR TABLET 5-20 MG ORAL (<i>amlodipine-olmesartan</i>)	Non Preferred	PA; Max 90-day supply per fill
AZOR TABLET 5-40 MG ORAL (<i>amlodipine-olmesartan</i>)	Non Preferred	PA; Max 90-day supply per fill
EXFORGE HCT TABLET 10-160-12.5 MG ORAL (<i>amlodipine-valsartan-hctz</i>)	Non Preferred	PA
EXFORGE HCT TABLET 10-160-25 MG ORAL (<i>amlodipine-valsartan-hctz</i>)	Non Preferred	PA
EXFORGE HCT TABLET 10-320-25 MG ORAL (<i>amlodipine-valsartan-hctz</i>)	Non Preferred	PA

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EXFORGE HCT TABLET 5-160-12.5 MG ORAL (<i>amlodipine-valsartan-hctz</i>)	Non Preferred	PA
EXFORGE HCT TABLET 5-160-25 MG ORAL (<i>amlodipine-valsartan-hctz</i>)	Non Preferred	PA
EXFORGE TABLET 10-160 MG ORAL (<i>amlodipine besylate-valsartan</i>)	Non Preferred	PA; Max 90-day supply per fill
EXFORGE TABLET 10-320 MG ORAL (<i>amlodipine besylate-valsartan</i>)	Non Preferred	PA; Max 90-day supply per fill
EXFORGE TABLET 5-160 MG ORAL (<i>amlodipine besylate-valsartan</i>)	Non Preferred	PA; Max 90-day supply per fill
EXFORGE TABLET 5-320 MG ORAL (<i>amlodipine besylate-valsartan</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTREL CAPSULE 10-20 MG ORAL (<i>amlodipine besy-benazepril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTREL CAPSULE 10-40 MG ORAL (<i>amlodipine besy-benazepril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTREL CAPSULE 5-10 MG ORAL (<i>amlodipine besy-benazepril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTREL CAPSULE 5-20 MG ORAL (<i>amlodipine besy-benazepril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>olmesartan-amlodipine-hctz tablet 20-5-12.5 mg oral</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hctz tablet 40-10-12.5 mg oral</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hctz tablet 40-10-25 mg oral</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hctz tablet 40-5-12.5 mg oral</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hctz tablet 40-5-25 mg oral</i>	Non Preferred	PA
TEKTURNA HCT TABLET 300-12.5 MG ORAL (<i>aliskiren-hydrochlorothiazide</i>)	Non Preferred	PA
TEKTURNA HCT TABLET 300-25 MG ORAL (<i>aliskiren-hydrochlorothiazide</i>)	Non Preferred	PA
TEKTURNA TABLET 150 MG ORAL (<i>aliskiren fumarate</i>)	Non Preferred	PA
TEKTURNA TABLET 300 MG ORAL (<i>aliskiren fumarate</i>)	Non Preferred	PA
<i>telmisartan-amlodipine tablet 40-10 mg oral</i>	Non Preferred	PA
<i>telmisartan-amlodipine tablet 40-5 mg oral</i>	Non Preferred	PA
<i>telmisartan-amlodipine tablet 80-10 mg oral</i>	Non Preferred	PA
<i>telmisartan-amlodipine tablet 80-5 mg oral</i>	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>trandolapril-verapamil hcl er tablet extended release 1-240 mg oral</i>	Non Preferred	PA
<i>trandolapril-verapamil hcl er tablet extended release 2-180 mg oral</i>	Non Preferred	PA
<i>trandolapril-verapamil hcl er tablet extended release 2-240 mg oral</i>	Non Preferred	PA
<i>trandolapril-verapamil hcl er tablet extended release 4-240 mg oral</i>	Non Preferred	PA
TRIBENZOR TABLET 20-5-12.5 MG ORAL (<i>olmesartan-amlodipine-hctz</i>)	Non Preferred	PA
TRIBENZOR TABLET 40-10-12.5 MG ORAL (<i>olmesartan-amlodipine-hctz</i>)	Non Preferred	PA
TRIBENZOR TABLET 40-10-25 MG ORAL (<i>olmesartan-amlodipine-hctz</i>)	Non Preferred	PA
TRIBENZOR TABLET 40-5-12.5 MG ORAL (<i>olmesartan-amlodipine-hctz</i>)	Non Preferred	PA
TRIBENZOR TABLET 40-5-25 MG ORAL (<i>olmesartan-amlodipine-hctz</i>)	Non Preferred	PA
ANTIHYPERTENSIVES: ANGIOTENSIN MODULATORS [OPEN CLASS]		
ACCUPRIL TABLET 10 MG ORAL (<i>quinapril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ACCUPRIL TABLET 20 MG ORAL (<i>quinapril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ACCUPRIL TABLET 40 MG ORAL (<i>quinapril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ACCUPRIL TABLET 5 MG ORAL (<i>quinapril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
ACCURETIC TABLET 10-12.5 MG ORAL (<i>quinapril-hydrochlorothiazide</i>)	Non Preferred	PA
ACCURETIC TABLET 20-12.5 MG ORAL (<i>quinapril-hydrochlorothiazide</i>)	Non Preferred	PA
ALTACE CAPSULE 1.25 MG ORAL (<i>ramipril</i>)	Non Preferred	PA; Max 90-day supply per fill
ALTACE CAPSULE 10 MG ORAL (<i>ramipril</i>)	Non Preferred	PA; Max 90-day supply per fill
ALTACE CAPSULE 2.5 MG ORAL (<i>ramipril</i>)	Non Preferred	PA; Max 90-day supply per fill
ALTACE CAPSULE 5 MG ORAL (<i>ramipril</i>)	Non Preferred	PA; Max 90-day supply per fill
ATACAND HCT TABLET 16-12.5 MG ORAL (<i>candesartan cilexetil-hctz</i>)	Non Preferred	PA
ATACAND HCT TABLET 32-12.5 MG ORAL (<i>candesartan cilexetil-hctz</i>)	Non Preferred	PA
ATACAND HCT TABLET 32-25 MG ORAL (<i>candesartan cilexetil-hctz</i>)	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ATACAND TABLET 16 MG ORAL (<i>candesartan cilexetil</i>)	Non Preferred	PA
ATACAND TABLET 32 MG ORAL (<i>candesartan cilexetil</i>)	Non Preferred	PA
ATACAND TABLET 4 MG ORAL (<i>candesartan cilexetil</i>)	Non Preferred	PA
ATACAND TABLET 8 MG ORAL (<i>candesartan cilexetil</i>)	Non Preferred	PA
AVALIDE TABLET 150-12.5 MG ORAL (<i>irbesartan-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
AVALIDE TABLET 300-12.5 MG ORAL (<i>irbesartan-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
AVAPRO TABLET 150 MG ORAL (<i>irbesartan</i>)	Non Preferred	PA; Max 90-day supply per fill
AVAPRO TABLET 300 MG ORAL (<i>irbesartan</i>)	Non Preferred	PA; Max 90-day supply per fill
AVAPRO TABLET 75 MG ORAL (<i>irbesartan</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>benazepril hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>benazepril hcl tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>benazepril hcl tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>benazepril hcl tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>benazepril-hydrochlorothiazide tablet 10-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>benazepril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>benazepril-hydrochlorothiazide tablet 20-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>benazepril-hydrochlorothiazide tablet 5-6.25 mg oral</i>	Preferred	Max 90-day supply per fill
BENICAR HCT TABLET 20-12.5 MG ORAL (<i>olmesartan medoxomil-hctz</i>)	Non Preferred	PA; Max 90-day supply per fill
BENICAR HCT TABLET 40-12.5 MG ORAL (<i>olmesartan medoxomil-hctz</i>)	Non Preferred	PA; Max 90-day supply per fill
BENICAR HCT TABLET 40-25 MG ORAL (<i>olmesartan medoxomil-hctz</i>)	Non Preferred	PA; Max 90-day supply per fill
BENICAR TABLET 20 MG ORAL (<i>olmesartan medoxomil</i>)	Non Preferred	PA; Max 90-day supply per fill
BENICAR TABLET 40 MG ORAL (<i>olmesartan medoxomil</i>)	Non Preferred	PA; Max 90-day supply per fill
BENICAR TABLET 5 MG ORAL (<i>olmesartan medoxomil</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>candesartan cilexetil tablet 16 mg oral</i>	Non Preferred	PA
<i>candesartan cilexetil tablet 32 mg oral</i>	Non Preferred	PA
<i>candesartan cilexetil tablet 4 mg oral</i>	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>candesartan cilexetil tablet 8 mg oral</i>	Non Preferred	PA
<i>candesartan cilexetil-hctz tablet 16-12.5 mg oral</i>	Non Preferred	PA
<i>candesartan cilexetil-hctz tablet 32-12.5 mg oral</i>	Non Preferred	PA
<i>candesartan cilexetil-hctz tablet 32-25 mg oral</i>	Non Preferred	PA
<i>captopril tablet 100 mg oral</i>	Non Preferred	PA
<i>captopril tablet 12.5 mg oral</i>	Non Preferred	PA
<i>captopril tablet 25 mg oral</i>	Non Preferred	PA
<i>captopril tablet 50 mg oral</i>	Non Preferred	PA
<i>captopril-hydrochlorothiazide tablet 25-15 mg oral</i>	Non Preferred	PA
<i>captopril-hydrochlorothiazide tablet 25-25 mg oral</i>	Non Preferred	PA
<i>captopril-hydrochlorothiazide tablet 50-15 mg oral</i>	Non Preferred	PA
<i>captopril-hydrochlorothiazide tablet 50-25 mg oral</i>	Non Preferred	PA
COZAAR TABLET 100 MG ORAL (<i>losartan potassium</i>)	Non Preferred	PA; Max 90-day supply per fill
COZAAR TABLET 25 MG ORAL (<i>losartan potassium</i>)	Non Preferred	PA; Max 90-day supply per fill
COZAAR TABLET 50 MG ORAL (<i>losartan potassium</i>)	Non Preferred	PA; Max 90-day supply per fill
DIOVAN HCT TABLET 160-12.5 MG ORAL (<i>valsartan-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
DIOVAN HCT TABLET 160-25 MG ORAL (<i>valsartan-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
DIOVAN HCT TABLET 320-12.5 MG ORAL (<i>valsartan-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
DIOVAN HCT TABLET 320-25 MG ORAL (<i>valsartan-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
DIOVAN HCT TABLET 80-12.5 MG ORAL (<i>valsartan-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
DIOVAN TABLET 160 MG ORAL (<i>valsartan</i>)	Non Preferred	PA; Max 90-day supply per fill
DIOVAN TABLET 320 MG ORAL (<i>valsartan</i>)	Non Preferred	PA; Max 90-day supply per fill
DIOVAN TABLET 40 MG ORAL (<i>valsartan</i>)	Non Preferred	PA; Max 90-day supply per fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
DIOVAN TABLET 80 MG ORAL (<i>valsartan</i>)	Non Preferred	PA; Max 90-day supply per fill
EDARBI TABLET 40 MG ORAL (<i>azilsartan medoxomil</i>)	Non Preferred	PA
EDARBI TABLET 80 MG ORAL (<i>azilsartan medoxomil</i>)	Non Preferred	PA
EDARBYCLOR TABLET 40-12.5 MG ORAL (<i>azilsartan-chlorthalidone</i>)	Non Preferred	PA
EDARBYCLOR TABLET 40-25 MG ORAL (<i>azilsartan-chlorthalidone</i>)	Non Preferred	PA
<i>enalapril maleate solution 1 mg/ml oral</i>	Non Preferred	PA
<i>enalapril maleate tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>enalapril maleate tablet 2.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>enalapril maleate tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>enalapril maleate tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>enalapril-hydrochlorothiazide tablet 10-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>enalapril-hydrochlorothiazide tablet 5-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
ENTRESTO TABLET 24-26 MG ORAL (<i>sacubitril-valsartan</i>)	Preferred	QL (2 EA per 1 day)
ENTRESTO TABLET 49-51 MG ORAL (<i>sacubitril-valsartan</i>)	Preferred	QL (2 EA per 1 day)
ENTRESTO TABLET 97-103 MG ORAL (<i>sacubitril-valsartan</i>)	Preferred	QL (2 EA per 1 day)
EPANED SOLUTION 1 MG/ML ORAL (<i>enalapril maleate</i>)	Non Preferred	PA
<i>fosinopril sodium tablet 10 mg oral</i>	Preferred	
<i>fosinopril sodium tablet 20 mg oral</i>	Preferred	
<i>fosinopril sodium tablet 40 mg oral</i>	Preferred	
<i>fosinopril sodium-hctz tablet 10-12.5 mg oral</i>	Non Preferred	PA
<i>fosinopril sodium-hctz tablet 20-12.5 mg oral</i>	Non Preferred	PA
HYZAAR TABLET 100-12.5 MG ORAL (<i>losartan potassium-hctz</i>)	Non Preferred	PA; Max 90-day supply per fill
HYZAAR TABLET 100-25 MG ORAL (<i>losartan potassium-hctz</i>)	Non Preferred	PA; Max 90-day supply per fill
HYZAAR TABLET 50-12.5 MG ORAL (<i>losartan potassium-hctz</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>irbesartan tablet 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>irbesartan tablet 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>irbesartan tablet 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>irbesartan-hydrochlorothiazide tablet 150-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>irbesartan-hydrochlorothiazide tablet 300-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lisinopril tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lisinopril tablet 2.5 mg oral</i>	Preferred	Max 90-day supply per fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>lisinopril tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lisinopril tablet 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lisinopril tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lisinopril tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lisinopril-hydrochlorothiazide tablet 10-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lisinopril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lisinopril-hydrochlorothiazide tablet 20-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>losartan potassium tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>losartan potassium tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>losartan potassium tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>losartan potassium-hctz tablet 100-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>losartan potassium-hctz tablet 100-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>losartan potassium-hctz tablet 50-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
LOTENSIN HCT TABLET 10-12.5 MG ORAL (<i>benazepril-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTENSIN HCT TABLET 20-12.5 MG ORAL (<i>benazepril-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTENSIN HCT TABLET 20-25 MG ORAL (<i>benazepril-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTENSIN TABLET 10 MG ORAL (<i>benazepril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTENSIN TABLET 20 MG ORAL (<i>benazepril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
LOTENSIN TABLET 40 MG ORAL (<i>benazepril hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
MICARDIS HCT TABLET 40-12.5 MG ORAL (<i>telmisartan-hctz</i>)	Non Preferred	PA
MICARDIS HCT TABLET 80-12.5 MG ORAL (<i>telmisartan-hctz</i>)	Non Preferred	PA
MICARDIS HCT TABLET 80-25 MG ORAL (<i>telmisartan-hctz</i>)	Non Preferred	PA
MICARDIS TABLET 20 MG ORAL (<i>telmisartan</i>)	Non Preferred	PA
MICARDIS TABLET 40 MG ORAL (<i>telmisartan</i>)	Non Preferred	PA
MICARDIS TABLET 80 MG ORAL (<i>telmisartan</i>)	Non Preferred	PA
<i>moexipril hcl tablet 15 mg oral</i>	Non Preferred	PA
<i>moexipril hcl tablet 7.5 mg oral</i>	Non Preferred	PA
<i>olmesartan medoxomil tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>olmesartan medoxomil tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>olmesartan medoxomil tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>olmesartan medoxomil-hctz tablet 20-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>olmesartan medoxomil-hctz tablet 40-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>olmesartan medoxomil-hctz tablet 40-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>perindopril erbumine tablet 2 mg oral</i>	Non Preferred	PA
<i>perindopril erbumine tablet 4 mg oral</i>	Non Preferred	PA
<i>perindopril erbumine tablet 8 mg oral</i>	Non Preferred	PA
QBRELIS SOLUTION 1 MG/ML ORAL (<i>lisinopril</i>)	Non Preferred	PA
<i>quinapril hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>quinapril hcl tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>quinapril hcl tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>quinapril hcl tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>quinapril-hydrochlorothiazide tablet 20-12.5 mg oral</i>	Non Preferred	PA
<i>quinapril-hydrochlorothiazide tablet 20-25 mg oral</i>	Non Preferred	PA
<i>ramipril capsule 1.25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ramipril capsule 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ramipril capsule 2.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ramipril capsule 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>telmisartan tablet 20 mg oral</i>	Non Preferred	PA
<i>telmisartan tablet 40 mg oral</i>	Non Preferred	PA
<i>telmisartan tablet 80 mg oral</i>	Non Preferred	PA
<i>telmisartan-hctz tablet 40-12.5 mg oral</i>	Non Preferred	PA
<i>telmisartan-hctz tablet 80-12.5 mg oral</i>	Non Preferred	PA
<i>telmisartan-hctz tablet 80-25 mg oral</i>	Non Preferred	PA
<i>trandolapril tablet 1 mg oral</i>	Preferred	
<i>trandolapril tablet 2 mg oral</i>	Preferred	
<i>trandolapril tablet 4 mg oral</i>	Preferred	
<i>valsartan tablet 160 mg oral</i>	Preferred	Max 90-day supply per fill
<i>valsartan tablet 320 mg oral</i>	Preferred	Max 90-day supply per fill
<i>valsartan tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>valsartan tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
<i>valsartan-hydrochlorothiazide tablet 160-12.5 mg oral</i>	Preferred	Max 90-day supply per fill

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>valsartan-hydrochlorothiazide tablet 160-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>valsartan-hydrochlorothiazide tablet 320-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>valsartan-hydrochlorothiazide tablet 320-25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>valsartan-hydrochlorothiazide tablet 80-12.5 mg oral</i>	Preferred	Max 90-day supply per fill
VASERETIC TABLET 10-25 MG ORAL (<i>enalapril-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
VASOTEC TABLET 10 MG ORAL (<i>enalapril maleate</i>)	Non Preferred	PA; Max 90-day supply per fill
VASOTEC TABLET 2.5 MG ORAL (<i>enalapril maleate</i>)	Non Preferred	PA; Max 90-day supply per fill
VASOTEC TABLET 20 MG ORAL (<i>enalapril maleate</i>)	Non Preferred	PA; Max 90-day supply per fill
VASOTEC TABLET 5 MG ORAL (<i>enalapril maleate</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTORETIC TABLET 10-12.5 MG ORAL (<i>lisinopril-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTORETIC TABLET 20-12.5 MG ORAL (<i>lisinopril-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTORETIC TABLET 20-25 MG ORAL (<i>lisinopril-hydrochlorothiazide</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 10 MG ORAL (<i>lisinopril</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 2.5 MG ORAL (<i>lisinopril</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 20 MG ORAL (<i>lisinopril</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 30 MG ORAL (<i>lisinopril</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 40 MG ORAL (<i>lisinopril</i>)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 5 MG ORAL (<i>lisinopril</i>)	Non Preferred	PA; Max 90-day supply per fill
ANTIHYPERTENSIVES: BETA BLOCKERS [OPEN CLASS]		
<i>acebutolol hcl capsule 200 mg oral</i>	Preferred	
<i>acebutolol hcl capsule 400 mg oral</i>	Preferred	
<i>atenolol tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>atenolol tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>atenolol tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>atenolol-chlorthalidone tablet 100-25 mg oral</i>	Preferred	
<i>atenolol-chlorthalidone tablet 50-25 mg oral</i>	Preferred	
BETAPACE AF TABLET 120 MG ORAL (<i>sotalol hcl af</i>)	Non Preferred	PA
BETAPACE AF TABLET 160 MG ORAL (<i>sotalol hcl af</i>)	Non Preferred	PA; Max 90-day supply per fill

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
BETAPACE AF TABLET 80 MG ORAL (<i>sotalol hcl af</i>)	Non Preferred	PA; Max 90-day supply per fill
BETAPACE TABLET 120 MG ORAL (<i>sotalol hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
BETAPACE TABLET 160 MG ORAL (<i>sotalol hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
BETAPACE TABLET 80 MG ORAL (<i>sotalol hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>betaxolol hcl tablet 10 mg oral</i>	Non Preferred	PA
<i>betaxolol hcl tablet 20 mg oral</i>	Non Preferred	PA
<i>bisoprolol fumarate tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bisoprolol fumarate tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>bisoprolol-hydrochlorothiazide tablet 10-6.25 mg oral</i>	Preferred	
<i>bisoprolol-hydrochlorothiazide tablet 2.5-6.25 mg oral</i>	Preferred	
<i>bisoprolol-hydrochlorothiazide tablet 5-6.25 mg oral</i>	Preferred	
BYSTOLIC TABLET 10 MG ORAL (<i>nebivolol hcl</i>)	Non Preferred	PA
BYSTOLIC TABLET 2.5 MG ORAL (<i>nebivolol hcl</i>)	Non Preferred	PA
BYSTOLIC TABLET 20 MG ORAL (<i>nebivolol hcl</i>)	Non Preferred	PA
BYSTOLIC TABLET 5 MG ORAL (<i>nebivolol hcl</i>)	Non Preferred	PA
<i>carvedilol phosphate er capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carvedilol phosphate er capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carvedilol phosphate er capsule extended release 24 hour 40 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carvedilol phosphate er capsule extended release 24 hour 80 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>carvedilol tablet 12.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>carvedilol tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>carvedilol tablet 3.125 mg oral</i>	Preferred	Max 90-day supply per fill
<i>carvedilol tablet 6.25 mg oral</i>	Preferred	Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (<i>carvedilol phosphate</i>)	Non Preferred	PA; Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (<i>carvedilol phosphate</i>)	Non Preferred	PA; Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL (<i>carvedilol phosphate</i>)	Non Preferred	PA; Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL (<i>carvedilol phosphate</i>)	Non Preferred	PA; Max 90-day supply per fill

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
COREG TABLET 12.5 MG ORAL (<i>carvedilol</i>)	Non Preferred	PA; Max 90-day supply per fill
COREG TABLET 25 MG ORAL (<i>carvedilol</i>)	Non Preferred	PA; Max 90-day supply per fill
COREG TABLET 3.125 MG ORAL (<i>carvedilol</i>)	Non Preferred	PA; Max 90-day supply per fill
COREG TABLET 6.25 MG ORAL (<i>carvedilol</i>)	Non Preferred	PA; Max 90-day supply per fill
CORGARD TABLET 20 MG ORAL (<i>nadolol</i>)	Non Preferred	PA
CORGARD TABLET 40 MG ORAL (<i>nadolol</i>)	Non Preferred	PA
HEMANGEOL SOLUTION 4.28 MG/ML ORAL (<i>propranolol hcl</i>)	Non Preferred	PA
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (<i>propranolol hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 160 MG ORAL (<i>propranolol hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL (<i>propranolol hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL (<i>propranolol hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
INDERAL XL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (<i>propranolol hcl sr beads</i>)	Non Preferred	PA
INDERAL XL CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL (<i>propranolol hcl sr beads</i>)	Non Preferred	PA
INNOPRAN XL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (<i>propranolol hcl sr beads</i>)	Non Preferred	PA
INNOPRAN XL CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL (<i>propranolol hcl sr beads</i>)	Non Preferred	PA
KAPSPARGO SPRINKLE CAPSULE ER 24 HOUR SPRINKLE 100 MG ORAL (<i>metoprolol succinate</i>)	Non Preferred	PA
KAPSPARGO SPRINKLE CAPSULE ER 24 HOUR SPRINKLE 200 MG ORAL (<i>metoprolol succinate</i>)	Non Preferred	PA
KAPSPARGO SPRINKLE CAPSULE ER 24 HOUR SPRINKLE 25 MG ORAL (<i>metoprolol succinate</i>)	Non Preferred	PA
KAPSPARGO SPRINKLE CAPSULE ER 24 HOUR SPRINKLE 50 MG ORAL (<i>metoprolol succinate</i>)	Non Preferred	PA
<i>labetalol hcl tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>labetalol hcl tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>labetalol hcl tablet 300 mg oral</i>	Preferred	Max 90-day supply per fill
LOPRESSOR TABLET 100 MG ORAL (<i>metoprolol tartrate</i>)	Non Preferred	PA; Max 90-day supply per fill
LOPRESSOR TABLET 50 MG ORAL (<i>metoprolol tartrate</i>)	Non Preferred	PA; Max 90-day supply per fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>metoprolol succinate er tablet extended release 24 hour 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol succinate er tablet extended release 24 hour 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol succinate er tablet extended release 24 hour 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol succinate er tablet extended release 24 hour 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol tartrate tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol tartrate tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol tartrate tablet 37.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol tartrate tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol tartrate tablet 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>metoprolol-hydrochlorothiazide tablet 100-25 mg oral</i>	Preferred	
<i>metoprolol-hydrochlorothiazide tablet 100-50 mg oral</i>	Preferred	
<i>metoprolol-hydrochlorothiazide tablet 50-25 mg oral</i>	Preferred	
<i>nadolol tablet 20 mg oral</i>	Non Preferred	PA
<i>nadolol tablet 40 mg oral</i>	Non Preferred	PA
<i>nadolol tablet 80 mg oral</i>	Non Preferred	PA
<i>nebivolol hcl tablet 10 mg oral</i>	Non Preferred	PA
<i>nebivolol hcl tablet 2.5 mg oral</i>	Non Preferred	PA
<i>nebivolol hcl tablet 20 mg oral</i>	Non Preferred	PA
<i>nebivolol hcl tablet 5 mg oral</i>	Non Preferred	PA
<i>pindolol tablet 10 mg oral</i>	Non Preferred	PA
<i>pindolol tablet 5 mg oral</i>	Non Preferred	PA
<i>propranolol hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl er capsule extended release 24 hour 160 mg oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl er capsule extended release 24 hour 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl er capsule extended release 24 hour 80 mg oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl solution 20 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl solution 40 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>propranolol hcl tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl tablet 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>propranolol hcl tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl (Sorine Tablet 120 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl (Sorine Tablet 160 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl (Sorine Tablet 240 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl (Sorine Tablet 80 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl (af) tablet 120 mg oral</i>	Preferred	
<i>sotalol hcl (af) tablet 160 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl (af) tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl tablet 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl tablet 160 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl tablet 240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sotalol hcl tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
SOTYLIZE SOLUTION 5 MG/ML ORAL (<i>sotalol hcl</i>)	Non Preferred	PA
TENORETIC 100 TABLET 100-25 MG ORAL (<i>atenolol-chlorthalidone</i>)	Non Preferred	PA
TENORETIC 50 TABLET 50-25 MG ORAL (<i>atenolol-chlorthalidone</i>)	Non Preferred	PA
TENORMIN TABLET 100 MG ORAL (<i>atenolol</i>)	Non Preferred	PA; Max 90-day supply per fill
TENORMIN TABLET 25 MG ORAL (<i>atenolol</i>)	Non Preferred	PA; Max 90-day supply per fill
TENORMIN TABLET 50 MG ORAL (<i>atenolol</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>timolol maleate tablet 10 mg oral</i>	Non Preferred	PA
<i>timolol maleate tablet 20 mg oral</i>	Non Preferred	PA
<i>timolol maleate tablet 5 mg oral</i>	Non Preferred	PA
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL (<i>metoprolol succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL (<i>metoprolol succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>metoprolol succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
TOPROL XL TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL (<i>metoprolol succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
ZIAC TABLET 10-6.25 MG ORAL (<i>bisoprolol-hydrochlorothiazide</i>)	Non Preferred	PA

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ZIAC TABLET 2.5-6.25 MG ORAL (<i>bisoprolol-hydrochlorothiazide</i>)	Non Preferred	PA
ZIAC TABLET 5-6.25 MG ORAL (<i>bisoprolol-hydrochlorothiazide</i>)	Non Preferred	PA
ANTIHYPERTENSIVES: CALCIUM CHANNEL BLOCKERS [OPEN CLASS]		
<i>amlodipine besylate tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besylate tablet 2.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>amlodipine besylate tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (<i>diltiazem hcl coated beads</i>)	Non Preferred	PA; Max 90-day supply per fill
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL (<i>diltiazem hcl coated beads</i>)	Non Preferred	PA; Max 90-day supply per fill
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL (<i>diltiazem hcl coated beads</i>)	Non Preferred	PA; Max 90-day supply per fill
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>diltiazem hcl coated beads</i>)	Non Preferred	PA; Max 90-day supply per fill
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL (<i>diltiazem hcl coated beads</i>)	Non Preferred	PA; Max 90-day supply per fill
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 120 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 180 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 240 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 360 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA
CARDIZEM LA TABLET EXTENDED RELEASE 24 HOUR 420 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA
CARDIZEM TABLET 120 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
CARDIZEM TABLET 30 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
CARDIZEM TABLET 60 MG ORAL (<i>diltiazem hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>diltiazem hcl coated beads</i> (Cartia Xt Capsule Extended Release 24 Hour 120 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl coated beads</i> (Cartia Xt Capsule Extended Release 24 Hour 180 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl coated beads</i> (Cartia Xt Capsule Extended Release 24 Hour 240 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl coated beads</i> (Cartia Xt Capsule Extended Release 24 Hour 300 Mg Oral)	Preferred	Max 90-day supply per fill

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>diltiazem hcl er beads capsule extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 180 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 360 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads capsule extended release 24 hour 420 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 12 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 12 hour 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 12 hour 90 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 180 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er coated beads capsule extended release 24 hour 360 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er tablet extended release 24 hour 120 mg oral</i>	Non Preferred	PA
<i>diltiazem hcl er tablet extended release 24 hour 180 mg oral</i>	Preferred	
<i>diltiazem hcl er tablet extended release 24 hour 240 mg oral</i>	Preferred	
<i>diltiazem hcl er tablet extended release 24 hour 300 mg oral</i>	Preferred	
<i>diltiazem hcl er tablet extended release 24 hour 360 mg oral</i>	Preferred	
<i>diltiazem hcl er tablet extended release 24 hour 420 mg oral</i>	Preferred	
<i>diltiazem hcl tablet 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl tablet 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl tablet 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diltiazem hcl tablet 90 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dilt-xr capsule extended release 24 hour 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dilt-xr capsule extended release 24 hour 180 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dilt-xr capsule extended release 24 hour 240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>felodipine er tablet extended release 24 hour 10 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>felodipine er tablet extended release 24 hour 2.5 mg oral</i>	Preferred	
<i>felodipine er tablet extended release 24 hour 5 mg oral</i>	Preferred	
<i>isradipine capsule 2.5 mg oral</i>	Non Preferred	PA
<i>isradipine capsule 5 mg oral</i>	Non Preferred	PA
KATERZIA SUSPENSION 1 MG/ML ORAL (<i>amlodipine benzoate</i>)	Non Preferred	PA
<i>levamlodipine maleate tablet 2.5 mg oral</i>	Non Preferred	PA
<i>levamlodipine maleate tablet 5 mg oral</i>	Non Preferred	PA
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 180 Mg Oral)</i>	Non Preferred	PA
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 240 Mg Oral)</i>	Non Preferred	PA
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 300 Mg Oral)</i>	Non Preferred	PA
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 360 Mg Oral)</i>	Non Preferred	PA
<i>diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 420 Mg Oral)</i>	Non Preferred	PA
<i>nicardipine hcl capsule 20 mg oral</i>	Non Preferred	PA
<i>nicardipine hcl capsule 30 mg oral</i>	Non Preferred	PA
<i>nifedipine capsule 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nifedipine capsule 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nifedipine er osmotic release tablet extended release 24 hour 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nifedipine er osmotic release tablet extended release 24 hour 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nifedipine er osmotic release tablet extended release 24 hour 90 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nifedipine er tablet extended release 24 hour 30 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nifedipine er tablet extended release 24 hour 60 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nifedipine er tablet extended release 24 hour 90 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nisoldipine er tablet extended release 24 hour 17 mg oral</i>	Non Preferred	PA
<i>nisoldipine er tablet extended release 24 hour 20 mg oral</i>	Non Preferred	PA
<i>nisoldipine er tablet extended release 24 hour 25.5 mg oral</i>	Non Preferred	PA
<i>nisoldipine er tablet extended release 24 hour 30 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>nisoldipine er tablet extended release 24 hour 34 mg oral</i>	Non Preferred	PA
<i>nisoldipine er tablet extended release 24 hour 40 mg oral</i>	Non Preferred	PA
<i>nisoldipine er tablet extended release 24 hour 8.5 mg oral</i>	Non Preferred	PA
NORLIQVA SOLUTION 1 MG/ML ORAL (<i>amlodipine besylate</i>)	Non Preferred	PA
NORVASC TABLET 10 MG ORAL (<i>amlodipine besylate</i>)	Non Preferred	PA; Max 90-day supply per fill
NORVASC TABLET 2.5 MG ORAL (<i>amlodipine besylate</i>)	Non Preferred	PA; Max 90-day supply per fill
NORVASC TABLET 5 MG ORAL (<i>amlodipine besylate</i>)	Non Preferred	PA; Max 90-day supply per fill
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 30 MG ORAL (<i>nifedipine</i>)	Non Preferred	PA; Max 90-day supply per fill
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 60 MG ORAL (<i>nifedipine</i>)	Non Preferred	PA; Max 90-day supply per fill
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 90 MG ORAL (<i>nifedipine</i>)	Non Preferred	PA; Max 90-day supply per fill
SULAR TABLET EXTENDED RELEASE 24 HOUR 17 MG ORAL (<i>nisoldipine</i>)	Non Preferred	PA
SULAR TABLET EXTENDED RELEASE 24 HOUR 34 MG ORAL (<i>nisoldipine</i>)	Non Preferred	PA
SULAR TABLET EXTENDED RELEASE 24 HOUR 8.5 MG ORAL (<i>nisoldipine</i>)	Non Preferred	PA
<i>diltiazem hcl er beads</i> (Taztia Xt Capsule Extended Release 24 Hour 120 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Taztia Xt Capsule Extended Release 24 Hour 180 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Taztia Xt Capsule Extended Release 24 Hour 240 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Taztia Xt Capsule Extended Release 24 Hour 300 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Taztia Xt Capsule Extended Release 24 Hour 360 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Tiadyt Er Capsule Extended Release 24 Hour 120 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Tiadyt Er Capsule Extended Release 24 Hour 180 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Tiadyt Er Capsule Extended Release 24 Hour 240 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Tiadyt Er Capsule Extended Release 24 Hour 300 Mg Oral)	Preferred	Max 90-day supply per fill
<i>diltiazem hcl er beads</i> (Tiadyt Er Capsule Extended Release 24 Hour 360 Mg Oral)	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>diltiazem hcl er beads</i> (Tiadylt Er Capsule Extended Release 24 Hour 420 Mg Oral)	Preferred	Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (<i>diltiazem hcl er beads</i>)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL (<i>diltiazem hcl er beads</i>)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL (<i>diltiazem hcl er beads</i>)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>diltiazem hcl er beads</i>)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL (<i>diltiazem hcl er beads</i>)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL (<i>diltiazem hcl er beads</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>verapamil hcl er capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA
<i>verapamil hcl er capsule extended release 24 hour 120 mg oral</i>	Preferred	
<i>verapamil hcl er capsule extended release 24 hour 180 mg oral</i>	Preferred	
<i>verapamil hcl er capsule extended release 24 hour 200 mg oral</i>	Non Preferred	PA
<i>verapamil hcl er capsule extended release 24 hour 240 mg oral</i>	Preferred	
<i>verapamil hcl er capsule extended release 24 hour 300 mg oral</i>	Non Preferred	PA
<i>verapamil hcl er capsule extended release 24 hour 360 mg oral</i>	Non Preferred	PA
<i>verapamil hcl er tablet extended release 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er tablet extended release 180 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl er tablet extended release 240 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl tablet 120 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>verapamil hcl tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (<i>verapamil hcl</i>)	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL (<i>verapamil hcl</i>)	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL (<i>verapamil hcl</i>)	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL (<i>verapamil hcl</i>)	Non Preferred	PA
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL (<i>verapamil hcl</i>)	Non Preferred	PA
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL (<i>verapamil hcl</i>)	Non Preferred	PA
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>verapamil hcl</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ANTIHYPERTENSIVES: SYMPATHOLYTICS [OPEN CLASS]		
CATAPRES-TTS-1 PATCH WEEKLY 0.1 MG/24HR TRANSDERMAL (<i>clonidine</i>)	Preferred	Max 90-day supply per fill
CATAPRES-TTS-2 PATCH WEEKLY 0.2 MG/24HR TRANSDERMAL (<i>clonidine</i>)	Preferred	Max 90-day supply per fill
CATAPRES-TTS-3 PATCH WEEKLY 0.3 MG/24HR TRANSDERMAL (<i>clonidine</i>)	Preferred	Max 90-day supply per fill
<i>clonidine hcl er tablet extended release 24 hour 0.17 mg oral</i>	Non Preferred	PA
<i>clonidine hcl tablet 0.1 mg oral</i>	Preferred	Max 90-day supply per fill
<i>clonidine hcl tablet 0.2 mg oral</i>	Preferred	Max 90-day supply per fill
<i>clonidine hcl tablet 0.3 mg oral</i>	Preferred	Max 90-day supply per fill
<i>clonidine patch weekly 0.1 mg/24hr transdermal</i>	Preferred	Max 90-day supply per fill
<i>clonidine patch weekly 0.2 mg/24hr transdermal</i>	Preferred	Max 90-day supply per fill
<i>clonidine patch weekly 0.3 mg/24hr transdermal</i>	Preferred	Max 90-day supply per fill
<i>guanfacine hcl tablet 1 mg oral</i>	Preferred	Max 90-day supply per fill
<i>guanfacine hcl tablet 2 mg oral</i>	Preferred	Max 90-day supply per fill
<i>methyldopa tablet 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>methyldopa tablet 500 mg oral</i>	Preferred	Max 90-day supply per fill
ANTIHYPERURICEMICS [OPEN CLASS]		
<i>allopurinol tablet 100 mg oral</i>	Preferred	Max 90-day supply per fill
<i>allopurinol tablet 200 mg oral</i>	Non Preferred	PA
<i>allopurinol tablet 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>colchicine capsule 0.6 mg oral</i>	Preferred	
<i>colchicine tablet 0.6 mg oral</i>	Preferred	Max 90-day supply per fill
<i>colchicine-probenecid tablet 0.5-500 mg oral</i>	Preferred	Max 90-day supply per fill
COLCRYS TABLET 0.6 MG ORAL (<i>colchicine</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>febuxostat tablet 40 mg oral</i>	Non Preferred	PA
<i>febuxostat tablet 80 mg oral</i>	Non Preferred	PA
GLOPERBA SOLUTION 0.6 MG/5ML ORAL (<i>colchicine</i>)	Non Preferred	PA
MITIGARE CAPSULE 0.6 MG ORAL (<i>colchicine</i>)	Non Preferred	PA
<i>probenecid tablet 500 mg oral</i>	Preferred	Max 90-day supply per fill
ULORIC TABLET 40 MG ORAL (<i>febuxostat</i>)	Non Preferred	PA
ULORIC TABLET 80 MG ORAL (<i>febuxostat</i>)	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ZYLOPRIM TABLET 100 MG ORAL (<i>allopurinol</i>)	Non Preferred	PA; Max 90-day supply per fill
ANTIMIGRAINE AGENTS [OPEN CLASS]		
<i>almotriptan malate tablet 12.5 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 Fill)
<i>almotriptan malate tablet 6.25 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 Fill)
<i>eletriptan hydrobromide tablet 20 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 Fill)
<i>eletriptan hydrobromide tablet 40 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 Fill)
FROVA TABLET 2.5 MG ORAL (<i>frovatriptan succinate</i>)	Non Preferred	PA; QL (12 EA per 1 Fill)
<i>frovatriptan succinate tablet 2.5 mg oral</i>	Non Preferred	PA; QL (12 EA per 1 Fill)
IMITREX SOLUTION 20 MG/ACT NASAL (<i>sumatriptan</i>)	Preferred	QL (6 EA per 30 days)
IMITREX SOLUTION 5 MG/ACT NASAL (<i>sumatriptan</i>)	Preferred	QL (6 EA per 30 days)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 4 MG/0.5ML SUBCUTANEOUS (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (2 ML per 30 days)
IMITREX STATDOSE REFILL SOLUTION CARTRIDGE 6 MG/0.5ML SUBCUTANEOUS (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (2 ML per 30 days)
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 4 MG/0.5ML SUBCUTANEOUS (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (2 ML per 30 days)
IMITREX STATDOSE SYSTEM SOLUTION AUTO-INJECTOR 6 MG/0.5ML SUBCUTANEOUS (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (2 ML per 30 days)
IMITREX TABLET 100 MG ORAL (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (9 EA per 1 Fill)
IMITREX TABLET 25 MG ORAL (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (18 EA per 1 Fill)
IMITREX TABLET 50 MG ORAL (<i>sumatriptan succinate</i>)	Non Preferred	PA; QL (18 EA per 1 Fill)
MAXALT TABLET 10 MG ORAL (<i>rizatriptan benzoate</i>)	Non Preferred	PA; QL (12 EA per 1 Fill)
MAXALT-MLT TABLET DISPERSIBLE 10 MG ORAL (<i>rizatriptan benzoate</i>)	Non Preferred	PA; QL (12 EA per 1 Fill)
<i>naratriptan hcl tablet 1 mg oral</i>	Non Preferred	PA; QL (9 EA per 1 Fill)
<i>naratriptan hcl tablet 2.5 mg oral</i>	Non Preferred	PA; QL (9 EA per 1 Fill)
ONZETRA XSAIL EXHALER POWDER 11 MG/NOSEPC NASAL (<i>sumatriptan succinate</i>)	Non Preferred	PA
RELPAK TABLET 20 MG ORAL (<i>eletriptan hydrobromide</i>)	Non Preferred	PA; QL (6 EA per 1 Fill)
RELPAK TABLET 40 MG ORAL (<i>eletriptan hydrobromide</i>)	Non Preferred	PA; QL (6 EA per 1 Fill)
<i>rizatriptan benzoate tablet 10 mg oral</i>	Preferred	QL (12 EA per 1 Fill)

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Drug Name	Formulary Status	Requirements/Limits
<i>rizatriptan benzoate tablet 5 mg oral</i>	Preferred	QL (12 EA per 1 Fill)
<i>rizatriptan benzoate tablet dispersible 10 mg oral</i>	Preferred	QL (12 EA per 1 Fill)
<i>rizatriptan benzoate tablet dispersible 5 mg oral</i>	Preferred	QL (12 EA per 1 Fill)
<i>sumatriptan solution 20 mg/act nasal</i>	Preferred	QL (6 EA per 30 days)
<i>sumatriptan solution 5 mg/act nasal</i>	Preferred	QL (6 EA per 30 days)
<i>sumatriptan succinate refill solution cartridge 4 mg/0.5ml subcutaneous</i>	Preferred	QL (2 ML per 30 days)
<i>sumatriptan succinate refill solution cartridge 6 mg/0.5ml subcutaneous</i>	Preferred	QL (2 ML per 30 days)
<i>sumatriptan succinate solution 6 mg/0.5ml subcutaneous</i>	Preferred	QL (1 ML per 30 days)
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml subcutaneous</i>	Preferred	QL (2 ML per 30 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml subcutaneous</i>	Preferred	QL (2 ML per 30 days)
<i>sumatriptan succinate tablet 100 mg oral</i>	Preferred	QL (9 EA per 1 Fill)
<i>sumatriptan succinate tablet 25 mg oral</i>	Preferred	QL (18 EA per 1 Fill)
<i>sumatriptan succinate tablet 50 mg oral</i>	Preferred	QL (18 EA per 1 Fill)
<i>sumatriptan-naproxen sodium tablet 85-500 mg oral</i>	Non Preferred	PA
TOSYMRA SOLUTION 10 MG/ACT NASAL (<i>sumatriptan</i>)	Non Preferred	PA; QL (6 EA per 30 days)
TREXIMET TABLET 85-500 MG ORAL (<i>sumatriptan-naproxen sodium</i>)	Non Preferred	PA
ZEMBRACE SYMTOUCH SOLUTION AUTO-INJECTOR 3 MG/0.5ML SUBCUTANEOUS (<i>sumatriptan succinate</i>)	Non Preferred	PA
<i>zolmitriptan solution 5 mg nasal</i>	Non Preferred	PA
<i>zolmitriptan tablet 2.5 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 Fill)
<i>zolmitriptan tablet 5 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 Fill)
<i>zolmitriptan tablet dispersible 2.5 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 Fill)
<i>zolmitriptan tablet dispersible 5 mg oral</i>	Non Preferred	PA; QL (8 EA per 1 Fill)
ZOMIG SOLUTION 2.5 MG NASAL (<i>zolmitriptan</i>)	Non Preferred	PA; QL (8 EA per 1 Fill)
ZOMIG SOLUTION 5 MG NASAL (<i>zolmitriptan</i>)	Non Preferred	PA
ZOMIG TABLET 2.5 MG ORAL (<i>zolmitriptan</i>)	Non Preferred	PA; QL (8 EA per 1 Fill)
ZOMIG TABLET 5 MG ORAL (<i>zolmitriptan</i>)	Non Preferred	PA; QL (8 EA per 1 Fill)

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Drug Name	Formulary Status	Requirements/Limits
ANTIMIGRAINE AGENTS, OTHERS [CLOSED CLASS]		
AIMOVIG SOLUTION AUTO-INJECTOR 140 MG/ML SUBCUTANEOUS (<i>erenumab-aooe</i>)	Preferred	PA (Eligible for auto-PA); QL (1 ML per 30 days); AGE (Min 18 Years)
AIMOVIG SOLUTION AUTO-INJECTOR 70 MG/ML SUBCUTANEOUS (<i>erenumab-aooe</i>)	Preferred	PA (Eligible for auto-PA); QL (1 ML per 30 days); AGE (Min 18 Years)
AJOVY SOLUTION AUTO-INJECTOR 225 MG/1.5ML SUBCUTANEOUS (<i>fremanezumab-vfrm</i>)	Preferred	PA (Eligible for auto-PA); QL (1.5 ML per 30 days); AGE (Min 18 Years)
AJOVY SOLUTION PREFILLED SYRINGE 225 MG/1.5ML SUBCUTANEOUS (<i>fremanezumab-vfrm</i>)	Preferred	PA (Eligible for auto-PA); QL (1.5 ML per 30 days); AGE (Min 18 Years)
EMGALITY (300 MG DOSE) SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS (<i>galcanezumab-gnlm</i>)	Non Preferred	PA; QL (3 ML per 30 days); AGE (Min 18 Years)
EMGALITY SOLUTION AUTO-INJECTOR 120 MG/ML SUBCUTANEOUS (<i>galcanezumab-gnlm</i>)	Preferred	PA (Eligible for auto-PA); QL (1 ML per 30 days); AGE (Min 18 Years)
EMGALITY SOLUTION PREFILLED SYRINGE 120 MG/ML SUBCUTANEOUS (<i>galcanezumab-gnlm</i>)	Preferred	PA (Eligible for auto-PA); QL (1 ML per 30 days); AGE (Min 18 Years)
NURTEC TABLET DISPERSIBLE 75 MG ORAL (<i>rimegepant sulfate</i>)	Preferred	PA (Eligible for auto-PA); QL (18 EA per 30 days); AGE (Min 18 Years)
QULIPTA TABLET 10 MG ORAL (<i>atogepant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QULIPTA TABLET 30 MG ORAL (<i>atogepant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QULIPTA TABLET 60 MG ORAL (<i>atogepant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
REYVOW TABLET 100 MG ORAL (<i>lasmiditan succinate</i>)	Non Preferred	PA; QL (8 EA per 30 days); AGE (Min 18 Years)
REYVOW TABLET 50 MG ORAL (<i>lasmiditan succinate</i>)	Non Preferred	PA; QL (8 EA per 30 days); AGE (Min 18 Years)
TRUDHESA AEROSOL SOLUTION 0.725 MG/ACT NASAL (<i>dihydroergotamine mesylate hfa</i>)	Non Preferred	PA; AGE (Min 18 Years)
UBRELVY TABLET 100 MG ORAL (<i>ubrogepant</i>)	Preferred	PA (Eligible for auto-PA); QL (16 EA per 30 days); AGE (Min 18 Years)
UBRELVY TABLET 50 MG ORAL (<i>ubrogepant</i>)	Preferred	PA (Eligible for auto-PA); QL (16 EA per 30 days); AGE (Min 18 Years)
ZAVZPRET SOLUTION 10 MG/ACT NASAL (<i>zavegepant hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: ATYPICAL [CLOSED CLASS]		
ABILIFY ASIMTUFII PREFILLED SYRINGE 720 MG/2.4ML INTRAMUSCULAR (<i>aripiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
ABILIFY ASIMTUFII PREFILLED SYRINGE 960 MG/3.2ML INTRAMUSCULAR (<i>aripiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 10 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 15 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 2 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 20 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 30 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 5 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 10 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 15 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 2 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 20 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 30 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 5 MG ORAL (<i>aripiprazole w/ sens-strip-pod</i>)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY TABLET 10 MG ORAL (<i>aripiprazole</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 15 MG ORAL (<i>aripiprazole</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 2 MG ORAL (<i>aripiprazole</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 20 MG ORAL (<i>aripiprazole</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 30 MG ORAL (<i>aripiprazole</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 5 MG ORAL (<i>aripiprazole</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>aripiprazole solution 1 mg/ml oral</i>	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>aripiprazole tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>aripiprazole tablet 15 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>aripiprazole tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>aripiprazole tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>aripiprazole tablet 30 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>aripiprazole tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>aripiprazole tablet dispersible 10 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>aripiprazole tablet dispersible 15 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>asenapine maleate tablet sublingual 10 mg sublingual</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
<i>asenapine maleate tablet sublingual 2.5 mg sublingual</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
<i>asenapine maleate tablet sublingual 5 mg sublingual</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
CAPLYTA CAPSULE 10.5 MG ORAL (<i>lumateperone tosylate</i>)	Non Preferred	PA; AGE (Min 18 Years)
CAPLYTA CAPSULE 21 MG ORAL (<i>lumateperone tosylate</i>)	Non Preferred	PA; AGE (Min 18 Years)
CAPLYTA CAPSULE 42 MG ORAL (<i>lumateperone tosylate</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>clozapine tablet 100 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>clozapine tablet 200 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>clozapine tablet 25 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>clozapine tablet 50 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>clozapine tablet dispersible 100 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>clozapine tablet dispersible 12.5 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>clozapine tablet dispersible 150 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>clozapine tablet dispersible 200 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>clozapine tablet dispersible 25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
CLOZARIL TABLET 100 MG ORAL (<i>clozapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
CLOZARIL TABLET 200 MG ORAL (<i>clozapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
CLOZARIL TABLET 25 MG ORAL (<i>clozapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
CLOZARIL TABLET 50 MG ORAL (<i>clozapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
FANAPT TABLET 1 MG ORAL (<i>iloperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TABLET 10 MG ORAL (<i>iloperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TABLET 12 MG ORAL (<i>iloperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TABLET 2 MG ORAL (<i>iloperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TABLET 4 MG ORAL (<i>iloperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TABLET 6 MG ORAL (<i>iloperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TABLET 8 MG ORAL (<i>iloperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TITRATION PACK TABLET 1 & 2 & 4 & 6 MG ORAL (<i>iloperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)
GEODON CAPSULE 20 MG ORAL (<i>ziprasidone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GEODON CAPSULE 40 MG ORAL (<i>ziprasidone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GEODON CAPSULE 60 MG ORAL (<i>ziprasidone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GEODON CAPSULE 80 MG ORAL (<i>ziprasidone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GEODON SOLUTION RECONSTITUTED 20 MG INTRAMUSCULAR (<i>ziprasidone mesylate</i>)	Non Preferred	PA; AGE (Min 18 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 1.5 MG ORAL (<i>paliperidone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL (<i>paliperidone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL (<i>paliperidone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
INVEGA TABLET EXTENDED RELEASE 24 HOUR 9 MG ORAL (<i>paliperidone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
LATUDA TABLET 120 MG ORAL (<i>lurasidone hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
LATUDA TABLET 20 MG ORAL (<i>lurasidone hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
LATUDA TABLET 40 MG ORAL (<i>lurasidone hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
LATUDA TABLET 60 MG ORAL (<i>lurasidone hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
LATUDA TABLET 80 MG ORAL (<i>lurasidone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 120 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 60 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>lurasidone hcl tablet 80 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
LYBALVI TABLET 10-10 MG ORAL (<i>olanzapine-samidorphan</i>)	Non Preferred	PA; AGE (Min 18 Years)
LYBALVI TABLET 15-10 MG ORAL (<i>olanzapine-samidorphan</i>)	Non Preferred	PA; AGE (Min 18 Years)
LYBALVI TABLET 20-10 MG ORAL (<i>olanzapine-samidorphan</i>)	Non Preferred	PA; AGE (Min 18 Years)
LYBALVI TABLET 5-10 MG ORAL (<i>olanzapine-samidorphan</i>)	Non Preferred	PA; AGE (Min 18 Years)
NUPLAZID CAPSULE 34 MG ORAL (<i>pimavanserin tartrate</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
NUPLAZID TABLET 10 MG ORAL (<i>pimavanserin tartrate</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
<i>olanzapine solution reconstituted 10 mg intramuscular</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet 15 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>olanzapine tablet 2.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet 20 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet 7.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet dispersible 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet dispersible 15 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet dispersible 20 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine tablet dispersible 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>olanzapine-fluoxetine hcl capsule 12-25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>olanzapine-fluoxetine hcl capsule 12-50 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>olanzapine-fluoxetine hcl capsule 3-25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>olanzapine-fluoxetine hcl capsule 6-25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>olanzapine-fluoxetine hcl capsule 6-50 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>paliperidone er tablet extended release 24 hour 1.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>paliperidone er tablet extended release 24 hour 3 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>paliperidone er tablet extended release 24 hour 6 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>paliperidone er tablet extended release 24 hour 9 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>quetiapine fumarate er tablet extended release 24 hour 150 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate er tablet extended release 24 hour 200 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate er tablet extended release 24 hour 300 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate er tablet extended release 24 hour 400 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate er tablet extended release 24 hour 50 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>quetiapine fumarate tablet 100 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 150 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>quetiapine fumarate tablet 200 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 25 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 300 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 400 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>quetiapine fumarate tablet 50 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
REXULTI TABLET 0.25 MG ORAL (<i>brexipiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 0.5 MG ORAL (<i>brexipiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 1 MG ORAL (<i>brexipiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 2 MG ORAL (<i>brexipiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 3 MG ORAL (<i>brexipiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 4 MG ORAL (<i>brexipiprazole</i>)	Non Preferred	PA; AGE (Min 18 Years)
RISPERDAL SOLUTION 1 MG/ML ORAL (<i>risperidone</i>)	Non Preferred	PA; QL (2 ML per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 0.5 MG ORAL (<i>risperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 1 MG ORAL (<i>risperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 2 MG ORAL (<i>risperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 3 MG ORAL (<i>risperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 4 MG ORAL (<i>risperidone</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone solution 1 mg/ml oral</i>	Preferred	QL (2 ML per 1 day); AGE (Min 18 Years); Max 90-day supply per fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>risperidone tablet 0.25 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet 0.5 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet 1 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet 2 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet 3 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet 4 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 0.25 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 0.5 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 1 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 2 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 3 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
<i>risperidone tablet dispersible 4 mg oral</i>	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
SAPHRIS TABLET SUBLINGUAL 10 MG SUBLINGUAL (<i>asenapine maleate</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
SAPHRIS TABLET SUBLINGUAL 2.5 MG SUBLINGUAL (<i>asenapine maleate</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
SAPHRIS TABLET SUBLINGUAL 5 MG SUBLINGUAL (<i>asenapine maleate</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
SECUADO PATCH 24 HOUR 3.8 MG/24HR TRANSDERMAL (<i>asenapine</i>)	Non Preferred	PA
SECUADO PATCH 24 HOUR 5.7 MG/24HR TRANSDERMAL (<i>asenapine</i>)	Non Preferred	PA
SECUADO PATCH 24 HOUR 7.6 MG/24HR TRANSDERMAL (<i>asenapine</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
SEROQUEL TABLET 100 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL TABLET 200 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL TABLET 25 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL TABLET 300 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL TABLET 400 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL TABLET 50 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 200 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 400 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SEROQUEL XR TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL (<i>quetiapine fumarate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
SYMBYAX CAPSULE 3-25 MG ORAL (<i>olanzapine-fluoxetine hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
SYMBYAX CAPSULE 6-25 MG ORAL (<i>olanzapine-fluoxetine hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
VERSACLOZ SUSPENSION 50 MG/ML ORAL (<i>clozapine</i>)	Non Preferred	PA; AGE (Min 18 Years)
VRAYLAR CAPSULE 1.5 MG ORAL (<i>cariprazine hcl</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
VRAYLAR CAPSULE 3 MG ORAL (<i>cariprazine hcl</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
VRAYLAR CAPSULE 4.5 MG ORAL (<i>cariprazine hcl</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
VRAYLAR CAPSULE 6 MG ORAL (<i>cariprazine hcl</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
VRAYLAR CAPSULE THERAPY PACK 1.5 & 3 MG ORAL (<i>cariprazine hcl</i>)	Preferred	AGE (Min 18 Years)
<i>ziprasidone hcl capsule 20 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>ziprasidone hcl capsule 40 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>ziprasidone hcl capsule 60 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>ziprasidone hcl capsule 80 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>ziprasidone mesylate solution reconstituted 20 mg intramuscular</i>	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA SOLUTION RECONSTITUTED 10 MG INTRAMUSCULAR (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA TABLET 10 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA TABLET 15 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA TABLET 2.5 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA TABLET 20 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA TABLET 5 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA TABLET 7.5 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA ZYDIS TABLET DISPERSIBLE 10 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA ZYDIS TABLET DISPERSIBLE 15 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA ZYDIS TABLET DISPERSIBLE 20 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ZYPREXA ZYDIS TABLET DISPERSIBLE 5 MG ORAL (<i>olanzapine</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ANTIPSYCHOTICS: ATYPICAL, LONG-ACTING INJECTABLE [CLOSED CLASS]		
ABILIFY MAINTENA PREFILLED SYRINGE 300 MG INTRAMUSCULAR (<i>aripiprazole</i>)	Preferred	AGE (Min 18 Years)
ABILIFY MAINTENA PREFILLED SYRINGE 400 MG INTRAMUSCULAR (<i>aripiprazole</i>)	Preferred	AGE (Min 18 Years)
ABILIFY MAINTENA SUSPENSION RECONSTITUTED ER 300 MG INTRAMUSCULAR (<i>aripiprazole</i>)	Preferred	AGE (Min 18 Years)
ABILIFY MAINTENA SUSPENSION RECONSTITUTED ER 400 MG INTRAMUSCULAR (<i>aripiprazole</i>)	Preferred	AGE (Min 18 Years)
ARISTADA INITIO PREFILLED SYRINGE 675 MG/2.4ML INTRAMUSCULAR (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years); Max 60-day supply per fill
ARISTADA PREFILLED SYRINGE 1064 MG/3.9ML INTRAMUSCULAR (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years); Max 60-day supply per fill
ARISTADA PREFILLED SYRINGE 441 MG/1.6ML INTRAMUSCULAR (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years); Max 60-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
ARISTADA PREFILLED SYRINGE 662 MG/2.4ML INTRAMUSCULAR (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years); Max 60-day supply per fill
ARISTADA PREFILLED SYRINGE 882 MG/3.2ML INTRAMUSCULAR (<i>aripiprazole lauroxil</i>)	Preferred	AGE (Min 18 Years); Max 60-day supply per fill
INVEGA HAFYERA SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years)
INVEGA HAFYERA SUSPENSION PREFILLED SYRINGE 1560 MG/5ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 156 MG/ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years)
INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years)
INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML INTRAMUSCULAR (<i>paliperidone palmitate</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
PERSERIS PREFILLED SYRINGE 120 MG SUBCUTANEOUS (<i>risperidone</i>)	Preferred	AGE (Min 18 Years)
PERSERIS PREFILLED SYRINGE 90 MG SUBCUTANEOUS (<i>risperidone</i>)	Preferred	AGE (Min 18 Years)
RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 12.5 MG INTRAMUSCULAR (<i>risperidone microspheres</i>)	Preferred	AGE (Min 18 Years)
RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 25 MG INTRAMUSCULAR (<i>risperidone microspheres</i>)	Preferred	QL (2 EA per 28 days); AGE (Min 18 Years)
RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 37.5 MG INTRAMUSCULAR (<i>risperidone microspheres</i>)	Preferred	QL (2 EA per 28 days); AGE (Min 18 Years)
RISPERDAL CONSTA SUSPENSION RECONSTITUTED ER 50 MG INTRAMUSCULAR (<i>risperidone microspheres</i>)	Preferred	QL (2 EA per 28 days); AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML SUBCUTANEOUS (<i>risperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 125 MG/0.35ML SUBCUTANEOUS (<i>risperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 150 MG/0.42ML SUBCUTANEOUS (<i>risperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 200 MG/0.56ML SUBCUTANEOUS (<i>risperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
UZEDY SUSPENSION PREFILLED SYRINGE 250 MG/0.7ML SUBCUTANEOUS (<i>risperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 50 MG/0.14ML SUBCUTANEOUS (<i>risperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)
UZEDY SUSPENSION PREFILLED SYRINGE 75 MG/0.21ML SUBCUTANEOUS (<i>risperidone</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 210 MG INTRAMUSCULAR (<i>olanzapine pamoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 300 MG INTRAMUSCULAR (<i>olanzapine pamoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 405 MG INTRAMUSCULAR (<i>olanzapine pamoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: TYPICAL [CLOSED CLASS]		
ADASUVE AEROSOL POWDER BREATH ACTIVATED 10 MG INHALATION (<i>loxapine</i>)	Non Preferred	PA
<i>chlorpromazine hcl concentrate 100 mg/ml oral</i>	Preferred	AGE (Min 18 Years)
<i>chlorpromazine hcl concentrate 30 mg/ml oral</i>	Preferred	AGE (Min 18 Years)
<i>chlorpromazine hcl solution 25 mg/ml injection</i>	Preferred	AGE (Min 18 Years)
<i>chlorpromazine hcl solution 50 mg/2ml injection</i>	Preferred	AGE (Min 18 Years)
<i>chlorpromazine hcl tablet 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>chlorpromazine hcl tablet 100 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>chlorpromazine hcl tablet 200 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>chlorpromazine hcl tablet 25 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>chlorpromazine hcl tablet 50 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>fluphenazine decanoate solution 25 mg/ml injection</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>fluphenazine hcl concentrate 5 mg/ml oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>fluphenazine hcl elixir 2.5 mg/5ml oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>fluphenazine hcl solution 2.5 mg/ml injection</i>	Preferred	AGE (Min 18 Years)
<i>fluphenazine hcl tablet 1 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>fluphenazine hcl tablet 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>fluphenazine hcl tablet 2.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>fluphenazine hcl tablet 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
HALDOL DECANOATE SOLUTION 100 MG/ML INTRAMUSCULAR (<i>haloperidol decanoate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
HALDOL DECANOATE SOLUTION 50 MG/ML INTRAMUSCULAR (<i>haloperidol decanoate</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol decanoate solution 100 mg/ml intramuscular</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol decanoate solution 50 mg/ml intramuscular</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol lactate concentrate 2 mg/ml oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol lactate solution 5 mg/ml injection</i>	Preferred	AGE (Min 18 Years)
<i>haloperidol tablet 0.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol tablet 1 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol tablet 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol tablet 2 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol tablet 20 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>haloperidol tablet 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>loxapine succinate capsule 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>loxapine succinate capsule 25 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>loxapine succinate capsule 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>loxapine succinate capsule 50 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>molindone hcl tablet 10 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>molindone hcl tablet 25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>molindone hcl tablet 5 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>perphenazine tablet 16 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>perphenazine tablet 2 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>perphenazine tablet 4 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>perphenazine tablet 8 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>perphenazine-amitriptyline tablet 2-10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>perphenazine-amitriptyline tablet 2-25 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>perphenazine-amitriptyline tablet 4-10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>perphenazine-amitriptyline tablet 4-25 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>perphenazine-amitriptyline tablet 4-50 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>pimozide tablet 1 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>pimozide tablet 2 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>thioridazine hcl tablet 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>thioridazine hcl tablet 100 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>thioridazine hcl tablet 25 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>thioridazine hcl tablet 50 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>thiothixene capsule 1 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>thiothixene capsule 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>thiothixene capsule 2 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>thiothixene capsule 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>trifluoperazine hcl tablet 1 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>trifluoperazine hcl tablet 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>trifluoperazine hcl tablet 2 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>trifluoperazine hcl tablet 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
BENIGN PROSTATIC HYPERTROPHY (BPH) [OPEN CLASS]		
<i>alfuzosin hcl er tablet extended release 24 hour 10 mg oral</i>	Preferred	Max 90-day supply per fill
AVODART CAPSULE 0.5 MG ORAL (<i>dutasteride</i>)	Non Preferred	PA; Max 90-day supply per fill
CIALIS TABLET 2.5 MG ORAL (<i>tadalafil</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
CIALIS TABLET 5 MG ORAL (<i>tadalafil</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>dutasteride capsule 0.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dutasteride-tamsulosin hcl capsule 0.5-0.4 mg oral</i>	Non Preferred	PA
ENTADFI CAPSULE 5-5 MG ORAL (<i>finasteride-tadalafil</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>finasteride tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
FLOMAX CAPSULE 0.4 MG ORAL (<i>tamsulosin hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
JALYN CAPSULE 0.5-0.4 MG ORAL (<i>dutasteride-tamsulosin hcl</i>)	Non Preferred	PA
PROSCAR TABLET 5 MG ORAL (<i>finasteride</i>)	Non Preferred	PA; Max 90-day supply per fill
RAPAFLO CAPSULE 4 MG ORAL (<i>silodosin</i>)	Non Preferred	PA
RAPAFLO CAPSULE 8 MG ORAL (<i>silodosin</i>)	Non Preferred	PA
<i>silodosin capsule 4 mg oral</i>	Non Preferred	PA
<i>silodosin capsule 8 mg oral</i>	Non Preferred	PA
<i>tadalafil tablet 2.5 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tadalafil tablet 5 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>tamsulosin hcl capsule 0.4 mg oral</i>	Preferred	Max 90-day supply per fill
BILE SALTS [OPEN CLASS]		
BYLVAY (PELLETS) CAPSULE SPRINKLE 200 MCG ORAL (<i>odevixibat</i>)	Non Preferred	PA
BYLVAY (PELLETS) CAPSULE SPRINKLE 600 MCG ORAL (<i>odevixibat</i>)	Non Preferred	PA
BYLVAY CAPSULE 1200 MCG ORAL (<i>odevixibat</i>)	Non Preferred	PA
BYLVAY CAPSULE 400 MCG ORAL (<i>odevixibat</i>)	Non Preferred	PA
CHENODAL TABLET 250 MG ORAL (<i>chenodiol</i>)	Non Preferred	PA
CHOLBAM CAPSULE 250 MG ORAL (<i>cholic acid</i>)	Non Preferred	PA
CHOLBAM CAPSULE 50 MG ORAL (<i>cholic acid</i>)	Non Preferred	PA
LIVMARLI SOLUTION 9.5 MG/ML ORAL (<i>maralixibat chloride</i>)	Non Preferred	PA
OCALIVA TABLET 10 MG ORAL (<i>obeticholic acid</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
OCALIVA TABLET 5 MG ORAL (<i>obeticholic acid</i>)	Non Preferred	PA
RELTONE CAPSULE 200 MG ORAL (<i>ursodiol</i>)	Non Preferred	PA
RELTONE CAPSULE 400 MG ORAL (<i>ursodiol</i>)	Non Preferred	PA
URSO 250 TABLET 250 MG ORAL (<i>ursodiol</i>)	Non Preferred	PA; Max 90-day supply per fill
URSO FORTE TABLET 500 MG ORAL (<i>ursodiol</i>)	Non Preferred	PA
<i>ursodiol capsule 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ursodiol tablet 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ursodiol tablet 500 mg oral</i>	Preferred	
BONE RESORPTION SUPPRESSION: BISPHOSPHONATES [OPEN CLASS]		
ACTONEL TABLET 150 MG ORAL (<i>risedronate sodium</i>)	Non Preferred	PA
ACTONEL TABLET 35 MG ORAL (<i>risedronate sodium</i>)	Non Preferred	PA
<i>alendronate sodium solution 70 mg/75ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>alendronate sodium tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>alendronate sodium tablet 35 mg oral</i>	Preferred	Max 90-day supply per fill
<i>alendronate sodium tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>alendronate sodium tablet 70 mg oral</i>	Preferred	Max 90-day supply per fill
ATELVIA TABLET DELAYED RELEASE 35 MG ORAL (<i>risedronate sodium</i>)	Non Preferred	PA
FOSAMAX PLUS D TABLET 70-2800 MG-UNIT ORAL (<i>alendronate-cholecalciferol</i>)	Non Preferred	PA
FOSAMAX PLUS D TABLET 70-5600 MG-UNIT ORAL (<i>alendronate-cholecalciferol</i>)	Non Preferred	PA
FOSAMAX TABLET 70 MG ORAL (<i>alendronate sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>ibandronate sodium tablet 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>risedronate sodium tablet 150 mg oral</i>	Non Preferred	PA
<i>risedronate sodium tablet 30 mg oral</i>	Non Preferred	PA
<i>risedronate sodium tablet 35 mg oral</i>	Non Preferred	PA
<i>risedronate sodium tablet 5 mg oral</i>	Non Preferred	PA
<i>risedronate sodium tablet delayed release 35 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
BONE RESORPTION SUPPRESSION: CALCITONINS [OPEN CLASS]		
<i>calcitonin (salmon) solution 200 unit/act nasal</i>	Preferred	Max 90-day supply per fill
BONE RESORPTION SUPPRESSION: OTHER [OPEN CLASS]		
EVISTA TABLET 60 MG ORAL (<i>raloxifene hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>raloxifene hcl tablet 60 mg oral</i>	Preferred	Max 90-day supply per fill
TYMLOS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML SUBCUTANEOUS (<i>abaloparatide</i>)	Non Preferred	PA
BRONCHODILATORS, LONG ACTING BETA ADRENERGICS (LABA) [OPEN CLASS]		
<i>arformoterol tartrate nebulization solution 15 mcg/2ml inhalation</i>	Non Preferred	PA
<i>arformoterol tartrate nebulization solution 15 mcg/2ml inhalation</i>	Preferred	
BROVANA NEBULIZATION SOLUTION 15 MCG/2ML INHALATION (<i>arformoterol tartrate</i>)	Non Preferred	PA
<i>formoterol fumarate nebulization solution 20 mcg/2ml inhalation</i>	Non Preferred	PA
PERFORMIST NEBULIZATION SOLUTION 20 MCG/2ML INHALATION (<i>formoterol fumarate</i>)	Non Preferred	PA
SEREVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION (<i>salmeterol xinafoate</i>)	Preferred	Max 90-day supply per fill
STRIVERDI RESPIMAT AEROSOL SOLUTION 2.5 MCG/ACT INHALATION (<i>olodaterol hcl</i>)	Preferred	
BRONCHODILATORS, SHORT ACTING BETA ADRENERGIC [OPEN CLASS]		
<i>albuterol sulfate hfa aerosol solution 108 (90 base) mcg/act inhalation</i>	Preferred	Max 90-day supply per fill
<i>albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083% inhalation</i>	Preferred	Max 90-day supply per fill
<i>albuterol sulfate nebulization solution (5 mg/ml) 0.5% inhalation</i>	Preferred	
<i>albuterol sulfate nebulization solution 0.63 mg/3ml inhalation</i>	Preferred	Max 90-day supply per fill
<i>albuterol sulfate nebulization solution 1.25 mg/3ml inhalation</i>	Preferred	Max 90-day supply per fill
<i>albuterol sulfate nebulization solution 2.5 mg/0.5ml inhalation</i>	Preferred	
<i>levalbuterol hcl nebulization solution 0.31 mg/3ml inhalation</i>	Non Preferred	PA
<i>levalbuterol hcl nebulization solution 0.63 mg/3ml inhalation</i>	Non Preferred	PA
<i>levalbuterol hcl nebulization solution 1.25 mg/0.5ml inhalation</i>	Non Preferred	PA
<i>levalbuterol hcl nebulization solution 1.25 mg/3ml inhalation</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>levalbuterol tartrate aerosol 45 mcg/act inhalation</i>	Non Preferred	PA
PROAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT INHALATION (<i>albuterol sulfate (sensor)</i>)	Non Preferred	PA
PROAIR RESPICLICK AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT INHALATION (<i>albuterol sulfate</i>)	Non Preferred	PA
PROVENTIL HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION (<i>albuterol sulfate</i>)	Non Preferred	PA; Max 90-day supply per fill
VENTOLIN HFA AEROSOL SOLUTION 108 (90 BASE) MCG/ACT INHALATION (<i>albuterol sulfate</i>)	Preferred	Max 90-day supply per fill
XOPENEX HFA AEROSOL 45 MCG/ACT INHALATION (<i>levalbuterol tartrate</i>)	Non Preferred	PA
CEPHALOSPORINS, ORAL [OPEN CLASS]		
<i>cefaclor capsule 250 mg oral</i>	Preferred	
<i>cefaclor capsule 500 mg oral</i>	Preferred	
<i>cefaclor er tablet extended release 12 hour 500 mg oral</i>	Non Preferred	PA
<i>cefaclor suspension reconstituted 125 mg/5ml oral</i>	Non Preferred	PA
<i>cefaclor suspension reconstituted 375 mg/5ml oral</i>	Non Preferred	PA
<i>cefdinir capsule 300 mg oral</i>	Preferred	
<i>cefdinir suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>cefdinir suspension reconstituted 250 mg/5ml oral</i>	Preferred	
<i>cefixime capsule 400 mg oral</i>	Non Preferred	PA
<i>cefixime suspension reconstituted 100 mg/5ml oral</i>	Non Preferred	PA
<i>cefixime suspension reconstituted 200 mg/5ml oral</i>	Non Preferred	PA
<i>cefpodoxime proxetil suspension reconstituted 100 mg/5ml oral</i>	Non Preferred	PA
<i>cefpodoxime proxetil suspension reconstituted 50 mg/5ml oral</i>	Non Preferred	PA
<i>cefpodoxime proxetil tablet 100 mg oral</i>	Non Preferred	PA
<i>cefpodoxime proxetil tablet 200 mg oral</i>	Non Preferred	PA
<i>cefprozil suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>cefprozil suspension reconstituted 250 mg/5ml oral</i>	Preferred	
<i>cefprozil tablet 250 mg oral</i>	Preferred	
<i>cefprozil tablet 500 mg oral</i>	Preferred	
<i>cefuroxime axetil tablet 250 mg oral</i>	Preferred	
<i>cefuroxime axetil tablet 500 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
SUPRAX CAPSULE 400 MG ORAL (<i>cefixime</i>)	Non Preferred	PA
SUPRAX SUSPENSION RECONSTITUTED 200 MG/5ML ORAL (<i>cefixime</i>)	Non Preferred	PA
SUPRAX SUSPENSION RECONSTITUTED 500 MG/5ML ORAL (<i>cefixime</i>)	Non Preferred	PA
SUPRAX TABLET CHEWABLE 100 MG ORAL (<i>cefixime</i>)	Non Preferred	PA
SUPRAX TABLET CHEWABLE 200 MG ORAL (<i>cefixime</i>)	Non Preferred	PA
CONTRACEPTIVES (LONG-ACTING IUDS & INJECTABLE) [OPEN CLASS]		
DEPO-PROVERA SUSPENSION 150 MG/ML INTRAMUSCULAR (<i>medroxyprogesterone acetate</i>)	Non Preferred	PA; Max 365-day supply per fill
DEPO-PROVERA SUSPENSION PREFILLED SYRINGE 150 MG/ML INTRAMUSCULAR (<i>medroxyprogesterone acetate</i>)	Non Preferred	PA; Max 365-day supply per fill
DEPO-SUBQ PROVERA 104 SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML SUBCUTANEOUS (<i>medroxyprogesterone acetate</i>)	Preferred	Max 365-day supply per fill
KYLEENA INTRAUTERINE DEVICE 19.5 MG INTRAUTERINE (<i>levonorgestrel</i>)	Preferred	Max 365-day supply per fill
LILETTA (52 MG) INTRAUTERINE DEVICE 20.1 MCG/DAY INTRAUTERINE (<i>levonorgestrel</i>)	Preferred	Max 365-day supply per fill
<i>medroxyprogesterone acetate suspension 150 mg/ml intramuscular</i>	Preferred	Max 365-day supply per fill
<i>medroxyprogesterone acetate suspension prefilled syringe 150 mg/ml intramuscular</i>	Preferred	Max 365-day supply per fill
MIRENA (52 MG) INTRAUTERINE DEVICE 20 MCG/DAY INTRAUTERINE (<i>levonorgestrel</i>)	Preferred	Max 365-day supply per fill
NEXPLANON IMPLANT 68 MG SUBCUTANEOUS (<i>etonogestrel</i>)	Preferred	Max 365-day supply per fill
PARAGARD INTRAUTERINE COPPER INTRAUTERINE DEVICE INTRAUTERINE (<i>copper</i>)	Preferred	Max 365-day supply per fill
SKYLA INTRAUTERINE DEVICE 13.5 MG INTRAUTERINE (<i>levonorgestrel</i>)	Preferred	Max 365-day supply per fill
COPD: BRONCHODILATORS AND PHOSPHODIESTERASE 4 (PDE4) INHIBITORS [CLOSED CLASS]		
ANORO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT INHALATION (<i>umeclidinium-vilanterol</i>)	Preferred	Max 90-day supply per fill
ATROVENT HFA AEROSOL SOLUTION 17 MCG/ACT INHALATION (<i>ipratropium bromide hfa</i>)	Preferred	Max 90-day supply per fill
BEVESPI AEROSPHERE AEROSOL 9-4.8 MCG/ACT INHALATION (<i>glycopyrrolate-formoterol</i>)	Non Preferred	PA; Max 90-day supply per fill
COMBIVENT RESPIMAT AEROSOL SOLUTION 20-100 MCG/ACT INHALATION (<i>ipratropium-albuterol</i>)	Preferred	Max 90-day supply per fill
DALIRESP TABLET 250 MCG ORAL (<i>roflumilast</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
DALIRESP TABLET 500 MCG ORAL (<i>roflumilast</i>)	Non Preferred	PA
DUAKLIR PRESSAIR AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT INHALATION (<i>aclidinium br-formoterol fum</i>)	Non Preferred	PA
INCRUSE ELLIPTA AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT INHALATION (<i>umeclidinium bromide</i>)	Non Preferred	PA
<i>ipratropium bromide solution 0.02 % inhalation</i>	Preferred	Max 90-day supply per fill
<i>ipratropium-albuterol solution 0.5-2.5 (3) mg/3ml inhalation</i>	Preferred	Max 90-day supply per fill
<i>roflumilast tablet 250 mcg oral</i>	Non Preferred	PA
<i>roflumilast tablet 500 mcg oral</i>	Non Preferred	PA
SPIRIVA HANDIHALER CAPSULE 18 MCG INHALATION (<i>tiotropium bromide monohydrate</i>)	Preferred	Max 90-day supply per fill
SPIRIVA RESPIMAT AEROSOL SOLUTION 1.25 MCG/ACT INHALATION (<i>tiotropium bromide monohydrate</i>)	Preferred	Max 90-day supply per fill
SPIRIVA RESPIMAT AEROSOL SOLUTION 2.5 MCG/ACT INHALATION (<i>tiotropium bromide monohydrate</i>)	Preferred	Max 90-day supply per fill
STIOLTO RESPIMAT AEROSOL SOLUTION 2.5-2.5 MCG/ACT INHALATION (<i>tiotropium bromide-olodaterol</i>)	Preferred	Max 90-day supply per fill
TUDORZA PRESSAIR AEROSOL POWDER BREATH ACTIVATED 400 MCG/ACT INHALATION (<i>aclidinium bromide</i>)	Non Preferred	PA
YUPELRI SOLUTION 175 MCG/3ML INHALATION (<i>revefenacin</i>)	Non Preferred	PA
COUGH AND COLD [OPEN CLASS]		
<i>guaifatussin ac syrup 100-10 mg/5ml oral</i>	Preferred	AGE (Min 18 Years)
<i>guaifenesin-codeine solution 100-10 mg/5ml oral (otc)</i>	Preferred	AGE (Min 18 Years)
HYCODAN SOLUTION 5-1.5 MG/5ML ORAL (<i>hydrocodone bit-homatrop mbr</i>)	Preferred	AGE (Min 18 Years)
HYCODAN TABLET 5-1.5 MG ORAL (<i>hydrocodone bit-homatrop mbr</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>hydrocod poli-chlorphe poli er suspension extended release 10-8 mg/5ml oral</i>	Non Preferred	PA; AGE (Min 6 Years)
<i>hydrocodone bit-homatrop mbr solution 5-1.5 mg/5ml oral</i>	Preferred	AGE (Min 18 Years)
<i>hydrocodone bit-homatrop mbr tablet 5-1.5 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>hydromet solution 5-1.5 mg/5ml oral</i>	Preferred	AGE (Min 18 Years)
MAR-COF CG EXPECTORANT LIQUID 225-7.5 MG/5ML ORAL (<i>guaifenesin-codeine</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>m-clear wc solution 100-6.33 mg/5ml oral</i>	Non Preferred	PA; AGE (Min 18 Years)
M-END PE LIQUID 3.33-1.33-6.33 MG/5ML ORAL (<i>phenylephrine-bromphen-codeine</i>)	Non Preferred	PA; AGE (Min 6 Years)
NINJACOF-XG LIQUID 200-8 MG/5ML ORAL (<i>guaifenesin-codeine</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>poly-tussin ac liquid 10-4-10 mg/5ml oral</i>	Non Preferred	PA; AGE (Min 6 Years)
<i>promethazine vc/codeine syrup 6.25-5-10 mg/5ml oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>promethazine-codeine solution 6.25-10 mg/5ml oral</i>	Preferred	AGE (Min 18 Years)
<i>promethazine-codeine syrup 6.25-10 mg/5ml oral</i>	Preferred	AGE (Min 18 Years)
TUXARIN ER TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG ORAL (<i>chlorpheniramine-codeine</i>)	Non Preferred	PA; AGE (Min 6 Years)
CYTOKINE AND CAM ANTAGONISTS AND RELATED AGENTS [CLOSED CLASS]		
ACTEMRA ACTPEN SOLUTION AUTO-INJECTOR 162 MG/0.9ML SUBCUTANEOUS (<i>tocilizumab</i>)	Non Preferred	PA
ACTEMRA SOLUTION 200 MG/10ML INTRAVENOUS (<i>tocilizumab</i>)	Non Preferred	PA
ACTEMRA SOLUTION 400 MG/20ML INTRAVENOUS (<i>tocilizumab</i>)	Non Preferred	PA
ACTEMRA SOLUTION 80 MG/4ML INTRAVENOUS (<i>tocilizumab</i>)	Non Preferred	PA
ACTEMRA SOLUTION PREFILLED SYRINGE 162 MG/0.9ML SUBCUTANEOUS (<i>tocilizumab</i>)	Non Preferred	PA
<i>adalimumab-adaz solution auto-injector 40 mg/0.4ml subcutaneous</i>	Non Preferred	PA
<i>adalimumab-adaz solution prefilled syringe 40 mg/0.4ml subcutaneous</i>	Non Preferred	PA
AMJEVITA SOLUTION AUTO-INJECTOR 40 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	Non Preferred	PA; AGE (Min 2 Years)
AMJEVITA SOLUTION PREFILLED SYRINGE 10 MG/0.2ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	Non Preferred	PA; AGE (Min 2 Years)
AMJEVITA SOLUTION PREFILLED SYRINGE 20 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	Non Preferred	PA; AGE (Min 2 Years)
AMJEVITA SOLUTION PREFILLED SYRINGE 40 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-atto</i>)	Non Preferred	PA; AGE (Min 2 Years)
ARCALYST SOLUTION RECONSTITUTED 220 MG SUBCUTANEOUS (<i>rilonacept</i>)	Non Preferred	PA
AVSOLA SOLUTION RECONSTITUTED 100 MG INTRAVENOUS (<i>infliximab-axxq</i>)	Non Preferred	PA
CIBINQO TABLET 100 MG ORAL (<i>abrocitinib</i>)	Non Preferred	PA; AGE (Min 18 Years)
CIBINQO TABLET 200 MG ORAL (<i>abrocitinib</i>)	Non Preferred	PA; AGE (Min 18 Years)
CIBINQO TABLET 50 MG ORAL (<i>abrocitinib</i>)	Non Preferred	PA; AGE (Min 18 Years)
CIMZIA KIT 2 X 200 MG SUBCUTANEOUS (<i>certolizumab pegol</i>)	Non Preferred	PA
CIMZIA PREFILLED SYRINGE KIT 2 X 200 MG/ML SUBCUTANEOUS (<i>certolizumab pegol</i>)	Non Preferred	PA

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CIMZIA STARTER KIT PREFILLED SYRINGE KIT 6 X 200 MG/ML SUBCUTANEOUS (<i>certolizumab pegol</i>)	Non Preferred	PA
COSENTYX (300 MG DOSE) SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS (<i>secukinumab</i>)	Non Preferred	PA
COSENTYX SENSOREADY (300 MG) SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS (<i>secukinumab</i>)	Non Preferred	PA
COSENTYX SENSOREADY PEN SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS (<i>secukinumab</i>)	Non Preferred	PA
COSENTYX SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS (<i>secukinumab</i>)	Non Preferred	PA
COSENTYX SOLUTION PREFILLED SYRINGE 75 MG/0.5ML SUBCUTANEOUS (<i>secukinumab</i>)	Non Preferred	PA
ENBREL MINI SOLUTION CARTRIDGE 50 MG/ML SUBCUTANEOUS (<i>etanercept</i>)	Preferred	QL (8 ML per 34 days); AGE (Min 2 Years)
ENBREL SOLUTION 25 MG/0.5ML SUBCUTANEOUS (<i>etanercept</i>)	Preferred	QL (4 ML per 34 days); AGE (Min 2 Years)
ENBREL SOLUTION PREFILLED SYRINGE 25 MG/0.5ML SUBCUTANEOUS (<i>etanercept</i>)	Preferred	QL (4 ML per 34 days); AGE (Min 2 Years)
ENBREL SOLUTION PREFILLED SYRINGE 50 MG/ML SUBCUTANEOUS (<i>etanercept</i>)	Preferred	QL (8 ML per 34 days); AGE (Min 2 Years)
ENBREL SURECLICK SOLUTION AUTO-INJECTOR 50 MG/ML SUBCUTANEOUS (<i>etanercept</i>)	Preferred	QL (8 ML per 34 days); AGE (Min 2 Years)
ENSPRYNG SOLUTION PREFILLED SYRINGE 120 MG/ML SUBCUTANEOUS (<i>satralizumab-mwge</i>)	Non Preferred	PA
ENTYVIO SOLUTION RECONSTITUTED 300 MG INTRAVENOUS (<i>vedolizumab</i>)	Non Preferred	PA
HADLIMA PUSHTOUCH SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-bwwd</i>)	Non Preferred	PA
HADLIMA PUSHTOUCH SOLUTION AUTO-INJECTOR 40 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-bwwd</i>)	Non Preferred	PA
HADLIMA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-bwwd</i>)	Non Preferred	PA
HADLIMA SOLUTION PREFILLED SYRINGE 40 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-bwwd</i>)	Non Preferred	PA
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PEN PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PEN-PEDIATRIC UC START PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PEN-PS/UV/ADOL HS START PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PEN-PSOR/UEIT STARTER PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HUMIRA PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS (<i>adalimumab</i>)	Preferred	AGE (Min 2 Years)
HYRIMOZ SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
HYRIMOZ SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
HYRIMOZ SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
HYRIMOZ SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
HYRIMOZ SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
HYRIMOZ-CROHNS/UC STARTER PACK SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
HYRIMOZ-PED CROHNS STARTER SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
HYRIMOZ-PED CROHNS STARTER SOLUTION PREFILLED SYRINGE 80 MG/0.8ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
HYRIMOZ-PLAQUE PSORIASIS START SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS (<i>adalimumab-adaz</i>)	Non Preferred	PA
ILARIS SOLUTION 150 MG/ML SUBCUTANEOUS (<i>canakinumab</i>)	Non Preferred	PA
ILUMYA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS (<i>tildrakizumab-asmn</i>)	Non Preferred	PA; AGE (Min 18 Years)
INFLECTRA SOLUTION RECONSTITUTED 100 MG INTRAVENOUS (<i>infliximab-dyyb</i>)	Non Preferred	PA
<i>infliximab solution reconstituted 100 mg intravenous</i>	Preferred	
KEVZARA SOLUTION AUTO-INJECTOR 150 MG/1.14ML SUBCUTANEOUS (<i>sarilumab</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
KEVZARA SOLUTION AUTO-INJECTOR 200 MG/1.14ML SUBCUTANEOUS (<i>sarilumab</i>)	Non Preferred	PA; AGE (Min 18 Years)
KEVZARA SOLUTION PREFILLED SYRINGE 150 MG/1.14ML SUBCUTANEOUS (<i>sarilumab</i>)	Non Preferred	PA; AGE (Min 18 Years)
KEVZARA SOLUTION PREFILLED SYRINGE 200 MG/1.14ML SUBCUTANEOUS (<i>sarilumab</i>)	Non Preferred	PA; AGE (Min 18 Years)
KINERET SOLUTION PREFILLED SYRINGE 100 MG/0.67ML SUBCUTANEOUS (<i>anakinra</i>)	Non Preferred	PA
<i>methotrexate sodium (pf) solution 1 gm/40ml injection</i>	Preferred	Max 90-day supply per fill
<i>methotrexate sodium (pf) solution 250 mg/10ml injection</i>	Preferred	Max 90-day supply per fill
<i>methotrexate sodium (pf) solution 50 mg/2ml injection</i>	Preferred	Max 90-day supply per fill
<i>methotrexate sodium solution 1000 mg/40ml injection</i>	Preferred	Max 90-day supply per fill
<i>methotrexate sodium solution 250 mg/10ml injection</i>	Preferred	Max 90-day supply per fill
<i>methotrexate sodium solution 50 mg/2ml injection</i>	Preferred	Max 90-day supply per fill
<i>methotrexate sodium solution reconstituted 1 gm injection</i>	Preferred	Max 90-day supply per fill
<i>methotrexate sodium tablet 2.5 mg oral</i>	Preferred	Max 90-day supply per fill
OLUMIANT TABLET 1 MG ORAL (<i>baricitinib</i>)	Non Preferred	PA; AGE (Min 18 Years)
OLUMIANT TABLET 2 MG ORAL (<i>baricitinib</i>)	Non Preferred	PA; AGE (Min 18 Years)
OLUMIANT TABLET 4 MG ORAL (<i>baricitinib</i>)	Non Preferred	PA; AGE (Min 18 Years)
ORENCIA CLICKJECT SOLUTION AUTO-INJECTOR 125 MG/ML SUBCUTANEOUS (<i>abatacept</i>)	Non Preferred	PA
ORENCIA SOLUTION PREFILLED SYRINGE 125 MG/ML SUBCUTANEOUS (<i>abatacept</i>)	Non Preferred	PA
ORENCIA SOLUTION PREFILLED SYRINGE 50 MG/0.4ML SUBCUTANEOUS (<i>abatacept</i>)	Non Preferred	PA
ORENCIA SOLUTION PREFILLED SYRINGE 87.5 MG/0.7ML SUBCUTANEOUS (<i>abatacept</i>)	Non Preferred	PA
ORENCIA SOLUTION RECONSTITUTED 250 MG INTRAVENOUS (<i>abatacept</i>)	Non Preferred	PA
OTEZLA TABLET 30 MG ORAL (<i>apremilast</i>)	Non Preferred	PA
OTEZLA TABLET THERAPY PACK 10 & 20 & 30 MG ORAL (<i>apremilast</i>)	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 10 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 12.5 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 15 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 17.5 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
OTREXUP SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 22.5 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
OTREXUP SOLUTION AUTO-INJECTOR 25 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 10 MG/0.2ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 12.5 MG/0.25ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 15 MG/0.3ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 17.5 MG/0.35ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 22.5 MG/0.45ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 25 MG/0.5ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 30 MG/0.6ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
RASUVO SOLUTION AUTO-INJECTOR 7.5 MG/0.15ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REDITREX SOLUTION PREFILLED SYRINGE 10 MG/0.4ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REDITREX SOLUTION PREFILLED SYRINGE 12.5 MG/0.5ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REDITREX SOLUTION PREFILLED SYRINGE 15 MG/0.6ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REDITREX SOLUTION PREFILLED SYRINGE 17.5 MG/0.7ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REDITREX SOLUTION PREFILLED SYRINGE 20 MG/0.8ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REDITREX SOLUTION PREFILLED SYRINGE 22.5 MG/0.9ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REDITREX SOLUTION PREFILLED SYRINGE 25 MG/ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REDITREX SOLUTION PREFILLED SYRINGE 7.5 MG/0.3ML SUBCUTANEOUS (<i>methotrexate (anti-rheumatic)</i>)	Non Preferred	PA
REMICADE SOLUTION RECONSTITUTED 100 MG INTRAVENOUS (<i>infliximab</i>)	Non Preferred	PA
RENFLEXIS SOLUTION RECONSTITUTED 100 MG INTRAVENOUS (<i>infliximab-abda</i>)	Non Preferred	PA
RINVOQ TABLET EXTENDED RELEASE 24 HOUR 15 MG ORAL (<i>upadacitinib</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
RINVOQ TABLET EXTENDED RELEASE 24 HOUR 30 MG ORAL (<i>upadacitinib</i>)	Non Preferred	PA
RINVOQ TABLET EXTENDED RELEASE 24 HOUR 45 MG ORAL (<i>upadacitinib</i>)	Non Preferred	PA
SILIQ SOLUTION PREFILLED SYRINGE 210 MG/1.5ML SUBCUTANEOUS (<i>brodalumab</i>)	Non Preferred	PA; AGE (Min 18 Years)
SIMPONI ARIA SOLUTION 50 MG/4ML INTRAVENOUS (<i>golimumab</i>)	Non Preferred	PA
SIMPONI SOLUTION AUTO-INJECTOR 100 MG/ML SUBCUTANEOUS (<i>golimumab</i>)	Non Preferred	PA
SIMPONI SOLUTION AUTO-INJECTOR 50 MG/0.5ML SUBCUTANEOUS (<i>golimumab</i>)	Non Preferred	PA
SIMPONI SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS (<i>golimumab</i>)	Non Preferred	PA
SIMPONI SOLUTION PREFILLED SYRINGE 50 MG/0.5ML SUBCUTANEOUS (<i>golimumab</i>)	Non Preferred	PA
SKYRIZI PEN SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS (<i>risankizumab-rzaa</i>)	Non Preferred	PA
SKYRIZI SOLUTION 600 MG/10ML INTRAVENOUS (<i>risankizumab-rzaa</i>)	Non Preferred	PA
SKYRIZI SOLUTION CARTRIDGE 180 MG/1.2ML SUBCUTANEOUS (<i>risankizumab-rzaa</i>)	Non Preferred	PA
SKYRIZI SOLUTION CARTRIDGE 360 MG/2.4ML SUBCUTANEOUS (<i>risankizumab-rzaa</i>)	Non Preferred	PA
SKYRIZI SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS (<i>risankizumab-rzaa</i>)	Non Preferred	PA
SOTYKTU TABLET 6 MG ORAL (<i>deucravacitinib</i>)	Non Preferred	PA
SPEVIGO SOLUTION 450 MG/7.5ML INTRAVENOUS (<i>spesolimab-sbzo</i>)	Non Preferred	PA; AGE (Min 18 Years)
STELARA SOLUTION 130 MG/26ML INTRAVENOUS (<i>ustekinumab</i>)	Non Preferred	PA
STELARA SOLUTION 45 MG/0.5ML SUBCUTANEOUS (<i>ustekinumab</i>)	Non Preferred	PA
STELARA SOLUTION PREFILLED SYRINGE 45 MG/0.5ML SUBCUTANEOUS (<i>ustekinumab</i>)	Non Preferred	PA
STELARA SOLUTION PREFILLED SYRINGE 90 MG/ML SUBCUTANEOUS (<i>ustekinumab</i>)	Non Preferred	PA
TALTZ SOLUTION AUTO-INJECTOR 80 MG/ML SUBCUTANEOUS (<i>ixekizumab</i>)	Non Preferred	PA
TALTZ SOLUTION PREFILLED SYRINGE 80 MG/ML SUBCUTANEOUS (<i>ixekizumab</i>)	Non Preferred	PA
TREMFYA SOLUTION PEN-INJECTOR 100 MG/ML SUBCUTANEOUS (<i>guselkumab</i>)	Non Preferred	PA
TREMFYA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS (<i>guselkumab</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TREXALL TABLET 10 MG ORAL (<i>methotrexate sodium</i>)	Non Preferred	PA
TREXALL TABLET 15 MG ORAL (<i>methotrexate sodium</i>)	Non Preferred	PA
TREXALL TABLET 5 MG ORAL (<i>methotrexate sodium</i>)	Non Preferred	PA
TREXALL TABLET 7.5 MG ORAL (<i>methotrexate sodium</i>)	Non Preferred	PA
UPLIZNA SOLUTION 100 MG/10ML INTRAVENOUS (<i>inebilizumab-cdon</i>)	Non Preferred	PA; AGE (Min 18 Years)
XATMEP SOLUTION 2.5 MG/ML ORAL (<i>methotrexate</i>)	Non Preferred	PA
XELJANZ SOLUTION 1 MG/ML ORAL (<i>tofacitinib citrate</i>)	Non Preferred	PA
XELJANZ TABLET 10 MG ORAL (<i>tofacitinib citrate</i>)	Non Preferred	PA
XELJANZ TABLET 5 MG ORAL (<i>tofacitinib citrate</i>)	Non Preferred	PA
XELJANZ XR TABLET EXTENDED RELEASE 24 HOUR 11 MG ORAL (<i>tofacitinib citrate</i>)	Non Preferred	PA
XELJANZ XR TABLET EXTENDED RELEASE 24 HOUR 22 MG ORAL (<i>tofacitinib citrate</i>)	Non Preferred	PA
YUFLYMA 1-PEN KIT AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-aaty</i>)	Non Preferred	PA
YUFLYMA 2-PEN KIT AUTO-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (<i>adalimumab-aaty</i>)	Non Preferred	PA
DIABETES ORAL HYPOGLYCEMICS: ALPHA-GLUCOSIDASE INHIBITORS [OPEN CLASS]		
<i>acarbose tablet 100 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>acarbose tablet 25 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>acarbose tablet 50 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>miglitol tablet 100 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>miglitol tablet 25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>miglitol tablet 50 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: BIGUANIDES [METFORMIN] [OPEN CLASS]		
<i>glipizide-metformin hcl tablet 2.5-250 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>glipizide-metformin hcl tablet 2.5-500 mg oral</i>	Preferred	AGE (Min 18 Years)
<i>glipizide-metformin hcl tablet 5-500 mg oral</i>	Preferred	AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
GLUMETZA TABLET EXTENDED RELEASE 24 HOUR 1000 MG ORAL (<i>metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years)
GLUMETZA TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL (<i>metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years); Max 90-day supply per fill
<i>glyburide-metformin tablet 1.25-250 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glyburide-metformin tablet 2.5-500 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glyburide-metformin tablet 5-500 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>metformin hcl er (mod) tablet extended release 24 hour 1000 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years)
<i>metformin hcl er (mod) tablet extended release 24 hour 500 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years); Max 90-day supply per fill
<i>metformin hcl er (osm) tablet extended release 24 hour 1000 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years)
<i>metformin hcl er (osm) tablet extended release 24 hour 500 mg oral</i>	Non Preferred	PA; AGE (Min 10 Years)
<i>metformin hcl er tablet extended release 24 hour 500 mg oral</i>	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
<i>metformin hcl er tablet extended release 24 hour 750 mg oral</i>	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
<i>metformin hcl solution 500 mg/5ml oral</i>	Non Preferred	PA; AGE (Min 10 Years)
<i>metformin hcl tablet 1000 mg oral</i>	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
<i>metformin hcl tablet 500 mg oral</i>	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
<i>metformin hcl tablet 850 mg oral</i>	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
RIOMET SOLUTION 500 MG/5ML ORAL (<i>metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years)
DIABETES ORAL HYPOGLYCEMICS: DPP-IV INHIBITORS AND COMBINATIONS [CLOSED CLASS]		
<i>alogliptin benzoate tablet 12.5 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin benzoate tablet 25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin benzoate tablet 6.25 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin-metformin hcl tablet 12.5-1000 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin-metformin hcl tablet 12.5-500 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin-pioglitazone tablet 12.5-30 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>alogliptin-pioglitazone tablet 25-15 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin-pioglitazone tablet 25-30 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alogliptin-pioglitazone tablet 25-45 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
GLYXAMBI TABLET 10-5 MG ORAL (<i>empagliflozin-linagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
GLYXAMBI TABLET 25-5 MG ORAL (<i>empagliflozin-linagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
JANUMET TABLET 50-1000 MG ORAL (<i>sitagliptin-metformin hcl</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
JANUMET TABLET 50-500 MG ORAL (<i>sitagliptin-metformin hcl</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG ORAL (<i>sitagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL (<i>sitagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL (<i>sitagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
JANUVIA TABLET 100 MG ORAL (<i>sitagliptin phosphate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
JANUVIA TABLET 25 MG ORAL (<i>sitagliptin phosphate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
JANUVIA TABLET 50 MG ORAL (<i>sitagliptin phosphate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
JENTADUETO TABLET 2.5-1000 MG ORAL (<i>linagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
JENTADUETO TABLET 2.5-500 MG ORAL (<i>linagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
JENTADUETO TABLET 2.5-850 MG ORAL (<i>linagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
JENTADUETO XR TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ORAL (<i>linagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
JENTADUETO XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL (<i>linagliptin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
KAZANO TABLET 12.5-1000 MG ORAL (<i>alogliptin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
KAZANO TABLET 12.5-500 MG ORAL (<i>alogliptin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ORAL (<i>saxagliptin-metformin</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL (<i>saxagliptin-metformin</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 5-500 MG ORAL (<i>saxagliptin-metformin</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
NESINA TABLET 12.5 MG ORAL (<i>alogliptin benzoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
NESINA TABLET 25 MG ORAL (<i>alogliptin benzoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
NESINA TABLET 6.25 MG ORAL (<i>alogliptin benzoate</i>)	Non Preferred	PA; AGE (Min 18 Years)
ONGLYZA TABLET 2.5 MG ORAL (<i>saxagliptin hcl</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
ONGLYZA TABLET 5 MG ORAL (<i>saxagliptin hcl</i>)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
OSENI TABLET 12.5-30 MG ORAL (<i>alogliptin-pioglitazone</i>)	Non Preferred	PA; AGE (Min 18 Years)
OSENI TABLET 25-15 MG ORAL (<i>alogliptin-pioglitazone</i>)	Non Preferred	PA; AGE (Min 18 Years)
OSENI TABLET 25-30 MG ORAL (<i>alogliptin-pioglitazone</i>)	Non Preferred	PA; AGE (Min 18 Years)
OSENI TABLET 25-45 MG ORAL (<i>alogliptin-pioglitazone</i>)	Non Preferred	PA; AGE (Min 18 Years)
QTERN TABLET 10-5 MG ORAL (<i>dapagliflozin-saxagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
QTERN TABLET 5-5 MG ORAL (<i>dapagliflozin-saxagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
STEGLUJAN TABLET 15-100 MG ORAL (<i>ertugliflozin-sitagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
STEGLUJAN TABLET 5-100 MG ORAL (<i>ertugliflozin-sitagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
TRADJENTA TABLET 5 MG ORAL (<i>linagliptin</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG ORAL (<i>empagliflozin-linagliptin-metformin</i>)	Non Preferred	PA; AGE (Min 18 Years)
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG ORAL (<i>empagliflozin-linagliptin-metformin</i>)	Non Preferred	PA; AGE (Min 18 Years)
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 25-5-1000 MG ORAL (<i>empagliflozin-linagliptin-metformin</i>)	Non Preferred	PA; AGE (Min 18 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 5-2.5-1000 MG ORAL (<i>empagliflozin-linagliptin-metformin</i>)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: MEGLINITIDES [OPEN CLASS]		
<i>nateglinide tablet 120 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>nateglinide tablet 60 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>repaglinide tablet 0.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>repaglinide tablet 1 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>repaglinide tablet 2 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
DIABETES ORAL HYPOGLYCEMICS: SECOND GENERATION SULFONYLUREAS [OPEN CLASS]		
<i>glimepiride tablet 1 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glimepiride tablet 2 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glimepiride tablet 4 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glipizide er tablet extended release 24 hour 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glipizide er tablet extended release 24 hour 2.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glipizide er tablet extended release 24 hour 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glipizide tablet 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glipizide tablet 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glipizide xl tablet extended release 24 hour 10 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glipizide xl tablet extended release 24 hour 2.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glipizide xl tablet extended release 24 hour 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 10 MG ORAL (<i>glipizide</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 2.5 MG ORAL (<i>glipizide</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 5 MG ORAL (<i>glipizide</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
<i>glyburide micronized tablet 1.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>glyburide micronized tablet 3 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glyburide micronized tablet 6 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glyburide tablet 1.25 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glyburide tablet 2.5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>glyburide tablet 5 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
GLYNASE TABLET 1.5 MG ORAL (<i>glyburide micronized</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GLYNASE TABLET 3 MG ORAL (<i>glyburide micronized</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GLYNASE TABLET 6 MG ORAL (<i>glyburide micronized</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
DIABETES ORAL HYPOGLYCEMICS: SODIUM GLUCOSE CO-TRANSPORTER 2 INHIBITOR [CLOSED CLASS]		
FARXIGA TABLET 10 MG ORAL (<i>dapagliflozin propanediol</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
FARXIGA TABLET 5 MG ORAL (<i>dapagliflozin propanediol</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
INPEFA TABLET 200 MG ORAL (<i>sitagliptin</i>)	Non Preferred	PA; AGE (Min 18 Years)
INVOKAMET TABLET 150-1000 MG ORAL (<i>canagliflozin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET TABLET 150-500 MG ORAL (<i>canagliflozin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET TABLET 50-1000 MG ORAL (<i>canagliflozin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET TABLET 50-500 MG ORAL (<i>canagliflozin-metformin hcl</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG ORAL (<i>canagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-500 MG ORAL (<i>canagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL (<i>canagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL (<i>canagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
INVOKANA TABLET 100 MG ORAL (<i>canagliflozin</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
INVOKANA TABLET 300 MG ORAL (<i>canagliflozin</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
JARDIANCE TABLET 10 MG ORAL (<i>empagliflozin</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years); Max 90-day supply per fill
JARDIANCE TABLET 25 MG ORAL (<i>empagliflozin</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years); Max 90-day supply per fill
SEGLUROMET TABLET 2.5-1000 MG ORAL (<i>ertugliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
SEGLUROMET TABLET 2.5-500 MG ORAL (<i>ertugliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
SEGLUROMET TABLET 7.5-1000 MG ORAL (<i>ertugliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
SEGLUROMET TABLET 7.5-500 MG ORAL (<i>ertugliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
STEGLATRO TABLET 15 MG ORAL (<i>ertugliflozin l-pyroglytamiticac</i>)	Non Preferred	PA; AGE (Min 18 Years)
STEGLATRO TABLET 5 MG ORAL (<i>ertugliflozin l-pyroglytamiticac</i>)	Non Preferred	PA; AGE (Min 18 Years)
SYNJARDY TABLET 12.5-1000 MG ORAL (<i>empagliflozin-metformin hcl</i>)	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
SYNJARDY TABLET 12.5-500 MG ORAL (<i>empagliflozin-metformin hcl</i>)	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
SYNJARDY TABLET 5-1000 MG ORAL (<i>empagliflozin-metformin hcl</i>)	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
SYNJARDY TABLET 5-500 MG ORAL (<i>empagliflozin-metformin hcl</i>)	Preferred	AGE (Min 10 Years); Max 90-day supply per fill
SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG ORAL (<i>empagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years); Max 90-day supply per fill
SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG ORAL (<i>empagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years); Max 90-day supply per fill
SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG ORAL (<i>empagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years); Max 90-day supply per fill
SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL (<i>empagliflozin-metformin hcl</i>)	Non Preferred	PA; AGE (Min 10 Years); Max 90-day supply per fill
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG ORAL (<i>dapagliflozin prop-metformin</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 10-500 MG ORAL (<i>dapagliflozin prop-metformin</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ORAL (<i>dapagliflozin prop-metformin</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL (<i>dapagliflozin prop-metformin</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR 5-500 MG ORAL (<i>dapagliflozin prop-metformin</i>)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
DIABETES ORAL HYPOGLYCEMICS: THIAZOLIDINEDIONES [OPEN CLASS]		
ACTOPLUS MET TABLET 15-850 MG ORAL (<i>pioglitazone hcl-metformin hcl</i>)	Non Preferred	PA
ACTOS TABLET 15 MG ORAL (<i>pioglitazone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ACTOS TABLET 30 MG ORAL (<i>pioglitazone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ACTOS TABLET 45 MG ORAL (<i>pioglitazone hcl</i>)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
DUETACT TABLET 30-2 MG ORAL (<i>pioglitazone hcl-glimepiride</i>)	Non Preferred	PA
DUETACT TABLET 30-4 MG ORAL (<i>pioglitazone hcl-glimepiride</i>)	Non Preferred	PA
<i>pioglitazone hcl tablet 15 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>pioglitazone hcl tablet 30 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>pioglitazone hcl tablet 45 mg oral</i>	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
<i>pioglitazone hcl-glimepiride tablet 30-2 mg oral</i>	Non Preferred	PA
<i>pioglitazone hcl-glimepiride tablet 30-4 mg oral</i>	Non Preferred	PA
<i>pioglitazone hcl-metformin hcl tablet 15-500 mg oral</i>	Non Preferred	PA
<i>pioglitazone hcl-metformin hcl tablet 15-850 mg oral</i>	Non Preferred	PA
DIABETES: INJECTABLE AMYLIN ANALOGS [CLOSED CLASS]		
SYMLINPEN 120 SOLUTION PEN-INJECTOR 2700 MCG/2.7ML SUBCUTANEOUS (<i>pramlintide acetate</i>)	Non Preferred	PA
SYMLINPEN 60 SOLUTION PEN-INJECTOR 1500 MCG/1.5ML SUBCUTANEOUS (<i>pramlintide acetate</i>)	Non Preferred	PA
DIABETES: INJECTABLE AND ORAL INCRETIN MIMETICS [CLOSED CLASS]		
BYDUREON BCISE AUTO-INJECTOR 2 MG/0.85ML SUBCUTANEOUS (<i>exenatide</i>)	Non Preferred	PA; QL (3.4 ML per 28 days)
BYETTA 10 MCG PEN SOLUTION PEN-INJECTOR 10 MCG/0.04ML SUBCUTANEOUS (<i>exenatide</i>)	Preferred	PA (Eligible for auto-PA); QL (7.2 ML per 90 days); Max 90-day supply per fill
BYETTA 5 MCG PEN SOLUTION PEN-INJECTOR 5 MCG/0.02ML SUBCUTANEOUS (<i>exenatide</i>)	Preferred	PA (Eligible for auto-PA); QL (3.6 ML per 90 days); Max 90-day supply per fill
MOUNJARO SOLUTION PEN-INJECTOR 10 MG/0.5ML SUBCUTANEOUS (<i>tirzepatide</i>)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
MOUNJARO SOLUTION PEN-INJECTOR 12.5 MG/0.5ML SUBCUTANEOUS (<i>tirzepatide</i>)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
MOUNJARO SOLUTION PEN-INJECTOR 15 MG/0.5ML SUBCUTANEOUS (<i>tirzepatide</i>)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
MOUNJARO SOLUTION PEN-INJECTOR 2.5 MG/0.5ML SUBCUTANEOUS (<i>tirzepatide</i>)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5ML SUBCUTANEOUS (<i>tirzepatide</i>)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
MOUNJARO SOLUTION PEN-INJECTOR 7.5 MG/0.5ML SUBCUTANEOUS (<i>tirzepatide</i>)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/3ML SUBCUTANEOUS (<i>semaglutide</i>)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4 MG/3ML SUBCUTANEOUS (<i>semaglutide</i>)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8 MG/3ML SUBCUTANEOUS (<i>semaglutide</i>)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
RYBELSUS TABLET 14 MG ORAL (<i>semaglutide</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
RYBELSUS TABLET 3 MG ORAL (<i>semaglutide</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
RYBELSUS TABLET 7 MG ORAL (<i>semaglutide</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SOLIQUA SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML SUBCUTANEOUS (<i>insulin glargine-lixisenatide</i>)	Non Preferred	PA
TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5ML SUBCUTANEOUS (<i>dulaglutide</i>)	Preferred	PA (Eligible for auto-PA); QL (6 ML per 84 days); Max 90-day supply per fill
TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5ML SUBCUTANEOUS (<i>dulaglutide</i>)	Preferred	PA (Eligible for auto-PA); QL (6 ML per 84 days); Max 90-day supply per fill
TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5ML SUBCUTANEOUS (<i>dulaglutide</i>)	Preferred	PA (Eligible for auto-PA); QL (6 ML per 84 days); AGE (Min 18 Years); Max 90-day supply per fill
TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5ML SUBCUTANEOUS (<i>dulaglutide</i>)	Preferred	PA (Eligible for auto-PA); QL (6 ML per 84 days); AGE (Min 18 Years); Max 90-day supply per fill
VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS (<i>liraglutide</i>)	Preferred	PA (Eligible for auto-PA); QL (27 ML per 90 days); AGE (Min 18 Years); Max 90-day supply per fill
XULTOPHY SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML SUBCUTANEOUS (<i>insulin degludec-liraglutide</i>)	Non Preferred	PA; QL (15 ML per 30 days)
EPINEPHRINE, SELF-INJECTED [OPEN CLASS]		
AUVI-Q SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML INJECTION (<i>epinephrine</i>)	Non Preferred	PA; QL (12 EA per 365 days)

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Drug Name	Formulary Status	Requirements/Limits
AUVI-Q SOLUTION AUTO-INJECTOR 0.15 MG/0.15ML INJECTION (<i>epinephrine</i>)	Non Preferred	PA; QL (12 EA per 365 days)
AUVI-Q SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML INJECTION (<i>epinephrine</i>)	Non Preferred	PA; QL (12 EA per 365 days)
<i>epinephrine solution auto-injector 0.15 mg/0.15ml injection</i>	Non Preferred	PA; QL (12 EA per 365 days)
<i>epinephrine solution auto-injector 0.15 mg/0.3ml injection</i>	Preferred	QL (12 EA per 365 days)
<i>epinephrine solution auto-injector 0.3 mg/0.3ml injection</i>	Preferred	QL (12 EA per 365 days)
EPIPEN 2-PAK SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML INJECTION (<i>epinephrine</i>)	Preferred	QL (12 EA per 365 days)
EPIPEN JR 2-PAK SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML INJECTION (<i>epinephrine</i>)	Preferred	QL (12 EA per 365 days)
SYMJEPI SOLUTION PREFILLED SYRINGE 0.15 MG/0.3ML INJECTION (<i>epinephrine</i>)	Non Preferred	PA; QL (12 EA per 365 days)
SYMJEPI SOLUTION PREFILLED SYRINGE 0.3 MG/0.3ML INJECTION (<i>epinephrine</i>)	Non Preferred	PA; QL (12 EA per 365 days)
ERYTHROPOIESIS STIMULATING PROTEINS [OPEN CLASS]		
ARANESP (ALBUMIN FREE) SOLUTION 100 MCG/ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 200 MCG/ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 25 MCG/ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 40 MCG/ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION 60 MCG/ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 100 MCG/0.5ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 200 MCG/0.4ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 25 MCG/0.42ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 300 MCG/0.6ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 40 MCG/0.4ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 500 MCG/ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA
ARANESP (ALBUMIN FREE) SOLUTION PREFILLED SYRINGE 60 MCG/0.3ML INJECTION (<i>darbepoetin alfa</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
EPOGEN SOLUTION 10000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Preferred	
EPOGEN SOLUTION 2000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Preferred	
EPOGEN SOLUTION 20000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Preferred	
EPOGEN SOLUTION 3000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Preferred	
EPOGEN SOLUTION 4000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Preferred	
MIRCERA SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML INJECTION (<i>methoxy peg-epoetin beta</i>)	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 120 MCG/0.3ML INJECTION (<i>methoxy peg-epoetin beta</i>)	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 150 MCG/0.3ML INJECTION (<i>methoxy peg-epoetin beta</i>)	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 200 MCG/0.3ML INJECTION (<i>methoxy peg-epoetin beta</i>)	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 30 MCG/0.3ML INJECTION (<i>methoxy peg-epoetin beta</i>)	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 50 MCG/0.3ML INJECTION (<i>methoxy peg-epoetin beta</i>)	Non Preferred	PA
MIRCERA SOLUTION PREFILLED SYRINGE 75 MCG/0.3ML INJECTION (<i>methoxy peg-epoetin beta</i>)	Non Preferred	PA
PROCRIT SOLUTION 10000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Non Preferred	PA
PROCRIT SOLUTION 2000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Non Preferred	PA
PROCRIT SOLUTION 20000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Non Preferred	PA
PROCRIT SOLUTION 3000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Non Preferred	PA
PROCRIT SOLUTION 4000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Non Preferred	PA
PROCRIT SOLUTION 40000 UNIT/ML INJECTION (<i>epoetin alfa</i>)	Non Preferred	PA
RETACRIT SOLUTION 10000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
RETACRIT SOLUTION 10000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 2000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
RETACRIT SOLUTION 2000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 20000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
RETACRIT SOLUTION 20000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 3000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
RETACRIT SOLUTION 3000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 4000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Non Preferred	PA
RETACRIT SOLUTION 4000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
RETACRIT SOLUTION 40000 UNIT/ML INJECTION (<i>epoetin alfa-epbx</i>)	Preferred	
GI ANTIBIOTICS [OPEN CLASS]		
AEMCOLO TABLET DELAYED RELEASE 194 MG ORAL (<i>rifamycin sodium</i>)	Non Preferred	PA
DIFICID SUSPENSION RECONSTITUTED 40 MG/ML ORAL (<i>fidaxomicin</i>)	Non Preferred	PA
DIFICID TABLET 200 MG ORAL (<i>fidaxomicin</i>)	Non Preferred	PA
FIRVANQ SOLUTION RECONSTITUTED 25 MG/ML ORAL (<i>vancomycin hcl</i>)	Preferred	
FIRVANQ SOLUTION RECONSTITUTED 50 MG/ML ORAL (<i>vancomycin hcl</i>)	Preferred	
FLAGYL CAPSULE 375 MG ORAL (<i>metronidazole</i>)	Non Preferred	PA
<i>metronidazole capsule 375 mg oral</i>	Non Preferred	PA
<i>metronidazole tablet 250 mg oral</i>	Preferred	
<i>metronidazole tablet 500 mg oral</i>	Preferred	
<i>neomycin sulfate tablet 500 mg oral</i>	Preferred	
<i>nitazoxanide tablet 500 mg oral</i>	Non Preferred	PA
SOLOSEC PACKET 2 GM ORAL (<i>secnidazole</i>)	Non Preferred	PA
<i>tinidazole tablet 250 mg oral</i>	Non Preferred	PA
<i>tinidazole tablet 500 mg oral</i>	Non Preferred	PA
VANCOCIN CAPSULE 125 MG ORAL (<i>vancomycin hcl</i>)	Non Preferred	PA
VANCOCIN CAPSULE 250 MG ORAL (<i>vancomycin hcl</i>)	Non Preferred	PA
<i>vancomycin hcl capsule 125 mg oral</i>	Preferred	
<i>vancomycin hcl capsule 250 mg oral</i>	Preferred	
<i>vancomycin hcl solution reconstituted 25 mg/ml oral</i>	Non Preferred	PA
<i>vancomycin hcl solution reconstituted 250 mg/5ml oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>vancomycin hcl solution reconstituted 50 mg/ml oral</i>	Non Preferred	PA
VOWST CAPSULE ORAL (<i>fecal microb spores, live-brpk</i>)	Non Preferred	PA; AGE (Min 18 Years)
XIFAXAN TABLET 200 MG ORAL (<i>rifaximin</i>)	Non Preferred	PA; QL (9 EA per 1 Fill); AGE (Min 12 Years)
XIFAXAN TABLET 550 MG ORAL (<i>rifaximin</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
GI MOTILITY, CHRONIC [OPEN CLASS]		
<i>alosetron hcl tablet 0.5 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>alosetron hcl tablet 1 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
AMITIZA CAPSULE 24 MCG ORAL (<i>lubiprostone</i>)	Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
AMITIZA CAPSULE 8 MCG ORAL (<i>lubiprostone</i>)	Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
IBSRELA TABLET 50 MG ORAL (<i>tenapanor hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
LINZESS CAPSULE 145 MCG ORAL (<i>linaclotide</i>)	Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
LINZESS CAPSULE 290 MCG ORAL (<i>linaclotide</i>)	Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
LINZESS CAPSULE 72 MCG ORAL (<i>linaclotide</i>)	Preferred	PA; AGE (Min 6 Years); Max 90-day supply per fill
LOTRONEX TABLET 0.5 MG ORAL (<i>alosetron hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
LOTRONEX TABLET 1 MG ORAL (<i>alosetron hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>lubiprostone capsule 24 mcg oral</i>	Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
<i>lubiprostone capsule 8 mcg oral</i>	Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
MOTEGRITY TABLET 1 MG ORAL (<i>prucalopride succinate</i>)	Non Preferred	PA; AGE (Min 18 Years)
MOTEGRITY TABLET 2 MG ORAL (<i>prucalopride succinate</i>)	Non Preferred	PA; AGE (Min 18 Years)
MOVANTIK TABLET 12.5 MG ORAL (<i>naloxegol oxalate</i>)	Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
MOVANTIK TABLET 25 MG ORAL (<i>naloxegol oxalate</i>)	Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
RELISTOR SOLUTION 12 MG/0.6ML SUBCUTANEOUS (<i>methylnaltrexone bromide</i>)	Non Preferred	PA; AGE (Min 18 Years)
RELISTOR SOLUTION 8 MG/0.4ML SUBCUTANEOUS (<i>methylnaltrexone bromide</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
RELISTOR TABLET 150 MG ORAL (<i>methylnaltrexone bromide</i>)	Non Preferred	PA; AGE (Min 18 Years)
SYMPROIC TABLET 0.2 MG ORAL (<i>naldemedine tosylate</i>)	Non Preferred	PA; AGE (Min 18 Years)
TRULANCE TABLET 3 MG ORAL (<i>plecanatide</i>)	Non Preferred	PA; AGE (Min 18 Years)
VIBERZI TABLET 100 MG ORAL (<i>eluxadoline</i>)	Non Preferred	PA; AGE (Min 18 Years)
VIBERZI TABLET 75 MG ORAL (<i>eluxadoline</i>)	Non Preferred	PA; AGE (Min 18 Years)
GLUCAGON AGENTS [CLOSED CLASS]		
BAQSIMI ONE PACK POWDER 3 MG/DOSE NASAL (<i>glucagon</i>)	Preferred	
BAQSIMI TWO PACK POWDER 3 MG/DOSE NASAL (<i>glucagon</i>)	Preferred	
<i>diazoxide suspension 50 mg/ml oral</i>	Non Preferred	PA
GLUCAGEN HYPOKIT SOLUTION RECONSTITUTED 1 MG INJECTION (<i>glucagon hcl (rdna)</i>)	Non Preferred	PA
<i>glucagon emergency kit 1 mg injection</i>	Non Preferred	PA
<i>glucagon emergency solution reconstituted 1 mg/ml injection</i>	Preferred	
GVOKE HYPOPEN 1-PACK SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML SUBCUTANEOUS (<i>glucagon</i>)	Preferred	
GVOKE HYPOPEN 1-PACK SOLUTION AUTO-INJECTOR 1 MG/0.2ML SUBCUTANEOUS (<i>glucagon</i>)	Preferred	
GVOKE HYPOPEN 2-PACK SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML SUBCUTANEOUS (<i>glucagon</i>)	Preferred	
GVOKE HYPOPEN 2-PACK SOLUTION AUTO-INJECTOR 1 MG/0.2ML SUBCUTANEOUS (<i>glucagon</i>)	Preferred	
GVOKE KIT SOLUTION 1 MG/0.2ML SUBCUTANEOUS (<i>glucagon</i>)	Preferred	
GVOKE PFS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML SUBCUTANEOUS (<i>glucagon</i>)	Preferred	
GVOKE PFS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML SUBCUTANEOUS (<i>glucagon</i>)	Preferred	
PROGLYCEM SUSPENSION 50 MG/ML ORAL (<i>diazoxide</i>)	Preferred	
ZEGALOGUE SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML SUBCUTANEOUS (<i>dasiglucagon hcl</i>)	Non Preferred	PA
ZEGALOGUE SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML SUBCUTANEOUS (<i>dasiglucagon hcl</i>)	Non Preferred	PA
GLUCOCORTICOIDS, ORAL [OPEN CLASS]		
ALKINDI SPRINKLE CAPSULE SPRINKLE 0.5 MG ORAL (<i>hydrocortisone</i>)	Non Preferred	PA; AGE (Max 17 Years)
ALKINDI SPRINKLE CAPSULE SPRINKLE 1 MG ORAL (<i>hydrocortisone</i>)	Non Preferred	PA; AGE (Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
ALKINDI SPRINKLE CAPSULE SPRINKLE 2 MG ORAL (hydrocortisone)	Non Preferred	PA; AGE (Max 17 Years)
ALKINDI SPRINKLE CAPSULE SPRINKLE 5 MG ORAL (hydrocortisone)	Non Preferred	PA; AGE (Max 17 Years)
<i>budesonide capsule delayed release particles 3 mg oral</i>	Preferred	
CORTEF TABLET 10 MG ORAL (hydrocortisone)	Non Preferred	PA
CORTEF TABLET 20 MG ORAL (hydrocortisone)	Non Preferred	PA
CORTEF TABLET 5 MG ORAL (hydrocortisone)	Non Preferred	PA
<i>cortisone acetate tablet 25 mg oral</i>	Non Preferred	PA
<i>dexamethasone elixir 0.5 mg/5ml oral</i>	Preferred	
DEXAMETHASONE INTENSOL CONCENTRATE 1 MG/ML ORAL (dexamethasone)	Preferred	
<i>dexamethasone solution 0.5 mg/5ml oral</i>	Preferred	
<i>dexamethasone tablet 0.5 mg oral</i>	Preferred	
<i>dexamethasone tablet 0.75 mg oral</i>	Preferred	
<i>dexamethasone tablet 1 mg oral</i>	Preferred	
<i>dexamethasone tablet 1.5 mg oral</i>	Preferred	
<i>dexamethasone tablet 2 mg oral</i>	Preferred	
<i>dexamethasone tablet 4 mg oral</i>	Preferred	
<i>dexamethasone tablet 6 mg oral</i>	Preferred	
<i>dexamethasone tablet therapy pack 1.5 mg (21) oral</i>	Non Preferred	PA
<i>dexamethasone tablet therapy pack 1.5 mg (35) oral</i>	Non Preferred	PA
<i>dexamethasone tablet therapy pack 1.5 mg (51) oral</i>	Non Preferred	PA
EMFLAZA SUSPENSION 22.75 MG/ML ORAL (deflazacort)	Non Preferred	PA; AGE (Min 2 Years)
EMFLAZA TABLET 18 MG ORAL (deflazacort)	Non Preferred	PA; AGE (Min 2 Years)
EMFLAZA TABLET 30 MG ORAL (deflazacort)	Non Preferred	PA; AGE (Min 2 Years)
EMFLAZA TABLET 36 MG ORAL (deflazacort)	Non Preferred	PA; AGE (Min 2 Years)
EMFLAZA TABLET 6 MG ORAL (deflazacort)	Non Preferred	PA; AGE (Min 2 Years)
HEMADY TABLET 20 MG ORAL (dexamethasone)	Non Preferred	PA
<i>hydrocortisone tablet 10 mg oral</i>	Preferred	
<i>hydrocortisone tablet 20 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>hydrocortisone tablet 5 mg oral</i>	Preferred	
MEDROL TABLET 16 MG ORAL (<i>methylprednisolone</i>)	Non Preferred	PA
MEDROL TABLET 2 MG ORAL (<i>methylprednisolone</i>)	Non Preferred	PA
MEDROL TABLET 4 MG ORAL (<i>methylprednisolone</i>)	Non Preferred	PA
MEDROL TABLET 8 MG ORAL (<i>methylprednisolone</i>)	Non Preferred	PA
MEDROL TABLET THERAPY PACK 4 MG ORAL (<i>methylprednisolone</i>)	Non Preferred	PA
<i>methylprednisolone tablet 16 mg oral</i>	Non Preferred	PA
<i>methylprednisolone tablet 32 mg oral</i>	Non Preferred	PA
<i>methylprednisolone tablet 4 mg oral</i>	Preferred	
<i>methylprednisolone tablet 8 mg oral</i>	Non Preferred	PA
<i>methylprednisolone tablet therapy pack 4 mg oral</i>	Preferred	
<i>prednisolone (Millipred Tablet 5 Mg Oral)</i>	Non Preferred	PA
ORTIKOS CAPSULE EXTENDED RELEASE 24 HOUR 6 MG ORAL (<i>budesonide</i>)	Non Preferred	PA
ORTIKOS CAPSULE EXTENDED RELEASE 24 HOUR 9 MG ORAL (<i>budesonide</i>)	Non Preferred	PA
<i>prednisolone sodium phosphate solution 10 mg/5ml oral</i>	Non Preferred	PA
<i>prednisolone sodium phosphate solution 15 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 20 mg/5ml oral</i>	Non Preferred	PA
<i>prednisolone sodium phosphate solution 25 mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate solution 6.7 (5 base) mg/5ml oral</i>	Preferred	
<i>prednisolone sodium phosphate tablet dispersible 10 mg oral</i>	Non Preferred	PA
<i>prednisolone sodium phosphate tablet dispersible 15 mg oral</i>	Non Preferred	PA
<i>prednisolone sodium phosphate tablet dispersible 30 mg oral</i>	Non Preferred	PA
<i>prednisolone solution 15 mg/5ml oral</i>	Preferred	
<i>prednisolone tablet 5 mg oral</i>	Non Preferred	PA
PREDNISONE INTENSOL CONCENTRATE 5 MG/ML ORAL (<i>prednisone</i>)	Preferred	
<i>prednisone solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>prednisone tablet 1 mg oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet 2.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet therapy pack 10 mg (21) oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet therapy pack 10 mg (48) oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet therapy pack 5 mg (21) oral</i>	Preferred	Max 90-day supply per fill
<i>prednisone tablet therapy pack 5 mg (48) oral</i>	Preferred	Max 90-day supply per fill
RAYOS TABLET DELAYED RELEASE 1 MG ORAL (<i>prednisone</i>)	Non Preferred	PA
RAYOS TABLET DELAYED RELEASE 2 MG ORAL (<i>prednisone</i>)	Non Preferred	PA
RAYOS TABLET DELAYED RELEASE 5 MG ORAL (<i>prednisone</i>)	Non Preferred	PA
TAPERDEX 12-DAY TABLET THERAPY PACK 1.5 MG (49) ORAL (<i>dexamethasone</i>)	Non Preferred	PA
<i>dexamethasone</i> (Taperdex 6-Day Tablet Therapy Pack 1.5 Mg (21) Oral)	Non Preferred	PA
<i>dexamethasone</i> (Taperdex 6-Day Tablet Therapy Pack 1.5 Mg Oral)	Non Preferred	PA
TAPERDEX 7-DAY TABLET THERAPY PACK 1.5 MG (27) ORAL (<i>dexamethasone</i>)	Non Preferred	PA
TARPEYO CAPSULE DELAYED RELEASE 4 MG ORAL (<i>budesonide</i>)	Non Preferred	PA
GROWTH HORMONE [CLOSED CLASS]		
GENOTROPIN CARTRIDGE 12 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN CARTRIDGE 5 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.2 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.4 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.6 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 0.8 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.2 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.4 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.6 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.8 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 2 MG SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
HUMATROPE CARTRIDGE 12 MG INJECTION (<i>somatropin</i>)	Non Preferred	PA
HUMATROPE CARTRIDGE 24 MG INJECTION (<i>somatropin</i>)	Non Preferred	PA
HUMATROPE CARTRIDGE 6 MG INJECTION (<i>somatropin</i>)	Non Preferred	PA
NORDITROPIN FLEXPLO SOLUTION PEN-INJECTOR 10 MG/1.5ML SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
NORDITROPIN FLEXPLO SOLUTION PEN-INJECTOR 15 MG/1.5ML SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
NORDITROPIN FLEXPLO SOLUTION PEN-INJECTOR 30 MG/3ML SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
NORDITROPIN FLEXPLO SOLUTION PEN-INJECTOR 5 MG/1.5ML SUBCUTANEOUS (<i>somatropin</i>)	Preferred	PA
NUTROPIN AQ NUSPIN 10 SOLUTION PEN-INJECTOR 10 MG/2ML SUBCUTANEOUS (<i>somatropin</i>)	Non Preferred	PA
NUTROPIN AQ NUSPIN 20 SOLUTION PEN-INJECTOR 20 MG/2ML SUBCUTANEOUS (<i>somatropin</i>)	Non Preferred	PA
NUTROPIN AQ NUSPIN 5 SOLUTION PEN-INJECTOR 5 MG/2ML SUBCUTANEOUS (<i>somatropin</i>)	Non Preferred	PA
OMNITROPE SOLUTION CARTRIDGE 10 MG/1.5ML SUBCUTANEOUS (<i>somatropin</i>)	Non Preferred	PA
OMNITROPE SOLUTION CARTRIDGE 5 MG/1.5ML SUBCUTANEOUS (<i>somatropin</i>)	Non Preferred	PA
OMNITROPE SOLUTION RECONSTITUTED 5.8 MG SUBCUTANEOUS (<i>somatropin</i>)	Non Preferred	PA
SAIZEN SOLUTION RECONSTITUTED 5 MG INJECTION (<i>somatropin (non-refrigerated)</i>)	Non Preferred	PA
SAIZEN SOLUTION RECONSTITUTED 8.8 MG INJECTION (<i>somatropin (non-refrigerated)</i>)	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 4 MG SUBCUTANEOUS (<i>somatropin (non-refrigerated)</i>)	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 5 MG SUBCUTANEOUS (<i>somatropin (non-refrigerated)</i>)	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 6 MG SUBCUTANEOUS (<i>somatropin (non-refrigerated)</i>)	Non Preferred	PA
SKYTROFA CARTRIDGE 11 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 13.3 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
SKYTROFA CARTRIDGE 3 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 3.6 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 4.3 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 5.2 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 6.3 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 7.6 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 9.1 MG SUBCUTANEOUS (<i>lonapegsomatropin-tcgd</i>)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SOGROYA SOLUTION PEN-INJECTOR 10 MG/1.5ML SUBCUTANEOUS (<i>somapacitan-beco</i>)	Non Preferred	PA; AGE (Min 2 Years)
SOGROYA SOLUTION PEN-INJECTOR 15 MG/1.5ML SUBCUTANEOUS (<i>somapacitan-beco</i>)	Non Preferred	PA; AGE (Min 2 Years)
SOGROYA SOLUTION PEN-INJECTOR 5 MG/1.5ML SUBCUTANEOUS (<i>somapacitan-beco</i>)	Non Preferred	PA; AGE (Min 2 Years)
ZOMACTON SOLUTION RECONSTITUTED 10 MG SUBCUTANEOUS (<i>somatropin</i>)	Non Preferred	PA
ZOMACTON SOLUTION RECONSTITUTED 5 MG SUBCUTANEOUS (<i>somatropin</i>)	Non Preferred	PA
H PYLORI TREATMENT [OPEN CLASS]		
<i>amoxicill-clarithro-lansopraz therapy pack 500 & 500 & 30 mg oral</i>	Non Preferred	PA
<i>bis subcit-metronid-tetracyc capsule 140-125-125 mg oral</i>	Non Preferred	PA
<i>bismuth/metronidaz/tetracyclin capsule 140-125-125 mg oral</i>	Non Preferred	PA
OMECLAMOX-PAK 500-500-20 MG ORAL (<i>amoxicill-clarithro-omeprazole</i>)	Non Preferred	PA
PYLERA CAPSULE 140-125-125 MG ORAL (<i>bis subcit-metronid-tetracyc</i>)	Preferred	
TALICIA CAPSULE DELAYED RELEASE 250-12.5-10 MG ORAL (<i>amoxicill-rifabutin-omeprazole</i>)	Non Preferred	PA
HEMOPHILIA TREATMENT [CLOSED CLASS]		
ADVATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
ADVATE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
ADVATE SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
ADVATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ADVATE SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
ADVATE SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
ADVATE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
<i>adynovate solution reconstituted 1000 unit intravenous</i>	Preferred	
<i>adynovate solution reconstituted 1500 unit intravenous</i>	Preferred	
<i>adynovate solution reconstituted 2000 unit intravenous</i>	Preferred	
<i>adynovate solution reconstituted 250 unit intravenous</i>	Preferred	
<i>adynovate solution reconstituted 3000 unit intravenous</i>	Preferred	
<i>adynovate solution reconstituted 500 unit intravenous</i>	Preferred	
<i>adynovate solution reconstituted 750 unit intravenous</i>	Preferred	
AFSTYLA KIT 1000 UNIT INTRAVENOUS (<i>antihemophil fact single chain</i>)	Preferred	
AFSTYLA KIT 1500 UNIT INTRAVENOUS (<i>antihemophil fact single chain</i>)	Preferred	
AFSTYLA KIT 2000 UNIT INTRAVENOUS (<i>antihemophil fact single chain</i>)	Preferred	
AFSTYLA KIT 250 UNIT INTRAVENOUS (<i>antihemophil fact single chain</i>)	Preferred	
AFSTYLA KIT 2500 UNIT INTRAVENOUS (<i>antihemophil fact single chain</i>)	Preferred	
AFSTYLA KIT 3000 UNIT INTRAVENOUS (<i>antihemophil fact single chain</i>)	Preferred	
AFSTYLA KIT 500 UNIT INTRAVENOUS (<i>antihemophil fact single chain</i>)	Preferred	
ALPHANATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
ALPHANATE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
ALPHANATE SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
ALPHANATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
ALPHANATE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
ALPHANINE SD SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>coagulation factor ix</i>)	Preferred	
ALPHANINE SD SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>coagulation factor ix</i>)	Preferred	
ALPHANINE SD SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>coagulation factor ix</i>)	Preferred	
ALPROLIX SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>coagulation factor ix (rfixfc)</i>)	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ALPROLIX SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>coagulation factor ix (rfixfc)</i>)	Preferred	
ALPROLIX SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>coagulation factor ix (rfixfc)</i>)	Preferred	
ALPROLIX SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>coagulation factor ix (rfixfc)</i>)	Preferred	
ALPROLIX SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS (<i>coagulation factor ix (rfixfc)</i>)	Preferred	
ALPROLIX SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>coagulation factor ix (rfixfc)</i>)	Preferred	
ALTUVIIIIO SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihem fact fc-vwf-xten-eh1</i>)	Preferred	PA
ALTUVIIIIO SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>antihem fact fc-vwf-xten-eh1</i>)	Preferred	PA
ALTUVIIIIO SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihem fact fc-vwf-xten-eh1</i>)	Preferred	PA
ALTUVIIIIO SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>antihem fact fc-vwf-xten-eh1</i>)	Preferred	PA
ALTUVIIIIO SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS (<i>antihem fact fc-vwf-xten-eh1</i>)	Preferred	PA
ALTUVIIIIO SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihem fact fc-vwf-xten-eh1</i>)	Preferred	PA
BENEFIX KIT 1000 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
BENEFIX KIT 2000 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
BENEFIX KIT 250 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
BENEFIX KIT 3000 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
BENEFIX KIT 500 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
COAGADEX SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>coagulation factor x (human)</i>)	Preferred	
COAGADEX SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>coagulation factor x (human)</i>)	Preferred	
CORIFACT KIT 1000-1600 UNIT INTRAVENOUS (<i>factor xiii concentrate human</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ELOCTATE SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 5000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 6000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ELOCTATE SOLUTION RECONSTITUTED 750 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviiiifc)</i>)	Preferred	
ESPEROCT SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihemoph fact rcmb gpeg-exei</i>)	Preferred	
ESPEROCT SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>antihemoph fact rcmb gpeg-exei</i>)	Preferred	
ESPEROCT SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>antihemoph fact rcmb gpeg-exei</i>)	Preferred	
ESPEROCT SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>antihemoph fact rcmb gpeg-exei</i>)	Preferred	
ESPEROCT SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihemoph fact rcmb gpeg-exei</i>)	Preferred	
FEIBA SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antiinhibitor coagulant cmplx</i>)	Preferred	
FEIBA SOLUTION RECONSTITUTED 2500 UNIT INTRAVENOUS (<i>antiinhibitor coagulant cmplx</i>)	Preferred	
FEIBA SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antiinhibitor coagulant cmplx</i>)	Preferred	
HEMLIBRA SOLUTION 105 MG/0.7ML SUBCUTANEOUS (<i>emicizumab-kxwh</i>)	Preferred	
HEMLIBRA SOLUTION 150 MG/ML SUBCUTANEOUS (<i>emicizumab-kxwh</i>)	Preferred	
HEMLIBRA SOLUTION 30 MG/ML SUBCUTANEOUS (<i>emicizumab-kxwh</i>)	Preferred	
HEMLIBRA SOLUTION 60 MG/0.4ML SUBCUTANEOUS (<i>emicizumab-kxwh</i>)	Preferred	
HEMOFIL M SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihemophilic factor</i>)	Preferred	
HEMOFIL M SOLUTION RECONSTITUTED 1700 UNIT INTRAVENOUS (<i>antihemophilic factor</i>)	Preferred	
HEMOFIL M SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihemophilic factor</i>)	Preferred	
HEMOFIL M SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihemophilic factor</i>)	Preferred	
HUMATE-P SOLUTION RECONSTITUTED 1000-2400 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
HUMATE-P SOLUTION RECONSTITUTED 250-600 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
HUMATE-P SOLUTION RECONSTITUTED 500-1200 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
IDELVION SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>coagulation factor ix (rix-fp)</i>)	Preferred	
IDELVION SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>coagulation factor ix (rix-fp)</i>)	Preferred	
IDELVION SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>coagulation factor ix (rix-fp)</i>)	Preferred	
IDELVION SOLUTION RECONSTITUTED 3500 UNIT INTRAVENOUS (<i>coagulation factor ix (rix-fp)</i>)	Preferred	
IDELVION SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>coagulation factor ix (rix-fp)</i>)	Preferred	
IXINITY SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
IXINITY SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
IXINITY SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
IXINITY SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
IXINITY SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
IXINITY SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>coagulation factor ix (recomb)</i>)	Preferred	
JIVI SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>ahf (bdd-rfviii peg-aucl)</i>)	Preferred	
JIVI SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>ahf (bdd-rfviii peg-aucl)</i>)	Preferred	
JIVI SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>ahf (bdd-rfviii peg-aucl)</i>)	Preferred	
JIVI SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>ahf (bdd-rfviii peg-aucl)</i>)	Preferred	
KOATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihemophilic factor</i>)	Preferred	
KOATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihemophilic factor</i>)	Preferred	
KOATE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihemophilic factor</i>)	Preferred	
KOATE-DVI SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihemophilic factor</i>)	Preferred	
KOGENATE FS KIT 1000 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	
KOGENATE FS KIT 2000 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
KOGENATE FS KIT 250 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	
KOGENATE FS KIT 3000 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	
KOGENATE FS KIT 500 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	
KOVALTRY SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
KOVALTRY SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
KOVALTRY SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
KOVALTRY SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
KOVALTRY SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihemophil factor (rahf-pfm)</i>)	Preferred	
NOVOEIGHT SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihemophil fact bd truncated</i>)	Preferred	
NOVOEIGHT SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>antihemophil fact bd truncated</i>)	Preferred	
NOVOEIGHT SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>antihemophil fact bd truncated</i>)	Preferred	
NOVOEIGHT SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihemophil fact bd truncated</i>)	Preferred	
NOVOEIGHT SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>antihemophil fact bd truncated</i>)	Preferred	
NOVOEIGHT SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihemophil fact bd truncated</i>)	Preferred	
NOVOSEVEN RT SOLUTION RECONSTITUTED 1 MG INTRAVENOUS (<i>coagulation factor viia recomb</i>)	Preferred	
NOVOSEVEN RT SOLUTION RECONSTITUTED 2 MG INTRAVENOUS (<i>coagulation factor viia recomb</i>)	Preferred	
NOVOSEVEN RT SOLUTION RECONSTITUTED 5 MG INTRAVENOUS (<i>coagulation factor viia recomb</i>)	Preferred	
NOVOSEVEN RT SOLUTION RECONSTITUTED 8 MG INTRAVENOUS (<i>coagulation factor viia recomb</i>)	Preferred	
NUWIQ KIT 1000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ KIT 1500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ KIT 2000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ KIT 250 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ KIT 2500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
NUWIQ KIT 3000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ KIT 4000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ KIT 500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ SOLUTION RECONSTITUTED 2500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ SOLUTION RECONSTITUTED 4000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
NUWIQ SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,sim)</i>)	Preferred	
<i>obizur solution reconstituted 500 unit intravenous</i>	Preferred	
PROFILNINE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>factor ix complex</i>)	Preferred	
PROFILNINE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (<i>factor ix complex</i>)	Preferred	
PROFILNINE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>factor ix complex</i>)	Preferred	
REBINYN SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (<i>coagulation factor ix glycopeg</i>)	Preferred	
REBINYN SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (<i>coagulation factor ix glycopeg</i>)	Preferred	
REBINYN SOLUTION RECONSTITUTED 3000 UNIT INTRAVENOUS (<i>coagulation factor ix glycopeg</i>)	Preferred	
REBINYN SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>coagulation factor ix glycopeg</i>)	Preferred	
RECOMBINATE SOLUTION RECONSTITUTED 1241-1800 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	
RECOMBINATE SOLUTION RECONSTITUTED 1801-2400 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	
RECOMBINATE SOLUTION RECONSTITUTED 220-400 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	
RECOMBINATE SOLUTION RECONSTITUTED 401-800 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
RECOMBINATE SOLUTION RECONSTITUTED 801-1240 UNIT INTRAVENOUS (<i>antihem factor recomb (rfviii)</i>)	Preferred	
<i>rixubis solution reconstituted 1000 unit intravenous</i>	Preferred	
<i>rixubis solution reconstituted 2000 unit intravenous</i>	Preferred	
<i>rixubis solution reconstituted 250 unit intravenous</i>	Preferred	
<i>rixubis solution reconstituted 3000 unit intravenous</i>	Preferred	
<i>rixubis solution reconstituted 500 unit intravenous</i>	Preferred	
SEVENFACT SOLUTION RECONSTITUTED 1 MG INTRAVENOUS (<i>coagulation factor viia-jncw</i>)	Preferred	
SEVENFACT SOLUTION RECONSTITUTED 5 MG INTRAVENOUS (<i>coagulation factor viia-jncw</i>)	Preferred	
TRETEN SOLUTION RECONSTITUTED 2500 UNIT INTRAVENOUS (<i>coagulation factor xiii a-sub</i>)	Preferred	
VONVENDI SOLUTION RECONSTITUTED 1300 UNIT INTRAVENOUS (<i>von willebrand factor (recomb)</i>)	Preferred	
VONVENDI SOLUTION RECONSTITUTED 650 UNIT INTRAVENOUS (<i>von willebrand factor (recomb)</i>)	Preferred	
WILATE KIT 1000-1000 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
WILATE KIT 500-500 UNIT INTRAVENOUS (<i>antihemophilic factor-vwf</i>)	Preferred	
XYNTHA KIT 1000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
XYNTHA KIT 2000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
XYNTHA KIT 250 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
XYNTHA KIT 500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
XYNTHA SOLOFUSE KIT 1000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
XYNTHA SOLOFUSE KIT 2000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
XYNTHA SOLOFUSE KIT 250 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
XYNTHA SOLOFUSE KIT 3000 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
XYNTHA SOLOFUSE KIT 500 UNIT INTRAVENOUS (<i>antihem fact (bdd-rfviii,mor)</i>)	Preferred	
HEPATITIS C AGENTS [CLOSED CLASS]		
EPCLUSA PACKET 150-37.5 MG ORAL (<i>sofosbuvir-velpatasvir</i>)	Non Preferred	PA; AGE (Min 3 Years)
EPCLUSA PACKET 200-50 MG ORAL (<i>sofosbuvir-velpatasvir</i>)	Non Preferred	PA; AGE (Min 3 Years)

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Drug Name	Formulary Status	Requirements/Limits
EPCLUSA TABLET 200-50 MG ORAL (<i>sofosbuvir-velpatasvir</i>)	Non Preferred	PA; AGE (Min 3 Years)
EPCLUSA TABLET 400-100 MG ORAL (<i>sofosbuvir-velpatasvir</i>)	Non Preferred	PA; AGE (Min 3 Years); Max 84-day supply per fill and per lifetime
HARVONI PACKET 33.75-150 MG ORAL (<i>ledipasvir-sofosbuvir</i>)	Non Preferred	PA; AGE (Min 3 Years)
HARVONI PACKET 45-200 MG ORAL (<i>ledipasvir-sofosbuvir</i>)	Non Preferred	PA; AGE (Min 3 Years)
HARVONI TABLET 45-200 MG ORAL (<i>ledipasvir-sofosbuvir</i>)	Non Preferred	PA; AGE (Min 3 Years)
HARVONI TABLET 90-400 MG ORAL (<i>ledipasvir-sofosbuvir</i>)	Non Preferred	PA; AGE (Min 3 Years)
<i>ledipasvir-sofosbuvir tablet 90-400 mg oral</i>	Non Preferred	PA; AGE (Min 3 Years)
MAVYRET PACKET 50-20 MG ORAL (<i>glecaprevir-pibrentasvir</i>)	Preferred	AGE (Min 3 Years); Max 84-day supply per fill and per lifetime
MAVYRET TABLET 100-40 MG ORAL (<i>glecaprevir-pibrentasvir</i>)	Preferred	AGE (Min 12 Years); Max 84-day supply per fill and per lifetime
PEGASYS SOLUTION 180 MCG/ML SUBCUTANEOUS (<i>peginterferon alfa-2a</i>)	Non Preferred	PA
PEGASYS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML SUBCUTANEOUS (<i>peginterferon alfa-2a</i>)	Non Preferred	PA
<i>sofosbuvir-velpatasvir tablet 400-100 mg oral</i>	Preferred	AGE (Min 3 Years); Max 84-day supply per fill and per lifetime
SOVALDI PACKET 150 MG ORAL (<i>sofosbuvir</i>)	Non Preferred	PA
SOVALDI PACKET 200 MG ORAL (<i>sofosbuvir</i>)	Non Preferred	PA
SOVALDI TABLET 200 MG ORAL (<i>sofosbuvir</i>)	Non Preferred	PA
SOVALDI TABLET 400 MG ORAL (<i>sofosbuvir</i>)	Non Preferred	PA
VOSEVI TABLET 400-100-100 MG ORAL (<i>sofosbuv-velpatasvir-voxilaprev</i>)	Non Preferred	PA
ZEPATIER TABLET 50-100 MG ORAL (<i>elbasvir-grazoprevir</i>)	Non Preferred	PA
HEREDITARY ANGIOEDEMA (HAE) AGENTS [OPEN CLASS]		
BERINERT KIT 500 UNIT INTRAVENOUS (<i>c1 esterase inhibitor (human)</i>)	Preferred	PA; QL (4 EA per 1 Fill); AGE (Min 6 Years)
CINRYZE SOLUTION RECONSTITUTED 500 UNIT INTRAVENOUS (<i>c1 esterase inhibitor (human)</i>)	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
FIRAZYR SOLUTION PREFILLED SYRINGE 30 MG/3ML SUBCUTANEOUS (<i>icatibant acetate</i>)	Non Preferred	PA; AGE (Min 18 Years)
HAEGARDA SOLUTION RECONSTITUTED 2000 UNIT SUBCUTANEOUS (<i>c1 esterase inhibitor (human)</i>)	Non Preferred	PA; AGE (Min 12 Years)
HAEGARDA SOLUTION RECONSTITUTED 3000 UNIT SUBCUTANEOUS (<i>c1 esterase inhibitor (human)</i>)	Non Preferred	PA; AGE (Min 12 Years)
<i>icatibant acetate solution prefilled syringe 30 mg/3ml subcutaneous</i>	Non Preferred	PA; AGE (Min 18 Years)
KALBITOR SOLUTION 10 MG/ML SUBCUTANEOUS (<i>ecallantide</i>)	Preferred	PA; QL (6 ML per 1 Fill); AGE (Min 12 Years)
ORLADEYO CAPSULE 110 MG ORAL (<i>berotralstat hcl</i>)	Non Preferred	PA; AGE (Min 12 Years)
ORLADEYO CAPSULE 150 MG ORAL (<i>berotralstat hcl</i>)	Non Preferred	PA; AGE (Min 12 Years)
RUCONEST SOLUTION RECONSTITUTED 2100 UNIT INTRAVENOUS (<i>c1 esterase inhibitor (recomb)</i>)	Non Preferred	PA; AGE (Min 13 Years)
<i>icatibant acetate</i> (Sajazir Solution Prefilled Syringe 30 Mg/3ML Subcutaneous)	Non Preferred	PA; AGE (Min 18 Years)
TAKHZYRO SOLUTION 300 MG/2ML SUBCUTANEOUS (<i>lanadelumab-flyo</i>)	Non Preferred	PA; AGE (Min 12 Years)
TAKHZYRO SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS (<i>lanadelumab-flyo</i>)	Non Preferred	PA; AGE (Min 12 Years)
TAKHZYRO SOLUTION PREFILLED SYRINGE 300 MG/2ML SUBCUTANEOUS (<i>lanadelumab-flyo</i>)	Non Preferred	PA; AGE (Min 12 Years)
HERPES ORAL [OPEN CLASS]		
<i>acyclovir capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>acyclovir suspension 200 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>acyclovir tablet 400 mg oral</i>	Preferred	Max 90-day supply per fill
<i>acyclovir tablet 800 mg oral</i>	Preferred	Max 90-day supply per fill
<i>famciclovir tablet 125 mg oral</i>	Preferred	Max 90-day supply per fill
<i>famciclovir tablet 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>famciclovir tablet 500 mg oral</i>	Preferred	Max 90-day supply per fill
SITAVIG TABLET 50 MG BUCCAL (<i>acyclovir</i>)	Non Preferred	PA
<i>valacyclovir hcl tablet 1 gm oral</i>	Preferred	Max 90-day supply per fill
<i>valacyclovir hcl tablet 500 mg oral</i>	Preferred	Max 90-day supply per fill
VALTREX TABLET 1 GM ORAL (<i>valacyclovir hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
VALTREX TABLET 500 MG ORAL (<i>valacyclovir hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
HERPES TOPICAL [OPEN CLASS]		
<i>acyclovir cream 5 % external</i>	Preferred	
<i>acyclovir ointment 5 % external</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
DENAVIR CREAM 1 % EXTERNAL (<i>penciclovir</i>)	Non Preferred	PA
<i>docosanol cream 10 % external (otc)</i>	Preferred	
<i>ft docosanol cream 10 % external</i>	Preferred	
<i>gnp docosanol cream 10 % external</i>	Preferred	
<i>penciclovir cream 1 % external</i>	Non Preferred	PA
XERESE CREAM 5-1 % EXTERNAL (<i>acyclovir-hydrocortisone</i>)	Non Preferred	PA
ZOVIRAX CREAM 5 % EXTERNAL (<i>acyclovir</i>)	Non Preferred	PA
ZOVIRAX OINTMENT 5 % EXTERNAL (<i>acyclovir</i>)	Non Preferred	PA
HISTAMINE-2 RECEPTOR ANTAGONISTS (H-2 RA) [OPEN CLASS]		
<i>acid reducer complete tablet chewable 10-800-165 mg oral</i>	Non Preferred	PA
<i>acid reducer maximum strength tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>acid reducer tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>cimetidine hcl solution 300 mg/5ml oral</i>	Non Preferred	PA
<i>cimetidine tablet 200 mg oral (rx)</i>	Non Preferred	PA
<i>cimetidine tablet 300 mg oral</i>	Non Preferred	PA
<i>cimetidine tablet 400 mg oral</i>	Non Preferred	PA
<i>cimetidine tablet 800 mg oral</i>	Non Preferred	PA
<i>famotidine maximum strength tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>famotidine orig st tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>famotidine suspension reconstituted 40 mg/5ml oral</i>	Preferred	PA (Eligible for auto-PA); AGE (Max 11 Years); Max 90-day supply per fill
<i>famotidine suspension reconstituted 40 mg/5ml oral</i>	Preferred	AGE (Max 11 Years); PA (Eligible for auto-PA); Max 90-day supply per fill
<i>famotidine tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>famotidine tablet 20 mg oral (otc)</i>	Preferred	Max 90-day supply per fill
<i>famotidine tablet 20 mg oral (rx)</i>	Preferred	Max 90-day supply per fill
<i>famotidine tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp acid reducer max st tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp acid reducer tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>heartburn relief max st tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>heartburn relief tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>hm dual action complete tablet chewable 10-800-165 mg oral</i>	Non Preferred	PA
<i>nizatidine capsule 150 mg oral</i>	Non Preferred	PA
<i>nizatidine capsule 300 mg oral</i>	Non Preferred	PA
PEPCID TABLET 20 MG ORAL (<i>famotidine</i>)	Non Preferred	PA; Max 90-day supply per fill
PEPCID TABLET 40 MG ORAL (<i>famotidine</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>sm acid reducer max st tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sm acid reducer tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
HIV/AIDS [CLOSED CLASS]		
<i>abacavir sulfate solution 20 mg/ml oral</i>	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
<i>abacavir sulfate tablet 300 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>abacavir sulfate-lamivudine tablet 600-300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR (<i>cabotegravir</i>)	Preferred	QL (3 ML per 28 days); Max 56-day supply per fill
APTIVUS CAPSULE 250 MG ORAL (<i>tipranavir</i>)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>atazanavir sulfate capsule 150 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atazanavir sulfate capsule 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>atazanavir sulfate capsule 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
ATRIPLA TABLET 600-200-300 MG ORAL (<i>efavirenz-emtricitab-tenofo df</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
BIKTARVY TABLET 30-120-15 MG ORAL (<i>bictegravir-emtricitab-tenofov</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
BIKTARVY TABLET 50-200-25 MG ORAL (<i>bictegravir-emtricitab-tenofov</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>cabenuva suspension extended release 400 & 600 mg/2ml intramuscular</i>	Preferred	QL (12 ML per 84 days); Max 90-day supply per fill
<i>cabenuva suspension extended release 600 & 900 mg/3ml intramuscular</i>	Preferred	Max 90-day supply per fill
CIMDUO TABLET 300-300 MG ORAL (<i>lamivudine-tenofovir</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
COMBIVIR TABLET 150-300 MG ORAL (<i>lamivudine-zidovudine</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
COMPLERA TABLET 200-25-300 MG ORAL (<i>emtricitab-rilpivir-tenofovir</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>darunavir tablet 600 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>darunavir tablet 800 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DELSTRIGO TABLET 100-300-300 MG ORAL (<i>doravirin-lamivudine-tenofovir df</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DESCOVY TABLET 120-15 MG ORAL (<i>emtricitabine-tenofovir af</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DESCOVY TABLET 200-25 MG ORAL (<i>emtricitabine-tenofovir af</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DOVATO TABLET 50-300 MG ORAL (<i>dolutegravir-lamivudine</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
EDURANT TABLET 25 MG ORAL (<i>rilpivirine hcl</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>efavirenz capsule 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>efavirenz capsule 50 mg oral</i>	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
<i>efavirenz tablet 600 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>efavirenz-emtricitabine-tenofovir df tablet 600-200-300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>efavirenz-lamivudine-tenofovir tablet 400-300-300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>efavirenz-lamivudine-tenofovir tablet 600-300-300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>emtricitabine capsule 200 mg oral</i>	Preferred	QL (24 EA per 1 day); Max 90-day supply per fill
<i>emtricitabine-tenofovir df tablet 100-150 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>emtricitabine-tenofovir df tablet 133-200 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>emtricitabine-tenofovir df tablet 167-250 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>emtricitabine-tenofovir df tablet 200-300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
EMTRIVA CAPSULE 200 MG ORAL (<i>emtricitabine</i>)	Preferred	QL (24 EA per 1 day); Max 90-day supply per fill
EMTRIVA SOLUTION 10 MG/ML ORAL (<i>emtricitabine</i>)	Preferred	QL (1 ML per 1 day); Max 90-day supply per fill
EPIVIR SOLUTION 10 MG/ML ORAL (<i>lamivudine</i>)	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
EPIVIR TABLET 150 MG ORAL (<i>lamivudine</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
EPIVIR TABLET 300 MG ORAL (<i>lamivudine</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
EPZICOM TABLET 600-300 MG ORAL (<i>abacavir sulfate-lamivudine</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>etravirine tablet 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>etravirine tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
EVOTAZ TABLET 300-150 MG ORAL (<i>atazanavir-cobicistat</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>fosamprenavir calcium tablet 700 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
FUZEON SOLUTION RECONSTITUTED 90 MG SUBCUTANEOUS (<i>enfuvirtide</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
GENVOYA TABLET 150-150-200-10 MG ORAL (<i>elviteg-cobic-emtricit-tenofaf</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
INTELENCE TABLET 100 MG ORAL (<i>etravirine</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
INTELENCE TABLET 200 MG ORAL (<i>etravirine</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
INTELENCE TABLET 25 MG ORAL (<i>etravirine</i>)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
ISENTRESS HD TABLET 600 MG ORAL (<i>raltegravir potassium</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
ISENTRESS PACKET 100 MG ORAL (<i>raltegravir potassium</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
ISENTRESS TABLET 400 MG ORAL (<i>raltegravir potassium</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
ISENTRESS TABLET CHEWABLE 100 MG ORAL (<i>raltegravir potassium</i>)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
ISENTRESS TABLET CHEWABLE 25 MG ORAL (<i>raltegravir potassium</i>)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
JULUCA TABLET 50-25 MG ORAL (<i>dolutegravir-rilpivirine</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
KALETRA SOLUTION 400-100 MG/5ML ORAL (<i>lopinavir-ritonavir</i>)	Preferred	QL (4 ML per 1 day); Max 90-day supply per fill
KALETRA TABLET 100-25 MG ORAL (<i>lopinavir-ritonavir</i>)	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
KALETRA TABLET 200-50 MG ORAL (<i>lopinavir-ritonavir</i>)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>lamivudine solution 10 mg/ml oral</i>	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
<i>lamivudine tablet 150 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>lamivudine tablet 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>lamivudine-zidovudine tablet 150-300 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
LEXIVA SUSPENSION 50 MG/ML ORAL (<i>fosamprenavir calcium</i>)	Preferred	QL (56 ML per 1 day); Max 90-day supply per fill
LEXIVA TABLET 700 MG ORAL (<i>fosamprenavir calcium</i>)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>lopinavir-ritonavir solution 400-100 mg/5ml oral</i>	Preferred	QL (4 ML per 1 day); Max 90-day supply per fill
<i>lopinavir-ritonavir tablet 100-25 mg oral</i>	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
<i>lopinavir-ritonavir tablet 200-50 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>maraviroc tablet 150 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>maraviroc tablet 300 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>nevirapine er tablet extended release 24 hour 100 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>nevirapine er tablet extended release 24 hour 400 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>nevirapine suspension 50 mg/5ml oral</i>	Preferred	QL (40 ML per 1 day); Max 90-day supply per fill
<i>nevirapine tablet 200 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
NORVIR PACKET 100 MG ORAL (<i>ritonavir</i>)	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
NORVIR TABLET 100 MG ORAL (<i>ritonavir</i>)	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
ODEFSEY TABLET 200-25-25 MG ORAL (<i>emtricitab- rilpivir- tenofov af</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
PIFELTRO TABLET 100 MG ORAL (<i>doravirine</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
PREZCOBIX TABLET 800-150 MG ORAL (<i>darunavir-cobicistat</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
PREZISTA SUSPENSION 100 MG/ML ORAL (<i>darunavir</i>)	Preferred	QL (12 ML per 1 day); Max 90-day supply per fill
PREZISTA TABLET 150 MG ORAL (<i>darunavir</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
PREZISTA TABLET 600 MG ORAL (<i>darunavir</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
PREZISTA TABLET 75 MG ORAL (<i>darunavir</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
PREZISTA TABLET 800 MG ORAL (<i>darunavir</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
RETROVIR CAPSULE 100 MG ORAL (<i>zidovudine</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
RETROVIR SYRUP 50 MG/5ML ORAL (<i>zidovudine</i>)	Preferred	QL (60 ML per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
REYATAZ CAPSULE 200 MG ORAL (<i>atazanavir sulfate</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
REYATAZ CAPSULE 300 MG ORAL (<i>atazanavir sulfate</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
REYATAZ PACKET 50 MG ORAL (<i>atazanavir sulfate</i>)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
<i>ritonavir tablet 100 mg oral</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
RUKOBIA TABLET EXTENDED RELEASE 12 HOUR 600 MG ORAL (<i>fostemsavir tromethamine</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
SELZENTRY SOLUTION 20 MG/ML ORAL (<i>maraviroc</i>)	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 150 MG ORAL (<i>maraviroc</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 25 MG ORAL (<i>maraviroc</i>)	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 300 MG ORAL (<i>maraviroc</i>)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 75 MG ORAL (<i>maraviroc</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>stavudine capsule 15 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>stavudine capsule 20 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>stavudine capsule 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
STRIBILD TABLET 150-150-200-300 MG ORAL (<i>elviteg-cobic-emtricit-tenofdf</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SUNLENCA SOLUTION 463.5 MG/1.5ML SUBCUTANEOUS (<i>lenacapavir sodium</i>)	Preferred	AGE (Min 18 Years)
SUNLENCA TABLET THERAPY PACK 4 X 300 MG ORAL (<i>lenacapavir sodium</i>)	Preferred	AGE (Min 18 Years)
SUNLENCA TABLET THERAPY PACK 5 X 300 MG ORAL (<i>lenacapavir sodium</i>)	Preferred	AGE (Min 18 Years)
SYMFI LO TABLET 400-300-300 MG ORAL (<i>efavirenz-lamivudine-tenofovir</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SYMFI TABLET 600-300-300 MG ORAL (<i>efavirenz-lamivudine-tenofovir</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SYMTUZA TABLET 800-150-200-10 MG ORAL (<i>darun-cobic-emtricit-tenofaf</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>tenofovir disoproxil fumarate tablet 300 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TIVICAY PD TABLET SOLUBLE 5 MG ORAL (<i>dolutegravir sodium</i>)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
TIVICAY TABLET 10 MG ORAL (<i>dolutegravir sodium</i>)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
TIVICAY TABLET 25 MG ORAL (<i>dolutegravir sodium</i>)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
TIVICAY TABLET 50 MG ORAL (<i>dolutegravir sodium</i>)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
TRIUMEQ PD TABLET SOLUBLE 60-5-30 MG ORAL (<i>abacavir-dolutegravir-lamivudine</i>)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
TRIUMEQ TABLET 600-50-300 MG ORAL (<i>abacavir-dolutegravir-lamivudine</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRIZIVIR TABLET 300-150-300 MG ORAL (<i>abacavir-lamivudine-zidovudine</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
TROGARZO SOLUTION 200 MG/1.33ML INTRAVENOUS (<i>ibalizumab-uiyk</i>)	Non Preferred	PA
TRUVADA TABLET 100-150 MG ORAL (<i>emtricitabine-tenofovir df</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 133-200 MG ORAL (<i>emtricitabine-tenofovir df</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 167-250 MG ORAL (<i>emtricitabine-tenofovir df</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 200-300 MG ORAL (<i>emtricitabine-tenofovir df</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TYBOST TABLET 150 MG ORAL (<i>cobicistat</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIRACEPT TABLET 250 MG ORAL (<i>nelfinavir mesylate</i>)	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
VIRACEPT TABLET 625 MG ORAL (<i>nelfinavir mesylate</i>)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
VIREAD POWDER 40 MG/GM ORAL (<i>tenofovir disoproxil fumarate</i>)	Preferred	QL (1 GM per 1 day); Max 90-day supply per fill
VIREAD TABLET 150 MG ORAL (<i>tenofovir disoproxil fumarate</i>)	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 200 MG ORAL (<i>tenofovir disoproxil fumarate</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 250 MG ORAL (<i>tenofovir disoproxil fumarate</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 300 MG ORAL (<i>tenofovir disoproxil fumarate</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
ZIAGEN SOLUTION 20 MG/ML ORAL (<i>abacavir sulfate</i>)	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
ZIAGEN TABLET 300 MG ORAL (<i>abacavir sulfate</i>)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>zidovudine capsule 100 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>zidovudine syrup 50 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day); Max 90-day supply per fill
<i>zidovudine tablet 300 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
IMMUNOMODULATORS ATOPIC DERMATITIS [CLOSED CLASS]		
ADBRY SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS (<i>tralokinumab-ldrm</i>)	Non Preferred	PA; QL (4 ML per 28 days); AGE (Min 18 Years)
DUPIXENT SOLUTION PEN-INJECTOR 200 MG/1.14ML SUBCUTANEOUS (<i>dupilumab</i>)	Preferred	PA (Eligible for auto-PA)
DUPIXENT SOLUTION PEN-INJECTOR 300 MG/2ML SUBCUTANEOUS (<i>dupilumab</i>)	Preferred	PA (Eligible for auto-PA)
DUPIXENT SOLUTION PREFILLED SYRINGE 100 MG/0.67ML SUBCUTANEOUS (<i>dupilumab</i>)	Preferred	PA
DUPIXENT SOLUTION PREFILLED SYRINGE 200 MG/1.14ML SUBCUTANEOUS (<i>dupilumab</i>)	Preferred	PA (Eligible for auto-PA)
DUPIXENT SOLUTION PREFILLED SYRINGE 300 MG/2ML SUBCUTANEOUS (<i>dupilumab</i>)	Preferred	PA (Eligible for auto-PA)
ELIDEL CREAM 1 % EXTERNAL (<i>pimecrolimus</i>)	Preferred	PA (Eligible for auto-PA); QL (30 GM per 30 days); AGE (Min 2 Years)
EUCRISA OINTMENT 2 % EXTERNAL (<i>crisaborole</i>)	Preferred	PA (Eligible for auto-PA); QL (300 GM per 365 days); AGE (Min 3 Months)
OPZELURA CREAM 1.5 % EXTERNAL (<i>ruxolitinib phosphate</i>)	Non Preferred	PA; QL (240 GM per 30 days); AGE (Min 12 Years)
<i>pimecrolimus cream 1 % external</i>	Non Preferred	PA; QL (30 GM per 30 days); AGE (Min 2 Years)
<i>tacrolimus ointment 0.03 % external</i>	Preferred	PA (Eligible for auto-PA); QL (30 GM per 30 days); AGE (Min 2 Years)
<i>tacrolimus ointment 0.1 % external</i>	Preferred	PA (Eligible for auto-PA); QL (30 GM per 30 days); AGE (Min 16 Years)
INFLUENZA [OPEN CLASS]		
<i>oseltamivir phosphate capsule 30 mg oral</i>	Preferred	
<i>oseltamivir phosphate capsule 45 mg oral</i>	Preferred	
<i>oseltamivir phosphate capsule 75 mg oral</i>	Preferred	
<i>oseltamivir phosphate suspension reconstituted 6 mg/ml oral</i>	Preferred	
RELENZA DISKHALER AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT INHALATION (<i>zanamivir</i>)	Non Preferred	PA
<i>rimantadine hcl tablet 100 mg oral</i>	Non Preferred	PA
TAMIFLU CAPSULE 30 MG ORAL (<i>oseltamivir phosphate</i>)	Non Preferred	PA
TAMIFLU CAPSULE 45 MG ORAL (<i>oseltamivir phosphate</i>)	Non Preferred	PA
TAMIFLU CAPSULE 75 MG ORAL (<i>oseltamivir phosphate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TAMIFLU SUSPENSION RECONSTITUTED 6 MG/ML ORAL (<i>oseltamivir phosphate</i>)	Non Preferred	PA
XOFLUZA (40 MG DOSE) TABLET THERAPY PACK 1 X 40 MG ORAL (<i>baloxavir marboxil</i>)	Non Preferred	PA
XOFLUZA (80 MG DOSE) TABLET THERAPY PACK 1 X 80 MG ORAL (<i>baloxavir marboxil</i>)	Non Preferred	PA
INHALED CORTICOSTEROIDS: COMBINATIONS [CLOSED CLASS]		
ADVAIR DISKUS AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Preferred	Max 90-day supply per fill
ADVAIR DISKUS AEROSOL POWDER BREATH ACTIVATED 250-50 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Preferred	Max 90-day supply per fill
ADVAIR DISKUS AEROSOL POWDER BREATH ACTIVATED 500-50 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Preferred	Max 90-day supply per fill
ADVAIR HFA AEROSOL 115-21 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Preferred	Max 90-day supply per fill
ADVAIR HFA AEROSOL 230-21 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Preferred	Max 90-day supply per fill
ADVAIR HFA AEROSOL 45-21 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Preferred	Max 90-day supply per fill
AIRDUO DIGIHALER AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT INHALATION (<i>fluticasone-salmeterol(sensor)</i>)	Non Preferred	PA
AIRDUO DIGIHALER AEROSOL POWDER BREATH ACTIVATED 232-14 MCG/ACT INHALATION (<i>fluticasone-salmeterol(sensor)</i>)	Non Preferred	PA
AIRDUO DIGIHALER AEROSOL POWDER BREATH ACTIVATED 55-14 MCG/ACT INHALATION (<i>fluticasone-salmeterol(sensor)</i>)	Non Preferred	PA
AIRDUO RESPICLICK 113/14 AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Non Preferred	PA
AIRDUO RESPICLICK 232/14 AEROSOL POWDER BREATH ACTIVATED 232-14 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Non Preferred	PA
AIRDUO RESPICLICK 55/14 AEROSOL POWDER BREATH ACTIVATED 55-14 MCG/ACT INHALATION (<i>fluticasone-salmeterol</i>)	Non Preferred	PA
AIRSUPRA AEROSOL 90-80 MCG/ACT INHALATION (<i>albuterol-budesonide</i>)	Non Preferred	PA; AGE (Min 18 Years)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT INHALATION (<i>fluticasone furoate-vilanterol</i>)	Non Preferred	PA
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-25 MCG/ACT INHALATION (<i>fluticasone furoate-vilanterol</i>)	Non Preferred	PA
BREZTRI AEROSPHERE AEROSOL 160-9-4.8 MCG/ACT INHALATION (<i>budeson-glycopyrrol-formoterol</i>)	Non Preferred	PA
<i>budesonide-formoterol fumarate aerosol 160-4.5 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>budesonide-formoterol fumarate aerosol 80-4.5 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
DULERA AEROSOL 100-5 MCG/ACT INHALATION (<i>mometasone furo-formoterol fum</i>)	Preferred	Max 90-day supply per fill
DULERA AEROSOL 200-5 MCG/ACT INHALATION (<i>mometasone furo-formoterol fum</i>)	Preferred	Max 90-day supply per fill
DULERA AEROSOL 50-5 MCG/ACT INHALATION (<i>mometasone furo-formoterol fum</i>)	Preferred	Max 90-day supply per fill
<i>fluticasone furoate-vilanterol aerosol powder breath activated 100-25 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone furoate-vilanterol aerosol powder breath activated 200-25 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone-salmeterol aerosol 115-21 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone-salmeterol aerosol 230-21 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone-salmeterol aerosol 45-21 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone-salmeterol aerosol powder breath activated 100-50 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone-salmeterol aerosol powder breath activated 113-14 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone-salmeterol aerosol powder breath activated 232-14 mcg/act inhalation</i>	Non Preferred	PA
<i>fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone-salmeterol aerosol powder breath activated 500-50 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone-salmeterol aerosol powder breath activated 55-14 mcg/act inhalation</i>	Non Preferred	PA
SYMBICORT AEROSOL 160-4.5 MCG/ACT INHALATION (<i>budesonide-formoterol fumarate</i>)	Preferred	Max 90-day supply per fill
SYMBICORT AEROSOL 80-4.5 MCG/ACT INHALATION (<i>budesonide-formoterol fumarate</i>)	Preferred	Max 90-day supply per fill
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT INHALATION (<i>fluticasone-umeclidin-vilant</i>)	Non Preferred	PA
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT INHALATION (<i>fluticasone-umeclidin-vilant</i>)	Non Preferred	PA
<i>fluticasone-salmeterol (Wixela Inhub Aerosol Powder Breath Activated 100-50 Mcg/Act Inhalation)</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone-salmeterol (Wixela Inhub Aerosol Powder Breath Activated 250-50 Mcg/Act Inhalation)</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone-salmeterol (Wixela Inhub Aerosol Powder Breath Activated 500-50 Mcg/Act Inhalation)</i>	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
INHALED CORTICOSTEROIDS: MDIS [CLOSED CLASS]		
ALVESCO AEROSOL SOLUTION 160 MCG/ACT INHALATION (<i>ciclesonide</i>)	Non Preferred	PA
ALVESCO AEROSOL SOLUTION 80 MCG/ACT INHALATION (<i>ciclesonide</i>)	Non Preferred	PA
ARMONAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 113 MCG/ACT INHALATION (<i>fluticasone propionate(sensor)</i>)	Non Preferred	PA
ARMONAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 232 MCG/ACT INHALATION (<i>fluticasone propionate(sensor)</i>)	Non Preferred	PA
ARMONAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 55 MCG/ACT INHALATION (<i>fluticasone propionate(sensor)</i>)	Non Preferred	PA
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT INHALATION (<i>fluticasone furoate</i>)	Non Preferred	PA
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 200 MCG/ACT INHALATION (<i>fluticasone furoate</i>)	Non Preferred	PA
ARNUITY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION (<i>fluticasone furoate</i>)	Non Preferred	PA
ASMANEX (120 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT INHALATION (<i>mometasone furoate</i>)	Preferred	Max 90-day supply per fill
ASMANEX (14 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT INHALATION (<i>mometasone furoate</i>)	Preferred	Max 90-day supply per fill
ASMANEX (30 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT INHALATION (<i>mometasone furoate</i>)	Preferred	Max 90-day supply per fill
ASMANEX (30 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT INHALATION (<i>mometasone furoate</i>)	Preferred	Max 90-day supply per fill
ASMANEX (60 METERED DOSES) AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT INHALATION (<i>mometasone furoate</i>)	Preferred	Max 90-day supply per fill
ASMANEX HFA AEROSOL 100 MCG/ACT INHALATION (<i>mometasone furoate</i>)	Non Preferred	PA
ASMANEX HFA AEROSOL 200 MCG/ACT INHALATION (<i>mometasone furoate</i>)	Non Preferred	PA
ASMANEX HFA AEROSOL 50 MCG/ACT INHALATION (<i>mometasone furoate</i>)	Non Preferred	PA
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT INHALATION (<i>fluticasone propionate (inhal)</i>)	Preferred	Max 90-day supply per fill
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 250 MCG/ACT INHALATION (<i>fluticasone propionate (inhal)</i>)	Preferred	Max 90-day supply per fill
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT INHALATION (<i>fluticasone propionate (inhal)</i>)	Preferred	Max 90-day supply per fill
FLOVENT HFA AEROSOL 110 MCG/ACT INHALATION (<i>fluticasone propionate hfa</i>)	Preferred	Max 90-day supply per fill
FLOVENT HFA AEROSOL 220 MCG/ACT INHALATION (<i>fluticasone propionate hfa</i>)	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
FLOVENT HFA AEROSOL 44 MCG/ACT INHALATION (<i>fluticasone propionate hfa</i>)	Preferred	Max 90-day supply per fill
<i>fluticasone propionate hfa aerosol 110 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone propionate hfa aerosol 220 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fluticasone propionate hfa aerosol 44 mcg/act inhalation</i>	Non Preferred	PA; Max 90-day supply per fill
PULMICORT FLEXHALER AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT INHALATION (<i>budesonide</i>)	Preferred	Max 90-day supply per fill
PULMICORT FLEXHALER AEROSOL POWDER BREATH ACTIVATED 90 MCG/ACT INHALATION (<i>budesonide</i>)	Preferred	Max 90-day supply per fill
QVAR REDIHALER AEROSOL BREATH ACTIVATED 40 MCG/ACT INHALATION (<i>beclomethasone diprop hfa</i>)	Non Preferred	PA
QVAR REDIHALER AEROSOL BREATH ACTIVATED 80 MCG/ACT INHALATION (<i>beclomethasone diprop hfa</i>)	Non Preferred	PA
INHALED CORTICOSTEROIDS: NEBULIZER SOLUTION [CLOSED CLASS]		
<i>budesonide suspension 0.25 mg/2ml inhalation</i>	Preferred	Max 90-day supply per fill
<i>budesonide suspension 0.5 mg/2ml inhalation</i>	Preferred	Max 90-day supply per fill
<i>budesonide suspension 1 mg/2ml inhalation</i>	Preferred	Max 90-day supply per fill
PULMICORT SUSPENSION 0.25 MG/2ML INHALATION (<i>budesonide</i>)	Non Preferred	PA; Max 90-day supply per fill
PULMICORT SUSPENSION 0.5 MG/2ML INHALATION (<i>budesonide</i>)	Non Preferred	PA; Max 90-day supply per fill
PULMICORT SUSPENSION 1 MG/2ML INHALATION (<i>budesonide</i>)	Non Preferred	PA; Max 90-day supply per fill
INSULINS: INSULIN MIX [OPEN CLASS]		
HUMALOG MIX 50/50 KWIKPEN SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro prot & lispro</i>)	Preferred	
HUMALOG MIX 50/50 SUSPENSION (50-50) 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro prot & lispro</i>)	Preferred	Max 90-day supply per fill
HUMALOG MIX 75/25 KWIKPEN SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro prot & lispro</i>)	Non Preferred	PA; Max 90-day supply per fill
HUMALOG MIX 75/25 SUSPENSION (75-25) 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro prot & lispro</i>)	Preferred	Max 90-day supply per fill
HUMULIN 70/30 KWIKPEN SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph isophane & regular</i>)	Preferred	Max 90-day supply per fill
HUMULIN 70/30 SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph isophane & regular</i>)	Preferred	Max 90-day supply per fill
<i>insulin asp prot & asp flexpen suspension pen-injector (70-30) 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>insulin aspart prot & aspart suspension (70-30) 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill
<i>insulin lispro prot & lispro suspension pen-injector (75-25) 100 unit/ml subcutaneous</i>	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN 70/30 FLEXPEN RELION SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph isophane & regular</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN 70/30 FLEXPEN SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph isophane & regular</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN 70/30 RELION SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph isophane & regular</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN 70/30 SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph isophane & regular</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLOG 70/30 FLEXPEN RELION SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart prot & aspart</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLOG MIX 70/30 FLEXPEN SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart prot & aspart</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLOG MIX 70/30 RELION SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart prot & aspart</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLOG MIX 70/30 SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart prot & aspart</i>)	Non Preferred	PA; Max 90-day supply per fill
INSULINS: INSULIN N [OPEN CLASS]		
HUMULIN N KWIKPEN SUSPENSION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph human (isophane)</i>)	Preferred	Max 90-day supply per fill
HUMULIN N SUSPENSION 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph human (isophane)</i>)	Preferred	Max 90-day supply per fill
NOVOLIN N FLEXPEN RELION SUSPENSION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph human (isophane)</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN N FLEXPEN SUSPENSION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (OTC) (<i>insulin nph human (isophane)</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN N RELION SUSPENSION 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph human (isophane)</i>)	Non Preferred	PA; Max 90-day supply per fill
NOVOLIN N SUSPENSION 100 UNIT/ML SUBCUTANEOUS (<i>insulin nph human (isophane)</i>)	Non Preferred	PA; Max 90-day supply per fill
INSULINS: INSULIN R [OPEN CLASS]		
HUMULIN R SOLUTION 100 UNIT/ML INJECTION (<i>insulin regular human</i>)	Preferred	Max 90-day supply per fill
NOVOLIN R FLEXPEN RELION SOLUTION PEN-INJECTOR 100 UNIT/ML INJECTION (<i>insulin regular human</i>)	Non Preferred	PA
NOVOLIN R FLEXPEN SOLUTION PEN-INJECTOR 100 UNIT/ML INJECTION (<i>insulin regular human</i>)	Non Preferred	PA
NOVOLIN R RELION SOLUTION 100 UNIT/ML INJECTION (<i>insulin regular human</i>)	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
NOVOLIN R SOLUTION 100 UNIT/ML INJECTION (<i>insulin regular human</i>)	Non Preferred	PA; Max 90-day supply per fill
INSULINS: LONG-ACTING [OPEN CLASS]		
BASAGLAR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin glargine</i>)	Preferred	Max 90-day supply per fill
BASAGLAR TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin glargine</i>)	Non Preferred	PA
<i>insulin degludec flextouch solution pen-injector 100 unit/ml subcutaneous</i>	Non Preferred	PA
<i>insulin degludec flextouch solution pen-injector 200 unit/ml subcutaneous</i>	Non Preferred	PA
<i>insulin degludec solution 100 unit/ml subcutaneous</i>	Non Preferred	PA
<i>insulin glargine solostar solution pen-injector 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill
<i>insulin glargine solution 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill
<i>insulin glargine-yfgn solution 100 unit/ml subcutaneous</i>	Preferred	
<i>insulin glargine-yfgn solution pen-injector 100 unit/ml subcutaneous</i>	Preferred	
LANTUS SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin glargine</i>)	Preferred	Max 90-day supply per fill
LANTUS SOLUTION 100 UNIT/ML SUBCUTANEOUS (<i>insulin glargine</i>)	Preferred	Max 90-day supply per fill
LEVEMIR FLEXPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin detemir</i>)	Preferred	Max 90-day supply per fill
LEVEMIR SOLUTION 100 UNIT/ML SUBCUTANEOUS (<i>insulin detemir</i>)	Preferred	Max 90-day supply per fill
REZVOGLAR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin glargine-aglr</i>)	Preferred	
SEMGLEE (YFGN) SOLUTION 100 UNIT/ML SUBCUTANEOUS (<i>insulin glargine-yfgn</i>)	Non Preferred	PA
SEMGLEE (YFGN) SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin glargine-yfgn</i>)	Non Preferred	PA
TOUJEO MAX SOLOSTAR SOLUTION PEN-INJECTOR 300 UNIT/ML SUBCUTANEOUS (<i>insulin glargine</i>)	Non Preferred	PA
TOUJEO SOLOSTAR SOLUTION PEN-INJECTOR 300 UNIT/ML SUBCUTANEOUS (<i>insulin glargine</i>)	Non Preferred	PA
TRESIBA FLEXTOUCH SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin degludec</i>)	Non Preferred	PA
TRESIBA FLEXTOUCH SOLUTION PEN-INJECTOR 200 UNIT/ML SUBCUTANEOUS (<i>insulin degludec</i>)	Non Preferred	PA
TRESIBA SOLUTION 100 UNIT/ML SUBCUTANEOUS (<i>insulin degludec</i>)	Non Preferred	PA
INSULINS: RAPID-ACTING [OPEN CLASS]		
ADMELOG SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro</i>)	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
ADMELOG SOLUTION 100 UNIT/ML INJECTION (<i>insulin lispro</i>)	Preferred	Max 90-day supply per fill
AFREZZA POWDER 12 UNIT INHALATION (<i>insulin regular human</i>)	Non Preferred	PA
AFREZZA POWDER 4 UNIT INHALATION (<i>insulin regular human</i>)	Non Preferred	PA
AFREZZA POWDER 60X4 & 60X8 & 60X12 UNIT INHALATION (<i>insulin regular human</i>)	Non Preferred	PA
AFREZZA POWDER 8 UNIT INHALATION (<i>insulin regular human</i>)	Non Preferred	PA
AFREZZA POWDER 90 X 4 UNIT & 90X8 UNIT INHALATION (<i>insulin regular human</i>)	Non Preferred	PA
AFREZZA POWDER 90 X 8 UNIT & 90X12 UNIT INHALATION (<i>insulin regular human</i>)	Non Preferred	PA
APIDRA SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin glulisine</i>)	Non Preferred	PA
APIDRA SOLUTION 100 UNIT/ML INJECTION (<i>insulin glulisine</i>)	Non Preferred	PA
FIASP FLEXTOUCH SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart (w/niacinamide)</i>)	Non Preferred	PA
FIASP PENFILL SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart (w/niacinamide)</i>)	Non Preferred	PA
FIASP SOLUTION 100 UNIT/ML INJECTION (<i>insulin aspart (w/niacinamide)</i>)	Non Preferred	PA
HUMALOG JUNIOR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro</i>)	Preferred	Max 90-day supply per fill
HUMALOG KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro</i>)	Preferred	Max 90-day supply per fill
HUMALOG KWIKPEN SOLUTION PEN-INJECTOR 200 UNIT/ML SUBCUTANEOUS (<i>insulin lispro</i>)	Non Preferred	PA
HUMALOG SOLUTION 100 UNIT/ML INJECTION (<i>insulin lispro</i>)	Preferred	Max 90-day supply per fill
HUMALOG SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro</i>)	Preferred	Max 90-day supply per fill
HUMALOG TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro</i>)	Non Preferred	PA
HUMULIN R U-500 (CONCENTRATED) SOLUTION 500 UNIT/ML SUBCUTANEOUS (<i>insulin regular human</i>)	Preferred	Max 90-day supply per fill
HUMULIN R U-500 KWIKPEN SOLUTION PEN-INJECTOR 500 UNIT/ML SUBCUTANEOUS (<i>insulin regular human</i>)	Preferred	Max 90-day supply per fill
<i>insulin aspart flexpen solution pen-injector 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill
<i>insulin aspart penfill solution cartridge 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill
<i>insulin aspart solution 100 unit/ml injection</i>	Preferred	Max 90-day supply per fill
<i>insulin lispro (1 unit dial) solution pen-injector 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>insulin lispro junior kwikpen solution pen-injector 100 unit/ml subcutaneous</i>	Preferred	Max 90-day supply per fill
<i>insulin lispro solution 100 unit/ml injection</i>	Preferred	Max 90-day supply per fill
LYUMJEV KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro-aabc</i>)	Non Preferred	PA
LYUMJEV KWIKPEN SOLUTION PEN-INJECTOR 200 UNIT/ML SUBCUTANEOUS (<i>insulin lispro-aabc</i>)	Non Preferred	PA
LYUMJEV SOLUTION 100 UNIT/ML INJECTION (<i>insulin lispro-aabc</i>)	Non Preferred	PA
LYUMJEV TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin lispro-aabc</i>)	Non Preferred	PA
NOVOLOG FLEXPEN RELION SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart</i>)	Preferred	Max 90-day supply per fill
NOVOLOG FLEXPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart</i>)	Preferred	Max 90-day supply per fill
NOVOLOG PENFILL SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS (<i>insulin aspart</i>)	Preferred	Max 90-day supply per fill
NOVOLOG RELION SOLUTION 100 UNIT/ML INJECTION (<i>insulin aspart</i>)	Preferred	Max 90-day supply per fill
NOVOLOG SOLUTION 100 UNIT/ML INJECTION (<i>insulin aspart</i>)	Preferred	Max 90-day supply per fill
INTRANASAL ANTIHISTAMINES [OPEN CLASS]		
<i>azelastine hcl solution 0.1 % nasal</i>	Preferred	
<i>azelastine hcl solution 0.15 % nasal</i>	Non Preferred	PA
<i>azelastine hcl solution 137 mcg/spray nasal</i>	Preferred	
<i>olopatadine hcl solution 0.6 % nasal</i>	Non Preferred	PA
PATANASE SOLUTION 0.6 % NASAL (<i>olopatadine hcl</i>)	Non Preferred	PA
RYALTRIS SUSPENSION 665-25 MCG/ACT NASAL (<i>olopatadine-mometasone</i>)	Non Preferred	PA; AGE (Min 6 Years)
LEUKOTRIENE RECEPTOR ANTAGONISTS [OPEN CLASS]		
ACCOLATE TABLET 10 MG ORAL (<i>zafirlukast</i>)	Non Preferred	PA
ACCOLATE TABLET 20 MG ORAL (<i>zafirlukast</i>)	Non Preferred	PA
<i>montelukast sodium packet 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>montelukast sodium tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>montelukast sodium tablet chewable 4 mg oral</i>	Preferred	Max 90-day supply per fill
<i>montelukast sodium tablet chewable 5 mg oral</i>	Preferred	Max 90-day supply per fill
SINGULAIR PACKET 4 MG ORAL (<i>montelukast sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
SINGULAIR TABLET 10 MG ORAL (<i>montelukast sodium</i>)	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
SINGULAIR TABLET CHEWABLE 4 MG ORAL (<i>montelukast sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
SINGULAIR TABLET CHEWABLE 5 MG ORAL (<i>montelukast sodium</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>zafirlukast tablet 10 mg oral</i>	Non Preferred	PA
<i>zafirlukast tablet 20 mg oral</i>	Non Preferred	PA
<i>zileuton er tablet extended release 12 hour 600 mg oral</i>	Non Preferred	PA
ZYFLO TABLET 600 MG ORAL (<i>zileuton</i>)	Non Preferred	PA
LIPOTROPICS: BILE ACID SEQUESTRANTS [OPEN CLASS]		
<i>cholestyramine light packet 4 gm oral</i>	Preferred	Max 90-day supply per fill
<i>cholestyramine light powder 4 gm/dose oral</i>	Preferred	Max 90-day supply per fill
<i>cholestyramine packet 4 gm oral</i>	Preferred	Max 90-day supply per fill
<i>cholestyramine powder 4 gm/dose oral</i>	Preferred	Max 90-day supply per fill
<i>colesevelam hcl packet 3.75 gm oral</i>	Non Preferred	PA
<i>colesevelam hcl tablet 625 mg oral</i>	Non Preferred	PA
COLESTID FLAVORED GRANULES 5 GM ORAL (<i>colestipol hcl</i>)	Non Preferred	PA
COLESTID FLAVORED PACKET 5 GM ORAL (<i>colestipol hcl</i>)	Non Preferred	PA
COLESTID GRANULES 5 GM ORAL (<i>colestipol hcl</i>)	Non Preferred	PA
COLESTID PACKET 5 GM ORAL (<i>colestipol hcl</i>)	Non Preferred	PA
COLESTID TABLET 1 GM ORAL (<i>colestipol hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>colestipol hcl granules 5 gm oral</i>	Non Preferred	PA
<i>colestipol hcl packet 5 gm oral</i>	Non Preferred	PA
<i>colestipol hcl tablet 1 gm oral</i>	Preferred	Max 90-day supply per fill
<i>cholestyramine light (Prevalite Packet 4 Gm Oral)</i>	Preferred	Max 90-day supply per fill
<i>cholestyramine light (Prevalite Powder 4 Gm/Dose Oral)</i>	Preferred	Max 90-day supply per fill
QUESTRAN LIGHT POWDER 4 GM/DOSE ORAL (<i>cholestyramine light</i>)	Non Preferred	PA; Max 90-day supply per fill
QUESTRAN PACKET 4 GM ORAL (<i>cholestyramine</i>)	Non Preferred	PA; Max 90-day supply per fill
QUESTRAN POWDER 4 GM/DOSE ORAL (<i>cholestyramine</i>)	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
WELCHOL PACKET 3.75 GM ORAL (<i>colesevelam hcl</i>)	Non Preferred	PA
WELCHOL TABLET 625 MG ORAL (<i>colesevelam hcl</i>)	Non Preferred	PA
LIPOTROPICS: CHOLESTEROL ABSORPTION INHIBITOR (CAI) AND /OR ACL INHIBITOR (ADENOSINE TRIPHOSPHATE CITRATE LYASE) [OPEN CLASS]		
<i>ezetimibe tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
NEXLETOL TABLET 180 MG ORAL (<i>bempedoic acid</i>)	Non Preferred	PA; AGE (Min 18 Years)
NEXLIZET TABLET 180-10 MG ORAL (<i>bempedoic acid-ezetimibe</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZETIA TABLET 10 MG ORAL (<i>ezetimibe</i>)	Non Preferred	PA; Max 90-day supply per fill
LIPOTROPICS: FIBRIC ACID DERIVATIVES [OPEN CLASS]		
ANTARA CAPSULE 90 MG ORAL (<i>fenofibrate micronized</i>)	Non Preferred	PA
<i>fenofibrate capsule 134 mg oral</i>	Non Preferred	PA
<i>fenofibrate capsule 150 mg oral</i>	Non Preferred	PA
<i>fenofibrate capsule 200 mg oral</i>	Non Preferred	PA
<i>fenofibrate capsule 50 mg oral</i>	Non Preferred	PA
<i>fenofibrate capsule 67 mg oral</i>	Non Preferred	PA
<i>fenofibrate micronized capsule 130 mg oral</i>	Non Preferred	PA
<i>fenofibrate micronized capsule 134 mg oral</i>	Non Preferred	PA
<i>fenofibrate micronized capsule 200 mg oral</i>	Non Preferred	PA
<i>fenofibrate micronized capsule 43 mg oral</i>	Non Preferred	PA
<i>fenofibrate micronized capsule 67 mg oral</i>	Non Preferred	PA
<i>fenofibrate micronized capsule 90 mg oral</i>	Non Preferred	PA
<i>fenofibrate tablet 120 mg oral</i>	Non Preferred	PA
<i>fenofibrate tablet 145 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate tablet 160 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>fenofibrate tablet 40 mg oral</i>	Non Preferred	PA
<i>fenofibrate tablet 48 mg oral</i>	Preferred	Max 90-day supply per fill
<i>fenofibrate tablet 54 mg oral</i>	Non Preferred	PA
<i>fenofibric acid capsule delayed release 135 mg oral</i>	Non Preferred	PA
<i>fenofibric acid capsule delayed release 45 mg oral</i>	Non Preferred	PA
<i>fenofibric acid tablet 105 mg oral</i>	Non Preferred	PA
<i>fenofibric acid tablet 35 mg oral</i>	Preferred	
FENOGLIDE TABLET 120 MG ORAL (<i>fenofibrate</i>)	Non Preferred	PA
FENOGLIDE TABLET 40 MG ORAL (<i>fenofibrate</i>)	Non Preferred	PA
<i>gemfibrozil tablet 600 mg oral</i>	Preferred	Max 90-day supply per fill
LIPOFEN CAPSULE 150 MG ORAL (<i>fenofibrate</i>)	Non Preferred	PA
LIPOFEN CAPSULE 50 MG ORAL (<i>fenofibrate</i>)	Non Preferred	PA
LOPID TABLET 600 MG ORAL (<i>gemfibrozil</i>)	Non Preferred	PA; Max 90-day supply per fill
TRICOR TABLET 145 MG ORAL (<i>fenofibrate</i>)	Non Preferred	PA; Max 90-day supply per fill
TRICOR TABLET 48 MG ORAL (<i>fenofibrate</i>)	Non Preferred	PA; Max 90-day supply per fill
TRILIPIX CAPSULE DELAYED RELEASE 135 MG ORAL (<i>choline fenofibrate</i>)	Non Preferred	PA
TRILIPIX CAPSULE DELAYED RELEASE 45 MG ORAL (<i>choline fenofibrate</i>)	Non Preferred	PA
LIPOTROPICS: JUXTAPID [OPEN CLASS]		
JUXTAPID CAPSULE 10 MG ORAL (<i>lomitapide mesylate</i>)	Non Preferred	PA
JUXTAPID CAPSULE 20 MG ORAL (<i>lomitapide mesylate</i>)	Non Preferred	PA
JUXTAPID CAPSULE 30 MG ORAL (<i>lomitapide mesylate</i>)	Non Preferred	PA
JUXTAPID CAPSULE 5 MG ORAL (<i>lomitapide mesylate</i>)	Non Preferred	PA
LIPOTROPICS: NIACIN DERIVATIVES [OPEN CLASS]		
<i>niacin er (antihyperlipidemic) tablet extended release 1000 mg oral</i>	Preferred	
<i>niacin er (antihyperlipidemic) tablet extended release 500 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>niacin er (antihyperlipidemic) tablet extended release 750 mg oral</i>	Preferred	
LIPOTROPICS: OMEGA 3 FATTY ACID AGENT [OPEN CLASS]		
<i>icosapent ethyl capsule 0.5 gm oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>icosapent ethyl capsule 1 gm oral</i>	Non Preferred	PA; AGE (Min 18 Years)
LOVAZA CAPSULE 1 GM ORAL (<i>omega-3-acid ethyl esters</i>)	Non Preferred	PA
<i>omega-3-acid ethyl esters capsule 1 gm oral</i>	Preferred	
VASCEPA CAPSULE 0.5 GM ORAL (<i>icosapent ethyl</i>)	Non Preferred	PA; AGE (Min 18 Years)
VASCEPA CAPSULE 1 GM ORAL (<i>icosapent ethyl</i>)	Non Preferred	PA; AGE (Min 18 Years)
LIPOTROPICS: PCSK9 [OPEN CLASS]		
LEQVIO SOLUTION PREFILLED SYRINGE 284 MG/1.5ML SUBCUTANEOUS (<i>inclisiran sodium</i>)	Non Preferred	PA
PRALUENT SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS (<i>alirocumab</i>)	Non Preferred	PA
PRALUENT SOLUTION AUTO-INJECTOR 75 MG/ML SUBCUTANEOUS (<i>alirocumab</i>)	Non Preferred	PA
REPATHA PUSHTRONEX SYSTEM SOLUTION CARTRIDGE 420 MG/3.5ML SUBCUTANEOUS (<i>evolocumab</i>)	Non Preferred	PA
REPATHA SOLUTION PREFILLED SYRINGE 140 MG/ML SUBCUTANEOUS (<i>evolocumab</i>)	Non Preferred	PA
REPATHA SURECLICK SOLUTION AUTO-INJECTOR 140 MG/ML SUBCUTANEOUS (<i>evolocumab</i>)	Non Preferred	PA
LIPOTROPICS: STATINS [OPEN CLASS]		
ALTOPREV TABLET EXTENDED RELEASE 24 HOUR 20 MG ORAL (<i>lovastatin</i>)	Non Preferred	PA
ALTOPREV TABLET EXTENDED RELEASE 24 HOUR 40 MG ORAL (<i>lovastatin</i>)	Non Preferred	PA
ALTOPREV TABLET EXTENDED RELEASE 24 HOUR 60 MG ORAL (<i>lovastatin</i>)	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 10-10 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 10-20 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 10-40 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 10-80 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 2.5-10 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>amlodipine-atorvastatin tablet 2.5-20 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 2.5-40 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 5-10 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 5-20 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 5-40 mg oral</i>	Non Preferred	PA
<i>amlodipine-atorvastatin tablet 5-80 mg oral</i>	Non Preferred	PA
ATORVALIQ SUSPENSION 20 MG/5ML ORAL (<i>atorvastatin calcium</i>)	Non Preferred	PA
<i>atorvastatin calcium tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>atorvastatin calcium tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>atorvastatin calcium tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>atorvastatin calcium tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
CADUET TABLET 10-10 MG ORAL (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
CADUET TABLET 10-20 MG ORAL (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
CADUET TABLET 10-40 MG ORAL (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
CADUET TABLET 10-80 MG ORAL (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
CADUET TABLET 5-10 MG ORAL (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
CADUET TABLET 5-20 MG ORAL (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
CADUET TABLET 5-40 MG ORAL (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
CADUET TABLET 5-80 MG ORAL (<i>amlodipine-atorvastatin</i>)	Non Preferred	PA
CRESTOR TABLET 10 MG ORAL (<i>rosuvastatin calcium</i>)	Non Preferred	PA; Max 90-day supply per fill
CRESTOR TABLET 20 MG ORAL (<i>rosuvastatin calcium</i>)	Non Preferred	PA; Max 90-day supply per fill
CRESTOR TABLET 40 MG ORAL (<i>rosuvastatin calcium</i>)	Non Preferred	PA; Max 90-day supply per fill
CRESTOR TABLET 5 MG ORAL (<i>rosuvastatin calcium</i>)	Non Preferred	PA; Max 90-day supply per fill
EZALLOR SPRINKLE CAPSULE SPRINKLE 10 MG ORAL (<i>rosuvastatin calcium</i>)	Non Preferred	PA
EZALLOR SPRINKLE CAPSULE SPRINKLE 20 MG ORAL (<i>rosuvastatin calcium</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
EZALLOR SPRINKLE CAPSULE SPRINKLE 40 MG ORAL (<i>rosuvastatin calcium</i>)	Non Preferred	PA
EZALLOR SPRINKLE CAPSULE SPRINKLE 5 MG ORAL (<i>rosuvastatin calcium</i>)	Non Preferred	PA
<i>ezetimibe-simvastatin tablet 10-10 mg oral</i>	Non Preferred	PA
<i>ezetimibe-simvastatin tablet 10-20 mg oral</i>	Non Preferred	PA
<i>ezetimibe-simvastatin tablet 10-40 mg oral</i>	Non Preferred	PA
<i>ezetimibe-simvastatin tablet 10-80 mg oral</i>	Non Preferred	PA
<i>fluvastatin sodium capsule 20 mg oral</i>	Non Preferred	PA
<i>fluvastatin sodium capsule 40 mg oral</i>	Non Preferred	PA
<i>fluvastatin sodium er tablet extended release 24 hour 80 mg oral</i>	Non Preferred	PA
LESCOL XL TABLET EXTENDED RELEASE 24 HOUR 80 MG ORAL (<i>fluvastatin sodium</i>)	Non Preferred	PA
LIPITOR TABLET 10 MG ORAL (<i>atorvastatin calcium</i>)	Non Preferred	PA; Max 90-day supply per fill
LIPITOR TABLET 20 MG ORAL (<i>atorvastatin calcium</i>)	Non Preferred	PA; Max 90-day supply per fill
LIPITOR TABLET 40 MG ORAL (<i>atorvastatin calcium</i>)	Non Preferred	PA; Max 90-day supply per fill
LIPITOR TABLET 80 MG ORAL (<i>atorvastatin calcium</i>)	Non Preferred	PA; Max 90-day supply per fill
LIVALO TABLET 1 MG ORAL (<i>pitavastatin calcium</i>)	Non Preferred	PA
LIVALO TABLET 2 MG ORAL (<i>pitavastatin calcium</i>)	Non Preferred	PA
LIVALO TABLET 4 MG ORAL (<i>pitavastatin calcium</i>)	Non Preferred	PA
<i>lovastatin tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lovastatin tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>lovastatin tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pravastatin sodium tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pravastatin sodium tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pravastatin sodium tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pravastatin sodium tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
<i>rosuvastatin calcium tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>rosuvastatin calcium tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>rosuvastatin calcium tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>rosuvastatin calcium tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>simvastatin tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>simvastatin tablet 20 mg oral</i>	Preferred	Max 90-day supply per fill
<i>simvastatin tablet 40 mg oral</i>	Preferred	Max 90-day supply per fill
<i>simvastatin tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>simvastatin tablet 80 mg oral</i>	Preferred	Max 90-day supply per fill
VYTORIN TABLET 10-10 MG ORAL (<i>ezetimibe-simvastatin</i>)	Non Preferred	PA
VYTORIN TABLET 10-20 MG ORAL (<i>ezetimibe-simvastatin</i>)	Non Preferred	PA
VYTORIN TABLET 10-40 MG ORAL (<i>ezetimibe-simvastatin</i>)	Non Preferred	PA
VYTORIN TABLET 10-80 MG ORAL (<i>ezetimibe-simvastatin</i>)	Non Preferred	PA
ZOCOR TABLET 10 MG ORAL (<i>simvastatin</i>)	Non Preferred	PA; Max 90-day supply per fill
ZOCOR TABLET 20 MG ORAL (<i>simvastatin</i>)	Non Preferred	PA; Max 90-day supply per fill
ZOCOR TABLET 40 MG ORAL (<i>simvastatin</i>)	Non Preferred	PA; Max 90-day supply per fill
ZYPITAMAG TABLET 2 MG ORAL (<i>pitavastatin magnesium</i>)	Non Preferred	PA
ZYPITAMAG TABLET 4 MG ORAL (<i>pitavastatin magnesium</i>)	Non Preferred	PA
MACROLIDES, ORAL [OPEN CLASS]		
<i>azithromycin packet 1 gm oral</i>	Preferred	
<i>azithromycin suspension reconstituted 100 mg/5ml oral</i>	Preferred	
<i>azithromycin suspension reconstituted 200 mg/5ml oral</i>	Preferred	
<i>azithromycin tablet 250 mg oral</i>	Preferred	
<i>azithromycin tablet 500 mg oral</i>	Preferred	
<i>azithromycin tablet 600 mg oral</i>	Preferred	
<i>clarithromycin er tablet extended release 24 hour 500 mg oral</i>	Non Preferred	PA
<i>clarithromycin suspension reconstituted 125 mg/5ml oral</i>	Preferred	
<i>clarithromycin suspension reconstituted 250 mg/5ml oral</i>	Preferred	
<i>clarithromycin tablet 250 mg oral</i>	Preferred	
<i>clarithromycin tablet 500 mg oral</i>	Preferred	
E.E.S. 400 TABLET 400 MG ORAL (<i>erythromycin ethylsuccinate</i>)	Non Preferred	PA
E.E.S. GRANULES SUSPENSION RECONSTITUTED 200 MG/5ML ORAL (<i>erythromycin ethylsuccinate</i>)	Non Preferred	PA
ERYPED 200 SUSPENSION RECONSTITUTED 200 MG/5ML ORAL (<i>erythromycin ethylsuccinate</i>)	Non Preferred	PA
ERYPED 400 SUSPENSION RECONSTITUTED 400 MG/5ML ORAL (<i>erythromycin ethylsuccinate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>erythromycin base</i> (Ery-Tab Tablet Delayed Release 250 Mg Oral)	Non Preferred	PA
<i>erythromycin base</i> (Ery-Tab Tablet Delayed Release 333 Mg Oral)	Non Preferred	PA
<i>erythromycin base</i> (Ery-Tab Tablet Delayed Release 500 Mg Oral)	Non Preferred	PA
ERYTHROCIN STEARATE TABLET 250 MG ORAL (<i>erythromycin stearate</i>)	Non Preferred	PA
<i>erythromycin base capsule delayed release particles 250 mg oral</i>	Preferred	
<i>erythromycin base tablet 250 mg oral</i>	Non Preferred	PA
<i>erythromycin base tablet 500 mg oral</i>	Non Preferred	PA
<i>erythromycin base tablet delayed release 250 mg oral</i>	Non Preferred	PA
<i>erythromycin base tablet delayed release 333 mg oral</i>	Non Preferred	PA
<i>erythromycin base tablet delayed release 500 mg oral</i>	Non Preferred	PA
<i>erythromycin ethylsuccinate suspension reconstituted 200 mg/5ml oral</i>	Preferred	
<i>erythromycin ethylsuccinate suspension reconstituted 400 mg/5ml oral</i>	Non Preferred	PA
<i>erythromycin ethylsuccinate tablet 400 mg oral</i>	Non Preferred	PA
<i>erythromycin tablet delayed release 250 mg oral</i>	Non Preferred	PA
<i>erythromycin tablet delayed release 333 mg oral</i>	Non Preferred	PA
<i>erythromycin tablet delayed release 500 mg oral</i>	Non Preferred	PA
ZITHROMAX PACKET 1 GM ORAL (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX SUSPENSION RECONSTITUTED 100 MG/5ML ORAL (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX SUSPENSION RECONSTITUTED 200 MG/5ML ORAL (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX TABLET 250 MG ORAL (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX TABLET 500 MG ORAL (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX TRI-PAK TABLET 500 MG ORAL (<i>azithromycin</i>)	Non Preferred	PA
ZITHROMAX Z-PAK TABLET 250 MG ORAL (<i>azithromycin</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
MOVEMENT DISORDERS [CLOSED CLASS]		
AUSTEDO TABLET 12 MG ORAL (<i>deutetrabenazine</i>)	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO TABLET 6 MG ORAL (<i>deutetrabenazine</i>)	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO TABLET 9 MG ORAL (<i>deutetrabenazine</i>)	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO XR TABLET EXTENDED RELEASE 24 HOUR 12 MG ORAL (<i>deutetrabenazine</i>)	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO XR TABLET EXTENDED RELEASE 24 HOUR 24 MG ORAL (<i>deutetrabenazine</i>)	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO XR TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL (<i>deutetrabenazine</i>)	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
INGREZZA CAPSULE 40 MG ORAL (<i>valbenazine tosylate</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA CAPSULE 60 MG ORAL (<i>valbenazine tosylate</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA CAPSULE 80 MG ORAL (<i>valbenazine tosylate</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA CAPSULE THERAPY PACK 40 & 80 MG ORAL (<i>valbenazine tosylate</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 1 day); AGE (Min 18 Years)
<i>tetrabenazine tablet 12.5 mg oral</i>	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
<i>tetrabenazine tablet 25 mg oral</i>	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
XENAZINE TABLET 12.5 MG ORAL (<i>tetrabenazine</i>)	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
XENAZINE TABLET 25 MG ORAL (<i>tetrabenazine</i>)	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day); AGE (Min 18 Years)
MULTIPLE SCLEROSIS [CLOSED CLASS]		
AMPYRA TABLET EXTENDED RELEASE 12 HOUR 10 MG ORAL (<i>dalfampridine</i>)	Non Preferred	PA
AUBAGIO TABLET 14 MG ORAL (<i>teriflunomide</i>)	Preferred	
AUBAGIO TABLET 7 MG ORAL (<i>teriflunomide</i>)	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
AVONEX PEN AUTO-INJECTOR KIT 30 MCG/0.5ML INTRAMUSCULAR (<i>interferon beta-1a</i>)	Preferred	
AVONEX PREFILLED PREFILLED SYRINGE KIT 30 MCG/0.5ML INTRAMUSCULAR (<i>interferon beta-1a</i>)	Preferred	
BAFIERTAM CAPSULE DELAYED RELEASE 95 MG ORAL (<i>monomethyl fumarate</i>)	Non Preferred	PA
BETASERON KIT 0.3 MG SUBCUTANEOUS (<i>interferon beta-1b</i>)	Preferred	
COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS (<i>glatiramer acetate</i>)	Preferred	
COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS (<i>glatiramer acetate</i>)	Non Preferred	PA
<i>dalfampridine er tablet extended release 12 hour 10 mg oral</i>	Preferred	
<i>dimethyl fumarate capsule delayed release 120 mg oral</i>	Preferred	
<i>dimethyl fumarate capsule delayed release 240 mg oral</i>	Preferred	
<i>dimethyl fumarate starter pack capsule delayed release therapy pack 120 & 240 mg oral</i>	Preferred	
EXTAVIA KIT 0.3 MG SUBCUTANEOUS (<i>interferon beta-1b</i>)	Non Preferred	PA
<i> fingolimod hcl capsule 0.5 mg oral</i>	Preferred	AGE (Min 10 Years)
GILENYA CAPSULE 0.25 MG ORAL (<i>fingolimod hcl</i>)	Non Preferred	PA; AGE (Min 10 Years)
GILENYA CAPSULE 0.5 MG ORAL (<i>fingolimod hcl</i>)	Non Preferred	PA; AGE (Min 10 Years)
<i>glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous</i>	Non Preferred	PA
<i>glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous</i>	Non Preferred	PA
<i>glatiramer acetate (Glatopa Solution Prefilled Syringe 20 Mg/ML Subcutaneous)</i>	Non Preferred	PA
<i>glatiramer acetate (Glatopa Solution Prefilled Syringe 40 Mg/ML Subcutaneous)</i>	Non Preferred	PA
KESIMPTA SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS (<i>ofatumumab</i>)	Preferred	PA (Eligible for auto-PA); AGE (Min 18 Years)
MAVENCLAD (10 TABS) TABLET THERAPY PACK 10 MG ORAL (<i>cladribine</i>)	Non Preferred	PA
MAVENCLAD (4 TABS) TABLET THERAPY PACK 10 MG ORAL (<i>cladribine</i>)	Non Preferred	PA
MAVENCLAD (5 TABS) TABLET THERAPY PACK 10 MG ORAL (<i>cladribine</i>)	Non Preferred	PA
MAVENCLAD (6 TABS) TABLET THERAPY PACK 10 MG ORAL (<i>cladribine</i>)	Non Preferred	PA
MAVENCLAD (7 TABS) TABLET THERAPY PACK 10 MG ORAL (<i>cladribine</i>)	Non Preferred	PA
MAVENCLAD (8 TABS) TABLET THERAPY PACK 10 MG ORAL (<i>cladribine</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
MAVENCLAD (9 TABS) TABLET THERAPY PACK 10 MG ORAL (<i>cladribine</i>)	Non Preferred	PA
MAYZENT STARTER PACK TABLET THERAPY PACK 12 X 0.25 MG ORAL (<i>siponimod fumarate</i>)	Non Preferred	PA
MAYZENT STARTER PACK TABLET THERAPY PACK 7 X 0.25 MG ORAL (<i>siponimod fumarate</i>)	Non Preferred	PA
MAYZENT TABLET 0.25 MG ORAL (<i>siponimod fumarate</i>)	Non Preferred	PA
MAYZENT TABLET 1 MG ORAL (<i>siponimod fumarate</i>)	Non Preferred	PA
MAYZENT TABLET 2 MG ORAL (<i>siponimod fumarate</i>)	Non Preferred	PA
PLEGRIDY SOLUTION PEN-INJECTOR 125 MCG/0.5ML SUBCUTANEOUS (<i>peginterferon beta-1a</i>)	Non Preferred	PA
PLEGRIDY SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML INTRAMUSCULAR (<i>peginterferon beta-1a</i>)	Non Preferred	PA
PLEGRIDY SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML SUBCUTANEOUS (<i>peginterferon beta-1a</i>)	Non Preferred	PA
PLEGRIDY STARTER PACK SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML SUBCUTANEOUS (<i>peginterferon beta-1a</i>)	Non Preferred	PA
PLEGRIDY STARTER PACK SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML SUBCUTANEOUS (<i>peginterferon beta-1a</i>)	Non Preferred	PA
PONVORY STARTER PACK TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG ORAL (<i>ponesimod</i>)	Non Preferred	PA
PONVORY TABLET 20 MG ORAL (<i>ponesimod</i>)	Non Preferred	PA
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 22 MCG/0.5ML SUBCUTANEOUS (<i>interferon beta-1a</i>)	Non Preferred	PA
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 44 MCG/0.5ML SUBCUTANEOUS (<i>interferon beta-1a</i>)	Non Preferred	PA
REBIF REBIDOSE TITRATION PACK SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG SUBCUTANEOUS (<i>interferon beta-1a</i>)	Non Preferred	PA
REBIF SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML SUBCUTANEOUS (<i>interferon beta-1a</i>)	Non Preferred	PA
REBIF SOLUTION PREFILLED SYRINGE 44 MCG/0.5ML SUBCUTANEOUS (<i>interferon beta-1a</i>)	Non Preferred	PA
REBIF TITRATION PACK SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG SUBCUTANEOUS (<i>interferon beta-1a</i>)	Non Preferred	PA
TASCENSO ODT TABLET DISPERSIBLE 0.25 MG ORAL (<i>fingolimod lauryl sulfite</i>)	Non Preferred	PA; AGE (Min 10 Years and Max 17 Years)
TASCENSO ODT TABLET DISPERSIBLE 0.5 MG ORAL (<i>fingolimod lauryl sulfite</i>)	Non Preferred	PA; AGE (Min 10 Years and Max 17 Years)
TECFIDERA CAPSULE DELAYED RELEASE 120 MG ORAL (<i>dimethyl fumarate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
TECFIDERA CAPSULE DELAYED RELEASE 240 MG ORAL (<i>dimethyl fumarate</i>)	Non Preferred	PA
TECFIDERA CAPSULE DELAYED RELEASE THERAPY PACK 120 & 240 MG ORAL (<i>dimethyl fumarate</i>)	Non Preferred	PA
<i>teriflunomide tablet 14 mg oral</i>	Non Preferred	PA
<i>teriflunomide tablet 7 mg oral</i>	Non Preferred	PA
TYSABRI CONCENTRATE 300 MG/15ML INTRAVENOUS (<i>natalizumab</i>)	Non Preferred	PA
VUMERITY CAPSULE DELAYED RELEASE 231 MG ORAL (<i>diroximel fumarate</i>)	Non Preferred	PA
ZEPOSIA 7-DAY STARTER PACK CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG ORAL (<i>ozanimod hcl</i>)	Non Preferred	PA
ZEPOSIA CAPSULE 0.92 MG ORAL (<i>ozanimod hcl</i>)	Non Preferred	PA
ZEPOSIA STARTER KIT CAPSULE THERAPY PACK 0.23MG & 0.46MG 0.92MG(21) ORAL (<i>ozanimod hcl</i>)	Non Preferred	PA
NASAL STEROIDS [OPEN CLASS]		
<i>allergy relief suspension 50 mcg/act nasal</i>	Preferred	
<i>azelastine-fluticasone suspension 137-50 mcg/act nasal</i>	Non Preferred	PA; AGE (Min 6 Years)
BECONASE AQ SUSPENSION 42 MCG/SPRAY NASAL (<i>beclomethasone diprop monohyd</i>)	Non Preferred	PA
<i>budesonide suspension 32 mcg/act nasal (otc)</i>	Non Preferred	PA
DYMISTA SUSPENSION 137-50 MCG/ACT NASAL (<i>azelastine-fluticasone</i>)	Preferred	AGE (Min 6 Years)
<i>flunisolide solution 25 mcg/act (0.025%) nasal</i>	Non Preferred	PA
<i>fluticasone propionate suspension 50 mcg/act nasal (otc)</i>	Preferred	
<i>fluticasone propionate suspension 50 mcg/act nasal (rx)</i>	Preferred	
<i>gnp 24 hour nasal allergy aerosol 55 mcg/act nasal</i>	Preferred	
<i>gnp budesonide nasal spray suspension 32 mcg/act nasal</i>	Non Preferred	PA
<i>gnp fluticasone propionate suspension 50 mcg/act nasal</i>	Preferred	
<i>goodsense 24-hr allergy nasal suspension 50 mcg/act nasal</i>	Preferred	
<i>goodsense nasal allergy spray aerosol 55 mcg/act nasal</i>	Preferred	
<i>hm 24 hour nasal allergy aerosol 55 mcg/act nasal</i>	Preferred	
<i>hm allergy relief suspension 50 mcg/act nasal</i>	Preferred	
<i>ipratropium bromide solution 0.03 % nasal</i>	Preferred	
<i>ipratropium bromide solution 0.06 % nasal</i>	Preferred	
<i>mometasone furoate suspension 50 mcg/act nasal</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>nasal allergy 24 hour aerosol 55 mcg/act nasal</i>	Preferred	
OMNARIS SUSPENSION 50 MCG/ACT NASAL (<i>ciclesonide</i>)	Non Preferred	PA
<i>qc allergy relief suspension 50 mcg/act nasal</i>	Preferred	
QNASL AEROSOL SOLUTION 80 MCG/ACT NASAL (<i>beclomethasone diprop (nasal)</i>)	Non Preferred	PA
QNASL CHILDRENS AEROSOL SOLUTION 40 MCG/ACT NASAL (<i>beclomethasone diprop (nasal)</i>)	Non Preferred	PA
<i>sm allergy relief suspension 50 mcg/act nasal</i>	Preferred	
<i>triamcinolone acetonide aerosol 55 mcg/act nasal (otc)</i>	Preferred	
XHANCE EXHALER SUSPENSION 93 MCG/ACT NASAL (<i>fluticasone propionate</i>)	Non Preferred	PA
ZETONNA AEROSOL SOLUTION 37 MCG/ACT NASAL (<i>ciclesonide</i>)	Non Preferred	PA
NEUROPATHIC PAIN [OPEN CLASS]		
<i>arthritis pain relieving cream 0.075 % external</i>	Preferred	
<i>capsaicin cream 0.025 % external</i>	Preferred	
<i>capsaicin cream 0.075 % external</i>	Preferred	
<i>capsaicin cream 0.1 % external</i>	Preferred	
<i>capsaicin pain relief cream 0.1 % external</i>	Preferred	
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 20 MG ORAL (<i>duloxetine hcl</i>)	Non Preferred	PA
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 30 MG ORAL (<i>duloxetine hcl</i>)	Non Preferred	PA
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 60 MG ORAL (<i>duloxetine hcl</i>)	Non Preferred	PA
<i>duloxetine hcl capsule delayed release particles 20 mg oral</i>	Preferred	
<i>duloxetine hcl capsule delayed release particles 30 mg oral</i>	Preferred	
<i>duloxetine hcl capsule delayed release particles 40 mg oral</i>	Non Preferred	PA
<i>duloxetine hcl capsule delayed release particles 60 mg oral</i>	Preferred	
<i>gabapentin capsule 100 mg oral</i>	Preferred	
<i>gabapentin capsule 300 mg oral</i>	Preferred	
<i>gabapentin capsule 400 mg oral</i>	Preferred	
<i>gabapentin solution 250 mg/5ml oral</i>	Preferred	
<i>gabapentin solution 300 mg/6ml oral</i>	Preferred	
<i>gabapentin tablet 600 mg oral</i>	Preferred	
<i>gabapentin tablet 800 mg oral</i>	Preferred	
GRALISE TABLET 300 MG ORAL (<i>gabapentin (once-daily)</i>)	Non Preferred	PA
GRALISE TABLET 450 MG ORAL (<i>gabapentin (once-daily)</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
GRALISE TABLET 600 MG ORAL (<i>gabapentin (once-daily)</i>)	Non Preferred	PA
GRALISE TABLET 750 MG ORAL (<i>gabapentin (once-daily)</i>)	Non Preferred	PA
GRALISE TABLET 900 MG ORAL (<i>gabapentin (once-daily)</i>)	Non Preferred	PA
HORIZANT TABLET EXTENDED RELEASE 300 MG ORAL (<i>gabapentin enacarbil</i>)	Non Preferred	PA
HORIZANT TABLET EXTENDED RELEASE 600 MG ORAL (<i>gabapentin enacarbil</i>)	Non Preferred	PA
<i>lidocaine patch 5 % external</i>	Preferred	QL (90 EA per 1 Fill)
LIDODERM PATCH 5 % EXTERNAL (<i>lidocaine</i>)	Non Preferred	PA; QL (90 EA per 1 Fill)
LYRICA CAPSULE 100 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CAPSULE 150 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CAPSULE 200 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CAPSULE 225 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CAPSULE 25 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CAPSULE 300 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CAPSULE 50 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CAPSULE 75 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CR TABLET EXTENDED RELEASE 24 HOUR 165 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CR TABLET EXTENDED RELEASE 24 HOUR 330 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA CR TABLET EXTENDED RELEASE 24 HOUR 82.5 MG ORAL (<i>pregabalin</i>)	Non Preferred	PA
LYRICA SOLUTION 20 MG/ML ORAL (<i>pregabalin</i>)	Non Preferred	PA
NEURONTIN CAPSULE 100 MG ORAL (<i>gabapentin</i>)	Non Preferred	PA
NEURONTIN CAPSULE 300 MG ORAL (<i>gabapentin</i>)	Non Preferred	PA
NEURONTIN CAPSULE 400 MG ORAL (<i>gabapentin</i>)	Non Preferred	PA
NEURONTIN SOLUTION 250 MG/5ML ORAL (<i>gabapentin</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
NEURONTIN TABLET 600 MG ORAL (<i>gabapentin</i>)	Non Preferred	PA
NEURONTIN TABLET 800 MG ORAL (<i>gabapentin</i>)	Non Preferred	PA
<i>pregabalin capsule 100 mg oral</i>	Preferred	
<i>pregabalin capsule 150 mg oral</i>	Preferred	
<i>pregabalin capsule 200 mg oral</i>	Preferred	
<i>pregabalin capsule 225 mg oral</i>	Preferred	
<i>pregabalin capsule 25 mg oral</i>	Preferred	
<i>pregabalin capsule 300 mg oral</i>	Preferred	
<i>pregabalin capsule 50 mg oral</i>	Preferred	
<i>pregabalin capsule 75 mg oral</i>	Preferred	
<i>pregabalin er tablet extended release 24 hour 165 mg oral</i>	Non Preferred	PA
<i>pregabalin er tablet extended release 24 hour 330 mg oral</i>	Non Preferred	PA
<i>pregabalin er tablet extended release 24 hour 82.5 mg oral</i>	Non Preferred	PA
<i>pregabalin solution 20 mg/ml oral</i>	Non Preferred	PA
QUTENZA (2 PATCH) KIT 8 % EXTERNAL (<i>capsaicin-cleansing gel</i>)	Non Preferred	PA
QUTENZA (4 PATCH) KIT 8 % EXTERNAL (<i>capsaicin-cleansing gel</i>)	Non Preferred	PA
QUTENZA KIT 8 % EXTERNAL (<i>capsaicin-cleansing gel</i>)	Non Preferred	PA
SAVELLA TABLET 100 MG ORAL (<i>milnacipran hcl</i>)	Non Preferred	PA
SAVELLA TABLET 12.5 MG ORAL (<i>milnacipran hcl</i>)	Non Preferred	PA
SAVELLA TABLET 25 MG ORAL (<i>milnacipran hcl</i>)	Non Preferred	PA
SAVELLA TABLET 50 MG ORAL (<i>milnacipran hcl</i>)	Non Preferred	PA
SAVELLA TITRATION PACK 12.5 & 25 & 50 MG ORAL (<i>milnacipran hcl</i>)	Non Preferred	PA
XYLIDERM KIT 5 % EXTERNAL (<i>lidocaine-adhesive sheets</i>)	Non Preferred	PA
ZTLIDO PATCH 1.8 % EXTERNAL (<i>lidocaine</i>)	Non Preferred	PA
NON-ERGOT DOPAMINE RECEPTOR AGONIST [OPEN CLASS]		
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 0.375 MG ORAL (<i>pramipexole dihydrochloride</i>)	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 0.75 MG ORAL (<i>pramipexole dihydrochloride</i>)	Non Preferred	PA; Max 90-day supply per fill
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 1.5 MG ORAL (<i>pramipexole dihydrochloride</i>)	Non Preferred	PA; Max 90-day supply per fill
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 2.25 MG ORAL (<i>pramipexole dihydrochloride</i>)	Non Preferred	PA; Max 90-day supply per fill
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL (<i>pramipexole dihydrochloride</i>)	Non Preferred	PA; Max 90-day supply per fill
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 3.75 MG ORAL (<i>pramipexole dihydrochloride</i>)	Non Preferred	PA; Max 90-day supply per fill
MIRAPEX ER TABLET EXTENDED RELEASE 24 HOUR 4.5 MG ORAL (<i>pramipexole dihydrochloride</i>)	Non Preferred	PA; Max 90-day supply per fill
NEUPRO PATCH 24 HOUR 1 MG/24HR TRANSDERMAL (<i>rotigotine</i>)	Non Preferred	PA
NEUPRO PATCH 24 HOUR 2 MG/24HR TRANSDERMAL (<i>rotigotine</i>)	Non Preferred	PA
NEUPRO PATCH 24 HOUR 3 MG/24HR TRANSDERMAL (<i>rotigotine</i>)	Non Preferred	PA
NEUPRO PATCH 24 HOUR 4 MG/24HR TRANSDERMAL (<i>rotigotine</i>)	Non Preferred	PA
NEUPRO PATCH 24 HOUR 6 MG/24HR TRANSDERMAL (<i>rotigotine</i>)	Non Preferred	PA
NEUPRO PATCH 24 HOUR 8 MG/24HR TRANSDERMAL (<i>rotigotine</i>)	Non Preferred	PA
<i>pramipexole dihydrochloride er tablet extended release 24 hour 0.375 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 0.75 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 1.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 2.25 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 3 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 3.75 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride er tablet extended release 24 hour 4.5 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 0.125 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 0.25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 0.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 0.75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 1 mg oral</i>	Preferred	Max 90-day supply per fill
<i>pramipexole dihydrochloride tablet 1.5 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>ropinirole hcl er tablet extended release 24 hour 12 mg oral</i>	Non Preferred	PA
<i>ropinirole hcl er tablet extended release 24 hour 2 mg oral</i>	Preferred	
<i>ropinirole hcl er tablet extended release 24 hour 4 mg oral</i>	Non Preferred	PA
<i>ropinirole hcl er tablet extended release 24 hour 6 mg oral</i>	Non Preferred	PA
<i>ropinirole hcl er tablet extended release 24 hour 8 mg oral</i>	Preferred	
<i>ropinirole hcl tablet 0.25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ropinirole hcl tablet 0.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ropinirole hcl tablet 1 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ropinirole hcl tablet 2 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ropinirole hcl tablet 3 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ropinirole hcl tablet 4 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ropinirole hcl tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
NSAIDS [OPEN CLASS]		
<i>acetaminophen-ibuprofen tablet 250-125 mg oral</i>	Non Preferred	PA
<i>all day pain relief tablet 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>all day relief tablet 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>arthritis pain reliever gel 1 % external</i>	Preferred	Max 90-day supply per fill
ARTHROTEC TABLET DELAYED RELEASE 50-0.2 MG ORAL (<i>diclofenac-misoprostol</i>)	Non Preferred	PA
ARTHROTEC TABLET DELAYED RELEASE 75-0.2 MG ORAL (<i>diclofenac-misoprostol</i>)	Non Preferred	PA
CELEBREX CAPSULE 100 MG ORAL (<i>celecoxib</i>)	Non Preferred	PA
CELEBREX CAPSULE 200 MG ORAL (<i>celecoxib</i>)	Non Preferred	PA
CELEBREX CAPSULE 400 MG ORAL (<i>celecoxib</i>)	Non Preferred	PA
CELEBREX CAPSULE 50 MG ORAL (<i>celecoxib</i>)	Non Preferred	PA
<i>celecoxib capsule 100 mg oral</i>	Preferred	
<i>celecoxib capsule 200 mg oral</i>	Preferred	
<i>celecoxib capsule 400 mg oral</i>	Non Preferred	PA
<i>celecoxib capsule 50 mg oral</i>	Non Preferred	PA
<i>childrens ibuprofen suspension 100 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
DAYPRO TABLET 600 MG ORAL (<i>oxaprozin</i>)	Non Preferred	PA
<i>diclofenac epolamine patch 1.3 % external</i>	Preferred	QL (30 EA per 1 Fill)

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Drug Name	Formulary Status	Requirements/Limits
<i>diclofenac potassium capsule 25 mg oral</i>	Non Preferred	PA
<i>diclofenac potassium tablet 25 mg oral</i>	Non Preferred	PA
<i>diclofenac potassium tablet 50 mg oral</i>	Non Preferred	PA
<i>diclofenac sodium er tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA
<i>diclofenac sodium gel 1 % external (otc)</i>	Preferred	Max 90-day supply per fill
<i>diclofenac sodium gel 1 % external (rx)</i>	Preferred	Max 90-day supply per fill
<i>diclofenac sodium solution 1.5 % external</i>	Non Preferred	PA
<i>diclofenac sodium solution 2 % external</i>	Non Preferred	PA
<i>diclofenac sodium tablet delayed release 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diclofenac sodium tablet delayed release 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diclofenac sodium tablet delayed release 75 mg oral</i>	Preferred	
<i>diclofenac sodium tablet delayed release 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>diclofenac-misoprostol tablet delayed release 50-0.2 mg oral</i>	Non Preferred	PA
<i>diclofenac-misoprostol tablet delayed release 75-0.2 mg oral</i>	Non Preferred	PA
<i>diflunisal tablet 500 mg oral</i>	Preferred	
DUEXIS TABLET 800-26.6 MG ORAL (<i>ibuprofen-famotidine</i>)	Non Preferred	PA
<i>ec-naproxen tablet delayed release 375 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ec-naproxen tablet delayed release 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>etodolac capsule 200 mg oral</i>	Preferred	
<i>etodolac capsule 300 mg oral</i>	Preferred	
<i>etodolac er tablet extended release 24 hour 400 mg oral</i>	Non Preferred	PA
<i>etodolac er tablet extended release 24 hour 500 mg oral</i>	Non Preferred	PA
<i>etodolac er tablet extended release 24 hour 600 mg oral</i>	Non Preferred	PA
<i>etodolac tablet 400 mg oral</i>	Preferred	
<i>etodolac tablet 500 mg oral</i>	Preferred	
FELDENE CAPSULE 10 MG ORAL (<i>piroxicam</i>)	Non Preferred	PA
FELDENE CAPSULE 20 MG ORAL (<i>piroxicam</i>)	Non Preferred	PA
<i>fenoprofen calcium capsule 400 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>fenoprofen calcium tablet 600 mg oral</i>	Non Preferred	PA
FLECTOR PATCH 1.3 % EXTERNAL (<i>diclofenac epolamine</i>)	Non Preferred	PA; QL (30 EA per 1 Fill)
<i>flurbiprofen tablet 100 mg oral</i>	Preferred	
<i>ft ibuprofen capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ft ibuprofen childrens suspension 100 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>ft naproxen sodium capsule 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp arthritis pain gel 1 % external</i>	Preferred	Max 90-day supply per fill
<i>gnp childrens ibuprofen suspension 100 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>gnp diclofenac sodium gel 1 % external</i>	Preferred	Max 90-day supply per fill
<i>gnp ibuprofen capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp ibuprofen childrens tablet chewable 100 mg oral</i>	Preferred	
<i>gnp ibuprofen infants suspension 50 mg/1.25ml oral</i>	Preferred	Max 90-day supply per fill
<i>gnp ibuprofen tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp naproxen sodium capsule 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp naproxen sodium tablet 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>goodsense arthritis pain gel 1 % external</i>	Preferred	Max 90-day supply per fill
<i>goodsense ibuprofen capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>goodsense ibuprofen childrens suspension 100 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>goodsense ibuprofen infants suspension 50 mg/1.25ml oral</i>	Preferred	Max 90-day supply per fill
<i>goodsense ibuprofen tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>goodsense naproxen sodium tablet 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>hm ibuprofen childrens suspension 100 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>hm ibuprofen tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>hm naproxen sodium capsule 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen (Ibu Tablet 400 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen (Ibu Tablet 600 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen (Ibu Tablet 800 Mg Oral)</i>	Preferred	Max 90-day supply per fill
<i>ibu-200 tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen childrens suspension 100 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen infants suspension 50 mg/1.25ml oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen junior strength tablet chewable 100 mg oral</i>	Preferred	
<i>ibuprofen suspension 100 mg/5ml oral (rx)</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen tablet 400 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen tablet 600 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen tablet 800 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ibuprofen-famotidine tablet 800-26.6 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>indomethacin capsule 25 mg oral</i>	Preferred	
<i>indomethacin capsule 50 mg oral</i>	Preferred	
<i>indomethacin er capsule extended release 75 mg oral</i>	Non Preferred	PA
<i>indomethacin suppository 50 mg rectal</i>	Preferred	Max 90-day supply per fill
<i>infants ibuprofen suspension 50 mg/1.25ml oral</i>	Preferred	Max 90-day supply per fill
<i>ketoprofen capsule 50 mg oral</i>	Non Preferred	PA
<i>ketoprofen er capsule extended release 24 hour 200 mg oral</i>	Non Preferred	PA
<i>ketorolac tromethamine solution 15.75 mg/spray nasal</i>	Non Preferred	PA
<i>ketorolac tromethamine tablet 10 mg oral</i>	Preferred	
LICART PATCH 24 HOUR 1.3 % EXTERNAL (<i>diclofenac epolamine</i>)	Non Preferred	PA; QL (30 EA per 1 Fill)
<i>diclofenac potassium (Lofena Tablet 25 Mg Oral)</i>	Non Preferred	PA
<i>meclofenamate sodium capsule 100 mg oral</i>	Non Preferred	PA
<i>meclofenamate sodium capsule 50 mg oral</i>	Non Preferred	PA
<i>mefenamic acid capsule 250 mg oral</i>	Non Preferred	PA
<i>meloxicam capsule 10 mg oral</i>	Non Preferred	PA
<i>meloxicam capsule 5 mg oral</i>	Non Preferred	PA
<i>meloxicam tablet 15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>meloxicam tablet 7.5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>nabumetone tablet 500 mg oral</i>	Non Preferred	PA
<i>nabumetone tablet 750 mg oral</i>	Non Preferred	PA
NALFON CAPSULE 400 MG ORAL (<i>fenoprofen calcium</i>)	Non Preferred	PA
NALFON TABLET 600 MG ORAL (<i>fenoprofen calcium</i>)	Non Preferred	PA
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 375 MG ORAL (<i>naproxen sodium</i>)	Non Preferred	PA
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL (<i>naproxen sodium</i>)	Non Preferred	PA
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 750 MG ORAL (<i>naproxen sodium</i>)	Non Preferred	PA
<i>naproxen dr tablet delayed release 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen sodium capsule 220 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>naproxen sodium er tablet extended release 24 hour 375 mg oral</i>	Non Preferred	PA
<i>naproxen sodium er tablet extended release 24 hour 500 mg oral</i>	Non Preferred	PA
<i>naproxen sodium er tablet extended release 24 hour 750 mg oral</i>	Non Preferred	PA
<i>naproxen sodium tablet 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen sodium tablet 275 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen sodium tablet 550 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen suspension 125 mg/5ml oral</i>	Non Preferred	PA
<i>naproxen tablet 250 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen tablet 375 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen tablet 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen tablet delayed release 375 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen tablet delayed release 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>naproxen-esomeprazole mg tablet delayed release 375-20 mg oral</i>	Non Preferred	PA
<i>naproxen-esomeprazole mg tablet delayed release 500-20 mg oral</i>	Non Preferred	PA
<i>oxaprozin tablet 600 mg oral</i>	Non Preferred	PA
PENNSAID SOLUTION 2 % EXTERNAL (<i>diclofenac sodium</i>)	Non Preferred	PA
<i>piroxicam capsule 10 mg oral</i>	Non Preferred	PA
<i>piroxicam capsule 20 mg oral</i>	Non Preferred	PA
<i>qc diclofenac sodium gel 1 % external</i>	Preferred	Max 90-day supply per fill
<i>qc ibuprofen capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>qc ibuprofen tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>qc naproxen sodium tablet 220 mg oral</i>	Preferred	Max 90-day supply per fill
RELAFEN DS TABLET 1000 MG ORAL (<i>nabumetone</i>)	Non Preferred	PA
<i>sm arthritis pain gel 1 % external</i>	Preferred	Max 90-day supply per fill
<i>sm childrens ibuprofen suspension 100 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>sm ibuprofen capsule 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sm ibuprofen ib childrens tablet chewable 100 mg oral</i>	Preferred	
<i>sm ibuprofen ib tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sm ibuprofen tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sm infants ibuprofen suspension 50 mg/1.25ml oral</i>	Preferred	Max 90-day supply per fill
<i>sm naproxen sodium tablet 220 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sulindac tablet 150 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>sulindac tablet 200 mg oral</i>	Preferred	Max 90-day supply per fill
<i>tolmetin sodium capsule 400 mg oral</i>	Non Preferred	PA
<i>tolmetin sodium tablet 600 mg oral</i>	Non Preferred	PA
VIMOVO TABLET DELAYED RELEASE 375-20 MG ORAL (<i>naproxen-esomeprazole</i>)	Non Preferred	PA
VIMOVO TABLET DELAYED RELEASE 500-20 MG ORAL (<i>naproxen-esomeprazole</i>)	Non Preferred	PA
OPHTHALMIC ANTIBIOTICS [OPEN CLASS]		
AZASITE SOLUTION 1 % OPHTHALMIC (<i>azithromycin</i>)	Non Preferred	PA
<i>bacitracin ointment 500 unit/gm ophthalmic</i>	Preferred	
<i>bacitracin-polymyxin b ointment 500-10000 unit/gm ophthalmic</i>	Preferred	
BESIVANCE SUSPENSION 0.6 % OPHTHALMIC (<i>besifloxacin hcl</i>)	Non Preferred	PA
CILOXAN OINTMENT 0.3 % OPHTHALMIC (<i>ciprofloxacin hcl</i>)	Non Preferred	PA
<i>ciprofloxacin hcl solution 0.3 % ophthalmic</i>	Preferred	
<i>erythromycin ointment 5 mg/gm ophthalmic</i>	Preferred	
<i>gatifloxacin solution 0.5 % ophthalmic</i>	Non Preferred	PA
<i>gentamicin sulfate solution 0.3 % ophthalmic</i>	Preferred	
<i>moxifloxacin hcl (2x day) solution 0.5 % ophthalmic</i>	Non Preferred	PA
<i>moxifloxacin hcl solution 0.5 % ophthalmic</i>	Preferred	
NATACYN SUSPENSION 5 % OPHTHALMIC (<i>natamycin</i>)	Non Preferred	PA
<i>neomycin-bacitracin zn-polymyx ointment 3.5-400-10000 ophthalmic</i>	Non Preferred	PA
<i>neomycin-bacitracin zn-polymyx ointment 5-400-10000 ophthalmic</i>	Non Preferred	PA
<i>neomycin-polymyxin-gramicidin solution 1.75-10000-.025 ophthalmic</i>	Non Preferred	PA
<i>neomycin-bacitracin zn-polymyx (Neo-Polycin Ointment 3.5-400-10000 Ophthalmic)</i>	Non Preferred	PA
OCUFLOX SOLUTION 0.3 % OPHTHALMIC (<i>ofloxacin</i>)	Non Preferred	PA
<i>ofloxacin solution 0.3 % ophthalmic</i>	Preferred	
<i>bacitracin-polymyxin b (Polycin Ointment 500-10000 Unit/Gm Ophthalmic)</i>	Preferred	
<i>polymyxin b-trimethoprim solution 10000-0.1 unit/ml-% ophthalmic</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
POLYTRIM SOLUTION 10000-0.1 UNIT/ML-% OPHTHALMIC (<i>polymyxin b-trimethoprim</i>)	Non Preferred	PA
<i>sulfacetamide sodium ointment 10 % ophthalmic</i>	Non Preferred	PA
<i>sulfacetamide sodium solution 10 % ophthalmic</i>	Non Preferred	PA
<i>tobramycin solution 0.3 % ophthalmic</i>	Preferred	
TOBREX OINTMENT 0.3 % OPHTHALMIC (<i>tobramycin</i>)	Non Preferred	PA
VIGAMOX SOLUTION 0.5 % OPHTHALMIC (<i>moxifloxacin hcl</i>)	Non Preferred	PA
ZYMAXID SOLUTION 0.5 % OPHTHALMIC (<i>gatifloxacin</i>)	Non Preferred	PA
OPHTHALMIC ANTIBIOTICS: STEROID COMBINATIONS [OPEN CLASS]		
<i>bacitra-neomycin-polymyxin-hc ointment 1 % ophthalmic</i>	Non Preferred	PA
MAXITROL OINTMENT 3.5-10000-0.1 OPHTHALMIC (<i>neomycin-polymyxin-dexameth</i>)	Non Preferred	PA
MAXITROL SUSPENSION 0.1 % OPHTHALMIC (<i>neomycin-polymyxin-dexameth</i>)	Non Preferred	PA
MAXITROL SUSPENSION 3.5-10000-0.1 OPHTHALMIC (<i>neomycin-polymyxin-dexameth</i>)	Non Preferred	PA
<i>neomycin-polymyxin-dexameth ointment 3.5-10000-0.1 ophthalmic</i>	Preferred	
<i>neomycin-polymyxin-dexameth suspension 3.5-10000-0.1 ophthalmic</i>	Preferred	
<i>neomycin-polymyxin-hc suspension 3.5-10000-1 ophthalmic</i>	Non Preferred	PA
<i>bacitracin-polymyx-neo-hc</i> (Neo-Polycin Hc Ointment 1 % Ophthalmic)	Non Preferred	PA
<i>sulfacetamide-prednisolone solution 10-0.23 % ophthalmic</i>	Preferred	
TOBRADEX OINTMENT 0.3-0.1 % OPHTHALMIC (<i>tobramycin-dexamethasone</i>)	Preferred	
TOBRADEX ST SUSPENSION 0.3-0.05 % OPHTHALMIC (<i>tobramycin-dexamethasone</i>)	Non Preferred	PA
TOBRADEX SUSPENSION 0.3-0.1 % OPHTHALMIC (<i>tobramycin-dexamethasone</i>)	Preferred	
<i>tobramycin-dexamethasone suspension 0.3-0.1 % ophthalmic</i>	Preferred	
ZYLET SUSPENSION 0.5-0.3 % OPHTHALMIC (<i>loteprednol-tobramycin</i>)	Non Preferred	PA
OPHTHALMIC ANTI-INFLAMMATORY [OPEN CLASS]		
ACULAR LS SOLUTION 0.4 % OPHTHALMIC (<i>ketorolac tromethamine</i>)	Non Preferred	PA
ACULAR SOLUTION 0.5 % OPHTHALMIC (<i>ketorolac tromethamine</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ACUVAIL SOLUTION 0.45 % OPHTHALMIC (<i>ketorolac tromethamine</i>)	Non Preferred	PA
ALREX SUSPENSION 0.2 % OPHTHALMIC (<i>loteprednol etabonate</i>)	Non Preferred	PA
<i>bromfenac sodium (once-daily) solution 0.09 % ophthalmic</i>	Non Preferred	PA
BROMSITE SOLUTION 0.075 % OPHTHALMIC (<i>bromfenac sodium</i>)	Non Preferred	PA
<i>dexamethasone sodium phosphate solution 0.1 % ophthalmic</i>	Non Preferred	PA
<i>diclofenac sodium solution 0.1 % ophthalmic</i>	Preferred	
<i>difluprednate emulsion 0.05 % ophthalmic</i>	Non Preferred	PA
DUREZOL EMULSION 0.05 % OPHTHALMIC (<i>difluprednate</i>)	Preferred	
FLAREX SUSPENSION 0.1 % OPHTHALMIC (<i>fluorometholone acetate</i>)	Non Preferred	PA
<i>fluorometholone suspension 0.1 % ophthalmic</i>	Preferred	
<i>flurbiprofen sodium solution 0.03 % ophthalmic</i>	Preferred	
FML FORTE SUSPENSION 0.25 % OPHTHALMIC (<i>fluorometholone</i>)	Non Preferred	PA
FML LIQUIFILM SUSPENSION 0.1 % OPHTHALMIC (<i>fluorometholone</i>)	Non Preferred	PA
ILEVRO SUSPENSION 0.3 % OPHTHALMIC (<i>nepafenac</i>)	Non Preferred	PA
INVELTYS SUSPENSION 1 % OPHTHALMIC (<i>loteprednol etabonate</i>)	Non Preferred	PA
<i>ketorolac tromethamine solution 0.4 % ophthalmic</i>	Preferred	
<i>ketorolac tromethamine solution 0.5 % ophthalmic</i>	Preferred	
LOTEMAX GEL 0.5 % OPHTHALMIC (<i>loteprednol etabonate</i>)	Non Preferred	PA
LOTEMAX OINTMENT 0.5 % OPHTHALMIC (<i>loteprednol etabonate</i>)	Non Preferred	PA
LOTEMAX SM GEL 0.38 % OPHTHALMIC (<i>loteprednol etabonate</i>)	Non Preferred	PA
LOTEMAX SUSPENSION 0.5 % OPHTHALMIC (<i>loteprednol etabonate</i>)	Non Preferred	PA
<i>loteprednol etabonate gel 0.5 % ophthalmic</i>	Preferred	
<i>loteprednol etabonate suspension 0.5 % ophthalmic</i>	Preferred	
MAXIDEX SUSPENSION 0.1 % OPHTHALMIC (<i>dexamethasone</i>)	Non Preferred	PA
NEVANAC SUSPENSION 0.1 % OPHTHALMIC (<i>nepafenac</i>)	Non Preferred	PA
PRED FORTE SUSPENSION 1 % OPHTHALMIC (<i>prednisolone acetate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
PRED MILD SUSPENSION 0.12 % OPHTHALMIC (<i>prednisolone acetate</i>)	Non Preferred	PA
<i>prednisolone acetate suspension 1 % ophthalmic</i>	Preferred	
<i>prednisolone sodium phosphate solution 1 % ophthalmic</i>	Non Preferred	PA
PROLENSA SOLUTION 0.07 % OPHTHALMIC (<i>bromfenac sodium</i>)	Non Preferred	PA
OPHTHALMIC GLAUCOMA AGENTS [OPEN CLASS]		
ALPHAGAN P SOLUTION 0.1 % OPHTHALMIC (<i>brimonidine tartrate</i>)	Preferred	
ALPHAGAN P SOLUTION 0.15 % OPHTHALMIC (<i>brimonidine tartrate</i>)	Preferred	
<i>apraclonidine hcl solution 0.5 % ophthalmic</i>	Non Preferred	PA
AZOPT SUSPENSION 1 % OPHTHALMIC (<i>brinzolamide</i>)	Preferred	
<i>betaxolol hcl solution 0.5 % ophthalmic</i>	Preferred	
BETIMOL SOLUTION 0.25 % OPHTHALMIC (<i>timolol hemihydrate</i>)	Non Preferred	PA
BETIMOL SOLUTION 0.5 % OPHTHALMIC (<i>timolol hemihydrate</i>)	Non Preferred	PA
BETOPTIC-S SUSPENSION 0.25 % OPHTHALMIC (<i>betaxolol hcl</i>)	Non Preferred	PA
<i>bimatoprost solution 0.03 % ophthalmic</i>	Non Preferred	PA
<i>brimonidine tartrate solution 0.1 % ophthalmic</i>	Non Preferred	PA
<i>brimonidine tartrate solution 0.15 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate solution 0.2 % ophthalmic</i>	Preferred	
<i>brimonidine tartrate-timolol solution 0.2-0.5 % ophthalmic</i>	Non Preferred	PA
<i>brinzolamide suspension 1 % ophthalmic</i>	Preferred	
<i>carteolol hcl solution 1 % ophthalmic</i>	Preferred	
COMBIGAN SOLUTION 0.2-0.5 % OPHTHALMIC (<i>brimonidine tartrate-timolol</i>)	Preferred	
COSOPT PF SOLUTION 2-0.5 % OPHTHALMIC (<i>dorzolamide hcl-timolol mal</i>)	Non Preferred	PA
COSOPT SOLUTION 2-0.5 % OPHTHALMIC (<i>dorzolamide hcl-timolol mal</i>)	Non Preferred	PA
<i>dorzolamide hcl solution 2 % ophthalmic</i>	Preferred	
<i>dorzolamide hcl-timolol mal pf solution 2-0.5 % ophthalmic</i>	Non Preferred	PA
<i>dorzolamide hcl-timolol mal solution 2-0.5 % ophthalmic</i>	Preferred	
IOPIDINE SOLUTION 1 % OPHTHALMIC (<i>apraclonidine hcl</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ISTALOL SOLUTION 0.5 % OPHTHALMIC (<i>timolol maleate</i>)	Non Preferred	PA
<i>latanoprost solution 0.005 % ophthalmic</i>	Preferred	
<i>levobunolol hcl solution 0.5 % ophthalmic</i>	Preferred	
LUMIGAN SOLUTION 0.01 % OPHTHALMIC (<i>bimatoprost</i>)	Non Preferred	PA
PHOSPHOLINE IODIDE SOLUTION RECONSTITUTED 0.125 % OPHTHALMIC (<i>echothiophate iodide</i>)	Non Preferred	PA
<i>pilocarpine hcl solution 1 % ophthalmic</i>	Preferred	
<i>pilocarpine hcl solution 2 % ophthalmic</i>	Preferred	
<i>pilocarpine hcl solution 4 % ophthalmic</i>	Preferred	
RHOPRESSA SOLUTION 0.02 % OPHTHALMIC (<i>netarsudil dimesylate</i>)	Preferred	
ROCKLATAN SOLUTION 0.02-0.005 % OPHTHALMIC (<i>netarsudil-latanoprost</i>)	Preferred	
SIMBRINZA SUSPENSION 1-0.2 % OPHTHALMIC (<i>brinzolamide-brimonidine</i>)	Non Preferred	PA
<i>tafluprost (pf) solution 0.0015 % ophthalmic</i>	Non Preferred	PA
<i>timolol maleate (once-daily) solution 0.5 % ophthalmic</i>	Non Preferred	PA
<i>timolol maleate gel forming solution 0.25 % ophthalmic</i>	Preferred	
<i>timolol maleate gel forming solution 0.5 % ophthalmic</i>	Preferred	
<i>timolol maleate (Timolol Maleate OcuDose Solution 0.5 % Ophthalmic)</i>	Preferred	
<i>timolol maleate pf solution 0.25 % ophthalmic</i>	Non Preferred	PA
<i>timolol maleate pf solution 0.5 % ophthalmic</i>	Preferred	
<i>timolol maleate solution 0.25 % ophthalmic</i>	Preferred	
<i>timolol maleate solution 0.5 % ophthalmic</i>	Preferred	
TIMOPTIC OCUDOSE SOLUTION 0.25 % OPHTHALMIC (<i>timolol maleate</i>)	Non Preferred	PA
TIMOPTIC OCUDOSE SOLUTION 0.5 % OPHTHALMIC (<i>timolol maleate</i>)	Non Preferred	PA
TRAVATAN Z SOLUTION 0.004 % OPHTHALMIC (<i>travoprost</i>)	Preferred	
<i>travoprost (bak free) solution 0.004 % ophthalmic</i>	Preferred	
VUITY SOLUTION 1.25 % OPHTHALMIC (<i>pilocarpine hcl</i>)	Non Preferred	PA
VYZULTA SOLUTION 0.024 % OPHTHALMIC (<i>latanoprostene bunod</i>)	Non Preferred	PA
XALATAN SOLUTION 0.005 % OPHTHALMIC (<i>latanoprost</i>)	Non Preferred	PA
XELPROS EMULSION 0.005 % OPHTHALMIC (<i>latanoprost</i>)	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ZIOPTAN SOLUTION 0.0015 % OPHTHALMIC (<i>tafluprost</i>)	Non Preferred	PA
OPHTHALMIC IMMUNOMODULATORS [CLOSED CLASS]		
CEQUA SOLUTION 0.09 % OPHTHALMIC (<i>cyclosporine</i>)	Non Preferred	PA
<i>cyclosporine emulsion 0.05 % ophthalmic</i>	Non Preferred	PA
EYSUVIS SUSPENSION 0.25 % OPHTHALMIC (<i>loteprednol etabonate</i>)	Non Preferred	PA
RESTASIS EMULSION 0.05 % OPHTHALMIC (<i>cyclosporine</i>)	Preferred	
RESTASIS MULTIDOSE EMULSION 0.05 % OPHTHALMIC (<i>cyclosporine</i>)	Preferred	
TYRVAYA SOLUTION 0.03 MG/ACT NASAL (<i>varenicline tartrate</i>)	Non Preferred	PA
VERKAZIA EMULSION 0.1 % OPHTHALMIC (<i>cyclosporine</i>)	Non Preferred	PA
XIIDRA SOLUTION 5 % OPHTHALMIC (<i>lifitegrast</i>)	Preferred	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS [OPEN CLASS]		
ALAWAY CHILDRENS ALLERGY SOLUTION 0.035 % OPHTHALMIC (<i>ketotifen fumarate</i>)	Preferred	
ALAWAY SOLUTION 0.035 % OPHTHALMIC (<i>ketotifen fumarate</i>)	Preferred	
ALOCRIAL SOLUTION 2 % OPHTHALMIC (<i>nedocromil sodium</i>)	Non Preferred	PA
ALOMIDE SOLUTION 0.1 % OPHTHALMIC (<i>lodoxamide tromethamine</i>)	Non Preferred	PA
<i>azelastine hcl solution 0.05 % ophthalmic</i>	Preferred	
<i>bepotastine besilate solution 1.5 % ophthalmic</i>	Non Preferred	PA
BEPREVE SOLUTION 1.5 % OPHTHALMIC (<i>bepotastine besilate</i>)	Non Preferred	PA
<i>cromolyn sodium solution 4 % ophthalmic</i>	Preferred	
<i>epinastine hcl solution 0.05 % ophthalmic</i>	Preferred	
<i>eye allergy itch relief solution 0.2 % ophthalmic</i>	Preferred	
<i>eye allergy itch/redness rel solution 0.1 % ophthalmic</i>	Preferred	
<i>eye itch relief solution 0.035 % ophthalmic</i>	Preferred	
<i>gnp olopatadine hcl solution 0.1 % ophthalmic</i>	Preferred	
<i>gnp olopatadine hcl solution 0.2 % ophthalmic</i>	Preferred	
<i>ketotifen fumarate solution 0.035 % ophthalmic</i>	Preferred	
LASTACRAFT SOLUTION 0.25 % OPHTHALMIC (OTC) (<i>alcaftadine</i>)	Non Preferred	PA
<i>olopatadine hcl solution 0.1 % ophthalmic (otc)</i>	Preferred	
<i>olopatadine hcl solution 0.1 % ophthalmic (rx)</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>olopatadine hcl solution 0.2 % ophthalmic (otc)</i>	Preferred	
<i>olopatadine hcl solution 0.2 % ophthalmic (rx)</i>	Preferred	
PATADAY SOLUTION 0.1 % OPHTHALMIC (<i>olopatadine hcl</i>)	Non Preferred	PA
PATADAY SOLUTION 0.2 % OPHTHALMIC (OTC) (<i>olopatadine hcl</i>)	Non Preferred	PA
PATADAY SOLUTION 0.7 % OPHTHALMIC (<i>olopatadine hcl</i>)	Non Preferred	PA
<i>qc olopatadine hcl solution 0.2 % ophthalmic</i>	Preferred	
<i>sm olopatadine hcl solution 0.2 % ophthalmic</i>	Preferred	
ZADITOR SOLUTION 0.035 % OPHTHALMIC (<i>ketotifen fumarate</i>)	Preferred	
ZERVIAE SOLUTION 0.24 % OPHTHALMIC (<i>cetirizine hcl</i>)	Non Preferred	PA
OPIOID DEPENDENCY - [CLOSED CLASS]		
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 16 MG/0.32ML SUBCUTANEOUS (<i>buprenorphine</i>)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 24 MG/0.48ML SUBCUTANEOUS (<i>buprenorphine</i>)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 32 MG/0.64ML SUBCUTANEOUS (<i>buprenorphine</i>)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 8 MG/0.16ML SUBCUTANEOUS (<i>buprenorphine</i>)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI SOLUTION PREFILLED SYRINGE 128 MG/0.36ML SUBCUTANEOUS (<i>buprenorphine</i>)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI SOLUTION PREFILLED SYRINGE 64 MG/0.18ML SUBCUTANEOUS (<i>buprenorphine</i>)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI SOLUTION PREFILLED SYRINGE 96 MG/0.27ML SUBCUTANEOUS (<i>buprenorphine</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>buprenorphine hcl tablet sublingual 2 mg sublingual</i>	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years)
<i>buprenorphine hcl tablet sublingual 8 mg sublingual</i>	Preferred	QL (2 EA per 1 day); AGE (Min 16 Years)
<i>buprenorphine hcl-naloxone hcl film 12-3 mg sublingual</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
<i>buprenorphine hcl-naloxone hcl film 2-0.5 mg sublingual</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
<i>buprenorphine hcl-naloxone hcl film 4-1 mg sublingual</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
<i>buprenorphine hcl-naloxone hcl film 8-2 mg sublingual</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>buprenorphine hcl-naloxone hcl tablet sublingual 2-0.5 mg sublingual</i>	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years)
<i>buprenorphine hcl-naloxone hcl tablet sublingual 8-2 mg sublingual</i>	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years)
KLOXXADO LIQUID 8 MG/0.1ML NASAL (<i>naloxone hcl</i>)	Preferred	
<i>naloxone hcl liquid 4 mg/0.1ml nasal (rx)</i>	Preferred	
<i>naloxone hcl solution 0.4 mg/ml injection</i>	Preferred	
<i>naloxone hcl solution 4 mg/10ml injection</i>	Preferred	
<i>naloxone hcl solution cartridge 0.4 mg/ml injection</i>	Preferred	
<i>naloxone hcl solution prefilled syringe 2 mg/2ml injection</i>	Preferred	
<i>naltrexone hcl tablet 50 mg oral</i>	Preferred	
NARCAN LIQUID 4 MG/0.1ML NASAL (RX) (<i>naloxone hcl</i>)	Preferred	
SUBLOCADE SOLUTION PREFILLED SYRINGE 100 MG/0.5ML SUBCUTANEOUS (<i>buprenorphine</i>)	Preferred	
SUBLOCADE SOLUTION PREFILLED SYRINGE 300 MG/1.5ML SUBCUTANEOUS (<i>buprenorphine</i>)	Preferred	
SUBOXONE FILM 12-3 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
SUBOXONE FILM 2-0.5 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
SUBOXONE FILM 4-1 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
SUBOXONE FILM 8-2 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
VIVITROL SUSPENSION RECONSTITUTED 380 MG INTRAMUSCULAR (<i>naltrexone</i>)	Preferred	QL (2 EA per 30 days)
ZIMHI SOLUTION PREFILLED SYRINGE 5 MG/0.5ML INJECTION (<i>naloxone hcl</i>)	Preferred	
ZUBSOLV TABLET SUBLINGUAL 0.7-0.18 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 1.4-0.36 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 11.4-2.9 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 2.9-0.71 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 5.7-1.4 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 8.6-2.1 MG SUBLINGUAL (<i>buprenorphine hcl-naloxone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)

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Drug Name	Formulary Status	Requirements/Limits
OPIOIDS - LONG ACTING (LAO) [OPEN CLASS]		
BELBUCA FILM 150 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
BELBUCA FILM 300 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
BELBUCA FILM 450 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
BELBUCA FILM 600 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
BELBUCA FILM 75 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (6 EA per 1 day)
BELBUCA FILM 750 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
BELBUCA FILM 900 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
<i>buprenorphine patch weekly 10 mcg/hr transdermal</i>	Preferred	PA; QL (0.29 EA per 1 day)
<i>buprenorphine patch weekly 15 mcg/hr transdermal</i>	Preferred	PA; QL (0.15 EA per 1 day)
<i>buprenorphine patch weekly 20 mcg/hr transdermal</i>	Preferred	PA; QL (0.15 EA per 1 day)
<i>buprenorphine patch weekly 5 mcg/hr transdermal</i>	Preferred	PA; QL (0.29 EA per 1 day)
<i>buprenorphine patch weekly 7.5 mcg/hr transdermal</i>	Preferred	PA; QL (0.29 EA per 1 day)
BUTRANS PATCH WEEKLY 10 MCG/HR TRANSDERMAL (<i>buprenorphine</i>)	Preferred	PA; QL (0.29 EA per 1 day)
BUTRANS PATCH WEEKLY 15 MCG/HR TRANSDERMAL (<i>buprenorphine</i>)	Preferred	PA; QL (0.15 EA per 1 day)
BUTRANS PATCH WEEKLY 20 MCG/HR TRANSDERMAL (<i>buprenorphine</i>)	Preferred	PA; QL (0.15 EA per 1 day)
BUTRANS PATCH WEEKLY 5 MCG/HR TRANSDERMAL (<i>buprenorphine</i>)	Preferred	PA; QL (0.29 EA per 1 day)
BUTRANS PATCH WEEKLY 7.5 MCG/HR TRANSDERMAL (<i>buprenorphine</i>)	Preferred	PA; QL (0.29 EA per 1 day)
CONZIP CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL (<i>tramadol hcl</i>)	Non Preferred	PA; AGE (Min 12 Years)
CONZIP CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL (<i>tramadol hcl</i>)	Non Preferred	PA; AGE (Min 12 Years)
CONZIP CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL (<i>tramadol hcl</i>)	Non Preferred	PA; AGE (Min 12 Years)
<i>fentanyl patch 72 hour 100 mcg/hr transdermal</i>	Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 12 mcg/hr transdermal</i>	Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 25 mcg/hr transdermal</i>	Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 37.5 mcg/hr transdermal</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 50 mcg/hr transdermal</i>	Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 62.5 mcg/hr transdermal</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>fentanyl patch 72 hour 75 mcg/hr transdermal</i>	Preferred	PA; QL (0.334 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>fentanyl patch 72 hour 87.5 mcg/hr transdermal</i>	Non Preferred	PA; QL (0.334 EA per 1 day)
<i>hydrocodone bitartrate er capsule extended release 12 hour 10 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>hydrocodone bitartrate er capsule extended release 12 hour 15 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>hydrocodone bitartrate er capsule extended release 12 hour 20 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>hydrocodone bitartrate er capsule extended release 12 hour 30 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hydrocodone bitartrate er capsule extended release 12 hour 40 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hydrocodone bitartrate er capsule extended release 12 hour 50 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 100 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 120 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 20 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 30 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 40 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 60 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydrocodone bitartrate er tablet er 24 hour abuse-deterrent 80 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydromorphone hcl er tablet extended release 24 hour 12 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hydromorphone hcl er tablet extended release 24 hour 16 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydromorphone hcl er tablet extended release 24 hour 32 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>hydromorphone hcl er tablet extended release 24 hour 8 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 100 MG ORAL (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 120 MG ORAL (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 20 MG ORAL (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (3 EA per 1 day)
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 30 MG ORAL (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (2 EA per 1 day)
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 40 MG ORAL (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 60 MG ORAL (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
HYSINGLA ER TABLET ER 24 HOUR ABUSE-DETERRENT 80 MG ORAL (<i>hydrocodone bitartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
<i>methadone hcl concentrate 10 mg/ml oral</i>	Non Preferred	PA; QL (4 EA per 1 day); AGE (Max 1 Years)
<i>methadone hcl (Methadone Hcl Intensol Concentrate 10 Mg/ML Oral)</i>	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
<i>methadone hcl solution 10 mg/5ml oral</i>	Non Preferred	PA; QL (15 ML per 1 day); AGE (Max 1 Years)
<i>methadone hcl solution 5 mg/5ml oral</i>	Non Preferred	PA; QL (40 ML per 1 day); AGE (Max 1 Years)
<i>methadone hcl tablet 10 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Max 1 Years)
<i>methadone hcl tablet 5 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Max 1 Years)
<i>methadone hcl tablet soluble 40 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Max 1 Years)
METHADOSE CONCENTRATE 10 MG/ML ORAL (<i>methadone hcl</i>)	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
METHADOSE SUGAR-FREE CONCENTRATE 10 MG/ML ORAL (<i>methadone hcl</i>)	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
<i>methadone hcl (Methadose Tablet Soluble 40 Mg Oral)</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Max 1 Years)
<i>morphine sulfate er beads capsule extended release 24 hour 120 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er beads capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate er beads capsule extended release 24 hour 45 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate er beads capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>morphine sulfate er beads capsule extended release 24 hour 75 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>morphine sulfate er beads capsule extended release 24 hour 90 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>morphine sulfate er capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>morphine sulfate er capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate er capsule extended release 24 hour 50 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>morphine sulfate er capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>morphine sulfate er capsule extended release 24 hour 80 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 100 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 15 mg oral</i>	Preferred	PA; QL (4 EA per 1 day)
<i>morphine sulfate er tablet extended release 200 mg oral</i>	Preferred	PA; QL (1 EA per 1 day)
<i>morphine sulfate er tablet extended release 30 mg oral</i>	Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate er tablet extended release 60 mg oral</i>	Preferred	PA; QL (2 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 100 MG ORAL (<i>morphine sulfate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 15 MG ORAL (<i>morphine sulfate</i>)	Non Preferred	PA; QL (4 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 200 MG ORAL (<i>morphine sulfate</i>)	Non Preferred	PA; QL (1 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 30 MG ORAL (<i>morphine sulfate</i>)	Non Preferred	PA; QL (3 EA per 1 day)
MS CONTIN TABLET EXTENDED RELEASE 60 MG ORAL (<i>morphine sulfate</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 100 MG ORAL (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 150 MG ORAL (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 200 MG ORAL (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 250 MG ORAL (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NUCYNTA ER TABLET EXTENDED RELEASE 12 HOUR 50 MG ORAL (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
<i>oxycodone hcl er tablet er 12 hour abuse-deterrent 10 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>oxycodone hcl er tablet er 12 hour abuse-deterrent 20 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>oxycodone hcl er tablet er 12 hour abuse-deterrent 40 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>oxycodone hcl er tablet er 12 hour abuse-deterrent 80 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (6 EA per 1 day)
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 15 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (5 EA per 1 day)
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 20 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 30 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 40 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 60 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
OXYCONTIN TABLET ER 12 HOUR ABUSE-DETERRENT 80 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
<i>oxymorphone hcl er tablet extended release 12 hour 10 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>oxymorphone hcl er tablet extended release 12 hour 15 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>oxymorphone hcl er tablet extended release 12 hour 20 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>oxymorphone hcl er tablet extended release 12 hour 30 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>oxymorphone hcl er tablet extended release 12 hour 40 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>oxymorphone hcl er tablet extended release 12 hour 5 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>oxymorphone hcl er tablet extended release 12 hour 7.5 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>tramadol hcl (er biphasic) capsule extended release 24 hour 100 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tramadol hcl (er biphasic) capsule extended release 24 hour 200 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tramadol hcl (er biphasic) capsule extended release 24 hour 300 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tramadol hcl (er biphasic) tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tramadol hcl (er biphasic) tablet extended release 24 hour 200 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tramadol hcl (er biphasic) tablet extended release 24 hour 300 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>tramadol hcl er tablet extended release 24 hour 100 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 12 Years)
<i>tramadol hcl er tablet extended release 24 hour 200 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 12 Years)
<i>tramadol hcl er tablet extended release 24 hour 300 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 12 Years)
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG ORAL (<i>oxycodone</i>)	Non Preferred	PA; QL (5 EA per 1 day)
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 18 MG ORAL (<i>oxycodone</i>)	Non Preferred	PA; QL (4 EA per 1 day)
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 27 MG ORAL (<i>oxycodone</i>)	Non Preferred	PA; QL (3 EA per 1 day)
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG ORAL (<i>oxycodone</i>)	Non Preferred	PA; QL (2 EA per 1 day)

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
XTAMPZA ER CAPSULE ER 12 HOUR ABUSE-DETERRENT 9 MG ORAL (<i>oxycodone</i>)	Non Preferred	PA; QL (6 EA per 1 day)
OPIOIDS - SHORT ACTING [OPEN CLASS]		
<i>acetaminophen-codeine solution 120-12 mg/5ml oral</i>	Preferred	QL (150 ML per 1 day); AGE (Min 12 Years)
<i>acetaminophen-codeine tablet 300-15 mg oral</i>	Preferred	QL (10 EA per 1 day); AGE (Min 12 Years)
<i>acetaminophen-codeine tablet 300-30 mg oral</i>	Preferred	QL (10 EA per 1 day); AGE (Min 12 Years)
<i>acetaminophen-codeine tablet 300-60 mg oral</i>	Preferred	QL (10 EA per 1 day); AGE (Min 12 Years)
<i>apap-caff-dihydrocodeine capsule 320.5-30-16 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>butalbital-asa-caff-codeine (Ascomp-Codeine Capsule 50-325-40-30 Mg Oral)</i>	Non Preferred	PA; AGE (Min 12 Years)
BELBUCA FILM 150 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
BELBUCA FILM 300 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
BELBUCA FILM 450 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
BELBUCA FILM 600 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
BELBUCA FILM 75 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (6 EA per 1 day)
BELBUCA FILM 750 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
BELBUCA FILM 900 MCG BUCCAL (<i>buprenorphine hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)
<i>butalbital-apap-caff-cod capsule 50-300-40-30 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>butalbital-apap-caff-cod capsule 50-325-40-30 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>butalbital-asa-caff-codeine capsule 50-325-40-30 mg oral</i>	Non Preferred	PA; AGE (Min 12 Years)
<i>butorphanol tartrate solution 10 mg/ml nasal</i>	Non Preferred	PA
<i>codeine sulfate tablet 15 mg oral</i>	Non Preferred	PA; QL (24 EA per 1 day); AGE (Min 12 Years)
<i>codeine sulfate tablet 30 mg oral</i>	Non Preferred	PA; QL (12 EA per 1 day); AGE (Min 12 Years)
<i>codeine sulfate tablet 60 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 12 Years)
DILAUDID LIQUID 1 MG/ML ORAL (<i>hydromorphone hcl</i>)	Non Preferred	PA; QL (22.5 ML per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
DILAUDID TABLET 2 MG ORAL (<i>hydromorphone hcl</i>)	Non Preferred	PA; QL (11.2 EA per 1 day)
DILAUDID TABLET 4 MG ORAL (<i>hydromorphone hcl</i>)	Non Preferred	PA; QL (5.6 EA per 1 day)
DILAUDID TABLET 8 MG ORAL (<i>hydromorphone hcl</i>)	Non Preferred	PA; QL (2.8 EA per 1 day)
<i>oxycodone-acetaminophen</i> (Endocet Tablet 10-325 Mg Oral)	Preferred	QL (6 EA per 1 day)
<i>oxycodone-acetaminophen</i> (Endocet Tablet 5-325 Mg Oral)	Preferred	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen</i> (Endocet Tablet 7.5-325 Mg Oral)	Preferred	QL (8 EA per 1 day)
<i>fentanyl citrate lozenge on a handle 1200 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 1600 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 200 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 400 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 600 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 800 mcg buccal</i>	Non Preferred	PA
<i>fentanyl citrate tablet 100 mcg buccal</i>	Non Preferred	PA; QL (7.2 EA per 1 day)
<i>fentanyl citrate tablet 200 mcg buccal</i>	Non Preferred	PA; QL (3.6 EA per 1 day)
<i>fentanyl citrate tablet 400 mcg buccal</i>	Non Preferred	PA; QL (1.8 EA per 1 day)
<i>fentanyl citrate tablet 600 mcg buccal</i>	Non Preferred	PA; QL (1.2 EA per 1 day)
<i>fentanyl citrate tablet 800 mcg buccal</i>	Non Preferred	PA; QL (0.9 EA per 1 day)
FENTORA TABLET 100 MCG BUCCAL (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (7.2 EA per 1 day)
FENTORA TABLET 200 MCG BUCCAL (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (3.6 EA per 1 day)
FENTORA TABLET 400 MCG BUCCAL (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (1.8 EA per 1 day)
FENTORA TABLET 600 MCG BUCCAL (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (1.2 EA per 1 day)
FENTORA TABLET 800 MCG BUCCAL (<i>fentanyl citrate</i>)	Non Preferred	PA; QL (0.9 EA per 1 day)
FIORICET/CODEINE CAPSULE 50-300-40-30 MG ORAL (<i>butalbital-apap-caff-cod</i>)	Non Preferred	PA; AGE (Min 12 Years)
<i>hydrocodone-acetaminophen solution 2.5-108 mg/5ml oral</i>	Preferred	QL (180 ML per 1 day)
<i>hydrocodone-acetaminophen solution 5-217 mg/10ml oral</i>	Preferred	QL (180 ML per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>hydrocodone-acetaminophen solution 7.5-325 mg/15ml oral</i>	Preferred	QL (180 ML per 1 day)
<i>hydrocodone-acetaminophen tablet 10-300 mg oral</i>	Preferred	QL (9 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 10-325 mg oral</i>	Preferred	QL (9 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 5-300 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 5-325 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 7.5-300 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hydrocodone-acetaminophen tablet 7.5-325 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>hydrocodone-ibuprofen tablet 10-200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>hydrocodone-ibuprofen tablet 5-200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>hydrocodone-ibuprofen tablet 7.5-200 mg oral</i>	Preferred	QL (5 EA per 1 day)
<i>hydromorphone hcl liquid 1 mg/ml oral</i>	Non Preferred	PA; QL (22.5 ML per 1 day)
<i>hydromorphone hcl suppository 3 mg rectal</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>hydromorphone hcl tablet 2 mg oral</i>	Preferred	QL (11.2 EA per 1 day)
<i>hydromorphone hcl tablet 4 mg oral</i>	Preferred	QL (5.6 EA per 1 day)
<i>hydromorphone hcl tablet 8 mg oral</i>	Preferred	QL (2.8 EA per 1 day)
<i>levorphanol tartrate tablet 2 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>levorphanol tartrate tablet 3 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>meperidine hcl solution 50 mg/5ml oral</i>	Non Preferred	PA; QL (90 ML per 1 day)
<i>meperidine hcl tablet 50 mg oral</i>	Non Preferred	PA; QL (18 EA per 1 day)
<i>morphine sulfate (concentrate) solution 100 mg/5ml oral</i>	Preferred	QL (4.5 ML per 1 day)
<i>morphine sulfate (concentrate) solution 20 mg/ml oral</i>	Preferred	QL (4.5 ML per 1 day)
<i>morphine sulfate solution 10 mg/5ml oral</i>	Preferred	QL (45 ML per 1 day)
<i>morphine sulfate solution 20 mg/5ml oral</i>	Preferred	QL (22.5 ML per 1 day)
<i>morphine sulfate suppository 10 mg rectal</i>	Non Preferred	PA; QL (9 EA per 1 day)
<i>morphine sulfate suppository 20 mg rectal</i>	Non Preferred	PA; QL (4.5 EA per 1 day)
<i>morphine sulfate suppository 30 mg rectal</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>morphine sulfate suppository 5 mg rectal</i>	Non Preferred	PA; QL (18 EA per 1 day)
<i>morphine sulfate tablet 15 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>morphine sulfate tablet 30 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>nalocet tablet 2.5-300 mg oral</i>	Non Preferred	PA; QL (12 EA per 1 day)
NUCYNTA TABLET 100 MG ORAL (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (2.25 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
NUCYNTA TABLET 50 MG ORAL (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (4.5 EA per 1 day)
NUCYNTA TABLET 75 MG ORAL (<i>tapentadol hcl</i>)	Non Preferred	PA; QL (3 EA per 1 day)
<i>oxycodone hcl capsule 5 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>oxycodone hcl concentrate 100 mg/5ml oral</i>	Non Preferred	PA; QL (3 ML per 1 day)
<i>oxycodone hcl solution 5 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day)
<i>oxycodone hcl tablet 10 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>oxycodone hcl tablet 15 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>oxycodone hcl tablet 20 mg oral</i>	Preferred	QL (3 EA per 1 day)
<i>oxycodone hcl tablet 30 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>oxycodone hcl tablet 5 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen solution 5-325 mg/5ml oral</i>	Preferred	QL (60 ML per 1 day)
<i>oxycodone-acetaminophen tablet 10-325 mg oral</i>	Preferred	QL (6 EA per 1 day)
<i>oxycodone-acetaminophen tablet 2.5-325 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen tablet 5-325 mg oral</i>	Preferred	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen tablet 7.5-325 mg oral</i>	Preferred	QL (8 EA per 1 day)
<i>oxymorphone hcl tablet 10 mg oral</i>	Non Preferred	PA; QL (3 EA per 1 day)
<i>oxymorphone hcl tablet 5 mg oral</i>	Non Preferred	PA; QL (6 EA per 1 day)
<i>pentazocine-naloxone hcl tablet 50-0.5 mg oral</i>	Non Preferred	PA; QL (4.9 EA per 1 day)
PERCOCET TABLET 10-325 MG ORAL (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (6 EA per 1 day)
PERCOCET TABLET 2.5-325 MG ORAL (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (12 EA per 1 day)
PERCOCET TABLET 5-325 MG ORAL (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (12 EA per 1 day)
PERCOCET TABLET 7.5-325 MG ORAL (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (8 EA per 1 day)
PROLATE SOLUTION 10-300 MG/5ML ORAL (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (60 ML per 1 day)
PROLATE TABLET 10-300 MG ORAL (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (6 EA per 1 day)
PROLATE TABLET 5-300 MG ORAL (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (12 EA per 1 day)
PROLATE TABLET 7.5-300 MG ORAL (<i>oxycodone-acetaminophen</i>)	Non Preferred	PA; QL (8 EA per 1 day)
ROXICODONE TABLET 15 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (4 EA per 1 day)
ROXICODONE TABLET 30 MG ORAL (<i>oxycodone hcl</i>)	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
ROXYBOND TABLET ABUSE-DETERRENT 15 MG ORAL (oxycodone hcl)	Non Preferred	PA; QL (4 EA per 1 day)
ROXYBOND TABLET ABUSE-DETERRENT 30 MG ORAL (oxycodone hcl)	Non Preferred	PA; QL (2 EA per 1 day)
ROXYBOND TABLET ABUSE-DETERRENT 5 MG ORAL (oxycodone hcl)	Non Preferred	PA; QL (12 EA per 1 day)
SEGLENTIS TABLET 56-44 MG ORAL (celecoxib-tramadol hcl)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
tramadol hcl solution 5 mg/ml oral	Non Preferred	PA; QL (80 ML per 1 day); AGE (Min 12 Years)
tramadol hcl tablet 100 mg oral	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 12 Years)
tramadol hcl tablet 50 mg oral	Preferred	QL (8 EA per 1 day); AGE (Min 12 Years)
tramadol-acetaminophen tablet 37.5-325 mg oral	Preferred	QL (8 EA per 1 day); AGE (Min 12 Years)
OTIC [OPEN CLASS]		
CIPRO HC SUSPENSION 0.2-1 % OTIC (ciprofloxacin-hydrocortisone)	Non Preferred	PA
CIPRODEX SUSPENSION 0.3-0.1 % OTIC (ciprofloxacin-dexamethasone)	Preferred	
ciprofloxacin hcl solution 0.2 % otic	Non Preferred	PA
ciprofloxacin-dexamethasone suspension 0.3-0.1 % otic	Non Preferred	PA
ciprofloxacin-fluocinolone pf solution 0.3-0.025 % otic	Non Preferred	PA
neomycin-polymyxin-hc solution 1 % otic	Preferred	
neomycin-polymyxin-hc solution 3.5-10000-1 otic	Preferred	
neomycin-polymyxin-hc suspension 3.5-10000-1 otic	Preferred	
ofloxacin solution 0.3 % otic	Preferred	
PANCREATIC ENZYMES [OPEN CLASS]		
CREON CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT ORAL (pancrelipase (lip-prot-amyl))	Preferred	PA; Max 90-day supply per fill
CREON CAPSULE DELAYED RELEASE PARTICLES 24000-76000 UNIT ORAL (pancrelipase (lip-prot-amyl))	Preferred	PA; Max 90-day supply per fill
CREON CAPSULE DELAYED RELEASE PARTICLES 3000-9500 UNIT ORAL (pancrelipase (lip-prot-amyl))	Preferred	PA; Max 90-day supply per fill
CREON CAPSULE DELAYED RELEASE PARTICLES 36000-114000 UNIT ORAL (pancrelipase (lip-prot-amyl))	Preferred	PA; Max 90-day supply per fill
CREON CAPSULE DELAYED RELEASE PARTICLES 6000-19000 UNIT ORAL (pancrelipase (lip-prot-amyl))	Preferred	PA; Max 90-day supply per fill
PERTZYE CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT ORAL (pancrelipase (lip-prot-amyl))	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
PERTZYE CAPSULE DELAYED RELEASE PARTICLES 24000-86250 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Non Preferred	PA
PERTZYE CAPSULE DELAYED RELEASE PARTICLES 4000-14375 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Non Preferred	PA
PERTZYE CAPSULE DELAYED RELEASE PARTICLES 8000-28750 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Non Preferred	PA
VIOKACE TABLET 10440-39150 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Non Preferred	PA
VIOKACE TABLET 20880-78300 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Non Preferred	PA
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; Max 90-day supply per fill
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 15000-47000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; Max 90-day supply per fill
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 20000-63000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; Max 90-day supply per fill
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 25000-79000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; Max 90-day supply per fill
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 3000-10000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; Max 90-day supply per fill
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 40000-126000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; Max 90-day supply per fill
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 5000-24000 UNIT ORAL (<i>pancrelipase (lip-prot-amyl)</i>)	Preferred	PA; Max 90-day supply per fill
PHOSPHATE BINDERS [OPEN CLASS]		
AURYXIA TABLET 1 GM 210 MG(Fe) ORAL (<i>ferric citrate</i>)	Non Preferred	PA
<i>calcium acetate (phos binder) capsule 667 mg oral</i>	Preferred	Max 90-day supply per fill
<i>calcium acetate (phos binder) tablet 667 mg oral (otc)</i>	Preferred	
<i>calcium acetate (phos binder) tablet 667 mg oral (rx)</i>	Preferred	
<i>calcium acetate tablet 667 mg oral</i>	Preferred	
<i>calcium acetate tablet 668 (169 ca) mg oral</i>	Preferred	
CALPHRON TABLET 667 MG ORAL (<i>calcium acetate (phos binder)</i>)	Preferred	
FOSRENOL PACKET 1000 MG ORAL (<i>lanthanum carbonate</i>)	Non Preferred	PA
FOSRENOL PACKET 750 MG ORAL (<i>lanthanum carbonate</i>)	Non Preferred	PA
FOSRENOL TABLET CHEWABLE 1000 MG ORAL (<i>lanthanum carbonate</i>)	Non Preferred	PA
FOSRENOL TABLET CHEWABLE 500 MG ORAL (<i>lanthanum carbonate</i>)	Non Preferred	PA
FOSRENOL TABLET CHEWABLE 750 MG ORAL (<i>lanthanum carbonate</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>lanthanum carbonate tablet chewable 1000 mg oral</i>	Non Preferred	PA
<i>lanthanum carbonate tablet chewable 500 mg oral</i>	Preferred	
<i>lanthanum carbonate tablet chewable 750 mg oral</i>	Preferred	
MAGNEBIND 400 TABLET 80-115 MG ORAL (<i>calcium carb-magnesium carb</i>)	Non Preferred	PA
RENAGEL TABLET 800 MG ORAL (<i>sevelamer hcl</i>)	Non Preferred	PA
REVELA PACKET 0.8 GM ORAL (<i>sevelamer carbonate</i>)	Non Preferred	PA
REVELA PACKET 2.4 GM ORAL (<i>sevelamer carbonate</i>)	Non Preferred	PA
REVELA TABLET 800 MG ORAL (<i>sevelamer carbonate</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>sevelamer carbonate packet 0.8 gm oral</i>	Non Preferred	PA
<i>sevelamer carbonate packet 2.4 gm oral</i>	Non Preferred	PA
<i>sevelamer carbonate tablet 800 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sevelamer hcl tablet 400 mg oral</i>	Non Preferred	PA
<i>sevelamer hcl tablet 800 mg oral</i>	Non Preferred	PA
VELPHORO TABLET CHEWABLE 500 MG ORAL (<i>sucroferric oxyhydroxide</i>)	Non Preferred	PA
PLATELET INHIBITORS [OPEN CLASS]		
<i>aspirin-dipyridamole er capsule extended release 12 hour 25-200 mg oral</i>	Non Preferred	PA
BRILINTA TABLET 60 MG ORAL (<i>ticagrelor</i>)	Preferred	Max 90-day supply per fill
BRILINTA TABLET 90 MG ORAL (<i>ticagrelor</i>)	Preferred	Max 90-day supply per fill
<i>clopidogrel bisulfate tablet 300 mg oral</i>	Preferred	Max 90-day supply per fill
<i>clopidogrel bisulfate tablet 75 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dipyridamole tablet 25 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dipyridamole tablet 50 mg oral</i>	Preferred	Max 90-day supply per fill
<i>dipyridamole tablet 75 mg oral</i>	Preferred	Max 90-day supply per fill
EFFIENT TABLET 10 MG ORAL (<i>prasugrel hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
EFFIENT TABLET 5 MG ORAL (<i>prasugrel hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
PLAVIX TABLET 75 MG ORAL (<i>clopidogrel bisulfate</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>prasugrel hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>prasugrel hcl tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
PROGESTATIONAL AGENTS [CLOSED CLASS]		
AYGESTIN TABLET 5 MG ORAL (<i>norethindrone acetate</i>)	Non Preferred	PA
CRINONE GEL 4 % VAGINAL (<i>progesterone</i>)	Non Preferred	PA
CRINONE GEL 8 % VAGINAL (<i>progesterone</i>)	Non Preferred	PA
<i>hydroxyprogesterone caproate oil 250 mg/ml intramuscular</i>	Non Preferred	PA
<i>hydroxyprogesterone caproate solution 1.25 gm/5ml intramuscular</i>	Non Preferred	PA
<i>medroxyprogesterone acetate tablet 10 mg oral</i>	Preferred	
<i>medroxyprogesterone acetate tablet 2.5 mg oral</i>	Preferred	
<i>medroxyprogesterone acetate tablet 5 mg oral</i>	Preferred	
<i>norethindrone acetate tablet 5 mg oral</i>	Preferred	
<i>progesterone capsule 100 mg oral</i>	Preferred	
<i>progesterone capsule 200 mg oral</i>	Preferred	
<i>progesterone oil 50 mg/ml intramuscular</i>	Preferred	
PROMETRIUM CAPSULE 100 MG ORAL (<i>progesterone</i>)	Non Preferred	PA
PROMETRIUM CAPSULE 200 MG ORAL (<i>progesterone</i>)	Non Preferred	PA
PROVERA TABLET 10 MG ORAL (<i>medroxyprogesterone acetate</i>)	Non Preferred	PA
PROVERA TABLET 2.5 MG ORAL (<i>medroxyprogesterone acetate</i>)	Non Preferred	PA
PROVERA TABLET 5 MG ORAL (<i>medroxyprogesterone acetate</i>)	Non Preferred	PA
PROGESTINS USED FOR CACHEXIA [OPEN CLASS]		
<i>megestrol acetate suspension 40 mg/ml oral</i>	Preferred	
<i>megestrol acetate suspension 400 mg/10ml oral</i>	Preferred	
<i>megestrol acetate suspension 625 mg/5ml oral</i>	Non Preferred	PA
<i>megestrol acetate tablet 20 mg oral</i>	Preferred	
<i>megestrol acetate tablet 40 mg oral</i>	Preferred	
PROTON PUMP INHIBITORS [OPEN CLASS]		
<i>acid reducer capsule delayed release 20.6 (20 base) mg oral</i>	Preferred	
ACIPHEX TABLET DELAYED RELEASE 20 MG ORAL (<i>rabeprazole sodium</i>)	Non Preferred	PA
DEXILANT CAPSULE DELAYED RELEASE 30 MG ORAL (<i>dexlansoprazole</i>)	Non Preferred	PA
DEXILANT CAPSULE DELAYED RELEASE 60 MG ORAL (<i>dexlansoprazole</i>)	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
<i>dexlansoprazole capsule delayed release 30 mg oral</i>	Non Preferred	PA
<i>dexlansoprazole capsule delayed release 60 mg oral</i>	Non Preferred	PA
<i>esomeprazole magnesium capsule delayed release 20 mg oral (otc)</i>	Preferred	QL (2 EA per 1 day)
<i>esomeprazole magnesium capsule delayed release 20 mg oral (rx)</i>	Preferred	QL (2 EA per 1 day)
<i>esomeprazole magnesium capsule delayed release 40 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>esomeprazole magnesium packet 10 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>esomeprazole magnesium packet 20 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>esomeprazole magnesium packet 40 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>esomeprazole magnesium tablet delayed release 20 mg oral (otc)</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>gnp esomeprazole magnesium capsule delayed release 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>gnp lansoprazole capsule delayed release 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>gnp omeprazole capsule delayed release 20.6 (20 base) mg oral</i>	Preferred	
<i>gnp omeprazole tablet delayed release 20 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>gnp omeprazole tablet delayed release dispersible 20 mg oral</i>	Preferred	
GOODSENSE ESOMEPRAZOLE CAPSULE DELAYED RELEASE 20 MG ORAL (<i>esomeprazole magnesium</i>)	Preferred	QL (2 EA per 1 day)
<i>goodsense lansoprazole capsule delayed release 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>goodsense lansoprazole tablet delayed release dispersible 15 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day)
<i>hm esomeprazole magnesium dr capsule delayed release 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
KONVOMEF SUSPENSION RECONSTITUTED 2-84 MG/ML ORAL (<i>omeprazole-sodium bicarbonate</i>)	Non Preferred	PA
<i>lansoprazole capsule delayed release 15 mg oral (otc)</i>	Preferred	QL (2 EA per 1 day)
<i>lansoprazole capsule delayed release 15 mg oral (rx)</i>	Preferred	QL (2 EA per 1 day)
<i>lansoprazole capsule delayed release 30 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>lansoprazole tablet delayed release dispersible 15 mg oral (rx)</i>	Non Preferred	PA
<i>lansoprazole tablet delayed release dispersible 30 mg oral</i>	Non Preferred	PA
NEXIUM CAPSULE DELAYED RELEASE 20 MG ORAL (<i>esomeprazole magnesium</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM CAPSULE DELAYED RELEASE 40 MG ORAL (<i>esomeprazole magnesium</i>)	Non Preferred	PA; QL (2 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
NEXIUM PACKET 10 MG ORAL (<i>esomeprazole magnesium</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM PACKET 2.5 MG ORAL (<i>esomeprazole magnesium</i>)	Non Preferred	PA
NEXIUM PACKET 20 MG ORAL (<i>esomeprazole magnesium</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM PACKET 40 MG ORAL (<i>esomeprazole magnesium</i>)	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM PACKET 5 MG ORAL (<i>esomeprazole magnesium</i>)	Non Preferred	PA
<i>omeprazole capsule delayed release 10 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>omeprazole capsule delayed release 20 mg oral</i>	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
<i>omeprazole capsule delayed release 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>omeprazole magnesium capsule delayed release 20.6 (20 base) mg oral</i>	Preferred	
<i>omeprazole magnesium tablet delayed release 20 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>omeprazole tablet delayed release 20 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>omeprazole tablet delayed release dispersible 20 mg oral</i>	Preferred	
<i>omeprazole-sodium bicarbonate capsule 20-1100 mg oral (rx)</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate capsule 40-1100 mg oral</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate packet 20-1680 mg oral</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate packet 40-1680 mg oral</i>	Non Preferred	PA
<i>pantoprazole sodium packet 40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>pantoprazole sodium tablet delayed release 20 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>pantoprazole sodium tablet delayed release 40 mg oral</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
PREVACID 24HR CAPSULE DELAYED RELEASE 15 MG ORAL (<i>lansoprazole</i>)	Non Preferred	PA; QL (2 EA per 1 day)
PREVACID CAPSULE DELAYED RELEASE 30 MG ORAL (<i>lansoprazole</i>)	Non Preferred	PA; QL (2 EA per 1 day)
PREVACID SOLUTAB TABLET DELAYED RELEASE DISPERSIBLE 15 MG ORAL (<i>lansoprazole</i>)	Non Preferred	PA
PREVACID SOLUTAB TABLET DELAYED RELEASE DISPERSIBLE 30 MG ORAL (<i>lansoprazole</i>)	Non Preferred	PA
PRILOSEC PACKET 10 MG ORAL (<i>omeprazole magnesium</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
PRILOSEC PACKET 2.5 MG ORAL (<i>omeprazole magnesium</i>)	Non Preferred	PA
PROTONIX PACKET 40 MG ORAL (<i>pantoprazole sodium</i>)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
PROTONIX TABLET DELAYED RELEASE 20 MG ORAL (<i>pantoprazole sodium</i>)	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
PROTONIX TABLET DELAYED RELEASE 40 MG ORAL (<i>pantoprazole sodium</i>)	Non Preferred	PA; QL (2 EA per 1 day); Max 90-day supply per fill
<i>qc esomeprazole magnesium capsule delayed release 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>qc lansoprazole capsule delayed release 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>qc omeprazole magnesium capsule delayed release 20.6 (20 base) mg oral</i>	Preferred	
<i>rabeprazole sodium tablet delayed release 20 mg oral</i>	Non Preferred	PA
<i>sm esomeprazole magnesium capsule delayed release 20 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>sm lansoprazole capsule delayed release 15 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>sm omeprazole tablet delayed release 20 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
ZEGERID CAPSULE 20-1100 MG ORAL (<i>omeprazole-sodium bicarbonate</i>)	Non Preferred	PA
ZEGERID CAPSULE 40-1100 MG ORAL (<i>omeprazole-sodium bicarbonate</i>)	Non Preferred	PA
ZEGERID PACKET 20-1680 MG ORAL (<i>omeprazole-sodium bicarbonate</i>)	Non Preferred	PA
ZEGERID PACKET 40-1680 MG ORAL (<i>omeprazole-sodium bicarbonate</i>)	Non Preferred	PA
PSORIASIS, TOPICAL [OPEN CLASS]		
<i>calcipotriene cream 0.005 % external</i>	Preferred	
<i>calcipotriene foam 0.005 % external</i>	Non Preferred	PA
<i>calcipotriene ointment 0.005 % external</i>	Preferred	
<i>calcipotriene solution 0.005 % external</i>	Preferred	
<i>calcipotriene-betameth diprop ointment 0.005-0.064 % external</i>	Non Preferred	PA
<i>calcipotriene-betameth diprop suspension 0.005-0.064 % external</i>	Non Preferred	PA
<i>calcitriol ointment 3 mcg/gm external</i>	Non Preferred	PA; AGE (Max 18 Years)
DUOBRII LOTION 0.01-0.045 % EXTERNAL (<i>halobetasol prop-tazarotene</i>)	Non Preferred	PA
ENSTILAR FOAM 0.005-0.064 % EXTERNAL (<i>calcipotriene-betameth diprop</i>)	Non Preferred	PA; AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
SORILUX FOAM 0.005 % EXTERNAL (<i>calcipotriene</i>)	Non Preferred	PA
TACLONEX OINTMENT 0.005-0.064 % EXTERNAL (<i>calcipotriene-betameth diprop</i>)	Non Preferred	PA
TACLONEX SUSPENSION 0.005-0.064 % EXTERNAL (<i>calcipotriene-betameth diprop</i>)	Non Preferred	PA
VTAMA CREAM 1 % EXTERNAL (<i>tapinarof</i>)	Non Preferred	PA; AGE (Min 18 Years)
ZORYVE CREAM 0.3 % EXTERNAL (<i>roflumilast</i>)	Non Preferred	PA; AGE (Min 12 Years)
PULMONARY ARTERIAL HYPERTENSION [OPEN CLASS]		
ADCIRCA TABLET 20 MG ORAL (<i>tadalafil (pah)</i>)	Non Preferred	PA; AGE (Min 18 Years)
ADEMPAS TABLET 0.5 MG ORAL (<i>riociguat</i>)	Non Preferred	PA
ADEMPAS TABLET 1 MG ORAL (<i>riociguat</i>)	Non Preferred	PA
ADEMPAS TABLET 1.5 MG ORAL (<i>riociguat</i>)	Non Preferred	PA
ADEMPAS TABLET 2 MG ORAL (<i>riociguat</i>)	Non Preferred	PA
ADEMPAS TABLET 2.5 MG ORAL (<i>riociguat</i>)	Non Preferred	PA
<i>tadalafil (pah)</i> (Alyq Tablet 20 Mg Oral)	Preferred	PA; AGE (Min 18 Years)
<i>ambrisentan tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>ambrisentan tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>bosentan tablet 125 mg oral</i>	Preferred	QL (2 EA per 1 day)
<i>bosentan tablet 62.5 mg oral</i>	Preferred	QL (2 EA per 1 day)
LETAIRIS TABLET 10 MG ORAL (<i>ambrisentan</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LETAIRIS TABLET 5 MG ORAL (<i>ambrisentan</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LIQREV SUSPENSION 10 MG/ML ORAL (<i>sildenafil citrate</i>)	Non Preferred	PA; AGE (Min 18 Years)
OPSUMIT TABLET 10 MG ORAL (<i>macitentan</i>)	Non Preferred	PA
ORENITRAM MONTH 1 TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ORAL (<i>treprostinil diolamine</i>)	Non Preferred	PA
ORENITRAM MONTH 2 TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG ORAL (<i>treprostinil diolamine</i>)	Non Preferred	PA
ORENITRAM MONTH 3 TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG ORAL (<i>treprostinil diolamine</i>)	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 0.125 MG ORAL (<i>treprostinil diolamine</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
ORENITRAM TABLET EXTENDED RELEASE 0.25 MG ORAL (<i>treprostinil diolamine</i>)	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 1 MG ORAL (<i>treprostinil diolamine</i>)	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 2.5 MG ORAL (<i>treprostinil diolamine</i>)	Non Preferred	PA
ORENITRAM TABLET EXTENDED RELEASE 5 MG ORAL (<i>treprostinil diolamine</i>)	Non Preferred	PA
REVATIO SUSPENSION RECONSTITUTED 10 MG/ML ORAL (<i>sildenafil citrate</i>)	Non Preferred	PA; AGE (Min 18 Years)
REVATIO TABLET 20 MG ORAL (<i>sildenafil citrate</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>sildenafil citrate suspension reconstituted 10 mg/ml oral</i>	Preferred	PA; AGE (Min 18 Years)
<i>sildenafil citrate tablet 20 mg oral</i>	Preferred	PA; AGE (Min 18 Years)
<i>tadalafil (pah) tablet 20 mg oral</i>	Preferred	PA; AGE (Min 18 Years)
TADLIQ SUSPENSION 20 MG/5ML ORAL (<i>tadalafil (pah)</i>)	Non Preferred	PA; AGE (Min 18 Years)
TRACLEER TABLET 125 MG ORAL (<i>bosentan</i>)	Preferred	QL (2 EA per 1 day)
TRACLEER TABLET 62.5 MG ORAL (<i>bosentan</i>)	Preferred	QL (2 EA per 1 day)
TRACLEER TABLET SOLUBLE 32 MG ORAL (<i>bosentan</i>)	Non Preferred	PA
TYVASO DPI MAINTENANCE KIT POWDER 16 MCG INHALATION (<i>treprostinil</i>)	Non Preferred	PA
TYVASO DPI MAINTENANCE KIT POWDER 32 MCG INHALATION (<i>treprostinil</i>)	Non Preferred	PA
TYVASO DPI MAINTENANCE KIT POWDER 48 MCG INHALATION (<i>treprostinil</i>)	Non Preferred	PA
TYVASO DPI MAINTENANCE KIT POWDER 64 MCG INHALATION (<i>treprostinil</i>)	Non Preferred	PA
TYVASO DPI TITRATION KIT POWDER 112 X 16MCG & 84 X 32MCG INHALATION (<i>treprostinil</i>)	Non Preferred	PA
TYVASO DPI TITRATION KIT POWDER 16 & 32 & 48 MCG INHALATION (<i>treprostinil</i>)	Non Preferred	PA
TYVASO REFILL SOLUTION 0.6 MG/ML INHALATION (<i>treprostinil</i>)	Non Preferred	PA
TYVASO SOLUTION 0.6 MG/ML INHALATION (<i>treprostinil</i>)	Non Preferred	PA
TYVASO STARTER SOLUTION 0.6 MG/ML INHALATION (<i>treprostinil</i>)	Non Preferred	PA
UPTRAVI TABLET 1000 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA
UPTRAVI TABLET 1200 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA
UPTRAVI TABLET 1400 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
UPTRAVI TABLET 1600 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA
UPTRAVI TABLET 200 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA
UPTRAVI TABLET 400 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA
UPTRAVI TABLET 600 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA
UPTRAVI TABLET 800 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA
UPTRAVI TABLET THERAPY PACK 200 & 800 MCG ORAL (<i>selexipag</i>)	Non Preferred	PA
VENTAVIS SOLUTION 10 MCG/ML INHALATION (<i>iloprost</i>)	Preferred	
VENTAVIS SOLUTION 20 MCG/ML INHALATION (<i>iloprost</i>)	Preferred	
QUINOLONES, ORAL [OPEN CLASS]		
BAXDELA TABLET 450 MG ORAL (<i>delafloxacin meglumine</i>)	Non Preferred	PA
CIPRO SUSPENSION RECONSTITUTED 250 MG/5ML (5%) ORAL (<i>ciprofloxacin</i>)	Non Preferred	PA
CIPRO SUSPENSION RECONSTITUTED 500 MG/5ML (10%) ORAL (<i>ciprofloxacin</i>)	Non Preferred	PA
CIPRO TABLET 250 MG ORAL (<i>ciprofloxacin hcl</i>)	Non Preferred	PA
CIPRO TABLET 500 MG ORAL (<i>ciprofloxacin hcl</i>)	Non Preferred	PA
<i>ciprofloxacin hcl tablet 100 mg oral</i>	Preferred	
<i>ciprofloxacin hcl tablet 250 mg oral</i>	Preferred	
<i>ciprofloxacin hcl tablet 500 mg oral</i>	Preferred	
<i>ciprofloxacin hcl tablet 750 mg oral</i>	Preferred	
<i>levofloxacin solution 25 mg/ml oral</i>	Non Preferred	PA
<i>levofloxacin tablet 250 mg oral</i>	Preferred	
<i>levofloxacin tablet 500 mg oral</i>	Preferred	
<i>levofloxacin tablet 750 mg oral</i>	Preferred	
<i>moxifloxacin hcl tablet 400 mg oral</i>	Non Preferred	PA
<i>ofloxacin tablet 300 mg oral</i>	Non Preferred	PA
<i>ofloxacin tablet 400 mg oral</i>	Non Preferred	PA
ROSACEA AGENTS, TOPICAL [OPEN CLASS]		
<i>azelaic acid gel 15 % external</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>brimonidine tartrate gel 0.33 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
FINACEA FOAM 15 % EXTERNAL (<i>azelaic acid</i>)	Non Preferred	PA; AGE (Min 18 Years)
FINACEA GEL 15 % EXTERNAL (<i>azelaic acid</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>ivermectin cream 1 % external</i>	Preferred	
<i>metronidazole cream 0.75 % external</i>	Preferred	
<i>metronidazole gel 0.75 % external</i>	Preferred	PA
<i>metronidazole gel 1 % external</i>	Non Preferred	PA
<i>metronidazole gel 1 % external</i>	Preferred	
<i>metronidazole lotion 0.75 % external</i>	Preferred	
NORITATE CREAM 1 % EXTERNAL (<i>metronidazole</i>)	Non Preferred	PA
RHOFADE CREAM 1 % EXTERNAL (<i>oxymetazoline hcl</i>)	Non Preferred	PA
ZILXI FOAM 1.5 % EXTERNAL (<i>minocycline hcl micronized</i>)	Non Preferred	PA; AGE (Min 18 Years)
SECOND GENERATION ANTIHISTAMINES AND COMBINATIONS [OPEN CLASS]		
<i>12hr allergy & congestion tablet extended release 12 hour 60-120 mg oral</i>	Preferred	
<i>12hr allergy relief tablet 60 mg oral</i>	Non Preferred	PA
<i>24hr allergy relief tablet 180 mg oral</i>	Non Preferred	PA
<i>all day allergy childrens solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>all day allergy tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>all day allergy-d tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>allergy 24-hr tablet 180 mg oral</i>	Non Preferred	PA
<i>allergy childrens solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>allergy childrens suspension 30 mg/5ml oral</i>	Non Preferred	PA
<i>allergy rel child (loratadine) solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>allergy relief (cetirizine) capsule 10 mg oral</i>	Non Preferred	PA
<i>allergy relief (loratadine) tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>allergy relief cetirizine tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>allergy relief cetirizine tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>allergy relief childrens solution 1 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>allergy relief d tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>allergy relief d-12 tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>allergy relief d-24 tablet extended release 24 hour 10-240 mg oral</i>	Non Preferred	PA
<i>allergy relief tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>allergy relief tablet 180 mg oral</i>	Non Preferred	PA
<i>allergy relief tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>allergy relief/indoor/outdoor tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>allergy relief/nasal decongest tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>allergy relief/nasal decongest tablet extended release 24 hour 10-240 mg oral</i>	Non Preferred	PA
<i>allergy/congestion relief tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>antihistamine & nasal deconges tablet extended release 12 hour 60-120 mg oral</i>	Preferred	
<i>cetirizine hcl allergy child solution 5 mg/5ml oral (otc)</i>	Preferred	Max 90-day supply per fill
<i>cetirizine hcl childrens alrgy solution 1 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>cetirizine hcl childrens solution 5 mg/5ml oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>cetirizine hcl solution 1 mg/ml oral (rx)</i>	Preferred	Max 90-day supply per fill
<i>cetirizine hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>cetirizine hcl tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>cetirizine hcl tablet chewable 10 mg oral</i>	Non Preferred	PA
<i>cetirizine hcl tablet chewable 5 mg oral</i>	Non Preferred	PA
<i>cetirizine-pseudoephedrine er tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>childrens loratadine solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
CLARINEX TABLET 5 MG ORAL (<i>desloratadine</i>)	Non Preferred	PA
CLARINEX-D 12 HOUR TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG ORAL (<i>desloratadine-pseudoephedrine</i>)	Non Preferred	PA
<i>desloratadine tablet 5 mg oral</i>	Non Preferred	PA
<i>desloratadine tablet dispersible 2.5 mg oral</i>	Non Preferred	PA
<i>desloratadine tablet dispersible 5 mg oral</i>	Non Preferred	PA
<i>fexofenadine hcl tablet 180 mg oral (otc)</i>	Non Preferred	PA

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>fexofenadine hcl tablet 60 mg oral (otc)</i>	Non Preferred	PA
<i>fexofenadine-pseudoephed er tablet extended release 12 hour 60-120 mg oral (otc)</i>	Preferred	
<i>ft all day allergy 24 hour tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>ft allergy & congestion-d 12hr tablet extended release 12 hour 60-120 mg oral</i>	Preferred	
<i>ft allergy relief 12 hour tablet 60 mg oral</i>	Non Preferred	PA
<i>ft allergy relief 24 hour tablet 180 mg oral</i>	Non Preferred	PA
<i>gnp all day allergy childrens solution 1 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>gnp all day allergy childrens solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>gnp all day allergy relief capsule 10 mg oral</i>	Non Preferred	PA
<i>gnp all day allergy tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp all day allergy-d tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>gnp allergy & congestion tablet extended release 24 hour 10-240 mg oral</i>	Non Preferred	PA
<i>gnp allergy relief 24 hr tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp allergy relief tablet 180 mg oral</i>	Non Preferred	PA
<i>gnp allergy/congestion relief tablet extended release 24 hour 10-240 mg oral</i>	Non Preferred	PA
<i>gnp fexofenadine/pse er tablet extended release 12 hour 60-120 mg oral</i>	Preferred	
<i>gnp loratadine childrens solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>gnp loratadine solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>gnp loratadine tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp loratadine tablet dispersible 10 mg oral</i>	Preferred	
<i>goodsense all day allergy solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>goodsense all day allergy tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>goodsense all day allergy-d tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>goodsense aller-ease tablet 180 mg oral</i>	Non Preferred	PA
<i>goodsense allergy relief tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>hm all day allergy childrens solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>hm allergy relief (cetirizine) tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>hm allergy relief tablet 180 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>hm allergy relief tablet 60 mg oral</i>	Non Preferred	PA
<i>hm allergy relief/nasal decong tablet extended release 24 hour 10-240 mg oral</i>	Non Preferred	PA
<i>hm cetirizine hcl tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>hm loratadine childrens solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>hm loratadine tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>levocetirizine dihydrochloride solution 2.5 mg/5ml oral</i>	Non Preferred	PA
<i>levocetirizine dihydrochloride tablet 5 mg oral (rx)</i>	Preferred	Max 90-day supply per fill
<i>loratadine childrens solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>loratadine childrens tablet chewable 5 mg oral</i>	Non Preferred	PA; AGE (Min 2 Years)
<i>loratadine solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>loratadine tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>loratadine tablet dispersible 10 mg oral</i>	Preferred	
<i>loratadine-d 12hr tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>loratadine-d 24hr tablet extended release 24 hour 10-240 mg oral</i>	Non Preferred	PA
<i>promethazine hcl syrup 6.25 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>qc loratadine allergy relief tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sm all day allergy childrens solution 1 mg/ml oral</i>	Preferred	Max 90-day supply per fill
<i>sm all day allergy childrens solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>sm all day allergy relief tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sm all day allergy tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sm all day allergy-d tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>sm allergy childrens solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>sm allergy relief tablet 60 mg oral</i>	Non Preferred	PA
<i>sm fexofenadine hcl tablet 180 mg oral</i>	Non Preferred	PA
<i>sm loratadine d 12hr tablet extended release 12 hour 5-120 mg oral</i>	Non Preferred	PA
<i>sm lorata-dine d tablet extended release 24 hour 10-240 mg oral</i>	Non Preferred	PA
<i>sm loratadine solution 5 mg/5ml oral</i>	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
<i>sm loratadine tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
SEDATIVES, HYPNOTICS [OPEN CLASS]		
AMBIEN CR TABLET EXTENDED RELEASE 12.5 MG ORAL (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN CR TABLET EXTENDED RELEASE 6.25 MG ORAL (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN TABLET 10 MG ORAL (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN TABLET 5 MG ORAL (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA TABLET 10 MG ORAL (<i>suvorexant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA TABLET 15 MG ORAL (<i>suvorexant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA TABLET 20 MG ORAL (<i>suvorexant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA TABLET 5 MG ORAL (<i>suvorexant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DAYVIGO TABLET 10 MG ORAL (<i>lemborexant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DAYVIGO TABLET 5 MG ORAL (<i>lemborexant</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DORAL TABLET 15 MG ORAL (<i>quazepam</i>)	Non Preferred	PA
<i>doxepin hcl tablet 3 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>doxepin hcl tablet 6 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
EDLUAR TABLET SUBLINGUAL 10 MG SUBLINGUAL (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
EDLUAR TABLET SUBLINGUAL 5 MG SUBLINGUAL (<i>zolpidem tartrate</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>estazolam tablet 1 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>estazolam tablet 2 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>eszopiclone tablet 1 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>eszopiclone tablet 2 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>eszopiclone tablet 3 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
HALCION TABLET 0.25 MG ORAL (<i>triazolam</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
HETLIOZ CAPSULE 20 MG ORAL (<i>tasimelteon</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 16 Years)

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Drug Name	Formulary Status	Requirements/Limits
HETLIOZ LQ SUSPENSION 4 MG/ML ORAL (<i>tasimelteon</i>)	Non Preferred	PA; QL (5 ML per 1 day); AGE (Min 3 Years and Max 15 Years)
LUNESTA TABLET 1 MG ORAL (<i>eszopiclone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LUNESTA TABLET 2 MG ORAL (<i>eszopiclone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LUNESTA TABLET 3 MG ORAL (<i>eszopiclone</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>quazepam tablet 15 mg oral</i>	Non Preferred	PA
QUVIVIQ TABLET 25 MG ORAL (<i>daridorexant hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QUVIVIQ TABLET 50 MG ORAL (<i>daridorexant hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>ramelteon tablet 8 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
RESTORIL CAPSULE 15 MG ORAL (<i>temazepam</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
RESTORIL CAPSULE 22.5 MG ORAL (<i>temazepam</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
RESTORIL CAPSULE 30 MG ORAL (<i>temazepam</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
RESTORIL CAPSULE 7.5 MG ORAL (<i>temazepam</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
ROZEREM TABLET 8 MG ORAL (<i>ramelteon</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SILENOR TABLET 3 MG ORAL (<i>doxepin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
SILENOR TABLET 6 MG ORAL (<i>doxepin hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>tasimelteon capsule 20 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 16 Years)
<i>temazepam capsule 15 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>temazepam capsule 22.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>temazepam capsule 30 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>temazepam capsule 7.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>triazolam tablet 0.125 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>triazolam tablet 0.25 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>zaleplon capsule 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zaleplon capsule 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate capsule 7.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate er tablet extended release 12.5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate er tablet extended release 6.25 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate tablet 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate tablet 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate tablet sublingual 1.75 mg sublingual</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>zolpidem tartrate tablet sublingual 3.5 mg sublingual</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SICKLE CELL ANEMIA TREATMENTS [CLOSED CLASS]		
ADAKVEO SOLUTION 100 MG/10ML INTRAVENOUS (<i>crizanlizumab-tmca</i>)	Non Preferred	PA; AGE (Min 16 Years)
DROXIA CAPSULE 200 MG ORAL (<i>hydroxyurea</i>)	Preferred	AGE (Min 18 Years)
DROXIA CAPSULE 300 MG ORAL (<i>hydroxyurea</i>)	Preferred	AGE (Min 18 Years)
DROXIA CAPSULE 400 MG ORAL (<i>hydroxyurea</i>)	Preferred	AGE (Min 18 Years)
ENDARI PACKET 5 GM ORAL (<i>glutamine (sickle cell)</i>)	Preferred	AGE (Min 5 Years)
OXBRYTA TABLET 300 MG ORAL (<i>voxelotor</i>)	Preferred	PA; AGE (Min 12 Years)
OXBRYTA TABLET 500 MG ORAL (<i>voxelotor</i>)	Preferred	AGE (Min 4 Years)
OXBRYTA TABLET SOLUBLE 300 MG ORAL (<i>voxelotor</i>)	Preferred	AGE (Min 4 Years)
SIKLOS TABLET 100 MG ORAL (<i>hydroxyurea</i>)	Non Preferred	PA; AGE (Min 2 Years)
SIKLOS TABLET 1000 MG ORAL (<i>hydroxyurea</i>)	Non Preferred	PA; AGE (Min 2 Years)
SKELETAL MUSCLE RELAXANTS [OPEN CLASS]		
AMRIX CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL (<i>cyclobenzaprine hcl</i>)	Non Preferred	PA
AMRIX CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL (<i>cyclobenzaprine hcl</i>)	Non Preferred	PA
<i>baclofen solution 5 mg/5ml oral</i>	Preferred	
<i>baclofen suspension 25 mg/5ml oral</i>	Non Preferred	PA
<i>baclofen tablet 10 mg oral</i>	Preferred	
<i>baclofen tablet 20 mg oral</i>	Preferred	
<i>baclofen tablet 5 mg oral</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>carisoprodol tablet 250 mg oral</i>	Non Preferred	PA; QL (4 EA per 1 day)
<i>carisoprodol tablet 350 mg oral</i>	Preferred	QL (4 EA per 1 day)
<i>chlorzoxazone tablet 250 mg oral</i>	Preferred	
<i>chlorzoxazone tablet 375 mg oral</i>	Preferred	
<i>chlorzoxazone tablet 500 mg oral</i>	Preferred	
<i>chlorzoxazone tablet 750 mg oral</i>	Preferred	
<i>cyclobenzaprine hcl er capsule extended release 24 hour 15 mg oral</i>	Non Preferred	PA
<i>cyclobenzaprine hcl er capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA
<i>cyclobenzaprine hcl tablet 10 mg oral</i>	Preferred	
<i>cyclobenzaprine hcl tablet 5 mg oral</i>	Preferred	
<i>cyclobenzaprine hcl tablet 7.5 mg oral</i>	Preferred	
DANTRIUM CAPSULE 25 MG ORAL (<i>dantrolene sodium</i>)	Non Preferred	PA
<i>dantrolene sodium capsule 100 mg oral</i>	Preferred	
<i>dantrolene sodium capsule 25 mg oral</i>	Preferred	
<i>dantrolene sodium capsule 50 mg oral</i>	Preferred	
<i>cyclobenzaprine hcl</i> (Fexmid Tablet 7.5 Mg Oral)	Non Preferred	PA
FLEQSUVY SUSPENSION 25 MG/5ML ORAL (<i>baclofen</i>)	Non Preferred	PA
<i>chlorzoxazone</i> (Lorzone Tablet 375 Mg Oral)	Non Preferred	PA
<i>chlorzoxazone</i> (Lorzone Tablet 750 Mg Oral)	Non Preferred	PA
LYVISPAH PACKET 10 MG ORAL (<i>baclofen</i>)	Non Preferred	PA
LYVISPAH PACKET 20 MG ORAL (<i>baclofen</i>)	Non Preferred	PA
LYVISPAH PACKET 5 MG ORAL (<i>baclofen</i>)	Non Preferred	PA
<i>metaxalone tablet 400 mg oral</i>	Non Preferred	PA
<i>metaxalone tablet 800 mg oral</i>	Non Preferred	PA
<i>methocarbamol tablet 500 mg oral</i>	Preferred	
<i>methocarbamol tablet 750 mg oral</i>	Preferred	
<i>norgesic forte tablet 50-770-60 mg oral</i>	Non Preferred	PA
<i>orphenadrine-aspirin-caffeine</i> (Norgesic Tablet 25-385-30 Mg Oral)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>orphenadrine citrate er tablet extended release 12 hour 100 mg oral</i>	Preferred	
<i>orphenadrine-aspirin-caffeine (Orphengesic Forte Tablet 50-770-60 Mg Oral)</i>	Non Preferred	PA
SOMA TABLET 250 MG ORAL (<i>carisoprodol</i>)	Non Preferred	PA; QL (4 EA per 1 day)
SOMA TABLET 350 MG ORAL (<i>carisoprodol</i>)	Non Preferred	PA; QL (4 EA per 1 day)
<i>tizanidine hcl capsule 2 mg oral</i>	Non Preferred	PA
<i>tizanidine hcl capsule 4 mg oral</i>	Non Preferred	PA
<i>tizanidine hcl capsule 6 mg oral</i>	Non Preferred	PA
<i>tizanidine hcl tablet 2 mg oral</i>	Preferred	
<i>tizanidine hcl tablet 4 mg oral</i>	Preferred	
ZANAFLEX CAPSULE 2 MG ORAL (<i>tizanidine hcl</i>)	Non Preferred	PA
ZANAFLEX CAPSULE 4 MG ORAL (<i>tizanidine hcl</i>)	Non Preferred	PA
ZANAFLEX CAPSULE 6 MG ORAL (<i>tizanidine hcl</i>)	Non Preferred	PA
ZANAFLEX TABLET 4 MG ORAL (<i>tizanidine hcl</i>)	Non Preferred	PA
SMOKING CESSATION [OPEN CLASS]		
<i>bupropion hcl er (smoking det) tablet extended release 12 hour 150 mg oral</i>	Preferred	Max 90-day supply per fill
<i>gnp nicotine gum 4 mg mouth/throat</i>	Preferred	
<i>gnp nicotine mini lozenge 2 mg mouth/throat</i>	Preferred	
<i>gnp nicotine mini lozenge 4 mg mouth/throat</i>	Preferred	
<i>gnp nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	
<i>gnp nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	
<i>gnp nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	
<i>gnp nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	
<i>gnp nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	
<i>gnp nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	
<i>gnp nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	
<i>goodsense nicotine gum 2 mg mouth/throat</i>	Preferred	
<i>goodsense nicotine gum 4 mg mouth/throat</i>	Preferred	
<i>goodsense nicotine lozenge 2 mg mouth/throat</i>	Preferred	
<i>goodsense nicotine lozenge 4 mg mouth/throat</i>	Preferred	
<i>hm nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	
<i>hm nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>hm nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	
<i>hm nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	
<i>hm nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	
<i>nicotine kit 21-14-7 mg/24hr transdermal</i>	Preferred	
<i>nicotine mini lozenge 2 mg mouth/throat</i>	Preferred	
<i>nicotine mini lozenge 4 mg mouth/throat</i>	Preferred	
<i>nicotine patch 24 hour 14 mg/24hr transdermal (otc)</i>	Preferred	
<i>nicotine patch 24 hour 21 mg/24hr transdermal (otc)</i>	Preferred	
<i>nicotine patch 24 hour 7 mg/24hr transdermal (otc)</i>	Preferred	
<i>nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	
<i>nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	
<i>nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	
<i>nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	
<i>nicotine polacrilex mini lozenge 2 mg mouth/throat</i>	Preferred	
<i>nicotine step 1 patch 24 hour 21 mg/24hr transdermal</i>	Preferred	
<i>nicotine step 2 patch 24 hour 14 mg/24hr transdermal</i>	Preferred	
<i>nicotine step 3 patch 24 hour 7 mg/24hr transdermal</i>	Preferred	
NICOTROL INHALER 10 MG INHALATION (<i>nicotine</i>)	Non Preferred	PA
NICOTROL NS SOLUTION 10 MG/ML NASAL (<i>nicotine</i>)	Non Preferred	PA
<i>sm nicotine gum 4 mg mouth/throat</i>	Preferred	
<i>sm nicotine lozenge 2 mg mouth/throat</i>	Preferred	
<i>sm nicotine patch 24 hour 14 mg/24hr transdermal</i>	Preferred	
<i>sm nicotine patch 24 hour 21 mg/24hr transdermal</i>	Preferred	
<i>sm nicotine patch 24 hour 7 mg/24hr transdermal</i>	Preferred	
<i>sm nicotine polacrilex gum 2 mg mouth/throat</i>	Preferred	
<i>sm nicotine polacrilex gum 4 mg mouth/throat</i>	Preferred	
<i>sm nicotine polacrilex lozenge 2 mg mouth/throat</i>	Preferred	
<i>sm nicotine polacrilex lozenge 4 mg mouth/throat</i>	Preferred	
<i>varenicline tartrate (starter) tablet therapy pack 0.5 mg x 11 & 1 mg x 42 oral</i>	Preferred	
<i>varenicline tartrate tablet 0.5 mg oral</i>	Preferred	
<i>varenicline tartrate tablet 1 mg oral</i>	Preferred	
STEROIDS, TOPICAL: HIGH POTENCY [OPEN CLASS]		
<i>betamethasone dipropionate aug cream 0.05 % external</i>	Preferred	
<i>betamethasone dipropionate aug gel 0.05 % external</i>	Non Preferred	PA
<i>betamethasone dipropionate aug lotion 0.05 % external</i>	Non Preferred	PA
<i>betamethasone dipropionate aug ointment 0.05 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>betamethasone dipropionate cream 0.05 % external</i>	Non Preferred	PA
<i>betamethasone dipropionate lotion 0.05 % external</i>	Non Preferred	PA
<i>betamethasone dipropionate ointment 0.05 % external</i>	Non Preferred	PA
<i>betamethasone valerate cream 0.1 % external</i>	Preferred	
<i>betamethasone valerate lotion 0.1 % external</i>	Preferred	
<i>betamethasone valerate ointment 0.1 % external</i>	Preferred	
<i>clobetasol propionate solution 0.05 % external</i>	Preferred	
<i>desoximetasone cream 0.05 % external</i>	Non Preferred	PA
<i>desoximetasone cream 0.25 % external</i>	Non Preferred	PA
<i>desoximetasone gel 0.05 % external</i>	Non Preferred	PA
<i>desoximetasone liquid 0.25 % external</i>	Non Preferred	PA
<i>desoximetasone ointment 0.05 % external</i>	Non Preferred	PA
<i>desoximetasone ointment 0.25 % external</i>	Non Preferred	PA
<i>diflorasone diacetate cream 0.05 % external</i>	Non Preferred	PA
<i>diflorasone diacetate ointment 0.05 % external</i>	Non Preferred	PA
DIPROLENE OINTMENT 0.05 % EXTERNAL (<i>betamethasone dipropionate aug</i>)	Non Preferred	PA
<i>fluocinonide cream 0.05 % external</i>	Non Preferred	PA
<i>fluocinonide cream 0.1 % external</i>	Non Preferred	PA
<i>fluocinonide emulsified base cream 0.05 % external</i>	Non Preferred	PA
<i>fluocinonide gel 0.05 % external</i>	Non Preferred	PA
<i>fluocinonide ointment 0.05 % external</i>	Non Preferred	PA
<i>fluocinonide solution 0.05 % external</i>	Non Preferred	PA
<i>halcinonide cream 0.1 % external</i>	Non Preferred	PA
HALOG CREAM 0.1 % EXTERNAL (<i>halcinonide</i>)	Non Preferred	PA
HALOG OINTMENT 0.1 % EXTERNAL (<i>halcinonide</i>)	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
HALOG SOLUTION 0.1 % EXTERNAL (<i>halcinonide</i>)	Non Preferred	PA
KENALOG AEROSOL SOLUTION 0.147 MG/GM EXTERNAL (<i>triamcinolone acetonide</i>)	Non Preferred	PA
TOPICORT CREAM 0.05 % EXTERNAL (<i>desoximetasone</i>)	Non Preferred	PA
TOPICORT CREAM 0.25 % EXTERNAL (<i>desoximetasone</i>)	Non Preferred	PA
TOPICORT GEL 0.05 % EXTERNAL (<i>desoximetasone</i>)	Non Preferred	PA
TOPICORT OINTMENT 0.05 % EXTERNAL (<i>desoximetasone</i>)	Non Preferred	PA
TOPICORT OINTMENT 0.25 % EXTERNAL (<i>desoximetasone</i>)	Non Preferred	PA
TOPICORT SPRAY LIQUID 0.25 % EXTERNAL (<i>desoximetasone</i>)	Non Preferred	PA
<i>triamcinolone acetonide aerosol solution 0.147 mg/gm external</i>	Non Preferred	PA
<i>triamcinolone acetonide cream 0.025 % external</i>	Preferred	
<i>triamcinolone acetonide cream 0.1 % external</i>	Preferred	
<i>triamcinolone acetonide cream 0.5 % external</i>	Preferred	
<i>triamcinolone acetonide lotion 0.025 % external</i>	Preferred	
<i>triamcinolone acetonide lotion 0.1 % external</i>	Preferred	
<i>triamcinolone acetonide ointment 0.025 % external</i>	Preferred	
<i>triamcinolone acetonide ointment 0.05 % external</i>	Preferred	
<i>triamcinolone acetonide ointment 0.1 % external</i>	Preferred	
<i>triamcinolone acetonide ointment 0.5 % external</i>	Preferred	
<i>triamcinolone in absorbbase ointment 0.05 % external</i>	Preferred	
VANOS CREAM 0.1 % EXTERNAL (<i>fluocinonide</i>)	Non Preferred	PA
STERIODS, TOPICAL: LOW POTENCY [OPEN CLASS]		
<i>alclometasone dipropionate cream 0.05 % external</i>	Non Preferred	PA
<i>alclometasone dipropionate ointment 0.05 % external</i>	Non Preferred	PA
<i>anti-itch maximum strength cream 1 % external</i>	Preferred	
ANUSOL-HC CREAM 2.5 % EXTERNAL (<i>hydrocortisone</i>)	Non Preferred	PA
DERMA-SMOOTH/FS BODY OIL 0.01 % EXTERNAL (<i>fluocinolone acetonide</i>)	Non Preferred	PA
DERMA-SMOOTH/FS SCALP OIL 0.01 % EXTERNAL (<i>fluocinolone acetonide</i>)	Non Preferred	PA
<i>desonide cream 0.05 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>desonide lotion 0.05 % external</i>	Non Preferred	PA
<i>desonide ointment 0.05 % external</i>	Non Preferred	PA
<i>fluocinolone acetonide body oil 0.01 % external</i>	Non Preferred	PA
<i>fluocinolone acetonide scalp oil 0.01 % external</i>	Non Preferred	PA
<i>gnp hydrocortisone cream 0.5 % external</i>	Preferred	
<i>gnp hydrocortisone max st ointment 1 % external</i>	Preferred	
<i>gnp hydrocortisone plus cream 1 % external</i>	Preferred	
<i>gnp hydrocortisone/aloe cream 1 % external</i>	Preferred	
<i>hm hydrocortisone plus cream 1 % external</i>	Preferred	
<i>hm hydrocortisone-aloe max st cream 1 % external</i>	Preferred	
<i>hydrocortisone (perianal) cream 2.5 % external</i>	Preferred	
<i>hydrocortisone acetate cream 1 % external</i>	Preferred	
<i>hydrocortisone acetate ointment 1 % external</i>	Preferred	
<i>hydrocortisone cream 0.5 % external</i>	Preferred	
<i>hydrocortisone cream 1 % external (otc)</i>	Preferred	
<i>hydrocortisone cream 1 % external (rx)</i>	Preferred	
<i>hydrocortisone cream 2.5 % external</i>	Preferred	
<i>hydrocortisone lotion 2.5 % external</i>	Preferred	
<i>hydrocortisone max st cream 1 % external</i>	Preferred	
<i>hydrocortisone max st ointment 1 % external</i>	Preferred	
<i>hydrocortisone max st/12 moist cream 1 % external</i>	Preferred	
<i>hydrocortisone ointment 1 % external (otc)</i>	Preferred	
<i>hydrocortisone ointment 1 % external (rx)</i>	Preferred	
<i>hydrocortisone ointment 2.5 % external</i>	Preferred	
<i>hydrocortisone/aloe max str cream 1 % external</i>	Preferred	
PROCTOCORT CREAM 1 % EXTERNAL (<i>hydrocortisone</i>)	Preferred	
<i>hydrocortisone (Procto-Med Hc Cream 2.5 % External)</i>	Preferred	
<i>hydrocortisone (Proctosol Hc Cream 2.5 % External)</i>	Preferred	
<i>hydrocortisone (Proctozone-Hc Cream 2.5 % External)</i>	Preferred	
<i>qc anti-itch aloe cream 1 % external</i>	Preferred	
<i>sm hydrocortisone cream 1 % external</i>	Preferred	
<i>sm hydrocortisone max st ointment 1 % external</i>	Preferred	
<i>sm hydrocortisone plus cream 1 % external</i>	Preferred	
TEXACORT SOLUTION 2.5 % EXTERNAL (<i>hydrocortisone</i>)	Non Preferred	PA
STERIODS, TOPICAL: MEDIUM POTENCY [OPEN CLASS]		
<i>betamethasone valerate foam 0.12 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>clocortolone pivalate cream 0.1 % external</i>	Non Preferred	PA
CLODERM CREAM 0.1 % EXTERNAL (<i>clocortolone pivalate</i>)	Non Preferred	PA
<i>fluocinolone acetonide cream 0.01 % external</i>	Non Preferred	PA
<i>fluocinolone acetonide cream 0.025 % external</i>	Non Preferred	PA
<i>fluocinolone acetonide ointment 0.025 % external</i>	Non Preferred	PA
<i>fluocinolone acetonide solution 0.01 % external</i>	Non Preferred	PA
<i>flurandrenolide cream 0.05 % external</i>	Non Preferred	PA
<i>flurandrenolide lotion 0.05 % external</i>	Non Preferred	PA
<i>fluticasone propionate cream 0.05 % external</i>	Preferred	
<i>fluticasone propionate lotion 0.05 % external</i>	Non Preferred	PA
<i>fluticasone propionate ointment 0.005 % external</i>	Preferred	
<i>hydrocortisone butyr lipo base cream 0.1 % external</i>	Non Preferred	PA
<i>hydrocortisone butyrate cream 0.1 % external</i>	Non Preferred	PA
<i>hydrocortisone butyrate lotion 0.1 % external</i>	Non Preferred	PA
<i>hydrocortisone butyrate ointment 0.1 % external</i>	Non Preferred	PA
<i>hydrocortisone butyrate solution 0.1 % external</i>	Non Preferred	PA
<i>hydrocortisone valerate cream 0.2 % external</i>	Non Preferred	PA
<i>hydrocortisone valerate ointment 0.2 % external</i>	Non Preferred	PA
LOCOID LIPOCREAM CREAM 0.1 % EXTERNAL (<i>hydrocortisone butyr lipo base</i>)	Non Preferred	PA
LOCOID LOTION 0.1 % EXTERNAL (<i>hydrocortisone butyrate</i>)	Non Preferred	PA
LUXIQ FOAM 0.12 % EXTERNAL (<i>betamethasone valerate</i>)	Non Preferred	PA
<i>mometasone furoate cream 0.1 % external</i>	Preferred	
<i>mometasone furoate ointment 0.1 % external</i>	Preferred	
<i>mometasone furoate solution 0.1 % external</i>	Preferred	
<i>triamcinolone acetonide</i> (Oralone Paste 0.1 % Mouth/Throat)	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
PANDEL CREAM 0.1 % EXTERNAL (<i>hydrocortisone probutate</i>)	Non Preferred	PA
SYNALAR (CREAM) KIT 0.025 % EXTERNAL (<i>fluocinolone-emollient</i>)	Non Preferred	PA
SYNALAR (OINTMENT) KIT 0.025 % EXTERNAL (<i>fluocinolone-emollient</i>)	Non Preferred	PA
SYNALAR CREAM 0.025 % EXTERNAL (<i>fluocinolone acetonide</i>)	Non Preferred	PA
SYNALAR OINTMENT 0.025 % EXTERNAL (<i>fluocinolone acetonide</i>)	Non Preferred	PA
SYNALAR SOLUTION 0.01 % EXTERNAL (<i>fluocinolone acetonide</i>)	Non Preferred	PA
SYNALAR TS KIT 0.01 % EXTERNAL (<i>fluocinolone & cleanser</i>)	Non Preferred	PA
<i>triamcinolone acetonide paste 0.1 % mouth/throat</i>	Non Preferred	PA
STERIODS, TOPICAL: VERY HIGH POTENCY [OPEN CLASS]		
APEXICON E CREAM 0.05 % EXTERNAL (<i>diflorasone diacet emoll base</i>)	Non Preferred	PA
BRYHALI LOTION 0.01 % EXTERNAL (<i>halobetasol propionate</i>)	Non Preferred	PA
<i>clobetasol prop emollient base cream 0.05 % external</i>	Preferred	
<i>clobetasol propionate cream 0.05 % external</i>	Preferred	
<i>clobetasol propionate e cream 0.05 % external</i>	Preferred	
<i>clobetasol propionate emulsion foam 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate foam 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate gel 0.05 % external</i>	Preferred	
<i>clobetasol propionate liquid 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate lotion 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate ointment 0.05 % external</i>	Preferred	
<i>clobetasol propionate shampoo 0.05 % external</i>	Non Preferred	PA
<i>clobetasol propionate solution 0.05 % external</i>	Preferred	
CLODAN KIT 0.05 % EXTERNAL (<i>clobetasol prop & cleanser</i>)	Non Preferred	PA
<i>clobetasol propionate (Clodan Shampoo 0.05 % External)</i>	Non Preferred	PA
<i>halobetasol propionate cream 0.05 % external</i>	Preferred	
<i>halobetasol propionate foam 0.05 % external</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>halobetasol propionate ointment 0.05 % external</i>	Non Preferred	PA
IMPEKLO LOTION 0.15 MG/ACT (0.05%) EXTERNAL (<i>clobetasol propionate</i>)	Non Preferred	PA
LEXETTE FOAM 0.05 % EXTERNAL (<i>halobetasol propionate</i>)	Non Preferred	PA
OLUX-E FOAM 0.05 % EXTERNAL (<i>clobetasol propionate emulsion</i>)	Non Preferred	PA
<i>clobetasol propionate emulsion</i> (Tovet Foam 0.05 % External)	Non Preferred	PA
TOVET KIT 0.05 % EXTERNAL (<i>clobetasol emul foam w/moistcr</i>)	Non Preferred	PA
ULTRAVATE LOTION 0.05 % EXTERNAL (<i>halobetasol propionate</i>)	Non Preferred	PA
STIMULANTS AND RELATED AGENTS [CLOSED CLASS]		
ADDERALL TABLET 10 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 12.5 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 15 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 20 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 30 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 5 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 7.5 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 15.7 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 18.8 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 3.1 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 6.3 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 9.4 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>amphetamine sulfate tablet 10 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>amphetamine sulfate tablet 5 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 15 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 25 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine capsule extended release 24 hour 5 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine tablet 10 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine tablet 12.5 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine tablet 15 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine tablet 20 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine tablet 30 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>amphetamine-dextroamphetamine tablet 5 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>amphetamine-dextroamphetamine tablet 7.5 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 50 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>armodafinil tablet 150 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>armodafinil tablet 200 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>armodafinil tablet 250 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>armodafinil tablet 50 mg oral</i>	Non Preferred	PA; AGE (Min 18 Years)
<i>atomoxetine hcl capsule 10 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atomoxetine hcl capsule 100 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atomoxetine hcl capsule 18 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atomoxetine hcl capsule 25 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atomoxetine hcl capsule 40 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atomoxetine hcl capsule 60 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>atomoxetine hcl capsule 80 mg oral</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
AZSTARYS CAPSULE 26.1-5.2 MG ORAL (<i>serdexmethylphen-dexmethylphen</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
AZSTARYS CAPSULE 39.2-7.8 MG ORAL (<i>serdexmethylphen-dexmethylphen</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
AZSTARYS CAPSULE 52.3-10.4 MG ORAL (<i>serdexmethylphen-dexmethylphen</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
<i>clonidine hcl er tablet extended release 12 hour 0.1 mg oral</i>	Preferred	Max 90-day supply per fill
CONCERTA TABLET EXTENDED RELEASE 18 MG ORAL (<i>methylphenidate hcl</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
CONCERTA TABLET EXTENDED RELEASE 27 MG ORAL (<i>methylphenidate hcl</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
CONCERTA TABLET EXTENDED RELEASE 36 MG ORAL (<i>methylphenidate hcl</i>)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
CONCERTA TABLET EXTENDED RELEASE 54 MG ORAL (<i>methylphenidate hcl</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
COTEMPLA XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG ORAL (<i>methylphenidate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
COTEMPLA XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 25.9 MG ORAL (<i>methylphenidate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
COTEMPLA XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 8.6 MG ORAL (<i>methylphenidate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DAYTRANA PATCH 10 MG/9HR TRANSDERMAL (<i>methylphenidate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DAYTRANA PATCH 15 MG/9HR TRANSDERMAL (<i>methylphenidate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DAYTRANA PATCH 20 MG/9HR TRANSDERMAL (<i>methylphenidate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DAYTRANA PATCH 30 MG/9HR TRANSDERMAL (<i>methylphenidate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DESOXYN TABLET 5 MG ORAL (<i>methamphetamine hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (<i>dextroamphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL (<i>dextroamphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 10 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 15 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>dexmethylphenidate hcl er capsule extended release 24 hour 20 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 25 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 30 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 35 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 40 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl er capsule extended release 24 hour 5 mg oral</i>	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl tablet 10 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl tablet 2.5 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>dexmethylphenidate hcl tablet 5 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 15 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate er capsule extended release 24 hour 5 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate solution 5 mg/5ml oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate tablet 10 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate tablet 15 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate tablet 20 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate tablet 30 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate tablet 5 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
DYANAVEL XR SUSPENSION EXTENDED RELEASE 2.5 MG/ML ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DYANAVEL XR TABLET CHEWABLE EXTENDED RELEASE 10 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
DYANAVEL XR TABLET CHEWABLE EXTENDED RELEASE 15 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DYANAVEL XR TABLET CHEWABLE EXTENDED RELEASE 20 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DYANAVEL XR TABLET CHEWABLE EXTENDED RELEASE 5 MG ORAL (<i>amphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO ODT TABLET DISPERSIBLE 10 MG ORAL (<i>amphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO ODT TABLET DISPERSIBLE 15 MG ORAL (<i>amphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO ODT TABLET DISPERSIBLE 20 MG ORAL (<i>amphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO ODT TABLET DISPERSIBLE 5 MG ORAL (<i>amphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO TABLET 10 MG ORAL (<i>amphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO TABLET 5 MG ORAL (<i>amphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
FOCALIN TABLET 10 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
FOCALIN TABLET 2.5 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
FOCALIN TABLET 5 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 35 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
FOCALIN XR CAPSULE EXTENDED RELEASE 24 HOUR 5 MG ORAL (<i>dexmethylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>guanfacine hcl er tablet extended release 24 hour 1 mg oral</i>	Preferred	Max 90-day supply per fill
<i>guanfacine hcl er tablet extended release 24 hour 2 mg oral</i>	Preferred	Max 90-day supply per fill
<i>guanfacine hcl er tablet extended release 24 hour 3 mg oral</i>	Preferred	Max 90-day supply per fill
<i>guanfacine hcl er tablet extended release 24 hour 4 mg oral</i>	Preferred	Max 90-day supply per fill
INTUNIV TABLET EXTENDED RELEASE 24 HOUR 1 MG ORAL (<i>guanfacine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
INTUNIV TABLET EXTENDED RELEASE 24 HOUR 2 MG ORAL (<i>guanfacine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
INTUNIV TABLET EXTENDED RELEASE 24 HOUR 3 MG ORAL (<i>guanfacine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
INTUNIV TABLET EXTENDED RELEASE 24 HOUR 4 MG ORAL (<i>guanfacine hcl</i>)	Non Preferred	PA; Max 90-day supply per fill
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
JORNAY PM CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methamphetamine hcl tablet 5 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
METHYLIN SOLUTION 10 MG/5ML ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
METHYLIN SOLUTION 5 MG/5ML ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (cd) capsule extended release 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (cd) capsule extended release 20 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (cd) capsule extended release 30 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (cd) capsule extended release 40 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (cd) capsule extended release 50 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>methylphenidate hcl er (cd) capsule extended release 60 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 40 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (la) capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) tablet extended release 18 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) tablet extended release 27 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) tablet extended release 36 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) tablet extended release 45 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) tablet extended release 54 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) tablet extended release 63 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
<i>methylphenidate hcl er (osm) tablet extended release 72 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 10 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 15 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 20 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 30 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 40 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 50 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er (xr) capsule extended release 24 hour 60 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er tablet extended release 10 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er tablet extended release 20 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er tablet extended release 24 hour 18 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er tablet extended release 24 hour 27 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er tablet extended release 24 hour 36 mg oral</i>	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl er tablet extended release 24 hour 54 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl solution 10 mg/5ml oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl solution 5 mg/5ml oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl tablet 10 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl tablet 20 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl tablet 5 mg oral</i>	Preferred	AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl tablet chewable 10 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl tablet chewable 2.5 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate hcl tablet chewable 5 mg oral</i>	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate patch 10 mg/9hr transdermal</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate patch 15 mg/9hr transdermal</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>methylphenidate patch 20 mg/9hr transdermal</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>methylphenidate patch 30 mg/9hr transdermal</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
<i>modafinil tablet 100 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
<i>modafinil tablet 200 mg oral</i>	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 37.5 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 50 MG ORAL (<i>amphetamine-dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
NUVIGIL TABLET 150 MG ORAL (<i>armodafinil</i>)	Non Preferred	PA; AGE (Min 18 Years)
NUVIGIL TABLET 200 MG ORAL (<i>armodafinil</i>)	Non Preferred	PA; AGE (Min 18 Years)
NUVIGIL TABLET 250 MG ORAL (<i>armodafinil</i>)	Non Preferred	PA; AGE (Min 18 Years)
NUVIGIL TABLET 50 MG ORAL (<i>armodafinil</i>)	Non Preferred	PA; AGE (Min 18 Years)
<i>dextroamphetamine sulfate</i> (Procentra Solution 5 Mg/5ML Oral)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
PROVIGIL TABLET 100 MG ORAL (<i>modafinil</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
PROVIGIL TABLET 200 MG ORAL (<i>modafinil</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL (<i>viloxazine hcl</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL (<i>viloxazine hcl</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL (<i>viloxazine hcl</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 20 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 30 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 40 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
QUILLIVANT XR SUSPENSION RECONSTITUTED ER 25 MG/5ML ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
RELEXXII TABLET EXTENDED RELEASE 45 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
RELEXXII TABLET EXTENDED RELEASE 63 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
RELEXXII TABLET EXTENDED RELEASE 72 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN TABLET 10 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
RITALIN TABLET 20 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
RITALIN TABLET 5 MG ORAL (<i>methylphenidate hcl</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
STRATTERA CAPSULE 10 MG ORAL (<i>atomoxetine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 100 MG ORAL (<i>atomoxetine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 18 MG ORAL (<i>atomoxetine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 25 MG ORAL (<i>atomoxetine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 40 MG ORAL (<i>atomoxetine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 60 MG ORAL (<i>atomoxetine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 80 MG ORAL (<i>atomoxetine hcl</i>)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
SUNOSI TABLET 150 MG ORAL (<i>solriamfetol hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
SUNOSI TABLET 75 MG ORAL (<i>solriamfetol hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
VYVANSE CAPSULE 10 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
VYVANSE CAPSULE 20 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 30 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 40 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 50 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 60 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 70 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 10 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 20 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 30 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 40 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 50 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 60 MG ORAL (<i>lisdexamfetamine dimesylate</i>)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
WAKIX TABLET 17.8 MG ORAL (<i>pitolisant hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
WAKIX TABLET 4.45 MG ORAL (<i>pitolisant hcl</i>)	Non Preferred	PA; AGE (Min 18 Years)
XELSTRYM PATCH 13.5 MG/9HR TRANSDERMAL (<i>dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
XELSTRYM PATCH 18 MG/9HR TRANSDERMAL (<i>dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
XELSTRYM PATCH 4.5 MG/9HR TRANSDERMAL (<i>dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
XELSTRYM PATCH 9 MG/9HR TRANSDERMAL (<i>dextroamphetamine</i>)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)

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Drug Name	Formulary Status	Requirements/Limits
<i>dextroamphetamine sulfate</i> (Zenzedi Tablet 10 Mg Oral)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate</i> (Zenzedi Tablet 15 Mg Oral)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ZENZEDI TABLET 2.5 MG ORAL (<i>dextroamphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate</i> (Zenzedi Tablet 20 Mg Oral)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate</i> (Zenzedi Tablet 30 Mg Oral)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
<i>dextroamphetamine sulfate</i> (Zenzedi Tablet 5 Mg Oral)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ZENZEDI TABLET 7.5 MG ORAL (<i>dextroamphetamine sulfate</i>)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
SUPPLEMENTAL		
*ACNE PRODUCTS**		
<i>isotretinoin</i> (Accutane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)
<i>acne maximum strength external cream 10 %</i>	Preferred	
<i>isotretinoin</i> (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)
CERAVE ACNE FOAMING CREAM EXTERNAL LIQUID 4 % (<i>benzoyl peroxide</i>)	Preferred	
<i>isotretinoin</i> (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)
CLEARASIL DAILY CLEAR ACNE EXTERNAL CREAM 10 % (<i>benzoyl peroxide</i>)	Preferred	
CLEARASIL RAPID RESCUE SPOT EXTERNAL CREAM 10 % (<i>benzoyl peroxide</i>)	Preferred	
CLEARSKIN EXTERNAL CREAM 10 % (<i>benzoyl peroxide</i>)	Preferred	
<i>cvs acne control cleanser external cream 10 %</i>	Preferred	
<i>cvs acne treatment external cream 10 %</i>	Preferred	
<i>cvs creamy acne face wash external liquid 4 %</i>	Preferred	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	Preferred	PA; QL (2 EA per 1 day)
PANOXYL CREAMY WASH EXTERNAL LIQUID 4 % (<i>benzoyl peroxide</i>)	Preferred	
<i>isotretinoin</i> (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)
*AGENTS FOR CHEMICAL DEPENDENCY**		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	Preferred	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	Preferred	
*ALKALINIZERS**		
<i>cytra-2 oral solution 500-334 mg/5ml</i>	Preferred	
<i>cytra-k oral solution 1100-334 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	Preferred	
<i>potassium citrate-citric acid oral solution 1100-334 mg/5ml</i>	Preferred	
<i>sod citrate-citric acid oral solution 1.5-1 gm/15ml, 3-2 gm/30ml, 500-334 mg/5ml</i>	Preferred	
*ALKYLATING AGENTS**		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	Preferred	PA
LEUKERAN ORAL TABLET 2 MG (<i>chlorambucil</i>)	Preferred	
<i>melphalan oral tablet 2 mg</i>	Preferred	
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	Preferred	PA
*ALTERNATIVE MEDICINE - A'S**		
<i>alpha-lipoic acid oral capsule 100 mg, 300 mg</i>	Preferred	
<i>ra alpha-lipoic acid oral capsule 100 mg</i>	Preferred	
*ALTERNATIVE MEDICINE - C'S**		
<i>co q 10 oral capsule 100 mg</i>	Preferred	
<i>co q-10 oral capsule 100 mg, 200 mg, 50 mg</i>	Preferred	
<i>co q10 oral capsule 30 mg</i>	Preferred	
<i>co-enzyme q10 oral capsule 100 mg, 200 mg</i>	Preferred	
<i>coenzyme q-10 oral capsule 100 mg, 200 mg, 30 mg</i>	Preferred	
<i>coenzyme q10 oral capsule 100 mg, 50 mg</i>	Preferred	
<i>co-enzyme q-10 oral capsule 30 mg</i>	Preferred	
<i>coq10 oral capsule 100 mg, 200 mg, 30 mg, 50 mg</i>	Preferred	
<i>coq-10 oral capsule 100 mg, 200 mg, 30 mg, 50 mg</i>	Preferred	
<i>cvs coenzyme q-10 oral capsule 100 mg</i>	Preferred	
<i>cvs coq-10 oral capsule 200 mg, 50 mg</i>	Preferred	
<i>eql coq10 oral capsule 100 mg, 200 mg</i>	Preferred	
<i>gnp co q-10 oral capsule 100 mg</i>	Preferred	
<i>gnp co q10 oral capsule 100 mg, 200 mg</i>	Preferred	
<i>hm coq-10 oral capsule 200 mg</i>	Preferred	
PRONUTRIENTS COQ10 ORAL CAPSULE 100 MG (<i>coenzyme q10</i>)	Preferred	
<i>qc co q-10 oral capsule 100 mg</i>	Preferred	
Q-SORB CO Q-10 ORAL CAPSULE 100 MG, 200 MG (<i>coenzyme q10</i>)	Preferred	
<i>ra coenzyme q-10 oral capsule 100 mg, 200 mg</i>	Preferred	
<i>sm co q-10 oral capsule 100 mg, 200 mg</i>	Preferred	
<i>sm coenzyme q-10 oral capsule 100 mg</i>	Preferred	
<i>sm coq-10 oral capsule 50 mg</i>	Preferred	
<i>yl coenzyme q10 oral capsule 30 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*ALTERNATIVE MEDICINE - M'S**		
<i>cvs melatonin oral tablet 3 mg, 5 mg</i>	Preferred	
<i>gnp melatonin maximum strength oral tablet 5 mg</i>	Preferred	
<i>gnp melatonin oral tablet 3 mg</i>	Preferred	
<i>hm melatonin oral tablet 5 mg</i>	Preferred	
<i>kp melatonin oral tablet 3 mg</i>	Preferred	
<i>melatonin maximum strength oral tablet 5 mg</i>	Preferred	
<i>melatonin oral tablet 1 mg, 3 mg, 5 mg</i>	Preferred	
<i>melatonin sublingual tablet sublingual 3 mg</i>	Preferred	
<i>qc melatonin max st oral tablet 5 mg</i>	Preferred	
<i>ra melatonin oral tablet 3 mg, 5 mg</i>	Preferred	
<i>sm melatonin oral tablet 3 mg, 5 mg</i>	Preferred	
<i>sv melatonin oral tablet 5 mg</i>	Preferred	
*ALTERNATIVE MEDICINE - U**		
<i>CYTO-Q MAX ORAL LIQUID 100 MG/ML (ubiquinol liposomal)</i>	Preferred	
*ALTERNATIVE MEDICINE COMBINATIONS**		
<i>co q-10 plus oral capsule 100-20 mg</i>	Preferred	
<i>COSAMIN DS ORAL TABLET 500-400 MG (glucosamine-chondroitin)</i>	Preferred	
<i>cvs glucosamine-chondroitin oral tablet 500-400 mg</i>	Preferred	
<i>glucosamine-chondroitin ds oral tablet 500-400 mg</i>	Preferred	
<i>glucosamine-chondroitin oral tablet 500-400 mg</i>	Preferred	
<i>glucosamine-chondroitin pm oral tablet 500-400 mg</i>	Preferred	
<i>LIQ-10 ORAL SYRUP 50-15 (coenzyme q10-vitamin e)</i>	Preferred	
<i>melatonin-pyridoxine oral tablet 5-10 mg</i>	Preferred	
<i>omega dha oral tablet chewable</i>	Preferred	
<i>px glucosamine-chondroitin ds oral tablet 500-400 mg</i>	Preferred	
<i>px glucosamine-chondroitin oral tablet 500-400 mg</i>	Preferred	
<i>ra glucosamine-chondroitin oral tablet 500-400 mg</i>	Preferred	
<i>ra melatonin oral tablet 3-2 mg</i>	Preferred	
*AMINOPENICILLINS**		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	Preferred	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	Preferred	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	Preferred	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	Preferred	
*ANALGESIC COMBINATIONS**		
<i>added strength headache relief oral tablet 250-250-65 mg</i>	Preferred	
<i>butalbital-apap-caffeine (Bac Oral Tablet 50-325-40 Mg)</i>	Preferred	QL (6 EA per 1 day)
<i>BAYER MIGRAINE ORAL TABLET 250-250-65 MG (aspirin-acetaminophen-caffeine)</i>	Preferred	

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<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-apap-caffeine oral tablet 50-325-40 mg</i>	Preferred	QL (6 EA per 1 day)
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	Preferred	QL (6 EA per 1 day)
<i>cvs headache relief oral tablet 250-250-65 mg</i>	Preferred	
<i>cvs migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>eq headache relief oral tablet 250-250-65 mg</i>	Preferred	
<i>eql migraine formula oral tablet 250-250-65 mg</i>	Preferred	
<i>extraprin oral tablet 250-250-65 mg</i>	Preferred	
<i>gnp headache relief extra str oral tablet 250-250-65 mg</i>	Preferred	
<i>gnp migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>goodsense headache relief oral tablet 250-250-65 mg</i>	Preferred	
<i>goodsense migraine formula oral tablet 250-250-65 mg</i>	Preferred	
<i>headache formula oral tablet 250-250-65 mg</i>	Preferred	
<i>headache relief oral tablet 250-250-65 mg</i>	Preferred	
<i>hm migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>kls migraine headache relief oral tablet 250-250-65 mg</i>	Preferred	
<i>meijer migraine formula oral tablet 250-250-65 mg</i>	Preferred	
<i>migraine formula oral tablet 250-250-65 mg</i>	Preferred	
<i>migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>pain reliever extra strength oral tablet 250-250-65 mg</i>	Preferred	
<i>pain reliever plus oral tablet 250-250-65 mg</i>	Preferred	
<i>pain-off oral tablet 250-250-65 mg</i>	Preferred	
PAMPRIIN MAX ORAL TABLET 250-250-65 MG (aspirin-acetaminophen-caffeine)	Preferred	
<i>px headache relief added st oral tablet 250-250-65 mg</i>	Preferred	
<i>px migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>qc headache relief oral tablet 250-250-65 mg</i>	Preferred	
<i>ra headache formula oral tablet 250-250-65 mg</i>	Preferred	
<i>ra migraine relief oral tablet 250-250-65 mg</i>	Preferred	
<i>ra pain reliever ex st oral tablet 250-250-65 mg</i>	Preferred	
<i>sb pain relief x-str oral tablet 250-250-65 mg</i>	Preferred	
<i>sm migraine relief oral tablet 250-250-65 mg</i>	Preferred	
TENCON ORAL TABLET 50-325 MG (butalbital-acetaminophen)	Preferred	QL (6 EA per 1 day)
*ANALGESICS OTHER**		
<i>8 hour arthritis pain oral tablet extended release 650 mg</i>	Preferred	
<i>8 hour pain reliever oral tablet extended release 650 mg</i>	Preferred	
<i>8 hr arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>acetaminophen 8 hour oral tablet extended release 650 mg</i>	Preferred	
<i>acetaminophen childrens oral solution 160 mg/5ml</i>	Preferred	
<i>acetaminophen childrens oral suspension 160 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>acetaminophen childrens oral tablet chewable 160 mg</i>	Preferred	
<i>acetaminophen er oral tablet extended release 650 mg</i>	Preferred	
<i>acetaminophen extra strength oral tablet 500 mg</i>	Preferred	
<i>acetaminophen infants oral suspension 160 mg/5ml</i>	Preferred	
<i>acetaminophen junior strength oral tablet dispersible 160 mg</i>	Preferred	
<i>acetaminophen oral liquid 160 mg/5ml</i>	Preferred	
<i>acetaminophen oral solution 160 mg/5ml, 325 mg/10.15ml, 650 mg/20.3ml</i>	Preferred	
<i>acetaminophen oral suspension 160 mg/5ml, 650 mg/20.3ml</i>	Preferred	
<i>acetaminophen oral tablet 325 mg, 500 mg</i>	Preferred	
<i>acetaminophen oral tablet chewable 160 mg</i>	Preferred	
<i>acetaminophen rectal suppository 120 mg, 650 mg</i>	Preferred	
APHEN ORAL TABLET 325 MG (acetaminophen)	Preferred	
<i>apra oral elixir 160 mg/5ml</i>	Preferred	
<i>arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>arthritis pain reliever oral tablet extended release 650 mg</i>	Preferred	
<i>betatemp childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>childrens acetaminophen oral suspension 160 mg/5ml</i>	Preferred	
<i>childrens apap oral tablet chewable 80 mg</i>	Preferred	
<i>childrens aspirin free oral elixir 80 mg/2.5ml</i>	Preferred	
CHILDRENS MEDI-TABS ORAL TABLET CHEWABLE 80 MG (acetaminophen)	Preferred	
<i>childrens non-aspirin oral suspension 160 mg/5ml</i>	Preferred	
<i>childrens non-aspirin oral tablet chewable 80 mg</i>	Preferred	
<i>childrens pain reliever oral tablet chewable 80 mg</i>	Preferred	
<i>childrens silapap oral liquid 160 mg/5ml</i>	Preferred	
<i>cvs 8hr arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>cvs 8hr muscle aches & pain oral tablet extended release 650 mg</i>	Preferred	
<i>cvs acetaminophen ex st oral liquid 500 mg/15ml</i>	Preferred	
<i>cvs acetaminophen ex st oral tablet 500 mg</i>	Preferred	
<i>cvs acetaminophen oral tablet 325 mg</i>	Preferred	
<i>cvs arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>cvs childs non-aspirin oral tablet chewable 80 mg</i>	Preferred	
<i>cvs fever reducing childrens rectal suppository 120 mg</i>	Preferred	
<i>cvs infants pain relief drops oral suspension 160 mg/5ml</i>	Preferred	
<i>cvs non-aspirin childrens oral tablet chewable 80 mg</i>	Preferred	
<i>cvs non-aspirin extra strength oral tablet 500 mg</i>	Preferred	
<i>cvs pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>cvs pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>cvs pain relief childrens oral tablet chewable 160 mg</i>	Preferred	
<i>cvs pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>cvs pain relief oral tablet 500 mg</i>	Preferred	
<i>cvs pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>ed-apap oral liquid 160 mg/5ml</i>	Preferred	
<i>eq 8hr arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>eq acetaminophen oral tablet 325 mg, 500 mg</i>	Preferred	
<i>eq arthritis pain oral tablet extended release 650 mg</i>	Preferred	
<i>eq pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>eq pain & fever childrens oral tablet chewable 160 mg</i>	Preferred	
<i>eq pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>eq pain relief/rapid burst oral liquid 500 mg/15ml</i>	Preferred	
<i>eq pain reliever ex st oral tablet 500 mg</i>	Preferred	
<i>eq pain reliever oral tablet 325 mg, 500 mg</i>	Preferred	
<i>eql acetaminophen childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>eql acetaminophen ex st oral tablet 500 mg</i>	Preferred	
<i>eql acetaminophen oral tablet 325 mg</i>	Preferred	
FEVERALL ADULTS RECTAL SUPPOSITORY 650 MG (acetaminophen)	Preferred	
FEVERALL CHILDRENS RECTAL SUPPOSITORY 120 MG (acetaminophen)	Preferred	
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG (acetaminophen)	Preferred	
FEVERALL JUNIOR STRENGTH RECTAL SUPPOSITORY 325 MG (acetaminophen)	Preferred	
<i>gnp 8 hour arthritis relief oral tablet extended release 650 mg</i>	Preferred	
<i>gnp 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>gnp 8 hour pain reliever oral tablet extended release 650 mg</i>	Preferred	
<i>gnp acetaminophen oral tablet 325 mg</i>	Preferred	
<i>gnp acetaminophen oral tablet chewable 160 mg</i>	Preferred	
<i>gnp children's pain & fever oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp infants pain/fever oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>gnp pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>gnp pain relief oral tablet 325 mg</i>	Preferred	
<i>goodsense arthritis pain oral tablet extended release 650 mg</i>	Preferred	
<i>goodsense pain & fever child oral suspension 160 mg/5ml</i>	Preferred	
<i>goodsense pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>goodsense pain relief extra st oral tablet 500 mg</i>	Preferred	
<i>goodsense pain relief oral tablet 325 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
HEALTHY MAMA SHAKE THAT ACHE ORAL TABLET 500 MG (acetaminophen)	Preferred	
<i>hm acetaminophen childrens oral tablet chewable 160 mg</i>	Preferred	
<i>hm arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>hm pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>hm pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>hm pain reliever oral tablet 325 mg</i>	Preferred	
<i>infants pain & fever oral suspension 160 mg/5ml</i>	Preferred	
<i>kls acetaminophen ex st oral tablet 500 mg</i>	Preferred	
<i>liquid acetaminophen oral liquid 160 mg/5ml</i>	Preferred	
<i>liquid pain relief oral liquid 160 mg/5ml</i>	Preferred	
LITTLE REMEDIES FOR FEVER ORAL LIQUID 160 MG/5ML (acetaminophen)	Preferred	
MAPAP ACETAMINOPHEN EXTRA STR ORAL LIQUID 500 MG/15ML (acetaminophen)	Preferred	
<i>mapap arthritis pain oral tablet extended release 650 mg</i>	Preferred	
MAPAP CHILDRENS ORAL TABLET CHEWABLE 160 MG, 80 MG (acetaminophen)	Preferred	
<i>mapap oral capsule 500 mg</i>	Preferred	
MAX RELIEF JUNIOR ORAL ELIXIR 160 MG/5ML (acetaminophen)	Preferred	
MEDI-TABS CHILDRENS ORAL ELIXIR 80 MG/2.5ML (acetaminophen)	Preferred	
MEDI-TABS EXTRA STRENGTH ORAL TABLET 500 MG (acetaminophen)	Preferred	
MEDI-TABS JUNIOR STRENGTH ORAL TABLET CHEWABLE 160 MG (acetaminophen)	Preferred	
<i>meijer aspirin free oral tablet 325 mg, 500 mg</i>	Preferred	
<i>meijer jr st aspirin free oral tablet chewable 160 mg</i>	Preferred	
MIDOL ORAL TABLET EXTENDED RELEASE 650 MG (acetaminophen)	Preferred	
MM ACETAMINOPHEN EX STR ORAL TABLET 500 MG (acetaminophen)	Preferred	
<i>mm arthritis pain oral tablet extended release 650 mg</i>	Preferred	
<i>m-pap oral liquid 160 mg/5ml</i>	Preferred	
<i>non-aspirin extra strength oral tablet 500 mg</i>	Preferred	
<i>non-aspirin jr strength oral tablet chewable 160 mg</i>	Preferred	
<i>non-aspirin oral tablet 325 mg, 500 mg</i>	Preferred	
<i>non-aspirin pain relief oral tablet 325 mg</i>	Preferred	
<i>pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>pain & fever childrens oral tablet chewable 160 mg</i>	Preferred	
<i>pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>pain & fever kids oral suspension 160 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>pain relief childrens oral elixir 160 mg/5ml</i>	Preferred	
<i>pain relief childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>pain relief extra strength oral capsule 500 mg</i>	Preferred	
<i>pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>pain relief oral liquid 500 mg/15ml</i>	Preferred	
<i>pain relief regular strength oral tablet 325 mg</i>	Preferred	
<i>pain reliever extra strength oral tablet 500 mg</i>	Preferred	
<i>pain reliever for adults oral tablet 500 mg</i>	Preferred	
<i>pain reliever oral liquid 500 mg/15ml</i>	Preferred	
<i>pain reliever oral tablet 325 mg</i>	Preferred	
<i>pain reliever/fever reducer rectal suppository 120 mg</i>	Preferred	
PANADOL CHILDRENS ORAL SUSPENSION 160 MG/5ML (acetaminophen)	Preferred	
PANADOL EXTRA STRENGTH ORAL TABLET 500 MG (acetaminophen)	Preferred	
PANADOL INFANTS ORAL SUSPENSION 160 MG/5ML (acetaminophen)	Preferred	
PEDIACARE CHILDREN ORAL SUSPENSION 160 MG/5ML (acetaminophen)	Preferred	
PEDIACARE INFANT FEVER/PAIN ORAL SUSPENSION 160 MG/5ML (acetaminophen)	Preferred	
PEDIACARE INFANTS ORAL SUSPENSION 160 MG/5ML (acetaminophen)	Preferred	
PHARBETOL EXTRA STRENGTH ORAL TABLET 500 MG (acetaminophen)	Preferred	
PHARBETOL ORAL TABLET 325 MG (acetaminophen)	Preferred	
<i>px arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>px childrens pain relief oral suspension 160 mg/5ml</i>	Preferred	
<i>px pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>qc 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>qc acetaminophen 8 hours oral tablet extended release 650 mg</i>	Preferred	
<i>qc acetaminophen 8hr arth pain oral tablet extended release 650 mg</i>	Preferred	
<i>qc acetaminophen 8hr musc ache oral tablet extended release 650 mg</i>	Preferred	
<i>qc acetaminophen infants oral suspension 160 mg/5ml</i>	Preferred	
<i>qc arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>qc non-aspirin 8 hour oral tablet extended release 650 mg</i>	Preferred	
<i>qc non-aspirin childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>qc non-aspirin childrens oral tablet chewable 160 mg</i>	Preferred	
<i>qc non-aspirin extra strength oral tablet 500 mg</i>	Preferred	
<i>qc pain relief childrens oral suspension 160 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>qc pain relief extra strength oral liquid 500 mg/15ml</i>	Preferred	
<i>qc pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>qc pain relief oral tablet 325 mg</i>	Preferred	
<i>ra 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>ra acetaminophen childrens oral tablet chewable 160 mg</i>	Preferred	
<i>ra acetaminophen ex st oral tablet 500 mg</i>	Preferred	
<i>ra acetaminophen oral tablet 325 mg</i>	Preferred	
<i>ra arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>ra childrens fever/pain oral suspension 160 mg/5ml</i>	Preferred	
<i>ra fever reducer/pain reliever oral suspension 160 mg/5ml</i>	Preferred	
<i>ra pain relief acetaminophen oral tablet 325 mg, 500 mg</i>	Preferred	
<i>ra pain reliever ex st oral liquid 500 mg/15ml</i>	Preferred	
<i>sb arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>sb non-aspirin extra strength oral tablet 500 mg</i>	Preferred	
<i>sb non-aspirin jr strength oral tablet dispersible 160 mg</i>	Preferred	
<i>sb non-aspirin oral tablet 325 mg</i>	Preferred	
<i>sb non-aspirin oral tablet chewable 160 mg, 80 mg</i>	Preferred	
<i>sb pain reliever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>sb pain reliever ex st oral tablet 500 mg</i>	Preferred	
<i>sm 8 hour pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>sm arthritis pain relief oral tablet extended release 650 mg</i>	Preferred	
<i>sm arthritis pain reliever oral tablet extended release 650 mg</i>	Preferred	
<i>sm pain & fever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>sm pain & fever infants oral suspension 160 mg/5ml</i>	Preferred	
<i>sm pain relief extra strength oral tablet 500 mg</i>	Preferred	
<i>sm pain relief oral tablet 500 mg</i>	Preferred	
<i>sm pain reliever childrens oral suspension 160 mg/5ml</i>	Preferred	
<i>sm pain reliever ex st oral tablet 500 mg</i>	Preferred	
<i>sm pain reliever oral tablet 325 mg</i>	Preferred	
<i>sm rapid melts junior oral tablet dispersible 160 mg</i>	Preferred	
TRIAMINIC FEVER REDUCER ORAL SYRUP 160 MG/5ML (acetaminophen)	Preferred	
TYLENOL 8 HOUR ARTHRITIS PAIN ORAL TABLET EXTENDED RELEASE 650 MG (acetaminophen)	Preferred	
TYLENOL 8 HOUR ORAL TABLET EXTENDED RELEASE 650 MG (acetaminophen)	Preferred	
TYLENOL CHILDRENS CHEWABLES ORAL TABLET CHEWABLE 160 MG (acetaminophen)	Preferred	
TYLENOL CHILDRENS ORAL SUSPENSION 160 MG/5ML (acetaminophen)	Preferred	
TYLENOL CHILDRENS PAIN + FEVER ORAL SUSPENSION 160 MG/5ML (acetaminophen)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
TYLENOL EXTRA STRENGTH ORAL TABLET 500 MG (<i>acetaminophen</i>)	Preferred	
TYLENOL FOR CHILDREN + ADULTS ORAL SUSPENSION 160 MG/5ML (<i>acetaminophen</i>)	Preferred	
TYLENOL INFANTS PAIN+FEVER ORAL SUSPENSION 160 MG/5ML (<i>acetaminophen</i>)	Preferred	
TYLENOL ORAL TABLET 325 MG (<i>acetaminophen</i>)	Preferred	
*ANDROGENS**		
<i>testosterone cypionate</i> (Depo-Testosterone Intramuscular Solution 100 Mg/ML, 200 Mg/ML)	Preferred	
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	Preferred	
*ANESTHETICS TOPICAL ORAL**		
CHLORASEPTIC MOUTH/THROAT LOZENGE 6-10 MG (<i>benzocaine-menthol</i>)	Preferred	
CHLORASEPTIC SORE THROAT MOUTH/THROAT LOZENGE 6-10 MG (<i>benzocaine-menthol</i>)	Preferred	
<i>cvs sore throat mouth/throat lozenge 15-2.6 mg, 15-3.6 mg</i>	Preferred	
<i>goodsense sore throat mouth/throat lozenge 15-3.6 mg</i>	Preferred	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	Preferred	
<i>sore throat lozenges mouth/throat lozenge 6-10 mg</i>	Preferred	
<i>sore throat mouth/throat lozenge 15-3.6 mg, 6-10 mg</i>	Preferred	
<i>ultra throat mouth/throat lozenge 6-10 mg</i>	Preferred	
*ANOREXIANTS NON-AMPHETAMINE**		
<i>benzphetamine hcl oral tablet 50 mg</i>	Preferred	PA
<i>diethylpropion hcl oral tablet 25 mg</i>	Preferred	PA
<i>phendimetrazine tartrate oral tablet 35 mg</i>	Preferred	PA
<i>phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg</i>	Preferred	PA
<i>phentermine hcl oral tablet 37.5 mg</i>	Preferred	PA
*ANTACID COMBINATIONS**		
ACID GONE ORAL SUSPENSION 95-358 MG/15ML (<i>alum hydroxide-mag carbonate</i>)	Preferred	
ACID GONE ORAL TABLET CHEWABLE 160-105 MG (<i>alum hydroxide-mag carbonate</i>)	Preferred	
ALKA-SELTZER HEARTBURN + GAS ORAL TABLET CHEWABLE 750-80 MG (<i>calcium carbonate-simethicone</i>)	Preferred	
ALMACONE DOUBLE STRENGTH ORAL SUSPENSION 400-400-40 MG/5ML (<i>alum & mag hydroxide-simeth</i>)	Preferred	
<i>alum & mag hydroxide-simeth oral suspension 1200-1200-120 mg/30ml</i>	Preferred	
<i>antacid & antigas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>antacid advanced oral suspension 400-400-40 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>antacid anti-gas max strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>antacid anti-gas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>antacid extra strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>antacid extra strength oral tablet chewable 160-105 mg, 675-135 mg</i>	Preferred	
<i>antacid fast relief oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>antacid i oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>antacid iii oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>antacid liquid oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>antacid m oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>antacid maximum strength oral suspension 400-400-40 mg/5ml, 800-800-80 mg/10ml</i>	Preferred	
<i>antacid multi-symptom oral tablet chewable 675-135-60 mg</i>	Preferred	
<i>antacid oral suspension 200-200-20 mg/5ml, 400-400-40 mg/10ml</i>	Preferred	
<i>antacid regular strength oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>antacid ultra strength oral tablet chewable 1000-200 mg</i>	Preferred	
<i>antacid/antigas oral suspension 400-400-40 mg/10ml</i>	Preferred	
<i>antacid/simethicone ds oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>comfort gel antacid & anti-gas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>comfort gel antacid anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	Preferred	
<i>comfort gel oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>cvs antacid & anti-gas oral tablet chewable 1000-60 mg</i>	Preferred	
<i>cvs antacid plus antigas oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>cvs antacid supreme oral suspension 400-135 mg/5ml</i>	Preferred	
<i>cvs antacid/anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	Preferred	
<i>cvs heartburn relief ex st oral suspension 254-237.5 mg/5ml</i>	Preferred	
<i>cvs heartburn relief oral tablet chewable 160-105 mg</i>	Preferred	
<i>eq antacid antigas multi-sympt oral tablet chewable 675-135-60 mg</i>	Preferred	
<i>eq antacid maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
GAVISCON EXTRA RELIEF FORMULA ORAL SUSPENSION 508-475 MG/10ML (<i>alum hydroxide-mag carbonate</i>)	Preferred	
GAVISCON EXTRA STRENGTH ORAL SUSPENSION 254-237.5 MG/5ML (<i>alum hydroxide-mag carbonate</i>)	Preferred	
GAVISCON ORAL SUSPENSION 95-358 MG/15ML (<i>alum hydroxide-mag carbonate</i>)	Preferred	

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<i>geri-lanta maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>geri-lanta oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>geri-lanta supreme oral suspension 400-135 mg/5ml</i>	Preferred	
<i>geri-mox oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>gnp antacid & anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml</i>	Preferred	
<i>gnp antacid & anti-gas oral tablet chewable 1000-60 mg</i>	Preferred	
<i>gnp antacid extra strength oral tablet chewable 160-105 mg</i>	Preferred	
<i>gnp antacid regular strength oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>goodsense advanced antacid oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>goodsense antacid & gas relief oral suspension 400-400-40 mg/10ml, 400-400-40 mg/5ml</i>	Preferred	
<i>heartburn antacid ex st oral tablet chewable 160-105 mg</i>	Preferred	
<i>heartburn relief ex st oral suspension 254-237.5 mg/5ml</i>	Preferred	
<i>hm antacid anti-gas ex st oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>hm antacid oral suspension 200-200-20 mg/5ml</i>	Preferred	
MAALOX MAX ORAL SUSPENSION 400-400-40 MG/5ML (<i>alum & mag hydroxide-simeth</i>)	Preferred	
MAALOX MULTI SYMPTOM MAX ST ORAL SUSPENSION 400-400-40 MG/5ML (<i>alum & mag hydroxide-simeth</i>)	Preferred	
<i>mag-al oral liquid 200-200 mg/5ml</i>	Preferred	
<i>mag-al plus oral liquid 200-200-20 mg/5ml</i>	Preferred	
<i>mag-al plus xs oral liquid 400-400-40 mg/5ml</i>	Preferred	
<i>meijer antacid anti-gas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>meijer antacid oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>mintox maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
MINTOX PLUS ORAL TABLET CHEWABLE 200-200-25 MG (<i>alum & mag hydroxide-simeth</i>)	Preferred	
MYLANTA MAXIMUM STRENGTH ORAL SUSPENSION 400-400-40 MG/5ML (<i>alum & mag hydroxide-simeth</i>)	Preferred	
<i>px antacid maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>px antacid regular strength oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>qc antacid multi-symptom oral tablet chewable 675-135-60 mg</i>	Preferred	
<i>qc antacid oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>qc antacid/anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/10ml, 400-400-40 mg/5ml</i>	Preferred	
<i>qc heartburn antacid oral tablet chewable 160-105 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ra antacid/anti-gas max st oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>ra antacid/anti-gas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>ra antacid/gas relief max st oral suspension 400-400-40 mg/5ml</i>	Preferred	
ROLAIDS ULTRA STRENGTH ORAL TABLET CHEWABLE 1000-200 MG (<i>ca carbonate-mag hydroxide</i>)	Preferred	
<i>sb antacid anti-gas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>sm antacid advanced max st oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>sm antacid advanced oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>sm antacid anti-gas oral suspension 200-200-20 mg/5ml</i>	Preferred	
<i>sm antacid maximum strength oral suspension 400-400-40 mg/5ml</i>	Preferred	
<i>sm antacid oral suspension 400-400-40 mg/10ml</i>	Preferred	
TUMS GAS RELIEF CHEWY BITES ORAL TABLET CHEWABLE 750-80 MG (<i>calcium carbonate-simethicone</i>)	Preferred	
*ANTACIDS - ALUMINUM SALTS**		
<i>aluminum hydroxide gel oral suspension 320 mg/5ml</i>	Preferred	
*ANTACIDS - BICARBONATE**		
ALKA-SELTZER GOLD ORAL TABLET EFFERVESCENT 1050-344-1000 MG (<i>sod bicarb-k bicarb-citric acid</i>)	Preferred	
<i>sodium bicarbonate oral tablet 325 mg, 650 mg</i>	Preferred	
*ANTACIDS - CALCIUM SALTS**		
ALKA-SELTZER HEARTBURN ORAL TABLET CHEWABLE 750 MG (<i>calcium carbonate antacid</i>)	Preferred	
<i>antacid calcium oral tablet chewable 500 mg</i>	Preferred	
<i>antacid calcium rich oral tablet chewable 500 mg</i>	Preferred	
<i>antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
ANTACID FLAVOR CHEWS ORAL TABLET CHEWABLE 750 MG (<i>calcium carbonate antacid</i>)	Preferred	
<i>antacid maximum oral tablet chewable 1000 mg</i>	Preferred	
<i>antacid oral tablet chewable 1177 mg, 500 mg, 750 mg</i>	Preferred	
<i>antacid regular strength oral tablet chewable 500 mg</i>	Preferred	
<i>antacid soft chews oral tablet chewable 1177 mg</i>	Preferred	
<i>antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>calcium antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>calcium antacid oral tablet chewable 500 mg</i>	Preferred	
<i>calcium carbonate antacid oral suspension 1250 mg/5ml</i>	Preferred	
<i>calcium carbonate antacid oral tablet 648 mg</i>	Preferred	
<i>calcium carbonate antacid oral tablet chewable 500 mg</i>	Preferred	
CAL-GEST ANTACID ORAL TABLET CHEWABLE 500 MG (<i>calcium carbonate antacid</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>cvs antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>cvs antacid kids oral tablet chewable 750 mg</i>	Preferred	
<i>cvs antacid maximum strength oral tablet chewable 1000 mg</i>	Preferred	
<i>cvs antacid soft chews ultr st oral tablet chewable 1177 mg</i>	Preferred	
<i>cvs antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
CVS CHEWY NOT CHALKY FLAVOR ORAL TABLET CHEWABLE 750 MG (<i>calcium carbonate antacid</i>)	Preferred	
<i>cvs smooth antacid extra st oral tablet chewable 750 mg</i>	Preferred	
<i>eq antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>eq antacid oral tablet chewable 500 mg</i>	Preferred	
<i>eq antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>eql antacid oral tablet chewable 500 mg</i>	Preferred	
<i>eql antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>gnp antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>gnp antacid oral tablet chewable 500 mg</i>	Preferred	
<i>gnp antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>goodsense antacid oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	Preferred	
HEALTHY MAMA TAME THE FLAME ORAL TABLET CHEWABLE 500 MG (<i>calcium carbonate antacid</i>)	Preferred	
<i>hm antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>hm antacid oral tablet chewable 500 mg</i>	Preferred	
<i>long lasting antacid oral tablet chewable 500 mg</i>	Preferred	
<i>px antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>px antacid maximum strength oral tablet chewable 1000 mg</i>	Preferred	
<i>px calcium antacid oral tablet chewable 500 mg</i>	Preferred	
<i>qc antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>qc antacid oral tablet chewable 500 mg</i>	Preferred	
<i>qc antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>ra antacid oral tablet chewable 500 mg</i>	Preferred	
<i>ra antacid ultra strength oral tablet chewable 1000 mg</i>	Preferred	
<i>sb antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
<i>sb antacid oral tablet chewable 500 mg</i>	Preferred	
<i>sm antacid oral tablet chewable 500 mg</i>	Preferred	
<i>sm calcium antacid ex st oral tablet chewable 750 mg</i>	Preferred	
<i>sm calcium antacid oral tablet chewable 500 mg</i>	Preferred	
<i>sm smooth antacid ex st oral tablet chewable 750 mg</i>	Preferred	
<i>smooth antacid extra strength oral tablet chewable 750 mg</i>	Preferred	
TUMS CHEWY BITES ORAL TABLET CHEWABLE 750 MG (<i>calcium carbonate antacid</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
TUMS CHEWY DELIGHTS ORAL TABLET CHEWABLE 1177 MG (<i>calcium carbonate antacid</i>)	Preferred	
TUMS E-X 750 ORAL TABLET CHEWABLE 750 MG (<i>calcium carbonate antacid</i>)	Preferred	
TUMS EXTRA STRENGTH 750 ORAL TABLET CHEWABLE 750 MG (<i>calcium carbonate antacid</i>)	Preferred	
TUMS LASTING EFFECTS ORAL TABLET CHEWABLE 500 MG (<i>calcium carbonate antacid</i>)	Preferred	
TUMS ORAL TABLET CHEWABLE 500 MG (<i>calcium carbonate antacid</i>)	Preferred	
TUMS SMOOTHIES ORAL TABLET CHEWABLE 750 MG (<i>calcium carbonate antacid</i>)	Preferred	
TUMS ULTRA 1000 ORAL TABLET CHEWABLE 1000 MG (<i>calcium carbonate antacid</i>)	Preferred	
*ANTACIDS - MAGNESIUM SALTS**		
<i>gnp magnesium oxide oral tablet 250 mg</i>	Preferred	
<i>magnesium oxide (antacid) oral capsule 500 mg</i>	Preferred	
<i>magnesium oxide (antacid) oral tablet 400 mg</i>	Preferred	
<i>magnesium oxide oral tablet 250 mg, 400 mg, 420 mg</i>	Preferred	
MAOX ORAL TABLET 420 MG (<i>magnesium oxide</i>)	Preferred	
<i>qc magnesium oral tablet 250 mg</i>	Preferred	
*ANTHELMINTICS**		
<i>albendazole oral tablet 200 mg</i>	Preferred	PA (Eligible for auto-PA); QL (4 EA per 1 day)
<i>cvs pinworm treatment oral suspension 144 (50 base) mg/ml</i>	Preferred	
<i>ivermectin oral tablet 3 mg</i>	Preferred	
<i>pin-away oral suspension 144 (50 base) mg/ml</i>	Preferred	
<i>pinworm medicine oral suspension 144 (50 base) mg/ml</i>	Preferred	
<i>reeses pinworm medicine oral suspension 144 (50 base) mg/ml</i>	Preferred	
*ANTIADRENERGIC ANTIHYPERTENSIVES**		
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	Preferred	Max 90-day supply per fill
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	Preferred	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Preferred	Max 90-day supply per fill
*ANTIANGINALS-OTHER**		
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	Preferred	QL (2 EA per 1 day)
*ANTIANSIETY AGENTS - MISC.**		
<i>buspirone hcl oral tablet 10 mg, 15 mg, 5 mg</i>	Preferred	
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Preferred	AGE (Min 2 Years)
<i>hydroxyzine pamoate oral capsule 100 mg</i>	Preferred	
<i>hydroxyzine pamoate oral capsule 25 mg, 50 mg</i>	Preferred	AGE (Min 2 Years)

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Drug Name	Formulary Status	Requirements/Limits
*ANTIARRHYTHMICS TYPE I-B**		
<i>lidocaine hcl (cardiac) pf intravenous solution 100 mg/5ml</i>	Preferred	
*ANTIARRHYTHMICS TYPE I-C**		
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	Preferred	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	Preferred	
*ANTIARRHYTHMICS TYPE III**		
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg</i>	Preferred	
<i>amiodarone hcl (Pacerone Oral Tablet 100 Mg, 200 Mg, 400 Mg)</i>	Preferred	
*ANTIASTHMATIC - MONOCLONAL ANTIBODIES**		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mepolizumab</i>)	Preferred	PA; QL (0.04 ML per 1 day)
*ANTIBIOTICS - TOPICAL**		
<i>antibiotic external ointment 500 unit/gm</i>	Preferred	
<i>bacitracin external ointment 500 unit/gm</i>	Preferred	
<i>bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>bacitracin zinc-aloe external ointment 500 unit/gm</i>	Preferred	
BACITRAYCIN PLUS EXTERNAL OINTMENT 500 UNIT/GM (<i>bacitracin</i>)	Preferred	
<i>cvs antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>cvs antibiotic pain/scar external ointment 1 %</i>	Preferred	
<i>cvs antibiotic/pain relief external cream 1 %</i>	Preferred	
<i>cvs bacitracin external ointment 500 unit/gm</i>	Preferred	
<i>cvs bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>cvs poly bacitracin external ointment 500-10000 unit/gm</i>	Preferred	
<i>cvs triple antibiotic/pain external ointment 1 %</i>	Preferred	
<i>double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>eq bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>eq triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>eql antibiotic + pain relief external cream 3.5-10000-10</i>	Preferred	
<i>eql bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>eql first aid antibiotic external ointment 1 %, 3.5-400-5000</i>	Preferred	
<i>first aid antibiotic external ointment 3.5-400-5000 mg-unit, 3.5-500-10000</i>	Preferred	
<i>gentamicin sulfate external cream 0.1 %</i>	Preferred	
<i>gentamicin sulfate external ointment 0.1 %</i>	Preferred	
<i>gnp antibiotic/pain relief external cream 3.5-10000-10</i>	Preferred	
<i>gnp bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>gnp triple antibiotic external ointment</i>	Preferred	
<i>gnp triple antibiotic plus external ointment 1 %</i>	Preferred	
<i>goodsense antibiotic/pain external cream 3.5-10000-10</i>	Preferred	

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<i>hm bacitracin zinc external ointment 500 unit/gm</i>	Preferred	
<i>hm double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>hm triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>hm triple antibiotic max st external ointment 1 %</i>	Preferred	
LANABIOTIC EXTERNAL OINTMENT 5-500-10000 (<i>neomycin-bacitracin-polymyxin</i>)	Preferred	
<i>medi-first triple antibiotic external ointment 5-400-5000 mg-unit</i>	Preferred	
<i>meijer triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>multi antibiotic plus external cream 3.5-10000-10</i>	Preferred	
NEOSPORIN + PAIN RELIEF MAX ST EXTERNAL OINTMENT 1 % (<i>neomy-bacit-polymyx-pramoxine</i>)	Preferred	
NEOSPORIN + PAIN/ITCH/SCAR EXTERNAL OINTMENT 1 % (<i>neomy-bacit-polymyx-pramoxine</i>)	Preferred	
NEOSPORIN EXTERNAL OINTMENT 500-10000 UNIT/GM (<i>bacitracin-polymyxin b</i>)	Preferred	
NEOSPORIN/BURN RELIEF EXTERNAL OINTMENT 1 % (<i>neomy-bacit-polymyx-pramoxine</i>)	Preferred	
<i>poly bacitracin external ointment 500-10000 unit/gm</i>	Preferred	
<i>px triple external ointment 3.5-400-5000</i>	Preferred	
<i>qc bacitracin external ointment 500 unit/gm</i>	Preferred	
<i>qc triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>qc triple antibiotic max st external ointment 1 %</i>	Preferred	
<i>qc triple antibiotic multi-act external ointment 1 %</i>	Preferred	
<i>qc triple antibiotic pain rlf external ointment 1 %</i>	Preferred	
<i>ra antibiotic + pain relief external ointment 1 %</i>	Preferred	
<i>ra antibiotic plus external cream 3.5-10000-10</i>	Preferred	
<i>ra antibiotic/pain relief external ointment 1 %</i>	Preferred	
<i>ra bacitracin external ointment 500 unit/gm</i>	Preferred	
<i>ra bacitracin zinc first aid external ointment 500 unit/gm</i>	Preferred	
<i>ra double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>ra triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>sb bacitracin external ointment 500 unit/gm</i>	Preferred	
<i>sb triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>sm antibiotic external ointment 500 unit/gm</i>	Preferred	
<i>sm antibiotic plus pain relief external cream 3.5-10000-10</i>	Preferred	
<i>sm double antibiotic external ointment 500-10000 unit/gm</i>	Preferred	
<i>sm triple antibiotic external ointment 3.5-400-5000</i>	Preferred	
<i>sm triple antibiotic max st external ointment 1 %</i>	Preferred	
<i>sm triple antibiotic original external ointment 3.5-400-5000</i>	Preferred	
<i>triple antibiotic external ointment , 3.5-400-5000 , 5-400-5000 , 5-400-5000 mg-unit</i>	Preferred	

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>triple antibiotic pain relief external ointment 1 %</i>	Preferred	
<i>triple antibiotic plus external ointment 1 %</i>	Preferred	
<i>triple antibiotic plus max st external ointment 1 %</i>	Preferred	
<i>triple antibiotic+pain relief external ointment 1 %</i>	Preferred	
<i>wal-sporin external ointment 500-100000 unit/gm</i>	Preferred	
*ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.**		
<i>4x probiotic oral tablet</i>	Preferred	
ABATINEX ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
<i>acidophilus extra strength oral capsule</i>	Preferred	
ACIDOPHILUS HIGH-POTENCY ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>acidophilus lactobacillus oral capsule</i>	Preferred	
<i>acidophilus oral capsule , 100 mg</i>	Preferred	
<i>acidophilus oral tablet , 0.5 mg</i>	Preferred	
ACIDOPHILUS PEARLS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>acidophilus probiotic blend oral capsule</i>	Preferred	
<i>acidophilus probiotic blend oral tablet</i>	Preferred	
<i>acidophilus probiotic formula oral tablet</i>	Preferred	
<i>acidophilus probiotic oral capsule , 10 mg, 100 mg</i>	Preferred	
<i>acidophilus probiotic oral tablet , 0.5 mg, 10 mg</i>	Preferred	
<i>acidophilus super probiotic oral capsule</i>	Preferred	
<i>acidophilus/goat milk oral capsule</i>	Preferred	
<i>acidophilus/l-sporogenes oral tablet</i>	Preferred	
<i>acidophilus/pectin oral capsule 100 mg</i>	Preferred	
ACTIPHLOA ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>advanced probiotic oral capsule</i>	Preferred	
<i>advanced probiotic-14 oral capsule</i>	Preferred	
ALIGN EXTRA STRENGTH ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
ALIGN ORAL CAPSULE , 4 MG (<i>probiotic product</i>)	Preferred	
<i>aloe 10000 & probiotics oral capsule</i>	Preferred	
AZO COMPLETE FEMININE BALANCE ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
AZO DUAL PROTECTION ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
<i>bacicap oral capsule</i>	Preferred	
BACID ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
BACID ORAL TABLET (<i>probiotic product</i>)	Preferred	
<i>bilac oral capsule</i>	Preferred	
BIOGAIA PROTECTIS MUM ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
<i>biohm probiotic supplement oral capsule</i>	Preferred	
<i>biohm probiotic/vitamin c oral capsule</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
BIO-KULT ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>biomepro oral capsule</i>	Preferred	
<i>biotinex oral capsule</i>	Preferred	
<i>bismatrol oral tablet chewable 262 mg</i>	Preferred	
<i>bismuth oral tablet chewable 262 mg</i>	Preferred	
<i>bismuth subsalicylate oral tablet chewable 262 mg</i>	Preferred	
CULTURELLE ADVANCED REGULARITY ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
CULTURELLE DIGESTIVE WOMENS ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
CULTURELLE HEALTH & WELLNESS ORAL CAPSULE (<i>lactobacillus rhamnosus (gg)</i>)	Preferred	
CULTURELLE IMMUNE DEFENSE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
CULTURELLE KID PROBIOTIC+FIBER ORAL PACKET (<i>lactobacillus rhamnosus (gg)</i>)	Preferred	
CULTURELLE KIDS ORAL PACKET (<i>lactobacillus rhamnosus (gg)</i>)	Preferred	
CULTURELLE KIDS PURELY ORAL PACKET (<i>lactobacillus rhamnosus (gg)</i>)	Preferred	
CULTURELLE METABOLISM-WEIGHT ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
CULTURELLE PRENATAL WELLNESS ORAL TABLET CHEWABLE (<i>lactobacillus</i>)	Preferred	
CULTURELLE PROBIOTICS KIDS ORAL PACKET 5 B CELL (<i>lactobacillus rhamnosus (gg)</i>)	Preferred	
CULTURELLE PRO-WELL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
CULTURELLE TOTAL BALANCE ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
CULTURELLE WOMEN'S WELLNESS ORAL TABLET CHEWABLE (<i>lactobacillus</i>)	Preferred	
<i>cvs acidophilus probiotic oral tablet , 0.5 mg</i>	Preferred	
<i>cvs adult 50+ probiotic oral capsule</i>	Preferred	
<i>cvs adult probiotic oral capsule</i>	Preferred	
<i>cvs anti-diarrheal oral suspension 262 mg/15ml</i>	Preferred	
<i>cvs daily probiotic oral capsule</i>	Preferred	
<i>cvs digestive probiotic oral capsule , 250 mg</i>	Preferred	
<i>cvs everyday care probiotic oral capsule</i>	Preferred	
<i>cvs mood support probiotic oral capsule</i>	Preferred	
<i>cvs probiotic (lactobacillus) oral capsule</i>	Preferred	
<i>cvs probiotic adult 50+ oral capsule</i>	Preferred	
<i>cvs probiotic maximum strength oral capsule</i>	Preferred	
<i>cvs probiotic oral capsule</i>	Preferred	
<i>cvs probiotic pearls ex st oral capsule</i>	Preferred	

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PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>cvs senior probiotic oral capsule</i>	Preferred	
<i>cvs stomach relief max st oral suspension 525 mg/15ml</i>	Preferred	
<i>cvs stomach relief oral suspension 525 mg/15ml, 525 mg/30ml</i>	Preferred	
<i>cvs stomach relief oral tablet 262 mg</i>	Preferred	
<i>cvs stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>daily digestive probiotic oral capsule</i>	Preferred	
<i>daily probiotic oral capsule</i>	Preferred	
<i>daily probiotic supplement oral capsule 250 mg</i>	Preferred	
DERMACINRX PROBISOL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
DERMACINRX PROBITRAN ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>diarrhea oral suspension 262 mg/15ml</i>	Preferred	
DIGESTIVE ADV DIGESTIVE/IMMUNE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
DIGESTIVE ADV LACTOSE SUPPORT ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
DIGESTIVE ADV MULTI-STRAIN ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
DIGESTIVE ADV+BOWEL SUPPORT ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
DIGESTIVE ADV+GAS DEFENSE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
DIGESTIVE ADV+LACTOSE SUPPORT ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
DIGESTIVE ADVANTAGE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>digestive health probiotic oral capsule</i>	Preferred	
<i>digestive probiotic oral capsule 250 mg</i>	Preferred	
<i>diotame instydose oral suspension 262 mg/15ml</i>	Preferred	
ENVIVE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>eq pink-bismuth oral tablet chewable 262 mg</i>	Preferred	
<i>eq probiotic oral capsule</i>	Preferred	
<i>eq probiotic oral capsule delayed release</i>	Preferred	
<i>eq probiotic-lactobacillus oral capsule</i>	Preferred	
<i>eq stomach relief oral suspension 262 mg/15ml</i>	Preferred	
<i>eql 2 in 1 probiotic oral tablet</i>	Preferred	
<i>eql 4x probiotic oral tablet</i>	Preferred	
<i>eql daily probiotic oral capsule</i>	Preferred	
<i>eql digestive probiotic oral capsule</i>	Preferred	
<i>eql probiotic colon support oral capsule</i>	Preferred	
<i>eql stomach relief max st oral suspension 525 mg/15ml</i>	Preferred	
<i>eql stomach relief oral suspension 262 mg/15ml</i>	Preferred	
<i>eql stomach relief oral tablet chewable 262 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
FEM-DOPHILUS WOMENS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FLORA VANCE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FLORAJEN ACIDOPHILUS ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
FLORAJEN DIGESTION ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FLORAJEN WOMEN ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
FLORAJEN3 ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FLORAJEN4KIDS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FLORANEX ORAL PACKET (<i>lactobacillus</i>)	Preferred	
FLORANEX ORAL TABLET (<i>lactobacillus</i>)	Preferred	
<i>florasave oral capsule delayed release</i>	Preferred	
FLORASTOR SELECT GUT BOOST ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FLORASTOR SELECT IMMUNITY BOOS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FORTIFY 30 BILLION PROBIOT 50+ ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
FORTIFY 50 BILLION PROBIOT 50+ ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
FORTIFY DAILY PROBIOTIC EX ST ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
FORTIFY DAILY PROBIOTIC ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
FORTIFY OPTIMA PROBIOTIC ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
FORTIFY PROBIOTIC WOMENS EX ST ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
FORTIFY PROBIOTIC WOMENS ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
<i>freeze dried acidophilus oral capsule</i>	Preferred	
<i>gnp acidophilus high potency oral capsule</i>	Preferred	
<i>gnp pink bismuth oral tablet 262 mg</i>	Preferred	
<i>gnp pink bismuth oral tablet chewable 262 mg</i>	Preferred	
<i>gnp probiotic colon support oral capsule</i>	Preferred	
<i>gnp stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>goodsense stomach relief oral suspension 1050 mg/30ml, 525 mg/30ml</i>	Preferred	
<i>high potency probiotic oral capsule</i>	Preferred	
<i>hm probiotic digestive health oral capsule</i>	Preferred	
<i>hm stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>hm stomach relief ultra oral suspension 525 mg/15ml</i>	Preferred	
<i>ideal bowel support oral capsule</i>	Preferred	
INTESTINEX ORAL CAPSULE 600 MG (<i>lactobacillus</i>)	Preferred	
JARRO-DOPHILUS EPS ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
JARRO-DOPHILUS EPS PROBIOTIC ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
JARRO-DOPHILUS HYPOALLERGENIC ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
JARRO-DOPHILUS PROBIOT+PRE+FOS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
JARRO-DOPHILUS VAGINAL PROBIOT ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
KAOPECTATE EXTRA STRENGTH ORAL SUSPENSION 525 MG/15ML (<i>bismuth subsalicylate</i>)	Preferred	
KAOPECTATE ORAL SUSPENSION 262 MG/15ML (<i>bismuth subsalicylate</i>)	Preferred	
KAOPECTATE ORAL TABLET 262 MG (<i>bismuth subsalicylate</i>)	Preferred	
LACTEROL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>lactobacillus extra strength oral capsule</i>	Preferred	
<i>lactobacillus oral packet</i>	Preferred	
<i>lactobacillus oral tablet , 0.05-0.05 mg</i>	Preferred	
<i>lactobacillus probiotic oral tablet</i>	Preferred	
<i>lacto-pectin oral capsule</i>	Preferred	
MAGE ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
<i>medi-bismuth oral tablet chewable 262 mg</i>	Preferred	
<i>mega probiotic oral capsule</i>	Preferred	
META BIOTIC/BIO-ACTIVE 12 ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
MOMMY'S BLISS PROBIOTIC ORAL PACKET 5 B CELL (<i>lactobacillus rhamnosus (gg)</i>)	Preferred	
MVW COMPLETE PROBIOTIC ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
<i>natrul probiotic oral capsule</i>	Preferred	
<i>newflora probiotic oral capsule</i>	Preferred	
NEXABIOTIC ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
PEARLS IC ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PEPTO-BISMOL MAX STRENGTH ORAL SUSPENSION 525 MG/15ML (<i>bismuth subsalicylate</i>)	Preferred	
PEPTO-BISMOL ORAL SUSPENSION 262 MG/15ML (<i>bismuth subsalicylate</i>)	Preferred	
PEPTO-BISMOL ORAL TABLET 262 MG (<i>bismuth subsalicylate</i>)	Preferred	
PEPTO-BISMOL ORAL TABLET CHEWABLE 262 MG (<i>bismuth subsalicylate</i>)	Preferred	
PEPTO-BISMOL TO-GO ORAL TABLET CHEWABLE 262 MG (<i>bismuth subsalicylate</i>)	Preferred	
PHILLIPS COLON HEALTH ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>pink bismuth maximum strength oral suspension 525 mg/15ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>pink bismuth oral suspension 262 mg/15ml</i>	Preferred	
<i>preorbotic oral capsule</i>	Preferred	
PRIMADOPHILUS BIFIDUS ORAL CAPSULE DELAYED RELEASE (<i>probiotic product</i>)	Preferred	
<i>primadophilus oral capsule</i>	Preferred	
PRIMIDAR ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBIATA ORAL TABLET (<i>lactobacillus</i>)	Preferred	
PROBINATE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBIO DEFENSE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBIOMAX COMPLETE DF ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>probiomax daily df oral capsule</i>	Preferred	
PROBIOMAX IG 26 DF ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBIOMAX LEAN DF ORAL CAPSULE 25 MG (<i>probiotic product</i>)	Preferred	
PROBIOMAX SB DF ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBIOMAX SERENITY ORAL CAPSULE 43.75 MG (<i>lactobacillus</i>)	Preferred	
<i>probiotic & acidophilus ex st oral capsule</i>	Preferred	
<i>probiotic (lactobacillus) oral capsule</i>	Preferred	
<i>probiotic + omega-3 oral capsule</i>	Preferred	
<i>probiotic + turmeric extract oral capsule 400 mg</i>	Preferred	
<i>probiotic 10 ultra strength oral capsule</i>	Preferred	
<i>probiotic acidophilus oral capsule</i>	Preferred	
<i>probiotic blend oral capsule</i>	Preferred	
<i>probiotic childrens oral packet</i>	Preferred	
<i>probiotic childrens oral tablet chewable</i>	Preferred	
<i>probiotic colon support oral capsule</i>	Preferred	
<i>probiotic daily oral capsule</i>	Preferred	
<i>probiotic digestive supp oral capsule</i>	Preferred	
<i>probiotic gold extra strength oral capsule</i>	Preferred	
<i>probiotic mature adult oral capsule</i>	Preferred	
<i>probiotic multi-enzyme oral tablet</i>	Preferred	
<i>probiotic oral capsule 250 mg</i>	Preferred	
PROBIOTIC PEARLS ADVANTAGE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBIOTIC PEARLS MAX POTENCY ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBIOTIC PEARLS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBIOTIC PEARLS WOMENS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>probiotic product oral capsule</i>	Preferred	
<i>probiotic/prebiotic/cranberry oral capsule</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
PROBIOTIC-10 ULTIMATE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROBITROL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>probizen oral capsule</i>	Preferred	
PRO-FLORA IMMUNE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>promella in prebiotic oral capsule</i>	Preferred	
PROMEROL ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
PROVELLA ORAL TABLET (<i>probiotic product</i>)	Preferred	
<i>px stomach relief max st oral suspension 525 mg/15ml</i>	Preferred	
<i>px stomach relief oral suspension 262 mg/15ml</i>	Preferred	
<i>px stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>qc diarrhea relief oral suspension 262 mg/15ml</i>	Preferred	
<i>qc pink bismuth oral suspension 262 mg/15ml, 525 mg/15ml</i>	Preferred	
<i>qc pink bismuth oral tablet 262 mg</i>	Preferred	
<i>qc stomach relief oral suspension 525 mg/30ml</i>	Preferred	
<i>qc stomach relief oral tablet 262 mg</i>	Preferred	
<i>qc stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>qc stomach relief ultra oral suspension 525 mg/15ml</i>	Preferred	
<i>quad-probiotic oral capsule</i>	Preferred	
<i>ra digestive health oral capsule</i>	Preferred	
<i>ra probiotic acidophilus oral capsule 1 mg</i>	Preferred	
<i>ra probiotic colon care oral capsule</i>	Preferred	
<i>ra probiotic complex oral capsule</i>	Preferred	
<i>ra probiotic digestive support oral capsule</i>	Preferred	
<i>ra probiotic max strength oral capsule</i>	Preferred	
<i>ra stomach relief oral suspension 262 mg/15ml</i>	Preferred	
<i>rejuvaflor oral capsule</i>	Preferred	
REPHRESH PRO-B ORAL CAPSULE (<i>lactobacillus</i>)	Preferred	
RESTORA ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
RISA-BID PROBIOTIC ORAL TABLET (<i>probiotic product</i>)	Preferred	
RISAQUAD ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
RISAQUAD-2 ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>saccharomyces boulardii oral capsule 250 mg</i>	Preferred	
SACCHAROMYCIN DF ORAL CAPSULE 250 MG (<i>saccharomyces boulardii</i>)	Preferred	
<i>sb bismuth oral tablet 262 mg</i>	Preferred	
<i>sd probiotic-10 complex ultra oral capsule</i>	Preferred	
<i>sm 4x probiotic oral tablet</i>	Preferred	
<i>sm acidophilus oral capsule , 10 mg</i>	Preferred	
<i>sm advanced probiotic oral capsule</i>	Preferred	
<i>sm probiotic oral capsule 250 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm stomach relief oral suspension 262 mg/15ml, 525 mg/30ml</i>	Preferred	
<i>sm stomach relief oral tablet 262 mg</i>	Preferred	
<i>sm stomach relief oral tablet chewable 262 mg</i>	Preferred	
SOOTHE MAXIMUM STRENGTH ORAL SUSPENSION 525 MG/15ML (<i>bismuth subsalicylate</i>)	Preferred	
SOOTHE ORAL SUSPENSION 262 MG/15ML, 525 MG/30ML (<i>bismuth subsalicylate</i>)	Preferred	
SOOTHE ORAL TABLET CHEWABLE 262 MG (<i>bismuth subsalicylate</i>)	Preferred	
STABLEGI ORAL CAPSULE 250 MG (<i>saccharomyces boulardii</i>)	Preferred	
<i>stomach relief extra strength oral suspension 525 mg/15ml</i>	Preferred	
<i>stomach relief oral suspension 525 mg/15ml, 525 mg/30ml, 527 mg/30ml</i>	Preferred	
<i>stomach relief oral tablet 262 mg</i>	Preferred	
<i>stomach relief oral tablet chewable 262 mg</i>	Preferred	
<i>stomach relief plus oral suspension 525 mg/15ml</i>	Preferred	
<i>stomach relief ultra oral suspension 525 mg/15ml</i>	Preferred	
<i>super probiotic digestive oral capsule</i>	Preferred	
<i>super probiotic oral capsule</i>	Preferred	
<i>superior probiotic oral capsule</i>	Preferred	
<i>triple probiotic oral tablet</i>	Preferred	
TRUBIOTICS DIGEST + IMM HEALTH ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
TRUBIOTICS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
ULTRAFLOA IMMUNE HEALTH ORAL CAPSULE 170 MG (<i>probiotic product</i>)	Preferred	
UP4 PROBIOTICS ADULT ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
UP4 PROBIOTICS MENS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
UP4 PROBIOTICS ULTRA ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
UP4 PROBIOTICS WOMENS ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
UPSPRING DUAL PRENATAL IMMUN ORAL CAPSULE (<i>lactobacillus rhamnosus (gg)</i>)	Preferred	
VH ESSENTIALS OPTIBALANCE ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
VISBIOME HIGH POTENCY ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
VSL#3 ORAL CAPSULE (<i>probiotic product</i>)	Preferred	
<i>xybiotic oral capsule</i>	Preferred	
<i>zelac oral capsule</i>	Preferred	
*ANTIDIARRHEAL/PROBIOTIC COMBINATIONS**		
<i>acidophilus/citrus pectin oral tablet</i>	Preferred	
<i>acidophilus/pectin oral capsule</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
CULTURELLE ADULT ULT BALANCE ORAL CAPSULE (<i>Lactobacillus-inulin</i>)	Preferred	
CULTURELLE DIGESTIVE DAILY ORAL CAPSULE (<i>Lactobacillus-inulin</i>)	Preferred	
CULTURELLE DIGESTIVE DAILY PRO ORAL CAPSULE (<i>Lactobacillus-inulin</i>)	Preferred	
CULTURELLE DIGESTIVE HEALTH ORAL CAPSULE (<i>Lactobacillus-inulin</i>)	Preferred	
CULTURELLE HEALTH (INULIN) ORAL CAPSULE (<i>Lactobacillus-inulin</i>)	Preferred	
CULTURELLE ULTIMATE STRENGTH ORAL CAPSULE (<i>Lactobacillus-inulin</i>)	Preferred	
<i>eql anti-diarrheal anti-gas oral tablet 2-125 mg</i>	Preferred	
<i>eql probiotic acidophilus oral capsule</i>	Preferred	
<i>gnp anti-diarrheal/anti-gas oral tablet 2-125 mg</i>	Preferred	
<i>goodsense anti-diarr/ant-gas oral tablet 2-125 mg</i>	Preferred	
<i>hm anti-diarrheal anti-gas oral tablet 2-125 mg</i>	Preferred	
IMODIUM MULTI-SYMPTOM RELIEF ORAL TABLET 2-125 MG (<i>loperamide-simethicone</i>)	Preferred	
KALA ORAL TABLET (<i>Lactobacillus acid-pectin</i>)	Preferred	
<i>loperamide-simethicone oral tablet 2-125 mg</i>	Preferred	
<i>probiotic digestive support oral capsule</i>	Preferred	
*ANTIDOTES - CHELATING AGENTS**		
<i>deferasirox granules oral packet 180 mg, 360 mg</i>	Preferred	PA
<i>deferasirox oral packet 180 mg, 360 mg</i>	Preferred	PA
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	Preferred	PA
*ANTIDOTES AND SPECIFIC ANTAGONISTS**		
<i>potassium iodide (antidote) oral solution 65 mg/ml</i>	Preferred	
*ANTIEMETICS - MISCELLANEOUS**		
<i>anti-nausea oral solution 1.87-1.87-21.5</i>	Preferred	
<i>cvs nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
EMETROL ORAL SOLUTION 1.87-1.87-21.5 (<i>fructose-dextrose-phosphor acid</i>)	Preferred	
<i>eql anti-nausea oral solution 1.87-1.87-21.5</i>	Preferred	
<i>gnp anti-nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
<i>gnp nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
<i>goodsense nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
<i>nausea control oral solution 1.87-1.87-21.5</i>	Preferred	
<i>nausea relief oral solution 1.87-1.87-21.5</i>	Preferred	
<i>qc anti-nausea oral solution 1.87-1.87-21.5</i>	Preferred	
<i>ra anti-nausea oral solution 1.87-1.87-21.5</i>	Preferred	
<i>sb anti-nausea oral solution 1.87-1.87-21.5</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*ANTIFLATULENTS**		
BICARSIM ORAL TABLET 80 MG (<i>simethicone</i>)	Preferred	
<i>cvs gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>cvs gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>cvs gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>cvs gas relief ultra strength oral capsule 180 mg</i>	Preferred	
<i>cvs infants gas relief oral suspension 20 mg/0.3ml</i>	Preferred	
<i>drxchoice gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>eq gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>eq gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>eq gas relief oral capsule 125 mg</i>	Preferred	
<i>eq infants gas relief oral suspension 20 mg/0.3ml, 40 mg/0.6ml</i>	Preferred	
<i>eql gas gone oral tablet chewable 125 mg</i>	Preferred	
<i>eql gas relief oral capsule 125 mg</i>	Preferred	
<i>eql gas relief ultra strength oral capsule 180 mg</i>	Preferred	
<i>gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>gas relief infants oral liquid 40 mg/0.6ml</i>	Preferred	
<i>gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>gas relief oral liquid 40 mg/0.6ml</i>	Preferred	
<i>gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>gas relief ultra strength oral capsule 180 mg</i>	Preferred	
GAS-X EXTRA STRENGTH ORAL CAPSULE 125 MG (<i>simethicone</i>)	Preferred	
GAS-X EXTRA STRENGTH ORAL STRIP 62.5 MG (<i>simethicone</i>)	Preferred	
GAS-X INFANT DROPS ORAL LIQUID 20 MG/0.3ML (<i>simethicone</i>)	Preferred	
GAS-X ULTRA STRENGTH ORAL CAPSULE 180 MG (<i>simethicone</i>)	Preferred	
<i>gnp anti-gas oral capsule 180 mg</i>	Preferred	
<i>gnp gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>gnp gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>gnp gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>gnp infant gas relief oral suspension 20 mg/0.3ml</i>	Preferred	
<i>goodsense gas relief oral tablet chewable 125 mg</i>	Preferred	
<i>heartland gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>hm gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>infants gas relief oral suspension 20 mg/0.3ml, 40 mg/0.6ml</i>	Preferred	
LITTLE REMEDIES FOR TUMMYS ORAL SUSPENSION 20 MG/0.3ML (<i>simethicone</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
LITTLE REMEDIES GAS RELIEF ORAL SUSPENSION 20 MG/0.3ML (<i>simethicone</i>)	Preferred	
MOMMY'S BLISS GAS RELIEF DROPS ORAL SUSPENSION 20 MG/0.3ML (<i>simethicone</i>)	Preferred	
PEDIACARE INFANTS GAS RELIEF ORAL SUSPENSION 20 MG/0.3ML (<i>simethicone</i>)	Preferred	
PHAZYME MAXIMUM STRENGTH ORAL CAPSULE 250 MG (<i>simethicone</i>)	Preferred	
PHAZYME ORAL TABLET CHEWABLE 125 MG (<i>simethicone</i>)	Preferred	
<i>px gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>px gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>px gas relief ultra strength oral capsule 180 mg</i>	Preferred	
<i>qc anti-gas oral capsule 180 mg</i>	Preferred	
<i>qc gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>qc gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>qc gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>qc gas relief oral capsule 250 mg</i>	Preferred	
<i>qc gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>ra gas relief extra strength oral tablet chewable 125 mg</i>	Preferred	
<i>ra gas relief oral capsule 125 mg</i>	Preferred	
<i>ra gas relief oral tablet chewable 80 mg</i>	Preferred	
<i>ra gas relief ultra strength oral capsule 180 mg</i>	Preferred	
<i>sb anti-gas oral capsule 180 mg</i>	Preferred	
<i>sb gas relief oral suspension 40 mg/0.6ml</i>	Preferred	
<i>sb gas relief oral tablet chewable 125 mg</i>	Preferred	
<i>simeped oral suspension 40 mg/0.6ml</i>	Preferred	
<i>simethicone drops infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>simethicone extra strength oral capsule 125 mg</i>	Preferred	
<i>simethicone oral capsule 125 mg, 180 mg</i>	Preferred	
<i>simethicone oral suspension 40 mg/0.6ml</i>	Preferred	
<i>simethicone oral tablet chewable 125 mg, 80 mg</i>	Preferred	
<i>simethicone ultra strength oral capsule 180 mg</i>	Preferred	
<i>sm gas relief extra strength oral capsule 125 mg</i>	Preferred	
<i>sm gas relief infants drops oral suspension 40 mg/0.6ml</i>	Preferred	
<i>sm gas relief infants oral suspension 20 mg/0.3ml</i>	Preferred	
<i>sm gas relief oral capsule 180 mg</i>	Preferred	
<i>sm gas relief oral tablet chewable 125 mg, 80 mg</i>	Preferred	
<i>teeny tummy gas relief drops oral suspension 20 mg/0.3ml</i>	Preferred	
*ANTIFUNGALS - TOPICAL**		
CRITIC-AID CLEAR AF EXTERNAL OINTMENT 2 % (<i>miconazole nitrate</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
TRIPLE PASTE AF EXTERNAL OINTMENT 2 % (<i>miconazole nitrate</i>)	Preferred	
*ANTIHISTAMINE HYPNOTICS**		
<i>acetaminophen pm ex st oral tablet 500-25 mg</i>	Preferred	
<i>acetaminophen pm oral tablet 500-25 mg</i>	Preferred	
<i>cvs acetaminophen pm ext st oral tablet 500-25 mg</i>	Preferred	
<i>cvs non-aspirin headache pm oral tablet 500-38 mg</i>	Preferred	
<i>cvs pain relief pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>cvs sleep aid nighttime oral tablet 25 mg</i>	Preferred	
<i>cvs sleep aid oral tablet 25 mg</i>	Preferred	
<i>eq acetaminophen pm oral tablet 500-25 mg</i>	Preferred	
<i>eql acetaminophen pm oral tablet 25-500 mg</i>	Preferred	
<i>eql nighttime sleep aid oral tablet 25 mg</i>	Preferred	
<i>eql pain relief pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>gnp pain relief pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>gnp sleep aid nighttime oral tablet 25 mg</i>	Preferred	
<i>goodsense pain relief pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>headache relief pm oral tablet 500-38 mg</i>	Preferred	
HEALTHY MAMA EAZZZE THE PAIN ORAL TABLET 500-25 MG (<i>diphenhydramine-apap (sleep)</i>)	Preferred	
<i>hm nighttime sleep aid oral tablet 25 mg</i>	Preferred	
<i>hm pain reliever pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>kls rapid release apap pm oral tablet 500-25 mg</i>	Preferred	
MEDI-TABS PM EXTRA STRENGTH ORAL TABLET 25-500 MG (<i>diphenhydramine-apap (sleep)</i>)	Preferred	
<i>night time pain medicine ex st oral tablet 25-500 mg</i>	Preferred	
<i>night time sleep aid oral tablet 25 mg</i>	Preferred	
<i>nighttime sleep aid oral tablet 25 mg</i>	Preferred	
<i>non-aspirin pm extra strength oral tablet 25-500 mg</i>	Preferred	
<i>non-aspirin pm oral tablet 25-500 mg</i>	Preferred	
NYTOL QUICKCAPS ORAL TABLET 25 MG (<i>diphenhydramine hcl (sleep)</i>)	Preferred	
<i>pain relief pm extra strength oral tablet 500-25 mg</i>	Preferred	
<i>pain reliever pm ex st oral tablet 25-500 mg, 500-25 mg</i>	Preferred	
<i>pain reliever pm oral tablet 25-500 mg, 500-25 mg</i>	Preferred	
PANADOL PM EXTRA STRENGTH ORAL TABLET 25-500 MG (<i>diphenhydramine-apap (sleep)</i>)	Preferred	
<i>px pain relief pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>qc acetaminophen pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>qc headache relief pm oral tablet 500-38 mg</i>	Preferred	
<i>qc pain relief extra strength oral tablet 500-25 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>qc pain reliever pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>qc rest simply oral tablet 25 mg</i>	Preferred	
<i>ra acetaminophen pm ex st oral tablet 25-500 mg</i>	Preferred	
<i>ra nighttime sleep aid oral tablet 25 mg</i>	Preferred	
<i>ra sleep aid (diphenhydramine) oral tablet 25 mg</i>	Preferred	
<i>sb non-asa night time oral tablet 500-25 mg</i>	Preferred	
<i>sb non-aspirin nighttime oral tablet 500-25 mg</i>	Preferred	
<i>sb pain reliever pm oral tablet 500-25 mg</i>	Preferred	
<i>sb sleep oral tablet 25 mg</i>	Preferred	
SIMPLY SLEEP ORAL TABLET 25 MG (<i>diphenhydramine hcl (sleep)</i>)	Preferred	
<i>sleep aid (diphenhydramine) oral tablet 25 mg</i>	Preferred	
<i>sleep tabs oral tablet 25 mg</i>	Preferred	
<i>sleep-tabs oral tablet 25 mg</i>	Preferred	
<i>sm headache relief pm oral tablet 500-38 mg</i>	Preferred	
<i>sm nighttime sleep aid oral tablet 25 mg</i>	Preferred	
<i>sm pain reliever pm ex st oral tablet 25-500 mg</i>	Preferred	
SOMINEX NIGHTTIME SLEEP-AID ORAL TABLET 25 MG (<i>diphenhydramine hcl (sleep)</i>)	Preferred	
TYLENOL PM EXTRA STRENGTH ORAL TABLET 500-25 MG (<i>diphenhydramine-apap (sleep)</i>)	Preferred	
*ANTIHISTAMINES - ALKYLAMINES**		
ALA-HIST IR ORAL TABLET 2 MG (<i>dexbrompheniramine maleate</i>)	Preferred	
<i>aller-chlor oral tablet 4 mg</i>	Preferred	
<i>allergy oral tablet 4 mg</i>	Preferred	
<i>allergy relief oral tablet 4 mg</i>	Preferred	
<i>chlorhist oral tablet 4 mg</i>	Preferred	
<i>chlorphen oral tablet 4 mg</i>	Preferred	
<i>chlorpheniramine maleate er oral tablet extended release 12 mg</i>	Preferred	
<i>chlorpheniramine maleate oral tablet 4 mg</i>	Preferred	
<i>cvs allergy relief oral tablet extended release 12 mg</i>	Preferred	
DIABETIC TUSSIN ALLERGY ORAL SYRUP 2 MG/5ML (<i>chlorpheniramine maleate</i>)	Preferred	
<i>ed chlorped jr oral syrup 2 mg/5ml</i>	Preferred	
<i>eq chlortabs oral tablet 4 mg</i>	Preferred	
<i>eql allergy oral tablet 4 mg</i>	Preferred	
<i>ft allergy relief oral tablet 4 mg</i>	Preferred	
<i>gnp allergy relief oral tablet 4 mg</i>	Preferred	
HISTEX ORAL SYRUP 2.5 MG/5ML (<i>triprolidine hcl</i>)	Preferred	
HISTEX PD ORAL LIQUID 0.938 MG/ML (<i>triprolidine hcl</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>hm allergy relief oral tablet 4 mg</i>	Preferred	
<i>pharbechlor oral tablet 4 mg</i>	Preferred	
<i>qc allergy relief oral tablet 4 mg</i>	Preferred	
<i>qc chlor-pheniramine oral tablet 4 mg</i>	Preferred	
<i>ra allergy relief oral tablet 4 mg</i>	Preferred	
<i>ra chlorpheniramine maleate oral tablet 4 mg</i>	Preferred	
<i>sb chlorpheniramine oral tablet 4 mg</i>	Preferred	
<i>sm allergy 4 hour oral tablet 4 mg</i>	Preferred	
<i>triprolidine hcl oral liquid 0.625 mg/ml, 0.938 mg/ml</i>	Preferred	
WAL-FINATE ORAL TABLET 4 MG (<i>chlorpheniramine maleate</i>)	Preferred	
*ANTI-HISTAMINES - ETHANOLAMINES**		
<i>aler-cap oral capsule 25 mg</i>	Preferred	
<i>alertab oral tablet 25 mg</i>	Preferred	
ALKA-SELTZER PLUS ALLERGY ORAL TABLET 25 MG (<i>diphenhydramine hcl</i>)	Preferred	
<i>allergy childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>allergy relief childrens oral tablet dispersible 12.5 mg</i>	Preferred	
<i>allergy relief oral capsule 25 mg</i>	Preferred	
<i>allergy relief oral liquid 25 mg/10ml</i>	Preferred	
<i>allergy relief oral tablet 25 mg</i>	Preferred	
<i>anti-hist allergy oral tablet 25 mg</i>	Preferred	
BANOPHEN ORAL CAPSULE 25 MG, 50 MG (<i>diphenhydramine hcl</i>)	Preferred	
BANOPHEN ORAL TABLET 25 MG (<i>diphenhydramine hcl</i>)	Preferred	
BENADRYL ALLERGY CHILDRENS ORAL TABLET CHEWABLE 12.5 MG (<i>diphenhydramine hcl</i>)	Preferred	
BENADRYL ALLERGY EXTRA STR ORAL TABLET 50 MG (<i>diphenhydramine hcl</i>)	Preferred	
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>carbinoxamine maleate oral tablet 4 mg</i>	Preferred	AGE (Min 2 Years)
<i>clemastine fumarate oral tablet 2.68 mg</i>	Preferred	AGE (Min 2 Years)
<i>complete allergy medicine oral capsule 25 mg</i>	Preferred	
<i>complete allergy medicine oral tablet 25 mg</i>	Preferred	
<i>complete allergy relief oral tablet 25 mg</i>	Preferred	
<i>cvs allergy oral capsule 25 mg</i>	Preferred	
<i>cvs allergy relief adult oral liquid 50 mg/20ml</i>	Preferred	
<i>cvs allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>cvs allergy relief childrens oral tablet chewable 12.5 mg</i>	Preferred	
<i>cvs allergy relief childrens oral tablet dispersible 12.5 mg</i>	Preferred	
<i>cvs allergy relief oral capsule 25 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>cvs allergy relief oral liquid 25 mg/10ml</i>	Preferred	
<i>cvs allergy relief oral tablet 25 mg</i>	Preferred	
<i>cvs childrens allergy oral liquid 12.5 mg/5ml</i>	Preferred	
DAYHIST ALLERGY 12 HOUR RELIEF ORAL TABLET 1.34 MG (clemastine fumarate)	Preferred	
<i>diphen oral tablet 25 mg</i>	Preferred	
<i>diphenhydramine hcl childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	Preferred	
<i>diphenhydramine hcl oral capsule 25 mg, 50 mg</i>	Preferred	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	Preferred	
<i>diphenhydramine hcl oral liquid 12.5 mg/5ml</i>	Preferred	
<i>diphenhydramine hcl oral tablet 25 mg</i>	Preferred	
<i>diphenhydramine hcl oral tablet chewable 12.5 mg</i>	Preferred	
<i>eq allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>eq allergy relief oral capsule 25 mg</i>	Preferred	
<i>eq allergy relief oral tablet 25 mg</i>	Preferred	
<i>eql allergy oral tablet 25 mg</i>	Preferred	
<i>eql allergy relief childrens oral tablet dispersible 12.5 mg</i>	Preferred	
<i>eql allergy relief oral tablet 25 mg</i>	Preferred	
<i>eql childrens allergy oral liquid 12.5 mg/5ml</i>	Preferred	
<i>ft allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>ft allergy relief oral capsule 25 mg</i>	Preferred	
<i>ft allergy relief oral tablet 25 mg</i>	Preferred	
<i>geri-dryl oral liquid 12.5 mg/5ml</i>	Preferred	
<i>geri-dryl oral tablet 25 mg</i>	Preferred	
<i>gnp allergy oral capsule 25 mg</i>	Preferred	
<i>gnp allergy oral tablet 25 mg</i>	Preferred	
<i>gnp allergy relief max st oral liquid 12.5 mg/5ml</i>	Preferred	
<i>gnp allergy relief oral capsule 25 mg</i>	Preferred	
<i>gnp allergy relief oral tablet 25 mg</i>	Preferred	
<i>gnp allergy relief oral tablet chewable 12.5 mg</i>	Preferred	
<i>gnp childrens allergy oral liquid 12.5 mg/5ml</i>	Preferred	
<i>h-e-b childrens allergy oral liquid 12.5 mg/5ml</i>	Preferred	
<i>hm allergy relief oral capsule 25 mg</i>	Preferred	
KINDERMED KIDS ALLERGY ORAL LIQUID 12.5 MG/5ML (diphenhydramine hcl)	Preferred	
<i>kls allergy medicine oral tablet 25 mg</i>	Preferred	
<i>kp diphenhydramine hcl oral capsule 50 mg</i>	Preferred	
<i>liquid allergy relief oral liquid 12.5 mg/5ml</i>	Preferred	
<i>m-dryl oral liquid 12.5 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MEDI-PHEDRYL ORAL CAPSULE 25 MG (<i>diphenhydramine hcl</i>)	Preferred	
<i>meijer antihistamine allergy oral capsule 25 mg</i>	Preferred	
MM ALLER-BEN ORAL TABLET 25 MG (<i>diphenhydramine hcl</i>)	Preferred	
NARAMIN ORAL LIQUID 12.5 MG/5ML (<i>diphenhydramine hcl</i>)	Preferred	
PEDIACARE CHILDRENS ALLERGY ORAL LIQUID 12.5 MG/5ML (<i>diphenhydramine hcl</i>)	Preferred	
<i>pharbedryl oral capsule 25 mg, 50 mg</i>	Preferred	
<i>px allergy oral capsule 25 mg</i>	Preferred	
<i>px allergy oral liquid 12.5 mg/5ml</i>	Preferred	
<i>px allergy oral tablet 25 mg</i>	Preferred	
PX DAYHIST ALLERGY ORAL TABLET 1.34 MG (<i>clemastine fumarate</i>)	Preferred	
<i>qc allergy childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>qc allergy relief oral capsule 25 mg</i>	Preferred	
<i>qc allergy relief oral tablet 25 mg</i>	Preferred	
<i>qc complete allergy medicine oral tablet 25 mg</i>	Preferred	
<i>ra allergy medication oral capsule 25 mg</i>	Preferred	
<i>ra allergy medication oral liquid 12.5 mg/5ml</i>	Preferred	
<i>ra allergy medication oral tablet 25 mg</i>	Preferred	
<i>ra allergy oral liquid 12.5 mg/5ml</i>	Preferred	
<i>ra allergy oral tablet 25 mg</i>	Preferred	
<i>ra allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>ra allergy relief childrens oral tablet dispersible 12.5 mg</i>	Preferred	
<i>ra allergy relief oral capsule 25 mg</i>	Preferred	
<i>ra complete allergy oral tablet 25 mg</i>	Preferred	
RA DIPHEDRYL ALLERGY ORAL LIQUID 12.5 MG/5ML (<i>diphenhydramine hcl</i>)	Preferred	
<i>sb allergy medicine oral liquid 12.5 mg/5ml</i>	Preferred	
<i>sb allergy medicine oral tablet 25 mg</i>	Preferred	
<i>sb allergy oral capsule 25 mg</i>	Preferred	
<i>siladryl allergy oral liquid 12.5 mg/5ml</i>	Preferred	
<i>sm allergy relief childrens oral liquid 12.5 mg/5ml</i>	Preferred	
<i>sm allergy relief oral tablet 25 mg</i>	Preferred	
TOTAL ALLERGY MEDICINE ORAL LIQUID 12.5 MG/5ML (<i>diphenhydramine hcl</i>)	Preferred	
<i>total allergy oral tablet 25 mg</i>	Preferred	
WAL-DRYL ALLERGY CHILDRENS ORAL LIQUID 12.5 MG/5ML (<i>diphenhydramine hcl</i>)	Preferred	
WAL-DRYL ALLERGY ORAL CAPSULE 25 MG (<i>diphenhydramine hcl</i>)	Preferred	
WAL-DRYL ALLERGY ORAL LIQUID 12.5 MG/5ML (<i>diphenhydramine hcl</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
WAL-DRYL ALLERGY ORAL TABLET 25 MG (<i>diphenhydramine hcl</i>)	Preferred	
WAL-DRYL ALLERGY REL CHILDRENS ORAL TABLET DISPERSIBLE 12.5 MG (<i>diphenhydramine hcl</i>)	Preferred	
*ANTI-HISTAMINES - NON-SEDATING**		
<i>cvs allergy relief oral tablet dispersible 5 mg</i>	Preferred	
*ANTI-HISTAMINES - PHENOTHIAZINES**		
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	Preferred	QL (100 ML per 1 day); AGE (Min 2 Years and Max 64 Years)
*ANTI-HISTAMINES - PIPERAZINES**		
AHIST ORAL TABLET 25 MG (<i>chlorcyclizine hcl</i>)	Preferred	
*ANTI-HISTAMINES - PIPERIDINES**		
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>cyproheptadine hcl oral tablet 4 mg</i>	Preferred	AGE (Min 2 Years)
*ANTI-HISTAMINES-TOPICAL**		
<i>anti-itch external cream 2-0.1 %</i>	Preferred	
<i>anti-itch extra strength external cream 2-0.1 %</i>	Preferred	
BANOPHEN EXTERNAL CREAM 2-0.1 % (<i>diphenhydramine-zinc acetate</i>)	Preferred	
BENADRYL EXTRA STRENGTH EXTERNAL CREAM 2-0.1 % (<i>diphenhydramine-zinc acetate</i>)	Preferred	
<i>cvs itch relief extra strength external cream 2-0.1 %</i>	Preferred	
<i>diphenhydramine-zinc acetate external cream 2-0.1 %</i>	Preferred	
<i>gnp anti-itch external cream 2-0.1 %</i>	Preferred	
<i>itch relief extra strength external cream 2-0.1 %</i>	Preferred	
<i>qc anti-itch extra strength external cream 2-0.1 %</i>	Preferred	
<i>ra allergy external cream 2-0.1 %</i>	Preferred	
<i>ra anti-itch skin protectant external cream 2-0.1 %</i>	Preferred	
<i>sm anti-itch extra strength external cream 2-0.1 %</i>	Preferred	
WAL-DRYL EXTERNAL CREAM 2-0.1 % (<i>diphenhydramine-zinc acetate</i>)	Preferred	
*ANTI-INFECTIVE AGENTS - MISC.**		
<i>trimethoprim oral tablet 100 mg</i>	Preferred	
*ANTI-INFECTIVE MISC. - COMBINATIONS**		
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	Preferred	Max 90-day supply per fill
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	Preferred	Max 90-day supply per fill
<i>sulfamethoxazole-trimethoprim (Sulfatrim Pediatric Oral Suspension 200-40 Mg/5MI)</i>	Preferred	Max 90-day supply per fill
*ANTIMALARIAL COMBINATIONS**		
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*ANTIMALARIALS**		
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	Preferred	PA
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	Preferred	
<i>mefloquine hcl oral tablet 250 mg</i>	Preferred	
<i>quinine sulfate oral capsule 324 mg</i>	Preferred	QL (42 EA per 365 days)
*ANTIMANIC AGENTS**		
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	Preferred	Max 90-day supply per fill
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	Preferred	Max 90-day supply per fill
<i>lithium carbonate oral tablet 300 mg</i>	Preferred	Max 90-day supply per fill
*ANTIMETABOLITES**		
<i>capecitabine oral tablet 150 mg, 500 mg</i>	Preferred	PA
<i>mercaptopurine oral tablet 50 mg</i>	Preferred	
*ANTIMYASTHENIC/CHOLINERGIC AGENTS**		
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	Preferred	
<i>pyridostigmine bromide oral tablet 60 mg</i>	Preferred	
*ANTIMYCOBACTERIAL AGENTS**		
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	Preferred	
<i>isoniazid oral syrup 50 mg/5ml</i>	Preferred	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	Preferred	
<i>rifabutin oral capsule 150 mg</i>	Preferred	PA
<i>rifampin oral capsule 150 mg, 300 mg</i>	Preferred	
*ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS**		
<i>abiraterone acetate oral tablet 250 mg</i>	Preferred	PA; QL (4 EA per 1 day)
<i>abiraterone acetate oral tablet 500 mg</i>	Preferred	PA; QL (2 EA per 1 day)
<i>anastrozole oral tablet 1 mg</i>	Preferred	
<i>bicalutamide oral tablet 50 mg</i>	Preferred	
<i>EULEXIN ORAL CAPSULE 125 MG (flutamide)</i>	Preferred	
<i>letrozole oral tablet 2.5 mg</i>	Preferred	
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	Preferred	
*ANTINEOPLASTIC ENZYME INHIBITORS**		
<i>imatinib mesylate oral tablet 100 mg</i>	Preferred	PA; QL (8 EA per 1 day)
<i>imatinib mesylate oral tablet 400 mg</i>	Preferred	PA; QL (2 EA per 1 day)
<i>sunitinib malate oral capsule 12.5 mg</i>	Preferred	PA; QL (7 EA per 1 day)
<i>sunitinib malate oral capsule 25 mg</i>	Preferred	PA; QL (3 EA per 1 day)
<i>sunitinib malate oral capsule 37.5 mg, 50 mg</i>	Preferred	PA; QL (1 EA per 1 day)
*ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL**		
<i>diclofenac sodium external gel 3 %</i>	Preferred	PA; QL (3.334 GM per 1 day)

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<i>fluorouracil external cream 5 %</i>	Preferred	
<i>fluorouracil external solution 5 %</i>	Preferred	
*ANTINEOPLASTICS MISC.**		
<i>hydroxyurea oral capsule 500 mg</i>	Preferred	
<i>tretinoin oral capsule 10 mg</i>	Preferred	PA; QL (90 EA per 365 days)
*ANTIPARKINSON ANTICHOLINERGICS**		
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	Preferred	Max 90-day supply per fill
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	Preferred	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	Preferred	
*ANTIPARKINSON DOPAMINERGICS**		
<i>amantadine hcl oral capsule 100 mg</i>	Preferred	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	Preferred	Max 90-day supply per fill
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	Preferred	Max 90-day supply per fill
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg</i>	Preferred	Max 90-day supply per fill
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	Preferred	
DHIVY ORAL TABLET 25-100 MG (<i>carbidopa-levodopa</i>)	Preferred	Max 90-day supply per fill
*ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS**		
<i>selegiline hcl oral capsule 5 mg</i>	Preferred	
<i>selegiline hcl oral tablet 5 mg</i>	Preferred	
*ANTIPERISTALTIC AGENTS**		
<i>anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>anti-diarrheal oral liquid 1 mg/7.5ml</i>	Preferred	
<i>anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>cvs anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>cvs anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>diamode oral tablet 2 mg</i>	Preferred	
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	Preferred	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	Preferred	
<i>eq anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>eq anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>eql anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>gnp anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>gnp anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>gnp loperamide hcl oral liquid 1 mg/7.5ml</i>	Preferred	
<i>goodsense anti-diarrheal oral liquid 1 mg/7.5ml</i>	Preferred	
<i>hm anti-diarrheal oral liquid 1 mg/7.5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>loperamide hcl oral capsule 2 mg</i>	Preferred	
<i>loperamide hcl oral liquid 1 mg/7.5ml</i>	Preferred	
<i>loperamide hcl oral suspension 1 mg/7.5ml</i>	Preferred	
<i>loperamide hcl oral tablet 2 mg</i>	Preferred	
<i>meijer anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>px anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>qc anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>qc anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>ra anti-diarrheal oral tablet 2 mg</i>	Preferred	
<i>sb anti-diarrhea oral tablet 2 mg</i>	Preferred	
<i>sm anti-diarrheal oral capsule 2 mg</i>	Preferred	
<i>sm anti-diarrheal oral liquid 1 mg/7.5ml</i>	Preferred	
<i>sm anti-diarrheal oral tablet 2 mg</i>	Preferred	
*ANTIPROTOZOAL AGENTS**		
<i>atovaquone oral suspension 750 mg/5ml</i>	Preferred	PA
*ANTIRETROVIRALS**		
<i>stavudine oral capsule 30 mg</i>	Preferred	
*ANTISEBORRHEIC PRODUCTS**		
<i>anti-dandruff external shampoo 1 %</i>	Preferred	
<i>beta med external shampoo 2 %</i>	Preferred	
<i>cvs anti-dandruff external lotion 1 %</i>	Preferred	
<i>dandruff shampoo external lotion 1 %</i>	Preferred	
DERMAZINC CREAM EXTERNAL CREAM (<i>antiseborrheic products, misc.</i>)	Preferred	
DERMAZINC SHAMPOO EXTERNAL SHAMPOO 2 % (<i>pyrithione zinc</i>)	Preferred	
<i>eql medicated dandruff external lotion 1 %</i>	Preferred	
NUTRASEB EXTERNAL CREAM (<i>antiseborrheic products, misc.</i>)	Preferred	
PROMISEB EXTERNAL CREAM (<i>antiseborrheic products, misc.</i>)	Preferred	
<i>selenium sulfide external lotion 2.5 %</i>	Preferred	
<i>selenium sulfide external shampoo 2.25 %</i>	Preferred	
*ANTISEPTICS - MOUTH/THROAT**		
CHLORASEPTIC MOUTH/THROAT LIQUID 1.4 % (<i>phenol</i>)	Preferred	
CHLORASEPTIC WARM SORE THROAT MOUTH/THROAT LIQUID 1.4 % (<i>phenol</i>)	Preferred	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	Preferred	
<i>cvs sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	
DIABETIC TUSSIN SORE THROAT MOUTH/THROAT LIQUID 1.4 % (<i>phenol</i>)	Preferred	
<i>eql sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	
<i>gnp sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>goodsense sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	
<i>ora relief mouth/throat liquid 1.4 %</i>	Preferred	
<i>oral relief mouth/throat liquid 1.4 %</i>	Preferred	
<i>oralseptic mouth/throat liquid 1.4 %</i>	Preferred	
<i>chlorhexidine gluconate (Periogard Mouth/Throat Solution 0.12 %)</i>	Preferred	
<i>phenaseptic mouth/throat liquid 1.4 %</i>	Preferred	
<i>px sore throat mouth/throat liquid 1.4 %</i>	Preferred	
<i>ra sore throat mouth/throat liquid 1.4 %</i>	Preferred	
<i>sb sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	
<i>sm sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	
<i>sore throat mouth/throat liquid , 1.4 %</i>	Preferred	
<i>sore throat spray mouth/throat liquid 1.4 %</i>	Preferred	
*ANTISPASMODICS**		
<i>dicyclomine hcl oral capsule 10 mg</i>	Preferred	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	Preferred	
<i>dicyclomine hcl oral tablet 20 mg</i>	Preferred	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	Preferred	
*ANTITHYROID AGENTS**		
<i>methimazole oral tablet 10 mg, 5 mg</i>	Preferred	
<i>propylthiouracil oral tablet 50 mg</i>	Preferred	
*ANTITUSSIVES**		
<i>benzonatate oral capsule 100 mg</i>	Preferred	QL (6 EA per 1 day); AGE (Min 6 Years)
<i>benzonatate oral capsule 200 mg</i>	Preferred	QL (2 EA per 1 day)
<i>cough dm childrens oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>cvs cough dm childrens oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>cvs cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>cvs tussin long-acting oral liquid 15 mg/5ml</i>	Preferred	
<i>cvs tussin maximum strength oral syrup 15 mg/5ml</i>	Preferred	
<i>daytime cough oral liquid 15 mg/15ml</i>	Preferred	
<i>DELSYM COUGH CHILDRENS ORAL SUSPENSION EXTENDED RELEASE 30 MG/5ML (dextromethorphan polistirex)</i>	Preferred	
<i>DELSYM ORAL SUSPENSION EXTENDED RELEASE 30 MG/5ML (dextromethorphan polistirex)</i>	Preferred	
<i>dextromethorphan hbr oral capsule 15 mg</i>	Preferred	
<i>dextromethorphan polistirex er oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>eq cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	

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<i>eql cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
GILTUSS HONEY DM CHILDRENS ORAL LIQUID 15 MG/5ML (<i>dextromethorphan hbr</i>)	Preferred	
GILTUSS HONEY DM ORAL LIQUID 30 MG/10ML (<i>dextromethorphan hbr</i>)	Preferred	
<i>gnp cough dm er oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>gnp tussin cough long acting oral syrup 15 mg/5ml</i>	Preferred	
<i>goodsense cough dm childrens oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>goodsense cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>hm cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
<i>px tussin max oral syrup 15 mg/5ml</i>	Preferred	
<i>qc cough relief oral liquid 15 mg/5ml</i>	Preferred	
<i>ra cough dm oral suspension extended release 30 mg/5ml</i>	Preferred	
ROBITUSSIN 12 HOUR COUGH CHILD ORAL SUSPENSION EXTENDED RELEASE 30 MG/5ML (<i>dextromethorphan polistirex</i>)	Preferred	
ROBITUSSIN 12 HOUR COUGH ORAL SUSPENSION EXTENDED RELEASE 30 MG/5ML (<i>dextromethorphan polistirex</i>)	Preferred	
<i>sm cough relief oral syrup 15 mg/5ml</i>	Preferred	
<i>tussin cough oral capsule 15 mg</i>	Preferred	
<i>tussin cough oral syrup 15 mg/5ml</i>	Preferred	
VICKS DAYQUIL COUGH ORAL LIQUID 15 MG/15ML (<i>dextromethorphan hbr</i>)	Preferred	
WAL-TUSSIN COUGH LONG ACTING ORAL LIQUID 15 MG/5ML (<i>dextromethorphan hbr</i>)	Preferred	
WAL-TUSSIN COUGH LONG ACTING ORAL SYRUP 15 MG/5ML (<i>dextromethorphan hbr</i>)	Preferred	
WAL-TUSSIN COUGH ORAL CAPSULE 15 MG (<i>dextromethorphan hbr</i>)	Preferred	
*ARTIFICIAL TEARS AND LUBRICANTS**		
ALCON TEARS OPHTHALMIC SOLUTION 0.5 % (<i>hypromellose</i>)	Preferred	
ALTALUBE OPHTHALMIC OINTMENT 85-15 % (<i>white petrolatum-mineral oil</i>)	Preferred	
<i>artificial tears ophthalmic solution , 0.1-0.3 % , 0.2-0.2-1 % , 0.5-0.6 % , 1 % , 5-6 mg/ml</i>	Preferred	
<i>artificial tears pf ophthalmic solution 0.1-0.3 %</i>	Preferred	
BIOLLE GEL TEARS OPHTHALMIC GEL 1 % (<i>carboxymethylcellulose sodium</i>)	Preferred	
BIOLLE TEARS OPHTHALMIC SOLUTION 0.5 % (<i>carboxymethylcellulose sodium</i>)	Preferred	
BION TEARS PF OPHTHALMIC SOLUTION 0.1-0.3 % (<i>dextran 70-hypromellose</i>)	Preferred	
<i>carboxymethylcellulose sodium ophthalmic solution 0.5 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
CLEAR EYES NATURAL TEARS OPHTHALMIC SOLUTION 5-6 MG/ML (<i>polyvinyl alcohol-povidone</i>)	Preferred	
<i>cvs dry eye relief ophthalmic solution 0.2-0.2-1 %</i>	Preferred	
<i>cvs dry-eye relief nighttime ophthalmic ointment 42.5-57.3 %</i>	Preferred	
<i>cvs eye lubricant ophthalmic ointment</i>	Preferred	
<i>cvs lubricant drops fast act ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>cvs lubricant drops long last ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>cvs lubricant drops ophthalmic gel 1 %</i>	Preferred	
<i>cvs lubricant drops ophthalmic solution 0.6 %</i>	Preferred	
<i>cvs lubricant eye drops (pf) ophthalmic solution 0.4-0.3 %, 0.5 %</i>	Preferred	
<i>cvs lubricant eye drops ophthalmic solution 0.4-0.3 %, 0.5 %, 0.6 %</i>	Preferred	
<i>cvs lubricating eye/overnight ophthalmic ointment</i>	Preferred	
<i>cvs natural tears pf ophthalmic solution 0.1-0.3 %</i>	Preferred	
<i>cvs nighttime dry-eye relief ophthalmic ointment</i>	Preferred	
<i>dry eye relief drops ophthalmic solution 0.2-0.2-1 %</i>	Preferred	
<i>dry eye relief ophthalmic gel 0.4-0.3 %, 1 %</i>	Preferred	
<i>eq lubricant eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>eq restore plus lubricant eye ophthalmic solution 0.5 %</i>	Preferred	
EQ RESTORE PM OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
<i>eq restore tears ophthalmic solution 0.5 %</i>	Preferred	
<i>eye lubricant ophthalmic ointment</i>	Preferred	
<i>for sty relief ophthalmic ointment 31.9-57.7 %</i>	Preferred	
FRESHKOTE OPHTHALMIC SOLUTION 2.7-2 % (<i>polyvinyl alcohol-povidone</i>)	Preferred	
GENTEAL SEVERE OPHTHALMIC GEL 0.3 % (<i>hypromellose</i>)	Preferred	
GENTEAL TEARS NIGHT-TIME OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
GENTEAL TEARS OPHTHALMIC SOLUTION 0.1-0.2-0.3 % (<i>artificial tear solution</i>)	Preferred	
GENTEAL TEARS SEVERE DAY/NIGHT OPHTHALMIC GEL 0.4-0.3 % (<i>polyethyl glycol-propyl glycol</i>)	Preferred	
<i>gnp artificial tears ophthalmic solution 5-6 mg/ml</i>	Preferred	
<i>gnp eye drops long lasting ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>gnp eye drops ophthalmic solution 0.2-0.2-1 %</i>	Preferred	
<i>gnp lubricating plus eye drops ophthalmic solution 0.5 %</i>	Preferred	
<i>goodsense artificial tears ophthalmic solution 0.5-0.6 %</i>	Preferred	
<i>goodsense lubricating eye drop ophthalmic solution 0.5 %</i>	Preferred	
<i>goodsense ultra lubricant drop ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>hm dry eye relief ophthalmic solution 0.2-0.2-1 %</i>	Preferred	

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<i>hm lubricating tears ophthalmic solution 0.4-0.3 %</i>	Preferred	
HYPOTEARs OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
<i>just tears eye drops ophthalmic solution</i>	Preferred	
<i>lubricant drops/dual-action ophthalmic solution 0.5-0.9 %</i>	Preferred	
<i>lubricant eye drops (pf) ophthalmic solution 0.1-0.3 %, 0.4-0.3 %</i>	Preferred	
<i>lubricant eye drops ophthalmic solution 0.4-0.3 %, 0.5 %, 0.6 %</i>	Preferred	
<i>lubricant eye drops pf ophthalmic solution 0.5 %</i>	Preferred	
<i>lubricant eye fast acting ophthalmic ointment</i>	Preferred	
<i>lubricant eye nighttime ophthalmic ointment</i>	Preferred	
<i>lubricant eye ophthalmic ointment</i>	Preferred	
<i>lubricant pm ophthalmic ointment</i>	Preferred	
<i>lubricating eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>lubricating plus eye drops ophthalmic solution 0.5 %</i>	Preferred	
<i>lubricating tears eye drops ophthalmic solution 0.1-0.3 %</i>	Preferred	
<i>lubrifresh p.m. ophthalmic ointment</i>	Preferred	
<i>polyvinyl alcohol ophthalmic solution 1.4 %</i>	Preferred	
PURE & GENTLE LUBRICANT OPHTHALMIC SOLUTION 3 MG/ML (<i>hypromellose</i>)	Preferred	
<i>px artificial tears ophthalmic solution 5-6 mg/ml</i>	Preferred	
<i>qc artificial tears ophthalmic solution 5-6 mg/ml</i>	Preferred	
<i>ra lubricant eye drops ophthalmic solution 0.5 %, 0.6 %</i>	Preferred	
<i>ra lubricant eye ophthalmic solution 0.4-0.3 %</i>	Preferred	
REFRESH CELLUVISC OPHTHALMIC GEL 1 % (<i>carboxymethylcellulose sodium</i>)	Preferred	
REFRESH DIGITAL OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH DIGITAL PF OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH LACRI-LUBE OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
REFRESH LIQUIGEL OPHTHALMIC GEL 1 % (<i>carboxymethylcellulose sodium</i>)	Preferred	
REFRESH OPHTHALMIC SOLUTION 1.4-0.6 % (<i>polyvinyl alcohol-povidone</i>)	Preferred	
REFRESH OPTIVE ADVANCED OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH OPTIVE ADVANCED PF OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	
REFRESH OPTIVE MEGA-3 OPHTHALMIC SOLUTION 0.5-1-0.5 % (<i>carboxymeth-glycerin-polysorb</i>)	Preferred	

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REFRESH OPTIVE OPHTHALMIC GEL 1-0.9 % (<i>carboxymethylcellul-glycerin</i>)	Preferred	
REFRESH OPTIVE PF OPHTHALMIC SOLUTION 0.5-0.9 % (<i>carboxymethylcellul-glycerin</i>)	Preferred	
REFRESH RELIEVA PF OPHTHALMIC SOLUTION 0.5-0.9 % (<i>carboxymethylcellul-glycerin</i>)	Preferred	
REFRESH TEARS OPHTHALMIC SOLUTION 0.5 % (<i>carboxymethylcellulose sodium</i>)	Preferred	
RETAIN PM OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
<i>sm artificial tears ophthalmic solution</i>	Preferred	
<i>sm dry eye relief ophthalmic solution 0.2-0.2-1 %</i>	Preferred	
<i>sm lubricant eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>sm lubricating plus ophthalmic solution 0.5 %</i>	Preferred	
<i>sm lubricating tears ophthalmic solution 0.4-0.3 %</i>	Preferred	
SOOTHE HYDRATION OPHTHALMIC SOLUTION 1.25 % (<i>artificial tear solution</i>)	Preferred	
SOOTHE NIGHTTIME OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
SOOTHE XP OPHTHALMIC SOLUTION (<i>artificial tear solution</i>)	Preferred	
SOOTHE XP XTRA PROTECTION OPHTHALMIC SOLUTION (<i>artificial tear solution</i>)	Preferred	
STYE OPHTHALMIC OINTMENT 31.9-57.7 % (<i>white petrolatum-mineral oil</i>)	Preferred	
STYE OPHTHALMIC SOLUTION 0.5-0.6 % (<i>polyvinyl alcohol-povidone</i>)	Preferred	
SYSTANE BALANCE OPHTHALMIC SOLUTION 0.6 % (<i>propylene glycol</i>)	Preferred	
SYSTANE COMPLETE OPHTHALMIC SOLUTION 0.6 % (<i>propylene glycol</i>)	Preferred	
SYSTANE CONTACTS OPHTHALMIC SOLUTION (<i>artificial tear solution</i>)	Preferred	
SYSTANE NIGHTTIME OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
SYSTANE OPHTHALMIC GEL 0.4-0.3 % (<i>polyethyl glycol-propyl glycol</i>)	Preferred	
THERATEARS NIGHTTIME OPHTHALMIC GEL 1 % (<i>carboxymethylcellulose sodium</i>)	Preferred	
ULTRA FRESH OPHTHALMIC SOLUTION 0.5 % (<i>carboxymethylcellulose sodium</i>)	Preferred	
ULTRA FRESH PM OPHTHALMIC OINTMENT (<i>white petrolatum-mineral oil</i>)	Preferred	
<i>ultra lubricating eye drops ophthalmic solution 0.4-0.3 %</i>	Preferred	
<i>ultra lubricating eye drops pf ophthalmic solution 0.4-0.3 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*B-COMPLEX VITAMINS**		
<i>b complex oral capsule</i>	Preferred	
<i>b complex vitamins oral capsule</i>	Preferred	
<i>b-complex plus b-12 oral tablet</i>	Preferred	
<i>b-complex/b-12 oral tablet</i>	Preferred	
<i>ra b-complex oral tablet</i>	Preferred	
<i>ra b-complex with b-12 oral tablet</i>	Preferred	
<i>vitamin b complex oral capsule</i>	Preferred	
<i>vitamin b complex oral tablet</i>	Preferred	
<i>vitamin-b complex oral tablet</i>	Preferred	
*B-COMPLEX W/ C**		
ALLBEE/C ORAL TABLET (<i>b complex-c</i>)	Preferred	
<i>b complex-c oral capsule</i>	Preferred	
<i>b complex-c oral tablet</i>	Preferred	
<i>b complex-vitamin c oral capsule</i>	Preferred	
<i>b-complex-c oral tablet</i>	Preferred	
<i>bec/zinc oral tablet</i>	Preferred	
<i>better b complex oral tablet</i>	Preferred	
<i>cvs b complex plus c oral tablet</i>	Preferred	
<i>cvs stress formula/zinc oral tablet</i>	Preferred	
<i>cvs super b complex/c oral tablet</i>	Preferred	
<i>eql stress b-complex c/zinc oral tablet</i>	Preferred	
<i>gnp b-complex plus vitamin c oral tablet</i>	Preferred	
<i>hm b complex/c oral tablet</i>	Preferred	
<i>qc b-complex/vitamin c oral tablet</i>	Preferred	
<i>sm super b complex/c oral tablet</i>	Preferred	
<i>sm vitamin b complex/vitamin c oral tablet</i>	Preferred	
<i>stress b/zinc oral tablet</i>	Preferred	
<i>stress b-complex/vit c/zinc oral tablet</i>	Preferred	
<i>stress formula/zinc (b-compl) oral tablet</i>	Preferred	
<i>stress plus zinc oral tablet</i>	Preferred	
<i>super b complex/vitamin c oral tablet</i>	Preferred	
<i>super b/c oral capsule</i>	Preferred	
<i>super b-complex + vitamin c oral tablet</i>	Preferred	
<i>vitamin b + c complex oral tablet</i>	Preferred	
<i>vitamin b complex-c oral capsule</i>	Preferred	
<i>zinc-vites oral tablet</i>	Preferred	
*B-COMPLEX W/ FOLIC ACID**		
<i>activite oral tablet 1 mg</i>	Preferred	
<i>b complex-c-folic acid (Dexifol Oral Tablet 5 Mg)</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
DIALYVITE 800 ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	Preferred	
DIALYVITE 800/ZINC ORAL TABLET 0.8 MG (<i>b complex-c-zn-folic acid</i>)	Preferred	
DIALYVITE 800-ZINC 15 ORAL TABLET 0.8 MG (<i>b complex-c-zn-folic acid</i>)	Preferred	
<i>b complex-c-folic acid</i> (Dialyvite Oral Tablet)	Preferred	
<i>folbee plus oral tablet</i>	Preferred	
<i>full spectrum b/vitamin c oral tablet 0.8 mg</i>	Preferred	
<i>b complex-c-folic acid</i> (Genicin Vita-S Oral Tablet 1 Mg)	Preferred	
<i>b complex-c-folic acid</i> (Mynephron Oral Capsule 1 Mg)	Preferred	
<i>nephro vitamins oral tablet 0.8 mg</i>	Preferred	
<i>b complex-c-folic acid</i> (Nephronex Oral Tablet)	Preferred	
NEPHRO-VITE ORAL TABLET 0.8 MG (<i>b complex-c-folic acid</i>)	Preferred	
<i>b complex-c-folic acid</i> (Renal Oral Capsule 1 Mg)	Preferred	
<i>renal vitamin oral tablet 0.8 mg</i>	Preferred	
<i>rena-vite oral tablet</i>	Preferred	
<i>rena-vite rx oral tablet 1 mg</i>	Preferred	
<i>reno caps oral capsule 1 mg</i>	Preferred	
<i>tm-vite rx oral tablet 1 mg</i>	Preferred	
<i>triphrocaps oral capsule 1 mg</i>	Preferred	
<i>tronvite oral tablet 1 mg</i>	Preferred	
<i>virt-caps oral capsule 1 mg</i>	Preferred	
<i>vitasure oral tablet 1 mg</i>	Preferred	
<i>vp-vite rx oral tablet 1 mg</i>	Preferred	
<i>wescaps oral capsule 1 mg</i>	Preferred	
*B-COMPLEX W/ MINERALS**		
ELDERTONIC ORAL LIQUID (<i>b complex-minerals</i>)	Preferred	
*BENZODIAZEPINES**		
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg</i>	Preferred	QL (4 EA per 1 day)
<i>alprazolam oral tablet 2 mg</i>	Preferred	QL (5 EA per 1 day)
<i>chlordiazepoxide hcl oral capsule 10 mg</i>	Preferred	QL (30 EA per 1 day)
<i>chlordiazepoxide hcl oral capsule 25 mg</i>	Preferred	QL (12 EA per 1 day)
<i>chlordiazepoxide hcl oral capsule 5 mg</i>	Preferred	QL (4 EA per 1 day)
<i>diazepam</i> (Diazepam Intensol Oral Concentrate 5 Mg/MI)	Preferred	
<i>diazepam oral concentrate 5 mg/ml</i>	Preferred	
<i>diazepam oral solution 5 mg/5ml</i>	Preferred	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	Preferred	
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	Preferred	QL (3 EA per 1 day)
<i>lorazepam oral tablet 2 mg</i>	Preferred	QL (5 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
*BULK CHEMICALS - C'S**		
<i>citrulline powder</i>	Preferred	
<i>l-citrulline powder</i>	Preferred	
*BULK CHEMICALS - P'S**		
<i>blueberry flavor liquid</i>	Preferred	
<i>butter rum flavor liquid</i>	Preferred	
<i>caramel flavor liquid</i>	Preferred	
<i>cherry flavor liquid</i>	Preferred	
<i>coconut flavor liquid</i>	Preferred	
<i>grape flavor liquid</i>	Preferred	
<i>kahlua flavor liquid</i>	Preferred	
<i>maple flavor liquid</i>	Preferred	
<i>peach flavor liquid</i>	Preferred	
<i>tropical punch flavor liquid</i>	Preferred	
<i>tutti frutti flavor liquid</i>	Preferred	
<i>vanilla butternut flavor liquid</i>	Preferred	
<i>watermelon flavor liquid</i>	Preferred	
*BULK LAXATIVES**		
<i>cvs daily fiber oral capsule 0.52 gm</i>	Preferred	
<i>cvs daily fiber oral packet 58.6 %</i>	Preferred	
<i>cvs fiber laxative oral tablet 625 mg</i>	Preferred	
<i>cvs fiber oral capsule 0.52 gm</i>	Preferred	
<i>cvs natural daily fiber oral powder 48.57 %, 58.6 %</i>	Preferred	
<i>cvs natural fiber supplement oral powder 100 %</i>	Preferred	
<i>cvs soluble fiber therapy oral tablet 500 mg</i>	Preferred	
<i>daily fiber oral packet 51.7 %</i>	Preferred	
<i>daily fiber oral powder 51.7 %</i>	Preferred	
<i>eq daily fiber oral powder 51.7 %</i>	Preferred	
<i>eq fiber therapy oral capsule 0.52 gm</i>	Preferred	
<i>eq fiber therapy oral tablet 500 mg, 625 mg</i>	Preferred	
<i>eq fiber laxative oral tablet 625 mg</i>	Preferred	
<i>eq fiber therapy oral powder 28.3 %, 48.57 %</i>	Preferred	
<i>eq fiber therapy oral tablet 500 mg</i>	Preferred	
<i>eq natural fiber oral powder 28.3 %</i>	Preferred	
<i>eq smooth texture fiber oral powder 51.7 %</i>	Preferred	
<i>EQUALACTIN ORAL TABLET CHEWABLE 625 MG (calcium polycarbophil)</i>	Preferred	
<i>EVAC ORAL POWDER (psyllium)</i>	Preferred	
<i>fiber laxative + calcium oral tablet 625 mg</i>	Preferred	
<i>fiber laxative oral tablet 625 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>fiber oral powder 28.3 %</i>	Preferred	
<i>fiber oral tablet 625 mg</i>	Preferred	
<i>fiber therapy oral tablet 500 mg</i>	Preferred	
FIBERCON ORAL TABLET 625 MG (<i>calcium polycarbophil</i>)	Preferred	
<i>fiber-lax oral tablet 625 mg</i>	Preferred	
<i>geri-mucil oral powder 25 %, 51.7 %</i>	Preferred	
<i>gnp fiber therapy oral tablet 500 mg</i>	Preferred	
<i>gnp fiber-caps oral tablet 625 mg</i>	Preferred	
<i>gnp natural fiber oral capsule 0.52 gm</i>	Preferred	
<i>gnp natural fiber oral powder 28.3 %, 48.57 %</i>	Preferred	
<i>goodsense fiber oral tablet 500 mg</i>	Preferred	
<i>goodsense psyllium fiber oral powder 51.7 %</i>	Preferred	
<i>hm fiber oral powder 51.7 %</i>	Preferred	
<i>hm fiber powder oral powder 25 %</i>	Preferred	
HYDROCIL ORAL PACKET 95 % (<i>psyllium</i>)	Preferred	
<i>konsyl daily fiber oral powder 28.3 %, 60.3 %</i>	Preferred	
KONSYL DAILY PSYLLIUM FIBER ORAL POWDER 25 % (<i>psyllium</i>)	Preferred	
MEDI-MUCIL ORAL CAPSULE 0.52 GM (<i>psyllium</i>)	Preferred	
METAMUCIL FIBER ORAL PACKET 51.7 % (<i>psyllium</i>)	Preferred	
METAMUCIL MULTIHEALTH FIBER ORAL PACKET 58.12 % (<i>psyllium</i>)	Preferred	
METAMUCIL ORAL CAPSULE 0.52 GM (<i>psyllium</i>)	Preferred	
METAMUCIL ORAL PACKET 28 % (<i>psyllium</i>)	Preferred	
METAMUCIL ORAL POWDER 48.57 % (<i>psyllium</i>)	Preferred	
METAMUCIL ORAL WAFER (<i>psyllium</i>)	Preferred	
METAMUCIL SMOOTH TEXTURE ORAL POWDER 28.3 %, 58.6 % (<i>psyllium</i>)	Preferred	
<i>natural fiber laxative oral powder 28.3 %, 48.57 %, 58.6 %</i>	Preferred	
<i>natural fiber oral powder 58.6 %</i>	Preferred	
<i>natural psyllium seed oral powder 100 %</i>	Preferred	
<i>natural vegetable fiber oral powder 48.57 %</i>	Preferred	
ONELAX FIBER THERAPY ORAL POWDER 25 % (<i>psyllium</i>)	Preferred	
<i>psyllium fiber oral capsule 0.52 gm</i>	Preferred	
<i>px fiber oral capsule 0.52 gm</i>	Preferred	
<i>px fiber oral tablet 625 mg</i>	Preferred	
<i>qc fiber laxative oral capsule 0.52 gm</i>	Preferred	
<i>qc fiber oral tablet 625 mg</i>	Preferred	
<i>qc fiber therapy oral powder 25 %, 51.7 %</i>	Preferred	
<i>qc fiber therapy oral tablet 500 mg</i>	Preferred	
<i>qc natural vegetable oral powder 95 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ra multihealth fiber oral powder 48.57 %, 58.6 %</i>	Preferred	
REGULOID ORAL CAPSULE 0.52 GM (<i>psyllium</i>)	Preferred	
REGULOID ORAL POWDER 28.3 %, 48.57 %, 51.7 % (<i>psyllium</i>)	Preferred	
<i>sb fiber laxative oral powder 48.57 %</i>	Preferred	
<i>sb fiber laxative oral tablet 625 mg</i>	Preferred	
<i>sm fiber laxative oral tablet 500 mg</i>	Preferred	
<i>sm fiber oral powder 28.3 %, 48.57 %, 51.7 %, 58.6 %</i>	Preferred	
<i>sm fiber oral tablet 625 mg</i>	Preferred	
<i>sm fiber powder oral powder 25 %</i>	Preferred	
SOLUBLE FIBER THERAPY ORAL POWDER (<i>methylcellulose (laxative)</i>)	Preferred	
WAL-MUCIL ORAL CAPSULE 0.52 GM (<i>psyllium</i>)	Preferred	
WAL-MUCIL ORAL POWDER 100 %, 28.3 %, 48.57 %, 51.7 %, 58.6 % (<i>psyllium</i>)	Preferred	
*BURN PRODUCTS**		
<i>silver sulfadiazine external cream 1 %</i>	Preferred	
<i>silver sulfadiazine (Ssd External Cream 1 %)</i>	Preferred	
*CALCIUM**		
<i>600+d3 oral tablet 600-20 mg-mcg</i>	Preferred	
CALCET PETITES ORAL TABLET 200-6.25 MG-MCG (<i>calcium-cholecalciferol</i>)	Preferred	
<i>calcitrate plus d oral tablet 315-5 mg-mcg</i>	Preferred	
<i>cal-citrate plus vitamin d oral tablet 250-2.5 mg-mcg</i>	Preferred	
<i>calcium + vitamin d3 oral tablet 500-5 mg-mcg, 600-10 mg-mcg, 600-5 mg-mcg</i>	Preferred	
<i>calcium 1000 + d oral tablet 1000-20 mg-mcg</i>	Preferred	
<i>calcium 500 + d oral tablet 500-3.125 mg-mcg, 500-5 mg-mcg</i>	Preferred	
<i>calcium 500 + d3 oral tablet 500-15 mg-mcg, 500-5 mg-mcg</i>	Preferred	
<i>calcium 500/d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>calcium 500/vitamin d oral tablet 500-3.125 mg-mcg</i>	Preferred	
<i>calcium 500+d high potency oral tablet 500-10 mg-mcg</i>	Preferred	
<i>calcium 500+d oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	Preferred	
<i>calcium 500+d3 oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	Preferred	
<i>calcium 600 + d oral tablet 600-5 mg-mcg</i>	Preferred	
<i>calcium 600 + minerals oral tablet 600-200 mg-unit</i>	Preferred	
<i>calcium 600 high potency oral tablet 600 mg</i>	Preferred	
<i>calcium 600 oral tablet 1500 (600 ca) mg, 600 mg</i>	Preferred	
<i>calcium 600/vitamin d oral tablet 600-10 mg-mcg</i>	Preferred	
<i>calcium 600/vitamin d oral tablet chewable 600-10 mg-mcg</i>	Preferred	
<i>calcium 600/vitamin d3 oral tablet 600-20 mg-mcg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>calcium 600+d high potency oral tablet 600-10 mg-mcg</i>	Preferred	
<i>calcium 600+d oral tablet 600-10 mg-mcg, 600-5 mg-mcg</i>	Preferred	
<i>calcium 600+d plus minerals oral tablet 600-400 mg-unit</i>	Preferred	
<i>calcium 600+d plus minerals oral tablet chewable 600-400 mg-unit</i>	Preferred	
<i>calcium 600+d3 oral tablet 600-10 mg-mcg, 600-20 mg-mcg, 600-5 mg-mcg</i>	Preferred	
<i>calcium 600+d3 plus minerals oral tablet 600-800 mg-unit</i>	Preferred	
<i>calcium 600+d3 plus minerals oral tablet chewable 600-800 mg-unit</i>	Preferred	
<i>calcium carb-cholecalciferol oral tablet 500-10 mg-mcg, 600-10 mg-mcg, 600-20 mg-mcg, 600-5 mg-mcg</i>	Preferred	
<i>calcium carb-cholecalciferol oral tablet chewable 500-10 mg-mcg</i>	Preferred	
<i>calcium carbonate oral powder 800 mg/2gm</i>	Preferred	
<i>calcium carbonate oral tablet 1250 (500 ca) mg, 1500 (600 ca) mg, 600 mg</i>	Preferred	
<i>calcium carbonate oral tablet chewable 1250 (500 ca) mg, 260 mg</i>	Preferred	
<i>calcium carbonate-vitamin d oral capsule 600-5 mg-mcg</i>	Preferred	
<i>calcium carbonate-vitamin d oral tablet 600-5 mg-mcg</i>	Preferred	
<i>calcium citrate + d oral tablet 315-5 mg-mcg</i>	Preferred	
<i>calcium citrate + d3 maximum oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>calcium citrate + d3 oral tablet 200-6.25 mg-mcg, 315-5 mg-mcg, 315-6.25 mg-mcg</i>	Preferred	
<i>calcium citrate + oral tablet 315-5 mg-mcg</i>	Preferred	
<i>calcium citrate malate-vit d oral tablet 250-2.5 mg-mcg</i>	Preferred	
<i>calcium citrate oral granules 760 mg/3.5gm</i>	Preferred	
<i>calcium citrate oral tablet 250 mg, 950 (200 ca) mg</i>	Preferred	
<i>calcium citrate+d3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>calcium citrate+d3 petites oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>calcium citrate-vitamin d oral tablet 200-3.125 mg-mcg, 315-5 mg-mcg</i>	Preferred	
<i>calcium citrate-vitamin d3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>calcium creamies oral tablet chewable 600-10 mg-mcg</i>	Preferred	
<i>calcium gluconate oral tablet 50 mg</i>	Preferred	
<i>calcium gummies oral tablet chewable 250-100-500 mg-unit</i>	Preferred	
<i>calcium high potency oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>calcium high potency/vitamin d oral tablet 600-5 mg-mcg</i>	Preferred	
<i>calcium lactate oral tablet 100 mg</i>	Preferred	
<i>calcium magnesium zinc oral tablet 333-133-5 mg</i>	Preferred	
<i>calcium oyster shell oral tablet 1250 (500 ca) mg, 500 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>calcium plus d3 absorbable oral capsule 600-62.5 mg-mcg</i>	Preferred	
<i>calcium plus vitamin d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>calcium plus vitamin d3 oral capsule 600-12.5 mg-mcg</i>	Preferred	
<i>calcium plus vitamin d3 oral tablet 600-20 mg-mcg</i>	Preferred	
<i>calcium/c/d oral tablet chewable 500-10-250 mg-mg-unit</i>	Preferred	
<i>calcium/vitamin d3 gummies oral tablet chewable 250-8.75 mg-mcg</i>	Preferred	
<i>calcium/vitamin d3/adult gummy oral tablet chewable 250-100-500 mg-mg-unit</i>	Preferred	
<i>calcium+d3 gradual release oral tablet extended release 24 hour 600-40-500 mg-mg-unit</i>	Preferred	
<i>calcium+d3 oral tablet 500-10 mg-mcg, 500-15 mg-mcg, 600-20 mg-mcg</i>	Preferred	
<i>calcium-magnesium-zinc oral tablet 333-133-5 mg, 333.33-133.33-5 mg</i>	Preferred	
<i>calcium-vitamin d oral tablet 600-3.125 mg-mcg</i>	Preferred	
<i>calcium-vitamin d3 oral capsule 600-12.5 mg-mcg</i>	Preferred	
<i>calcium-vitamin d3 oral tablet 250-3.125 mg-mcg</i>	Preferred	
<i>calcium-vitamin d-minerals oral tablet chewable 600-400 mg-unit, 600-800 mg-unit</i>	Preferred	
<i>cal-mint oral tablet chewable 260 mg</i>	Preferred	
<i>CAL-QUICK ORAL LIQUID 500-10 MG-MCG/5ML (calcium carb-cholecalciferol)</i>	Preferred	
<i>CALTRATE 600+D PLUS MINERALS ORAL TABLET CHEWABLE 600-800 MG-UNIT (calcium carbonate-vit d-min)</i>	Preferred	
<i>CALTRATE 600+D3 SOFT ORAL TABLET CHEWABLE 600-20 MG-MCG (calcium carb-cholecalciferol)</i>	Preferred	
<i>chelated calcium oral tablet 200 mg</i>	Preferred	
<i>CITRACAL +D3 ORAL TABLET CHEWABLE 250-107-500 MG-MG-UNIT (calcium-phosphorus-vitamin d)</i>	Preferred	
<i>citrus calcium/vitamin d oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>cvs calcium + d3 oral tablet 600-20 mg-mcg</i>	Preferred	
<i>cvs calcium 600 & vitamin d3 oral tablet 600-20 mg-mcg</i>	Preferred	
<i>cvs calcium 600 + d/minerals oral tablet 600-800 mg-unit</i>	Preferred	
<i>cvs calcium 600 + d/minerals oral tablet chewable 600-800 mg-unit</i>	Preferred	
<i>cvs calcium 600+d oral tablet 600-20 mg-mcg</i>	Preferred	
<i>cvs calcium carbonate oral tablet 1250 (500 ca) mg</i>	Preferred	
<i>cvs calcium citrate+d3 petites oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>cvs calcium oral tablet 600 mg</i>	Preferred	
<i>cvs calcium-magnesium-zinc oral tablet 333-133-5 mg</i>	Preferred	
<i>cvs calcium-vitamin d oral tablet chewable 250-10 mg-mcg</i>	Preferred	
<i>cvs oyster shell calcium-vit d oral tablet 500-3.125 mg-mcg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>eq calcium 500+d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>eq calcium 600+d oral tablet 600-20 mg-mcg</i>	Preferred	
<i>eq calcium 600+d+minerals oral tablet 600-800 mg-unit</i>	Preferred	
<i>eq calcium citrate+d oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>eq calcium citrate+d3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>eq calcium citrate+d3 petites oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>eql calcium citrate/vitamin d oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>eql calcium citrate/vitamin d3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>eql calcium gummies oral tablet chewable 250-10 mg-mcg</i>	Preferred	
<i>eql calcium/vitamin d oral tablet 600-10 mg-mcg</i>	Preferred	
<i>eql calcium/vitamin d3 oral tablet 600-20 mg-mcg</i>	Preferred	
<i>finest nutrition calcium/vit d oral capsule 600-12.5 mg-mcg</i>	Preferred	
<i>gnp calcium 500 +d3 oral tablet 500-15 mg-mcg</i>	Preferred	
<i>gnp calcium 600 +d/minerals oral tablet 600-800 mg-unit</i>	Preferred	
<i>gnp calcium 600 +d3 oral tablet 600-20 mg-mcg</i>	Preferred	
<i>gnp calcium 600 +d3/minerals oral tablet chewable 600-800 mg-unit</i>	Preferred	
<i>gnp calcium citrate +d3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>gnp calcium oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>hm calcium citrate+d3 petite oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>hm calcium oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>hm calcium-vitamin d-minerals oral tablet 600-400 mg-unit</i>	Preferred	
<i>kp calcium 600+d oral capsule 600-12.5 mg-mcg</i>	Preferred	
<i>kp calcium 600+d oral tablet 600-10 mg-mcg, 600-20 mg-mcg</i>	Preferred	
<i>kp calcium 600+d3 oral capsule 600-12.5 mg-mcg</i>	Preferred	
<i>kp calcium citrate+d oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>kp calcium-magnesium-zinc oral tablet 333-133-5 mg</i>	Preferred	
<i>liquid calcium with d3 oral capsule 600-12.5 mg-mcg, 600-25 mg-mcg</i>	Preferred	
<i>liquid calcium/vitamin d oral capsule 600-5 mg-mcg</i>	Preferred	
<i>MAGNEBIND 300 ORAL TABLET 250-300 MG (calcium carb-magnesium carb)</i>	Preferred	
<i>nat-rul oyster calcium+vit d oral tablet 500-3.125 mg-mcg</i>	Preferred	
<i>OS-CAL CALCIUM + D3 ORAL TABLET 500-5 MG-MCG (calcium carb-cholecalciferol)</i>	Preferred	
<i>OS-CAL EXTRA D3 ORAL TABLET 500-15 MG-MCG (calcium carb-cholecalciferol)</i>	Preferred	
<i>OS-CAL ORAL TABLET CHEWABLE 500-15 MCG (calcium carb-cholecalciferol)</i>	Preferred	
<i>OYSCO 500+D ORAL TABLET 500-5 MG-MCG (calcium carb-cholecalciferol)</i>	Preferred	
<i>oyster calcium/d3 oral tablet 500-5 mg-mcg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>oyster shell calcium + d oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	Preferred	
<i>oyster shell calcium + d3 oral tablet 500-10 mg-mcg</i>	Preferred	
<i>oyster shell calcium oral tablet 500 mg, 500-10 mg-mcg</i>	Preferred	
<i>oyster shell calcium plus d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>oyster shell calcium w/d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>oyster shell calcium/d oral tablet 250-3.125 mg-mcg, 500-10 mg-mcg</i>	Preferred	
<i>oyster shell calcium/d3 oral tablet 500-10 mg-mcg, 500-5 mg-mcg</i>	Preferred	
<i>oyster shell calcium/vit d oral tablet 500-5 mg-mcg</i>	Preferred	
<i>oyster shell calcium/vit d3 oral tablet 250-3.125 mg-mcg</i>	Preferred	
<i>oyster shell calcium/vitamin d oral tablet 250-3.125 mg-mcg, 500-5 mg-mcg</i>	Preferred	
PRONUTRIENTS CALCIUM+D3 ORAL TABLET 600-20 MG-MCG (calcium carb-cholecalciferol)	Preferred	
<i>pure calcium carbonate oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>px calcium&d oral tablet 600-10 mg-mcg</i>	Preferred	
<i>qc calcium 600 +d3/minerals oral tablet chewable 600-800 mg-unit</i>	Preferred	
<i>qc calcium fast dissolution oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>qc calcium/minerals/vitamin d oral tablet 600-400 mg-unit</i>	Preferred	
<i>ra calcium 600 oral tablet 1500 (600 ca) mg</i>	Preferred	
<i>ra calcium 600/vit d/minerals oral tablet 600-200 mg-unit</i>	Preferred	
<i>ra calcium 600/vit d/minerals oral tablet chewable 600-400 mg-unit</i>	Preferred	
<i>ra calcium 600/vitamin d-3 oral tablet 600-10 mg-mcg</i>	Preferred	
<i>ra calcium cit plus vit d-3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>ra calcium citrate plus vit d oral tablet 315-5 mg-mcg</i>	Preferred	
<i>ra calcium cit-vit d-3 petites oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>ra calcium high potency oral tablet 600 mg</i>	Preferred	
<i>ra calcium oral tablet 500 mg</i>	Preferred	
<i>ra calcium plus vitamin d oral tablet 600-10 mg-mcg, 600-5 mg-mcg</i>	Preferred	
<i>ra calcium plus vitamin d3 oral tablet 600-10 mg-mcg</i>	Preferred	
<i>ra calcium/vitamin d/minerals oral tablet 600-400 mg-unit</i>	Preferred	
RA HI CAL ORAL TABLET 500-5 MG-MCG (calcium carb-cholecalciferol)	Preferred	
<i>risacal-d oral tablet 105-81-120 mg-mg-unit</i>	Preferred	
<i>sb calcium + d oral tablet 600-5 mg-mcg</i>	Preferred	
<i>sb oyster shell calcium oral tablet 500 mg</i>	Preferred	
<i>sm calcium 500/vitamin d3 oral tablet 500-10 mg-mcg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm calcium 600/vitamin d oral tablet 600-10 mg-mcg</i>	Preferred	
<i>sm calcium 600+d plus minerals oral tablet chewable 600-800 mg-unit</i>	Preferred	
<i>sm calcium 600+d3 oral tablet 600-20 mg-mcg</i>	Preferred	
<i>sm calcium citrate+/vit d3 oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>sm calcium citrate+d3 petite oral tablet 200-6.25 mg-mcg</i>	Preferred	
<i>sm calcium citrate+vit d3 max oral tablet 315-6.25 mg-mcg</i>	Preferred	
<i>sm calcium citrate-vit d oral tablet 315-5 mg-mcg</i>	Preferred	
<i>sm calcium/vitamin d oral tablet 500-5 mg-mcg, 600-20 mg-mcg</i>	Preferred	
<i>sm calcium/vitamin d3 oral tablet 600-800 mg-unit</i>	Preferred	
<i>sm calcium-magnesium-zinc oral tablet 333-133-5 mg</i>	Preferred	
<i>sm calcium-vitamin d oral tablet 500-5 mg-mcg, 600-10 mg-mcg</i>	Preferred	
SM CORAL CALCIUM ORAL TABLET 1000 (390 CA) MG (<i>coral calcium</i>)	Preferred	
<i>sm oyster shell calcium/vit d oral tablet 500-10 mg-mcg</i>	Preferred	
<i>sm oyster shell calcium/vit d3 oral tablet 500-10 mg-mcg</i>	Preferred	
<i>super calcium 600 + d 400 oral tablet 600-10 mg-mcg</i>	Preferred	
<i>super calcium 600 + d3 oral tablet 600-10 mg-mcg</i>	Preferred	
<i>super calcium oral tablet 1500 (600 ca) mg</i>	Preferred	
UPCAL D ORAL PACKET 500-12.5 MG-MCG (<i>calcium citrate-vitamin d</i>)	Preferred	
UPCAL D ORAL POWDER 500-12.5 MG-MCG/5GM (<i>calcium citrate-vitamin d</i>)	Preferred	
*CARBOHYDRATES**		
<i>cvs glucose shot oral liquid</i>	Preferred	
<i>dextrose intravenous solution 5 %</i>	Preferred	
<i>gluco shot oral liquid</i>	Preferred	
<i>glucose oral liquid</i>	Preferred	
*CARBONIC ANHYDRASE INHIBITORS**		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	Preferred	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	Preferred	
*CARDIAC GLYCOSIDES**		
<i>digoxin oral solution 0.05 mg/ml</i>	Preferred	Max 90-day supply per fill
<i>digoxin oral tablet 125 mcg, 250 mcg</i>	Preferred	Max 90-day supply per fill
*CEPHALOSPORINS - 1ST GENERATION**		
<i>cefadroxil oral capsule 500 mg</i>	Preferred	
<i>cefadroxil oral suspension reconstituted 500 mg/5ml</i>	Preferred	
<i>cefadroxil oral tablet 1 gm</i>	Preferred	
<i>cephalexin oral capsule 250 mg, 500 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Preferred	
*CHELATING AGENTS**		
<i>penicillamine oral tablet 250 mg</i>	Preferred	PA; QL (4 EA per 1 day)
*CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS**		
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	Preferred	
*CHLORINE ANTISEPTICS**		
<i>H-CHLOR 12 EXTERNAL SOLUTION 0.125 % (sodium hypochlorite)</i>	Preferred	
<i>HYSEPT EXTERNAL SOLUTION 0.25 % (sodium hypochlorite)</i>	Preferred	
*COBALAMINS**		
<i>b-12 (methylcobalamin) sublingual tablet sublingual 1000 mcg</i>	Preferred	
<i>B-12 DOTS ORAL TABLET DISPERSIBLE 500 MCG (cyanocobalamin)</i>	Preferred	
<i>B-12 MICROLOZENGE SUBLINGUAL TABLET SUBLINGUAL 500 MCG (cyanocobalamin)</i>	Preferred	
<i>b-12 oral capsule 1000 mcg</i>	Preferred	
<i>b-12 oral lozenge 1000 mcg</i>	Preferred	
<i>b-12 oral tablet 100 mcg, 1000 mcg, 2000 mcg, 250 mcg, 2500 mcg, 50 mcg, 500 mcg</i>	Preferred	
<i>b-12 oral tablet dispersible 5000 mcg</i>	Preferred	
<i>b-12 oral tablet extended release 1000 mcg</i>	Preferred	
<i>b-12 sublingual tablet sublingual 1000 mcg, 2500 mcg, 3000 mcg, 500 mcg</i>	Preferred	
<i>b-12 super strength sublingual liquid 5000 mcg/ml</i>	Preferred	
<i>b-12 tr oral tablet extended release 1000 mcg</i>	Preferred	
<i>b-12-sl sublingual tablet sublingual 1000 mcg</i>	Preferred	
<i>cvs b12 oral liquid 1000 mcg/15ml</i>	Preferred	
<i>cvs b-12 oral liquid 1000 mcg/15ml</i>	Preferred	
<i>cvs b-12 oral tablet 500 mcg</i>	Preferred	
<i>cvs vitamin b12 oral tablet 1000 mcg</i>	Preferred	
<i>cvs vitamin b-12 oral tablet 1000 mcg</i>	Preferred	
<i>cvs vitamin b12 oral tablet extended release 1000 mcg</i>	Preferred	
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	Preferred	
<i>cyanocobalamin (Dodex Injection Solution 1000 Mcg/MI)</i>	Preferred	
<i>eql b-12 oral tablet 1000 mcg</i>	Preferred	
<i>eql vitamin b-12 oral tablet 500 mcg</i>	Preferred	
<i>eql vitamin b-12 tr oral tablet extended release 1000 mcg</i>	Preferred	
<i>gnp b-12 sublingual tablet sublingual 2500 mcg</i>	Preferred	
<i>gnp vitamin b-12 oral tablet 500 mcg</i>	Preferred	
<i>gnp vitamin b-12 oral tablet extended release 1000 mcg</i>	Preferred	

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<i>hm vitamin b-12 oral tablet 500 mcg</i>	Preferred	
<i>kp vitamin b-12 oral tablet 1000 mcg</i>	Preferred	
<i>methylcobalamin oral tablet dispersible 5000 mcg</i>	Preferred	
<i>qc vitamin b12 oral tablet 500 mcg</i>	Preferred	
<i>qc vitamin b12 oral tablet extended release 1000 mcg</i>	Preferred	
<i>ra vitamin b-12 oral liquid 1000 mcg/ml</i>	Preferred	
<i>ra vitamin b-12 oral tablet 100 mcg</i>	Preferred	
<i>ra vitamin b-12 tr oral tablet extended release 1000 mcg</i>	Preferred	
<i>sm vitamin b-12 oral tablet 100 mcg, 500 mcg</i>	Preferred	
<i>sm vitamin b12 tr oral tablet extended release 1000 mcg</i>	Preferred	
<i>sv vitamin b-12 er oral tablet extended release 1000 mcg</i>	Preferred	
<i>vitamin b 12 oral tablet 500 mcg</i>	Preferred	
<i>vitamin b-12 er oral tablet extended release 1000 mcg</i>	Preferred	
<i>vitamin b-12 oral liquid 1000 mcg/15ml</i>	Preferred	
<i>vitamin b12 oral tablet 100 mcg</i>	Preferred	
<i>vitamin b-12 oral tablet 100 mcg, 1000 mcg, 250 mcg, 50 mcg, 500 mcg</i>	Preferred	
<i>vitamin b12 oral tablet extended release 1000 mcg</i>	Preferred	
<i>vitamin b12 sublingual liquid 3000 mcg/ml</i>	Preferred	
<i>vitamin b-12 sublingual liquid 3000 mcg/ml</i>	Preferred	
<i>vitamin b-12 sublingual tablet sublingual 1000 mcg, 2500 mcg, 3000 mcg, 500 mcg</i>	Preferred	
<i>vitamin b12 sublingual tablet sublingual 3000 mcg</i>	Preferred	
*COMBINATION CONTRACEPTIVES - ORAL**		
<i>levonorgestrel-ethinyl estrad (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad (Altavera Oral Tablet 0.15-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day (Amethia Oral Tablet 0.15-0.03 &0.01 Mg)</i>	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol (Apri Oral Tablet 0.15-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethin-eth estrad triphasic (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day (Ashlyna Oral Tablet 0.15-0.03 &0.01 Mg)</i>	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>norethindrone acet-ethinyl est</i> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per fill
BALCOLTRA ORAL TABLET 0.1-20 MG-MCG(21) (<i>levonorgestrel-eth estrad-fe bisg</i>)	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norgestrel-ethinyl estradiol</i> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin-eth estrad triphasic</i> (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Delyla Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg</i> (21/5)	Preferred	Max 365-day supply per fill
<i>drosipren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	Preferred	Max 365-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	Preferred	Max 365-day supply per fill
<i>norgestrel-ethinyl estradiol (Elinest Oral Tablet 0.3-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>levonorg-eth estrad triphasic (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)</i>	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol (Enskyce Oral Tablet 0.15-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norgestimate-eth estradiol (Estarylla Oral Tablet 0.25-35 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad (Falmina Oral Tablet 0.1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe (Gemmily Oral Capsule 1-20 Mg-Mcg(24))</i>	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day (Iclevia Oral Tablet 0.15-0.03 Mg)</i>	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day (Introvale Oral Tablet 0.15-0.03 Mg)</i>	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol (Isibloom Oral Tablet 0.15-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day (Jaimiess Oral Tablet 0.15-0.03 &0.01 Mg)</i>	Preferred	Max 365-day supply per fill
<i>drospirenone-ethinyl estradiol (Jasmiel Oral Tablet 3-0.02 Mg)</i>	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day (Jolessa Oral Tablet 0.15-0.03 Mg)</i>	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol (Juleber Oral Tablet 0.15-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)</i>	Preferred	Max 365-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per fill
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin-eth estradiol-fe</i> (Layolis Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin-eth estrad triphasic</i> (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorg-eth estrad triphasic</i> (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg, 0.15-0.03 mg</i>	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Loestrin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Loestrin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Loestrin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Loestrin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	Preferred	Max 365-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per fill
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Merzee Oral Capsule 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norgestimate-eth estradiol</i> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	Preferred	Max 365-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Nikki Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per fill

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin-eth estrad triphasic</i> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norgestimate-eth estradiol</i> (Nymyo Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Ocella Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Pirmella 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin-eth estrad triphasic</i> (Pirmella 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Setlakin Oral Tablet 0.15-0.03 Mg)	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per fill
<i>levonorgest-eth estrad 91-day</i> (Simpesse Oral Tablet 0.15-0.03 & 0.01 Mg)	Preferred	Max 365-day supply per fill
<i>norgestimate-eth estradiol</i> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Syeda Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin ace-eth estrad-fe</i> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per fill
<i>norethindron-ethinyl estrad-fe</i> (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per fill
<i>norethindron-ethinyl estrad-fe</i> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>norgestim-eth estrad triphasic</i> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Nymyo Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per fill
<i>levonorg-eth estrad triphasic</i> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per fill
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per fill
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	Preferred	Max 365-day supply per fill
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	Preferred	Max 365-day supply per fill
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (<i>desogestrel-ethinyl estradiol</i>)	Preferred	Max 365-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Vestura Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per fill
<i>levonorgestrel-ethinyl estrad</i> (Vienva Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	Preferred	Max 365-day supply per fill
<i>desogestrel-ethinyl estradiol</i> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norgestimate-eth estradiol</i> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethindrone-eth estradiol</i> (Wera Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per fill
<i>drospirenone-ethinyl estradiol</i> (Zumandimine Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
*COMBINATION CONTRACEPTIVES - TRANSDERMAL**		
<i>norelgestromin-eth estradiol</i> (Xulane Transdermal Patch Weekly 150-35 Mcg/24Hr)	Preferred	QL (0.12 EA per 1 day); Max 365-day supply per fill
<i>norelgestromin-eth estradiol</i> (Zafemy Transdermal Patch Weekly 150-35 Mcg/24Hr)	Preferred	QL (0.12 EA per 1 day); Max 365-day supply per fill
*COMBINATION CONTRACEPTIVES - VAGINAL**		
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per fill
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per fill
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per fill
*CONTRACEPTIVES**		
<i>aimsco lubricated</i>	Preferred	
DUREX EXTRA SENSITIVE THIN DEVICE (<i>condoms latex lubricated</i>)	Preferred	
DUREX REALFEEL DEVICE (<i>condoms non-latex lubricated</i>)	Preferred	
FANTASY LUBRICATED (<i>condoms latex lubricated</i>)	Preferred	
FANTASY LUBRICATED/SPERMICIDE (<i>condoms latex lubricated</i>)	Preferred	
KAMELEON LUBRICATED (<i>condoms latex lubricated</i>)	Preferred	
<i>kimono</i>	Preferred	
KIMONO COLORS DEVICE (<i>condoms latex lubricated</i>)	Preferred	
<i>kimono micro thin</i>	Preferred	
<i>kimono micro thin plus</i>	Preferred	
<i>kimono plus</i>	Preferred	
<i>kimono ps</i>	Preferred	
<i>kimono ps plus</i>	Preferred	
<i>kimono sensation</i>	Preferred	
<i>kimono sensation plus</i>	Preferred	
KIMONO SPECIAL DEVICE (<i>condoms latex lubricated</i>)	Preferred	
K-Y ME & YOU EXTRA LUBRICATED DEVICE (<i>condoms latex lubricated</i>)	Preferred	
K-Y ME & YOU INTENSE DEVICE (<i>condoms latex lubricated</i>)	Preferred	
<i>maxx</i>	Preferred	
<i>maxx plus</i>	Preferred	
REALITY LATEX CONDOMS (<i>condoms latex lubricated</i>)	Preferred	
REALITY LATEX/ULTRA TEXTURED DEVICE (<i>condoms latex lubricated</i>)	Preferred	
REALITY LATEX/ULTRA THIN DEVICE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX COLOR CONDOMS + LUBE (<i>condoms latex lubricated</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
TRUSTEX LUB/RIBBED/STUDED (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUB/SPERMICIDE EX ST (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUB/SPERMICIDE XL (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUBRICATED (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUBRICATED EX LARGE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUBRICATED EXTRA ST (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX LUBRICATED/SPERMICIDE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX NATURAL CONDOMS + LUBE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	Preferred	
TRUSTEX RIA LUB/SPERMICIDE (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX RIA LUBRICATED (<i>condoms latex lubricated</i>)	Preferred	
TRUSTEX RIA NON-LUBRICATED (<i>condoms latex non-lubricated</i>)	Preferred	
TRUSTEX-NONOXYNOL-9/RIB/STUD (<i>condoms latex lubricated</i>)	Preferred	
*CORTICOSTEROIDS - TOPICAL**		
AQUANIL HC EXTERNAL LOTION 1 % (<i>hydrocortisone</i>)	Preferred	
<i>beta hc external lotion 1 %</i>	Preferred	
CORTIZONE-10 DIABETICS SKIN EXTERNAL LOTION 1 % (<i>hydrocortisone</i>)	Preferred	
CORTIZONE-10 ECZEMA EXTERNAL LOTION 1 % (<i>hydrocortisone</i>)	Preferred	
CORTIZONE-10 HYDRATENSIVE EXTERNAL LOTION 1 % (<i>hydrocortisone</i>)	Preferred	
CORTIZONE-10 PSORIASIS EXTERNAL LOTION 1 % (<i>hydrocortisone</i>)	Preferred	
<i>cvs cortisone maximum strength external lotion 1 %</i>	Preferred	
DERMAREST ECZEMA EXTERNAL LOTION 1 % (<i>hydrocortisone</i>)	Preferred	
<i>hydrocortisone external lotion 1 %</i>	Preferred	
<i>hydrocortisone external ointment 0.5 %</i>	Preferred	
SARNOL-HC EXTERNAL LOTION 1 % (<i>hydrocortisone</i>)	Preferred	
<i>scalp relief maximum strength external solution 1 %</i>	Preferred	
SCALPICIN MAXIMUM STRENGTH EXTERNAL SOLUTION 1 % (<i>hydrocortisone</i>)	Preferred	
<i>sm hydrocortisone external ointment 0.5 %</i>	Preferred	
*COUGH/COLD/ALLERGY COMBINATIONS**		
<i>24hr allergy & congestion reli oral tablet extended release 24 hour 180-240 mg</i>	Preferred	
ACTICON ORAL SOLUTION 1-30 MG/5ML (<i>dexbrompheniramine-pseudoeph</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ACTICON ORAL TABLET 2-60 MG (<i>dexbrompheniramine-pseudoeph</i>)	Preferred	
ADVIL COLD/SINUS ORAL TABLET 30-200 MG (<i>pseudoephedrine-ibuprofen</i>)	Preferred	
ALKA-SELTZER PLS SINUS & COUGH ORAL CAPSULE 10-5-325 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
ALKA-SELTZER PLUS DAY COLD/FLU ORAL CAPSULE 10-5-325 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
ALKA-SELTZER PLUS MUCUS & CONG ORAL CAPSULE 10-200 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
ALLEGRA-D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 24 HOUR 180-240 MG (<i>fexofenadine-pseudoephedrine</i>)	Preferred	
<i>allergy multi-symptom daytime oral tablet 2-5-325 mg</i>	Preferred	
<i>allergy multi-symptom night oral tablet 25-5-325 mg</i>	Preferred	
<i>allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>allergy relief d oral tablet 4-60 mg</i>	Preferred	
<i>allergy relief d oral tablet extended release 24 hour 180-240 mg</i>	Preferred	
<i>all-nite cold & flu nighttime oral liquid 30-12.5-650 mg/30ml</i>	Preferred	
<i>altarussin dm oral syrup 100-10 mg/5ml</i>	Preferred	
APRODINE ORAL TABLET 2.5-60 MG (<i>triprolidine-pseudoephedrine</i>)	Preferred	
<i>biocotron oral liquid 10-100 mg/5ml</i>	Preferred	
<i>bionel oral liquid 30-15-200 mg/5ml</i>	Preferred	
<i>pseudoeph-bromphen-dm (Bromfed Dm Oral Syrup 2-30-10 Mg/5MI)</i>	Preferred	AGE (Min 2 Years)
<i>capcof oral syrup 5-2-10 mg/5ml</i>	Preferred	
<i>capmist dm oral tablet 60-15-400 mg</i>	Preferred	
<i>capron dm oral liquid 7.5-7.5 mg/5ml</i>	Preferred	
<i>chest congestion relief dm oral syrup 10-100 mg/5ml</i>	Preferred	
<i>chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>chest congestion/cough relief oral tablet 20-400 mg</i>	Preferred	
<i>childrens cold & allergy oral elixir 1-2.5 mg/5ml</i>	Preferred	
<i>childrens cough oral liquid 5-100 mg/5ml</i>	Preferred	
<i>childrens mucus relief cough oral liquid 5-100 mg/5ml</i>	Preferred	
<i>childrens plus flu oral suspension 2.5-1-5-160 mg/5ml</i>	Preferred	
<i>childrens plus multi-sympt cld oral suspension 2.5-1-5-160 mg/5ml</i>	Preferred	
<i>cold & allergy d oral tablet 2.5-60 mg</i>	Preferred	
<i>cold & allergy oral elixir 1-2.5 mg/5ml</i>	Preferred	
<i>cold & cough childrens oral liquid 1-5-2.5 mg/5ml, 2.5-1-5 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>cold & flu nighttime oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>cold & flu nighttime relief oral capsule 15-6.25-325 mg</i>	Preferred	
<i>cold & flu relief daytime oral capsule 10-5-325 mg</i>	Preferred	
<i>cold & flu relief nighttime oral capsule 15-6.25-325 mg</i>	Preferred	
<i>cold & flu relief nighttime oral liquid 12.5-5-325 mg/10ml, 15-6.25-325 mg/15ml</i>	Preferred	
<i>cold & flu severe daytime oral liquid 5-10-200-325 mg/15ml</i>	Preferred	
<i>cold & flu severe daytime oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>cold & sinus oral tablet 30-200 mg</i>	Preferred	
<i>cold multi-symptom daytime oral tablet 10-5-325 mg</i>	Preferred	
<i>cold multi-symptom warm night oral liquid 5-6.25-10-325 mg/15ml</i>	Preferred	
<i>cold/cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>cold/cough dm childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>cold/flu daytime relief oral capsule 10-5-325 mg</i>	Preferred	
<i>cold/flu relief nighttime oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
COMTrex COLD & COUGH MAX ST ORAL TABLET 10-5-325 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
COMTrex COLD & COUGH NIGHTTIME ORAL TABLET 5-2-10-325 MG (<i>phenyleph-cpm-dm-apap</i>)	Preferred	
COMTrex FLU THERAPY DAY/NIGHT ORAL 2-5-325 & 5-325 MG (<i>chlorphen-pe-acetaminophen</i>)	Preferred	
COMTrex SEVERE COLD & SINUS ORAL 2-5-325 & 5-325 MG (<i>chlorphen-pe-acetaminophen</i>)	Preferred	
CONEX COLD/ALLERGY ORAL SOLUTION 1-30 MG/5ML (<i>dexbrompheniramine-pseudoeph</i>)	Preferred	
CONEX COLD/ALLERGY ORAL TABLET 2-60 MG (<i>dexbrompheniramine-pseudoeph</i>)	Preferred	
CORICIDIN D COLD/FLU/SINUS ORAL TABLET 2-5-325 MG (<i>chlorphen-pe-acetaminophen</i>)	Preferred	
CORICIDIN HBP CONGESTION/COUGH ORAL CAPSULE 10-200 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
CORICIDIN HBP COUGH/COLD ORAL TABLET 4-30 MG (<i>chlorpheniramine-dm</i>)	Preferred	
CORICIDIN HBP NIGHTTIME COLD ORAL LIQUID 15-6.25-325 MG/15ML, 15-6.25-500 MG/15ML (<i>dm-doxylamine-acetaminophen</i>)	Preferred	
<i>cough & chest congestion dm oral liquid 5-100 mg/5ml</i>	Preferred	
<i>cough & cold hbp oral tablet 4-30 mg</i>	Preferred	
<i>cough & cold oral tablet 4-30 mg</i>	Preferred	
<i>cough & congestion kids oral liquid 5-100 mg/5ml</i>	Preferred	
<i>cough & sore throat nighttime oral liquid 15-6.25-500 mg/15ml</i>	Preferred	
<i>cough/cold/sore throat child oral liquid 5-10-200-325 mg/10ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>cvs allergy relief d24 oral tablet extended release 24 hour 180-240 mg</i>	Preferred	
<i>cvs chest congest/cough child oral liquid 5-100 mg/5ml</i>	Preferred	
<i>cvs chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>cvs chest congestion-cough hbp oral capsule 10-200 mg</i>	Preferred	
<i>cvs cold & cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>cvs cold & cough nightttime oral liquid 6.25-2.5 mg/5ml</i>	Preferred	
<i>cvs cold & sinus multi-symptom oral liquid 10-650-400 mg/20ml</i>	Preferred	
<i>cvs cold & sinus relief oral tablet 30-200 mg</i>	Preferred	
<i>cvs cold/flu nightttime oral capsule 15-6.25-325 mg</i>	Preferred	
<i>cvs cold/flu/sore throat adult oral liquid 5-10-200-325 mg/10ml</i>	Preferred	
<i>cvs cough & chest congestion oral liquid 20-400 mg/20ml</i>	Preferred	
<i>cvs cough & cold hbp oral tablet 4-30 mg</i>	Preferred	
<i>cvs daytime cold/flu relief oral liquid 325-10-5 mg/15ml</i>	Preferred	
<i>cvs dm maximum adult oral liquid 5-100 mg/5ml</i>	Preferred	
<i>cvs flu relief childrens oral suspension 2.5-1-5-160 mg/5ml</i>	Preferred	
<i>cvs flu/severe cold daytime oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>cvs mucus d extended release oral tablet extended release 12 hour 60-600 mg</i>	Preferred	
<i>cvs mucus d max st er oral tablet extended release 12 hour 1200-120 mg</i>	Preferred	
<i>cvs mucus dm extended release oral tablet extended release 12 hour 30-600 mg, 60-1200 mg</i>	Preferred	
<i>cvs multi-symptoms cold child oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>cvs multi-symptoms cold/fever oral liquid 5-10-200-325 mg/10ml</i>	Preferred	
<i>cvs night time cold/flu relief oral liquid 15-6.25-500 mg/15ml</i>	Preferred	
<i>cvs nighttime cold/flu relief oral liquid 15-6.25-325 mg/15ml, 650-30-12.5 mg/30ml</i>	Preferred	
<i>cvs nighttime cough oral liquid 6.25-15 mg/15ml</i>	Preferred	
<i>cvs sev allergy/sinus headache oral tablet 25-5-325 mg</i>	Preferred	
<i>cvs severe cold/flu daytime oral liquid 650-20-10 mg/30ml</i>	Preferred	
<i>cvs severe cold/flu nighttime oral liquid 12.5-5-325 mg/15ml</i>	Preferred	
<i>cvs severe congestion relief oral liquid 10-650-400 mg/20ml</i>	Preferred	
<i>cvs severe cough/congest oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>cvs sinus congest/pain dt/nt oral 2-5-325 & 5-325 mg</i>	Preferred	
<i>cvs sinus headache pe oral tablet 5-325 mg</i>	Preferred	
<i>cvs sinus pain/congest night oral tablet 2-5-325 mg</i>	Preferred	
<i>cvs sinus pain/congestion day oral tablet 5-325 mg</i>	Preferred	
<i>cvs sinus pe/allergy max st oral tablet 4-10 mg</i>	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>cvs sinus relief pressure/pain oral tablet 5-325-200 mg</i>	Preferred	
<i>cvs stuffy nose & cold child oral liquid 2.5-100 mg/5ml</i>	Preferred	
<i>cvs triacting cough/runny nose oral liquid 1-5 mg/5ml</i>	Preferred	
<i>cvs tussin dm max st oral liquid 20-400 mg/20ml</i>	Preferred	
<i>cvs tussin dm oral liquid 10-100 mg/5ml, 20-200 mg/10ml, 200-20 mg/10ml</i>	Preferred	
DAYQUIL SEVERE + VAPOCOOL ORAL LIQUID 5-10-200-325 MG/15ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
<i>daytime cold & flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>daytime cold/flu relief oral capsule 10-5-325 mg</i>	Preferred	
<i>daytime cold/flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>day-time cold/flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>day-time pe cold/flu relief oral capsule 10-5-325 mg</i>	Preferred	
DELSYM CGH/CHEST CONG DM CHILD ORAL LIQUID 5-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
DELSYM CGH/CLD NIGHTTIME CHILD ORAL LIQUID 12.5-5-325 MG/10ML (<i>diphenhydramine-pe-apap</i>)	Preferred	
DELSYM COUGH/CHEST CONGEST DM ORAL LIQUID 5-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
DELSYM COUGH/COLD NIGHT TIME ORAL LIQUID 12.5-5-325 MG/10ML (<i>diphenhydramine-pe-apap</i>)	Preferred	
DESGEN DM ORAL LIQUID 5-10-100 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
<i>despec dm oral syrup 5-10-100 mg/5ml</i>	Preferred	
<i>despec dm-g oral syrup 5-10-100 mg/5ml</i>	Preferred	
<i>dextromethorphan-guaifenesin oral liquid 10-100 mg/5ml</i>	Preferred	
<i>dextromethorphan-guaifenesin oral syrup 10-100 mg/5ml</i>	Preferred	
<i>dextromethorphan-guaifenesin oral tablet 20-400 mg</i>	Preferred	
DIABETIC TUSSIN DM MAX ST ORAL LIQUID 10-200 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	QL (10 ML per 1 day)
DIABETIC TUSSIN DM ORAL LIQUID 100-10 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
DIMAPHEN DM COLD/COUGH ORAL LIQUID 2.5-1-5 MG/5ML (<i>phenylephrine-bromphen-dm</i>)	Preferred	
DIMETAPP CHILDRENS COLD/COUGH ORAL LIQUID 2.5-1-5 MG/5ML (<i>phenylephrine-bromphen-dm</i>)	Preferred	
DIMETAPP COLD/COUGH CHILDRENS ORAL LIQUID 2.5-1-5 MG/5ML (<i>phenylephrine-bromphen-dm</i>)	Preferred	
DIMETAPP MULTISYMP TOM COLD/FLU ORAL LIQUID 6.25-2.5-160 MG/5ML (<i>diphenhydramine-pe-apap</i>)	Preferred	
DIMETAPP NIGHT COLD/CONGESTION ORAL LIQUID 6.25-2.5 MG/5ML (<i>diphenhydramine-phenylephrine</i>)	Preferred	
<i>dm-guaifenesin er oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ED A-HIST ORAL LIQUID 4-10 MG/5ML (<i>chlorpheniramine-phenylephrine</i>)	Preferred	
ED A-HIST ORAL TABLET 4-10 MG (<i>chlorpheniramine-phenylephrine</i>)	Preferred	
<i>ed-a-hist dm oral liquid 10-4-15 mg/5ml</i>	Preferred	
ENDACOF-DM ORAL LIQUID 2.5-1-5 MG/5ML (<i>phenylephrine-bromphen-dm</i>)	Preferred	
<i>eq cold flu & sore throat oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>eq cold/cough dm childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>eq cough childrens oral liquid 5-100 mg/5ml</i>	Preferred	
<i>eq daytime cold/flu ms relief oral capsule 10-5-325 mg</i>	Preferred	
<i>eq daytime cold/flu ms relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>eq mucus dm oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>eq mucus relief congest/cough oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>eq mucus relief dm oral liquid 20-400 mg/20ml</i>	Preferred	
<i>eq mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	Preferred	
<i>eq multi-symp cold/fever child oral liquid 5-10-200-325 mg/10ml</i>	Preferred	
<i>eq multi-symptom cold children oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>eq nitetime cold/flu ms relief oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>eq sinus congestion & pain oral tablet 5-325-200 mg</i>	Preferred	
<i>eq suphedrine pe oral tablet 4-10 mg</i>	Preferred	
<i>eq tussin dm cough/chest oral syrup 10-100 mg/5ml</i>	Preferred	
<i>eq tussin dm max adult oral liquid 20-400 mg/20ml</i>	Preferred	
<i>eq tussin dm max daytime oral liquid 20-400 mg/20ml</i>	Preferred	
<i>eql cold multi-symptom severe oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>eql cold/cough oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>eql daytime cold & flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>eql daytime severe cold/flu oral liquid 5-10-200-325 mg/15ml</i>	Preferred	
<i>eql mucus relief cold/flu oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>eql mucus relief max strength oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>eql mucus-dm oral tablet extended release 12 hour 30-600 mg</i>	Preferred	
<i>eql nighttime cold & flu oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>eql nighttime cold/flu relief oral liquid 30-12.5-650 mg/30ml</i>	Preferred	
<i>eql nighttime cough relief oral liquid 12.5-30 mg/30ml</i>	Preferred	
<i>eql nighttime severe cold/flu oral liquid 5-6.25-10-325 mg/15ml</i>	Preferred	
<i>eql pressure & pain pls/mucus oral tablet 5-325-200 mg</i>	Preferred	
<i>eql sinus & allergy pe oral tablet 4-10 mg</i>	Preferred	
<i>eql tussin cough/chest dm max oral liquid 20-400 mg/20ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>eql tussin dm cough/chest cong oral syrup 100-10 mg/5ml</i>	Preferred	
FENESIN DM IR ORAL TABLET 20-400 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
<i>fexofenadine-pseudoephed er oral tablet extended release 24 hour 180-240 mg</i>	Preferred	
<i>flu/severe cold & cough day oral packet 20-10-650 mg</i>	Preferred	
<i>ft allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>ft mucus relief d 12 hour oral tablet extended release 12 hour 60-600 mg</i>	Preferred	
<i>ft sinus severe oral tablet 5-325-200 mg</i>	Preferred	
<i>ft tussin cf adult oral liquid 10-20-200 mg/10ml</i>	Preferred	
<i>geri-tussin dm oral liquid 10-100 mg/5ml</i>	Preferred	
<i>geri-tussin dm oral syrup 10-100 mg/5ml</i>	Preferred	
GILTUSS COUGH & CHEST CHILDREN ORAL LIQUID 10-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
GILTUSS COUGH & CHEST ORAL LIQUID 20-200 MG/10ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
GILTUSS DIABETIC COUGH & COLD ORAL LIQUID 10-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
GILTUSS HONEY CGH/CHEST CONGES ORAL LIQUID 20-200 MG/10ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
GILTUSS HONEY CGH/CHST CHILD ORAL LIQUID 10-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
<i>glenmax peb oral liquid 4-10 mg/5ml</i>	Preferred	
<i>gnp allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>gnp cold max daytime oral tablet 10-5-325 mg</i>	Preferred	
<i>gnp cold/cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>gnp cold/flu severe oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>gnp cold/head congestion oral tablet 5-325-200 mg</i>	Preferred	
<i>gnp day time cold/flu oral capsule 10-5-325 mg</i>	Preferred	
<i>gnp mucus dm max strength oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>gnp mucus relief dm oral tablet 20-400 mg</i>	Preferred	
<i>gnp night time cold & flu oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>gnp night time cold-flu oral capsule 15-6.25-325 mg</i>	Preferred	
<i>gnp night time cough oral liquid 6.25-15 mg/15ml</i>	Preferred	
<i>gnp sinus pressure/pain oral tablet 5-325 mg</i>	Preferred	
<i>gnp sinus severe daytime oral tablet 5-325-200 mg</i>	Preferred	
<i>gnp sinus/headache oral tablet 5-325 mg</i>	Preferred	
<i>gnp tab tussin dm oral tablet 20-400 mg</i>	Preferred	
<i>gnp tussin cf cough & cold oral syrup 5-10-100 mg/5ml</i>	Preferred	
<i>gnp tussin dm cough oral liquid 100-10 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>goodsense allergy plus sinus oral tablet 25-5-325 mg</i>	Preferred	
<i>goodsense cold & flu oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>goodsense cold & head congest oral tablet 5-325-200 mg</i>	Preferred	
<i>goodsense day time cold & flu oral capsule 10-5-325 mg</i>	Preferred	
<i>goodsense day time cold & flu oral liquid 5-10-200-325 mg/15ml</i>	Preferred	
<i>goodsense daytime oral capsule 10-5-325 mg</i>	Preferred	
<i>goodsense mucus dm oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>goodsense mucus relief child oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>goodsense mucus/congest/cough oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>goodsense night time cough oral liquid 6.25-15 mg/15ml</i>	Preferred	
<i>goodsense nighttime cold & flu oral capsule 15-6.25-325 mg</i>	Preferred	
<i>goodsense nighttime cold & flu oral liquid 5-6.25-10-325 mg/15ml</i>	Preferred	
<i>goodsense pressure/pain pe oral tablet 5-325 mg</i>	Preferred	
<i>goodsense pressure/pain/mucus oral tablet 5-325-200 mg</i>	Preferred	
<i>goodsense severe cold/cough oral liquid 20-10-650 mg/30ml</i>	Preferred	
<i>goodsense sinus congest/pain oral 2-5-325 & 5-325 mg</i>	Preferred	
<i>goodsense sinus severe daytime oral tablet 5-325-200 mg</i>	Preferred	
<i>goodsense tussin cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>goodsense tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>guaiasorb dm oral liquid 10-100 mg/5ml, 20-200 mg/10ml</i>	Preferred	
<i>guaicon dms oral syrup 100-10 mg/5ml</i>	Preferred	
<i>guaifenesin-dm oral syrup 100-10 mg/5ml</i>	Preferred	
G-ZYNCOF ORAL SYRUP 20-400 MG/5ML (dextromethorphan-guaifenesin)	Preferred	
<i>head congestion/mucus oral tablet 5-325-200 mg</i>	Preferred	
<i>herbiomed allergy cold & sinus oral liquid 12.5-5-325 mg/10ml</i>	Preferred	
<i>herbiomed severe cold & flu oral liquid 5-10-200-325 mg/10ml</i>	Preferred	
<i>hm allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>hm chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>hm cold & cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>hm cold & sinus relief oral tablet 30-200 mg</i>	Preferred	
<i>hm daytime cold & flu oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>hm mucus relief dm oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>hm night time cold & flu oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>hm nighttime cold & flu relief oral capsule 15-6.25-325 mg</i>	Preferred	
<i>ibuprofen cold & sinus oral tablet 30-200 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>intense cough reliever oral liquid 20-300 mg/5ml, 30-200 mg/5ml</i>	Preferred	
KINDERMED NIGHT COLD & CGH KID ORAL SYRUP 6.25-2.5 MG/5ML (<i>diphenhydramine-phenylephrine</i>)	Preferred	
<i>kls mucus-dm max strength oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
LOHIST-D ORAL LIQUID 2-30 MG/5ML (<i>chlorpheniramine-pseudoeph</i>)	Preferred	
<i>lohist-dm oral syrup 5-2-10 mg/5ml</i>	Preferred	
MAPAP COLD FORMULA MULTI-SYMPPT ORAL TABLET 10-5-325 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
MAX TUSSIN DM COUGH&CHEST CONG ORAL LIQUID 20-200 MG/10ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
<i>maxi-tuss g oral liquid 10-100 mg/5ml</i>	Preferred	
<i>maxi-tuss gmx oral liquid 10-200 mg/5ml</i>	Preferred	QL (10 ML per 1 day)
<i>maxi-tuss pe jr oral liquid 2.5-50 mg/5ml</i>	Preferred	
MEDICIDIN-D ORAL TABLET 2-5-325 MG (<i>chlorphen-pe-acetaminophen</i>)	Preferred	
<i>medi-tussin dm double strength oral liquid 30-200 mg/5ml</i>	Preferred	
<i>medi-tussin dm oral syrup 100-10 mg/5ml</i>	Preferred	
MUCINEX CHILD MULTI-SYMPPT ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
MUCINEX CHILDRENS FREEFROM ORAL LIQUID 2.5-5-100 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
MUCINEX CHILDRENS FREEFROM ORAL LIQUID 5-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
MUCINEX CHILDRENS FREEFROM ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
MUCINEX CHILDRENS NIGHT TIME ORAL LIQUID 12.5-5-325 MG/10ML (<i>diphenhydramine-pe-apap</i>)	Preferred	
MUCINEX COLD CGH THROAT CHILD ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
MUCINEX COLD CHILDRENS ORAL LIQUID 2.5-5-100 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
MUCINEX COUGH & CHEST CONGEST ORAL CAPSULE 10-200 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
MUCINEX COUGH & CONGEST CHILD ORAL LIQUID 2.5-5-100 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
MUCINEX COUGH CHILDRENS ORAL LIQUID 5-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
MUCINEX COUGH FOR KIDS ORAL PACKET 5-100 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
MUCINEX D MAX STRENGTH ORAL TABLET EXTENDED RELEASE 12 HOUR 120-1200 MG (<i>pseudoephedrine-guaifenesin</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MUCINEX D ORAL TABLET EXTENDED RELEASE 12 HOUR 60-600 MG (<i>pseudoephedrine-guaifenesin</i>)	Preferred	
MUCINEX DM MAXIMUM STRENGTH ORAL TABLET EXTENDED RELEASE 12 HOUR 60-1200 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
MUCINEX DM ORAL TABLET EXTENDED RELEASE 12 HOUR 30-600 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
MUCINEX FAST-MAX CLD FLU THRT ORAL TABLET 5-10-200-325 MG (<i>phenylephrine-dm-gg-apap</i>)	Preferred	QL (1 EA per 1 day)
MUCINEX FAST-MAX COLD & SINUS ORAL TABLET 5-325-200 MG (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
MUCINEX FAST-MAX COLD FLU NGHT ORAL LIQUID 12.5-5-325 MG/10ML (<i>diphenhydramine-pe-apap</i>)	Preferred	
MUCINEX FAST-MAX COLD FLU ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
MUCINEX FAST-MAX COLD/FLU MS ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
MUCINEX FAST-MAX COLD/FLU ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
MUCINEX FAST-MAX COLD/FLU ORAL TABLET 5-10-200-325 MG (<i>phenylephrine-dm-gg-apap</i>)	Preferred	QL (1 EA per 1 day)
MUCINEX FAST-MAX CONG HEADACHE ORAL CAPSULE 10-5-325 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
MUCINEX FAST-MAX CONGEST COUGH ORAL LIQUID 2.5-5-100 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
MUCINEX FAST-MAX DM MAX ORAL LIQUID 20-400 MG/20ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
MUCINEX FAST-MAX ORAL LIQUID 10-650-400 MG/20ML (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
MUCINEX FREEFROM CLD/FLU/CNGST ORAL LIQUID 10-650-400 MG/20ML (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
MUCINEX FREEFROM COLD/FLU DAY ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
MUCINEX FREEFROM SEV CNGST/CGH ORAL LIQUID 10-20-400 MG/20ML (<i>phenylephrine-dm-gg</i>)	Preferred	
MUCINEX SINUS-MAX CONG & PAIN ORAL LIQUID 10-650-400 MG/20ML (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
MUCINEX SINUS-MAX CONGESTION ORAL LIQUID 10-650-400 MG/20ML (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
MUCINEX SINUS-MAX CONGESTION ORAL TABLET 5-325-200 MG (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
MUCINEX SINUS-MAX NIGHT TIME ORAL LIQUID 12.5-5-325 MG/10ML (<i>diphenhydramine-pe-apap</i>)	Preferred	
MUCINEX SINUS-MAX ORAL TABLET 5-10-200-325 MG (<i>phenylephrine-dm-gg-apap</i>)	Preferred	QL (1 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
MUCINEX SINUS-MAX SEV CONG/PN ORAL CAPSULE 10-5-325 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
MUCINEX SINUS-MAX SEV CONG/PN ORAL TABLET 5-325-200 MG (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
MUCINEX STUFFY NOSE & CHEST ORAL LIQUID 2.5-100 MG/5ML (<i>phenylephrine-guaifenesin</i>)	Preferred	
<i>mucus congest & cough child oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>mucus d oral tablet extended release 12 hour 120-1200 mg</i>	Preferred	
<i>mucus dm oral tablet extended release 12 hour 30-600 mg</i>	Preferred	
<i>mucus relief childrens oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>mucus relief cold flu throat oral liquid 5-10-200-325 mg/10ml</i>	Preferred	
<i>mucus relief cold/sinus max st oral liquid 10-650-400 mg/20ml</i>	Preferred	
<i>mucus relief cough childrens oral liquid 5-100 mg/5ml</i>	Preferred	
<i>mucus relief d 12hr er oral tablet extended release 12 hour 60-600 mg</i>	Preferred	
<i>mucus relief d oral tablet extended release 12 hour 120-1200 mg, 60-600 mg</i>	Preferred	
<i>mucus relief dm cough oral tablet 20-400 mg</i>	Preferred	
<i>mucus relief dm max oral liquid 20-400 mg/20ml, 5-100 mg/5ml</i>	Preferred	
<i>mucus relief dm max oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>mucus relief dm oral liquid 20-400 mg/20ml</i>	Preferred	
<i>mucus relief dm oral tablet 20-400 mg</i>	Preferred	
<i>mucus relief dm oral tablet extended release 12 hour 30-600 mg, 60-1200 mg</i>	Preferred	
<i>mucus relief multi symptom oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>mucus relief plus oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>mucus relief severe cong/cold oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>mucus relief severe congest/cgh oral liquid 10-20-400 mg/20ml, 2.5-5-100 mg/5ml</i>	Preferred	
<i>mucus relief severe sinus oral tablet 5-325-200 mg</i>	Preferred	
<i>mucus-d oral tablet extended release 12 hour 60-600 mg</i>	Preferred	
<i>mucus-dm max oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>mucus-dm maximum strength oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>mucus-dm oral tablet extended release 12 hour 30-600 mg</i>	Preferred	
<i>multi-symptom cold childrens oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>multi-symptom cold childrens oral suspension 2.5-1-5-160 mg/5ml</i>	Preferred	
<i>multi-symptom cold plus child oral liquid 2.5-5-100 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>multi-symptom cold plus child oral suspension 2.5-1-5-160 mg/5ml</i>	Preferred	
<i>neotuss oral liquid 30-200 mg/5ml</i>	Preferred	
NEXAFED SINUS PRESSURE + PAIN ORAL TABLET 30-325 MG (<i>pseudoephedrine-acetaminophen</i>)	Preferred	
<i>night time cold & cough oral syrup 6.25-2.5 mg/5ml</i>	Preferred	
<i>night time cold/flu relief oral capsule 15-6.25-325 mg</i>	Preferred	
<i>nighttime cold & flu max str oral liquid 12.5-5-325 mg/10ml</i>	Preferred	
<i>nighttime cold medicine oral liquid 15-6.25-500 mg/15ml</i>	Preferred	
<i>nighttime cold/flu relief oral capsule 15-6.25-325 mg</i>	Preferred	
<i>nighttime cold/flu relief oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>nighttime cough oral liquid 12.5-30 mg/30ml, 6.25-15 mg/15ml</i>	Preferred	
<i>nohist-dm oral liquid 10-4-15 mg/5ml</i>	Preferred	
<i>nohist-lq oral liquid 4-10 mg/5ml</i>	Preferred	
NYQUIL HBP COLD & FLU ORAL LIQUID 15-6.25-325 MG/15ML (<i>dm-doxylamine-acetaminophen</i>)	Preferred	
NYQUIL SEVERE COLD/FLU ORAL LIQUID 5-6.25-10-325 MG/15ML (<i>phenyleph-doxylamine-dm-apap</i>)	Preferred	
NYQUIL SEVERE+ VAPOCOOL ORAL LIQUID 5-6.25-10-325 MG/15ML (<i>phenyleph-doxylamine-dm-apap</i>)	Preferred	
PANADOL COLD/FLU ORAL TABLET 5-325 MG (<i>phenylephrine-acetaminophen</i>)	Preferred	
PEDIACARE COUGH/CONGESTION ORAL LIQUID 5-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
PEDIACARE MULTI-SYMPTOM ORAL LIQUID 2.5-1-5-160 MG/5ML (<i>phenyleph-cpm-dm-apap</i>)	Preferred	
<i>pharbinex-dm oral tablet 20-400 mg</i>	Preferred	
<i>pres gen oral liquid 5-10-200 mg/5ml</i>	Preferred	
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	Preferred	AGE (Min 6 Years)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	Preferred	AGE (Min 2 Years)
PRO-RED AC ORAL SYRUP 5-1-9 MG/5ML (<i>phenyleph-dexchlorphen-codeine</i>)	Preferred	
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	Preferred	AGE (Min 2 Years)
<i>pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 120-1200 mg, 60-600 mg</i>	Preferred	
<i>px allergy sinus pe oral tablet 2-5-325 mg</i>	Preferred	
<i>px daytime cold oral tablet 10-5-325 mg</i>	Preferred	
<i>px daytime cold/flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>px daytime pe oral capsule 10-5-325 mg</i>	Preferred	
<i>px dibromm cold/allergy child oral elixir 1-2.5 mg/5ml</i>	Preferred	
<i>px dibromm dm cold/cough child oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>px ibuprofen cold & sinus oral tablet 30-200 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>px nighttime cold oral tablet 5-2-10-325 mg</i>	Preferred	
<i>px nitetime cold/flu relief oral capsule 15-6.25-325 mg</i>	Preferred	
<i>px nitetime cold/flu relief oral liquid 15-6.25-500 mg/15ml</i>	Preferred	
<i>px nitetime cough oral liquid 6.25-15 mg/15ml</i>	Preferred	
<i>px severe cold oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>px sinus relief oral tablet 5-325 mg</i>	Preferred	
<i>px tussin cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>px tussin dm oral liquid 100-10 mg/5ml</i>	Preferred	
<i>qc allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>qc cough/cold hbp oral tablet 4-30 mg</i>	Preferred	
<i>qc daytime cold/flu oral capsule 10-5-325 mg</i>	Preferred	
<i>qc daytime cold/flu oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>qc dibromm childrens cold/cgh oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>qc ibuprofen cold/sinus oral tablet 30-200 mg</i>	Preferred	
<i>qc medifin dm oral tablet 20-400 mg</i>	Preferred	
<i>qc mucus & cough relief child oral liquid 5-100 mg/5ml</i>	Preferred	
<i>qc mucus cold flu & throat oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>qc mucus relief cold & flu oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>qc mucus relief dm max oral liquid 5-100 mg/5ml</i>	Preferred	
<i>qc mucus relief dm max oral tablet extended release 12 hour 60-1200 mg</i>	Preferred	
<i>qc mucus relief severe con/cgh oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>qc mucus relief sinus pressure oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>qc mucus relief sinus severe oral tablet 5-325-200 mg</i>	Preferred	
<i>qc nighttime cold & flu oral capsule 15-6.25-325 mg</i>	Preferred	
<i>qc nighttime cold & flu oral liquid 15-6.25-325 mg/15ml</i>	Preferred	
<i>qc nighttime cold/flu relief oral liquid 15-6.25-500 mg/15ml</i>	Preferred	
<i>qc nighttime cough oral liquid 15-6.25 mg/15ml, 6.25-15 mg/15ml</i>	Preferred	
<i>qc nighttime multi-symptom oral capsule 15-6.25-325 mg</i>	Preferred	
<i>qc pressure pain & mucus pe oral tablet 5-325-200 mg</i>	Preferred	
<i>qc severe allergy relief sinus oral tablet 25-5-325 mg</i>	Preferred	
<i>qc severe cold & flu oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>qc severe cold head congestion oral tablet 5-325-200 mg</i>	Preferred	
<i>qc severe cold/cough daytime oral packet 20-10-650 mg</i>	Preferred	
<i>qc sinus & headache oral tablet 5-325 mg</i>	Preferred	
<i>qc sinus congest/pain severe oral tablet 5-325-200 mg</i>	Preferred	
<i>qc triacting daytime childrens oral syrup 5-2.5 mg/5ml</i>	Preferred	
<i>qc tussin cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>qc tussin dm cough/congestion oral liquid 10-100 mg/5ml, 20-200 mg/10ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ra cold & cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>ra cold & sinus relief oral tablet 30-200 mg</i>	Preferred	
<i>ra cold multi-symptom daytime oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>ra cold/cough dm oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>ra cold/flu relief daytime oral capsule 10-5-325 mg</i>	Preferred	
<i>ra cold/flu relief nighttime oral capsule 15-6.25-325 mg</i>	Preferred	
<i>ra cold/flu/sore throat max oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>ra cold/sinus max oral tablet 5-325-200 mg</i>	Preferred	
<i>ra daytime cold/flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>ra ibu-profen cold/sinus oral tablet 30-200 mg</i>	Preferred	
<i>ra mucus relief d max strength oral tablet extended release 12 hour 120-1200 mg</i>	Preferred	
<i>ra mucus relief d oral tablet extended release 12 hour 60-600 mg, 600-60 mg</i>	Preferred	
<i>ra mucus relief dm oral tablet extended release 12 hour 30-600 mg</i>	Preferred	
<i>ra nighttime cold/flu relief oral liquid 30-12.5-650 mg/30ml</i>	Preferred	
<i>ra severe congestion/cold max oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>ra sinus congest/pain relief oral tablet 5-325-200 mg</i>	Preferred	
<i>ra sinus congestion/pain day oral tablet 5-325 mg</i>	Preferred	
<i>ra suphedrine pe oral tablet 4-10 mg, 5-325 mg</i>	Preferred	
<i>ra tussin cgh & cold mucus cf oral liquid 5-10-200 mg/5ml</i>	Preferred	
<i>ra tussin cgh/chest congest dm oral liquid 100-10 mg/5ml</i>	Preferred	
<i>ra tussin cough dm sugar free oral syrup 100-10 mg/5ml</i>	Preferred	
<i>ra tussin cough oral liquid 10-100 mg/5ml</i>	Preferred	
<i>ra tussin cough/chest dm max oral liquid 10-200 mg/5ml</i>	Preferred	QL (10 ML per 1 day)
<i>ra tussin dm oral liquid 100-10 mg/5ml</i>	Preferred	
<i>refenesen dm oral tablet 400-20 mg</i>	Preferred	
<i>robafen cf multi-symptom cold oral liquid 5-10-100 mg/5ml</i>	Preferred	
ROBITUSSIN CHILD COUGH/COLD CF ORAL LIQUID 2.5-5-50 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
ROBITUSSIN CHILD COUGH/COLD LA ORAL LIQUID 1-7.5 MG/5ML (<i>chlorpheniramine-dm</i>)	Preferred	
ROBITUSSIN COUGH+CHEST CONG DM ORAL CAPSULE 10-200 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
ROBITUSSIN COUGH+CHEST CONG DM ORAL LIQUID 20-400 MG/20ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
ROBITUSSIN NIGHTTIME COUGH ORAL LIQUID 1-7.5 MG/5ML (<i>chlorpheniramine-dm</i>)	Preferred	
ROBITUSSIN PEAK COLD MULTI-SYM ORAL LIQUID 5-10-100 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
ROBITUSSIN SEVERE MULTI-SYMP ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ROBITUSSIN SEVERE NIGHTTIME ORAL LIQUID 12.5-5-325 MG/10ML (<i>diphenhydramine-pe-apap</i>)	Preferred	
ROMPE PECHO MAX ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
<i>rynex dm oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>rynex pe oral elixir 1-2.5 mg/5ml</i>	Preferred	
<i>rynex pse oral liquid 1-15 mg/5ml</i>	Preferred	
SAFETUSSIN DM COUGH/CHEST CONG ORAL LIQUID 10-100 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
<i>sb allergy multi-symptom oral tablet 2-5-325 mg</i>	Preferred	
<i>sb childrens multisympt cold oral suspension 2.5-1-5-160 mg/5ml</i>	Preferred	
<i>sb cold & allergy childrens oral elixir 1-2.5 mg/5ml</i>	Preferred	
<i>sb cold & cough dm childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>sb cold & cough hbp oral tablet 4-30 mg</i>	Preferred	
<i>sb cold head congestion severe oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sb cold multi-symptom severe oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sb cough control cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>sb daytime oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>sb daytime sinus oral capsule 5-325 mg</i>	Preferred	
<i>sb flu maximum strength hbp oral tablet 15-500-2 mg</i>	Preferred	
<i>sb flu relief therapy daytime oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>sb flu relief therapy night oral liquid 12.5-5-325 mg/15ml</i>	Preferred	
<i>sb mucus relief dm oral tablet 20-400 mg</i>	Preferred	
<i>sb night time cold/flu relief oral liquid 15-6.25-500 mg/15ml</i>	Preferred	
<i>sb nighttime cough oral liquid 6.25-15 mg/15ml</i>	Preferred	
<i>sb nighttime sinus multi-sympt oral capsule 6.25-5-325 mg</i>	Preferred	
<i>sb sinus & allergy max st oral tablet 4-10 mg</i>	Preferred	
<i>sb sinus congest/pain day/nght oral 2-5-325 & 5-325 mg</i>	Preferred	
<i>sb sinus congestion/pain day oral tablet 5-325 mg</i>	Preferred	
<i>sb sinus congestion/pain night oral tablet 2-5-325 mg</i>	Preferred	
<i>sb sinus congestion/pain oral tablet 5-325-200 mg</i>	Preferred	
SB TAB TUSSIN DM ORAL TABLET 20-400 MG (<i>dextromethorphan-guaifenesin</i>)	Preferred	
SCOT-TUSSIN SENIOR ORAL LIQUID 15-200 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
<i>severe cold & flu oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>severe cold/flu nighttime ms oral liquid 5-6.25-10-325 mg/15ml</i>	Preferred	
<i>severe congestion oral liquid 10-650-400 mg/20ml</i>	Preferred	
<i>siltussin dm das oral liquid 100-10 mg/5ml</i>	Preferred	
<i>siltussin-dm alcohol free oral syrup 100-10 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
SINEX SEVERE+ VAPOCOOL ORAL LIQUID 5-6.25-10-325 MG/15ML (<i>phenyleph-doxylamine-dm-apap</i>)	Preferred	
<i>sinus + headache oral tablet 5-325 mg</i>	Preferred	
<i>sinus congestion/pain daytime oral tablet 5-325 mg, 5-325-200 mg</i>	Preferred	
<i>sinus congestion/pain oral tablet 5-325 mg</i>	Preferred	
<i>sinus pressure + pain oral tablet 5-325 mg</i>	Preferred	
<i>sinus relief congestion-pain oral tablet 5-325-200 mg</i>	Preferred	
<i>sm chest congestion relief dm oral tablet 20-400 mg</i>	Preferred	
<i>sm cold & allergy childrens oral elixir 1-15 mg/5ml</i>	Preferred	
<i>sm cold & allergy pe oral tablet 4-10 mg</i>	Preferred	
<i>sm cold & cough childrens oral liquid 2.5-1-5 mg/5ml</i>	Preferred	
<i>sm cold & flu severe oral tablet 5-10-200-325 mg</i>	Preferred	QL (1 EA per 1 day)
<i>sm cold & sinus relief oral tablet 30-200 mg</i>	Preferred	
<i>sm cold head congestion night oral tablet 5-2-10-325 mg</i>	Preferred	
<i>sm cough/runny nose childrens oral liquid 1-5 mg/5ml</i>	Preferred	
<i>sm cough/sore throat nighttime oral liquid 30-12.5-1000 mg/30ml</i>	Preferred	
<i>sm day time cold & flu relief oral liquid 10-5-325 mg/15ml</i>	Preferred	
<i>sm daytime severe cold & flu oral liquid 5-10-200-325 mg/15ml</i>	Preferred	
<i>sm flu relief therapy night oral liquid 12.5-5-325 mg/15ml</i>	Preferred	
<i>sm mucus relief cold childrens oral liquid 2.5-5-100 mg/5ml</i>	Preferred	
<i>sm nite time cold & flu oral liquid 15-6.25-325 mg/15ml, 5-6.25-10-325 mg/15ml</i>	Preferred	
<i>sm severe congestion & cough oral liquid 10-20-400 mg/20ml</i>	Preferred	
<i>sm sinus & allergy max st oral tablet 4-60 mg</i>	Preferred	
<i>sm sinus severe for adults oral tablet 5-325-200 mg</i>	Preferred	
<i>sm tussin cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>sm tussin cough/chest congest oral liquid 20-200 mg/10ml</i>	Preferred	
<i>sm tussin cough/chest congest oral syrup 100-10 mg/5ml</i>	Preferred	
<i>sm tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>sm tussin dm oral syrup 100-10 mg/5ml</i>	Preferred	
SORBUGEN NR ORAL LIQUID 15-150 MG/7.5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
<i>sorbutuss nr oral liquid 10-100 mg/5ml</i>	Preferred	
SUDAFED PE HEAD CONGESTION ORAL TABLET 5-325-200 MG (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
SUDAFED PE SINUS PRESSURE+PAIN ORAL TABLET 5-325 MG (<i>phenylephrine-acetaminophen</i>)	Preferred	
SUDOGEST SINUS/ALLERGY ORAL TABLET 4-60 MG (<i>chlorpheniramine-pseudoeph</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
SUPRESS-PE PEDIATRIC ORAL LIQUID 2.5-50 MG/ML (phenylephrine-guaifenesin)	Preferred	
<i>teo-tus oral liquid 5-10-200 mg/5ml</i>	Preferred	
THERAFLU EXPRESSMAX ORAL LIQUID 20-10-650 MG/30ML (dm-phenylephrine-acetaminophen)	Preferred	
THERAFLU EXPRESSMAX SEV CLD/CG ORAL LIQUID 12.5-5-325 MG/15ML (diphenhydramine-pe-apap)	Preferred	
THERAFLU EXPRESSMAX SEV CLD/CG ORAL TABLET 10-5-325 MG (dm-phenylephrine-acetaminophen)	Preferred	
THERAFLU EXPRESSMAX SEV CLD/FL ORAL LIQUID 5-10-200-325 MG/15ML (phenylephrine-dm-gg-apap)	Preferred	
THERAFLU EXPRESSMAX SEV CLD/FL ORAL TABLET 5-10-200-325 MG (phenylephrine-dm-gg-apap)	Preferred	QL (1 EA per 1 day)
THERAFLU SEVERE COLD DAYTIME ORAL TABLET 15-5-325 MG (dm-phenylephrine-acetaminophen)	Preferred	
THERAFLU SEVERE COLD NIGHTTIME ORAL TABLET 5-2-10-325 MG (phenyleph-cpm-dm-apap)	Preferred	
THERAFLU SEVERE COLD/CGH DAY ORAL TABLET 10-5-325 MG (dm-phenylephrine-acetaminophen)	Preferred	
TRIAMINIC CHEST/NASAL CONGEST ORAL LIQUID 2.5-50 MG/5ML (phenylephrine-guaifenesin)	Preferred	
TRIAMINIC COLD/COUGH DAY TIME ORAL SYRUP 2.5-5 MG/5ML (phenylephrine-dm)	Preferred	
TRIAMINIC FEVER & COLD ORAL SUSPENSION 2.5-1-5-160 MG/5ML (phenyleph-cpm-dm-apap)	Preferred	
TRIAMINIC FLU COUGH & FEVER ORAL SYRUP 7.5-160-1 MG/5ML (dm-apap-cpm)	Preferred	
TRIAMINIC NIGHT TIME COLD/CGH ORAL SYRUP 6.25-2.5 MG/5ML (diphenhydramine-phenylephrine)	Preferred	
<i>tusnel diabetic oral liquid 10-100 mg/5ml</i>	Preferred	
TUSNEL ORAL LIQUID 30-15-200 MG/5ML (pseudoephedrine-dm-gg)	Preferred	
TUSNEL PEDIATRIC ORAL LIQUID 15-5-50 MG/5ML (pseudoephedrine-dm-gg)	Preferred	
<i>tussin cf cough & cold oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>tussin cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
<i>tussin cf severe multi-symptom oral liquid 5-10-200-325 mg/10ml</i>	Preferred	
<i>tussin cough+chest cong dm sf oral liquid 10-100 mg/5ml</i>	Preferred	
<i>tussin cough+chest congest dm oral liquid 10-100 mg/5ml</i>	Preferred	
<i>tussin dm cough + chest oral liquid 10-100 mg/5ml, 20-400 mg/20ml</i>	Preferred	
<i>tussin dm max adult oral liquid 5-100 mg/5ml</i>	Preferred	
<i>tussin dm max oral liquid 20-400 mg/20ml</i>	Preferred	
<i>tussin dm oral liquid 100-10 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>tussin dm oral syrup 100-10 mg/5ml</i>	Preferred	
<i>tussin multi-symptom cold cf oral liquid 5-10-100 mg/5ml</i>	Preferred	
TUSSI-PRES ORAL LIQUID 5-10-200 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
TUSSI-PRES PE PEDIATRIC ORAL LIQUID 2.5-100 MG/5ML (<i>phenylephrine-guaifenesin</i>)	Preferred	
TYLENOL CHILDRENS COLD/COUGH ORAL SUSPENSION 160-5 MG/5ML (<i>acetaminophen-dm</i>)	Preferred	
TYLENOL CHILDRENS COLD/FLU ORAL SUSPENSION 2.5-1-5-160 MG/5ML (<i>phenyleph-cpm-dm-apap</i>)	Preferred	
TYLENOL CHILDRENS PLUS MS COLD ORAL SUSPENSION 2.5-1-5-160 MG/5ML (<i>phenyleph-cpm-dm-apap</i>)	Preferred	
TYLENOL COLD & HEAD ORAL TABLET 5-325-200 MG (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
TYLENOL COLD/FLU SEVERE ORAL TABLET 5-10-200-325 MG (<i>phenylephrine-dm-gg-apap</i>)	Preferred	QL (1 EA per 1 day)
TYLENOL COLD/FLU/COUGH NIGHT ORAL LIQUID 5-6.25-10-325 MG/15ML (<i>phenyleph-doxylamine-dm-apap</i>)	Preferred	
TYLENOL SINUS SEVERE ORAL TABLET 5-325-200 MG (<i>phenylephrine-apap-guaifenesin</i>)	Preferred	
TYLENOL SINUS+HEADACHE ORAL TABLET 5-325 MG (<i>phenylephrine-acetaminophen</i>)	Preferred	
TYLENOL WARMING COUGH/CONGEST ORAL LIQUID 5-10-200-325 MG/15ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
VALIHIST ORAL TABLET 2-5-325 MG (<i>chlorphen-pe-acetaminophen</i>)	Preferred	
VICKS DAYQUIL COLD & FLU ORAL CAPSULE 10-5-325 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
VICKS DAYQUIL COLD & FLU ORAL LIQUID 10-5-325 MG/15ML (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
VICKS DAYQUIL MUCUS CONTROL DM ORAL LIQUID 10-200 MG/15ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
VICKS DAYQUIL SEVERE COLD/FLU ORAL LIQUID 5-10-200-325 MG/15ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
VICKS DAYQUIL SEVERE COLD/FLU ORAL TABLET 5-10-200-325 MG (<i>phenylephrine-dm-gg-apap</i>)	Preferred	QL (1 EA per 1 day)
VICKS NYQUIL CHILDRENS CLD/CGH ORAL LIQUID 2-15 MG/15ML (<i>chlorpheniramine-dm</i>)	Preferred	
VICKS NYQUIL COLD & FLU NIGHT ORAL CAPSULE 15-6.25-325 MG (<i>dm-doxylamine-acetaminophen</i>)	Preferred	
VICKS NYQUIL COLD & FLU NIGHT ORAL LIQUID 15-6.25-325 MG/15ML (<i>dm-doxylamine-acetaminophen</i>)	Preferred	
VICKS NYQUIL COLD & FLU ORAL CAPSULE 15-6.25-325 MG (<i>dm-doxylamine-acetaminophen</i>)	Preferred	
VICKS NYQUIL COLD & FLU ORAL LIQUID 15-6.25-325 MG/15ML (<i>dm-doxylamine-acetaminophen</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
VICKS NYQUIL COUGH ORAL LIQUID 12.5-30 MG/30ML, 6.25-15 MG/15ML (<i>doxylamine-dm</i>)	Preferred	
VICKS NYQUIL SEVERE COLD/FLU ORAL LIQUID 5-6.25-10-325 MG/15ML (<i>phenyleph-doxylamine-dm-apap</i>)	Preferred	
VICKS SINEX DAYTIME ORAL CAPSULE 5-325 MG (<i>phenylephrine-acetaminophen</i>)	Preferred	
WAL-ACT D ORAL TABLET 2.5-60 MG (<i>triprolidine-pseudoephedrine</i>)	Preferred	
WAL-DRYL ALLERGY/SINUS HEADACHE ORAL TABLET 25-5-325 MG (<i>diphenhydramine-pe-apap</i>)	Preferred	
WAL-FEX D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 24 HOUR 180-240 MG (<i>fexofenadine-pseudoephedrine</i>)	Preferred	
WAL-FLU SEVERE COLD & COUGH ORAL LIQUID 10-5-325 MG/15ML (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
WAL-FLU SEVERE COLD & COUGH ORAL PACKET 20-10-650 MG (<i>dm-phenylephrine-acetaminophen</i>)	Preferred	
WAL-FLU SEVERE COLD DAYTIME ORAL PACKET 10-650 MG (<i>phenylephrine-acetaminophen</i>)	Preferred	
<i>wal-flu severe cold nighttime oral liquid 12.5-5-325 mg/15ml</i>	Preferred	
WAL-PHED PE NIGHTTIME COLD ORAL TABLET 25-5-325 MG (<i>diphenhydramine-pe-apap</i>)	Preferred	
WAL-PHED PE SINUS/ALLERGY ORAL TABLET 4-10 MG (<i>chlorpheniramine-phenylephrine</i>)	Preferred	
WAL-PHED SINUS/ALLERGY ORAL TABLET 4-60 MG (<i>chlorpheniramine-pseudoeph</i>)	Preferred	
WAL-PROFEN COLD & SINUS ORAL TABLET 30-200 MG (<i>pseudoephedrine-ibuprofen</i>)	Preferred	
<i>wal-tap cold/allergy oral elixir 1-15 mg/5ml</i>	Preferred	
WAL-TUSSIN CF MAX ORAL LIQUID 5-10-200 MG/5ML (<i>phenylephrine-dm-gg</i>)	Preferred	
WAL-TUSSIN CF MAX ORAL LIQUID 5-10-200-325 MG/10ML (<i>phenylephrine-dm-gg-apap</i>)	Preferred	
WAL-TUSSIN COUGH/CHEST DM ORAL SYRUP 100-10 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
WAL-TUSSIN DM CGH/CHEST CONG ORAL LIQUID 100-10 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
ZYNCOF ORAL SYRUP 20-400 MG/5ML (<i>dextromethorphan-guaifenesin</i>)	Preferred	
*CYCLOPLEGIC MYDRIATICS**		
<i>atropine sulfate ophthalmic solution 1 %</i>	Preferred	
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	Preferred	
ISOPTO ATROPINE OPHTHALMIC SOLUTION 1 % (<i>atropine sulfate</i>)	Preferred	
<i>tropicamide ophthalmic solution 1 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*CYSTIC FIBROSIS AGENTS**		
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>dornase alfa</i>)	Preferred	PA; QL (5 ML per 1 day)
*DENTAL PRODUCTS**		
<i>sodium fluoride</i> (Denta 5000 Plus Dental Cream 1.1 %)	Preferred	
<i>sodium fluoride</i> (Dentagel Dental Gel 1.1 %)	Preferred	
<i>sodium fluoride</i> (Just Right 5000 Dental Gel 1.1 %)	Preferred	
<i>sf 5000 plus dental cream 1.1 %</i>	Preferred	
<i>sf dental gel 1.1 %</i>	Preferred	
<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	Preferred	
<i>sodium fluoride 5000 ppm dental cream 1.1 %</i>	Preferred	
<i>sodium fluoride dental cream 1.1 %</i>	Preferred	
<i>sodium fluoride dental gel 1.1 %</i>	Preferred	
*DIABETIC OTHER**		
<i>cvs glucose bits oral tablet chewable 1 gm</i>	Preferred	
<i>cvs glucose oral gel 15 gm/38gm, 40 %</i>	Preferred	
<i>cvs glucose oral tablet chewable 4 gm, 4-6 gm-mg</i>	Preferred	
<i>cvs glucose shot oral liquid 15 gm/59ml</i>	Preferred	
<i>cvs soft glucose oral tablet chewable 4 gm</i>	Preferred	
DEX4 GLUCOSE GO-POUCH ORAL GEL 15 GM/33GM (<i>dextrose (diabetic use)</i>)	Preferred	
DEX4 GLUCOSE ORAL TABLET CHEWABLE 4-6 GM-MG (<i>glucose-vitamin c</i>)	Preferred	
DEX4 NATURALS ORAL TABLET CHEWABLE 4-6 GM-MG (<i>glucose-vitamin c</i>)	Preferred	
DEX4 ORAL TABLET CHEWABLE 4-6 GM-MG (<i>glucose-vitamin c</i>)	Preferred	
DEX4 POUCH PACK ORAL TABLET CHEWABLE 4-6 GM-MG (<i>glucose-vitamin c</i>)	Preferred	
DEX4 QUICK DISSOLVE GLUCOSE ORAL TABLET CHEWABLE 4 GM (<i>dextrose (diabetic use)</i>)	Preferred	
GLUCO TO GO 15 ORAL GEL 40 % (<i>dextrose (diabetic use)</i>)	Preferred	
GLUCO TO GO ORAL TABLET CHEWABLE 4 GM (<i>dextrose (diabetic use)</i>)	Preferred	
<i>glucose instant energy oral tablet chewable 4-6 gm-mg, 6-4 mg-gm</i>	Preferred	
<i>glucose oral gel 15 gm/33gm, 40 %</i>	Preferred	
<i>glucose oral liquid 15 gm/59ml, 15 gm/60ml</i>	Preferred	
<i>glucose oral tablet chewable 4 gm, 4-6 gm-mg</i>	Preferred	
GLUTOSE 15 ORAL GEL 40 % (<i>dextrose (diabetic use)</i>)	Preferred	
GLUTOSE 45 ORAL GEL 40 % (<i>dextrose (diabetic use)</i>)	Preferred	
GLUTOSE 5 ORAL GEL 40 % (<i>dextrose (diabetic use)</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp glucose oral tablet chewable 4 gm, 4-6 gm-mg</i>	Preferred	
<i>gnp quick dissolve glucose oral tablet chewable 4 gm</i>	Preferred	
<i>goodsense glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>hy-vee glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
INSTA-GLUCOSE ORAL GEL 77.4 % (<i>dextrose (diabetic use)</i>)	Preferred	
<i>croger glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>leader glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>leader quick dissolve glucose oral tablet chewable 4 gm</i>	Preferred	
<i>longs glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>meijer glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>preferred plus glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>px glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>ra glucose oral tablet chewable 4-6 gm-mg, 6-4 mg-gm</i>	Preferred	
RA TRUEPLUS GLUCOSE ORAL GEL 15 GM/32ML (<i>dextrose (diabetic use)</i>)	Preferred	
RELION GLUCOSE ORAL GEL 15 GM/38GM (<i>dextrose (diabetic use)</i>)	Preferred	
RELION GLUCOSE ORAL TABLET CHEWABLE 4-6 GM-MG (<i>glucose-vitamin c</i>)	Preferred	
<i>sm glucose oral tablet chewable 4 gm, 4-6 gm-mg</i>	Preferred	
SMART SENSE GLUCOSE ORAL TABLET CHEWABLE 4-6 GM-MG (<i>glucose-vitamin c</i>)	Preferred	
SWEET CHEEKS ORAL GEL 40 % (<i>dextrose (diabetic use)</i>)	Preferred	
<i>tgt glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
TRUEPLUS GLUCOSE ON THE GO ORAL TABLET CHEWABLE 4 GM (<i>dextrose (diabetic use)</i>)	Preferred	
TRUEPLUS GLUCOSE ORAL GEL 15 GM/32ML (<i>dextrose (diabetic use)</i>)	Preferred	
TRUEPLUS GLUCOSE ORAL TABLET CHEWABLE 4 GM (<i>dextrose (diabetic use)</i>)	Preferred	
<i>up & up glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>value plus glucose oral gel 40 %</i>	Preferred	
<i>value plus glucose oral tablet chewable 4-6 gm-mg</i>	Preferred	
<i>walgreens glucose oral tablet chewable 4 gm, 4-6 gm-mg</i>	Preferred	
*DIABETIC SUPPLIES**		
ACCU-CHEK FASTCLIX LANCET KIT (<i>lancets misc.</i>)	Preferred	
ACCU-CHEK FASTCLIX LANCETS (<i>lancets</i>)	Preferred	
ACCU-CHEK SAFE-T PRO LANCETS (<i>lancets</i>)	Preferred	
ACCU-CHEK SOFTCLIX LANCET DEV KIT (<i>lancets misc.</i>)	Preferred	
ACCU-CHEK SOFTCLIX LANCETS (<i>lancets</i>)	Preferred	
<i>acti-lance 28g</i>	Preferred	
<i>acti-lance lite lancets 28g</i>	Preferred	

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<i>acti-lance special lancets 17g</i>	Preferred	
<i>acti-lance universal 23g</i>	Preferred	
<i>adjustable lancing device</i>	Preferred	
<i>advanced mobile lancet</i>	Preferred	
ADVOCATE LANCETS (<i>lancets</i>)	Preferred	
ADVOCATE LANCETS 30G (<i>lancets</i>)	Preferred	
ADVOCATE LANCING DEVICE (<i>lancet devices</i>)	Preferred	
ADVOCATE RAPID-SAFE LANCING (<i>lancet devices</i>)	Preferred	
ADVOCATE SAFETY LANCETS (<i>lancets</i>)	Preferred	
ADVOCATE SAFETY LANCETS 26G (<i>lancets</i>)	Preferred	
AGAMATRIX ULTRA-THIN LANCETS (<i>lancets</i>)	Preferred	
<i>aimsco twist lancets 32g</i>	Preferred	
AIMSCO TWIST LANCETS 33G (<i>lancets</i>)	Preferred	
AMBI-TRAY (<i>insulin admin supplies</i>)	Preferred	
AQUALANCE LANCETS 30G (<i>lancets</i>)	Preferred	
<i>assure comfort lancets 28g</i>	Preferred	
ASSURE HAEMOLANCE PLUS HIGH (<i>lancets</i>)	Preferred	
ASSURE HAEMOLANCE PLUS LOW (<i>lancets</i>)	Preferred	
ASSURE HAEMOLANCE PLUS MICRO (<i>lancets</i>)	Preferred	
ASSURE HAEMOLANCE PLUS NORMAL (<i>lancets</i>)	Preferred	
ASSURE HAEMOLANCE PLUS PED (<i>lancets</i>)	Preferred	
ASSURE LANCE LANCETS (<i>lancets</i>)	Preferred	
ASSURE LANCE LANCETS 21G (<i>lancets</i>)	Preferred	
ASSURE LANCE PLUS SAFETY 25G (<i>lancets</i>)	Preferred	
ASSURE LANCE PLUS SAFETY 30G (<i>lancets</i>)	Preferred	
ASSURE LANCE SAFETY LANCET 28G (<i>lancets</i>)	Preferred	
<i>aurora lancet super thin 30g</i>	Preferred	
<i>aurora lancet thin 23g</i>	Preferred	
AUTO-LANCET (<i>lancet devices</i>)	Preferred	
AUTO-LANCET MINI (<i>lancet devices</i>)	Preferred	
AUTOLET II CLINISAFE KIT (<i>lancets misc.</i>)	Preferred	
AUTOLET LANCING DEVICE (<i>lancet devices</i>)	Preferred	
AUTOLET LITE CLINISAFE KIT (<i>lancets misc.</i>)	Preferred	
AUTOLET LITE STARTER PACK KIT (<i>lancets misc.</i>)	Preferred	
AUTOLET MINI (<i>lancet devices</i>)	Preferred	
AUTOLET PLATFORMS (<i>lancets misc.</i>)	Preferred	
AUTOLET PLUS (<i>lancet devices</i>)	Preferred	
BD MICROTAINER LANCETS (<i>lancets</i>)	Preferred	
BIGFOOT UNITY PEN CAP/ADMELOG (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/APIIDRA (<i>insulin admin supplies</i>)	Preferred	

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BIGFOOT UNITY PEN CAP/ASPART (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/BASAGLAR (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/FIASP (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/HUMALOG (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/LANTUS (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/LISPRO (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/LYUMJEV (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/NOVOLOG (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/TOUJEO (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/TOUJEO M (<i>insulin admin supplies</i>)	Preferred	
BIGFOOT UNITY PEN CAP/TRESIBA (<i>insulin admin supplies</i>)	Preferred	
CARDIOCOM LANCING DEVICE (<i>lancet devices</i>)	Preferred	
<i>careone advanced lancing dev</i>	Preferred	
CAREONE LANCET SUPER THIN 30G (<i>lancets</i>)	Preferred	
<i>careone lancet thin 23g</i>	Preferred	
CARESENS LANCETS (<i>lancets</i>)	Preferred	
CARETOUCH LANCING/EJECTOR (<i>lancet devices</i>)	Preferred	
CARETOUCH SAFETY LANCETS (<i>lancets</i>)	Preferred	
CARETOUCH SAFETY LANCETS 26G (<i>lancets</i>)	Preferred	
CARETOUCH TWIST LANCETS 28G (<i>lancets</i>)	Preferred	
CARETOUCH TWIST LANCETS 30G (<i>lancets</i>)	Preferred	
CARETOUCH TWIST LANCETS 33G (<i>lancets</i>)	Preferred	
CARETOUCH TWIST MC LANCETS 30G (<i>lancets</i>)	Preferred	
CLEANLET LANCETS 28G (<i>lancets</i>)	Preferred	
CLEVER CHEK LANCETS (<i>lancets</i>)	Preferred	
CLEVER CHOICE COMFORT EZ (<i>lancets</i>)	Preferred	
CLEVER CHOICE LANCETS 21G (<i>lancets</i>)	Preferred	
CLEVER CHOICE LANCETS 23G (<i>lancets</i>)	Preferred	
CLEVER CHOICE LANCETS 28G (<i>lancets</i>)	Preferred	
COAGUCHEK LANCETS (<i>lancets</i>)	Preferred	
<i>comfort assured lancets 28g</i>	Preferred	
<i>comfort assured lancets 33g</i>	Preferred	
COMFORT TOUCH LANCETS 31G (<i>lancets</i>)	Preferred	
COMFORT TOUCH PLUS LANCETS 28G (<i>lancets</i>)	Preferred	
COMFORT TOUCH PLUS LANCETS 30G (<i>lancets</i>)	Preferred	
<i>cvs lancets 21g</i>	Preferred	
<i>cvs lancets micro thin 33g</i>	Preferred	
<i>cvs lancets original</i>	Preferred	
<i>cvs lancets thin 26g</i>	Preferred	
<i>cvs lancets ultra thin 30g</i>	Preferred	

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<i>cvs lancets ultra-thin 30g</i>	Preferred	
<i>cvs lancing device</i>	Preferred	
<i>cvs ultra thin lancets</i>	Preferred	
DEXCOM G6 RECEIVER DEVICE (<i>continuous blood gluc receiver</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 365 days); Max 365-day supply per fill
DEXCOM G6 SENSOR (<i>continuous blood gluc sensor</i>)	Preferred	PA (Eligible for auto-PA); QL (3 EA per 30 days)
DEXCOM G6 TRANSMITTER (<i>continuous blood gluc transmit</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 90 days); Max 90-day supply per fill
DEXCOM G7 RECEIVER DEVICE (<i>continuous blood gluc receiver</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 365 days); Max 365-day supply per fill
DEXCOM G7 SENSOR (<i>continuous blood gluc sensor</i>)	Preferred	PA (Eligible for auto-PA); QL (3 EA per 30 days)
DIATHRIVE LANCET ULTRA THIN 30 (<i>lancets</i>)	Preferred	
DIATHRIVE LANCETS (<i>lancets</i>)	Preferred	
DIATHRIVE LANCING DEVICE (<i>lancet devices</i>)	Preferred	
DROPLET GENTEEL LANCING DEVICE (<i>lancet devices</i>)	Preferred	
DROPLET LANCETS ULTRA THIN 30G (<i>lancets</i>)	Preferred	
DROPLET LANCING DEVICE (<i>lancet devices</i>)	Preferred	
DROPLET PERSONAL LANCETS 30G (<i>lancets</i>)	Preferred	
<i>drug mart lancets thin 26g</i>	Preferred	
DRUG MART LANCING DEVICE (<i>lancet devices</i>)	Preferred	
DRUG MART ON-THE-GO LANCET 30G (<i>lancets</i>)	Preferred	
DRUG MART UNILET LANCETS 28G (<i>lancets</i>)	Preferred	
DRUG MART UNILET LANCETS 30G (<i>lancets</i>)	Preferred	
DRUG MART UNILET LANCETS 33G (<i>lancets</i>)	Preferred	
<i>easy comfort lancets</i>	Preferred	
<i>easy comfort lancets twist top</i>	Preferred	
<i>easy mini eject lancing device</i>	Preferred	
<i>easy mini lancing device</i>	Preferred	
EASY TOUCH INSULIN BARRELS 1ML (<i>insulin admin supplies</i>)	Preferred	
EASY TOUCH LANCETS 21G (<i>lancets</i>)	Preferred	
EASY TOUCH LANCETS 23G (<i>lancets</i>)	Preferred	
EASY TOUCH LANCETS 26G (<i>lancets</i>)	Preferred	
EASY TOUCH LANCETS 28G (<i>lancets</i>)	Preferred	
EASY TOUCH LANCETS 28G/TWIST (<i>lancets</i>)	Preferred	
EASY TOUCH LANCETS 30G (<i>lancets</i>)	Preferred	
EASY TOUCH LANCETS 30G/TWIST (<i>lancets</i>)	Preferred	
EASY TOUCH LANCETS 32G (<i>lancets</i>)	Preferred	

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EASY TOUCH LANCETS 32G/TWIST (<i>lancets</i>)	Preferred	
EASY TOUCH LANCETS 33G/TWIST (<i>lancets</i>)	Preferred	
EASY TOUCH LANCING DEVICE (<i>lancet devices</i>)	Preferred	
EASY TOUCH SAFETY LANCETS 21G (<i>lancets</i>)	Preferred	
EASY TOUCH SAFETY LANCETS 23G (<i>lancets</i>)	Preferred	
EASY TOUCH SAFETY LANCETS 26G (<i>lancets</i>)	Preferred	
EASY TOUCH SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	
EMBRACE LANCETS ULTRA THIN 30G (<i>lancets</i>)	Preferred	
<i>embrace lancet device/ejector</i>	Preferred	
EMBRACE PRESSURE ACTIVATED 21G (<i>lancets</i>)	Preferred	
EMBRACE PRESSURE ACTIVATED 28G (<i>lancets</i>)	Preferred	
<i>eql color lancets 21g</i>	Preferred	
<i>eql color lancets micro 33g</i>	Preferred	
<i>eql super thin lancets 30g</i>	Preferred	
<i>eql thin lancets 26g</i>	Preferred	
E-Z JECT LANCET MICRO-THIN 33G (<i>lancets</i>)	Preferred	
E-Z JECT LANCET SUPER THIN 30G (<i>lancets</i>)	Preferred	
E-Z JECT LANCETS (<i>lancets</i>)	Preferred	
E-Z JECT LANCETS 21G (<i>lancets</i>)	Preferred	
E-Z JECT LANCETS THIN 26G (<i>lancets</i>)	Preferred	
EZ-LETS LANCETS 21G (<i>lancets</i>)	Preferred	
EZ-LETS LANCETS 26G (<i>lancets</i>)	Preferred	
EZ-LETS LANCETS 28G (<i>lancets</i>)	Preferred	
EZ-LETS LANCETS 30G (<i>lancets</i>)	Preferred	
FIFTY50 SAFETY SEAL LANCETS (<i>lancets</i>)	Preferred	
FIFTY50 UNILET LANCETS 33G (<i>lancets</i>)	Preferred	
FINE 30 (<i>lancets</i>)	Preferred	
FINGERSTIX LANCETS (<i>lancets</i>)	Preferred	
FORA LANCETS (<i>lancets</i>)	Preferred	
FORA LANCING DEVICE (<i>lancet devices</i>)	Preferred	
FREESTYLE LANCETS (<i>lancets</i>)	Preferred	
FREESTYLE LIBRE 14 DAY READER DEVICE (<i>continuous blood gluc receiver</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 365 days); Max 365-day supply per fill
FREESTYLE LIBRE 14 DAY SENSOR (<i>continuous blood gluc sensor</i>)	Preferred	PA (Eligible for auto-PA); QL (2 EA per 28 days)
FREESTYLE LIBRE 2 READER DEVICE (<i>continuous blood gluc receiver</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 365 days); Max 365-day supply per fill
FREESTYLE LIBRE 2 SENSOR (<i>continuous blood gluc sensor</i>)	Preferred	PA (Eligible for auto-PA); QL (2 EA per 28 days)

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<i>freestyle libre 3 sensor</i>	Preferred	PA (Eligible for auto-PA); QL (2 EA per 28 days)
FREESTYLE LIBRE READER DEVICE (<i>continuous blood gluc receiver</i>)	Preferred	PA (Eligible for auto-PA); QL (1 EA per 365 days); Max 365-day supply per fill
FREESTYLE UNISTICK II LANCETS (<i>lancets</i>)	Preferred	
GENTEEL BUTTERFLY TOUCH LANCET (<i>lancets</i>)	Preferred	
GENTEEL CONTACT TIPS (BLUE) (<i>lancets misc.</i>)	Preferred	
GENTEEL CONTACT TIPS (CLEAR) (<i>lancets misc.</i>)	Preferred	
GENTEEL CONTACT TIPS (GREEN) (<i>lancets misc.</i>)	Preferred	
GENTEEL CONTACT TIPS (ORANGE) (<i>lancets misc.</i>)	Preferred	
GENTEEL CONTACT TIPS (RAINBOW) (<i>lancets misc.</i>)	Preferred	
GENTEEL CONTACT TIPS (VIOLET) (<i>lancets misc.</i>)	Preferred	
GENTEEL CONTACT TIPS (YELLOW) (<i>lancets misc.</i>)	Preferred	
GENTEEL LANCING KIT (BLUE) KIT (<i>lancets misc.</i>)	Preferred	
GENTEEL NOZZLES (<i>lancets misc.</i>)	Preferred	
GENTEEL PLUS LANCING (BLACK) (<i>lancet devices</i>)	Preferred	
GENTEEL PLUS LANCING (PURPLE) (<i>lancet devices</i>)	Preferred	
GENTEEL PLUS LANCING (WHITE) (<i>lancet devices</i>)	Preferred	
GENTEEL PLUS LANCING DEV(BLUE) (<i>lancet devices</i>)	Preferred	
GENTEEL PLUS LANCING DEV(PINK) (<i>lancet devices</i>)	Preferred	
GENTLE-LET GP LANCETS (<i>lancets</i>)	Preferred	
GENTLE-LET LANCETS (<i>lancets</i>)	Preferred	
GENTLE-LET PLATFORMS (<i>lancets misc.</i>)	Preferred	
<i>global inject ease lancets 28g</i>	Preferred	
<i>global inject ease lancets 30g</i>	Preferred	
<i>global lancing device</i>	Preferred	
GLUCOCOM LANCETS 28G (<i>lancets</i>)	Preferred	
GLUCOCOM LANCETS 30G (<i>lancets</i>)	Preferred	
GLUCOCOM LANCETS 33G (<i>lancets</i>)	Preferred	
<i>gnp lancets 21g</i>	Preferred	
<i>gnp lancets thin 26g</i>	Preferred	
GNP LANCING SYSTEM DEVICE (<i>lancet devices</i>)	Preferred	
<i>gnp sterile lancets 28g</i>	Preferred	
<i>gnp sterile lancets 30g</i>	Preferred	
<i>gnp sterile lancets 33g</i>	Preferred	
GOJJI LANCING DEVICE/CLEAR CAP (<i>lancet devices</i>)	Preferred	
GOJJI STERILE LANCETS (<i>lancets</i>)	Preferred	
<i>goodsense color lancets 33g</i>	Preferred	
<i>goodsense lancets 26g univ</i>	Preferred	
<i>goodsense lancets 30g</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>goodsense lancets 30g univ</i>	Preferred	
<i>goodsense lancets 33g</i>	Preferred	
<i>goodsense lancets 33g univ</i>	Preferred	
<i>goodsense lancing device</i>	Preferred	
HAEMOLANCE (<i>lancets</i>)	Preferred	
HAEMOLANCE LOW FLOW LANCETS (<i>lancets</i>)	Preferred	
HAEMOLANCE PLUS (<i>lancets</i>)	Preferred	
HAEMOLANCE PLUS HIGH FLOW (<i>lancets</i>)	Preferred	
HAEMOLANCE PLUS LOW FLOW (<i>lancets</i>)	Preferred	
HAEMOLANCE PLUS MAX FLOW (<i>lancets</i>)	Preferred	
HAEMOLANCE PLUS PEDIATRIC FLOW (<i>lancets</i>)	Preferred	
HEALTH CARE LANCING DEVICE (<i>lancet devices</i>)	Preferred	
<i>h-e-b incontrol adv lancing</i>	Preferred	
<i>h-e-b incontrol lancets 28g</i>	Preferred	
<i>h-e-b incontrol lancets 30g</i>	Preferred	
<i>h-e-b incontrol lancets 33g</i>	Preferred	
HYPOLANCE AST LANCING KIT (<i>lancets misc.</i>)	Preferred	
HY-VEE LANCETS (<i>lancets</i>)	Preferred	
<i>hy-vee thin lancets</i>	Preferred	
IN TOUCH LANCING DEVICE (<i>lancet devices</i>)	Preferred	
IN TOUCH STERILE LANCETS 30G (<i>lancets</i>)	Preferred	
INSUL-CAP (<i>insulin admin supplies</i>)	Preferred	
INSUL-EZE (<i>insulin admin supplies</i>)	Preferred	
<i>kinney lancets</i>	Preferred	
<i>kinney thin lancets</i>	Preferred	
KROGER AUTOLET LANCING DEVICE (<i>lancet devices</i>)	Preferred	
KROGER HEALTHPRO LANCET 26G (<i>lancets</i>)	Preferred	
<i>croger lancets</i>	Preferred	
<i>croger lancets 21g</i>	Preferred	
<i>croger lancets micro thin 33g</i>	Preferred	
<i>croger lancets super thin</i>	Preferred	
<i>croger lancets thin</i>	Preferred	
<i>croger lancets thin 26g</i>	Preferred	
<i>croger lancets ultrathin 30g</i>	Preferred	
<i>croger lancing device</i>	Preferred	
<i>lancet device</i>	Preferred	
<i>lancet device with ejector</i>	Preferred	
<i>lancet transporter case</i>	Preferred	
<i>lancets</i>	Preferred	
<i>lancets 30g</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>lancets 33g</i>	Preferred	
<i>lancets micro thin 33g</i>	Preferred	
<i>lancets super thin 28g</i>	Preferred	
<i>lancets thin</i>	Preferred	
LANCETS ULTRA THIN (<i>lancets</i>)	Preferred	
<i>lancets ultra thin 30g</i>	Preferred	
<i>lancing device</i>	Preferred	
LANZO (<i>lancet devices</i>)	Preferred	
<i>leader advanced lancing device</i>	Preferred	
LIBERTY MEDICAL LANCETS (<i>lancets</i>)	Preferred	
LIBERTY MINI LANCING DEVICE (<i>lancet devices</i>)	Preferred	
<i>lite touch lancets</i>	Preferred	
LITE TOUCH LANCING PEN (<i>lancet devices</i>)	Preferred	
LITETOUCH LANCETS (<i>lancets</i>)	Preferred	
<i>live better lancet super thin</i>	Preferred	
<i>longs lancets standard</i>	Preferred	
<i>longs lancets thin</i>	Preferred	
<i>longs lancets ultra thin</i>	Preferred	
<i>medichoice safety lancet</i>	Preferred	
<i>medichoice safety lancet extra</i>	Preferred	
<i>medichoice safety lancet norm</i>	Preferred	
MEDLANCE EXTRA 21G (<i>lancets</i>)	Preferred	
MEDLANCE LITE 25G (<i>lancets</i>)	Preferred	
MEDLANCE PLUS EXTRA 21G (<i>lancets</i>)	Preferred	
MEDLANCE PLUS LANCETS (<i>lancets</i>)	Preferred	
MEDLANCE PLUS LITE 25G (<i>lancets</i>)	Preferred	
MEDLANCE PLUS SPECIAL 0.8MM (<i>lancets</i>)	Preferred	
MEDLANCE PLUS SUPERLITE 30G (<i>lancets</i>)	Preferred	
MEDLANCE PLUS UNIVERSAL 21G (<i>lancets</i>)	Preferred	
MEDLANCE UNIVERSAL 21G (<i>lancets</i>)	Preferred	
MEIJER LANCETS (<i>lancets</i>)	Preferred	
MEIJER LANCETS THIN (<i>lancets</i>)	Preferred	
MEIJER LANCETS UNIVERSAL 21G (<i>lancets</i>)	Preferred	
MEIJER LANCETS UNIVERSAL 30G (<i>lancets</i>)	Preferred	
MEIJER LANCETS UNIVERSAL 33G (<i>lancets</i>)	Preferred	
MEIJER SUPER THIN LANCETS (<i>lancets</i>)	Preferred	
MICROLET LANCETS (<i>lancets</i>)	Preferred	
MICROLET NEXT LANCING DEVICE (<i>lancet devices</i>)	Preferred	
<i>mini lancing device</i>	Preferred	
MM LANCING DEVICE (<i>lancet devices</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MM TWIST LANCETS (<i>lancets</i>)	Preferred	
MONOLET LANCETS (<i>lancets</i>)	Preferred	
MONOLET OPD LANCETS (<i>lancets</i>)	Preferred	
MONOLETTOR SAFETY LANCETS (<i>lancets</i>)	Preferred	
<i>mpd safety lancet 21g</i>	Preferred	
<i>mpd safety lancet 23g</i>	Preferred	
<i>mpd safety lancet 28g</i>	Preferred	
<i>mpd safety lancet 30g</i>	Preferred	
<i>multi-lancet device</i>	Preferred	
MULTI-LANCET DEVICE 2 KIT (<i>lancets misc.</i>)	Preferred	
MYGLUCOHEALTH LANCETS 30G (<i>lancets</i>)	Preferred	
NOVA SAFETY LANCETS 23G (<i>lancets</i>)	Preferred	
NOVA SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	
NOVA SUREFLEX LANCETS (<i>lancets</i>)	Preferred	
NOVA SUREFLEX LANCING DEVICE (<i>lancet devices</i>)	Preferred	
OMNIPOD 5 G6 INTRO (GEN 5) KIT (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD 5 G6 POD (GEN 5) (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD CLASSIC PODS (GEN 3) (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD DASH INTRO (GEN 4) KIT (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD DASH PDM (GEN 4) KIT (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD DASH PODS (GEN 4) (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD GO KIT 20 UNIT/24HR, 30 UNIT/24HR, 40 UNIT/24HR (<i>insulin disposable pump</i>)	Preferred	PA
OMNIPOD POD PALS (<i>insulin dispos pmp accessories</i>)	Preferred	PA
ONETOUCH DELICA PLUS LANCET30G (<i>lancets</i>)	Preferred	
ONETOUCH DELICA PLUS LANCET33G (<i>lancets</i>)	Preferred	
ONETOUCH DELICA PLUS LANCING (<i>lancet devices</i>)	Preferred	
ONETOUCH DELICA SAFETY LANCING (<i>lancet devices</i>)	Preferred	
ONETOUCH ULTRASOFT 2 LANCETS (<i>lancets</i>)	Preferred	
PERFECT LANCETS 28G (<i>lancets</i>)	Preferred	
PERFECT LANCETS 30G (<i>lancets</i>)	Preferred	
PHARMACIST CHOICE LANCETS (<i>lancets</i>)	Preferred	
PHARMACY COUNTER LANCETS (<i>lancets</i>)	Preferred	
<i>pip lancets 28g</i>	Preferred	
<i>pip lancets 30g</i>	Preferred	
PRECISION THINS GP LANCETS (<i>lancets</i>)	Preferred	
<i>preferred plus lancets colored</i>	Preferred	
<i>preferred plus lancets thin</i>	Preferred	
<i>pro comfort lancets 30g</i>	Preferred	
<i>pro comfort lancets 31g</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>pro comfort safety lancets 30g</i>	Preferred	
PRODIGY COUNT-A-DOSE (<i>insulin admin supplies</i>)	Preferred	
PRODIGY LANCETS 28G (<i>lancets</i>)	Preferred	
PRODIGY LANCING DEVICE (<i>lancet devices</i>)	Preferred	
PRODIGY SAFETY LANCETS 26G (<i>lancets</i>)	Preferred	
PRODIGY TWIST TOP LANCETS 28G (<i>lancets</i>)	Preferred	
PSS SELECT GP LANCETS (<i>lancets</i>)	Preferred	
PSS SELECT PLATFORMS (<i>lancets misc.</i>)	Preferred	
PSS SELECT SAFETY LANCETS (<i>lancets</i>)	Preferred	
<i>pure comfort lancets 30g</i>	Preferred	
<i>px advanced lancing device</i>	Preferred	
<i>px lancet auto injector</i>	Preferred	
<i>px lancets microthin 33g</i>	Preferred	
<i>px lancets ultra thin 28g</i>	Preferred	
<i>qc advanced lancing device</i>	Preferred	
<i>qc lancets super thin 30g</i>	Preferred	
<i>qc lancets ultra thin</i>	Preferred	
<i>qc unilet lancets 28g</i>	Preferred	
<i>qc unilet lancets micro thin</i>	Preferred	
RA E-ZJECT LANCETS 28G (<i>lancets</i>)	Preferred	
RA E-ZJECT LANCETS THIN 26G (<i>lancets</i>)	Preferred	
RA E-ZJECT LANCETS THIN 28G (<i>lancets</i>)	Preferred	
RA E-ZJECT LANCETS ULTRA THIN (<i>lancets</i>)	Preferred	
READYLANCE SAFETY LANCETS (<i>lancets</i>)	Preferred	
<i>reality lancets</i>	Preferred	
<i>reality trigger lancets</i>	Preferred	
RELION LANCET DEVICES 30G (<i>lancet devices</i>)	Preferred	
RELION LANCETS MICRO-THIN 33G (<i>lancets</i>)	Preferred	
RELION LANCETS THIN 26G (<i>lancets</i>)	Preferred	
RELION LANCETS ULTRA-THIN 30G (<i>lancets</i>)	Preferred	
RELION LANCING DEVICE (<i>lancet devices</i>)	Preferred	
RELION LANCING DEVICE KIT (<i>lancets misc.</i>)	Preferred	
RELION ULTRA THIN LANCETS 30G (<i>lancets</i>)	Preferred	
RELION ULTRA THIN PLUS LANCETS (<i>lancets</i>)	Preferred	
REXALL LANCETS ULTRA THIN 30G (<i>lancets</i>)	Preferred	
RIGHTEST ALTERNATE SITE ADAPT (<i>lancets misc.</i>)	Preferred	
RIGHTEST GD500 LANCING DEVICE (<i>lancet devices</i>)	Preferred	
RIGHTEST GL300 LANCETS (<i>lancets</i>)	Preferred	
SAFE-T-LANCE (<i>lancets</i>)	Preferred	
SAFE-T-LANCE PLUS (<i>lancets</i>)	Preferred	

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<i>safety lancet 30g/pressure act</i>	Preferred	
SAFETY LANCETS (<i>lancets</i>)	Preferred	
SAFETY LANCETS 21G (<i>lancets</i>)	Preferred	
SAFETY LANCETS 23G (<i>lancets</i>)	Preferred	
<i>safety lancets 28g</i>	Preferred	
<i>saps health plus lancets</i>	Preferred	
<i>saps health twist top lancets</i>	Preferred	
<i>saps twist top lancets</i>	Preferred	
<i>sapscare twist top lancets</i>	Preferred	
<i>sb lancets thin</i>	Preferred	
<i>sb lancets ultra thin</i>	Preferred	
<i>select-lite device/lancets kit</i>	Preferred	
<i>select-lite lancing device</i>	Preferred	
SIMPLE DIAGNOSTICS LANCING DEV (<i>lancet devices</i>)	Preferred	
SINGLE-LET (<i>lancets</i>)	Preferred	
<i>sm lancets 33g</i>	Preferred	
SM TRUEDRAW LANCING DEVICE (<i>lancet devices</i>)	Preferred	
SMART DIABETES VANTAGE LANCING (<i>lancet devices</i>)	Preferred	
SMART SENSE COLOR LANCETS 33G (<i>lancets</i>)	Preferred	
SMART SENSE STANDARD LANCETS (<i>lancets</i>)	Preferred	
SMART SENSE SUPER THIN LANCETS (<i>lancets</i>)	Preferred	
SMART SENSE THIN LANCETS 26G (<i>lancets</i>)	Preferred	
SMARTTEST LANCETS 28G (<i>lancets</i>)	Preferred	
SOLUS V2 LANCETS 28G (<i>lancets</i>)	Preferred	
SOLUS V2 LANCING DEVICE (<i>lancet devices</i>)	Preferred	
SOLUS V2 TWIST LANCETS 30G (<i>lancets</i>)	Preferred	
STERILANCE PA (<i>lancets misc.</i>)	Preferred	
STERILANCE TL (<i>lancets</i>)	Preferred	
<i>super thin lancets</i>	Preferred	
<i>sure comfort lancets 18g</i>	Preferred	
<i>sure comfort lancets 21g</i>	Preferred	
<i>sure comfort lancets 23g</i>	Preferred	
<i>sure comfort lancets 28g</i>	Preferred	
<i>sure comfort lancets 30g</i>	Preferred	
<i>sure comfort lancing pen</i>	Preferred	
SURELITE LANCETS (<i>lancets</i>)	Preferred	
TECHLITE AST LANCETS (<i>lancets</i>)	Preferred	
TECHLITE LANCETS (<i>lancets</i>)	Preferred	
TECHLITE LANCETS 30G (<i>lancets</i>)	Preferred	
<i>tgt lancet micro thin 33g</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>tgt lancet thin 26g</i>	Preferred	
<i>tgt lancet ultra thin 30g</i>	Preferred	
<i>tgt lancing device</i>	Preferred	
THINLETS GP LANCETS (<i>lancets</i>)	Preferred	
<i>todays health lancing device</i>	Preferred	
<i>todays health thin lancets 28g</i>	Preferred	
<i>todays health thin lancets 30g</i>	Preferred	
<i>topcare lancets micro-thin 33g</i>	Preferred	
TRAVEL LANCETS ADVANCED 28G (<i>lancets</i>)	Preferred	
<i>true comfort safety lancets</i>	Preferred	
<i>true comfort twist top lancets</i>	Preferred	
TRUE METRIX LEVEL 1 SOLUTION LOW IN VITRO (<i>blood glucose calibration</i>)	Preferred	
TRUE METRIX LEVEL 2 SOLUTION NORMAL IN VITRO (<i>blood glucose calibration</i>)	Preferred	
TRUE METRIX LEVEL 3 SOLUTION HIGH IN VITRO (<i>blood glucose calibration</i>)	Preferred	
TRUEDRAW LANCING DEVICE (<i>lancet devices</i>)	Preferred	
TRUEPLUS LANCETS 26G (<i>lancets</i>)	Preferred	
TRUEPLUS LANCETS 28G (<i>lancets</i>)	Preferred	
TRUEPLUS LANCETS 30G (<i>lancets</i>)	Preferred	
TRUEPLUS LANCETS 33G (<i>lancets</i>)	Preferred	
TRUEPLUS SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	
<i>twist top lancets 30g</i>	Preferred	
ULTI-LANCE AUTOMATIC (<i>lancet devices</i>)	Preferred	
ULTILET CLASSIC LANCETS (<i>lancets</i>)	Preferred	
ULTILET LANCETS (<i>lancets</i>)	Preferred	
ULTILET SAFETY LANCETS (<i>lancets</i>)	Preferred	
ULTILET SAFETY LANCETS 23G (<i>lancets</i>)	Preferred	
<i>ultra thin lancets 31g</i>	Preferred	
<i>ultra-care lancets 30g</i>	Preferred	
ULTRA-THIN II AUTO LANCET (<i>lancets</i>)	Preferred	
ULTRA-THIN II LANCETS (<i>lancets</i>)	Preferred	
UNILET COMFORTOUCH LANCET (<i>lancets</i>)	Preferred	
UNILET EXCELITE (<i>lancets</i>)	Preferred	
UNILET EXCELITE II (<i>lancets</i>)	Preferred	
UNILET G.P. LANCET (<i>lancets</i>)	Preferred	
UNILET G.P. SUPERLITE LANCET (<i>lancets</i>)	Preferred	
UNILET GP 28 ULTRA THIN (<i>lancets</i>)	Preferred	
UNILET LANCET (<i>lancets</i>)	Preferred	
UNILET MICRO-THIN 33G (<i>lancets</i>)	Preferred	

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UNILET SUPERLITE LANCET (<i>lancets</i>)	Preferred	
UNILET SUPER-THIN 30G (<i>lancets</i>)	Preferred	
UNILET ULTRA-THIN 28G (<i>lancets</i>)	Preferred	
UNISTIK 1 (<i>lancets misc.</i>)	Preferred	
UNISTIK 2 (<i>lancets misc.</i>)	Preferred	
UNISTIK 2 COMFORT (<i>lancets misc.</i>)	Preferred	
UNISTIK 2 EXTRA (<i>lancets misc.</i>)	Preferred	
UNISTIK 2 NEONATAL (<i>lancets misc.</i>)	Preferred	
UNISTIK 2 NORMAL (<i>lancets misc.</i>)	Preferred	
UNISTIK 2 SUPER (<i>lancets misc.</i>)	Preferred	
UNISTIK 3 (<i>lancets misc.</i>)	Preferred	
UNISTIK 3 COMFORT (<i>lancets misc.</i>)	Preferred	
UNISTIK 3 EXTRA (<i>lancets misc.</i>)	Preferred	
UNISTIK 3 GENTLE (<i>lancets</i>)	Preferred	
UNISTIK 3 NEONATAL (<i>lancets misc.</i>)	Preferred	
UNISTIK 3 NORMAL (<i>lancets misc.</i>)	Preferred	
UNISTIK CZT COMFORT (<i>lancets misc.</i>)	Preferred	
UNISTIK CZT NORMAL (<i>lancets misc.</i>)	Preferred	
UNISTIK NORMAL (<i>lancets misc.</i>)	Preferred	
UNISTIK PRO SAFETY LANCET (<i>lancets</i>)	Preferred	
UNISTIK SAFETY LANCETS 28G (<i>lancets</i>)	Preferred	
UNISTIK SAFETY LANCETS 30G (<i>lancets</i>)	Preferred	
UNISTIK TOUCH SAFETY LANC 21G (<i>lancets</i>)	Preferred	
UNISTIK TOUCH SAFETY LANC 23G (<i>lancets</i>)	Preferred	
UNISTIK TOUCH SAFETY LANC 28G (<i>lancets</i>)	Preferred	
UNISTIK TOUCH SAFETY LANC 30G (<i>lancets</i>)	Preferred	
UNIVERSAL 1 LANCETS THIN 26G (<i>lancets</i>)	Preferred	
UNIVERSAL 1 LANCETS THIN 33G (<i>lancets</i>)	Preferred	
UNIVERSAL 1 LANCETS ULTRA THIN (<i>lancets</i>)	Preferred	
<i>value plus lancet standard 21g</i>	Preferred	
<i>value plus lancets super thin</i>	Preferred	
<i>value plus lancets thin 26g</i>	Preferred	
<i>value plus lancing device</i>	Preferred	
VERIFINE UNIVERSAL LANCETS 28G (<i>lancets</i>)	Preferred	
VERIFINE UNIVERSAL LANCETS 30G (<i>lancets</i>)	Preferred	
VERIFINE UNIVERSAL LANCETS 33G (<i>lancets</i>)	Preferred	
V-GO 20 KIT 20 UNIT/24HR (<i>insulin disposable pump</i>)	Preferred	PA
V-GO 30 KIT 30 UNIT/24HR (<i>insulin disposable pump</i>)	Preferred	PA
V-GO 40 KIT 40 UNIT/24HR (<i>insulin disposable pump</i>)	Preferred	PA
VIVAGUARD LANCETS (<i>lancets</i>)	Preferred	

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VIVAGUARD LANCING DEVICE (<i>lancet devices</i>)	Preferred	
VIVI CAP (<i>insulin admin supplies</i>)	Preferred	
VIVI CAP1 (<i>insulin admin supplies</i>)	Preferred	
WALGREENS LANCETS (<i>lancets</i>)	Preferred	
<i>walgreens lancets micro thin</i>	Preferred	
<i>walgreens lancets super thin</i>	Preferred	
WALGREENS THIN LANCETS (<i>lancets</i>)	Preferred	
WALGREENS ULTRA THIN LANCETS (<i>lancets</i>)	Preferred	
<i>zevrx twist top lancets 30g</i>	Preferred	
*DIAGNOSTIC TESTS**		
RELION TRUE METRIX TEST STRIPS STRIP IN VITRO (<i>glucose blood</i>)	Preferred	QL (10 EA per 1 day)
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO (<i>glucose blood</i>)	Preferred	QL (8 strips/day for up to 18 years old, insulin users, or pregnancy; 4 strips/day for all others); QL (10 EA per 1 day)
*DIAPER RASH PRODUCTS**		
BENSONS BOTTOM PAINT EXTERNAL CREAM (<i>diaper rash products</i>)	Preferred	
<i>cvs diaper external cream 1-10 %</i>	Preferred	
*DIETARY MANAGEMENT PRODUCTS**		
CEREFOLIN ORAL TABLET 6-1-50-5 MG (<i>l-methylfolate-b12-b6-b2</i>)	Preferred	
DEPLIN 15 ORAL CAPSULE 15-90.314 MG (<i>l-methylfolate-algae</i>)	Preferred	
DEPLIN 7.5 ORAL CAPSULE 7.5-90.314 MG (<i>l-methylfolate-algae</i>)	Preferred	
ELFOLATE PLUS ORAL TABLET 3-35-2 MG (<i>l-methylfolate-b6-b12</i>)	Preferred	
FOLBIC ORAL TABLET 2.5-25-2 MG (<i>fa-pyridoxine-cyanocobalamin</i>)	Preferred	
FOLBIC RF ORAL TABLET 1.13-25-2 MG (<i>l-methylfolate-b6-b12</i>)	Preferred	
FOLTANX ORAL TABLET 3-35-2 MG (<i>l-methylfolate-b6-b12</i>)	Preferred	
FOLTIX ORAL TABLET 1.13-25-2 MG (<i>l-methylfolate-b6-b12</i>)	Preferred	
<i>l-methylfolate forte oral capsule 15-90.314 mg, 7.5-90.314 mg</i>	Preferred	
<i>l-methylfolate-algae oral capsule 15-90.314 mg</i>	Preferred	
<i>l-methyl-mc oral tablet 6-1-50-5 mg</i>	Preferred	
METAFOLBIC ORAL TABLET 6-1-50-5 MG (<i>l-methylfolate-b12-b6-b2</i>)	Preferred	
NIVA-FOL ORAL TABLET 2.5-25-2 MG (<i>fa-pyridoxine-cyanocobalamin</i>)	Preferred	
<i>westab max oral tablet 2.5-25-2 mg</i>	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
*DIURETIC COMBINATIONS**		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	Preferred	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	Preferred	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	Preferred	Max 90-day supply per fill
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	Preferred	Max 90-day supply per fill
*ELECTROLYTE MIXTURES**		
ADVANTAGE CARE ELECTROLYTE PED ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
BIOLYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
CERALYTE 50 ORAL PACKET 1.3-2.2-2.9 GM/L (<i>oral electrolytes</i>)	Preferred	
CERALYTE 50 POTASSIUM FREE ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
CERALYTE 70 ORAL PACKET , 1.3-2.2-2.9 GM/L (<i>oral electrolytes</i>)	Preferred	
CERALYTE 70 ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
CERALYTE 90 ORAL PACKET 1.3-3.4-2.9 GM/L (<i>oral electrolytes</i>)	Preferred	
CERASPORT ENDURANCE ORAL PACKET 160-400 MG (<i>oral electrolytes</i>)	Preferred	
CERASPORT EX1 ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
CERASPORT EX1 ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
CERASPORT EX1 ORAL SOLUTION RECONSTITUTED (<i>oral electrolytes</i>)	Preferred	
CERASPORT ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
CERASPORT ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
CERASPORT ORAL SOLUTION RECONSTITUTED (<i>oral electrolytes</i>)	Preferred	
CERASPORT PLUS ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
<i>cvs electrolyte solution oral solution</i>	Preferred	
<i>cvs ped electrolyte freeze pop oral solution</i>	Preferred	
<i>cvs pediatric electrolyte oral solution</i>	Preferred	
DRIPDROP HYDRATION ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
DRIPDROP ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
EMERGEN-C ELECTRO MIX ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
ENFAMIL ENFALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
ENSURE RAPID HYDRATION ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
EQUALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
<i>gnp electrolyte powder oral packet</i>	Preferred	
<i>h-e-b oral electrolyte oral solution</i>	Preferred	
HYDRALYTE FREEZER POPS ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
HYDRALYTE ORAL PACKET (<i>oral electrolytes</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
HYDRALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
HYDRALYTE ORAL SOLUTION RECONSTITUTED (<i>oral electrolytes</i>)	Preferred	
KINDERLYTE IMMUNITY ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
KINDERLYTE ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
KINDERLYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
KINDERLYTE PREMAX ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
KINDERLYTE PREMAX ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
LIQUID I.V. ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
NORMALYTE ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
<i>oral electrolyte freezer pops oral solution</i>	Preferred	
<i>oral electrolytes oral solution</i>	Preferred	
ORALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
<i>ped electrolyte freeze pops oral solution</i>	Preferred	
<i>ped electrolyte freezer pops oral solution</i>	Preferred	
PEDIA VANCE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
PEDIALYTE ADVANCED CARE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
PEDIALYTE FREEZER POPS ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
PEDIALYTE ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
PEDIALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
PEDIALYTE SINGLES ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
PEDIALYTE SPARKLING RUSH ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
PEDIA-POP ORAL PACKET (<i>oral electrolytes</i>)	Preferred	
<i>pediatric electrolyte oral packet</i>	Preferred	
<i>pediatric electrolyte oral solution</i>	Preferred	
<i>pediatric electrolyte-zinc oral solution</i>	Preferred	
<i>ra pediatric electrolyte oral solution</i>	Preferred	
REHYDRALYTE ORAL SOLUTION (<i>oral electrolytes</i>)	Preferred	
REPLACE SR ORAL TABLET EXTENDED RELEASE (<i>oral electrolytes</i>)	Preferred	
<i>sb pediatric electrolyte oral solution</i>	Preferred	
<i>sm pediatric electrolyte oral solution</i>	Preferred	
*EMERGENCY CONTRACEPTIVES**		
AFTERA ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
AFTERPILL ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
CURAE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
HER STYLE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
<i>levonorgestrel oral tablet 1.5 mg</i>	Preferred	
MY CHOICE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MY WAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
NEW DAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
OPTION 2 ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
PLAN B ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
REACT ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
TAKE ACTION ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Preferred	
*EMOLLIENT/KERATOLYTIC AGENTS**		
AQUA CARE EXTERNAL CREAM 10 % (<i>urea</i>)	Preferred	
AQUA CARE EXTERNAL LOTION 10 % (<i>urea</i>)	Preferred	
<i>gormel 10 external lotion 10 %</i>	Preferred	
<i>gormel external cream 20 %</i>	Preferred	
NUTRAPLUS EXTERNAL CREAM 10 % (<i>urea</i>)	Preferred	
NUTRAPLUS EXTERNAL LOTION 10 % (<i>urea</i>)	Preferred	
<i>urea 10 hydrating external cream 10 %</i>	Preferred	
<i>urea 20 intensive hydrating external cream 20 %</i>	Preferred	
<i>ureacin-10 external lotion 10 %</i>	Preferred	
<i>ureacin-20 external cream 20 %</i>	Preferred	
*EMOLLIENTS**		
<i>a&d external ointment</i>	Preferred	
<i>advanced healing/baby external ointment</i>	Preferred	
AL12 EXTERNAL LOTION 12 % (<i>ammonium lactate</i>)	Preferred	
AMLACTIN DAILY EXTERNAL LOTION 12 % (<i>ammonium lactate</i>)	Preferred	
AMLACTIN RAPID RELIEF EXTERNAL LOTION 15 % (<i>emollient</i>)	Preferred	
AMLACTIN ULTRA SMOOTHING EXTERNAL CREAM 15 % (<i>emollient</i>)	Preferred	
<i>ammonium lactate external cream 12 %</i>	Preferred	
<i>ammonium lactate external lotion 12 %</i>	Preferred	
AQUA GLYCOLIC FACE EXTERNAL CREAM (<i>emollient</i>)	Preferred	
AQUA GLYCOLIC HAND/BODY EXTERNAL LOTION (<i>emollient</i>)	Preferred	
AQUA LACTEN EXTERNAL LOTION (<i>emollient</i>)	Preferred	
AQUA-CERIN EXTERNAL CREAM (<i>emollient</i>)	Preferred	
AQUAMED EXTERNAL LOTION (<i>emollient</i>)	Preferred	
AQUA-NU EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
AQUAPHILIC EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
AQUAPHOR ADV HEALING BABY EXTERNAL OINTMENT 41 % (<i>emollient</i>)	Preferred	
AQUAPHOR ADV PROTECT HEALING EXTERNAL OINTMENT , 41 % (<i>emollient</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
AQUAPHOR ADV THERAPY CHILDRENS EXTERNAL OINTMENT 41 % (<i>emollient</i>)	Preferred	
AQUAPHOR ADV THERAPY HEALING EXTERNAL OINTMENT , 41 % (<i>emollient</i>)	Preferred	
AQUAPHOR ADVANCED THERAPY BABY EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
AQUAPHOR ADVANCED THERAPY EXTERNAL OINTMENT , 41 % (<i>emollient</i>)	Preferred	
AQUAPHOR EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
AVEENO DAILY MOISTURIZING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
AVEENO DAILY MOISTURIZING FACE EXTERNAL CREAM (<i>emollient</i>)	Preferred	
AVEENO INTENSE RELIEF HAND EXTERNAL CREAM (<i>emollient</i>)	Preferred	
AVEENO POSITIVELY RADIANT EXTERNAL CREAM (<i>emollient</i>)	Preferred	
AVEENO RESTORATIVE SKIN THERAP EXTERNAL CREAM (<i>emollient</i>)	Preferred	
AVEENO SKIN RELF MOIST REPAIR EXTERNAL CREAM (<i>emollient</i>)	Preferred	
AVEENO STRESS RELIEF EXTERNAL LOTION (<i>emollient</i>)	Preferred	
BAG BALM EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
BALMBARR MOISTURIZING EXTERNAL CREAM (<i>emollient</i>)	Preferred	
BEAUTY 360 ADVANCED SKIN CARE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>beauty lotion external lotion</i>	Preferred	
<i>beta care external cream</i>	Preferred	
<i>beta care external lotion</i>	Preferred	
BETA XMA EXTERNAL CREAM (<i>emollient</i>)	Preferred	
BOUDREAUXS BABY BUTT SMOOTH EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
CAM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CERAVE AM SPF 30 EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CERAVE DAILY MOISTURIZING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CERAVE DIABETICS DRY SKIN EXTERNAL CREAM (<i>emollient</i>)	Preferred	
CERAVE HEALING EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
CERAVE MOISTURIZING EXTERNAL CREAM (<i>emollient</i>)	Preferred	
CERAVE PM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CERAVE SA ROUGH & BUMPY SKIN EXTERNAL CREAM (<i>emollient</i>)	Preferred	
CERAVE SA ROUGH & BUMPY SKIN EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CETAPHIL ADVANCED RELIEF EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CETAPHIL DAILY ADVANCE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CETAPHIL DAILY FACIAL SPF 15 EXTERNAL LOTION (<i>emollient</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
CETAPHIL MOISTURIZING EXTERNAL CREAM (<i>emollient</i>)	Preferred	
CETAPHIL MOISTURIZING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CETAPHIL RESTORADERM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
CETAPHIL THERAPEUTIC HAND EXTERNAL CREAM (<i>emollient</i>)	Preferred	
CICAPLAST BAUME B5 SOOTH BALM EXTERNAL CREAM (<i>emollient</i>)	Preferred	
CLN FACIAL MOISTURIZER NOURISH EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>cocoa butter external lotion</i>	Preferred	
<i>cocoa butter hand & body external lotion</i>	Preferred	
<i>cocoa butter skin external cream</i>	Preferred	
<i>coconut oil beauty external cream</i>	Preferred	
<i>collagen external cream</i>	Preferred	
<i>collagen premium skin external cream</i>	Preferred	
<i>complete moisture external lotion</i>	Preferred	
CORN HUSKERS EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>cvs advanced healing external ointment</i>	Preferred	
<i>cvs beauty 360 dry skin external lotion</i>	Preferred	
<i>cvs daily ultra moisture external lotion</i>	Preferred	
<i>cvs dry skin therapy external cream</i>	Preferred	
<i>cvs dry skin therapy external lotion</i>	Preferred	
<i>cvs extra moisturizing external lotion</i>	Preferred	
<i>cvs gentle skin cleanser external lotion</i>	Preferred	
<i>cvs hydrating skin treatment external lotion 12 %</i>	Preferred	
<i>cvs intense dry skin therapy external lotion</i>	Preferred	
<i>cvs moisturizing external cream</i>	Preferred	
<i>cvs moisturizing external lotion</i>	Preferred	
<i>cvs skin treatment external lotion 12 %</i>	Preferred	
<i>cvs special care external lotion</i>	Preferred	
<i>cvs vitamin a&d external ointment</i>	Preferred	
DAILY MOISTURIZING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
D-CERIN EXTERNAL CREAM 33 % (<i>emollient</i>)	Preferred	
DERMABASE EXTERNAL CREAM (<i>emollient</i>)	Preferred	
<i>dermaide aloe external cream 70 %</i>	Preferred	
DERMAL THERAPY EXTRA STRENGTH EXTERNAL LOTION 10 % (<i>emollient</i>)	Preferred	
DERMAL THERAPY FACE CARE EXTERNAL LOTION 1 % (<i>emollient</i>)	Preferred	
DERMAL THERAPY FOOT MASSAGE EXTERNAL LOTION 1 % (<i>emollient</i>)	Preferred	
DERMAL THERAPY HAND/ELBOW EXTERNAL LOTION 15 % (<i>emollient</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
DERMAL THERAPY HEEL CARE EXTERNAL LOTION 25 % (<i>emollient</i>)	Preferred	
DERMEND BRUISE FORMULA EXTERNAL CREAM (<i>emollient</i>)	Preferred	
DERMEND FRAGILE SKIN EXTERNAL CREAM (<i>emollient</i>)	Preferred	
DIABETIDERM EXTERNAL CREAM (<i>emollient</i>)	Preferred	
DIABETIDERM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
DIABETIDERM FOOT REJUVENATING EXTERNAL CREAM (<i>emollient</i>)	Preferred	
DML EXTERNAL LOTION (<i>emollient</i>)	Preferred	
DML FORTE EXTERNAL CREAM (<i>emollient</i>)	Preferred	
<i>dry skin treatment adv therapy external ointment</i>	Preferred	
<i>dry skin treatment external ointment</i>	Preferred	
ELON SKIN REPAIR SYSTEM EXTERNAL CREAM (<i>emollient</i>)	Preferred	
EMOLLIA-CREME EXTERNAL CREAM (<i>emollient</i>)	Preferred	
EMOLLIA-LOTION EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>e-ointment external ointment</i>	Preferred	
EPILYT EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>eq therapeutic dry skin external cream</i>	Preferred	
<i>eq therapeutic moisturizing external cream</i>	Preferred	
<i>eq vitamins a & d external ointment</i>	Preferred	
<i>eql absolute moisture dry skin external lotion</i>	Preferred	
<i>eql advanced healing external ointment 41 %</i>	Preferred	
<i>eql advanced recovery external lotion</i>	Preferred	
<i>eql advanced skin therapy external lotion</i>	Preferred	
<i>eql aloe after sun external lotion</i>	Preferred	
<i>eql moisturizing external cream</i>	Preferred	
<i>eql ultra moisturizing daily external lotion</i>	Preferred	
<i>eucerin advanced repair external cream</i>	Preferred	
EUCERIN ADVANCED REPAIR HAND EXTERNAL CREAM (<i>emollient</i>)	Preferred	
EUCERIN BABY EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN CALMING DAILY MOIST EXTERNAL CREAM (<i>emollient</i>)	Preferred	
EUCERIN DAILY HYDRATION EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN DAILY HYDRATION SPF15 EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN DAILY PROTECTION/SPF30 EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN INTENSIVE REPAIR EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN ORIGINAL HEALING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN PLUS EXTERNAL CREAM 2.5-10 % (<i>emollient</i>)	Preferred	

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EUCERIN PLUS EXTERNAL LOTION 5-5 % (<i>emollient</i>)	Preferred	
EUCERIN PROFESSIONAL REPAIR EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN REDNESS RELIEF NIGHT EXTERNAL CREAM (<i>emollient</i>)	Preferred	
EUCERIN ROUGHNESS RELIEF EXTERNAL CREAM (<i>emollient</i>)	Preferred	
EUCERIN ROUGHNESS RELIEF EXTERNAL LOTION (<i>emollient</i>)	Preferred	
EUCERIN SKIN CALMING EXTERNAL CREAM (<i>emollient</i>)	Preferred	
EUCERIN SMOOTHING REPAIR EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND ADVANCED HEALING EXTERNAL OINTMENT 45 % (<i>emollient</i>)	Preferred	
GOLD BOND CREPE CORRECTOR EXTERNAL CREAM (<i>emollient</i>)	Preferred	
GOLD BOND DIABETICS DRY SKIN EXTERNAL CREAM (<i>emollient</i>)	Preferred	
GOLD BOND ESSENTIALS MENS EXTERNAL CREAM (<i>emollient</i>)	Preferred	
GOLD BOND HEALING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND HEALING HAND EXTERNAL CREAM (<i>emollient</i>)	Preferred	
GOLD BOND MEDICATED BODY EX ST EXTERNAL LOTION 0.5 %, 5-0.5 % (<i>emollient</i>)	Preferred	
GOLD BOND MEDICATED BODY EXTERNAL LOTION 5-0.15 % (<i>emollient</i>)	Preferred	
GOLD BOND PURE MOISTURE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND RADIANCE RENEWAL EXTERNAL CREAM (<i>emollient</i>)	Preferred	
GOLD BOND ULT ROUGH/BUMPY SKIN EXTERNAL CREAM (<i>emollient</i>)	Preferred	
GOLD BOND ULT SHEER RIBBONS EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE HEALING EXTERNAL CREAM (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE HEALING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE HEALING EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE OVERNIGHT EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE PROTECTION EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE RESTORING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE SOFTENING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
GOLD BOND ULTIMATE SOOTHING EXTERNAL CREAM (<i>emollient</i>)	Preferred	

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GOLD BOND ULTIMATE SOOTHING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>gordomatic external lotion</i>	Preferred	
HYDRASYN25 EXTERNAL CREAM (<i>emollient</i>)	Preferred	
<i>hydrazone lotion external lotion</i>	Preferred	
HYDROLATUM EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
<i>hydrophor external ointment</i>	Preferred	
J & J BURN CREAM EXTERNAL CREAM (<i>emollient</i>)	Preferred	
JOHNSONS SKIN NOURISH MOIST EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERADAN EXTERNAL CREAM (<i>emollient</i>)	Preferred	
KERI ADVANCED MOISTURE THERAPY EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI BASIC ESSENTIALS EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI LONG LASTING EXTERNAL CREAM (<i>emollient</i>)	Preferred	
KERI NOURISHING SHEA BUTTER EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI ORIGINAL DAILY MOISTURE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI ORIGINAL EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI OVERNIGHT EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI RENEWAL MILK BODY EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI RENEWAL SKIN FIRING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI RENEWAL STRETCH MARK EXTERNAL LOTION (<i>emollient</i>)	Preferred	
KERI SENSITIVE SKIN EXTERNAL LOTION (<i>emollient</i>)	Preferred	
LACTINOL HX EXTERNAL CREAM (<i>emollient</i>)	Preferred	
LANAPHILIC EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
<i>leader finger cream external cream</i>	Preferred	
<i>lubricating lotion external lotion</i>	Preferred	
LUBRIDERM ADVANCED THERAPY EXTERNAL CREAM (<i>emollient</i>)	Preferred	
LUBRIDERM ADVANCED THERAPY EXTERNAL LOTION (<i>emollient</i>)	Preferred	
LUBRIDERM DAILY MOISTURE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
LUBRIDERM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
LUBRIDERM INTENSE SKIN REPAIR EXTERNAL LOTION (<i>emollient</i>)	Preferred	
LUBRISOFT EXTERNAL LOTION (<i>emollient</i>)	Preferred	
MEDERMA AG FACE EXTERNAL CREAM (<i>emollient</i>)	Preferred	
MEDERMA AG HAND & BODY EXTERNAL LOTION (<i>emollient</i>)	Preferred	
MEDERMA STRETCH MARKS THERAPY EXTERNAL CREAM (<i>emollient</i>)	Preferred	

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MEDPURA VITAMIN A & D EXTERNAL OINTMENT (<i>vitamins a & d</i>)	Preferred	
<i>mineral oil-hydrophil petrolat external ointment</i>	Preferred	
MINERIN EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>moisture external lotion</i>	Preferred	
<i>moisture recovery external lotion</i>	Preferred	
<i>moisturizing cream external cream</i>	Preferred	
<i>moisturizing lotion external lotion</i>	Preferred	
<i>moisturizing sensitive skin external lotion</i>	Preferred	
<i>msm skin external lotion</i>	Preferred	
NEUTROGENA HAND EXTERNAL CREAM (<i>emollient</i>)	Preferred	
NEUTROGENA MOISTURE SENS SKIN EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NISEKO HYDRATING FACIAL EXTERNAL CREAM (<i>emollient</i>)	Preferred	
NIVEA ESSENTIALLY ENRICHED EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NIVEA EXTERNAL CREAM (<i>emollient</i>)	Preferred	
NIVEA EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NIVEA INTENSE HEALING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NIVEA ORIGINAL MOISTURE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NIVEA SHEA NOURISH EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NIVEA VISAGE EXTERNAL CREAM (<i>emollient</i>)	Preferred	
NIVEA VISAGE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NIVEA VISAGE INNER BEAUTY EXTERNAL CREAM (<i>emollient</i>)	Preferred	
NUTRADERM ADVANCED FORMULA EXTERNAL LOTION (<i>emollient</i>)	Preferred	
NUTRADERM EXTERNAL CREAM (<i>emollient</i>)	Preferred	
NUTRADERM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>ointment base external ointment</i>	Preferred	
OKEEFFES WORKING HANDS EXTERNAL CREAM (<i>emollient</i>)	Preferred	
PALMERS COCOA BUTTER FORMULA EXTERNAL CREAM (<i>emollient</i>)	Preferred	
PALMERS COCOA BUTTER FORMULA EXTERNAL LOTION (<i>emollient</i>)	Preferred	
PALMERS COCONUT OIL BODY EXTERNAL LOTION (<i>emollient</i>)	Preferred	
PALMERS COCONUT OIL HAND EXTERNAL CREAM (<i>emollient</i>)	Preferred	
PALMERS INTENSIVE RELIEF HAND EXTERNAL CREAM (<i>emollient</i>)	Preferred	
PALMERS NIGHT CREAM EXTERNAL CREAM (<i>emollient</i>)	Preferred	
PALMERS STRETCH MARKS EXTERNAL CREAM (<i>emollient</i>)	Preferred	
PALMERS STRETCH MARKS EXTERNAL LOTION (<i>emollient</i>)	Preferred	
PEN-KERA EXTERNAL CREAM (<i>emollient</i>)	Preferred	
PENTRAVAN EXTERNAL CREAM (<i>emollient</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
PENTRAVAN PLUS EXTERNAL CREAM (<i>emollient</i>)	Preferred	
PRETTY FEET/HANDS EXTERNAL CREAM (<i>emollient</i>)	Preferred	
<i>ra advanced healing external ointment</i>	Preferred	
<i>ra daylogic healing dry skin external lotion</i>	Preferred	
<i>radiaguard advanced external lotion</i>	Preferred	
<i>refreshing aloe external lotion</i>	Preferred	
RESTA EXTERNAL CREAM (<i>emollient</i>)	Preferred	
RESTA LITE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
RISABAL-PH EXTERNAL CREAM (<i>emollient</i>)	Preferred	
SKIN REPAIR EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>sm dry skin therapy external lotion</i>	Preferred	
<i>special care external cream</i>	Preferred	
STUDIO 35 EXTRA MOISTURIZING EXTERNAL LOTION (<i>emollient</i>)	Preferred	
STUDIO 35 MOISTURIZING SKIN EXTERNAL CREAM (<i>emollient</i>)	Preferred	
THERABETIC SKIN CARE EXTERNAL LOTION (<i>emollient</i>)	Preferred	
<i>thera-derm external lotion</i>	Preferred	
<i>therapeutic moisturizing external cream</i>	Preferred	
UDDERLY SMOOTH EXTERNAL CREAM (<i>emollient</i>)	Preferred	
UDDERLY SMOOTH EXTRA CARE 20 EXTERNAL CREAM (<i>emollient</i>)	Preferred	
UDDERLY SMOOTH EXTRA CARE EXTERNAL CREAM (<i>emollient</i>)	Preferred	
VANICREAM EXTERNAL CREAM (<i>emollient</i>)	Preferred	
VANICREAM EXTERNAL LOTION (<i>emollient</i>)	Preferred	
VANICREAM EXTERNAL OINTMENT (<i>emollient</i>)	Preferred	
VELVACHOL EXTERNAL CREAM (<i>emollient</i>)	Preferred	
<i>vitamin a & d external ointment</i>	Preferred	
<i>vitamin a & d skin protectant external ointment</i>	Preferred	
<i>vitamin e with panthenol external cream</i>	Preferred	
<i>vitamins a & d external ointment</i>	Preferred	
WIBI EXTERNAL LOTION (<i>emollient</i>)	Preferred	
*ESTROGEN COMBINATIONS**		
<i>estradiol-norethindrone acet</i> (Amabelz Oral Tablet 1-0.5 Mg)	Preferred	QL (1 EA per 1 day)
<i>estradiol-norethindrone acet oral tablet 1-0.5 mg</i>	Preferred	QL (1 EA per 1 day)
<i>estradiol-norethindrone acet</i> (Mimvey Oral Tablet 1-0.5 Mg)	Preferred	QL (1 EA per 1 day)
*ESTROGENS**		
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (<i>estradiol</i>)	Preferred	QL (0.29 EA per 1 day)
<i>estradiol</i> (Dotti Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	Preferred	QL (0.29 EA per 1 day)

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Drug Name	Formulary Status	Requirements/Limits
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	Preferred	QL (0.29 EA per 1 day)
<i>estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	Preferred	QL (0.15 EA per 1 day)
<i>estradiol valerate intramuscular oil 40 mg/ml</i>	Preferred	
<i>estradiol (Lyllana Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)</i>	Preferred	QL (0.29 EA per 1 day)
*EXPECTORANTS**		
<i>12 hr mucus relief max oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>altarussin oral liquid 100 mg/5ml</i>	Preferred	
BUCKLEYS CHEST CONGESTION ORAL LIQUID 100 MG/5ML (<i>guaifenesin</i>)	Preferred	
<i>chest congestion relief child oral liquid 100 mg/5ml</i>	Preferred	
<i>chest congestion relief oral liquid 100 mg/5ml</i>	Preferred	
<i>chest congestion relief oral tablet 400 mg</i>	Preferred	
<i>coughtab oral tablet 200 mg</i>	Preferred	
<i>cvs chest congestion relief oral tablet 400 mg</i>	Preferred	
<i>cvs mucus extended release oral tablet extended release 12 hour 1200 mg, 600 mg</i>	Preferred	
<i>cvs tussin adult chest congest oral liquid 100 mg/5ml</i>	Preferred	
DIABETIC TUSSIN CHEST/CONGEST ORAL LIQUID 100 MG/5ML (<i>guaifenesin</i>)	Preferred	
DIABETIC TUSSIN EX ORAL LIQUID 100 MG/5ML (<i>guaifenesin</i>)	Preferred	
<i>eq 12 hour mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	
EQ MUCUS ER ORAL TABLET EXTENDED RELEASE 12 HOUR 1200 MG, 600 MG (<i>guaifenesin</i>)	Preferred	
<i>eq mucus relief 12 hour max st oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>eq1 tussin mucus/chest congest oral liquid 100 mg/5ml</i>	Preferred	
<i>ft mucus relief 12hr oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>ft tussin adult oral liquid 200 mg/10ml</i>	Preferred	
<i>geri-tussin oral liquid 100 mg/5ml</i>	Preferred	
<i>geri-tussin oral syrup 100 mg/5ml</i>	Preferred	
<i>gnp mucus er oral tablet extended release 12 hour 1200 mg, 600 mg</i>	Preferred	
<i>gnp mucus relief oral tablet 400 mg</i>	Preferred	
<i>gnp mucus relief oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>gnp tab tussin oral tablet 400 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp tussin mucus & chest cong oral liquid 100 mg/5ml</i>	Preferred	
<i>goodsense mucus er maximum str oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>goodsense mucus er oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>guaifenesin er oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>guaifenesin oral liquid 100 mg/5ml</i>	Preferred	
<i>guaifenesin oral tablet 200 mg, 400 mg</i>	Preferred	
<i>hm chest congestion relief oral tablet 400 mg</i>	Preferred	
<i>kls mucus relief chest oral tablet 400 mg</i>	Preferred	
MAX TUSSIN MUCUS & CHEST CONG ORAL LIQUID 200 MG/10ML (<i>guaifenesin</i>)	Preferred	
MUCINEX FAST-MAX CHEST CONG MS ORAL LIQUID 400 MG/20ML (<i>guaifenesin</i>)	Preferred	
MUCINEX FOR KIDS ORAL PACKET 100 MG (<i>guaifenesin</i>)	Preferred	
MUCINEX MAXIMUM STRENGTH ORAL TABLET EXTENDED RELEASE 12 HOUR 1200 MG (<i>guaifenesin</i>)	Preferred	
MUCINEX ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (<i>guaifenesin</i>)	Preferred	
<i>mucosa oral tablet 400 mg</i>	Preferred	
<i>mucus relief chest congestion oral liquid 400 mg/20ml</i>	Preferred	
<i>mucus relief chest congestion oral tablet 400 mg</i>	Preferred	
<i>mucus relief er oral tablet extended release 12 hour 1200 mg, 600 mg</i>	Preferred	
<i>mucus relief max st oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>mucus relief oral tablet 400 mg</i>	Preferred	
<i>mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>mucus+chest congestion oral liquid 200 mg/10ml</i>	Preferred	
<i>pharbinex oral tablet 400 mg</i>	Preferred	
<i>px tussin oral liquid 100 mg/5ml</i>	Preferred	
<i>qc medifin 400 oral tablet 400 mg</i>	Preferred	
<i>qc medifin mucus relief child oral liquid 100 mg/5ml</i>	Preferred	
<i>qc mucus relief childrens oral liquid 100 mg/5ml</i>	Preferred	
<i>qc mucus relief er oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>qc mucus relief max st oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>qc mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>qc tussin expectorant adult oral liquid 100 mg/5ml</i>	Preferred	
<i>qc tussin mucus/congestion oral liquid 100 mg/5ml</i>	Preferred	
<i>ra mucus relief max st oral tablet extended release 12 hour 1200 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ra mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>ra tussin chest congestion oral liquid 100 mg/5ml</i>	Preferred	
<i>ra tussin oral liquid 100 mg/5ml</i>	Preferred	
<i>refenesen 400 oral tablet 400 mg</i>	Preferred	
ROBAFEN MUCUS/CHEST CONGESTION ORAL LIQUID 200 MG/10ML (<i>guaifenesin</i>)	Preferred	
<i>sb cough control oral liquid 100 mg/5ml</i>	Preferred	
<i>sb coughtab oral tablet 200 mg</i>	Preferred	
<i>sb mucus relief oral tablet 400 mg</i>	Preferred	
<i>scot-tussin expectorant oral liquid 100 mg/5ml</i>	Preferred	
<i>siltussin sa oral liquid 100 mg/5ml</i>	Preferred	
<i>sm chest congestion relief oral tablet 400 mg</i>	Preferred	
<i>sm mucus relief childrens oral liquid 100 mg/5ml</i>	Preferred	
<i>sm mucus relief max strength oral tablet extended release 12 hour 1200 mg</i>	Preferred	
<i>sm mucus relief oral tablet extended release 12 hour 600 mg</i>	Preferred	
<i>sm tussin mucus+chest congest oral liquid 100 mg/5ml</i>	Preferred	
TUSNEL-EX ORAL LIQUID 100 MG/5ML (<i>guaifenesin</i>)	Preferred	
<i>tussin mucus & chest congest oral liquid 100 mg/5ml</i>	Preferred	
<i>tussin mucus+chest congest sf oral liquid 200 mg/10ml</i>	Preferred	
<i>tussin mucus+chest congestion oral liquid 100 mg/5ml</i>	Preferred	
WAL-TUSSIN CHEST CONGESTION ORAL LIQUID 100 MG/5ML (<i>guaifenesin</i>)	Preferred	
XPECT ORAL TABLET 400 MG (<i>guaifenesin</i>)	Preferred	
*FLAVORING AGENTS**		
<i>almond oil bitter flavor liquid</i>	Preferred	
<i>anise extract liquid</i>	Preferred	
<i>apple flavor liquid</i>	Preferred	
<i>apricot flavor liquid</i>	Preferred	
<i>bacon flavor liquid</i>	Preferred	
<i>banana concentrate liquid</i>	Preferred	
<i>banana cream flavor liquid</i>	Preferred	
<i>banana creme flavor liquid</i>	Preferred	
<i>banana flavor liquid</i>	Preferred	
<i>beef (grilled) flavor oil sol liquid</i>	Preferred	
<i>beef braised natural flavor liquid</i>	Preferred	
<i>beef flavor liquid</i>	Preferred	
<i>beef type flavor natural liquid</i>	Preferred	
<i>beef type flavor os liquid</i>	Preferred	
<i>bitter stop flavor liquid</i>	Preferred	
<i>bitterness mask flavor liquid</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>bitterness suppressor flavor liquid</i>	Preferred	
<i>blackberry flavor liquid</i>	Preferred	
<i>blood orange os liquid</i>	Preferred	
<i>bubble gum concentrate liquid</i>	Preferred	
<i>bubble gum flavor liquid</i>	Preferred	
<i>bubble gum os liquid</i>	Preferred	
<i>bubble gum ws liquid</i>	Preferred	
<i>butter flavor liquid</i>	Preferred	
<i>butterscotch flavor liquid</i>	Preferred	
<i>caramel os liquid</i>	Preferred	
<i>cheesecake flavor liquid</i>	Preferred	
<i>chicken (grilled) flavor liquid</i>	Preferred	
<i>chicken flavor liquid</i>	Preferred	
<i>chicken flavor oil miscible liquid</i>	Preferred	
<i>chicken flavor oil soluble liquid</i>	Preferred	
<i>chicken flavor water miscible liquid</i>	Preferred	
<i>chicken roasted concentrate liquid</i>	Preferred	
<i>chocolate flavor liquid</i>	Preferred	
<i>chocolate hazelnut flavor liquid</i>	Preferred	
<i>coffee flavor liquid</i>	Preferred	
<i>cola flavor liquid</i>	Preferred	
<i>cotton candy flavor liquid</i>	Preferred	
<i>cran-raspberry flavor liquid</i>	Preferred	
<i>creme de menthe flavor liquid</i>	Preferred	
<i>creme dementhe flavor liquid</i>	Preferred	
<i>creme os liquid</i>	Preferred	
<i>english toffee flavor liquid</i>	Preferred	
<i>eugenol flavor liquid</i>	Preferred	
<i>fish flavor liquid</i>	Preferred	
FLAVORX LIQUID (<i>flavoring agent</i>)	Preferred	
<i>grape concord os liquid</i>	Preferred	
<i>green apple os liquid</i>	Preferred	
<i>guava flavor liquid</i>	Preferred	
<i>ham flavor liquid</i>	Preferred	
<i>honey flavor liquid</i>	Preferred	
<i>lemon extract liquid</i>	Preferred	
<i>lemon flavor liquid</i>	Preferred	
<i>licorice flavor liquid</i>	Preferred	
<i>liver concentrate liquid</i>	Preferred	
<i>liver flavor liquid</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>mango flavor liquid</i>	Preferred	
<i>mango passion fruit os liquid</i>	Preferred	
<i>marshmallow flavor liquid</i>	Preferred	
<i>marshmallow os liquid</i>	Preferred	
MARSHMALLOW WS LIQUID (<i>flavoring agent</i>)	Preferred	
<i>mint chocolate chip flavor liquid</i>	Preferred	
<i>natural caramel liquid</i>	Preferred	
<i>orange concentrate liquid</i>	Preferred	
<i>orange cream flavor liquid</i>	Preferred	
<i>orange flavor liquid</i>	Preferred	
<i>orange oil flavor liquid</i>	Preferred	
PCCA SWEETNESS ENHANCER LIQUID (<i>flavoring agent</i>)	Preferred	
<i>peanut butter flavor liquid</i>	Preferred	
<i>peppermint burst os liquid</i>	Preferred	
<i>pina colada flavor liquid</i>	Preferred	
<i>pineapple flavor liquid</i>	Preferred	
<i>pralines and cream flavor liquid</i>	Preferred	
<i>pumpkin flavor liquid</i>	Preferred	
<i>raspberry flavor liquid</i>	Preferred	
<i>raspberry os liquid</i>	Preferred	
<i>root beer flavor liquid</i>	Preferred	
<i>sardine flavor liquid</i>	Preferred	
<i>shrimp flavor liquid</i>	Preferred	
<i>spearmint os liquid</i>	Preferred	
<i>stevia glycerite extract liquid</i>	Preferred	
<i>strawberry flavor liquid</i>	Preferred	
<i>strawberry os liquid</i>	Preferred	
<i>sweetening enhancer liquid</i>	Preferred	
<i>tropical fusion os liquid</i>	Preferred	
TROPICAL FUSION WS LIQUID (<i>flavoring agent</i>)	Preferred	
<i>tuna flavor liquid</i>	Preferred	
<i>tuna type flavor os liquid</i>	Preferred	
<i>tutti-frutti flavor liquid</i>	Preferred	
<i>vanilla flavor liquid</i>	Preferred	
<i>vanilla os liquid</i>	Preferred	
<i>very berry os liquid</i>	Preferred	
<i>vitamin/iron masking agent liquid</i>	Preferred	
<i>wild cherry flavor liquid</i>	Preferred	
<i>wild cherry os liquid</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*FLUORIDE**		
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	Preferred	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg</i>	Preferred	
*FOLIC ACID/FOLATES**		
<i>cvs folic acid oral tablet 800 mcg</i>	Preferred	
FA-8 ORAL CAPSULE 0.8 MG (<i>folic acid</i>)	Preferred	
<i>folate oral tablet 400 mcg</i>	Preferred	
<i>folic acid oral capsule 0.8 mg, 20 mg</i>	Preferred	
<i>folic acid oral tablet 1 mg, 400 mcg, 800 mcg</i>	Preferred	
<i>gnp folic acid oral tablet 400 mcg</i>	Preferred	
<i>hm folic acid oral tablet 400 mcg</i>	Preferred	
<i>kp folic acid oral tablet 1 mg, 800 mcg</i>	Preferred	
<i>px folic acid oral tablet 400 mcg</i>	Preferred	
<i>qc folic acid oral tablet 800 mcg</i>	Preferred	
<i>ra folic acid oral tablet 400 mcg, 800 mcg</i>	Preferred	
<i>sm folic acid oral tablet 400 mcg</i>	Preferred	
<i>yl folic acid oral tablet 400 mcg</i>	Preferred	
*GENITOURINARY IRRIGANTS**		
<i>acetic acid irrigation solution 0.25 %</i>	Preferred	
<i>sodium chloride (gu irrigant) (Argyle Sterile Saline Irrigation Solution 0.9 %)</i>	Preferred	
<i>sodium chloride (gu irrigant) (Curity Sterile Saline Irrigation Solution 0.9 %)</i>	Preferred	
<i>sodium chloride irrigation solution 0.9 %</i>	Preferred	
*HEMATOPOIETIC GROWTH FACTORS**		
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-sndz</i>)	Preferred	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-bmez</i>)	Preferred	PA
*HEMATOPOIETIC MIXTURES**		
BIFERA ORAL TABLET 28 MG (<i>polysacch fe cmp-fe heme poly</i>)	Preferred	
<i>fe c tab oral tablet 100-250 mg</i>	Preferred	
FEOSOL BIFERA ORAL TABLET 28 MG (<i>polysacch fe cmp-fe heme poly</i>)	Preferred	
<i>ferocon oral capsule</i>	Preferred	
<i>ferotrinsic oral capsule</i>	Preferred	
FOLITAB 500 ORAL TABLET EXTENDED RELEASE 105-500-0.8 MG (<i>ferrous sulfate-c-folic acid</i>)	Preferred	
<i>foltrin oral capsule</i>	Preferred	
<i>hematinic/folic acid oral tablet 324-1 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
HEMATOGEN FORTE ORAL CAPSULE 460-60-0.01-1 MG (<i>fe fum-vit c-vit b12-fa</i>)	Preferred	
<i>iron 100/c oral tablet 100-250 mg</i>	Preferred	
<i>iron-vitamin c oral tablet 100-250 mg</i>	Preferred	
<i>fe fumarate-b12-vit c-fa-ifc</i> (Tricon Oral Capsule)	Preferred	
<i>trigels-f forte oral capsule 460-60-0.01-1 mg</i>	Preferred	
*HEMATORHEOLOGIC AGENTS**		
<i>pentoxifylline er oral tablet extended release 400 mg</i>	Preferred	
*HEMOSTATICS - SYSTEMIC**		
<i>tranexamic acid oral tablet 650 mg</i>	Preferred	QL (6 EA per 1 day)
*HEPATITIS AGENTS**		
<i>entecavir oral tablet 0.5 mg</i>	Preferred	PA; QL (1 EA per 1 day)
<i>entecavir oral tablet 1 mg</i>	Preferred	QL (1 EA per 1 day)
<i>lamivudine oral tablet 100 mg</i>	Preferred	
<i>ribavirin oral capsule 200 mg</i>	Preferred	QL (6 EA per 1 day)
<i>ribavirin oral tablet 200 mg</i>	Preferred	QL (6 EA per 1 day)
*HORMONE RECEPTOR MODULATORS**		
OSPHENA ORAL TABLET 60 MG (<i>ospemifene</i>)	Preferred	QL (1 EA per 1 day)
*IMMUNOMODULATING AGENTS - TOPICAL**		
<i>imiquimod external cream 5 %</i>	Preferred	QL (0.434 EA per 1 day); AGE (Min 12 Years)
*IMMUNOSUPPRESSIVE AGENTS**		
<i>azathioprine oral tablet 50 mg</i>	Preferred	Max 90-day supply per fill
<i>cyclosporine modified oral capsule 100 mg, 25 mg</i>	Preferred	
<i>cyclosporine modified oral solution 100 mg/ml</i>	Preferred	
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	Preferred	
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/MI)	Preferred	
<i>mycophenolate mofetil oral capsule 250 mg</i>	Preferred	
<i>mycophenolate mofetil oral tablet 500 mg</i>	Preferred	
<i>mycophenolate sodium oral tablet delayed release 360 mg</i>	Preferred	
<i>sirolimus oral solution 1 mg/ml</i>	Preferred	
<i>sirolimus oral tablet 0.5 mg, 2 mg</i>	Preferred	
<i>tacrolimus oral capsule 0.5 mg</i>	Preferred	QL (2 EA per 1 day)
<i>tacrolimus oral capsule 1 mg</i>	Preferred	QL (8 EA per 1 day)
<i>tacrolimus oral capsule 5 mg</i>	Preferred	QL (4 EA per 1 day)
*INTESTINAL ACIDIFIERS**		
<i>enulose oral solution 10 gm/15ml</i>	Preferred	
<i>generlac oral solution 10 gm/15ml</i>	Preferred	
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
*IODINE ANTISEPTICS**		
BETADINE EXTERNAL SOLUTION 10 % (<i>povidone-iodine</i>)	Preferred	
BETADINE SURGICAL SCRUB EXTERNAL SOLUTION 7.5 % (<i>povidone-iodine</i>)	Preferred	
<i>cvs povidone-iodine external solution 10 %</i>	Preferred	
<i>eq first aid antiseptic external solution 10 %</i>	Preferred	
<i>eq povidone-iodine external solution 10 %</i>	Preferred	
<i>first aid antiseptic external ointment 10 %</i>	Preferred	
<i>gnp povidone-iodine external solution 10 %</i>	Preferred	
<i>povidone-iodine external solution 10 %</i>	Preferred	
<i>qc povidone iodine external solution 10 %</i>	Preferred	
<i>ra antiseptic external solution 10 %</i>	Preferred	
<i>sb povidone-iodine external solution 10 %</i>	Preferred	
SCRUB CARE POVIDONE-IODINE EXTERNAL SOLUTION 10 % (<i>povidone-iodine</i>)	Preferred	
<i>sm povidone-iodine external solution 10 %</i>	Preferred	
*IRON**		
BPROTECTED PEDIA IRON ORAL SOLUTION 75 (15 FE) MG/ML (<i>ferrous sulfate</i>)	Preferred	
<i>cvs iron oral tablet 240 (27 fe) mg</i>	Preferred	
<i>cvs iron oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>cvs slow release iron oral tablet extended release 143 (45 fe) mg, 45 mg</i>	Preferred	
<i>eq slow-release iron oral tablet extended release 45 mg</i>	Preferred	
<i>eql carbonyl iron oral tablet 45 mg</i>	Preferred	
<i>eql iron supplement therapy oral tablet 325 mg</i>	Preferred	Max 90-day supply per fill
<i>eql slow release iron oral tablet extended release 160 (50 fe) mg</i>	Preferred	
<i>fe tabs oral tablet delayed release 325 (65 fe) mg</i>	Preferred	
FERATE ORAL TABLET 240 (27 FE) MG (<i>ferrous gluconate</i>)	Preferred	
FERGON ORAL TABLET 240 (27 FE) MG (<i>ferrous gluconate</i>)	Preferred	
FEROSUL ORAL TABLET 325 (65 FE) MG (<i>ferrous sulfate</i>)	Preferred	Max 90-day supply per fill
<i>ferretts oral tablet 325 (106 fe) mg</i>	Preferred	
FERREX 150 ORAL CAPSULE 150 MG (<i>polysaccharide iron complex</i>)	Preferred	
<i>ferric x-150 oral capsule 150 mg</i>	Preferred	
FERRIMIN 150 ORAL TABLET 150 MG (<i>ferrous fumarate</i>)	Preferred	
FERROCITE ORAL TABLET 324 MG (<i>ferrous fumarate</i>)	Preferred	
<i>ferrotabs oral tablet 240 mg</i>	Preferred	
<i>ferrous fumarate oral tablet 29 mg, 324 (106 fe) mg, 324 mg</i>	Preferred	
<i>ferrous gluconate oral tablet 240 (27 fe) mg, 324 (37.5 fe) mg, 324 (38 fe) mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ferrous sulfate er oral tablet extended release 140 (45 fe) mg</i>	Preferred	
<i>ferrous sulfate oral elixir 220 (44 fe) mg/5ml</i>	Preferred	
<i>ferrous sulfate oral liquid 220 (44 fe) mg/5ml</i>	Preferred	
<i>ferrous sulfate oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>ferrous sulfate oral syrup 300 (60 fe) mg/5ml</i>	Preferred	
<i>ferrous sulfate oral tablet 27 mg</i>	Preferred	
<i>ferrous sulfate oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>ferrous sulfate oral tablet delayed release 324 (65 fe) mg, 324 mg, 325 (65 fe) mg</i>	Preferred	
<i>fe-vite iron oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>gnp iron oral tablet 200 (65 fe) mg</i>	Preferred	
<i>gnp iron oral tablet extended release 142 (45 fe) mg</i>	Preferred	
GOODSENSE IRON ORAL TABLET 325 MG (<i>ferrous sulfate</i>)	Preferred	Max 90-day supply per fill
IFEREX 150 ORAL CAPSULE 150 MG (<i>polysaccharide iron complex</i>)	Preferred	
<i>iron (ferrous sulfate) oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>iron (ferrous sulfate) oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>iron 27 oral tablet 240 (27 fe) mg</i>	Preferred	
<i>iron chews pediatric oral tablet chewable 15 mg</i>	Preferred	
<i>iron high-potency oral tablet 325 mg</i>	Preferred	Max 90-day supply per fill
<i>iron high-potency oral tablet extended release 142 (45 fe) mg</i>	Preferred	
<i>iron infant & toddler oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>iron infant/toddler oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>iron oral tablet 240 (27 fe) mg, 90 (18 fe) mg</i>	Preferred	
<i>iron oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>iron slow release oral tablet extended release 140 (45 fe) mg, 142 (45 fe) mg, 143 (45 fe) mg</i>	Preferred	
<i>iron supplement childrens oral solution 75 (15 fe) mg/ml</i>	Preferred	
<i>iron supplement oral elixir 220 (44 fe) mg/5ml</i>	Preferred	
<i>iron supplement oral solution 75 (15 fe) mg/ml</i>	Preferred	
IRON UP ORAL LIQUID 15 MG/0.5ML (<i>polysaccharide iron complex</i>)	Preferred	
<i>kp ferrous gluconate oral tablet 324 (37.5 fe) mg</i>	Preferred	
<i>kp ferrous sulfate oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>meijer ferrous sulfate oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>nat-rul iron oral tablet 325 mg</i>	Preferred	Max 90-day supply per fill
NOVAFERRUM PEDIATRIC DROPS ORAL LIQUID 15 MG/ML (<i>polysaccharide iron complex</i>)	Preferred	
NU-IRON ORAL CAPSULE 150 MG (<i>polysaccharide iron complex</i>)	Preferred	
ONE VITE FERROUS SULFATE ORAL LIQUID 220 (44 FE) MG/5ML (<i>ferrous sulfate</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>pc pediatric iron drops oral solution 75 (15 fe) mg/ml</i>	Preferred	
POLY-IRON 150 ORAL CAPSULE 150 MG (<i>polysaccharide iron complex</i>)	Preferred	
<i>polysaccharide iron complex oral capsule 150 mg</i>	Preferred	
<i>polysaccharide-iron complex oral capsule 150 mg</i>	Preferred	
PROFE ORAL CAPSULE 391.3 (180 FE) MG (<i>polysaccharide iron complex</i>)	Preferred	
PROFERRIN ES ORAL TABLET 12 MG (<i>iron heme polypeptide</i>)	Preferred	
<i>px iron oral tablet 200 (65 fe) mg, 27 mg</i>	Preferred	
<i>qc ferrous sulfate oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>ra high potency iron oral tablet 27 mg</i>	Preferred	
<i>ra iron oral tablet 27 mg</i>	Preferred	
<i>ra iron oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>ra slow release iron oral tablet extended release 45 mg</i>	Preferred	
SLOW FE ORAL TABLET EXTENDED RELEASE 142 (45 FE) MG (<i>ferrous sulfate</i>)	Preferred	
<i>slow iron oral tablet extended release 160 (50 fe) mg</i>	Preferred	
<i>slow release iron oral tablet extended release 160 (50 fe) mg, 45 mg, 47.5 mg</i>	Preferred	
<i>sm iron oral tablet 325 (65 fe) mg</i>	Preferred	Max 90-day supply per fill
<i>sm iron slow release oral tablet extended release 160 (50 fe) mg</i>	Preferred	
<i>sm slow release iron oral tablet extended release 142 (45 fe) mg, 143 (45 fe) mg, 45 mg</i>	Preferred	
<i>sv iron oral tablet 325 mg</i>	Preferred	Max 90-day supply per fill
<i>wee care oral suspension 15 mg/1.25ml</i>	Preferred	
*IRRIGATION SOLUTIONS**		
<i>water for irrigation, sterile (Argyle Sterile Water Irrigation Solution)</i>	Preferred	
<i>sterile water for irrigation irrigation solution</i>	Preferred	
<i>water for irrigation, sterile irrigation solution</i>	Preferred	
*KERATOLYTIC/ANTIMITOTIC AGENTS**		
BETASAL EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	
COMPOUND W FAST ACTING/CONSEAL EXTERNAL GEL 17 % (<i>salicylic acid</i>)	Preferred	
COMPOUND W MAXIMUM STRENGTH EXTERNAL GEL 17 % (<i>salicylic acid</i>)	Preferred	
<i>cvs psoriasis medicated external shampoo 3 %</i>	Preferred	
<i>cvs therapeutic dandruff external shampoo 3 %</i>	Preferred	
<i>cvs wart remover pen external gel 17 %</i>	Preferred	
DENOREX EX ST MEDICATED EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
DERMAREST PSORIASIS EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	
MG217 DANDRUFF SHAMPOO/COND EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	
MG217 PSORIASIS THER SHAM/COND EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	
NEUTROGENA T/SAL EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	
<i>podofilox external solution 0.5 %</i>	Preferred	
<i>ra wart remover external gel 17 %</i>	Preferred	
SELSUN BLUE DEEP CLEANSING EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	
SELSUN BLUE NATURALS DRY SCALP EXTERNAL SHAMPOO 3 % (<i>salicylic acid</i>)	Preferred	
<i>therapeutic dandruff external shampoo 3 %</i>	Preferred	
<i>therapeutic t+plus max st external shampoo 3 %</i>	Preferred	
<i>wart remover external gel 17 %</i>	Preferred	
<i>wart remover maximum strength external gel 17 %</i>	Preferred	
*LAXATIVE COMBINATIONS**		
COLACE 2-IN-1 ORAL TABLET 8.6-50 MG (<i>sennosides-docusate sodium</i>)	Preferred	
<i>cvs senna plus oral tablet 8.6-50 mg</i>	Preferred	
<i>cvs stool softener/laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>docuzen oral tablet 8.6-50 mg</i>	Preferred	
<i>easy-lax plus oral tablet 8.6-50 mg</i>	Preferred	
<i>eq senna-s oral tablet 8.6-50 mg</i>	Preferred	
<i>eq stool softener/laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>eql senna-s oral tablet 8.6-50 mg</i>	Preferred	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (<i>peg 3350-kcl-nabcb-nacl-nasulf</i>)	Preferred	
<i>peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted 236 Gm)</i>	Preferred	
<i>gnp senna plus oral tablet 8.6-50 mg</i>	Preferred	
<i>gnp stool softener/laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>goodsense stimulant laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>hm stool softener/laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>laxacin oral tablet 8.6-50 mg</i>	Preferred	
<i>medi-natural plus oral tablet 8.6-50 mg</i>	Preferred	
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	Preferred	
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	Preferred	
<i>peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm</i>	Preferred	
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>qc senna-s oral tablet 8.6-50 mg</i>	Preferred	
<i>qc stool softener pls laxative oral tablet 50-8.6 mg, 8.6-50 mg</i>	Preferred	
<i>ra 2-in-1 lax/stool softener oral tablet 8.6-50 mg</i>	Preferred	
<i>ra p col-rite oral tablet 8.6-50 mg</i>	Preferred	
<i>sb docusate sodium/senna oral tablet 8.6-50 mg</i>	Preferred	
SENEXON-S ORAL TABLET 8.6-50 MG (<i>sennosides-docusate sodium</i>)	Preferred	
<i>senna plus oral tablet 8.6-50 mg</i>	Preferred	
<i>senna s oral tablet 8.6-50 mg</i>	Preferred	
<i>senna-docusate sodium oral tablet 8.6-50 mg</i>	Preferred	
<i>senna-plus oral tablet 8.6-50 mg</i>	Preferred	
<i>senna-s oral tablet 8.6-50 mg</i>	Preferred	
<i>senna-time s oral tablet 8.6-50 mg</i>	Preferred	
<i>sennosides-docusate sodium oral tablet 8.6-50 mg</i>	Preferred	
SENOKOT S ORAL TABLET 8.6-50 MG (<i>sennosides-docusate sodium</i>)	Preferred	
<i>sm senna-s oral tablet 8.6-50 mg</i>	Preferred	
<i>sm stool softener/laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>stimulant laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>stool softener laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>stool softener plus laxative oral tablet 8.6-50 mg</i>	Preferred	
<i>stool softener/laxative oral tablet 50-8.6 mg</i>	Preferred	
<i>vegetable lax+stool softener oral tablet 8.6-50 mg</i>	Preferred	
*LAXATIVES - MISCELLANEOUS**		
AVEDANA GLYCERIN (ADULT) RECTAL SUPPOSITORY 2 GM (<i>glycerin (laxative)</i>)	Preferred	
CEO-TWO RECTAL SUPPOSITORY (<i>co2-releasing</i>)	Preferred	
CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
<i>constulose oral solution 10 gm/15ml</i>	Preferred	
<i>cvs glycerin adult rectal suppository 2 gm, 2.1 gm</i>	Preferred	
<i>cvs glycerin child rectal suppository 1 gm</i>	Preferred	
CVS PURELAX ORAL PACKET 17 GM (<i>polyethylene glycol 3350</i>)	Preferred	
CVS PURELAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
EQ CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
EQL CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
FLEET LIQUID GLYCERIN SUPP RECTAL ENEMA 5.4 GM/DOSE (<i>glycerin (laxative)</i>)	Preferred	
<i>gavilax oral powder 17 gm/scoop</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gentlelax oral powder 17 gm/scoop</i>	Preferred	
<i>glycerin (adult) rectal suppository 2 gm, 2.1 gm</i>	Preferred	
<i>glycerin (child) rectal suppository 1.2 gm</i>	Preferred	
<i>glycerin (infants & children) rectal suppository 1 gm, 1.2 gm</i>	Preferred	
<i>glycerin (pediatric) rectal suppository 1.2 gm</i>	Preferred	
<i>glycerin adult rectal suppository 2 gm</i>	Preferred	
<i>glycerin childrens rectal suppository 1 gm</i>	Preferred	
GLYCOLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
GNP CLEARLAX ORAL PACKET 17 GM (<i>polyethylene glycol 3350</i>)	Preferred	
GNP CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
<i>gnp glycerin (adult) rectal suppository 2.1 gm</i>	Preferred	
<i>gnp glycerin child rectal suppository 1.2 gm</i>	Preferred	
GOODSENSE CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
HEALTHYLAX ORAL PACKET 17 GM (<i>polyethylene glycol 3350</i>)	Preferred	
HM CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
KLS LAXACLEAR ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
<i>lactulose oral solution 10 gm/15ml, 20 gm/30ml</i>	Preferred	
MM CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
PEDIA-LAX RECTAL SUPPOSITORY 2.8 GM (<i>glycerin (laxative)</i>)	Preferred	
<i>peg 3350 oral packet 17 gm</i>	Preferred	
<i>peg 3350 oral powder 17 gm/scoop</i>	Preferred	
<i>polyethylene glycol 3350 oral packet 17 gm</i>	Preferred	
<i>polyethylene glycol 3350 oral powder 17 gm/scoop</i>	Preferred	
<i>px glycerin rectal suppository 2.1 gm</i>	Preferred	
<i>qc natura-lax oral powder 17 gm/scoop</i>	Preferred	
<i>ra glycerin adult rectal suppository 80.7 %</i>	Preferred	
<i>ra glycerin child rectal suppository 80.7 %</i>	Preferred	
<i>ra laxative oral powder 17 gm/scoop</i>	Preferred	
<i>sb glycerin adult rectal suppository 2.1 gm</i>	Preferred	
<i>sb glycerin pediatric rectal suppository 1.2 gm</i>	Preferred	
<i>sb polyethylene glycol 3350 oral powder 17 gm/scoop</i>	Preferred	
SM CLEARLAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
<i>sm glycerin pediatric rectal suppository 1.2 gm, 80.7 %</i>	Preferred	
SMOOTH LAX ORAL PACKET 17 GM (<i>polyethylene glycol 3350</i>)	Preferred	

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SMOOTH LAX ORAL POWDER 17 GM/SCOOP (<i>polyethylene glycol 3350</i>)	Preferred	
<i>sorbitol oral solution 70 %</i>	Preferred	
<i>sorbitol rectal solution 70 %</i>	Preferred	
*LEPROSTATICS**		
<i>dapsone oral tablet 100 mg, 25 mg</i>	Preferred	
*LINCOSAMIDES**		
<i>clindamycin hcl oral capsule 150 mg, 300 mg</i>	Preferred	QL (4 EA per 1 day)
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	Preferred	QL (70 ML per 1 day)
*LINIMENTS**		
ZIKS ARTHRITIS PAIN RELIEF EXTERNAL CREAM 0.025-1-12 % (<i>capsaicin-menthol-methyl sal</i>)	Preferred	
*LIQUID VEHICLES**		
FLAVOR BLEND ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
<i>flavor plus oral liquid</i>	Preferred	
<i>flavor sweet oral syrup</i>	Preferred	
<i>flavor sweet-sf oral syrup</i>	Preferred	
<i>grape syrup oral syrup</i>	Preferred	
MX-SOL BLEND ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
MX-SOL BLEND SF ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
MX-SOL ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
MX-SOL SF ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
MX-SOL SUSPEND ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
ORA-BLEND ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
ORA-BLEND SF ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
ORAL MIX ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
ORAL MIX SF ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
<i>oral suspend oral liquid</i>	Preferred	
<i>oral syrup oral syrup</i>	Preferred	
<i>oral syrup sf oral syrup</i>	Preferred	
ORAPENN SD ANHYD SWEETENED ORAL LIQUID (<i>oral vehicles</i>)	Preferred	
ORAPENN SD ANHYD UNSWEETEN ORAL LIQUID (<i>oral vehicles</i>)	Preferred	
ORA-PLUS ORAL LIQUID (<i>oral vehicles</i>)	Preferred	
ORA-SWEET ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
ORA-SWEET SF ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
PCCA SWEET-SF ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
PCCA SYRUP VEHICLE ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
PCCA-PLUS ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
<i>simple syrup oral syrup</i>	Preferred	

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<i>sorbitol solution , 70 %</i>	Preferred	
SOSWEET ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
<i>sterile water for injection injection solution</i>	Preferred	
SUSPENDIT ANHYDROUS ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
SUSPENDRX W/BITTERBLOC SWEET ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
SUSPENDRX W/BITTERBLOC UNSWEET ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
<i>suspension vehicle oral suspension</i>	Preferred	
SYRPALTA (RED) ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
SYRPALTA ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
SYRPALTA ORAL SYRUP 85 % (<i>simple syrup</i>)	Preferred	
SYRSPEND SF ORAL LIQUID (<i>oral vehicles</i>)	Preferred	
<i>syrup nf oral syrup 85 %</i>	Preferred	
<i>syrup vehicle oral syrup</i>	Preferred	
<i>syrup vehicle sf oral syrup</i>	Preferred	
UNISPEND ANHYDROUS SWEETENED ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
UNISPEND ANHYDROUS UNSWEETENED ORAL SUSPENSION (<i>oral vehicles</i>)	Preferred	
VERSAFREE ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
VERSAPLUS ORAL SYRUP (<i>oral vehicles</i>)	Preferred	
*LIQUIDS**		
<i>castor oil oil</i>	Preferred	
<i>qc castor oil oil</i>	Preferred	
<i>sesame oil oil</i>	Preferred	
*LOCAL ANESTHETICS - TOPICAL**		
ANECREAM EXTERNAL CREAM 4 % (<i>lidocaine</i>)	Preferred	
ASPERCREME LIDOCAINE EXTERNAL CREAM 4 % (<i>lidocaine hcl</i>)	Preferred	
ASPERCREME LIDOCAINE EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
ASPERCREME W/LIDOCAINE EXTERNAL CREAM 4 % (<i>lidocaine hcl</i>)	Preferred	
<i>asperflex max st external patch 4 %</i>	Preferred	
ASPERFLEX PAIN RELIEVING EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
BENGAY LIDOCAINE EXTERNAL CREAM 4 % (<i>lidocaine hcl</i>)	Preferred	
BLUE-EMU PAIN RELIEF DRY EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
<i>cvs lidocaine maximum strength external cream 4 %</i>	Preferred	
<i>cvs pain relief external cream 4 %</i>	Preferred	
<i>cvs pain relief external patch 4 %</i>	Preferred	
<i>eq lidocaine pain relieving external patch 4 %</i>	Preferred	
<i>eq pain relieving external cream 4 %</i>	Preferred	

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FIRST CARE PAIN RELIEF EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
<i>gnp lidocaine pain relief external patch 4 %</i>	Preferred	
<i>gnp lidocaine pain relieving external cream 4 %</i>	Preferred	
GOLD BOND MULTI-SYMP TOM EXTERNAL CREAM 4 % (<i>lidocaine hcl</i>)	Preferred	
GOLD BOND PAIN & ITCH RELIEF EXTERNAL CREAM 4 % (<i>lidocaine hcl</i>)	Preferred	
HEALTHWISE PAIN RELIEF EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
<i>hm lidocaine patch external patch 4 %</i>	Preferred	
LIDO KING EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
<i>lidocaine external cream 4 %</i>	Preferred	
<i>lidocaine external patch 4 %</i>	Preferred	
<i>lidocaine hcl external cream 4 %</i>	Preferred	
<i>lidocaine max st 24 hours external patch 4 %</i>	Preferred	
<i>lidocaine pain relief external patch 4 %</i>	Preferred	
<i>lidocaine pain relief max st external cream 4 %</i>	Preferred	
<i>lidocaine pain relief max st external patch 4 %</i>	Preferred	
<i>lidocaine pain relieving external patch 4 %</i>	Preferred	
<i>lidocaine plus external cream 4 %</i>	Preferred	
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	Preferred	
<i>lidocanna external patch 4 %</i>	Preferred	
<i>lidocore external patch 4 %</i>	Preferred	
<i>pain relief maximum strength external patch 4 %</i>	Preferred	
<i>pain relieving + lidocaine external cream 4 %</i>	Preferred	
<i>pain relieving lidocaine external patch 4 %</i>	Preferred	
PHARMACIST CHOICE PAIN RELIEF EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
<i>qc lidocaine pain relief external patch 4 %</i>	Preferred	
<i>qc pain relieving + lidocaine external cream 4 %</i>	Preferred	
<i>ra lidocaine pain relieving external patch 4 %</i>	Preferred	
<i>ra pain relief external cream 4 %</i>	Preferred	
<i>ra pain relieving external patch 4 %</i>	Preferred	
RE-LIEVED MAXIMUM STRENGTH EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
SALONPAS PAIN RELIEVING EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
<i>theracare pain relief external patch 4 %</i>	Preferred	
WELMATE LIDOCAINE PAIN RELIEV EXTERNAL PATCH 4 % (<i>lidocaine</i>)	Preferred	
<i>xolido xp external cream 4 %</i>	Preferred	
*LOOP DIURETICS**		
<i>bumetanide oral tablet 0.5 mg, 1 mg</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>bumetanide oral tablet 2 mg</i>	Preferred	QL (5 EA per 1 day); Max 90-day supply per fill
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	Preferred	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	Preferred	Max 90-day supply per fill
SOAANZ ORAL TABLET 20 MG (<i>torsemide</i>)	Preferred	Max 90-day supply per fill
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	Preferred	Max 90-day supply per fill
*LUBRICANT LAXATIVES**		
<i>cvs mineral oil enema rectal enema</i>	Preferred	
<i>cvs mineral oil oral oil</i>	Preferred	
<i>enema mineral oil rectal enema</i>	Preferred	
<i>eq mineral oil oral oil</i>	Preferred	
<i>gnp mineral oil oral oil</i>	Preferred	
<i>goodsense mineral oil oral oil</i>	Preferred	
<i>hm enema mineral oil rectal enema</i>	Preferred	
<i>mineral oil heavy oral oil</i>	Preferred	
<i>mineral oil oral oil</i>	Preferred	
<i>qc mineral oil heavy oral oil</i>	Preferred	
<i>ra mineral oil oral oil</i>	Preferred	
<i>sm mineral oil oral oil</i>	Preferred	
<i>sm mineral oil rectal enema</i>	Preferred	
*MAGNESIUM**		
BEELITH ORAL TABLET 362-20 MG (<i>magnesium oxide-pyridoxine hcl</i>)	Preferred	
<i>cvs magnesium oral tablet 500 mg</i>	Preferred	
<i>cvs magnesium oxide oral tablet 250 mg</i>	Preferred	
<i>kp mag-oxide magnesium oral tablet 200 mg</i>	Preferred	
<i>mag glycinate oral tablet 100 mg</i>	Preferred	
MAG64 ORAL TABLET DELAYED RELEASE 64 MG (<i>magnesium chloride</i>)	Preferred	
MAGDELAY ORAL TABLET DELAYED RELEASE 64 MG (<i>magnesium chloride</i>)	Preferred	
<i>mag-g oral tablet 500 (27 mg) mg</i>	Preferred	
<i>magnesium bisglycinate oral tablet 100 mg</i>	Preferred	
<i>magnesium citrate oral capsule 125 mg</i>	Preferred	
<i>magnesium citrate oral tablet 100 mg</i>	Preferred	
<i>magnesium extra strength oral capsule 400 mg</i>	Preferred	
<i>magnesium gluconate oral tablet 27.5 mg</i>	Preferred	
<i>magnesium lactate oral tablet extended release 84 mg (7meq)</i>	Preferred	
<i>magnesium oral tablet 200 mg, 250 mg, 30 mg, 400 mg</i>	Preferred	
<i>magnesium oxide -mg supplement oral capsule 400 mg, 500 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>magnesium oxide -mg supplement oral tablet 200 mg, 250 mg, 400 (240 mg) mg, 500 mg</i>	Preferred	
MAGNESIUM-OXIDE ORAL TABLET 400 (240 MG) MG (<i>magnesium oxide</i>)	Preferred	
MAGONATE ORAL LIQUID 54 (MAG EQUIV) MG/5ML (<i>magnesium carbonate</i>)	Preferred	
MAG-OXIDE ORAL TABLET 200 MG (<i>magnesium oxide</i>)	Preferred	
MAG-TAB SR ORAL TABLET EXTENDED RELEASE 84 MG (7MEQ) (<i>magnesium lactate</i>)	Preferred	
<i>mgo oral tablet 400 (240 mg) mg</i>	Preferred	
<i>natrul magnesium oral tablet 250 mg</i>	Preferred	
NU-MAG ORAL TABLET DELAYED RELEASE 71.5-119 MG (<i>magnesium cl-calcium carbonate</i>)	Preferred	
<i>potassium & magnesium aspartat oral capsule 250-250 mg</i>	Preferred	
<i>ra magnesium oral capsule 500 mg</i>	Preferred	
<i>ra natural magnesium oral tablet 250 mg</i>	Preferred	
<i>ra potassium/magnesium oral capsule 250-250 mg</i>	Preferred	
SLOWMAG MG MUSCLE/HEART ORAL TABLET DELAYED RELEASE 71.5-119 MG (<i>magnesium cl-calcium carbonate</i>)	Preferred	
SLOW-MAG ORAL TABLET DELAYED RELEASE 71.5-119 MG (<i>magnesium cl-calcium carbonate</i>)	Preferred	
<i>sm magnesium oral tablet 250 mg</i>	Preferred	
<i>sm magnesium oxide oral tablet 250 mg</i>	Preferred	
*METABOLIC MODIFIERS**		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	Preferred	
<i>cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg</i>	Preferred	PA; QL (2 EA per 1 day)
*MINERALOCORTICOIDS**		
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	Preferred	
*MISC. ANTI-ULCER**		
<i>sucralfate oral suspension 1 gm/10ml</i>	Preferred	
<i>sucralfate oral tablet 1 gm</i>	Preferred	
*MISC. DEVICES**		
ADVOCATE ALCOHOL PREP PADS PAD 70 % (<i>alcohol swabs</i>)	Preferred	
ALCOH-GLOVE CONTOURED WIPE PAD (<i>alcohol swabs</i>)	Preferred	
<i>alcohol pads pad 70 %</i>	Preferred	
<i>alcohol prep pad , 70 %</i>	Preferred	
<i>alcohol prep pads pad 70 %</i>	Preferred	
<i>alcohol swabs pad , 70 %</i>	Preferred	
ALCOHOL SWABSTICK PAD (<i>alcohol swabs</i>)	Preferred	
<i>alcoh-wipe sheet</i>	Preferred	
ALLERGARD SURGICAL GLOVES (<i>disposable gloves</i>)	Preferred	
ASSURANCE VINYL EXAM GLOVES (<i>disposable gloves</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
BD SWAB SINGLE USE REGULAR PAD (<i>alcohol swabs</i>)	Preferred	
CAREMATES LATEX-PF GLOVE LARGE (<i>disposable gloves</i>)	Preferred	
CAREMATES LATEX-PF GLOVE MED (<i>disposable gloves</i>)	Preferred	
CAREMATES LATEX-PF GLOVE SMALL (<i>disposable gloves</i>)	Preferred	
CAREMATES LATEX-PF GLOVE XL (<i>disposable gloves</i>)	Preferred	
CAREMATES NITRILE GLOVES LARGE (<i>disposable gloves</i>)	Preferred	
CAREMATES NITRILE GLOVES MED (<i>disposable gloves</i>)	Preferred	
CAREMATES NITRILE GLOVES SMALL (<i>disposable gloves</i>)	Preferred	
CAREMATES NITRILE GLOVES XL (<i>disposable gloves</i>)	Preferred	
CARETOUCH ALCOHOL PREP PAD 70 % (<i>alcohol swabs</i>)	Preferred	
CHEMOPLUS LATEX GLOVES (<i>disposable gloves</i>)	Preferred	
CHEMOPLUS NEOPRENE GLOVE (<i>disposable gloves</i>)	Preferred	
CHEMOPLUS NITRILE GLOVES (<i>disposable gloves</i>)	Preferred	
CLEVER CHOICE COMFORT EZ GLOVE (<i>disposable gloves</i>)	Preferred	
COMFORT TOUCH ALCOHOL PREP PAD 70 % (<i>alcohol swabs</i>)	Preferred	
COMFORT TOUCH VINYL GLOVES/L (<i>disposable gloves</i>)	Preferred	
COMFORT TOUCH VINYL GLOVES/M (<i>disposable gloves</i>)	Preferred	
COMFORT TOUCH VINYL GLOVES/S (<i>disposable gloves</i>)	Preferred	
<i>cotton gloves medium</i>	Preferred	
CURITY ALCOHOL PREPS PAD 70 % (<i>alcohol swabs</i>)	Preferred	
<i>cvs alcohol prep pads pad 70 %</i>	Preferred	
<i>cvs gloves</i>	Preferred	
<i>cvs gloves vinyl</i>	Preferred	
<i>cvs latex gloves small</i>	Preferred	
<i>cvs nitrile exam gloves</i>	Preferred	
<i>cvs nyplex gloves</i>	Preferred	
<i>cvs prep pad 70 %</i>	Preferred	
<i>cvs super-soft vinyl gloves</i>	Preferred	
DIGITEX EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
DROPSAFE ALCOHOL PREP PAD 70 % (<i>alcohol swabs</i>)	Preferred	
<i>easy comfort alcohol pads pad</i>	Preferred	
EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 % (<i>alcohol swabs</i>)	Preferred	
<i>eql alcohol swabs pad 70 %</i>	Preferred	
<i>eql latex exam gloves</i>	Preferred	
<i>eql nitrile exam gloves</i>	Preferred	
<i>eql vinyl exam gloves</i>	Preferred	
<i>eql vinyl gloves one size</i>	Preferred	
<i>essentra wipes 9x9" sheet 70 %</i>	Preferred	
FIFTY50 ALCOHOL PREP PAD 70 % (<i>alcohol swabs</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>global alcohol prep ease pad 70 %</i>	Preferred	
<i>gnp alcohol swabs pad 70 %</i>	Preferred	
<i>gnp latex exam gloves</i>	Preferred	
<i>gnp nitrile exam gloves</i>	Preferred	
<i>gnp vinyl exam gloves</i>	Preferred	
<i>h-e-b incontol alcohol pad</i>	Preferred	
<i>hm sterile alcohol prep pad</i>	Preferred	
J & J HEALTH CARE GLOVES (<i>disposable gloves</i>)	Preferred	
<i>latex gloves</i>	Preferred	
<i>latex gloves large</i>	Preferred	
<i>latex gloves medium</i>	Preferred	
<i>latex gloves one size</i>	Preferred	
<i>latex gloves small</i>	Preferred	
<i>lavender nitrile gloves/medium</i>	Preferred	
MAXXUS ORTHO SURGICAL GLOVES (<i>disposable gloves</i>)	Preferred	
<i>meijer alcohol swabs pad 70 %</i>	Preferred	
MICRO-TOUCH GLOVES (<i>disposable gloves</i>)	Preferred	
MICRO-TOUCH XP GLOVES (<i>disposable gloves</i>)	Preferred	
NEUTRALON 50 BROWN LATEX GLOVE (<i>disposable gloves</i>)	Preferred	
NEUTRALON BROWN SURGICAL GLOVE (<i>disposable gloves</i>)	Preferred	
<i>nitrile exam gloves large</i>	Preferred	
<i>nitrile exam gloves medium</i>	Preferred	
<i>nitrile gloves large</i>	Preferred	
<i>nitrile gloves medium</i>	Preferred	
<i>nitrile gloves small</i>	Preferred	
<i>nitrile gloves x-large</i>	Preferred	
<i>nitrile gloves/one size</i>	Preferred	
<i>nitrile gloves/size 10</i>	Preferred	
<i>nitrile gloves/size 6</i>	Preferred	
<i>nitrile gloves/size 6.5</i>	Preferred	
<i>nitrile gloves/size 7</i>	Preferred	
<i>nitrile gloves/size 7.5</i>	Preferred	
<i>nitrile gloves/size 8</i>	Preferred	
<i>nitrile gloves/size 8.5</i>	Preferred	
<i>nitrile gloves/size 9</i>	Preferred	
<i>nitrile gloves/size 9.5 medium</i>	Preferred	
PHARMACIST CHOICE ALCOHOL PAD (<i>alcohol swabs</i>)	Preferred	
<i>powder free nitrile gloves lg</i>	Preferred	
<i>powder free nitrile gloves med</i>	Preferred	
<i>powder free nitrile gloves sm</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>powder free nitrile gloves xl</i>	Preferred	
<i>pro comfort alcohol pad 70 %</i>	Preferred	
<i>pro comfort gloves large</i>	Preferred	
<i>pro comfort gloves medium</i>	Preferred	
<i>pro comfort gloves x-large</i>	Preferred	
<i>pro-comfort examination gloves</i>	Preferred	
<i>pure comfort alcohol prep pad</i>	Preferred	
PURE-COMFORT DISPOSABLE VINYL (<i>disposable gloves</i>)	Preferred	
PURE-COMFORT NITRILE EXAM (<i>disposable gloves</i>)	Preferred	
PURE-COMFORT SYNTHETIC NITRILE (<i>disposable gloves</i>)	Preferred	
<i>qc alcohol swabs pad 70 %</i>	Preferred	
<i>ra alcohol swabs pad 70 %</i>	Preferred	
<i>ra extended cuff nitrile glove</i>	Preferred	
<i>ra heavy duty latex gloves</i>	Preferred	
<i>ra vinyl gloves</i>	Preferred	
<i>reality swabs pad</i>	Preferred	
RELION ALCOHOL SWABS PAD , 70 % (<i>alcohol swabs</i>)	Preferred	
RELION NITRILE EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-L (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-M (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-S (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-XL (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-L (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-M (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-S (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-XL (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVES-NITRILE-L (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVES-NITRILE-M (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVES-NITRILE-S (<i>disposable gloves</i>)	Preferred	
SAFE-SENSE GLOVES-NITRILE-XL (<i>disposable gloves</i>)	Preferred	
SAFESKIN NITRILE EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
<i>saps care alcohol prep pad 70 %</i>	Preferred	
<i>saps health alcohol prep pad , 70 %</i>	Preferred	
<i>saps health care alcohol prep pad 70 %</i>	Preferred	
<i>sb alcohol prep pad 70 %</i>	Preferred	
SECURE GLOVES (<i>disposable gloves</i>)	Preferred	
SHAMROCK LATEX EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
SHAMROCK VINYL EXAM GLOVES (<i>disposable gloves</i>)	Preferred	
<i>sm alcohol prep pad , 70 %</i>	Preferred	
<i>sure comfort alcohol prep pad 70 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
SURGIKOS LATEX SURGICAL GLOVES (<i>disposable gloves</i>)	Preferred	
<i>synthetic vinyl exam gloves</i>	Preferred	
TRANQUILITY VINYL GLOVES LARGE (<i>disposable gloves</i>)	Preferred	
TRANQUILITY VINYL GLOVES MED (<i>disposable gloves</i>)	Preferred	
TRANQUILITY VINYL GLOVES SMALL (<i>disposable gloves</i>)	Preferred	
<i>true comfort alcohol prep pads pad 70 %</i>	Preferred	
<i>true comfort pro alcohol prep pad 70 %</i>	Preferred	
ULTICARE ALCOHOL SWABS PAD , 70 % (<i>alcohol swabs</i>)	Preferred	
<i>ultilet alcohol swabs pad</i>	Preferred	
<i>ultra-care alcohol prep pads pad 70 %</i>	Preferred	
<i>ultra-soft gloves</i>	Preferred	
<i>vinyl gloves</i>	Preferred	
<i>vinyl gloves medium</i>	Preferred	
<i>vinyl gloves one size</i>	Preferred	
WEBCOL ALCOHOL PREP LARGE PAD 70 % (<i>alcohol swabs</i>)	Preferred	
WEBCOL ALCOHOL PREP MEDIUM PAD 70 % (<i>alcohol swabs</i>)	Preferred	
<i>zevrx sterile alcohol prep pad pad 70 %</i>	Preferred	
*MISC. NUTRITIONAL SUBSTANCES**		
<i>cvs fish oil half-the-size oral capsule 500 mg</i>	Preferred	
<i>cvs fish oil oral capsule 1000 mg, 1200 mg</i>	Preferred	
<i>cvs fish oil oral capsule delayed release 1200 mg</i>	Preferred	
<i>cvs natural fish oil oral capsule 1000 mg, 1200 mg</i>	Preferred	
<i>cvs omega-3 gummy fish oral tablet chewable 113.5 mg</i>	Preferred	
<i>eql fish oil oral capsule 1000 mg</i>	Preferred	
<i>eql omega 3 fish oil oral capsule 1000 mg, 1200 mg</i>	Preferred	
<i>eql omega 3 fish oil oral capsule delayed release 1000 mg, 1200 mg</i>	Preferred	
<i>fish oil adult gummies oral tablet chewable 113.5 mg</i>	Preferred	
<i>fish oil burp-less oral capsule 1000 mg, 1200 mg, 500 mg</i>	Preferred	
<i>fish oil concentrate oral capsule 1000 mg, 435 mg</i>	Preferred	
<i>fish oil double strength oral capsule 1200 mg</i>	Preferred	
<i>fish oil extra strength oral capsule 1200 mg, 435 mg</i>	Preferred	
<i>fish oil high potency oral capsule 1000 mg</i>	Preferred	
<i>fish oil maximum strength oral capsule 1200 mg</i>	Preferred	
<i>fish oil maximum strength oral capsule delayed release 1200 mg</i>	Preferred	
<i>fish oil odor-less oral capsule 1200 mg</i>	Preferred	
<i>fish oil omega-3 oral capsule 1000 mg</i>	Preferred	
<i>fish oil oral capsule 1000 mg, 1200 mg, 435 mg, 500 mg</i>	Preferred	
<i>fish oil oral capsule delayed release 1000 mg, 1200 mg</i>	Preferred	

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<i>fish oil/super potent/no burp oral capsule 1000 mg</i>	Preferred	
<i>gnp fish oil max st oral capsule delayed release 1200 mg</i>	Preferred	
<i>gnp fish oil oral capsule 1000 mg</i>	Preferred	
<i>gnp fish oil oral capsule delayed release 1000 mg</i>	Preferred	
<i>hm fish oil oral capsule 1000 mg, 1200 mg</i>	Preferred	
<i>kp fish oil oral capsule 1200 mg</i>	Preferred	
<i>kp omega-3 fish oil oral capsule 1200 mg</i>	Preferred	
<i>kp omega-3 fish oil oral capsule delayed release 1200 mg</i>	Preferred	
<i>maxepa oral capsule 1000 mg</i>	Preferred	
MAXIMUM EPA ORAL CAPSULE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	
<i>norwegian salmon oil oral capsule 1000 mg</i>	Preferred	
<i>odorless coated fish oil oral capsule delayed release 1000 mg</i>	Preferred	
<i>omega 3 oral capsule 1000 mg, 1200 mg</i>	Preferred	
<i>omega iii epa+dha oral capsule 1000 mg</i>	Preferred	
<i>omega-3 cf oral capsule 1000 mg</i>	Preferred	
<i>omega-3 fish oil concentrate oral capsule delayed release 1000 mg</i>	Preferred	
<i>omega-3 fish oil oral capsule 1000 mg, 1200 mg, 500 mg</i>	Preferred	
<i>omega-3 oral capsule 1000 mg</i>	Preferred	
OMEGAPURE 600 EC ORAL CAPSULE DELAYED RELEASE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	
OMEGAPURE 820 ORAL CAPSULE 1250 MG (<i>omega-3 fatty acids</i>)	Preferred	
OVEGA-3 ORAL CAPSULE 500 MG (<i>omega-3 fatty acids</i>)	Preferred	
<i>px fish oil oral capsule 1000 mg</i>	Preferred	
<i>qc fish oil oral capsule 1000 mg</i>	Preferred	
<i>ra fish oil oral capsule 1000 mg</i>	Preferred	
<i>ra fish oil oral capsule delayed release 1000 mg</i>	Preferred	
RELION GLUCOSE SHOT ORAL LIQUID (<i>glucose-cholecalciferol</i>)	Preferred	
<i>sam-e.p.a. oral capsule 200-300 mg</i>	Preferred	
<i>sb omega-3 fish oil oral capsule 1000 mg</i>	Preferred	
SEA-OMEGA ORAL CAPSULE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	
<i>sm fish oil oral capsule 1000 mg, 1200 mg</i>	Preferred	
<i>sm fish oil oral capsule delayed release 1000 mg</i>	Preferred	
<i>sm omega-3 fish oil oral capsule 1200 mg</i>	Preferred	
SUPER DHA GEMS ORAL CAPSULE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	
<i>super omega 3 epa/dha oral capsule 1000 mg</i>	Preferred	
SUPER OMEGA 3 ORAL CAPSULE 500 MG (<i>omega-3 fatty acids</i>)	Preferred	
SUPER OMEGA-3 ORAL CAPSULE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sv fish oil oral capsule 500 mg</i>	Preferred	
THERAGRAN-M FISH OIL CONC ORAL CAPSULE 1200 MG (<i>omega-3 fatty acids</i>)	Preferred	
THEROMEGA ORAL CAPSULE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	
TRUEPLUS GLUCOSE SHOT ORAL LIQUID (<i>glucose-cholecalciferol</i>)	Preferred	
ULTRA OMEGA 3 ORAL CAPSULE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	
VITEYES OMEGA-3 VISION SUPPORT ORAL CAPSULE DELAYED RELEASE 1000 MG (<i>omega-3 fatty acids</i>)	Preferred	
*MISC. RESPIRATORY INHALANTS**		
<i>sodium chloride inhalation nebulization solution 0.9 %</i>	Preferred	
*MISC. TOPICAL**		
A.E.R. TRAVELER EXTERNAL PAD (<i>witch hazel-glycerin</i>)	Preferred	
A.E.R. WITCH HAZEL EXTERNAL PAD (<i>witch hazel-glycerin</i>)	Preferred	
ABSORBASE EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
ACUWASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
ALOE VESTA BODY WASH/SHAMPOO EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
ALOE VESTA PROTECTIVE EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
ALOE VESTA SKIN CONDITIONER EXTERNAL LOTION 3 % (<i>dimethicone</i>)	Preferred	
AMERICERIN EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
AMERIDERM PERISHIELD EXTERNAL OINTMENT 3.8 % (<i>skin protectants, misc.</i>)	Preferred	
AMERIPHOR EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
AQUA GLYCOLIC FACIAL CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
AQUA GLYCOLIC SHAMPOO/BODY EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
AQUA GLYCOLIC TONER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>aquagard hydrating external ointment 41 %</i>	Preferred	
AQUAPHOR LIP REPAIR EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
AVEENO BABY CALMING COMFORT EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
AVEENO BABY CLEANSING THERAPY EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
AVEENO CALM & RESTORE CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
AVEENO DAILY MOISTURIZ FACIAL EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
BALMEX SKIN PROTECTANT EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
BASIS CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
BASIS FACIAL MOISTURIZER EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
BASIS OVERNIGHT EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
<i>benzoin compound external tincture</i>	Preferred	
<i>boro-packs external packet 49-51 %</i>	Preferred	
BOUDREAU'S BUTT BATH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
BOUDREAU'S BUTT PASTE EXTERNAL OINTMENT 40 % (<i>zinc oxide</i>)	Preferred	
B-SURE WITCH HAZEL EXTERNAL PAD 50 % (<i>witch hazel</i>)	Preferred	
<i>calamine external lotion 8-8 %</i>	Preferred	
<i>calamine phenolated external lotion</i>	Preferred	
<i>calamine-zinc oxide external lotion , 8-8 %</i>	Preferred	
CALMOSEPTINE EXTERNAL OINTMENT 0.44-20.6 % (<i>menthol-zinc oxide</i>)	Preferred	
CALPROTECT EXTERNAL OINTMENT 0.44-20.6 % (<i>menthol-zinc oxide</i>)	Preferred	
CARMEX CLASSIC LIP BALM EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
CERAVE FOAMING FACIAL CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CERAVE HYDRATING CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CERAVE SA BODY WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CERAVE THERAPEUTIC HAND CREAM EXTERNAL CREAM 1 % (<i>dimethicone</i>)	Preferred	
CETAPHIL DERMACONTROL FOAM WSH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CETAPHIL EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CETAPHIL GENTLE CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CETAPHIL RESTORADERM EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CHAPSTICK OVERNIGHT EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
CHAPSTICK ULTRASMooth FORTIFY EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
CHAPSTICK ULTRASMooth NOURISH EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
CHAPSTICK ULTRASMooth REJUVEN EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
CHAPSTICK ULTRASMOOTH SOOTHE EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
CLEAN & CLEAR ALOE VERA CLEANS EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLEAN & CLEAR ESSENTIALS EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLEAN & CLEAR FACIAL CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLEAN & CLEAR MORNING BURST EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLEAN & CLEAR NIGHT RELAX WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLN BODY WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLN FACIAL CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLN HAND & FOOT WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLN SPORT WASH HIGH PERFORM EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CLN SPORTWASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
CRITIC-AID CLEAR EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
<i>cvs astringent solution external packet</i>	Preferred	
<i>cvs daily facial cleanser external liquid</i>	Preferred	
<i>cvs diaper rash external ointment 40 %</i>	Preferred	
<i>cvs medicated wipes external pad 50 %</i>	Preferred	
<i>cvs medicated witch hazel external pad 50 %</i>	Preferred	
<i>cvs multi-purpose external ointment 15.5-53.4 %</i>	Preferred	
<i>cvs zinc oxide external ointment 20 %</i>	Preferred	
DERMAFIX EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
<i>diaper rash external ointment 40 %</i>	Preferred	
DOMEBORO EXTERNAL PACKET (<i>alum sulfate-ca acetate</i>)	Preferred	
<i>eq diaper rash external ointment 40 %</i>	Preferred	
<i>eq hemorrhoidal external pad 50 %</i>	Preferred	
<i>eq hygienic cleansing wipes external pad</i>	Preferred	
<i>eql baby basics diaper rash external ointment 40 %</i>	Preferred	
<i>eql body wash/sensitive skin external liquid</i>	Preferred	
<i>eql body wash/shear butter external liquid</i>	Preferred	
<i>eql clear hand soap refill external liquid</i>	Preferred	
<i>eql gentle skin cleanser external liquid</i>	Preferred	
<i>eql high power body wash external liquid</i>	Preferred	
<i>eql liquid hand soap external liquid</i>	Preferred	
<i>eql skin astringent external liquid</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
EUCERIN ADVANCED CLEANSING EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
EUCERIN ORIGINAL HEALING EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
EUCERIN SKIN CALMING BODY WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
EYESCRUB EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
FREE & CLEAR/SENSITIVE EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>gentle skin cleanser external liquid</i>	Preferred	
<i>gnp calamine external lotion 8-8 %</i>	Preferred	
<i>gnp calamine phenolated external lotion</i>	Preferred	
<i>gnp gentle skin cleanser external liquid</i>	Preferred	
<i>gnp zinc oxide external ointment 20 %</i>	Preferred	
GOLD BOND ULT WASH/EXFOLIATING EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
GOLD BOND ULT WASH/HEALING EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
GOLD BOND ULT WASH/SENSITIVE EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
GOLD BOND ULT WASH/SOFTENING EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>goodsense medicated external pad 50 %</i>	Preferred	
<i>goodsense medicated wipes external pad 50 %</i>	Preferred	
<i>hemorrhoidal external pad 50 %</i>	Preferred	
<i>hemorrhoidal hygiene external pad 50 %</i>	Preferred	
<i>hm medicated cooling external pad 50 %</i>	Preferred	
<i>hydrocerin external cream</i>	Preferred	
<i>hygienic cleansing external pad 50 %</i>	Preferred	
IONIL EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
JOHNSONS KIDS CLEAN & FRESH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
JOHNSONS SKIN NOURISH WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>kp gentle skin cleanser external liquid</i>	Preferred	
<i>lip balm external ointment</i>	Preferred	
MEDERMA AG BODY CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
MEDERMA AG FACIAL CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
MEDERMA AG FACIAL TONER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>medicated pads external pad 50 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>medicated wipes (glycerin) external pad 50 %</i>	Preferred	
<i>medicated wipes external pad 50 %</i>	Preferred	
<i>medi-pads external pad 50 %</i>	Preferred	
MEDPURA HYDROSEPTINE EXTERNAL OINTMENT 0.44-20.6 % (<i>menthol-zinc oxide</i>)	Preferred	
MEDPURA ZINC OXIDE EXTERNAL OINTMENT 20 % (<i>zinc oxide</i>)	Preferred	
<i>meijer calamine external lotion</i>	Preferred	
<i>meijer zinc oxide external ointment 20 %</i>	Preferred	
MINERIN CREME EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
<i>moisture barrier external ointment 0.44-20.6 %</i>	Preferred	
MOISTUREL EXTERNAL LOTION 3 % (<i>dimethicone</i>)	Preferred	
NEOSPORIN LIP HEALTH OVERNIGHT EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
NEUTROGENA DEEP CLEAN EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
NIVEA VISAGE EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
PERISHIELD EXTERNAL OINTMENT (<i>skin protectants, misc.</i>)	Preferred	
<i>petroleum jelly lip treatment external ointment</i>	Preferred	
<i>pre-moistened witch hazel external pad 50 %</i>	Preferred	
PREPARATION H EXTERNAL PAD 50 % (<i>witch hazel</i>)	Preferred	
PREPARATION H FOR WOMEN EXTERNAL PAD 20 % (<i>witch hazel</i>)	Preferred	
PREPARATION H SOOTHING RELIEF EXTERNAL PAD 20 % (<i>witch hazel</i>)	Preferred	
PREPARATION H TOTABLES WIPES EXTERNAL PAD 50 % (<i>witch hazel</i>)	Preferred	
PURPOSE GENTLE CLEANING WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>px calamine external lotion</i>	Preferred	
<i>qc calamine external lotion</i>	Preferred	
<i>qc diaper rash external ointment 40 %</i>	Preferred	
<i>qc medicated pads external pad</i>	Preferred	
<i>qc medicated pre-moistened external pad 50 %</i>	Preferred	
<i>qc medicated wipes external pad</i>	Preferred	
<i>qc zinc oxide external ointment 20 %</i>	Preferred	
<i>ra hemorrhoidal medicated external pad 50 %</i>	Preferred	
<i>ra medicated wipes external pad 50 %</i>	Preferred	
<i>ra zinc oxide external ointment 20 %</i>	Preferred	
<i>refresh cleanser external liquid</i>	Preferred	
<i>refreshing facial cleanser external liquid</i>	Preferred	

Drug Name	Formulary Status	Requirements/Limits
REHYLA HAIR + BODY CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
REHYLA WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>sb hemorrhoid external pad</i>	Preferred	
SENSI-CARE MOISTURIZING EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
SENSI-CARE SEPTI-SOFT EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>sm calamine external lotion</i>	Preferred	
<i>sm calamine phenolated external lotion</i>	Preferred	
<i>sm hygienic cleansing external pad 50 %</i>	Preferred	
<i>sm medicated wipes external pad 50 %</i>	Preferred	
SORBIDON HYDRATE EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
STERI-STRIP COMPOUND BENZOIN EXTERNAL TINCTURE (<i>benzoin compound</i>)	Preferred	
SWEEN MOISTURIZING BODY EXTERNAL CREAM (<i>skin protectants, misc.</i>)	Preferred	
TENA SKIN-CARING BODY WASH EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
TENA SKIN-CARING WASH CREAM EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
TN DICKINSONS WITCH HAZEL EXTERNAL PAD , 50 % (<i>witch hazel</i>)	Preferred	
VANICREAM CLEANSER EXTERNAL LIQUID (<i>soap & cleansers</i>)	Preferred	
<i>zinc oxide external ointment 20 %, 40 %</i>	Preferred	
*MITOTIC INHIBITORS**		
<i>etoposide oral capsule 50 mg</i>	Preferred	
*MONOCLONAL ANTIBODIES**		
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML (<i>palivizumab</i>)	Preferred	PA
*MUCOLYTICS**		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	Preferred	
*MULTIPLE VITAMINS W/ IRON**		
<i>daily vite multivitamin/iron oral tablet</i>	Preferred	
<i>daily-vitamin/iron oral tablet</i>	Preferred	
<i>multiple vitamins/iron oral tablet</i>	Preferred	
<i>multivitamin plus iron adult oral tablet</i>	Preferred	
<i>multi-vitamin/iron oral tablet</i>	Preferred	
<i>nat-rul daily-vite+iron oral tablet</i>	Preferred	
<i>one daily multivitamin/iron oral tablet</i>	Preferred	
<i>one-daily multi-vitamin/iron oral tablet</i>	Preferred	
<i>one-daily/iron oral tablet</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>qc daily multivitamins/iron oral tablet</i>	Preferred	
<i>sm multiple vitamins/iron oral tablet</i>	Preferred	
<i>stress b complex/iron oral tablet</i>	Preferred	
<i>stress formula/iron oral tablet</i>	Preferred	
<i>tab-a-vite/iron oral tablet</i>	Preferred	
TAB-A-VITE/IRON/BETA CAROTENE ORAL TABLET (<i>multiple vitamins-iron</i>)	Preferred	
*MULTIPLE VITAMINS W/ MINERALS**		
3 PER DAY BONEUP ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>50+ adult eye health oral capsule</i>	Preferred	
<i>a thru z advanced adult oral tablet</i>	Preferred	
<i>a thru z advanced oral tablet</i>	Preferred	
<i>a thru z high potency oral tablet</i>	Preferred	
<i>a thru z select 50+ advanced oral tablet</i>	Preferred	
<i>a thru z select 50+ mens oral tablet</i>	Preferred	
<i>a thru z select advanced oral tablet</i>	Preferred	
<i>a thru z select oral tablet</i>	Preferred	
<i>a thru z select oral tablet chewable</i>	Preferred	
<i>a thru z select ultimate women oral tablet</i>	Preferred	
<i>a thru z ultimate mens oral tablet</i>	Preferred	
<i>abc complete senior 50+ oral tablet</i>	Preferred	
<i>abc complete senior mens 50+ oral tablet</i>	Preferred	
<i>abc complete senior womens 50+ oral tablet</i>	Preferred	
<i>actical oral capsule</i>	Preferred	
ACTIVNUTRIENTS ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
ACTIVNUTRIENTS PERFORMANCE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
ACTIVNUTRIENTS W/O IRON ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
ADEK GUMMIES PLUS ZN ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>adult one daily gummies oral tablet chewable</i>	Preferred	
<i>advanced diabetic multivitamin oral tablet</i>	Preferred	
<i>advanced eye health oral capsule</i>	Preferred	
ADVANCED MULTI EA ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
AIRBORNE GUMMIES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
AIRBORNE KIDS ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
AIRBORNE ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
AIRBORNE+GOOD REST ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
AIRBORNE+NATURAL ENERGY ORAL LIQUID (<i>multiple vitamins-minerals</i>)	Preferred	
AIRBORNE+PROBIOTIC ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>algae based calcium oral tablet</i>	Preferred	
ALIVE DIABETIC MULTIVITAMIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE ENERGY 50+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE EVERYDAY IMMUNE HEALTH ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE HAIR, SKIN & NAILS ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE MENS 50+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE MULTI-VITAMIN ORAL LIQUID (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE MULTI-VITAMIN ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE ONCE DAILY WOMENS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE ULTRA POTENCY WOMENS 50+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE WOMENS 50+ GUMMY ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE WOMENS 50+ ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE WOMENS ENERGY ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ALIVE WOMENS GUMMY ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
AMORYN MOOD BOOSTER ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>antioxidant a/c/e/selenium oral tablet</i>	Preferred	
<i>antioxidant formula oral tablet</i>	Preferred	
<i>antioxidant formula/minerals oral capsule</i>	Preferred	
<i>antioxidant oral capsule</i>	Preferred	
<i>antioxidant protection formula oral tablet</i>	Preferred	
<i>antioxidant vitamins oral tablet</i>	Preferred	
APETIBEX ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
APPE-CURB ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
AZO HORMONAL HEALTH CYCLE CARE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
AZO HORMONAL HEALTH HAPPY CYCL ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
BACMIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
BARIATRIC FUSION ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>bariatric multivitamins/iron oral capsule</i>	Preferred	
<i>basic am oral tablet</i>	Preferred	
<i>basic pm oral tablet</i>	Preferred	
BIO-35 GLUTEN-FREE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
BIO-35 IRON FREE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>biocal oral capsule</i>	Preferred	
<i>biocel oral tablet</i>	Preferred	
<i>body/hair/skin/nails oral capsule</i>	Preferred	
BONEUP ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>b-plex plus oral tablet</i>	Preferred	
BPROTECTED MULTI-VITE ORAL LIQUID (<i>multiple vitamins-minerals</i>)	Preferred	
BURIED TREASURE ACTIVE 55 PLUS ORAL LIQUID (<i>multiple vitamins-minerals</i>)	Preferred	
CAL-DAY 1000 ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CELEBRATE MULTI-COMPLETE 18 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
CELEBRATE MULTI-COMPLETE 18 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CELEBRATE MULTI-COMPLETE 36 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
CELEBRATE MULTI-COMPLETE 36 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CELEBRATE MULTI-COMPLETE 45 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
CELEBRATE MULTI-COMPLETE 45 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CELEBRATE MULTI-COMPLETE 60 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
CELEBRATE MULTI-COMPLETE 60 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>centavite a-z complete-mineral oral tablet</i>	Preferred	
<i>centravites 50 plus oral tablet</i>	Preferred	
<i>centravites adults oral tablet</i>	Preferred	
<i>centravites oral tablet</i>	Preferred	
CENTRUM ADULT ORAL LIQUID (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM ADULTS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
CENTRUM ADULTS ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM CARDIO ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM FLAVOR BURST ADULT ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM FLAVOR BURST ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM FRESH/FRUITY 50+ ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM FRESH/FRUITY ADULT ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM MEN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM MINIS WOMEN 50+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM MULTI + OMEGA 3 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM ORAL LIQUID (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SILVER 50+MEN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SILVER 50+WOMEN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SILVER ADULT 50+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SILVER ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SILVER ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SILVER ULTRA WOMENS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SPECIALIST HEART ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SPECIALIST IMMUNE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM SPECIALIST VISION ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM ULTRA WOMENS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM VITAMINTS ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CENTRUM WOMEN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>century mature oral tablet</i>	Preferred	
<i>century oral tablet</i>	Preferred	
CEROVITE SENIOR ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CERTAVITE SENIOR ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CERTAVITE SENIOR/ANTIOXIDANT ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
CERTAVITE/ANTIOXIDANTS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CHOICEFUL MULTIVITAMIN ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
CHOICEFUL MULTIVITAMIN ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>companion oral tablet</i>	Preferred	
COMPETE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>complete multivitamin/mineral oral liquid</i>	Preferred	
<i>coral calcium plus oral capsule</i>	Preferred	
CORVITA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
CULTURELLE PROBIOTICS + MULTIV ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>cvs adult 50+ eye health oral capsule</i>	Preferred	
CVS AIRSHIELD IMMUNITY SUPPORT ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
CVS AIRSHIELD ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>cvs daily gummies adult oral tablet chewable</i>	Preferred	
<i>cvs daily gummies oral tablet chewable</i>	Preferred	
<i>cvs daily multiple for men oral tablet</i>	Preferred	
<i>cvs daily multiple women 50+ oral tablet</i>	Preferred	
<i>cvs eye health & lutein oral tablet</i>	Preferred	
<i>cvs eye health adult 50+ oral capsule</i>	Preferred	
<i>cvs mens daily gummies oral tablet chewable</i>	Preferred	
<i>cvs one daily essential oral tablet</i>	Preferred	
<i>cvs one daily mens 50+ adv oral tablet</i>	Preferred	
<i>cvs one daily mens formula oral tablet</i>	Preferred	
<i>cvs one daily womens 50+ adv oral tablet</i>	Preferred	
<i>cvs one daily womens formula oral tablet</i>	Preferred	
<i>cvs spectravite adult 50+ oral tablet</i>	Preferred	
<i>cvs spectravite adult 50+ oral tablet chewable</i>	Preferred	
<i>cvs spectravite adults oral tablet</i>	Preferred	
<i>cvs spectravite advanced oral tablet</i>	Preferred	
<i>cvs spectravite men 50+ oral tablet</i>	Preferred	
<i>cvs spectravite men oral tablet</i>	Preferred	
<i>cvs spectravite senior oral tablet</i>	Preferred	
<i>cvs spectravite ultra men 50+ oral tablet</i>	Preferred	
<i>cvs spectravite ultra mens oral tablet</i>	Preferred	
<i>cvs spectravite ultra women oral tablet</i>	Preferred	
<i>cvs spectravite women 50+ oral tablet</i>	Preferred	
<i>cvs spectravite women oral tablet</i>	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>cvs spectravite women oral tablet chewable</i>	Preferred	
<i>cvs spectravite womens senior oral tablet</i>	Preferred	
<i>cvs vision health oral capsule</i>	Preferred	
<i>cvs womens active daily oral tablet</i>	Preferred	
<i>cvs womens daily gummies oral tablet chewable</i>	Preferred	
<i>daily betic oral tablet</i>	Preferred	
<i>daily combo multi vitamins oral tablet</i>	Preferred	
<i>daily mens health formula oral tablet</i>	Preferred	
<i>daily multiple vitamins/min oral tablet</i>	Preferred	
<i>daily multivitamin oral capsule</i>	Preferred	
<i>daily vitamin plus oral capsule</i>	Preferred	
<i>daily womens health formula oral tablet</i>	Preferred	
<i>daily-vitamin maximum formula oral tablet</i>	Preferred	
<i>dayavite oral tablet</i>	Preferred	
DECUBI-VITE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>dekas bariatric oral tablet chewable</i>	Preferred	
DEKAS PLUS OCEAN ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
DEKAS PLUS ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
DEKAS PLUS ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
DERMACINRX MULTITAM ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
DERMACINRX RIBOTIN-E ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
DERMACINRX ZINTREXYL-C ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
DERMAVITE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
DEXATRAN ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>diabetes health formula oral tablet</i>	Preferred	
<i>dialyvite 800/ultra d oral tablet</i>	Preferred	
DIALYVITE SUPREME D ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
DRY EYE FORMULA ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
EMERGEN-C IMMUNE PLUS/VIT D ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
EMERGEN-C VITAMIN C ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>eq complete multivit adult 50+ oral tablet</i>	Preferred	
<i>eq complete multivitamin-adult oral tablet</i>	Preferred	
<i>eq multivitamins adult gummy oral tablet chewable</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>eq one daily mens 50+ oral tablet</i>	Preferred	
<i>eq one daily mens health oral tablet</i>	Preferred	
EQ ONE DAILY WOMENS 50+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>eq one daily womens health oral tablet</i>	Preferred	
<i>eq vision formula 50+ oral capsule</i>	Preferred	
<i>eql century mature adults 50+ oral tablet</i>	Preferred	
<i>eql century mature men 50+ oral tablet</i>	Preferred	
<i>eql century mature oral tablet</i>	Preferred	
<i>eql century mature women 50+ oral tablet</i>	Preferred	
<i>eql century mens oral tablet</i>	Preferred	
<i>eql century oral tablet</i>	Preferred	
<i>eql century womens oral tablet</i>	Preferred	
<i>eql one daily adult gummies oral tablet chewable</i>	Preferred	
<i>eql one daily mens 50+ advance oral tablet</i>	Preferred	
<i>eql one daily mens health oral tablet</i>	Preferred	
<i>eql one daily mens oral tablet</i>	Preferred	
<i>eql one daily womens 50+ adv oral tablet</i>	Preferred	
<i>eql vision formula oral tablet</i>	Preferred	
ESSENTIA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>essential balance oral tablet</i>	Preferred	
ESTROVEN MENOPAUSE SUPPLEMENT ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>eye health + lutein oral tablet</i>	Preferred	
<i>eye health oral capsule</i>	Preferred	
<i>eye multivitamin/sodium oral tablet</i>	Preferred	
EYE VITAMINS ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
EYE-VITES ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
FITNESS TABS FOR MEN AM/PM ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
FITNESS TABS FOR WOMEN AM/PM ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>folagent dha oral capsule</i>	Preferred	
<i>folamax oral tablet</i>	Preferred	
<i>folamed dha oral capsule</i>	Preferred	
FOLIFLEX ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
FOLITIN-Z ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
FOSFREE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>freedavite oral tablet</i>	Preferred	
<i>genadek step 1 oral capsule</i>	Preferred	
<i>genadek step 2 oral capsule</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>geri-freeda senior formula oral tablet</i>	Preferred	
<i>gerivite complete oral tablet</i>	Preferred	
<i>glucoten oral capsule</i>	Preferred	
<i>gnp century mature women's 50+ oral tablet</i>	Preferred	
<i>gnp hair/skin/nails oral tablet</i>	Preferred	
<i>gnp healthy eyes oral tablet</i>	Preferred	
<i>gnp healthy eyes supervision 2 oral capsule</i>	Preferred	
<i>gnp mega multi for men oral tablet</i>	Preferred	
<i>gnp mega multi for women oral tablet</i>	Preferred	
<i>gnp one daily mens health 50+ oral tablet</i>	Preferred	
<i>gnp one daily mens/lycopene oral tablet</i>	Preferred	
<i>gnp one daily womens 50+ oral tablet</i>	Preferred	
<i>gnp one daily womens oral tablet</i>	Preferred	
<i>gnp therapeutic-m oral tablet</i>	Preferred	
<i>hair skin & nails advanced oral tablet</i>	Preferred	
<i>hair skin and nails formula oral tablet</i>	Preferred	
<i>hair skin nails oral capsule</i>	Preferred	
<i>hair/skin/nails oral capsule</i>	Preferred	
<i>hair/skin/nails oral tablet</i>	Preferred	
<i>healthy eyes oral tablet</i>	Preferred	
<i>healthy eyes supervision 2 oral capsule</i>	Preferred	
<i>healthy eyes/lutein-zeaxanthin oral capsule</i>	Preferred	
<i>high pot multivitamin/beta-car oral tablet</i>	Preferred	
<i>high potency multivit/fa oral tablet</i>	Preferred	
<i>hi-kovite 2-part formula oral tablet</i>	Preferred	
<i>hi-potency multi-vitamin oral tablet</i>	Preferred	
<i>hm complete men oral tablet</i>	Preferred	
<i>hm complete women oral tablet</i>	Preferred	
<i>hm hair/skin/nails oral tablet</i>	Preferred	
<i>hm womens 50+ advanced daily oral tablet</i>	Preferred	
<i>hylazinc oral tablet</i>	Preferred	
ICAPS AREDS FORMULA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ICAPS LUTEIN & OMEGA-3 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
ICAPS MV ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ICAPS ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
IMMUNE ESSENTIALS DAILY ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>immune support oral tablet chewable</i>	Preferred	
<i>i-vite oral tablet</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>keyfolic oral tablet</i>	Preferred	
<i>kp adults 50+ daily formula oral tablet</i>	Preferred	
<i>kp adults daily formula oral tablet</i>	Preferred	
<i>kp mens 50+ daily formula oral tablet</i>	Preferred	
<i>kp mens daily formula oral tablet</i>	Preferred	
KP VISION FORMULA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
KP VISION FORMULA/LUTEIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>kp womens 50+ daily formula oral tablet</i>	Preferred	
<i>kp womens daily formula oral tablet</i>	Preferred	
K-PAX IMMUNE PROFESSIONAL ST ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>liver detox oral tablet</i>	Preferred	
<i>lutein-zeaxanthin oral tablet</i>	Preferred	
LYSIPLEX PLUS ORAL LIQUID (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multiple vitamins-minerals</i> (Lysiplex Plus Oral Tablet)	Preferred	
MACULAR HEALTH FORMULA ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
MACUVITE EYE CARE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
MACUVITE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
MACUVITE/LUTEIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>maximum daily green oral tablet</i>	Preferred	
<i>mega multi for women oral tablet</i>	Preferred	
MEGA MULTI MEN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>megavite fruits & veggies oral tablet</i>	Preferred	
<i>megavite golden years 55+ oral tablet</i>	Preferred	
<i>meijer advanced formula oral tablet</i>	Preferred	
<i>mens 50+ advanced oral capsule</i>	Preferred	
<i>mens 50+ multi vitamin/min oral tablet</i>	Preferred	
<i>mens 50+ multivitamin oral tablet</i>	Preferred	
<i>mens daily formula/lycopene oral capsule</i>	Preferred	
MENS LIFE PACK ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>mens multi vitamin & mineral oral tablet</i>	Preferred	
<i>mens multivitamin oral tablet</i>	Preferred	
<i>mens multivitamin oral tablet chewable</i>	Preferred	
MILLTRIUM ADVANCED FORMULA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
MILLTRIUM CARDIO ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
MILLTRIUM SENIOR ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
MOOD FOOD ES ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MOOD FOOD ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multi + omega-3 adult gummies oral tablet chewable</i>	Preferred	
<i>multi adult gummies oral tablet chewable</i>	Preferred	
MULTI COMPLETE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multi complete/iron oral tablet</i>	Preferred	
<i>multi for her 50+ oral capsule</i>	Preferred	
<i>multi for her 50+ oral tablet</i>	Preferred	
<i>multi for her oral capsule</i>	Preferred	
<i>multi for her oral tablet</i>	Preferred	
<i>multi for him 50+ oral tablet</i>	Preferred	
MULTI FOR HIM ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
MULTI FOR HIM ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multi vitamin/minerals oral tablet</i>	Preferred	
MULTI-LEAN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multiple vit/minerals/no iron oral tablet</i>	Preferred	
<i>multiple vitamins/womens oral tablet</i>	Preferred	
<i>multipro oral capsule</i>	Preferred	
<i>multivit/multimineral adult oral liquid</i>	Preferred	
<i>multivitamin & mineral oral liquid</i>	Preferred	
<i>multivitamin adult (minerals) oral tablet</i>	Preferred	
<i>multivitamin adults 50+ oral tablet</i>	Preferred	
<i>multivitamin adults oral tablet</i>	Preferred	
<i>multivitamin gummies adult oral tablet chewable</i>	Preferred	
<i>multivitamin gummies mens oral tablet chewable</i>	Preferred	
<i>multi-vitamin gummies oral tablet chewable</i>	Preferred	
<i>multivitamin gummies womens oral tablet chewable</i>	Preferred	
<i>multivitamin men 50+ oral tablet</i>	Preferred	
<i>multivitamin men oral tablet</i>	Preferred	
<i>multi-vitamin menopausal oral tablet</i>	Preferred	
<i>multi-vitamin monocaps oral tablet</i>	Preferred	
<i>multivitamin oral liquid</i>	Preferred	
<i>multivitamin women 50+ oral tablet</i>	Preferred	
<i>multivitamin women oral tablet</i>	Preferred	
<i>multivitamin womens 50+ adv oral tablet</i>	Preferred	
<i>multi-vitamin/minerals oral tablet</i>	Preferred	
<i>multivitamin/zinc stress oral tablet</i>	Preferred	
<i>multivitamin-minerals oral tablet</i>	Preferred	
<i>multi-vite oral liquid</i>	Preferred	
MVW COMPLETE FORMULATION D3000 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MVW COMPLETE FORMULATION D5000 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
MVW COMPLETE FORMULATION MINIS ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
MVW COMPLETE FORMULATION ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
MVW MODULATOR FORMULATION MINI ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
MVW MODULATOR FORMULATION ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>myamulti oral tablet</i>	Preferred	
<i>nat-rul theravite-m oral tablet</i>	Preferred	
<i>natrul-vites oral tablet</i>	Preferred	
<i>neovite oral tablet</i>	Preferred	
NICADAN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
NICAZEL FORTE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
NICAZEL ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>no iron mult vitamin-minerals oral tablet</i>	Preferred	
NUTRICAP ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multiple vitamins-minerals (Nutrifac Zx Oral Tablet)</i>	Preferred	
<i>ocular vitamins oral tablet</i>	Preferred	
<i>ocutabs oral tablet</i>	Preferred	
<i>ocutabs-lutein oral tablet</i>	Preferred	
OCUVEL ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE ADULT 50+ ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE ADULT FORMULA ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE EXTRA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE EYE + MULTI ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE EYE HEALTH FORMULA ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE EYE HEATLH GUMMIES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE-LUTEIN ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
OCUVITE-LUTEIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONCOVITE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE A DAY IMMUNITY DEFENSE ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ONE A DAY MENS VITACRAVES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ONE A DAY WOMEN 50 PLUS ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>one daily 50 plus oral tablet</i>	Preferred	
<i>one daily calcium/iron oral tablet</i>	Preferred	
<i>one daily complete for men oral tablet</i>	Preferred	
<i>one daily complete oral tablet</i>	Preferred	
<i>one daily for men 50+ advanced oral tablet</i>	Preferred	
<i>one daily for men/lycopene oral tablet</i>	Preferred	
<i>one daily for women 50+ adv oral tablet</i>	Preferred	
<i>one daily for women oral tablet</i>	Preferred	
<i>one daily healthy weight adv oral tablet</i>	Preferred	
<i>one daily healthy weight oral tablet</i>	Preferred	
<i>one daily maximum oral tablet</i>	Preferred	
<i>one daily men formula w/o iron oral tablet</i>	Preferred	
<i>one daily mens 50+ multivit oral tablet</i>	Preferred	
<i>one daily mens 50+/lycopene oral tablet</i>	Preferred	
<i>one daily mens health oral tablet</i>	Preferred	
<i>one daily mens oral tablet</i>	Preferred	
<i>one daily multivit/iron-free oral tablet</i>	Preferred	
<i>one daily multivitamin men oral tablet</i>	Preferred	
<i>one daily multivitamin women oral tablet</i>	Preferred	
<i>one daily womens 50 plus oral tablet</i>	Preferred	
<i>one daily womens 50+ oral tablet</i>	Preferred	
<i>one daily womens oral tablet</i>	Preferred	
<i>one daily/minerals oral tablet</i>	Preferred	
ONE-A-DAY ENERGY ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY FOR HER VITACRAVES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY FOR HIM VITACRAVES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY MENOPAUSE FORMULA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY MENS (MINERALS) ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY MENS 50+ ADVANTAGE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY MENS 50+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY MENS HEALTH FORMULA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY MENS PRO EDGE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
ONE-A-DAY MENS VITACRAVES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY PROACTIVE 65+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY TEEN ADVANTAGE/HER ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY TEEN ADVANTAGE/HIM ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY VITACRAVES ADULT ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY VITACRAVES IMMUNITY ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY VITACRAVES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY VITACRAVES SOUR ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WEIGHT SMART ADVANCE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WOMENS 50 PLUS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WOMENS 50+ ADVANTAGE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WOMENS 50+ ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WOMENS HEALTHY SKIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WOMENS MIND & BODY ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WOMENS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WOMENS PETITES ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ONE-A-DAY WOMENS VITACRAVES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>one-daily multi caps oral capsule</i>	Preferred	
<i>one-daily multi-vit/mineral oral tablet</i>	Preferred	
<i>onevite oral tablet</i>	Preferred	
<i>optic-vites oral tablet</i>	Preferred	
<i>optic-vites with lutein oral tablet</i>	Preferred	
OPTIFAST POST BARIATRIC ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>optimum airvites oral tablet chewable</i>	Preferred	
<i>optimum pms oral tablet</i>	Preferred	
OPTISOURCE POST BARIATRIC SURG ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
OPTIVITE P.M.T. ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
OPURITY BYPASS OPTIMIZED ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
OPURITY ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
OSTEOPRIME PLUS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
OSTEOPRIME ULTRA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>parvlex oral tablet</i>	Preferred	
PHYTOMULTI ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
PRESERVISION AREDS 2 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
PRESERVISION AREDS 2 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
PRESERVISION AREDS 2+MULTI VIT ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
PRESERVISION AREDS ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
PRESERVISION AREDS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
PRESERVISION/LUTEIN ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>prevent oral capsule</i>	Preferred	
PRO-CAL ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
PROCERV HP ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>profola oral tablet</i>	Preferred	
PRORENAL + D ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
PRORENAL + D W/ OMEGA-3 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
PROSIGHT ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
PROTECT CARDIO AF ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
PROTECT PLUS SO ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
PROTEGRA ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
PROVIT ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>px advanced formula multivits oral tablet</i>	Preferred	
<i>px complete senior multivits oral tablet</i>	Preferred	
<i>px mens multivitamins oral tablet</i>	Preferred	
<i>qc daily multivit/multimineral oral tablet</i>	Preferred	
<i>qc hair skin & nails oral tablet</i>	Preferred	
<i>qc mens daily multivitamin oral tablet</i>	Preferred	
<i>qc multi-vite 50 & over oral tablet</i>	Preferred	
<i>qc multi-vite oral tablet</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
QC OCUEALTH VISION SUPPORT 2 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>qc therin-m oral tablet</i>	Preferred	
<i>qc womens daily multivitamin oral tablet</i>	Preferred	
<i>quin b strong oral tablet</i>	Preferred	
<i>quintabs-m oral tablet</i>	Preferred	
<i>ra central-vite mens mature oral tablet</i>	Preferred	
RA CENTRAL-VITE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>ra central-vite womens mature oral tablet</i>	Preferred	
<i>ra one daily maximum oral tablet</i>	Preferred	
<i>ra one daily mens 50+ w/vit d3 oral tablet</i>	Preferred	
<i>ra one daily mens multi oral tablet</i>	Preferred	
<i>ra one daily mens/vit d-3 oral tablet</i>	Preferred	
<i>rayavit oral tablet</i>	Preferred	
REMEDIENT ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
RENAPLEX ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
RENAPLEX-D ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>senior tabs oral tablet</i>	Preferred	
<i>sentry oral tablet</i>	Preferred	
<i>sentry senior oral tablet</i>	Preferred	
<i>sentry senior/lutein oral tablet</i>	Preferred	
SIDEROL ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>sm antioxidant vitamins oral tablet</i>	Preferred	
<i>sm complete 50+ oral tablet</i>	Preferred	
<i>sm complete 50+ ultimate mens oral tablet</i>	Preferred	
<i>sm complete 50+ ultimate women oral tablet</i>	Preferred	
<i>sm complete advanced formula oral tablet</i>	Preferred	
<i>sm complete oral tablet</i>	Preferred	
<i>sm complete senior formula oral tablet</i>	Preferred	
<i>sm daily diet support oral tablet</i>	Preferred	
<i>sm hair/skin/nails oral tablet</i>	Preferred	
<i>sm one daily mens oral tablet</i>	Preferred	
<i>sm one daily womens oral tablet</i>	Preferred	
<i>sm opti-vitamins oral tablet</i>	Preferred	
<i>solo oral tablet</i>	Preferred	
SPECTRAVITE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>stress b complex/antioxid/zinc oral tablet</i>	Preferred	
<i>stress formula/zinc oral tablet</i>	Preferred	
STRESSTABS ADVANCED ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
STROVITE ONE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>super antioxidant oral capsule</i>	Preferred	
<i>super antioxidants protector oral capsule</i>	Preferred	
<i>super aytinal 50 plus oral tablet</i>	Preferred	
<i>super aytinal oral tablet</i>	Preferred	
<i>super multiple oral tablet</i>	Preferred	
<i>super thera vite m oral tablet</i>	Preferred	
<i>super vita-mins oral tablet</i>	Preferred	
<i>support oral liquid</i>	Preferred	
SUPPORT-500 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
SYSTANE ICAPS AREDS2 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
SYSTANE ICAPS AREDS2 ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
SYSTANE ICAPS AREDS2 ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
THERA M PLUS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>thera vital m oral tablet</i>	Preferred	
<i>thera vital-m oral tablet</i>	Preferred	
<i>therabasic-m oral tablet</i>	Preferred	
THERABETIC MULTI-VITAMIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERADEX M ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERADEX M/BETA CAROTENE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERAGRAN-M ADVANCED 50 PLUS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERAGRAN-M ADVANCED ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERAGRAN-M ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERAGRAN-M PREMIER 50 PLUS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERAGRAN-M PREMIER ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>thera-m oral tablet</i>	Preferred	
THERAMILL FORTE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
THERA-MILL M ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERANATAL LACTATION ONE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>therapeutic formula/hematinics oral tablet</i>	Preferred	
<i>therapeutic-m oral tablet</i>	Preferred	
<i>therapeutic-m/lutein oral tablet</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>thera-tabs m oral tablet</i>	Preferred	
THERATRUM COMPLETE 50 PLUS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THERATRUM COMPLETE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THEREMS-M ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
THRIVE FOR LIFE WOMENS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>tropical liquid nutrition oral liquid</i>	Preferred	
<i>t-vites oral tablet</i>	Preferred	
UDAMIN SP ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ULTRA BONEUP ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>ultra freeda oral tablet</i>	Preferred	
<i>ultra freeda/iron oral tablet</i>	Preferred	
<i>ultra multi formula/iron oral capsule</i>	Preferred	
ULTRACHOICE ADV FORMULA MATURE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
ULTRACHOICE ADVANCED FORMULA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>v-c forte oral capsule</i>	Preferred	
VEGETARIAN BONEUP ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VENEXA FE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VENEXA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VENTRIXYL FE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VENTRIXYL ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>multiple vitamins-minerals (Vic-Forte Oral Capsule)</i>	Preferred	
<i>vision formula 2 oral capsule</i>	Preferred	
<i>vision formula/lutein oral tablet</i>	Preferred	
<i>vision health oral capsule</i>	Preferred	
<i>vision plus oral capsule</i>	Preferred	
<i>vision vitamins oral tablet</i>	Preferred	
<i>visivites oral tablet</i>	Preferred	
<i>visivites/lutein oral tablet</i>	Preferred	
VISTA ADVANCED AREDS2 FORMULA ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
VISTA ADVANCED DRY EYE FORMULA ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>vita hair oral tablet</i>	Preferred	
<i>multiple vitamins-minerals (Vita S Forte Oral Tablet)</i>	Preferred	
<i>vitabasic complete oral tablet</i>	Preferred	
<i>vitabasic senior oral tablet</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>vitabex oral capsule</i>	Preferred	
<i>vitabex plus oral capsule</i>	Preferred	
<i>multiple vitamins-minerals (Vitacel Oral Tablet)</i>	Preferred	
<i>vitachew adult multi vitamin oral tablet chewable</i>	Preferred	
<i>vitamin d3 complete oral tablet</i>	Preferred	
<i>vita-min oral capsule</i>	Preferred	
<i>vitamins a-d-e/selenium oral tablet</i>	Preferred	
VITAROCA PLUS ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITASANA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITATRUM COMPLETE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>vitatrum oral tablet</i>	Preferred	
<i>vitatrum oral tablet chewable</i>	Preferred	
VITEYES CLASSIC ADVANCED ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
VITEYES CLASSIC MACULAR SUPPOR ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
VITEYES CLASSIC MULTIVITAMIN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITEYES CLASSIC+OMEGA-3 ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
VITEYES COMPLETE ORAL CAPSULE (<i>multiple vitamins-minerals</i>)	Preferred	
VITEYES OPTIC NERVE SUPPORT ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITRAMYN ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITRANOL FE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITRANOL ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITREXATE FE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITREXATE ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITREXYL + IRON ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
VITREXYL ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
<i>vitrum 50+ adult-multi oral tablet</i>	Preferred	
<i>vitrum 50+ senior multi oral tablet</i>	Preferred	
VITRUM SENIOR ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
WAL-BORN VITAMIN C ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
<i>wellfola oral tablet</i>	Preferred	
<i>womens 50+ advanced oral capsule</i>	Preferred	
<i>womens 50+ multi vitamin oral tablet</i>	Preferred	
<i>womens 50+ multi vitamin/min oral tablet</i>	Preferred	
<i>womens daily form/fa/ca/fe oral tablet</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
womens daily formula oral tablet	Preferred	
WOMENS LIFE PACK ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
womens multi gummies oral tablet chewable	Preferred	
womens multi oral capsule	Preferred	
womens multi vitamin & mineral oral tablet	Preferred	
womens multivitamin + collagen oral tablet chewable	Preferred	
womens multivitamin oral tablet	Preferred	
YELETS TEENAGE FORMULA ORAL TABLET (<i>multiple vitamins-minerals</i>)	Preferred	
YOUR LIFE MULTI ADULT GUMMIES ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
YUMVS MULTI ZERO ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
YUMVS ZERO DIABETIC MULTIVITAM ORAL TABLET CHEWABLE (<i>multiple vitamins-minerals</i>)	Preferred	
*MULTIVITAMINS**		
AMLADEX ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
anti-oxidant oral tablet	Preferred	
daily multiple vitamins oral tablet	Preferred	
daily value multivitamin oral tablet	Preferred	
daily vitamins oral tablet	Preferred	
daily vite oral tablet	Preferred	
daily vites oral tablet	Preferred	
daily-vitamin oral tablet	Preferred	
daily-vite multivitamin oral tablet	Preferred	
daily-vite oral tablet	Preferred	
ESTROFACTORS ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
GENICIN VITA-Q ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
gnp essential one daily oral tablet	Preferred	
healthy hair/skin/nails oral tablet	Preferred	
high potency multivitamin oral tablet	Preferred	
multi vitamin oral tablet	Preferred	
multi vitamin w/d-3 oral tablet	Preferred	
multiple vitamin-folic acid oral tablet	Preferred	
multiple vitamins essential oral tablet	Preferred	
multiple vitamins oral tablet	Preferred	
multivitamin adult oral tablet	Preferred	
multivitamin iron-free oral tablet	Preferred	
multivitamin oral tablet	Preferred	
multi-vitamin oral tablet	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
NEOMULTIVITE ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
<i>omnicap oral tablet</i>	Preferred	
<i>once daily oral tablet</i>	Preferred	
ONE DAILY ESSENTIAL ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
<i>one daily multivitamin adult oral tablet</i>	Preferred	
<i>one daily oral tablet</i>	Preferred	
ONE VITE DAILY MULTIVITAMIN ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
ONE-A-DAY ESSENTIAL ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
ONE-A-DAY MENS ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
<i>one-daily multi vitamins oral tablet</i>	Preferred	
<i>one-daily multi-vitamin oral tablet</i>	Preferred	
<i>qc essentials oral tablet</i>	Preferred	
<i>quintabs oral tablet</i>	Preferred	
<i>sm multiple vitamins essential oral tablet</i>	Preferred	
<i>stress formula oral tablet</i>	Preferred	
STRESSTABS ENERGY ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
TAB-A-VITE ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
TAB-A-VITE/BETA CAROTENE ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
THERA ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
<i>thera-mill oral tablet</i>	Preferred	
<i>thera-tabs oral tablet</i>	Preferred	
THEREMS ORAL TABLET (<i>multiple vitamin</i>)	Preferred	
<i>tm-daily vite oral tablet</i>	Preferred	
<i>vit e-vit c-beta carotene oral tablet 200-250-5000</i>	Preferred	
<i>vitalee oral tablet</i>	Preferred	
*NASAL AGENTS - MISC.**		
AFRIN SALINE NASAL MIST NASAL SOLUTION 0.65 % (<i>saline</i>)	Preferred	
<i>altamist spray nasal solution 0.65 %</i>	Preferred	
AYR NASAL MIST ALLERGY/SINUS NASAL SOLUTION 2.65 % (<i>saline</i>)	Preferred	
AYR NASAL SOLUTION 0.65 % (<i>saline</i>)	Preferred	
AYR SALINE NASAL DROPS NASAL SOLUTION 0.65 % (<i>saline</i>)	Preferred	
AYR SALINE NASAL NASAL GEL (<i>saline</i>)	Preferred	
AYR SALINE NASAL NO-DRIP NASAL GEL (<i>saline</i>)	Preferred	
BABY AYR SALINE NASAL SOLUTION 0.65 % (<i>saline</i>)	Preferred	
<i>cvs nasal mist nasal aerosol solution 0.9 %, 3 %</i>	Preferred	
<i>cvs saline nasal spray nasal solution 0.65 %</i>	Preferred	
<i>deep sea nasal spray nasal solution 0.65 %</i>	Preferred	
<i>eq saline nasal spray nasal solution 0.65 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>eql saline nasal spray nasal solution 0.65 %</i>	Preferred	
<i>gnp nasal moisturizing nasal solution 0.65 %</i>	Preferred	
<i>meijer saline nasal spray nasal solution 0.65 %</i>	Preferred	
NASAL MOIST NASAL SOLUTION 0.65 % (<i>saline</i>)	Preferred	
<i>nasal moisturizing spray nasal solution 0.65 %</i>	Preferred	
NASOGEL NASAL GEL (<i>saline</i>)	Preferred	
OCEAN FOR KIDS NASAL SOLUTION 0.65 % (<i>saline</i>)	Preferred	
<i>px saline nasal spray nasal solution 0.65 %</i>	Preferred	
<i>qc saline nasal relief nasal solution 0.65 %</i>	Preferred	
<i>qc saline nasal spray nasal solution 0.65 %</i>	Preferred	
<i>ra saline nasal spray nasal solution 0.65 %</i>	Preferred	
<i>ra sterile saline nasal mist nasal solution 0.9 %</i>	Preferred	
<i>saline mist spray nasal solution 0.65 %</i>	Preferred	
<i>saline nasal gel</i>	Preferred	
<i>saline nasal spray nasal solution 0.65 %</i>	Preferred	
<i>sb saline nose nasal solution 0.65 %</i>	Preferred	
SIMPLY SALINE NASAL AEROSOL SOLUTION 0.9 % (<i>saline</i>)	Preferred	
<i>sm nasal spray saline nasal solution 0.65 %</i>	Preferred	
*NASAL ANTIALLERGY**		
<i>cromolyn sodium nasal aerosol solution 5.2 mg/act</i>	Preferred	
NASALCROM NASAL AEROSOL SOLUTION 5.2 MG/ACT (<i>cromolyn sodium</i>)	Preferred	
*NASAL STEROIDS**		
FLONASE SENSIMIST NASAL SUSPENSION 27.5 MCG/SPRAY (<i>fluticasone furoate</i>)	Preferred	
*NATURAL PENICILLINS**		
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	Preferred	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	Preferred	
*NITRATES**		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
NITRO-BID TRANSDERMAL OINTMENT 2 % (<i>nitroglycerin</i>)	Preferred	QL (4 GM per 1 day); Max 90-day supply per fill
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg</i>	Preferred	QL (6 EA per 1 day)
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr</i>	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
*NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)**		
ADVIL JUNIOR STRENGTH ORAL TABLET 100 MG (<i>ibuprofen</i>)	Preferred	
<i>sm ibuprofen jr oral tablet 100 mg</i>	Preferred	
*NUTRITIONAL SUPPLEMENTS**		
ADVERA ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ARGINAID EXTRA ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>balanced nutritional drink oral liquid</i>	Preferred	
<i>balanced nutritional drink pls oral liquid</i>	Preferred	
<i>balanced nutritional shake pls oral liquid</i>	Preferred	
<i>beef/potatoes/spinach oral liquid</i>	Preferred	
BENECALORIE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST BREEZE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST GLUCOSE CONTROL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST GLUCOSE CTRL MAX PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST HIGH PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST KID ESSENTIALS 1.0 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST KID ESSENTIALS 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST KID ESSENTIALS 1.5/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST MAX 30G PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST PLUS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST VERY HIGH CALORIE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST VHC ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BOOST WOMEN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
BRIGHT BEGINNINGS PEDIATRIC ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
CARNATION BREAKFAST ESSENTIALS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
CFPREOP ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>chicken/carrots/brown rice oral liquid</i>	Preferred	
COMPLEAT ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
COMPLEAT ORGANIC BLENDS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
COMPLEAT PEDI PEPTIDE 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
COMPLEAT PEDI STANDARD 1.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
COMPLEAT PEDI STANDARD 1.4 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
COMPLEAT PEDIATRIC ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
COMPLEAT PEDIATRIC ORG BLENDS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
COMPLEAT PEPTIDE 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
COMPLEAT STANDARD 1.4 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>cvs nutrition liquid oral liquid</i>	Preferred	
<i>cvs nutrition plus chocolate oral liquid</i>	Preferred	
<i>cvs nutrition plus oral liquid</i>	Preferred	
<i>cvs nutrition plus vanilla oral liquid</i>	Preferred	
<i>cvs nutritional shake oral liquid</i>	Preferred	
DIABETISOURCE AC ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>eggs/apples/oats oral liquid</i>	Preferred	
ENLIVE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE ACTIVE HEART HEALTH ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE ACTIVE HIGH PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE ACTIVE LIGHT ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE ACTIVE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE BONE HEALTH REVIGOR ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE CLEAR ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE CLINICAL ST REVIGOR ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE COMPACT ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE COMPLETE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE COMPLETE SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE ENLIVE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE HEALTHY MOM ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE HIGH CALCIUM ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE HIGH PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE IMMUNE HEALTH ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE MAX PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ENSURE MUSCLE HEALTH REVIGOR ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE NUTRA SHAKE HI-CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE NUTRITION SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE ORIG THERAPEUTIC NUTRI ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE ORIGINAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE PLANT-BASED PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE PLUS HIGH PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE PLUS HN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE PLUS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE PRE-SURGERY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE SURGERY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE SURGICAL NUTRITION ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENSURE/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENTERADE IBS-D ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENTERADE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENU COMPLETE NUTRITION SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ENU NUTRITIONAL SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
EO28 SPLASH ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>eq nutritional shake oral liquid</i>	Preferred	
<i>eq nutritional shake plus oral liquid</i>	Preferred	
<i>eq weight loss shake oral liquid</i>	Preferred	
EQUATE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
EQUATE PLUS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
EXPEDITE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
FIBER FLOW ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
FIBERSOURCE HN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GELATEIN MCT ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA 1.0 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA 1.0 CAL/CARBSTEADY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA 1.0 CAL/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA 1.2 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
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Drug Name	Formulary Status	Requirements/Limits
GLUCERNA 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA 1.5 CAL/CARBSTEADY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA ADVANCE SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA CARBSTEADY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA HUNGER SMART SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA OS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA SELECT ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA SNACK SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLUCERNA WEIGHT LOSS SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLYTACTIN RESTORE 10 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLYTACTIN RESTORE LITE 10 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLYTACTIN RTD 10 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLYTACTIN RTD 15 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLYTACTIN RTD LITE 15 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
GLYTROL PREBIO1 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>goodsense nutrisure original oral liquid</i>	Preferred	
<i>goodsense nutrisure plus oral liquid</i>	Preferred	
<i>haelan 951 fermented soy oral liquid</i>	Preferred	
<i>haelan htpi fermented soy oral liquid</i>	Preferred	
HCU COOLER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
HCU LOPHLEX LQ ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
HEALTHY ACCENTS NUTRA FIT ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
HEALTHY ACCENTS NUTRA FIT PLUS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
HI-CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>high-protein nutritional shake oral liquid</i>	Preferred	
<i>hm nutrisure oral liquid</i>	Preferred	
<i>hm nutrisure plus oral liquid</i>	Preferred	
HOMACTIN AA PLUS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
IMPACT ADVANCED RECOVERY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
IMPACT ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
IMPACT PEPTIDE 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
INNOVACIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
INTROLITE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ISOSOURCE 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ISOSOURCE HN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
JEVITY 1 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
JEVITY 1 CAL/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
JEVITY 1.2 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
JEVITY 1.2 CAL/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
JEVITY 1.5 CAL/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
JUICE PLUS FIBRE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KATE FARMS GLUCOSE SUPPORT 1.2 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KATE FARMS PED PEPTIDE 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KATE FARMS PED STANDARD 1.2 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KATE FARMS PEPTIDE 1.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KATE FARMS PEPTIDE 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KATE FARMS RENAL SUPPORT 1.8 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KATE FARMS STANDARD 1.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KATE FARMS STANDARD 1.4 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>keto oral liquid</i>	Preferred	
KETOCAL 2.5:1 LQ MULTI FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KETOCAL 4:1 LQ MULTI FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KETOCAL 4:1 LQ MULTI-FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KETOCAL 4:1 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KETOVIE 4:1 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KETOVIE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KETOVIE PEPTIDE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KFLO ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
KIDS PROTEIN ORGANIC SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
KINDERSPROUT PLANT PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
LIQUID HOPE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
LIQUID HOPE PEPTIDE BERRY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
LIQUID HOPE PEPTIDE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
LOPHLEX LQ 20 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
LPS CRITICAL CARE SUGAR FREE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
LPS SUGAR FREE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
MMA/PA COOLER15 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
MSUD COOLER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
MSUD LOPHLEX LQ ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NEOCATE SPLASH ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NEPRO ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NEPRO/CARBSTEADY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NOURISH ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NOURISH PEPTIDE FORMULA ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NOVASOURCE RENAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTRA/SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN 1.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN 1.0/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN 2.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN JR FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN JR ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN JUNIOR 1.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN JUNIOR/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
NUTREN PULMONARY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>nutrifocus oral liquid</i>	Preferred	
NUTRIHEP 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>nutritional drink oral liquid</i>	Preferred	
<i>nutritional drink plus oral liquid</i>	Preferred	
<i>nutritional shake complete oral liquid</i>	Preferred	
<i>nutritional shake high protein oral liquid</i>	Preferred	
<i>nutritional shake oral liquid</i>	Preferred	
<i>nutritional shake plus oral liquid</i>	Preferred	
<i>nutritional shake plus protein oral liquid</i>	Preferred	
<i>nutritional supplement oral liquid</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>nutritional supplement plus oral liquid</i>	Preferred	
OPTIMENTAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ORGANIC NUTRITION SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
OSMOLITE 1 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
OSMOLITE 1.2 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
OSMOLITE 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
OSMOLITE HN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
OSMOLITE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
OXEPA 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
OXEPA ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE 1.0 CAL/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE 1.5 CAL/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE GROW & GAIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE GROW & GAIN ORGANIC ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE GROW & GAIN/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE HARVEST 1.0 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE NUTRIPALS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE PEDIATRIC ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE PEPTIDE 1.0 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE PEPTIDE 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE REDUCED CALORIE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE SHAKE/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE SIDEKICKS CLEAR ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE SIDEKICKS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE SIDEKICKS SHAKE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEDIASURE/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>pediatric drink oral liquid</i>	Preferred	
PEPTAMEN 1 CAL/PREBIO1 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN 1.5 CAL/PREBIO1 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN AF ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN INTENSE VHP ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN JUNIOR 1 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN JUNIOR 1 CAL/PREBIO1 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN JUNIOR 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN JUNIOR 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN JUNIOR FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN JUNIOR HP ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN JUNIOR PHGG 1.2 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN JUNIOR/PREBIO1 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PEPTAMEN/PREBIO1 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PERATIVE 1.3 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PERATIVE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PHENYLADE GMP READY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PHENYLADE RTD PKU 10 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PIVOT 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PKU AIR20 GOLD ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PKU AIR20 GREEN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PKU AIR20 YELLOW ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PKU COOLER 10 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PKU COOLER 15 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PKU COOLER 20 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PKU LOPHLEX LQ 20 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PKU SPHERE 20 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROMOD ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROMOTE 1.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
PROMOTE 1.0 WITH FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROMOTE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROMOTE/FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROSOURCE NO CARB ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROSOURCE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROSOURCE PLUS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROSOURCE TF ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROSOURCE ZAC ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PROSURE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PULMOCARE 1.5 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
PULMOCARE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>px vanilla plus oral liquid</i>	Preferred	
<i>quinoa/kale/hemp oral liquid</i>	Preferred	
RE/NEPH LP/HC ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
RE/NEPH ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
RE/NEPH REDUCED SUGAR ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
REASON ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>regular nutritional shake oral liquid</i>	Preferred	
RENALCAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
RENASTEP ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
REPLETE FIBER 1 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
REPLETE FIBER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
REPLETE ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
RESOURCE 2.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>salmon/oats/squash oral liquid</i>	Preferred	
<i>sb complete nutrition oral liquid</i>	Preferred	
<i>sb complete nutrition plus oral liquid</i>	Preferred	
SM NUTRI-DRINK + ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
SM NUTRI-DRINK ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
SUPLENA 1.8/CARBSTEADY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
SUPLENA ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
SUPLENA/CARB STEADY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
THICK-IT THICKENED CRANBERRY ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
<i>thrivacin 30 oral liquid</i>	Preferred	
<i>thrivacin detox oral liquid</i>	Preferred	
<i>turkey/sweet potatoes/peaches oral liquid</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
TWOCAL HN 2.0 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
TWOCAL HN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
TYLACTIN RESTORE 10 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
TYLACTIN RTD 15 ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
TYR COOLER ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
TYR LOPHLEX LQ ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
ULTRIANT 1.5 SAFE-T FEED ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VILACTIN AA PLUS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VITAL 1.0 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VITAL 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VITAL AF 1.2 CAL ADV FORMULA ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VITAL AF 1.2 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VITAL HIGH PROTEIN ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VITAL HP 1.0 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VITAL JR ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VITAL PEPTIDE 1.5 CAL ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VIVONEX PEDIATRIC RTF ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
VIVONEX RTF ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
XTRACAL PLUS ORAL LIQUID (<i>nutritional supplements</i>)	Preferred	
*OIL SOLUBLE VITAMINS**		
<i>a-10000 oral capsule 3 mg (10000 ut)</i>	Preferred	
<i>aqueous vitamin d oral liquid 10 mcg/ml</i>	Preferred	
<i>aqueous vitamin e oral solution 15 mg/0.67ml</i>	Preferred	
BPROTECTED PEDIA D-VITE ORAL LIQUID 10 MCG/ML (<i>cholecalciferol</i>)	Preferred	
CALCIDOL ORAL SOLUTION 200 MCG/ML (<i>ergocalciferol</i>)	Preferred	
<i>cvs d3 oral capsule 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>cvs e oral capsule 90 mg (200 unit)</i>	Preferred	
<i>cvs vitamin d3 oral capsule 250 mcg (10000 ut)</i>	Preferred	
<i>cvs vitamin e oral capsule 180 mg (400 unit), 450 mg (1000 ut)</i>	Preferred	
<i>d 1000 oral capsule 25 mcg (1000 ut)</i>	Preferred	
<i>d 10000 oral capsule 250 mcg (10000 ut)</i>	Preferred	
<i>d 5000 oral capsule 125 mcg (5000 ut)</i>	Preferred	
<i>d-1000 extra strength oral tablet 25 mcg (1000 ut)</i>	Preferred	
<i>d-1000 oral tablet 25 mcg (1000 ut)</i>	Preferred	
<i>d2000 ultra strength oral capsule 50 mcg (2000 ut)</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>d3 2000 oral capsule 50 mcg (2000 ut)</i>	Preferred	
<i>d3 5000 oral capsule 125 mcg (5000 ut)</i>	Preferred	
<i>d3 high potency oral capsule 125 mcg (5000 ut), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>d3 high potency oral tablet 10 mcg (400 unit)</i>	Preferred	
<i>d3 kids oral tablet chewable 10 mcg (400 unit)</i>	Preferred	
<i>d3 maximum strength oral capsule 125 mcg (5000 ut)</i>	Preferred	
<i>d3 oral tablet 50 mcg (2000 ut)</i>	Preferred	
<i>d3 oral tablet chewable 10 mcg (400 unit)</i>	Preferred	
<i>d3 super strength oral capsule 50 mcg (2000 ut)</i>	Preferred	
<i>d3-1000 oral capsule 25 mcg (1000 ut)</i>	Preferred	
<i>d3-1000 oral tablet 25 mcg (1000 ut)</i>	Preferred	
<i>d-3-5 oral capsule 125 mcg (5000 ut)</i>	Preferred	
D3-50 ORAL CAPSULE 1.25 MG (50000 UT) (cholecalciferol)	Preferred	
<i>d-400 oral tablet 10 mcg (400 unit)</i>	Preferred	
<i>d-5000 oral tablet 125 mcg (5000 ut)</i>	Preferred	
DECARA ORAL CAPSULE 1.25 MG (50000 UT) (cholecalciferol)	Preferred	
<i>delta d3 oral tablet 10 mcg (400 unit)</i>	Preferred	
DIALYVITE VITAMIN D 5000 ORAL CAPSULE 125 MCG (5000 UT) (cholecalciferol)	Preferred	
DIALYVITE VITAMIN D3 MAX ORAL TABLET 1.25 MG (50000 UT) (cholecalciferol)	Preferred	
D-VI-SOL ORAL LIQUID 10 MCG/ML (cholecalciferol)	Preferred	
<i>d-vite pediatric oral liquid 10 mcg/ml</i>	Preferred	
<i>e 1000 oral capsule 450 mg (1000 ut), 670 mg (1000 ut)</i>	Preferred	
<i>e-1000 oral capsule 1000 unit, 450 mg (1000 ut)</i>	Preferred	
<i>e-200 oral capsule 200 unit, 90 mg (200 unit)</i>	Preferred	
<i>e200 oral capsule 90 mg (200 unit)</i>	Preferred	
<i>e400 oral capsule 180 mg (400 unit), 268 mg (400 unit)</i>	Preferred	
<i>e-400 oral capsule 180 mg (400 unit), 268 mg (400 unit), 400 unit</i>	Preferred	
<i>e-400-clear oral capsule 268 mg (400 unit)</i>	Preferred	
<i>eql vitamin d3 oral capsule 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>eql vitamin e oral capsule 400 unit</i>	Preferred	
<i>ergocalciferol oral capsule 1.25 mg (50000 ut)</i>	Preferred	Max 90-day supply per fill
<i>ergocalciferol oral solution 200 mcg/ml</i>	Preferred	
<i>finest nutrition vitamin d3 oral capsule 25 mcg (1000 ut)</i>	Preferred	
<i>gnp d 1000 oral capsule 25 mcg (1000 ut)</i>	Preferred	
<i>gnp vitamin a oral capsule 3 mg (10000 ut)</i>	Preferred	
<i>gnp vitamin d maximum strength oral tablet 50 mcg (2000 ut)</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp vitamin d oral tablet 25 mcg (1000 ut)</i>	Preferred	
<i>gnp vitamin d oral tablet chewable 10 mcg (400 unit)</i>	Preferred	
<i>gnp vitamin d super strength oral tablet 125 mcg (5000 ut)</i>	Preferred	
<i>gnp vitamin d3 extra strength oral tablet 25 mcg (1000 ut)</i>	Preferred	
<i>gnp vitamin d3 oral tablet 10 mcg (400 unit)</i>	Preferred	
<i>gnp vitamin e oral capsule 180 mg (400 unit), 400 unit, 450 mg (1000 ut), 90 mg (200 unit)</i>	Preferred	
HEALTHY KIDS VITAMIN D3 ORAL TABLET CHEWABLE 10 MCG (400 UNIT) (<i>cholecalciferol</i>)	Preferred	
<i>high potency e oral capsule 450 mg (1000 ut)</i>	Preferred	
<i>hm e vitamin oral capsule 180 mg (400 unit)</i>	Preferred	
<i>hm vitamin d3 oral tablet 25 mcg (1000 ut)</i>	Preferred	
IS-D 10,000 ORAL CAPSULE 250 MCG (10000 UT) (<i>cholecalciferol</i>)	Preferred	
<i>k 100 oral tablet 100 mcg</i>	Preferred	
<i>kls d3 oral capsule 50 mcg (2000 ut)</i>	Preferred	
<i>kp vitamin d oral capsule 25 mcg (1000 ut)</i>	Preferred	
<i>kp vitamin d oral tablet chewable 10 mcg (400 unit)</i>	Preferred	
<i>kp vitamin d3 oral capsule 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>kp vitamin e oral capsule 45 mg (100 unit)</i>	Preferred	
<i>nat-rul vitamin d oral tablet 125 mcg (5000 ut), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>natural vitamin a oral capsule 3 mg (10000 ut)</i>	Preferred	
<i>natural vitamin d-3 oral tablet 125 mcg (5000 ut)</i>	Preferred	
<i>natural vitamin e oral capsule 100 unit, 400 unit, 670 mg (1000 ut)</i>	Preferred	
OPTIMAL D3 ORAL CAPSULE 1.25 MG (50000 UT) (<i>cholecalciferol</i>)	Preferred	
<i>pharmacist choice d-vitamin oral liquid 400 unit/ml</i>	Preferred	
<i>phytonadione oral tablet 5 mg</i>	Preferred	PA
PRONUTRIENTS VITAMIN D3 ORAL CAPSULE 25 MCG (1000 UT) (<i>cholecalciferol</i>)	Preferred	
<i>px vitamin e oral capsule 400 unit</i>	Preferred	
<i>qc vitamin d3 oral capsule 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>qc vitamin d3 oral tablet 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>qc vitamin e oral capsule 180 mg (400 unit)</i>	Preferred	
<i>ra natural vitamin e oral capsule 268 mg (400 unit)</i>	Preferred	
<i>ra vitamin a oral capsule 3 mg (10000 ut)</i>	Preferred	
<i>ra vitamin d-3 oral capsule 125 mcg (5000 ut), 50 mcg (2000 ut)</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ra vitamin d-3 oral tablet 25 mcg (1000 ut)</i>	Preferred	
<i>ra vitamin e natural oral capsule 670 mg (1000 ut)</i>	Preferred	
<i>ra vitamin e oral capsule 134 mg (200 unit), 268 mg (400 unit)</i>	Preferred	
RADIANCE PLATINUM VITAMIN D3 ORAL TABLET 125 MCG (5000 UT) (<i>cholecalciferol</i>)	Preferred	
<i>sm vitamin d oral tablet 10 mcg (400 unit)</i>	Preferred	
<i>sm vitamin d3 oral capsule 125 mcg (5000 ut), 50 mcg, 50 mcg (2000 ut)</i>	Preferred	
<i>sm vitamin d3 oral tablet 125 mcg (5000 ut), 25 mcg (1000 ut)</i>	Preferred	
<i>sm vitamin e oral capsule 180 mg (400 unit), 450 mg (1000 ut), 90 mg (200 unit)</i>	Preferred	
SOLUVITA E ORAL SOLUTION 15.8 MG/0.7ML (<i>vitamin e</i>)	Preferred	
SUPERIORSOURCE K1 ORAL TABLET DISPERSIBLE 500 MCG (<i>phytonadione</i>)	Preferred	
THERA-D 2000 ORAL TABLET 50 MCG (2000 UT) (<i>cholecalciferol</i>)	Preferred	
THERA-D RAPID REPLETION ORAL TABLET 50 MCG (2000 UT) (<i>cholecalciferol</i>)	Preferred	
<i>vitamin a oral capsule 3 mg (10000 ut)</i>	Preferred	
<i>vitamin a oral tablet 3 mg (10000 ut)</i>	Preferred	
<i>vitamin a palmitate oral tablet 3 mg (10000 ut), 4.5 mg (15000 ut)</i>	Preferred	
<i>vitamin d (cholecalciferol) oral capsule 10 mcg (400 unit), 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d (cholecalciferol) oral tablet 10 mcg (400 unit), 25 mcg (1000 ut)</i>	Preferred	
<i>vitamin d (cholecalciferol) oral tablet chewable 10 mcg (400 unit)</i>	Preferred	
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit</i>	Preferred	Max 90-day supply per fill
<i>vitamin d (ergocalciferol) oral capsule 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d high potency oral capsule 25 mcg (1000 ut)</i>	Preferred	
<i>vitamin d infant oral liquid 10 mcg/ml</i>	Preferred	
<i>vitamin d oral capsule 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d oral liquid 10 mcg/ml</i>	Preferred	
<i>vitamin d oral tablet 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
VITAMIN D-1000 MAX ST ORAL TABLET 25 MCG (1000 UT) (<i>cholecalciferol</i>)	Preferred	
<i>vitamin d2 oral tablet 10 mcg (400 unit), 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d3 maximum strength oral capsule 125 mcg (5000 ut)</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>vitamin d3 oral capsule 1.25 mg (50000 ut), 10 mcg (400 unit), 1000 unit, 125 mcg (5000 ut), 25 mcg (1000 ut), 250 mcg (10000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d-3 oral capsule 25 mcg (1000 ut)</i>	Preferred	
<i>vitamin d3 oral liquid 10 mcg/ml, 125 mcg/ml</i>	Preferred	
<i>vitamin d3 oral tablet 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg, 25 mcg (1000 ut), 50 mcg (2000 ut)</i>	Preferred	
<i>vitamin d-3 oral tablet 125 mcg (5000 ut)</i>	Preferred	
<i>vitamin d3 oral tablet chewable 10 mcg (400 unit)</i>	Preferred	
<i>vitamin d3 ultra potency oral tablet 1250 mcg</i>	Preferred	
<i>vitamin e blend oral capsule 400 unit</i>	Preferred	
<i>vitamin e high potency oral capsule 180 mg (400 unit), 90 mg</i>	Preferred	
<i>vitamin e oral capsule 100 unit, 1000 unit, 134 mg (200 unit), 180 mg (400 unit), 200 unit, 268 mg (400 unit), 400 unit, 45 mg (100 unit), 450 mg (1000 ut), 670 mg (1000 ut), 90 mg (200 unit)</i>	Preferred	
<i>vitamin e oral solution 15 mg/0.67ml</i>	Preferred	
<i>vitamin e oral tablet 100 unit, 67 mg (100 unit)</i>	Preferred	
<i>vitamin e water soluble oral capsule 180 mg (400 unit), 450 mg (1000 ut)</i>	Preferred	
<i>vitamin e/d-alpha natural oral capsule 134 mg (200 unit), 268 mg (400 unit)</i>	Preferred	
<i>vitamin e/d-alpha oral capsule 134 mg (200 unit)</i>	Preferred	
<i>vitamin k (phytonadione) oral tablet 100 mcg</i>	Preferred	
<i>vitamin k2 oral tablet 40 mcg</i>	Preferred	
<i>WEEKLY-D ORAL CAPSULE 1.25 MG (50000 UT) (cholecalciferol)</i>	Preferred	
<i>xcellent a 3000 oral capsule 3000 mcg</i>	Preferred	
*OPHTHALMIC DECONGESTANTS**		
<i>allergy eye ophthalmic solution 0.025-0.3 %</i>	Preferred	
<i>cvs astringent eye drops ophthalmic solution 0.05-0.25 %</i>	Preferred	
<i>cvs eye allergy relief ophthalmic solution 0.027-0.315 %</i>	Preferred	
<i>cvs eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>eq eye allergy relief ophthalmic solution 0.027-0.315 %</i>	Preferred	
<i>eq eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>eql eye drops ac ophthalmic solution 0.05-0.25 %</i>	Preferred	
<i>eql eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>eye allergy relief ophthalmic solution 0.025-0.3 %, 0.027-0.315 %</i>	Preferred	
<i>eye drops ar ophthalmic solution 0.05-0.25 %</i>	Preferred	
<i>eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>gnp eye drops ophthalmic solution 0.05 %, 0.05-0.25 %</i>	Preferred	
<i>goodsense eye drops ophthalmic solution 0.05 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>goodsense relief eye drops ophthalmic solution 0.05-0.25 %</i>	Preferred	
<i>hm eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>px sterile eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>qc eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>qc eye irritation relief drops ophthalmic solution 0.05-0.25 %</i>	Preferred	
<i>ra eye allergy relief ophthalmic solution 0.027-0.315 %</i>	Preferred	
<i>redness reliever eye drops ophthalmic solution 0.05 %</i>	Preferred	
<i>relief drops ophthalmic solution 0.05-0.25 %</i>	Preferred	
<i>relief eye drops ophthalmic solution 0.05-0.25 %</i>	Preferred	
<i>sm eye drops ophthalmic solution 0.05 %</i>	Preferred	
VISINE OPHTHALMIC SOLUTION 0.025-0.3 % (<i>naphazoline-pheniramine</i>)	Preferred	
VISINE RED EYE COMFORT OPHTHALMIC SOLUTION 0.05 % (<i>tetrahydrozoline hcl</i>)	Preferred	
VISINE-AC OPHTHALMIC SOLUTION 0.05-0.25 % (<i>tetrahydrozoline-zn sulfate</i>)	Preferred	
*OPHTHALMIC LOCAL ANESTHETICS**		
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	Preferred	
*OPHTHALMICS - MISC.**		
ALTACHLORE OPHTHALMIC OINTMENT 5 % (<i>sodium chloride hypertonic</i>)	Preferred	
ALTACHLORE OPHTHALMIC SOLUTION 5 % (<i>sodium chloride hypertonic</i>)	Preferred	
COLLYRIUM EYE WASH OPHTHALMIC SOLUTION (<i>ophthalmic irrigation solution</i>)	Preferred	
<i>collyrium for fresh eyes ophthalmic solution 0.01 %</i>	Preferred	
<i>cvs eye wash ophthalmic solution 99.05 %</i>	Preferred	
<i>cvs sod chloride hypertonicity ophthalmic ointment 5 %</i>	Preferred	
<i>cvs sodium chloride ophthalmic ointment 5 %</i>	Preferred	
<i>cvs sodium chloride ophthalmic solution 5 %</i>	Preferred	
EYE STREAM OPHTHALMIC SOLUTION (<i>ophth irr soln-extraocular</i>)	Preferred	
<i>eye wash ophthalmic solution</i>	Preferred	
<i>mediwash eye irrigant ophthalmic solution</i>	Preferred	
MURO 128 OPHTHALMIC SOLUTION 2 % (<i>sodium chloride hypertonic</i>)	Preferred	
<i>qc eye wash ophthalmic solution 99.05 %</i>	Preferred	
<i>ra sterile eye wash ophthalmic solution</i>	Preferred	
<i>sm eye wash ophthalmic solution 0.002 %</i>	Preferred	
<i>sodium chloride (hypertonic) ophthalmic ointment 5 %</i>	Preferred	
<i>sodium chloride (hypertonic) ophthalmic solution 5 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
*OTIC AGENTS - MISCELLANEOUS**		
<i>acetic acid otic solution 2 %</i>	Preferred	
CLEARCANAL EARWAX SOFTENER OTIC SOLUTION 6.5 % (<i>carbamide peroxide</i>)	Preferred	
CLINERE EARWAX REMOVAL KIT OTIC SOLUTION 6.5 % (<i>carbamide peroxide</i>)	Preferred	
<i>cvs ear drops otic solution 6.5 %</i>	Preferred	
<i>cvs ear wax removal system otic solution 6.5 %</i>	Preferred	
<i>cvs earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>ear drops otic solution 6.5 %</i>	Preferred	
<i>ear wax removal drops otic solution 6.5 %</i>	Preferred	
<i>ear wax removal kit otic solution 6.5 %</i>	Preferred	
<i>ear wax removal system otic solution 6.5 %</i>	Preferred	
<i>earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>earwax removal otic solution 6.5 %</i>	Preferred	
<i>eq ear wax removal aid otic solution 6.5 %</i>	Preferred	
<i>eq earwax removal aid otic solution 6.5 %</i>	Preferred	
<i>gnp earwax removal drops otic solution 6.5 %</i>	Preferred	
<i>gnp earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>goodsense ear wax kit otic solution 6.5 %</i>	Preferred	
<i>goodsense ear wax removal otic solution 6.5 %</i>	Preferred	
<i>hm earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>hm earwax removal otic solution 6.5 %</i>	Preferred	
MURINE EAR OTIC SOLUTION 6.5 % (<i>carbamide peroxide</i>)	Preferred	
MURINE EAR WAX REMOVAL SYSTEM OTIC SOLUTION 6.5 % (<i>carbamide peroxide</i>)	Preferred	
<i>qc ear wax removal otic solution 6.5 %</i>	Preferred	
<i>qc earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>qc earwax removal otic solution 6.5 %</i>	Preferred	
<i>ra ear drops otic solution 6.5 %</i>	Preferred	
<i>ra earwax removal kit otic solution 6.5 %</i>	Preferred	
<i>sm ear drops otic solution 6.5 %</i>	Preferred	
*OTIC STEROIDS**		
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	Preferred	
*OXAZOLIDINONES**		
<i>linezolid oral tablet 600 mg</i>	Preferred	QL (2 EA per 1 day)
*OXYTOCICS**		
<i>methylergonovine maleate (Methergine Oral Tablet 0.2 Mg)</i>	Preferred	QL (6 EA per 1 day)
<i>methylergonovine maleate oral tablet 0.2 mg</i>	Preferred	QL (6 EA per 1 day)
*PARENTERAL THERAPY SUPPLIES**		
<i>1st tier unifine pentips 33g x 4 mm</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>1st tier unifine pentips plus 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
ABOUTTIME PEN NEEDLE 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
ASSURE ID SAFETY PEN NEEDLES 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
<i>aum mini insulin pen needle 32g x 5 mm , 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
<i>aum pen needle 32g x 5 mm , 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
BD ALLERGY SYRINGE 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
BD AUTOSHIELD DUO 30G X 5 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
BD BLUNT FILL NEEDLE 18G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD BLUNT FILTER NEEDLE 18G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD DISP NEEDLE 23G X 1" , 25G X 1" (<i>needle (disp)</i>)	Preferred	
BD DISP NEEDLES 18G X 1-1/2" , 20G X 1" , 22G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD DISP NEEDLES 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (<i>needle (disp)</i>)	Preferred	Max 90-day supply per fill
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (<i>needle (disp)</i>)	Preferred	Max 90-day supply per fill
BD ECLIPSE NEEDLE 23G X 1" , 25G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD ECLIPSE NEEDLE 25G X 5/8" (<i>needle (disp)</i>)	Preferred	Max 90-day supply per fill
BD ECLIPSE SHIELDED NEEDLE 18G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD ECLIPSE SYRINGE 21G X 1" 3 ML, 25G X 1" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD ECLIPSE SYRINGE/NEEDLE 22G X 1" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD FILTER NEEDLE/5 MICRON (<i>needles & syringes</i>)	Preferred	
BD HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
BD INSULIN SYRINGE U-100 1 ML (<i>insulin syringes (disposable)</i>)	Preferred	Max 90-day supply per fill
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (<i>insulin syringe/needle u-500</i>)	Preferred	Max 90-day supply per fill
BD INTEGRA NEEDLE 23G X 1" (<i>needle (disp)</i>)	Preferred	
BD INTEGRA SYRINGE 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
BD LUER-LOCK SYRINGE 18G X 1-1/2" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	

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BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML, 20G X 1" 1 ML, 20G X 1" 10 ML, 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1" 5 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (syringe/needle (disp))	Preferred	
BD NOKOR ADMIX NEEDLE 18G X 1-1/2" (needle (disp))	Preferred	
BD PHLEBOTOMY SHARPS COLLECTOR (sharps container)	Preferred	QL (1 EA per 1 day)
BD PLASTIPAK SYRINGE 21G X 1" 3 ML (syringe/needle (disp))	Preferred	
BD PRECISIONGLIDE NEEDLE 23G X 1-1/2" , 27G X 1-1/2" (needle (disp))	Preferred	
BD SAFETYGLIDE ALLERGY SYRINGE 27G X 1/2" 1 ML (tuberculin-allergy syringes)	Preferred	
BD SAFETYGLIDE NEEDLE 18G X 1-1/2" , 25G X 1" (needle (disp))	Preferred	
BD SAFETYGLIDE NEEDLE 21G X 1-1/2" 3 ML (syringe/needle (disp))	Preferred	
BD SAFETYGLIDE NEEDLE 25G X 5/8" (needle (disp))	Preferred	Max 90-day supply per fill
BD SAFETYGLIDE SHIELDED NEEDLE 22G X 1-1/2" , 23G X 1" (needle (disp))	Preferred	
BD SAFETYGLIDE SYRINGE/NEEDLE 25G X 1" 3 ML (syringe/needle (disp))	Preferred	
BD SHARPS COLLECTOR (sharps container)	Preferred	QL (1 EA per 1 day)
<i>bd sharps container home</i>	Preferred	QL (1 EA per 1 day)
BD SHARPS DISPOSAL BY MAIL (sharps container)	Preferred	QL (1 EA per 1 day)
BD SYRINGE LUER-LOK 1 ML (syringe (disposable))	Preferred	
BD SYRINGE SLIP TIP 1 ML (syringe (disposable))	Preferred	
BD SYRINGE SLIP TIP 25G X 5/8" 1 ML (tuberculin-allergy syringes)	Preferred	
BD SYRINGE/NEEDLE 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 5/8" 3 ML (syringe/needle (disp))	Preferred	
BD TB SYRINGE 27G X 1/2" 1 ML (tuberculin-allergy syringes)	Preferred	
CAREFINE PEN NEEDLES 30G X 8 MM , 32G X 5 MM (insulin pen needle)	Preferred	Max 90-day supply per fill
<i>careone unifine pentips plus 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
<i>carepoint poly hub needle 18g x 1" , 18g x 1-1/2" , 20g x 1" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"</i>	Preferred	
<i>carepoint poly hub needle 25g x 5/8" , 27g x 1/2" , 30g x 1/2"</i>	Preferred	Max 90-day supply per fill
<i>carepoint safety 1st needle 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"</i>	Preferred	
<i>carepoint safety 1st needle 25g x 5/8"</i>	Preferred	Max 90-day supply per fill
CAREPOINT SAFETY1ST SYR/NEEDLE 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (syringe/needle (disp))	Preferred	
<i>carepoint syringe luer lock 1 ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
CAREPOINT SYRINGE LUER LOCK 20G X 1" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
<i>carepoint syringe luer slip 1 ml</i>	Preferred	
<i>carepoint tubercln syr/luer sl 25g x 5/8" 1 ml</i>	Preferred	
CARETOUCH HYPODERMIC NEEDLE 18G X 1-1/2" , 20G X 1" , 22G X 1" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
CARETOUCH HYPODERMIC NEEDLE 25G X 5/8" (<i>needle (disp)</i>)	Preferred	Max 90-day supply per fill
CARETOUCH LUER LOCK 1 ML (<i>syringe (disposable)</i>)	Preferred	
CARETOUCH LUER LOCK 23G X 1" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
CARETOUCH LUER LOCK SYR/NEEDLE 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
CARETOUCH LUER SLIP 1 ML (<i>syringe (disposable)</i>)	Preferred	
CARETOUCH PEN NEEDLES 32G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
CLEVER CHOICE COMFORT EZ 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
COMFORT EZ PEN NEEDLES 32G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
COMPLETE NEEDLE COLLECTION SYS (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
<i>cvs needle collection/disposal</i>	Preferred	QL (1 EA per 1 day)
DROPLET PEN NEEDLES 30G X 8 MM , 32G X 5 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
<i>easy comfort pen needles 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
EASY GLIDE LUER LOCK SYRINGE 1 ML (<i>syringe (disposable)</i>)	Preferred	
<i>easy glide pen needles 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
<i>easy glide slip lock syringe 1 ml</i>	Preferred	
EASY TOUCH ALLERGY SYRINGE 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
EASY TOUCH FLIPLOCK NEEDLES 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
EASY TOUCH FLIPLOCK NEEDLES 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (<i>needle (disp)</i>)	Preferred	Max 90-day supply per fill
EASY TOUCH FLIPLOCK SAFETY SYR 18G X 1-1/2" 3 ML, 20G X 1" 10 ML, 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
EASY TOUCH HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (needle (disp))	Preferred	
EASY TOUCH HYPODERMIC NEEDLE 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (needle (disp))	Preferred	Max 90-day supply per fill
EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML (insulin syringe-needle u-100)	Preferred	Max 90-day supply per fill
EASY TOUCH PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 32G X 5 MM (insulin pen needle)	Preferred	Max 90-day supply per fill
EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM , 30G X 8 MM (insulin pen needle)	Preferred	Max 90-day supply per fill
EASY TOUCH SAFETY SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (syringe/needle (disp))	Preferred	
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (syringe/needle (disp))	Preferred	
EASY TOUCH SYRINGE BARREL 10ML (needles & syringes)	Preferred	
EASY TOUCH SYRINGE BARREL 1ML (needles & syringes)	Preferred	
EASY TOUCH SYRINGE BARREL 3ML (needles & syringes)	Preferred	
EASY TOUCH SYRINGE BARREL 5ML (needles & syringes)	Preferred	
EASY TOUCH TB FLIPLOCK SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (tuberculin-allergy syringes)	Preferred	
EASY TOUCH TB SHEATHLOCK SYR 25G X 5/8" 1 ML, 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (tuberculin-allergy syringes)	Preferred	
EASYPOINT NEEDLE 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" , 25G X 1-1/2" (needle (disp))	Preferred	
EASYPOINT NEEDLE 25G X 5/8" (needle (disp))	Preferred	Max 90-day supply per fill
EASYPOINT NEEDLE/SYRINGE 18G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (syringe/needle (disp))	Preferred	
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM (insulin pen needle)	Preferred	Max 90-day supply per fill
H-E-B INCONTROL UNIFINE PENTIP 33G X 4 MM (insulin pen needle)	Preferred	Max 90-day supply per fill
hypodermic needle 18g x 1" , 18g x 1-1/2" , 20g x 1" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1-1/2" , 27g x 1-1/2"	Preferred	
hypodermic needle 25g x 5/8" , 27g x 1/2"	Preferred	Max 90-day supply per fill
insulin syringe-needle u-100 31g x 1/4" 0.3 ml	Preferred	Max 90-day supply per fill
insupen pen needles 33g x 4 mm	Preferred	Max 90-day supply per fill
INSUPEN ULTRAFIN 30G X 8 MM (insulin pen needle)	Preferred	Max 90-day supply per fill
kmart valu insulin syringe 29g u-100 1 ml	Preferred	Max 90-day supply per fill
kmart valu insulin syringe 30g u-100 1 ml	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i> Kroger pen needles 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
LUER LOCK SAFETY SYRINGES 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
MAGELLAN TUBERCULIN SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
MICRODOT PEN NEEDLE 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
MONOJECT FILTER ASPIRATOR (<i>needles & syringes</i>)	Preferred	
MONOJECT HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
MONOJECT HYPODERMIC NEEDLE 25G X 5/8" , 27G X 1/2" (<i>needle (disp)</i>)	Preferred	Max 90-day supply per fill
MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
MONOJECT INSULIN SYRINGE U-100 1 ML (<i>insulin syringes (disposable)</i>)	Preferred	Max 90-day supply per fill
MONOJECT MAGELLAN SAFETY NDL 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" (<i>needle (disp)</i>)	Preferred	
MONOJECT MAGELLAN SAFETY NDL 25G X 5/8" (<i>needle (disp)</i>)	Preferred	Max 90-day supply per fill
MONOJECT MAGELLAN SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
MONOJECT PHARMACY TRAY 1 ML (<i>syringe (disposable)</i>)	Preferred	
MONOJECT SHARPS CONTAINER (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
MONOJECT SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML, 27G X 1-1/4" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
MONOJECT SYRINGE 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
MONOJECT SYRINGE PHARMACY TRAY 1 ML (<i>syringe (disposable)</i>)	Preferred	
MONOJECT TB SAFETY SYRINGE 25G X 5/8" 1 ML, 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
MONOJECT TB SYRINGE 1 ML (<i>syringe (disposable)</i>)	Preferred	
MONOJECT TB SYRINGE 25G X 5/8" 1 ML, 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
NOKOR VENTED NEEDLE 18G X 1" (<i>needle (disp)</i>)	Preferred	
NORM-JECT LUER SLIP SYRINGE 1 ML (<i>syringe (disposable)</i>)	Preferred	
NOVOFINE AUTOCOVER PEN NEEDLE 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>pen needles 30g x 5 mm , 30g x 8 mm , 32g x 5 mm , 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
<i>poly hub needle 18g x 1" , 18g x 1-1/2" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"</i>	Preferred	
<i>poly hub needle 25g x 5/8" , 27g x 1/2" , 30g x 1/2"</i>	Preferred	Max 90-day supply per fill
<i>pro comfort pen needles 32g x 5 mm</i>	Preferred	Max 90-day supply per fill
<i>pure comfort pen needle 32g x 5 mm</i>	Preferred	Max 90-day supply per fill
<i>safety pen needles 30g x 5 mm , 30g x 8 mm</i>	Preferred	Max 90-day supply per fill
SECURES SAFE HYPODERMIC NEEDLE 22G X 1" , 25G X 1-1/2" (<i>needle (disp)</i>)	Preferred	
SECURES SAFE HYPODERMIC NEEDLE 27G X 1/2" (<i>needle (disp)</i>)	Preferred	Max 90-day supply per fill
SECURES SAFE SAFETY PEN NEEDLES 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
SECURES SAFE SYRINGE/NEEDLE 20G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
<i>sharps collector</i>	Preferred	QL (1 EA per 1 day)
<i>sharps container</i>	Preferred	QL (1 EA per 1 day)
<i>sharps disposal by mail system</i>	Preferred	QL (1 EA per 1 day)
<i>sure comfort insulin syringe 31g x 1/4" 0.3 ml</i>	Preferred	Max 90-day supply per fill
<i>sure comfort pen needles 30g x 8 mm</i>	Preferred	Max 90-day supply per fill
<i>syringe luer lock 20g x 1" 10 ml, 20g x 1" 3 ml, 21g x 1" 3 ml, 21g x 1-1/2" 3 ml, 22g x 1" 3 ml, 22g x 1-1/2" 3 ml, 23g x 1" 3 ml, 23g x 1-1/2" 3 ml, 25g x 1" 3 ml, 25g x 1-1/2" 3 ml, 25g x 5/8" 3 ml</i>	Preferred	
<i>syringe luer slip 1 ml</i>	Preferred	
<i>techlite insulin syringe 29g x 1/2" 0.3 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 29g x 1/2" 0.5 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 29g x 1/2" 1 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 30g x 1/2" 0.5 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 30g x 1/2" 1 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 30g x 5/16" 0.3 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 30g x 5/16" 0.5 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 31g x 15/64" 0.3 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 31g x 15/64" 0.5 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 31g x 15/64" 1 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 31g x 5/16" 0.3 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 31g x 5/16" 0.5 ml</i>	Preferred	Max 90-day supply per fill
<i>techlite insulin syringe 31g x 5/16" 1 ml</i>	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 29G X 10MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 29G X 12MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 31G X 5 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
TECHLITE PEN NEEDLES 31G X 6 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 31G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 32G X 6 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 32G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
<i>true comfort pro pen needles 32g x 5 mm , 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.5 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 1 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 29G X 12MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 31G X 5 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 31G X 6 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 31G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 32G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
ULTICARE INSULIN SYR 1/2 UNIT 31G X 1/4" 0.3 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML (<i>insulin syringe-needle u-100</i>)	Preferred	Max 90-day supply per fill
ULTICARE MINI PEN NEEDLES 30G X 5 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
ULTICARE SHORT PEN NEEDLES 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
ULTICARE SYRINGE 22G X 1-1/2" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
ULTICARE TUBERCULIN SAFETY SYR 25G X 1" 1 ML, 25G X 5/8" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
ULTILET SHARPS CONTAINER 1QT (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
ULTILET SHARPS CONTAINER 2QT (<i>sharps container</i>)	Preferred	QL (1 EA per 1 day)
ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
<i>ultracare pen needles 32g x 5 mm , 33g x 4 mm</i>	Preferred	Max 90-day supply per fill
UNIFINE PENTIPS 30G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
UNIFINE PENTIPS PLUS 30G X 5 MM , 33G X 4 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM , 30G X 8 MM (<i>insulin pen needle</i>)	Preferred	Max 90-day supply per fill
VANISHPOINT SAFETY SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
VANISHPOINT SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (<i>syringe/needle (disp)</i>)	Preferred	
VANISHPOINT TUBERCULIN SYRINGE 25G X 1" 1 ML, 25G X 5/8" 1 ML, 27G X 1/2" 1 ML (<i>tuberculin-allergy syringes</i>)	Preferred	
*PED MULTIPLE VITAMINS W/ MINERALS**		
MVW COMPLETE FORMULATION ORAL SOLUTION (<i>pediatric multivit-minerals</i>)	Preferred	
*PED MV W/ FLUORIDE**		
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (<i>pediatric multivitamins-fl</i>)	Preferred	
<i>multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	Preferred	
<i>multivitamin/fluoride oral solution 0.25 mg/ml</i>	Preferred	
<i>multi-vitamin/fluoride oral solution 0.25 mg/ml</i>	Preferred	
<i>multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg</i>	Preferred	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</i>)	Preferred	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML (<i>pediatric multivitamins-fl</i>)	Preferred	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (<i>pediatric multivitamins-fl</i>)	Preferred	
*PED MV W/ IRON**		
<i>bite-a-mins/iron oral tablet chewable 15 mg</i>	Preferred	
BPROTECTED PEDIA POLY-VITE/FE ORAL SOLUTION 10 MG/ML (<i>pediatric multivitamins-iron</i>)	Preferred	
CEROVITE JR ORAL TABLET CHEWABLE 18 MG (<i>pediatric multivitamins-iron</i>)	Preferred	
<i>childrens animal shapes oral tablet chewable 18 mg</i>	Preferred	
<i>cvs chewable childrens vitamin oral tablet chewable 18 mg</i>	Preferred	
<i>cvs childrens complete oral tablet chewable 18 mg</i>	Preferred	
<i>eq complete multivitamin child oral tablet chewable 18 mg</i>	Preferred	
<i>eql child multivit/minerals oral tablet chewable 18 mg</i>	Preferred	
FLINTSTONES COMPLETE ORAL TABLET CHEWABLE 18 MG (<i>pediatric multivitamins-iron</i>)	Preferred	
FLINTSTONES PLUS EXTRA IRON ORAL TABLET CHEWABLE 18 MG (<i>pediatric multivitamins-iron</i>)	Preferred	
FLINTSTONES W/IRON ORAL TABLET CHEWABLE 18 MG (<i>pediatric multivitamins-iron</i>)	Preferred	
<i>fruity chews/iron oral tablet chewable</i>	Preferred	
<i>gnp childrens chewables/iron oral tablet chewable 15 mg</i>	Preferred	
LAND BEFORE TIME MULTIVITAMIN ORAL TABLET CHEWABLE 15 MG (<i>pediatric multivitamins-iron</i>)	Preferred	
<i>multivitamin drops/iron oral solution 11 mg/ml</i>	Preferred	
<i>multivitamin infant & toddler oral solution 11 mg/ml</i>	Preferred	
<i>multivitamins plus iron child oral tablet chewable 18 mg</i>	Preferred	
<i>pc pediatric poly-vita/fe drop oral solution 10 mg/ml</i>	Preferred	
POLY-VI-SOL/IRON ORAL SOLUTION 11 MG/ML (<i>pediatric multivitamins-iron</i>)	Preferred	
<i>poly-vita/iron oral solution 10 mg/ml</i>	Preferred	
<i>poly-vite/iron oral solution 11 mg/ml</i>	Preferred	
PX CHILDRENS VITAMIN ORAL TABLET CHEWABLE 18 MG (<i>pediatric multivitamins-iron</i>)	Preferred	
<i>qc childrens complete oral tablet chewable 18 mg</i>	Preferred	
<i>qc childrens vitamins/iron oral tablet chewable 15 mg</i>	Preferred	
<i>ra vitamins complete childrens oral tablet chewable 18 mg</i>	Preferred	
<i>sm animal shapes complete oral tablet chewable 18 mg</i>	Preferred	
ULTRA CHOICE MULTIVITAMIN KIDS ORAL TABLET CHEWABLE 18 MG (<i>pediatric multivitamins-iron</i>)	Preferred	
*PEDIATRIC MULTIPLE VITAMINS**		
<i>bite-a-mins oral tablet chewable</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
BPROTECTED PEDIA POLY-VITE ORAL SOLUTION (<i>pediatric multiple vitamins</i>)	Preferred	
<i>childrens chew multivitamin oral tablet chewable</i>	Preferred	
<i>childrens chewable vitamins oral tablet chewable</i>	Preferred	
CULTURELLE KIDS COMPLETE ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
CULTURELLE KIDS PROBIOTIC-MV ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
FLINSTONES GUMMIES OMEGA-3 DHA ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
FLINTSTONES MULTIVITAMIN ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
FLINTSTONES PLUS CALCIUM ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
FLINTSTONES/MY FIRST ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
<i>fruity chews oral tablet chewable</i>	Preferred	
GERBER GROW MIGHTY ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
GERBER LIL' BRAINIES ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
<i>gnp childrens chewables/ex c oral tablet chewable</i>	Preferred	
<i>gnp little ones childrens oral tablet chewable</i>	Preferred	
LAND BEFORE TIME MULTIVITAMIN ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
<i>little animals oral tablet chewable</i>	Preferred	
<i>multivitamin childrens (w/ fa) oral tablet chewable</i>	Preferred	
<i>multivitamin childrens oral tablet chewable</i>	Preferred	
<i>multivitamin infant & toddler oral solution</i>	Preferred	
NOVAMV PEDIATRIC MULTI-VITAMIN ORAL LIQUID (<i>pediatric multiple vitamins</i>)	Preferred	
ONE-A-DAY VITACRAVES+OMEGA-3 ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
<i>pc pediatric poly-vitamin drop oral solution</i>	Preferred	
POLY-VI-SOL ORAL SOLUTION (<i>pediatric multiple vitamins</i>)	Preferred	
<i>poly-vita oral solution</i>	Preferred	
<i>poly-vite pediatric oral solution</i>	Preferred	
<i>qc childrens vitamins/extra c oral tablet chewable</i>	Preferred	
<i>sm animal shapes kids first oral tablet chewable</i>	Preferred	
ZOO FRIENDS/EXTRA C ORAL TABLET CHEWABLE (<i>pediatric multiple vitamins</i>)	Preferred	
*PENICILLIN COMBINATIONS**		
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	Preferred	
<i>amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg</i>	Preferred	
*PENICILLINASE-RESISTANT PENICILLINS**		
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	Preferred	
*PHARMACEUTICAL EXCIPIENTS**		
<i>methylcellulose powder</i>	Preferred	
*PHOSPHATE**		
<i>phos-nak oral packet 280-160-250 mg</i>	Preferred	
<i>k phos mono-sod phos di & mono (Phospha 250 Neutral Oral Tablet 155-852-130 Mg)</i>	Preferred	
<i>phosphorous oral tablet 155-852-130 mg</i>	Preferred	
<i>phosphorus supplement oral packet 280-160-250 mg</i>	Preferred	
<i>phosphorus w/sod & potassium oral packet 280-160-250 mg</i>	Preferred	
<i>k phos mono-sod phos di & mono (Phospho-Trin 250 Neutral Oral Tablet 155-852-130 Mg)</i>	Preferred	
<i>potassium phosphate monobasic (Phospho-Trin K500 Oral Tablet 500 Mg)</i>	Preferred	
<i>sodium-potassium-phosphorus oral packet 160-280-250 mg</i>	Preferred	
<i>wes-phos 250 neutral oral tablet 155-852-130 mg</i>	Preferred	
*PLATELET AGGREGATION INHIBITORS**		
<i>cilostazol oral tablet 100 mg, 50 mg</i>	Preferred	QL (2 EA per 1 day)
*POSTERIOR PITUITARY HORMONES**		
<i>desmopressin acetate nasal solution 1.5 mg/ml</i>	Preferred	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	Preferred	
*POTASSIUM REMOVING AGENTS**		
<i>sodium polystyrene sulfonate oral powder</i>	Preferred	
*POTASSIUM SPARING DIURETICS**		
<i>amiloride hcl oral tablet 5 mg</i>	Preferred	
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	Max 90-day supply per fill
*POTASSIUM**		
<i>cvs potassium gluconate oral tablet 595 mg</i>	Preferred	
<i>potassium bicarbonate (Effer-K Oral Tablet Effervescent 25 Meq)</i>	Preferred	
<i>gnp potassium gluconate oral tablet 595 (99 k) mg</i>	Preferred	
<i>potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)</i>	Preferred	Max 90-day supply per fill
<i>potassium chloride crys er (Klor-Con M10 Oral Tablet Extended Release 10 Meq)</i>	Preferred	
<i>potassium chloride crys er (Klor-Con M20 Oral Tablet Extended Release 20 Meq)</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>potassium chloride</i> (Klor-Con Oral Tablet Extended Release 8 Meq)	Preferred	Max 90-day supply per fill
<i>potassium bicarbonate</i> (Klor-Con/Ef Oral Tablet Effervescent 25 Meq)	Preferred	
<i>potassium bicarbonate</i> (K-Prime Oral Tablet Effervescent 25 Meq)	Preferred	
<i>potassium chloride crys er oral tablet extended release 10 meq</i>	Preferred	
<i>potassium chloride crys er oral tablet extended release 20 meq</i>	Preferred	Max 90-day supply per fill
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	Preferred	Max 90-day supply per fill
<i>potassium chloride er oral tablet extended release 10 meq, 8 meq</i>	Preferred	Max 90-day supply per fill
<i>potassium chloride er oral tablet extended release 20 meq</i>	Preferred	
<i>potassium chloride oral solution 10 %, 20 meq/15ml (10%)</i>	Preferred	
<i>potassium chloride oral solution 40 meq/15ml (20%)</i>	Preferred	Max 90-day supply per fill
<i>potassium gluconate oral tablet 550 (90 k) mg, 550 mg, 595 (99 k) mg</i>	Preferred	
<i>qc potassium oral tablet 595 (99 k) mg</i>	Preferred	
<i>ra potassium gluconate oral tablet 595 (99 k) mg</i>	Preferred	
<i>sd potassium gluconate oral tablet 595 (99 k) mg</i>	Preferred	
<i>sm potassium oral tablet 595 (99 k) mg</i>	Preferred	
*PRENATAL VITAMINS**		
CENTRUM SPECIALIST PRENATAL ORAL 27-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	Preferred	
<i>classic prenatal oral tablet 28-0.8 mg</i>	Preferred	
<i>completenate oral tablet chewable 29-1 mg</i>	Preferred	
CO-NATAL FA ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
<i>cvs prenatal multi+dha oral capsule 27-0.8-250 mg</i>	Preferred	
<i>cvs prenatal oral tablet 27-0.8 mg</i>	Preferred	
ENFAMIL EXPECTA ORAL 28-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	Preferred	
<i>eql prenatal formula oral tablet 28-0.8 mg</i>	Preferred	
<i>gnp prenatal oral tablet 28-0.8 mg</i>	Preferred	
<i>kp prenatal multivitamins oral tablet 28-0.8 mg</i>	Preferred	
<i>kpn prenatal oral tablet 0.1 mg</i>	Preferred	
<i>masonatal oral tablet 28-0.8 mg</i>	Preferred	
<i>m-natal plus oral tablet 27-1 mg</i>	Preferred	
<i>multi prenatal oral tablet 27-0.8 mg</i>	Preferred	
<i>neonatal complete oral tablet 27-1 mg, 29-1 mg</i>	Preferred	
NEONATAL PLUS ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
<i>neonatal prenatal oral tablet 27-0.8 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
NEONATAL VITAMIN ORAL TABLET 27-0.8 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
NIVA-PLUS ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
<i>one vite womens oral tablet 27-0.8 mg</i>	Preferred	
<i>one vite womens plus oral tablet 27-1 mg</i>	Preferred	
ONE-A-DAY WOMENS PRENATAL 1 ORAL CAPSULE 28-0.8-235 MG (<i>prenat-fe carbonyl-fa-omega 3</i>)	Preferred	
ONE-A-DAY WOMENS PRENATAL ORAL 28-0.8 & 440 MG (<i>prenatal vit-fe fum-fa-omega</i>)	Preferred	
<i>prenatabs fa oral tablet 29-1 mg</i>	Preferred	
PRENATABS RX ORAL TABLET 29-1 MG (<i>prenatal vit-iron carbonyl-fa</i>)	Preferred	
<i>prenatal (w/iron & fa) oral tablet 27-0.8 mg</i>	Preferred	
<i>prenatal + complete multi oral therapy pack 0.267 & 373 mg, 18-0.8 & 290 mg</i>	Preferred	
<i>prenatal 19 oral tablet , 29-1 mg</i>	Preferred	
<i>prenatal 19 oral tablet chewable , 29-1 mg</i>	Preferred	
<i>prenatal formula a-free oral tablet 9-0.267 mg</i>	Preferred	
<i>prenatal formula oral capsule 28-0.8-235 mg</i>	Preferred	
<i>prenatal forte oral tablet</i>	Preferred	
<i>prenatal gummies/dha & fa oral tablet chewable 0.4-32.5 mg</i>	Preferred	
<i>prenatal multi +dha oral capsule 27-0.8-250 mg</i>	Preferred	
PRENATAL MULTIVITAMIN + DHA ORAL 28-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	Preferred	
<i>prenatal multivitamin plus dha oral capsule 27-0.8-250 mg</i>	Preferred	
<i>prenatal one daily oral tablet 27-0.8 mg</i>	Preferred	
<i>prenatal oral tablet 27-0.8 mg, 27-1 mg, 28-0.8 mg, 6.75-0.2 mg</i>	Preferred	
<i>prenatal plus oral tablet 27-1 mg</i>	Preferred	
<i>prenatal plus vitamin/mineral oral tablet 27-1 mg</i>	Preferred	
<i>prenatal vitamin and mineral oral tablet 28-0.8 mg</i>	Preferred	
<i>prenatal vitamins oral tablet 28-0.8 mg</i>	Preferred	
<i>prenatal/iron oral tablet , 28-0.8 mg</i>	Preferred	
PRENATRIX ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
PRENATRYL ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
<i>prenatvite rx oral tablet 0.8 mg</i>	Preferred	
<i>px prenatal multivitamins oral tablet 28-0.8 mg</i>	Preferred	
<i>qc prenatal oral tablet 28-0.8 mg</i>	Preferred	
<i>ra prenatal formula oral tablet 28-0.8 mg</i>	Preferred	
<i>ra prenatal oral tablet 28-0.8 mg</i>	Preferred	

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<i>se-natal 19 oral tablet 29-1 mg</i>	Preferred	
<i>se-natal 19 oral tablet chewable 29-1 mg</i>	Preferred	
SIMILAC PRENATAL EARLY SHIELD ORAL 27-0.8 & 200 MG (<i>prenatal mv-min-fe fum-fa-dha</i>)	Preferred	
<i>sm one daily prenatal oral 28-0.8 & 440 mg</i>	Preferred	
<i>sm prenatal vitamins oral tablet 28-0.8 mg</i>	Preferred	
STUART ONE ORAL CAPSULE 27-0.8-200 MG (<i>prenatal mv-min-fe cbn-fa-dha</i>)	Preferred	
THERANATAL CORE NUTRITION ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
THERANATAL ONE ORAL CAPSULE 27-1-300 MG (<i>prenatal-fefum-fa-dha w/o a</i>)	Preferred	
THERANATAL OVAVITE ORAL THERAPY PACK 18-1 & 125 MG (<i>prenat fefum-fa & coenzyme q10</i>)	Preferred	
<i>thrivite rx oral tablet 29-1 mg</i>	Preferred	
TRICARE ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
<i>trinatal rx 1 oral tablet 60-1 mg</i>	Preferred	
VINATE ONE ORAL TABLET 60-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
VITAFOL-OB ORAL TABLET (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
VITATHELY WITH GINGER ORAL TABLET 27-1 MG (<i>prenatal vit-fe fumarate-fa</i>)	Preferred	
<i>westab plus oral tablet 27-1 mg</i>	Preferred	
*PROGESTIN CONTRACEPTIVES - ORAL**		
<i>norethindrone (Camila Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Deblitane Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Errin Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Heather Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Incassia Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Jencycla Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Lyleq Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Lyza Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Nora-Be Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone oral tablet 0.35 mg</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Norlyroc Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
<i>norethindrone (Sharobel Oral Tablet 0.35 Mg)</i>	Preferred	Max 365-day supply per fill
*PROLACTIN INHIBITORS**		
<i>cabergoline oral tablet 0.5 mg</i>	Preferred	
*PROTEINS**		
<i>nac 600 oral capsule 600 mg</i>	Preferred	
<i>nac oral capsule 600 mg</i>	Preferred	
<i>n-acetyl cysteine oral capsule 600 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
NF FORMULAS NAC ORAL CAPSULE 600 MG (<i>acetylcysteine</i>)	Preferred	
*PSEUDOBULBAR AFFECT (PBA) AGENTS**		
NUEDEXTA ORAL CAPSULE 20-10 MG (<i>dextromethorphan-quinidine</i>)	Preferred	PA
*PYRIMIDINE SYNTHESIS INHIBITORS**		
<i>leflunomide oral tablet 10 mg, 20 mg</i>	Preferred	
*RECTAL COMBINATIONS**		
AVEDANA HEMORRHOID PAIN RELIEF EXTERNAL CREAM 1-0.25-14.4-15 % (<i>pramox-pe-glycerin-petrolatum</i>)	Preferred	
AVEDANA HEMORRHOID PAIN RELIEF RECTAL OINTMENT 0.25-14-74.9 % (<i>phenylephrine-mineral oil-pet</i>)	Preferred	
AVEDANA HEMORRHOIDAL RECTAL SUPPOSITORY 0.25-88.44 % (<i>phenylephrine-cocoa butter</i>)	Preferred	
AVEDANA HEMORRHOIDAL COOLING EXTERNAL GEL 0.25-50 % (<i>phenylephrine-witch hazel</i>)	Preferred	
<i>cvs hemorrhoidal external cream 1-0.25-14.4-15 %</i>	Preferred	
<i>cvs hemorrhoidal rectal suppository 0.25-88.44 %</i>	Preferred	
<i>eq hemorrhoidal rectal suppository 0.25-85.39 %</i>	Preferred	
<i>eql hemorrhoidal external cream 1-0.25-14.4-15 %</i>	Preferred	
<i>eql hemorrhoidal rectal suppository 0.25-88.44 %</i>	Preferred	
<i>gnp hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
<i>goodsense hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
<i>goodsense hemorrhoidal rectal suppository 0.25-88.44 %</i>	Preferred	
<i>hemorrhoidal cooling external gel 0.25-50 %</i>	Preferred	
<i>hemorrhoidal external cream 1-0.25-14.4-15 %</i>	Preferred	
<i>hemorrhoidal max st/aloe external cream 1-0.25-14.4-15 %</i>	Preferred	
<i>hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
<i>hemorrhoidal rectal suppository 0.25-3-85.5 %, 0.25-85.39 %, 0.25-88.44 %</i>	Preferred	
PREPARATION H RECTAL SUPPOSITORY 0.25-88.44 % (<i>phenylephrine-cocoa butter</i>)	Preferred	
<i>px hemorrhoidal external cream 1-0.25-14.4-15 %</i>	Preferred	
<i>px hemorrhoidal rectal ointment 0.25-3-14-71.9 %</i>	Preferred	
<i>px hemorrhoidal rectal suppository 0.25-3-85.5 %</i>	Preferred	
<i>qc hemorrhoidal max external cream 1-0.25-14.4-15 %</i>	Preferred	
<i>qc hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
<i>qc hemorrhoidal rectal suppository 0.25-88.44 %</i>	Preferred	
<i>qc hemorrhoidal with aloe external cream 1-0.25-14.4-15 %</i>	Preferred	
<i>ra hemorrhoidal external cream 1-0.25-14.4-15 %</i>	Preferred	
<i>ra hemorrhoidal rectal ointment 0.25-3-14-71.9 %</i>	Preferred	
<i>ra hemorrhoidal rectal suppository 0.25-3-85.5 %</i>	Preferred	
<i>sb hemorrhoid rectal ointment 0.25-3-14-71.9 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm hemorrhoidal cooling external gel 0.25-50 %</i>	Preferred	
<i>sm hemorrhoidal rectal ointment 0.25-14-74.9 %</i>	Preferred	
*RECTAL LOCAL ANESTHETICS**		
ANECREAM5 EXTERNAL CREAM 5 % (<i>lidocaine (anorectal)</i>)	Preferred	
<i>cvs hemorrhoidal relief max st external cream 5 %</i>	Preferred	
<i>gnp anorectal external cream 5 %</i>	Preferred	
<i>lidocaine (anorectal) external cream 5 %</i>	Preferred	
LIPOCAINE 5 EXTERNAL CREAM 5 % (<i>lidocaine (anorectal)</i>)	Preferred	
<i>pramoxine hcl (perianal) external foam 1 %</i>	Preferred	
<i>ra anorectal external cream 5 %</i>	Preferred	
RECTASMOOTH EXTERNAL CREAM 5 % (<i>lidocaine (anorectal)</i>)	Preferred	
*RESPIRATORY AIDS**		
ACTEEV PROTECT FACE MASK (<i>masks</i>)	Preferred	
<i>breathe comfort protect shield</i>	Preferred	
CLEVER CHOICE DISPOSABLE MASK (<i>masks</i>)	Preferred	
CLEVER CHOICE FACE MASK (<i>masks</i>)	Preferred	
<i>cvs medical face masks earloop</i>	Preferred	
<i>cvs procedural mask</i>	Preferred	
<i>disposable face mask</i>	Preferred	
<i>disposable face mask 3-ply</i>	Preferred	
<i>ear-loop mask small</i>	Preferred	
EASY FLOW KN 95 (<i>masks</i>)	Preferred	
<i>face mask</i>	Preferred	
<i>face mask earloop-style</i>	Preferred	
<i>face mask resp n-100 part</i>	Preferred	
<i>face mask respirator r-95 part</i>	Preferred	
<i>face masks 3 layer non-medical</i>	Preferred	
J & J GERM FILTER MASK (<i>masks</i>)	Preferred	
<i>kn95 disposable mask</i>	Preferred	
<i>kn95 medical protective mask</i>	Preferred	
<i>mask pediatric size 1"</i>	Preferred	
<i>n95 face mask</i>	Preferred	
<i>n95 parti respirator face mask</i>	Preferred	
NEXCARE ALL PURPOSE MASK (<i>masks</i>)	Preferred	
NEXCARE EARLOOP MASK (<i>masks</i>)	Preferred	
<i>pediatric medium mask</i>	Preferred	
<i>pediatric small mask</i>	Preferred	
SAFE-SENSE EARLOOP FACE MASK (<i>masks</i>)	Preferred	
SHIELD-SECURE FULL FACE SHIELD (<i>masks</i>)	Preferred	
<i>surgical face mask/niosh n95</i>	Preferred	

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*RESPIRATORY THERAPY SUPPLIES**		
ACE AEROSOL CLOUD ENHANCER (<i>respiratory therapy supplies</i>)	Preferred	
ACTIVITY POUCH (<i>respiratory therapy supplies</i>)	Preferred	
ADAPTER PED DISPOSABLE MOUTHPIECE (<i>respiratory therapy supplies</i>)	Preferred	
<i>adult aerosol mask</i>	Preferred	
<i>adult disposable mouthpiece</i>	Preferred	
<i>adult mask device</i>	Preferred	
<i>adult mask large</i>	Preferred	
AEROBIKA DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
AEROCHAMBER MINI CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER MV (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU LARGE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU MEDIUM (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU SMALL (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLO-VU W/MASK (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER PLUS FLOW VU (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER W/FLOWSIGNAL (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS CHAMBR (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS/LARGE (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS/MEDIUM (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROCHAMBER Z-STAT PLUS/SMALL (<i>spacer/aero-holding chambers</i>)	Preferred	
AEROTRACH PLUS (<i>respiratory therapy supplies</i>)	Preferred	
AEROVENT PLUS DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
AIRS PEDIATRIC AEROSOL MASK (<i>respiratory therapy supplies</i>)	Preferred	
AIRZONE PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
ALL FLOW 1000 PFT FILTER (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 1000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
ALL FLOW 2000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 3000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 4000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 5000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 6000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ALL FLOW 7000 PFT FILTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ASSESS PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
<i>breathe comfort chamber/adult device</i>	Preferred	
<i>breathe comfort chamber/child device</i>	Preferred	
<i>breathe ease large device</i>	Preferred	
<i>breathe ease medium device</i>	Preferred	
<i>breathe ease neb mask/child</i>	Preferred	
<i>breathe ease neb mask/infant</i>	Preferred	
<i>breathe ease peak flow meter device</i>	Preferred	
<i>breathe ease small device</i>	Preferred	
BREATHERITE VALVED MDI CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
BUBBLES THE FISH II PEDI MASK (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH 2 CPAP HOSE HANGER (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH CPAP & BIPAP HOSE (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH CPAP MASK WIPES (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH CPAP PRE-WASH SOLN (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH CPAP TUBE BRUSH (<i>respiratory therapy supplies</i>)	Preferred	
CARETOUCH UNIVERSL CPAP FILTER (<i>respiratory therapy supplies</i>)	Preferred	
CLEVER CHOICE HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
CLEVER CHOICE PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
<i>co monitor device</i>	Preferred	
<i>co monitor replacement pieces</i>	Preferred	
COMPACT SPACE CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
COMPACT SPACE CHAMBER/LG MASK DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
COMPACT SPACE CHAMBER/MED MASK DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
COMPACT SPACE CHAMBER/SM MASK DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
<i>disposable full range mouthpiece</i>	Preferred	
<i>disposable low range mouthpiece</i>	Preferred	
<i>disposable low range/pediatric mouthpiece</i>	Preferred	
<i>disposable paper mouthpiece</i>	Preferred	
<i>disposable universal range mouthpiece</i>	Preferred	
EASIVENT (<i>spacer/aero-holding chambers</i>)	Preferred	
EASIVENT MASK LARGE (<i>spacer/aero-holding chambers</i>)	Preferred	
EASIVENT MASK MEDIUM (<i>spacer/aero-holding chambers</i>)	Preferred	
EASIVENT MASK SMALL (<i>spacer/aero-holding chambers</i>)	Preferred	
EASY FLOW 300 MM HOSE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW 400 MM HOSE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW AIR NOZZLE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/BLUE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/ORANGE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/RED DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/WHITE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW BLACK/YELLOW DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW HEPA FILTER (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/BLUE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/GREEN DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/PINK DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/WHITE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EASY FLOW WHITE/YELLOW DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
EBASE CONTROLLER KIT (<i>respiratory therapy supplies</i>)	Preferred	
<i>eq space chamber anti-static device</i>	Preferred	
<i>eq space chamber anti-static l device</i>	Preferred	
<i>eq space chamber anti-static m device</i>	Preferred	
<i>eq space chamber anti-static s device</i>	Preferred	
<i>expiratory mouthpiece</i>	Preferred	
<i>filter air pp</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
FLEXICHAMBER ADULT MASK/SMALL (<i>spacer/aero-hold chamber mask</i>)	Preferred	
FLEXICHAMBER CHILD MASK/LARGE (<i>spacer/aero-hold chamber mask</i>)	Preferred	
FLEXICHAMBER CHILD MASK/SMALL (<i>spacer/aero-hold chamber mask</i>)	Preferred	
FLEXICHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
FLYP HYPERSONIQ CARTRIDGE (<i>respiratory therapy supplies</i>)	Preferred	
full kit nebulizer set	Preferred	
GORDO-POOL CONCENTRATE (<i>humidifier/vaporizer supplies</i>)	Preferred	
IN-CHECK DIAL FLOW TRAINER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
IN-CHECK INSPIRATORY FLOW MTR DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
INNOSPIRE REPLACEMENT FILTER (<i>respiratory therapy supplies</i>)	Preferred	
INSPIRACHAMBER/LARGE DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
INSPIRACHAMBER/MEDIUM DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
INSPIRACHAMBER/MOUTHPIECE DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
INSPIRACHAMBER/SMALL DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
INSPIREASE (<i>spacer/aero-holding chambers</i>)	Preferred	
KAZ BACTERIOSTATIC TREATMENT LIQUID (<i>humidifier/vaporizer supplies</i>)	Preferred	
KAZ INHALANT LIQUID (<i>humidifier/vaporizer supplies</i>)	Preferred	
KAZ WATER TREATMENT LIQUID (<i>humidifier/vaporizer supplies</i>)	Preferred	
KOKO PEAK PRO MOUTHPIECE (<i>respiratory therapy supplies</i>)	Preferred	
LITETOUCH MASK LARGE (<i>respiratory therapy supplies</i>)	Preferred	
LITETOUCH MASK MEDIUM (<i>respiratory therapy supplies</i>)	Preferred	
LITETOUCH MASK SMALL (<i>respiratory therapy supplies</i>)	Preferred	
lung perform peak flow meter device	Preferred	
MASK VORTEX/CHILD/FROG (<i>spacer/aero-hold chamber mask</i>)	Preferred	
MASK VORTEX/TODDLER/LADYBUG (<i>spacer/aero-hold chamber mask</i>)	Preferred	
MICROCHAMBER (<i>spacer/aero-holding chambers</i>)	Preferred	
MICROCHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
MICROLIFE DIGITAL PEAK FLOW DEVICE (<i>peak flow meter</i>)	Preferred	
MICROSPACER (<i>spacer/aero-holding chambers</i>)	Preferred	
MINI WRIGHT PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MINIELITE FILTER REPLACEMENTS (<i>respiratory therapy supplies</i>)	Preferred	
<i>nebulizer air tube/plugs</i>	Preferred	
<i>nebulizer cup/tubing device</i>	Preferred	
<i>nebulizer mask adult</i>	Preferred	
<i>nebulizer mask child</i>	Preferred	
<i>nose clip</i>	Preferred	
OMBRA TABLE TOP COMPRESSOR DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ONE FLOW SPIROMETER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
ONE FLOW TESTER MOUTHPIECE (<i>respiratory therapy supplies</i>)	Preferred	
<i>one-way valved expiratory mouthpiece</i>	Preferred	
<i>one-way valved inspiratory mouthpiece</i>	Preferred	
OPTICHAMBER DIAMOND (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND-LG MASK DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND-MD MASK (<i>spacer/aero-holding chambers</i>)	Preferred	
OPTICHAMBER DIAMOND-SM MASK (<i>spacer/aero-holding chambers</i>)	Preferred	
PANDA MASK LARGE (<i>spacer/aero-hold chamber mask</i>)	Preferred	
PANDA MASK MEDIUM (<i>spacer/aero-hold chamber mask</i>)	Preferred	
PANDA MASK SMALL (<i>spacer/aero-hold chamber mask</i>)	Preferred	
PARI ALTERA NEBULIZER HANDSET (<i>respiratory therapy supplies</i>)	Preferred	
PARI BABY CONVERSION KIT (<i>respiratory therapy supplies</i>)	Preferred	
PARI ERAPID NEBULIZER HANDSET (<i>respiratory therapy supplies</i>)	Preferred	
PARI EXPIRATORY FILTER SET DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
PARI MANUAL INTERRUPTER DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
PARI MASK SET (<i>respiratory therapy supplies</i>)	Preferred	
PARI SMARTMASK BABY/ELBOW (<i>respiratory therapy supplies</i>)	Preferred	
PARI SOFT PLASTIC ADULT MASK (<i>respiratory therapy supplies</i>)	Preferred	
PARI SOFT PLASTIC PED MASK (<i>respiratory therapy supplies</i>)	Preferred	
PARI TREK S COMBO PACK DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
PARI VORTEX ADULT MASK (<i>spacer/aero-hold chamber mask</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>peak a-i-r flow meter device</i>	Preferred	
PEAK AIR PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
<i>peak flow meter universal rang device</i>	Preferred	
<i>ped disposable mouthpiece</i>	Preferred	
<i>pediatric mouthpiece</i>	Preferred	
PEDIATRIC PANDA MASK (<i>spacer/aero-hold chamber mask</i>)	Preferred	
PERSONAL BEST FULL RANGE DEVICE (<i>peak flow meter</i>)	Preferred	
PFLEX (<i>respiratory therapy supplies</i>)	Preferred	
<i>pharmacist choice mask wipes</i>	Preferred	
PIKO 1 DEVICE (<i>peak flow meter</i>)	Preferred	
<i>pillow mask/adult</i>	Preferred	
<i>pillow mask/child</i>	Preferred	
<i>pillow mask/pediatric</i>	Preferred	
POCKET CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
POCKET PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
POCKET SPACER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
POCKETPEAK PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
<i>pro comfort spacer adult</i>	Preferred	
<i>pro comfort spacer child</i>	Preferred	
<i>pro comfort spacer infant device</i>	Preferred	
<i>procare spacer/adult mask device</i>	Preferred	
<i>procare spacer/child mask device</i>	Preferred	
PRONEB ULTRA FILTER SET (<i>respiratory therapy supplies</i>)	Preferred	
<i>pure comfort 3-ball breathe ex device</i>	Preferred	
<i>pure comfort flow meter adult device</i>	Preferred	
<i>pure comfort flow meter child device</i>	Preferred	
<i>pure comfort spacer chamber device</i>	Preferred	
QUAKE DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
<i>replacement air filter</i>	Preferred	
<i>replacement filters</i>	Preferred	
RITEFLO DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
SAMI THE SEAL FILTERS (<i>respiratory therapy supplies</i>)	Preferred	
SIDESTREAM ADULT FACE MASK (<i>respiratory therapy supplies</i>)	Preferred	
SIDESTREAM PEDIATRIC FACE MASK (<i>respiratory therapy supplies</i>)	Preferred	
SIDESTREAM PLS ADULT FACE MASK (<i>respiratory therapy supplies</i>)	Preferred	
<i>silicone mask/adult</i>	Preferred	
<i>silicone mask/infant</i>	Preferred	
<i>silicone mask/pediatric</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm vaporizer cleaning tablet soluble</i>	Preferred	
<i>sm vaporizer inhalant liquid</i>	Preferred	
<i>sootheneb nbl 100 adult mask</i>	Preferred	
<i>sootheneb nbl 100 child mask</i>	Preferred	
<i>sootheneb nbl 100 med cup</i>	Preferred	
<i>sootheneb nbl 100 mesh cap</i>	Preferred	
<i>spiro pd device</i>	Preferred	
THRESHOLD IMT (<i>respiratory therapy supplies</i>)	Preferred	
THRESHOLD PEP DEVICE (<i>respiratory therapy supplies</i>)	Preferred	
TRUZONE PEAK FLOW METER DEVICE (<i>peak flow meter</i>)	Preferred	
<i>tubing/wing tip</i>	Preferred	
VORTEX HOLD CHMBR/MASK/CHILD DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
VORTEX HOLD CHMBR/MASK/TODDLER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
VORTEX VALVED HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Preferred	
WINDMILL TRAINER (<i>respiratory therapy supplies</i>)	Preferred	
SALICYLATES		
<i>adult aspirin regimen oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
ALKA-SELTZER EXTRA STRENGTH ORAL TABLET EFFERVESCENT 500 MG (<i>aspirin effervescent</i>)	Preferred	
ASCRIPTIN ORAL TABLET 325 MG (<i>aspirin buf(alhyd-mghyd-cacar)</i>)	Preferred	
<i>aspirin 81 oral tablet chewable 81 mg</i>	Preferred	
<i>aspirin 81 oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>aspirin adult low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>aspirin childrens oral tablet chewable 81 mg</i>	Preferred	
<i>aspirin ec low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>aspirin ec low strength oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>aspirin low dose oral tablet chewable 81 mg</i>	Preferred	
<i>aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>aspirin oral tablet 325 mg</i>	Preferred	
<i>aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>aspirin oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>aspirin rectal suppository 300 mg</i>	Preferred	
<i>aspirin regimen oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
BAYER ADVANCED ASPIRIN EX ST ORAL TABLET 500 MG (<i>aspirin</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
BAYER ADVANCED ASPIRIN REG ST ORAL TABLET 325 MG (<i>aspirin</i>)	Preferred	
BAYER ASPIRIN EC LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	Preferred	Max 90-day supply per fill
BAYER ASPIRIN ORAL TABLET 325 MG (<i>aspirin</i>)	Preferred	
BAYER ASPIRIN ORAL TABLET DELAYED RELEASE 325 MG (<i>aspirin</i>)	Preferred	
BAYER LOW DOSE ORAL TABLET CHEWABLE 81 MG (<i>aspirin</i>)	Preferred	
BAYER LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	Preferred	Max 90-day supply per fill
BUFFERIN EXTRA STRENGTH ORAL TABLET 500 MG (<i>aspirin buf(cacarb-mgcarb-mgo)</i>)	Preferred	
BUFFERIN ORAL TABLET 325 MG (<i>aspirin buf(cacarb-mgcarb-mgo)</i>)	Preferred	QL (24 EA per 1 day)
<i>childrens aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>cvs antacid & pain reliever oral tablet effervescent 325-1000-1916 mg</i>	Preferred	
<i>cvs aspirin adult low dose oral tablet chewable 81 mg</i>	Preferred	
<i>cvs aspirin adult low strength oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>cvs aspirin ec oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>cvs aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>cvs aspirin low strength oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>cvs aspirin oral tablet 325 mg</i>	Preferred	
<i>cvs genuine aspirin oral tablet 325 mg</i>	Preferred	
ECOTRIN LOW STRENGTH ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	Preferred	Max 90-day supply per fill
<i>effervescent antacid/pain rel oral tablet effervescent 500 mg</i>	Preferred	
<i>effervescent pain relief oral tablet effervescent 325-1000-1916 mg</i>	Preferred	
<i>eq antacid & pain relief oral tablet effervescent 325 mg</i>	Preferred	
<i>eq aspirin adult low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>eq aspirin low dose oral tablet chewable 81 mg</i>	Preferred	
<i>eq aspirin oral tablet 325 mg</i>	Preferred	
<i>eql antacid/pain relief oral tablet effervescent 325-1000-1916 mg</i>	Preferred	
<i>eql aspirin ec oral tablet delayed release 325 mg</i>	Preferred	
<i>eql aspirin low dose oral tablet chewable 81 mg</i>	Preferred	
<i>eql aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>genuine aspirin oral tablet 325 mg</i>	Preferred	
<i>gnp adult aspirin low strength oral tablet chewable 81 mg</i>	Preferred	
<i>gnp aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>gnp aspirin oral tablet 325 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>gnp aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>gnp aspirin oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>goodsense antacid/pain relief oral tablet effervescent 325 mg, 325-1000-1916 mg</i>	Preferred	
<i>goodsense aspirin adults oral tablet 325 mg</i>	Preferred	
<i>goodsense aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>goodsense aspirin oral tablet 325 mg</i>	Preferred	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>goodsense aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>h-e-b aspirin oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>hm adult aspirin oral tablet 325 mg</i>	Preferred	
<i>hm aspirin ec low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>hm aspirin ec oral tablet delayed release 325 mg</i>	Preferred	
<i>hm aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>kls aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>kp aspirin oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
MEDI-FIRST ASPIRIN ORAL TABLET 325 MG (<i>aspirin</i>)	Preferred	
MEDIQUE ASPIRIN ORAL TABLET 325 MG (<i>aspirin</i>)	Preferred	
<i>medi-seltzer oral tablet effervescent 325 mg</i>	Preferred	
<i>meijer aspirin ec oral tablet delayed release 325 mg</i>	Preferred	
<i>mm aspirin oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>px aspirin oral tablet 325 mg</i>	Preferred	
<i>px aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>px effervescent oral tablet effervescent 325-1000-1916 mg</i>	Preferred	
<i>px enteric aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>px enteric aspirin oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>qc antacid & pain relief oral tablet effervescent 500 mg</i>	Preferred	
<i>qc aspirin low dose oral tablet chewable 81 mg</i>	Preferred	
<i>qc aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>qc aspirin oral tablet 325 mg</i>	Preferred	
<i>qc aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>qc childrens aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>qc effervescent antacid/pain oral tablet effervescent 325-1000-1916 mg</i>	Preferred	
<i>qc enteric aspirin oral tablet delayed release 325 mg</i>	Preferred	
<i>ra aspirin adult low dose oral tablet chewable 81 mg</i>	Preferred	
<i>ra aspirin adult low strength oral tablet chewable 81 mg</i>	Preferred	
<i>ra aspirin childrens oral tablet chewable 81 mg</i>	Preferred	
<i>ra aspirin ec adult low st oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>ra aspirin ec oral tablet delayed release 325 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ra aspirin ec oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>ra aspirin oral tablet 325 mg</i>	Preferred	
<i>ra pain relief aspirin oral tablet 325 mg</i>	Preferred	
<i>sb aspirin ec oral tablet delayed release 325 mg</i>	Preferred	
<i>sb aspirin oral tablet 325 mg</i>	Preferred	
<i>sb childrens aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>sb effervescent pain relief oral tablet effervescent 325-1000-1916 mg</i>	Preferred	
<i>sb low dose asa ec oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>sm aspirin adult low strength oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>sm aspirin ec low strength oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>sm aspirin ec oral tablet delayed release 325 mg</i>	Preferred	
<i>sm aspirin low dose oral tablet chewable 81 mg</i>	Preferred	
<i>sm aspirin low dose oral tablet delayed release 81 mg</i>	Preferred	Max 90-day supply per fill
<i>sm aspirin oral tablet 325 mg</i>	Preferred	
<i>sm aspirin tri-buffered oral tablet 325 mg</i>	Preferred	QL (24 EA per 1 day)
<i>sm childrens aspirin oral tablet chewable 81 mg</i>	Preferred	
<i>sm effervescent pain relief oral tablet effervescent 325-1000-1916 mg</i>	Preferred	
ST JOSEPH ASPIRIN ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	Preferred	Max 90-day supply per fill
ST JOSEPH LOW DOSE ORAL TABLET CHEWABLE 81 MG (<i>aspirin</i>)	Preferred	
ST JOSEPH LOW DOSE ORAL TABLET DELAYED RELEASE 81 MG (<i>aspirin</i>)	Preferred	Max 90-day supply per fill
<i>tri-buffered aspirin oral tablet 325 mg</i>	Preferred	QL (24 EA per 1 day)
*SALINE LAXATIVES**		
<i>citrate of magnesia oral solution</i>	Preferred	
CITROMA ORAL SOLUTION 1.745 GM/30ML (<i>magnesium citrate</i>)	Preferred	
<i>cvs enema disposable rectal enema 19-7 gm/118ml</i>	Preferred	
<i>cvs enema ready-to-use rectal enema 7-19 gm/118ml</i>	Preferred	
<i>cvs epsom salt granules</i>	Preferred	
<i>cvs epsom salt oral granules</i>	Preferred	
<i>cvs laxative dietary supplemnt oral tablet 500 mg</i>	Preferred	
<i>cvs magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>cvs milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
DULCOLAX MILK OF MAGNESIA ORAL SUSPENSION 400 MG/5ML (<i>magnesium hydroxide</i>)	Preferred	
DULCOLAX ORAL SUSPENSION 1200 MG/15ML (<i>magnesium hydroxide</i>)	Preferred	
<i>enema disposable rectal enema</i>	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
PA - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>enema pediatric rectal enema 3.5-9.5 gm/59ml</i>	Preferred	
<i>enema ready-to-use rectal enema 7-19 gm/118ml</i>	Preferred	
<i>enema rectal enema , 7-19 gm/118ml</i>	Preferred	
<i>epsom salt granules</i>	Preferred	
<i>epsom salt oral granules</i>	Preferred	
<i>eq enema rectal enema 19-7 gm/118ml</i>	Preferred	
<i>eq magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>eql epsom salt granules</i>	Preferred	
<i>eql ready-to-use enema rectal enema , 7-19 gm/118ml</i>	Preferred	
FLEET ENEMA RECTAL ENEMA , 7-19 GM/118ML (<i>sodium phosphates</i>)	Preferred	
<i>gnp epsom salt oral granules</i>	Preferred	
<i>gnp magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>gnp milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>goodsense enema rectal enema 19-7 gm/118ml, 7-19 gm/118ml</i>	Preferred	
<i>goodsense epsom salt oral granules</i>	Preferred	
<i>goodsense magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>goodsense milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>hm enema rectal enema 7-19 gm/118ml</i>	Preferred	
<i>hm magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>hm milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>milk of magnesia concentrate oral suspension 2400 mg/10ml</i>	Preferred	
<i>milk of magnesia oral suspension 1200 mg/15ml, 2400 mg/30ml, 400 mg/5ml, 7.75 %</i>	Preferred	
ONELAX MAGNESIUM CITRATE ORAL SOLUTION 1.745 GM/30ML (<i>magnesium citrate</i>)	Preferred	
PEDIA-LAX ORAL TABLET CHEWABLE 400 MG (<i>magnesium hydroxide</i>)	Preferred	
PHILLIPS MILK OF MAGNESIA ORAL SUSPENSION 400 MG/5ML, 800 MG/5ML (<i>magnesium hydroxide</i>)	Preferred	
<i>px milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
<i>qc enema rectal enema 16-6 gm/133ml</i>	Preferred	
<i>qc epsom salt oral granules</i>	Preferred	
<i>qc magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>qc milk of magnesia oral suspension 400 mg/5ml</i>	Preferred	
<i>ra enema rectal enema 7-19 gm/118ml</i>	Preferred	
<i>ra epsom salt granules</i>	Preferred	
<i>ra epsom salt oral granules</i>	Preferred	
<i>ra magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>ra milk of magnesia oral suspension 400 mg/5ml</i>	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
<i>ra saline enema rectal enema 19-7 gm/118ml</i>	Preferred	
<i>sb magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>sb milk of magnesia oral suspension 400 mg/5ml</i>	Preferred	
<i>sm enema rectal enema , 7-19 gm/118ml</i>	Preferred	
<i>sm epsom salt oral granules</i>	Preferred	
<i>sm magnesium citrate oral solution 1.745 gm/30ml</i>	Preferred	
<i>sm milk of magnesia oral suspension 1200 mg/15ml</i>	Preferred	
*SCABICIDES & PEDICULICIDES**		
<i>cvs ivermectin lice treatment external lotion 0.5 %</i>	Preferred	
<i>cvs lice killing external shampoo 0.33-4 %</i>	Preferred	
CVS LICE SOLUTION COMBINATION KIT (<i>pyreth-pip butox-permeth-nitre</i>)	Preferred	
<i>cvs lice treatment external liquid 1 %</i>	Preferred	
<i>eq lice killing max st external shampoo 0.33-4 %</i>	Preferred	
<i>eql lice killing max st external shampoo 0.33-4 %</i>	Preferred	
<i>gnp lice treatment external liquid 1 %</i>	Preferred	
<i>gnp lice treatment external shampoo 0.33-4 %</i>	Preferred	
<i>goodsense lice killing external liquid 1 %</i>	Preferred	
<i>ivermectin external lotion 0.5 %</i>	Preferred	
<i>lice killing external shampoo 0.33-4 %, 4-0.33 %</i>	Preferred	
<i>lice killing maximum strength external shampoo 0.33-4 %</i>	Preferred	
<i>lice treatment creme rinse external liquid 1 %</i>	Preferred	
<i>lice treatment external liquid 1 %</i>	Preferred	
<i>lice treatment external lotion 1 %</i>	Preferred	
LICEMD EXTERNAL GEL (<i>nit remover</i>)	Preferred	
LICEOUT EXTERNAL GEL (<i>nit remover</i>)	Preferred	
LYCELLE EXTERNAL GEL (<i>nit remover</i>)	Preferred	
MEDI-LICE COMBING EXTERNAL GEL (<i>nit remover</i>)	Preferred	
NIX COMPLETE LICE TREATMENT COMBINATION KIT 1 & 0.25 % (<i>permethrin-nit remover</i>)	Preferred	
NIX CREME RINSE EXTERNAL LIQUID 1 % (<i>permethrin</i>)	Preferred	
<i>permethrin external cream 5 %</i>	Preferred	
<i>ra lice maximum strength external shampoo 0.33-4 %</i>	Preferred	
<i>ra lice solution combination kit 0.5-0.33-4 %</i>	Preferred	
<i>ra lice treatment external lotion 1 %</i>	Preferred	
RID LICE KILLING SHAMPOO EXTERNAL SHAMPOO 0.33-4 % (<i>pyrethrins-piperonyl butoxide</i>)	Preferred	
<i>sb lice killing max st external shampoo 0.33-4 %</i>	Preferred	
<i>sb lice treatment external liquid 0.3-3 %, 1 %</i>	Preferred	
<i>sm lice killing external shampoo 0.33-4 %</i>	Preferred	
<i>sm lice killing max strength external shampoo 0.33-4 %</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>sm lice treatment external lotion 1 %</i>	Preferred	
<i>stop lice complete treatment combination kit 0.33-4-0.5 %</i>	Preferred	
<i>stop lice maximum strength external liquid 0.33-4 %</i>	Preferred	
STOP LICE STEP 2 EXTERNAL GEL (<i>nit remover</i>)	Preferred	
*SEMI SOLID VEHICLES**		
<i>1st base external cream</i>	Preferred	
ALTADERM EXTERNAL CREAM (<i>cream base</i>)	Preferred	
ARBEM H-COSMETIC EXTERNAL CREAM (<i>cream base</i>)	Preferred	
ARBEM LIOPEN EXTERNAL CREAM (<i>cream base</i>)	Preferred	
ATREVIS HYDROGEL EXTERNAL CREAM (<i>cream base</i>)	Preferred	
AUXIPRO VANISHING EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>az cream external cream</i>	Preferred	
<i>baby skin protectant external ointment 41 %</i>	Preferred	
BASE PCCA CLARIFYING EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>base w301 external cream</i>	Preferred	
CHRYSADERM DAY EXTERNAL CREAM (<i>cream base</i>)	Preferred	
CHRYSADERM NIGHT EXTERNAL CREAM (<i>cream base</i>)	Preferred	
CLEODERM EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>cream base external cream</i>	Preferred	
<i>cream concentrate external cream</i>	Preferred	
<i>cutis plus external cream</i>	Preferred	
<i>daily moisturizer external ointment 41 %</i>	Preferred	
DURABASE ADVANCED EXTERNAL CREAM (<i>cream base</i>)	Preferred	
DURABASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
EMOLIVAN EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>emollient base external cream</i>	Preferred	
<i>fagron ls plus external cream</i>	Preferred	
<i>fagron natural external cream</i>	Preferred	
<i>fagron supreme external cream</i>	Preferred	
FITALITE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>freedom adaptaderm external cream</i>	Preferred	
<i>freedom derma serum external cream</i>	Preferred	
FREEDOM DERMA-D EXTERNAL CREAM (<i>cream base</i>)	Preferred	
FREEDOM DERMA-N EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>goodsense petroleum jelly gel</i>	Preferred	
<i>hm petroleum jelly gel</i>	Preferred	
<i>hydrous emulsified base external cream</i>	Preferred	
LIOPEN ABSORPTION ENHANCING EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>lipo cream base external cream</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
LIPOCREAM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>lipopen ultra base external cream</i>	Preferred	
<i>liposomal heavy external cream</i>	Preferred	
<i>liposomal regular external cream</i>	Preferred	
MEDIDERM EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>microderm base external cream</i>	Preferred	
MICROSOME BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
MULTIBASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>multi-phasic penetrating cmpd external cream</i>	Preferred	
NOURILITE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
NOURIVAN ANTIOX BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
OMNIBASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA ALADERM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA ANHYDROUS LIPODERM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA BASE 7542 EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA BIOPEPTIDE BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA CANNIDEX 2.0 CUSTOM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA CANNIDEX CUSTOM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA COSMETIC HRT BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA EMOLLIENT CREAM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA HYDRABASE SB CUSTOM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA LIPODERM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA MVC BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA NATACREAM EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA PRACASIL TM-PLUS BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA VANISHING CREAM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA VANISHING CREAM LIGHT EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA VANPEN BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PCCA WAV CUSTOM BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PENCREAM EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>penderm external cream</i>	Preferred	
<i>pensomal external cream</i>	Preferred	
<i>petrolatum external ointment 42 %</i>	Preferred	
<i>petrolatum gel</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>petrolatum white external ointment</i>	Preferred	
<i>petrolatum white gel</i>	Preferred	
<i>petroleum jelly baby external ointment</i>	Preferred	
<i>petroleum jelly external ointment</i>	Preferred	
<i>petroleum jelly gel</i>	Preferred	
PFCB EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PHARMABASE ANTIOXIDANT EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PHARMABASE COSMETIC EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PHARMABASE COSMETIC NATURAL EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PHARMABASE HEAVY EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PHARMABASE LIGHT EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PHARMABASE VAGINAL EXTERNAL CREAM (<i>cream base</i>)	Preferred	
PHYTOBASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>p-siloxan ds external cream</i>	Preferred	
<i>ra petroleum jelly external ointment</i>	Preferred	
<i>sa3 derm external cream</i>	Preferred	
<i>salt durable cream external cream</i>	Preferred	
SALT STABLE LS ADVANCED EXTERNAL CREAM (<i>cream base</i>)	Preferred	
SALTSTABLE LO EXTERNAL CREAM (<i>cream base</i>)	Preferred	
SANARE ADVANCED SCAR THERAPY EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>sanare scar therapy external cream</i>	Preferred	
<i>scar care external cream</i>	Preferred	
<i>silprotex plus external cream</i>	Preferred	
<i>skin protectant external ointment 44.28 %</i>	Preferred	
<i>skyy derm external cream</i>	Preferred	
<i>sm petroleum jelly gel</i>	Preferred	
<i>teroderm external cream</i>	Preferred	
<i>teroderm-plus external cream</i>	Preferred	
U-BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
VANIBASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>vanishing cream botanical base external cream</i>	Preferred	
<i>vanishing external cream</i>	Preferred	
<i>vanish-pen external cream</i>	Preferred	
<i>white petrolatum</i> (Vaseline Gel)	Preferred	
VASELINE PURE ULTRA WHITE GEL (<i>white petrolatum</i>)	Preferred	
VERSAPRO EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>versatile cream base external cream</i>	Preferred	
VERSATILE RICH BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
VERSIGEL EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>vp dermabase external cream</i>	Preferred	
<i>white petrolatum external ointment , 100 %</i>	Preferred	
<i>white petrolatum gel</i>	Preferred	
<i>wound care external cream</i>	Preferred	
XCEL 100 EXTERNAL CREAM (<i>cream base</i>)	Preferred	
XEMATOP BASE EXTERNAL CREAM (<i>cream base</i>)	Preferred	
<i>yellow petrolatum external ointment</i>	Preferred	
*SODIUM**		
<i>sodium chloride oral tablet 1 gm</i>	Preferred	
*SOLIDS**		
<i>butylated hydroxytoluene powder</i>	Preferred	
*SOMATOSTATIC AGENTS**		
<i>octreotide acetate injection solution 100 mcg/ml</i>	Preferred	PA
*SPECIALTY VITAMINS PRODUCTS**		
<i>a thru z advantage oral tablet</i>	Preferred	
<i>adrenal stress calm oral tablet</i>	Preferred	
ALLERWELL ALLERGY FORMULA ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
<i>biotin plus keratin oral tablet 10000-100 mcg-mg</i>	Preferred	
<i>brain might/dha & co q10 oral tablet</i>	Preferred	
CENTRUM PERFORMANCE ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
CENTRUM SPECIALIST ENERGY ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
<i>cvs hair/skin/nails oral tablet</i>	Preferred	
<i>cvs menopause support oral tablet</i>	Preferred	
ELON MATRIX 5000 COMPLETE ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
ELON MATRIX 5000 ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
ELON MATRIX COMPLETE ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
ELON MATRIX PLUS ORAL TABLET 3000-50-100 MCG-MG-MG (<i>specialty vitamins products</i>)	Preferred	
ELON R3 ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
HAIR FARE ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
<i>hair nourishing supplement oral tablet</i>	Preferred	
<i>healthy heart complex oral tablet</i>	Preferred	
HEART TABS ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
LIPIDSHIELD PLUS ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MG PLUS PROTEIN ORAL TABLET 133 MG (<i>specialty vitamins products</i>)	Preferred	
MIL ADREGEN ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
MILLTRIUM STAMINA PLUS ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
<i>ra ear care oral tablet</i>	Preferred	
THERABETIC EYE HEALTH ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
<i>ultimate fat burner oral tablet</i>	Preferred	
UPSPRING HE NATAL ORAL TABLET (<i>specialty vitamins products</i>)	Preferred	
<i>urosex oral tablet</i>	Preferred	
<i>varisan vitality oral tablet</i>	Preferred	
<i>vitamins for hair oral tablet</i>	Preferred	
<i>weight loss daily multi oral tablet</i>	Preferred	
*SPERMICIDES**		
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (<i>nonoxynol-9</i>)	Preferred	
TODAY SPONGE VAGINAL 1000 MG (<i>nonoxynol-9</i>)	Preferred	
VCF VAGINAL CONTRACEPTIVE VAGINAL FOAM 12.5 % (<i>nonoxynol-9</i>)	Preferred	
*STIMULANT LAXATIVES**		
ALOPHEN ORAL TABLET DELAYED RELEASE 5 MG (<i>bisacodyl</i>)	Preferred	
<i>bisacodyl ec oral tablet delayed release 5 mg</i>	Preferred	
<i>bisacodyl laxative rectal suppository 10 mg</i>	Preferred	
<i>bisacodyl oral tablet delayed release 5 mg</i>	Preferred	
<i>bisacodyl rectal suppository 10 mg</i>	Preferred	
<i>castor oil oral oil 100 %</i>	Preferred	
<i>castor oil stimulant laxative oral oil 100 %</i>	Preferred	
<i>chocolated laxative oral tablet chewable 15 mg</i>	Preferred	
<i>cvs castor oil oral oil 100 %</i>	Preferred	
<i>cvs chocolate laxative pieces oral tablet chewable 15 mg</i>	Preferred	
<i>cvs c-lax laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>cvs gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>cvs gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>cvs gentle laxative womens oral tablet delayed release 5 mg</i>	Preferred	
<i>cvs laxative pills max st oral tablet 25 mg</i>	Preferred	
<i>cvs senna oral tablet 8.6 mg</i>	Preferred	
<i>cvs senna-extra oral tablet 17.2 mg</i>	Preferred	
DULCOLAX ORAL TABLET DELAYED RELEASE 5 MG (<i>bisacodyl</i>)	Preferred	
DULCOLAX PINK LAXATIVE ORAL TABLET DELAYED RELEASE 5 MG (<i>bisacodyl</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>eq gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>eq laxative maximum strength oral tablet 25 mg</i>	Preferred	
<i>eq natural vegetable laxative oral tablet 8.6 mg</i>	Preferred	
<i>eq vegetable laxative oral tablet 8.6 mg</i>	Preferred	
<i>eql castor oil oral oil 100 %</i>	Preferred	
<i>eql gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>eql laxative maximum strength oral tablet 25 mg</i>	Preferred	
<i>eql laxative oral tablet chewable 15 mg</i>	Preferred	
<i>eql laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>eql senna laxative oral tablet 8.6 mg</i>	Preferred	
EVAC-U-GEN ORAL TABLET 8.6 MG (<i>sennosides</i>)	Preferred	
EX-LAX MAXIMUM STRENGTH ORAL TABLET 25 MG (<i>sennosides</i>)	Preferred	
EX-LAX ULTRA ORAL TABLET DELAYED RELEASE 5 MG (<i>bisacodyl</i>)	Preferred	
FLEET BISACODYL RECTAL ENEMA 10 MG/30ML (<i>bisacodyl</i>)	Preferred	
<i>ft gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>geri-kot oral tablet 8.6 mg</i>	Preferred	
<i>gnp castor oil oral oil 100 %</i>	Preferred	
<i>gnp gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>gnp gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>gnp senna lax oral tablet 8.6 mg</i>	Preferred	
<i>gnp womens gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>goodsense bisacodyl ec oral tablet delayed release 5 mg</i>	Preferred	
<i>goodsense bisacodyl laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>goodsense castor oil oral oil 100 %</i>	Preferred	
<i>goodsense laxative pills oral tablet 25 mg</i>	Preferred	
<i>goodsense senna laxative oral tablet 8.6 mg</i>	Preferred	
<i>goodsense womens laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>hm gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>hm laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>hm senna oral tablet 8.6 mg</i>	Preferred	
<i>kp bisacodyl oral tablet delayed release 5 mg</i>	Preferred	
<i>kp senna oral tablet 8.6 mg</i>	Preferred	
<i>laxative max str oral tablet 25 mg</i>	Preferred	
<i>laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>laxative rectal suppository 10 mg</i>	Preferred	
<i>laxative regular strength oral tablet 15 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MEDI-LAX ORAL TABLET 15 MG (<i>sennosides</i>)	Preferred	
<i>medi-natural oral tablet 8.6 mg</i>	Preferred	
<i>natural senna laxative oral tablet 8.6 mg</i>	Preferred	
ONELAX RECTAL SUPPOSITORY 10 MG (<i>bisacodyl</i>)	Preferred	
ONELAX SENNA ORAL SYRUP 8.8 MG/5ML (<i>sennosides</i>)	Preferred	
PERDIEM OVERNIGHT RELIEF ORAL TABLET 15 MG (<i>sennosides</i>)	Preferred	
<i>px laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>px vegetable laxative oral tablet 8.6 mg</i>	Preferred	
<i>qc chocolate laxative oral tablet chewable 15 mg</i>	Preferred	
<i>qc gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>qc gentle laxative rectal suppository 10 mg</i>	Preferred	
<i>qc gentle laxative womens oral tablet delayed release 5 mg</i>	Preferred	
<i>qc laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>qc senna oral tablet 8.6 mg</i>	Preferred	
<i>qc vegetable laxative oral tablet 8.6 mg</i>	Preferred	
<i>ra fast relief laxative rectal suppository 10 mg</i>	Preferred	
<i>ra laxative oral tablet chewable 15 mg</i>	Preferred	
<i>ra laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>ra womens laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>sb bisacodyl laxative ec oral tablet delayed release 5 mg</i>	Preferred	
<i>sb gentle lax-women oral tablet delayed release 5 mg</i>	Preferred	
<i>sb laxative rectal suppository 10 mg</i>	Preferred	
<i>sb senna-lax oral tablet 8.6 mg</i>	Preferred	
<i>senna laxative oral tablet 8.6 mg</i>	Preferred	
<i>senna oral capsule 8.6 mg</i>	Preferred	
<i>senna oral liquid 8.8 mg/5ml</i>	Preferred	
<i>senna oral syrup 176 mg/5ml, 8.8 mg/5ml</i>	Preferred	
<i>senna oral tablet 8.6 mg</i>	Preferred	
SENNA SMOOTH ORAL TABLET 15 MG (<i>sennosides</i>)	Preferred	
<i>senna-lax oral tablet 8.6 mg</i>	Preferred	
<i>senna-tabs oral tablet 8.6 mg</i>	Preferred	
<i>senna-time oral tablet 8.6 mg</i>	Preferred	
<i>sennazon oral syrup 8.8 mg/5ml</i>	Preferred	
SEKOKOT EXTRA STRENGTH ORAL TABLET 17.2 MG (<i>sennosides</i>)	Preferred	
<i>sm gentle laxative oral tablet delayed release 5 mg</i>	Preferred	
<i>sm laxative rectal suppository 10 mg</i>	Preferred	
<i>sm senna laxative oral tablet 8.6 mg</i>	Preferred	
THE MAGIC BULLET RECTAL SUPPOSITORY 10 MG (<i>bisacodyl</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
womans laxative oral tablet delayed release 5 mg	Preferred	
womens laxative oral tablet delayed release 5 mg	Preferred	
*SURFACTANT LAXATIVES**		
COLACE CLEAR ORAL CAPSULE 50 MG (<i>docusate sodium</i>)	Preferred	
cvs mini enema kids rectal enema 100 mg/5ml	Preferred	
cvs mini enema rectal enema 20-283 mg	Preferred	
cvs stool softener oral capsule 100 mg, 240 mg, 250 mg, 50 mg	Preferred	
docusate calcium oral capsule 240 mg	Preferred	
docusate mini rectal enema 283 mg/5ml	Preferred	
docusate sodium oral capsule 100 mg, 250 mg	Preferred	
docusate sodium oral liquid 100 mg/10ml, 50 mg/5ml	Preferred	
docusate sodium oral syrup 60 mg/15ml	Preferred	
DOCUSOL KIDS RECTAL ENEMA 100 MG/5ML (<i>docusate sodium</i>)	Preferred	
DOCUSOL MINI RECTAL ENEMA 283 MG/5ML (<i>docusate sodium</i>)	Preferred	
DOCUSOL PLUS MINI-ENEMA RECTAL ENEMA 20-283 MG (<i>benzocaine-docusate sodium</i>)	Preferred	
DOK ORAL TABLET 100 MG (<i>docusate sodium</i>)	Preferred	
dss oral capsule 100 mg, 250 mg	Preferred	
DULCOLAX PINK STOOL SOFTENER ORAL CAPSULE 100 MG (<i>docusate sodium</i>)	Preferred	
DULCOLAX STOOL SOFTENER ORAL CAPSULE 100 MG (<i>docusate sodium</i>)	Preferred	
easy-lax oral capsule 100 mg	Preferred	
ENEMEEZ MINI RECTAL ENEMA 283 MG/5ML (<i>docusate sodium</i>)	Preferred	
ENEMEEZ PLUS RECTAL ENEMA 20-283 MG (<i>benzocaine-docusate sodium</i>)	Preferred	
eq stool softener oral capsule 100 mg	Preferred	
eql stool softener oral capsule 100 mg	Preferred	
gnp stool softener oral capsule 100 mg, 240 mg, 250 mg	Preferred	
goodsense stool softener oral capsule 100 mg	Preferred	
HEALTHY MAMA MOVE IT ALONG ORAL TABLET 100 MG (<i>docusate sodium</i>)	Preferred	
hm stool softener oral capsule 100 mg, 250 mg	Preferred	
mm stool softener laxative oral capsule 100 mg	Preferred	
ONELAX DOCUSATE SODIUM ORAL LIQUID 50 MG/5ML (<i>docusate sodium</i>)	Preferred	
PEDIA-LAX ORAL LIQUID 50 MG/15ML (<i>docusate sodium</i>)	Preferred	
PHILLIPS STOOL SOFTENER ORAL CAPSULE 100 MG (<i>docusate sodium</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>px docusate sodium oral capsule 100 mg</i>	Preferred	
<i>qc docusate calcium oral capsule 240 mg</i>	Preferred	
<i>qc stool softener oral capsule 100 mg, 250 mg</i>	Preferred	
<i>ra col-rite oral capsule 100 mg, 250 mg</i>	Preferred	
<i>ra stool softener oral capsule 100 mg</i>	Preferred	
<i>sb docusate sodium oral capsule 100 mg</i>	Preferred	
<i>sb stool softener oral capsule 240 mg</i>	Preferred	
<i>sm docusate calcium oral capsule 240 mg</i>	Preferred	
<i>sm stool softener oral capsule 100 mg, 250 mg</i>	Preferred	
<i>sm stool softener oral tablet 100 mg</i>	Preferred	
<i>stool softener laxative oral capsule 100 mg</i>	Preferred	
<i>stool softener oral capsule 100 mg, 240 mg, 250 mg</i>	Preferred	
<i>stool softener oral liquid 50 mg/5ml</i>	Preferred	
<i>stool softener oral tablet 100 mg</i>	Preferred	
SURFAK ORAL CAPSULE 240 MG (<i>docusate calcium</i>)	Preferred	
*SYMPATHOMIMETIC DECONGESTANTS**		
<i>12 hour decongestant nasal solution 0.05 %</i>	Preferred	
<i>12 hour decongestant oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>12 hour nasal decongestant nasal solution 0.05 %</i>	Preferred	
<i>12 hour nasal decongestant oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>12 hour nasal relief spray nasal solution 0.05 %</i>	Preferred	
<i>12 hour nasal spray nasal solution 0.05 %</i>	Preferred	
4-WAY FAST ACTING NASAL SOLUTION 1 % (<i>phenylephrine hcl</i>)	Preferred	
4-WAY MENTHOL NASAL SOLUTION 1 % (<i>phenylephrine hcl</i>)	Preferred	
AFRIN 12 HOUR NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
AFRIN ALL NIGHT NODRIP NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
AFRIN NODRIP EXTRA MOISTURE NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
AFRIN NODRIP ORIGINAL NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
AFRIN NODRIP SEVERE CONGEST NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
AFRIN NODRIP SINUS NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
AFRIN PUMP MIST NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
<i>anefrin spray nasal solution 0.05 %</i>	Preferred	
<i>cvs 12 hour nasal decongestant oral tablet extended release 12 hour 120 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>cvs allergy nasal mist no drip nasal solution 0.05 %</i>	Preferred	
<i>cvs nasal decongestant oral tablet 30 mg</i>	Preferred	
<i>cvs nasal mist nasal solution 0.05 %</i>	Preferred	
<i>cvs nasal spray nasal solution 0.05 %, 1 %</i>	Preferred	
<i>cvs sinus nasal spray nasal solution 0.05 %</i>	Preferred	
<i>cvs sinus pe decongestant oral tablet 10 mg</i>	Preferred	
<i>decongestant oral tablet 30 mg</i>	Preferred	
DRISTAN NASAL SOLUTION 0.05 % (oxymetazoline hcl)	Preferred	
<i>ephrine nose drops nasal solution 1 %</i>	Preferred	
<i>eq nasal spray fast acting nasal solution 1 %</i>	Preferred	
<i>eq nasal spray nasal solution 0.05 %</i>	Preferred	
<i>eq sinus 12-hour oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>eql nasal decongestant oral tablet 30 mg</i>	Preferred	
<i>eql nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>eql nasal spray 12 hour nasal solution 0.05 %</i>	Preferred	
<i>eql nasal spray fast acting nasal solution 1 %</i>	Preferred	
<i>eql nasal spray no drip nasal solution 0.05 %</i>	Preferred	
<i>ft nasal decongestant max str oral tablet 30 mg</i>	Preferred	
GILTUSS SEVERE SINUS NASAL SOLUTION 0.05 % (oxymetazoline hcl)	Preferred	
<i>gnp nasal decongestant oral tablet 30 mg</i>	Preferred	
<i>gnp nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>gnp nasal four spray nasal solution 1 %</i>	Preferred	
<i>gnp nasal spray extra moist nasal solution 0.05 %</i>	Preferred	
<i>gnp nasal spray fast acting nasal solution 1 %</i>	Preferred	
<i>gnp nasal spray nasal solution 0.05 %</i>	Preferred	
<i>gnp no drip nasal spray nasal solution 0.05 %</i>	Preferred	
<i>gnp pseudoephedrine hcl 12 hr oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>hm nasal decongestant 12 hour oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>hm nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>hm nose drops nasal solution 1 %</i>	Preferred	
<i>kp pseudoephedrine hcl oral tablet 30 mg, 60 mg</i>	Preferred	
<i>long acting nasal spray nasal solution 0.05 %</i>	Preferred	
<i>long lasting nasal spray nasal solution 0.05 %</i>	Preferred	
<i>meijer nasal decongestant oral tablet 30 mg</i>	Preferred	
MUCINEX CHILDRENS STUFFY NOSE NASAL SOLUTION 0.05 % (oxymetazoline hcl)	Preferred	
MUCINEX SINUS-MAX CLEAR & COOL NASAL SOLUTION 0.05 % (oxymetazoline hcl)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
MUCINEX SINUS-MAX SINUS/ALLRGY NASAL SOLUTION 0.05 % (oxymetazoline hcl)	Preferred	
nasal decongestant 12hr oral tablet extended release 12 hour 120 mg	Preferred	
nasal decongestant d oral tablet 30 mg	Preferred	
nasal decongestant oral tablet 30 mg	Preferred	
nasal decongestant pe max st oral tablet 10 mg	Preferred	
nasal decongestant pe oral tablet 10 mg	Preferred	
nasal decongestant spray nasal solution 0.05 %	Preferred	
nasal four nasal solution 1 %	Preferred	
nasal relief nasal solution 0.05 %	Preferred	
nasal spray 12 hour nasal solution 0.05 %	Preferred	
nasal spray extra moisturizing nasal solution 0.05 %	Preferred	
nasal spray max strength nasal solution 0.05 %	Preferred	
nasal spray nasal solution 0.05 %	Preferred	
nasal spray no drip nasal solution 0.05 %	Preferred	
nasal spray sinus nasal solution 0.05 %	Preferred	
no drip nasal spray nasal solution 0.05 %	Preferred	
non-pseudo sinus decongestant oral tablet 10 mg	Preferred	
NOSTRILLA NASAL SOLUTION 0.05 % (oxymetazoline hcl)	Preferred	
phenylephrine hcl oral tablet 10 mg	Preferred	
pseudoephedrine hcl er oral tablet extended release 12 hour 120 mg	Preferred	
pseudoephedrine hcl oral tablet 30 mg, 60 mg	Preferred	
px nasal decongestant oral tablet 30 mg	Preferred	
px nasal decongestant oral tablet extended release 12 hour 120 mg	Preferred	
px nasal decongestant pe oral tablet 10 mg	Preferred	
px nasal four nasal solution 1 %	Preferred	
px nasal spray moisturizing nasal solution 0.05 %	Preferred	
px no drip nasal spray nasal solution 0.05 %	Preferred	
px original nasal spray nasal solution 0.05 %	Preferred	
qc nasal decongestant pe oral tablet 10 mg, 30 mg	Preferred	
qc nasal mist no drip nasal solution 0.05 %	Preferred	
qc nasal spray nasal solution 0.05 %, 1 %	Preferred	
qc no drip extra moisturizing nasal solution 0.05 %	Preferred	
qc no drip nasal relief nasal solution 0.05 %	Preferred	
qc no drip original 12 hours nasal solution 0.05 %	Preferred	
qc suphedrine maximum strength oral tablet extended release 12 hour 120 mg	Preferred	
QLEARQUIL NASAL SOLUTION 0.05 % (oxymetazoline hcl)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>ra 12 hour nasal spray nasal solution 0.05 %</i>	Preferred	
<i>ra nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>ra nose drops extra strength nasal solution 1 %</i>	Preferred	
<i>ra sinus/congestion relief oral tablet 30 mg</i>	Preferred	
<i>ra sinus/congestion relief oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>ra sinus/congestion relief pe oral tablet 10 mg</i>	Preferred	
<i>ra suphedrine oral tablet 30 mg</i>	Preferred	
<i>ra suphedrine oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>sb 12hr nasal spray nasal solution 0.05 %</i>	Preferred	
<i>sb nasal spray no-drip nasal solution 0.05 %</i>	Preferred	
<i>sb sinus relief nasal solution 0.05 %</i>	Preferred	
<i>sinus 12 hour oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>sinus congestion max strength oral tablet 30 mg</i>	Preferred	
<i>sinus nasal spray nasal solution 0.05 %</i>	Preferred	
<i>sinus relief extra strength nasal solution 1 %</i>	Preferred	
<i>sinus relief mist nasal solution 0.05 %</i>	Preferred	
<i>sinus relief nasal solution 0.05 %</i>	Preferred	
<i>sm nasal decongestant max st oral tablet 30 mg</i>	Preferred	
<i>sm nasal decongestant oral tablet extended release 12 hour 120 mg</i>	Preferred	
<i>sm nasal decongestant pe oral tablet 10 mg</i>	Preferred	
<i>sm nasal spray 12 hour nasal solution 0.05 %</i>	Preferred	
<i>sm nasal spray nasal solution 0.05 %</i>	Preferred	
<i>sm nasal spray sinus nasal solution 0.05 %</i>	Preferred	
<i>sm nose drops nasal decongest nasal solution 1 %</i>	Preferred	
SUDAFED PE SINUS CONGESTION ORAL TABLET 10 MG (<i>phenylephrine hcl</i>)	Preferred	
SUDAFED SINUS CONGESTION 12HR ORAL TABLET EXTENDED RELEASE 12 HOUR 120 MG (<i>pseudoephedrine hcl</i>)	Preferred	
<i>sudogest 12 hour oral tablet extended release 12 hour 120 mg</i>	Preferred	
SUDOGEST MAXIMUM STRENGTH ORAL TABLET 30 MG (<i>pseudoephedrine hcl</i>)	Preferred	
SUDOGEST ORAL TABLET 30 MG, 60 MG (<i>pseudoephedrine hcl</i>)	Preferred	
<i>suphedrine 12hour oral tablet extended release 12 hour 120 mg</i>	Preferred	
VICKS SINEX 12 HOUR DECONGEST NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
VICKS SINEX MOISTURIZING NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
VICKS SINEX SEVERE DECONGEST NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
VICKS SINEX SEVERE NASAL SOLUTION 0.05 % (<i>oxymetazoline hcl</i>)	Preferred	
WAL-FOUR NASAL SOLUTION 1 % (<i>phenylephrine hcl</i>)	Preferred	
WAL-PHED 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 120 MG (<i>pseudoephedrine hcl</i>)	Preferred	
WAL-PHED D ORAL TABLET 30 MG (<i>pseudoephedrine hcl</i>)	Preferred	
WAL-PHED D ORAL TABLET EXTENDED RELEASE 12 HOUR 120 MG (<i>pseudoephedrine hcl</i>)	Preferred	
WAL-PHED PE ORAL TABLET 10 MG (<i>phenylephrine hcl</i>)	Preferred	
*SYMPATHOMIMETICS**		
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	Preferred	
ASTHMANEFRIN REFILL INHALATION NEBULIZATION SOLUTION 2.25 % (<i>racepinephrine hcl</i>)	Preferred	
S2 (RACEPINEPHRINE) INHALATION NEBULIZATION SOLUTION 2.25 % (<i>racepinephrine hcl</i>)	Preferred	
*TAR PRODUCTS**		
BETA CARE BETATAR GEL EXTERNAL SHAMPOO 2.5 % (<i>coal tar extract</i>)	Preferred	
<i>cvs therapeutic dandruff external shampoo 1 %</i>	Preferred	
<i>cvs therapeutic external shampoo 0.5 %</i>	Preferred	
DHS TAR EXTERNAL SHAMPOO 0.5 % (<i>coal tar extract</i>)	Preferred	
DHS TAR GEL EXTERNAL SHAMPOO 0.5 % (<i>coal tar extract</i>)	Preferred	
<i>eql therapeutic external shampoo 0.5 %</i>	Preferred	
IONIL-T EXTERNAL SHAMPOO 1 % (<i>coal tar extract</i>)	Preferred	
<i>sm anti-dandruff coal tar external shampoo 0.5 %</i>	Preferred	
<i>therapeutic external shampoo 0.5 %</i>	Preferred	
THERAPEUTIC T+PLUS EXTERNAL SHAMPOO 0.5 % (<i>coal tar extract</i>)	Preferred	
*TETRACYCLINES**		
<i>avidoxy oral tablet 100 mg</i>	Preferred	
<i>doxycycline hyclate (Doxy 100 Intravenous Solution Reconstituted 100 Mg)</i>	Preferred	
<i>doxycycline hyclate intravenous solution reconstituted 100 mg</i>	Preferred	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	Preferred	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	Preferred	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Preferred	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	Preferred	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	Preferred	
<i>minocycline hcl oral capsule 100 mg, 75 mg</i>	Preferred	QL (2 EA per 1 day)
<i>minocycline hcl oral capsule 50 mg</i>	Preferred	QL (4 EA per 1 day)
<i>doxycycline monohydrate (Mondoxyne NI Oral Capsule 100 Mg)</i>	Preferred	

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*THIAZIDES AND THIAZIDE-LIKE DIURETICS**		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Preferred	Max 90-day supply per fill
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	Preferred	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	Preferred	Max 90-day supply per fill
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	Preferred	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	Preferred	
*THROAT PRODUCTS - MISC.**		
ANBESOL COLD SORE THERAPY EXTERNAL OINTMENT (<i>cold sore products</i>)	Preferred	
AQUORAL MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	Preferred	
BIOTENE DRY MOUTH MOISTURIZING MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	Preferred	
CAPHOSOL MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	Preferred	
<i>cvs dry mouth mouth/throat solution</i>	Preferred	
<i>eql dry mouth oral rinse mouth/throat solution</i>	Preferred	
LIP CLEAR LYSINE EXTERNAL OINTMENT 0.1 % (<i>cold sore products</i>)	Preferred	
<i>lip-guard external ointment</i>	Preferred	
<i>l-lysine external ointment</i>	Preferred	
MOI-STIR MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	Preferred	
MOUTH KOTE MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	Preferred	
MOUTH KOTE REMINT MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	Preferred	
NUMOISYN MOUTH/THROAT LIQUID (<i>artificial saliva</i>)	Preferred	
<i>oral relief spray mouth/throat solution</i>	Preferred	
<i>ra dry mouth mouth/throat solution</i>	Preferred	
XEROSTOMIA RELIEF SPRAY MOUTH/THROAT SOLUTION (<i>artificial saliva</i>)	Preferred	
*THYROID HORMONES**		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (<i>thyroid</i>)	Preferred	
<i>levothyroxine sodium</i> (Euthyrox Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levo-T Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	Max 90-day supply per fill
<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	Preferred	Max 90-day supply per fill
<i>levothyroxine sodium</i> (Levoxyl Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	Max 90-day supply per fill
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>niva thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	Preferred	
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (<i>thyroid</i>)	Preferred	
<i>thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	Preferred	
<i>levothyroxine sodium</i> (Unithroid Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	Max 90-day supply per fill
*TRICYCLIC AGENTS**		
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Preferred	
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	Preferred	
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Preferred	
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Preferred	
<i>doxepin hcl oral concentrate 10 mg/ml</i>	Preferred	
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Preferred	
<i>imipramine pamoate oral capsule 100 mg, 150 mg, 75 mg</i>	Preferred	
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	Preferred	
*ULCER DRUGS - PROSTAGLANDINS**		
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	Preferred	
*URINARY ANALGESICS**		
<i>azo tabs oral tablet 95 mg</i>	Preferred	
AZO URINARY PAIN RELIEF ORAL TABLET 95 MG (<i>phenazopyridine hcl</i>)	Preferred	
<i>cvs urinary pain relief max st oral tablet 97.5 mg</i>	Preferred	
<i>cvs urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>eq urinary pain relief max st oral tablet 97.5 mg</i>	Preferred	
<i>eq urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>gnp urinary pain relief oral tablet 95 mg, 97.5 mg</i>	Preferred	
<i>hm urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>phenazopyridine hcl</i> (Phenazo Oral Tablet 200 Mg)	Preferred	
PHENAZO ORAL TABLET 95 MG (<i>phenazopyridine hcl</i>)	Preferred	
<i>phenazopyridine hcl oral tablet 100 mg, 200 mg</i>	Preferred	
<i>qc azo oral tablet 95 mg</i>	Preferred	
<i>qc urinary pain relief max st oral tablet 97.5 mg</i>	Preferred	
<i>qc urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>ra urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>sb urinary pain relief max st oral tablet 97.5 mg</i>	Preferred	
<i>sb urinary pain relief oral tablet 95 mg</i>	Preferred	
<i>sm urinary pain relief max st oral tablet 97.5 mg</i>	Preferred	
<i>sm urinary pain relief oral tablet 95 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>urinary pain relief max st oral tablet 97.5 mg</i>	Preferred	
<i>urinary pain relief oral tablet 95 mg</i>	Preferred	
VH ESSENTIALS UTI RELIEF ORAL TABLET 97.2 MG (phenazopyridine hcl)	Preferred	
*URINARY ANTI-INFECTIVES**		
<i>fosfomycin tromethamine oral packet 3 gm</i>	Preferred	
<i>methenamine hippurate oral tablet 1 gm</i>	Preferred	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg</i>	Preferred	
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	Preferred	
*URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS**		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	Preferred	
*VAGINAL ANTI-INFECTIVES**		
<i>3 day vaginal vaginal cream 2 %</i>	Preferred	
<i>clotrimazole 3 vaginal cream 2 %</i>	Preferred	
<i>clotrimazole vaginal cream 1 %</i>	Preferred	
<i>clotrimazole-7 vaginal cream 1 %</i>	Preferred	
<i>cvs clotrimazole 3 vaginal cream 2 %</i>	Preferred	
<i>cvs miconazole 1 combo pack vaginal kit 1200 & 2 mg & %</i>	Preferred	
<i>cvs miconazole 3 combo pack vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>cvs miconazole 3 combo-supp vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>cvs miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>cvs tioconazole 1 vaginal ointment 6.5 %</i>	Preferred	
<i>eq miconazole 1 vaginal kit 1200 & 2 mg & %</i>	Preferred	
<i>eq miconazole 7 day treatment vaginal cream 2 %</i>	Preferred	
<i>eq tioconazole 1 vaginal ointment 6.5 %</i>	Preferred	
<i>eql miconazole 3 vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>eql miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>eql tioconazole-1 vaginal ointment 6.5 %</i>	Preferred	
<i>gnp clotrimazole 3 vaginal cream 2 %</i>	Preferred	
<i>gnp miconazole 1 vaginal kit 1200 & 2 mg & %</i>	Preferred	
<i>gnp miconazole 3 vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>gnp miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>miconazole 1 vaginal kit 1200 & 2 mg & %</i>	Preferred	
<i>miconazole 3 combo pack app vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>miconazole 3 combo pack vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>miconazole 3 combo-supp vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>miconazole 7 vaginal suppository 100 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>miconazole nitrate vaginal cream 2 %</i>	Preferred	
MONISTAT 1-DAY VAGINAL OINTMENT 6.5 % (<i>tioconazole</i>)	Preferred	
MONISTAT 3 COMBINATION PACK VAGINAL KIT 200 & 2 MG-% (9GM) (<i>miconazole nitrate</i>)	Preferred	
MONISTAT 3 COMBO PACK APP VAGINAL KIT 200 & 2 MG-% (9GM) (<i>miconazole nitrate</i>)	Preferred	
MONISTAT 7 COMBO PACK APP VAGINAL KIT 100 & 2 MG-% (9GM) (<i>miconazole nitrate</i>)	Preferred	
MONISTAT 7 SIMPLY CURE VAGINAL CREAM 2 % (<i>miconazole nitrate</i>)	Preferred	
<i>px miconazole 3-day combo vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>qc 3 day vaginal cream 4 %</i>	Preferred	
<i>qc clotrimazole vaginal cream 1 %</i>	Preferred	
<i>qc miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>ra clotrimazole 7 vaginal cream 1 %</i>	Preferred	
<i>ra miconazole 3 combo pack app vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>ra miconazole 3 combo pack vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>ra miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>ra tioconazole 1 vaginal ointment 6.5 %</i>	Preferred	
<i>sm 3-day vaginal vaginal cream 2 %</i>	Preferred	
<i>sm clotrimazole vaginal vaginal cream 1 %</i>	Preferred	
<i>sm miconazole 3 applicator vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>sm miconazole 3 vaginal kit 200 & 2 mg-% (9gm)</i>	Preferred	
<i>sm miconazole 7 vaginal cream 2 %</i>	Preferred	
<i>sm miconazole 7 vaginal suppository 100 mg</i>	Preferred	
<i>sm tioconazole-1 vaginal ointment 6.5 %</i>	Preferred	
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	Preferred	
<i>terconazole vaginal suppository 80 mg</i>	Preferred	QL (1.5 EA per 1 day)
<i>tioconazole-1 vaginal ointment 6.5 %</i>	Preferred	
VAGISTAT-3 VAGINAL KIT 200 & 2 MG-% (9GM) (<i>miconazole nitrate</i>)	Preferred	
*VASODILATORS**		
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Preferred	Max 90-day supply per fill
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	Preferred	
*VASOPRESSORS**		
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	Preferred	
*VISCOSUPPLEMENTS**		
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (<i>sodium hyaluronate (viscosup)</i>)	Preferred	PA
HYALGAN INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (<i>sodium hyaluronate (viscosup)</i>)	Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
SYNOJOYNT INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (<i>sodium hyaluronate (viscosup)</i>)	Preferred	PA
TRILURON INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (<i>sodium hyaluronate (viscosup)</i>)	Preferred	PA
*VITAMIN MIXTURES**		
<i>cvs niacin flush free oral capsule 400-100 mg</i>	Preferred	
<i>gnp niacin flush free oral capsule 400-100 mg</i>	Preferred	
<i>niacin flush free oral capsule 400-100 mg</i>	Preferred	
<i>no flush niacin oral capsule 400-100 mg</i>	Preferred	
*WATER SOLUBLE VITAMINS**		
<i>acerola c-500 oral tablet chewable 500 mg</i>	Preferred	
<i>ascorbic acid oral tablet 1000 mg, 500 mg</i>	Preferred	
<i>b1 oral tablet 100 mg</i>	Preferred	
<i>b-1 oral tablet 100 mg, 250 mg</i>	Preferred	
<i>b-2 oral tablet 100 mg, 50 mg</i>	Preferred	
<i>b6 natural oral tablet 100 mg</i>	Preferred	
<i>b-6 oral tablet 100 mg, 250 mg, 50 mg, 500 mg</i>	Preferred	
<i>biotin maximum strength oral capsule 5000 mcg</i>	Preferred	
<i>biotin oral capsule 5 mg, 5000 mcg</i>	Preferred	
B-NATAL MOUTH/THROAT LOZENGE 25 MG (<i>pyridoxine hcl</i>)	Preferred	
B-NATAL MOUTH/THROAT LOZENGE ON A HANDLE 25 MG (<i>pyridoxine hcl</i>)	Preferred	
<i>c 1000 oral tablet 1000 mg</i>	Preferred	
<i>c 250 oral tablet 250 mg</i>	Preferred	
<i>c 500 oral tablet 500 mg</i>	Preferred	
<i>c 500 oral tablet chewable 500 mg</i>	Preferred	
<i>c 500/rose hips oral tablet 500 mg</i>	Preferred	
<i>c-1000 oral tablet 1000 mg</i>	Preferred	
<i>c-1000/rose hips oral tablet 1000 mg</i>	Preferred	
<i>c-250 oral tablet 250 mg</i>	Preferred	
<i>c-500 non-acid oral tablet 500 mg</i>	Preferred	
<i>c-500 oral tablet 500 mg</i>	Preferred	
<i>c-500 oral tablet chewable 500 mg</i>	Preferred	
<i>c-500/rose hips oral tablet 500 mg</i>	Preferred	
<i>calcium ascorbate oral tablet 500 mg</i>	Preferred	
<i>c-chewable oral tablet chewable 500 mg</i>	Preferred	
<i>cvs b-1 oral tablet 100 mg</i>	Preferred	
<i>cvs b6 oral tablet 100 mg</i>	Preferred	
<i>cvs biotin oral capsule 5000 mcg</i>	Preferred	
<i>cvs chewable c with rose hips oral tablet chewable 500 mg</i>	Preferred	
<i>cvs vitamin b-2 oral tablet 100 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>cvs vitamin c oral tablet 1000 mg, 250 mg, 500 mg</i>	Preferred	
<i>cvs vitamin c-rose hips oral tablet 1000 mg, 500 mg</i>	Preferred	
CYTO B2 ORAL POWDER 343 MG/GM (<i>riboflavin</i>)	Preferred	
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 250 MG, 750 MG (<i>niacin</i>)	Preferred	
ENDUR-ACIN ORAL TABLET EXTENDED RELEASE 500 MG (<i>niacin</i>)	Preferred	QL (3 EA per 1 day)
ENDUR-AMIDE ORAL TABLET EXTENDED RELEASE 500 MG (<i>niacinamide</i>)	Preferred	
<i>eql b-6 oral tablet 100 mg</i>	Preferred	
<i>eql biotin oral capsule 5000 mcg</i>	Preferred	
<i>eql vitamin c oral tablet 1000 mg, 500 mg</i>	Preferred	
<i>eql vitamin c/rose hips oral tablet 1000 mg, 500 mg</i>	Preferred	
<i>fruit c 500 oral tablet chewable 500 mg</i>	Preferred	
<i>gnp biotin oral capsule 5000 mcg</i>	Preferred	
<i>gnp vitamin b-1 oral tablet 100 mg</i>	Preferred	
<i>gnp vitamin b-6 oral tablet 100 mg</i>	Preferred	
<i>gnp vitamin c oral tablet 1000 mg, 250 mg, 500 mg</i>	Preferred	
<i>gnp vitamin c oral tablet chewable 500 mg</i>	Preferred	
<i>gnp vitamin c w/rose hips oral tablet 500-37 mg</i>	Preferred	
<i>gnp vitamin c/rose hips oral tablet 1000 mg</i>	Preferred	
<i>hm biotin oral capsule 5000 mcg</i>	Preferred	
<i>hm vitamin c oral tablet chewable 500 mg</i>	Preferred	
<i>kp niacin oral tablet 500 mg</i>	Preferred	
<i>kp vitamin b-6 oral tablet 100 mg</i>	Preferred	
<i>meijer c oral tablet 500 mg</i>	Preferred	
MERIBIN ORAL CAPSULE 5 MG (<i>biotin</i>)	Preferred	
<i>natural c/rose hips oral tablet 1000 mg, 500 mg</i>	Preferred	
<i>niacin er oral capsule extended release 250 mg, 500 mg</i>	Preferred	
<i>niacin er oral tablet extended release 250 mg</i>	Preferred	
<i>niacin er oral tablet extended release 500 mg</i>	Preferred	QL (3 EA per 1 day)
<i>niacin oral tablet 100 mg, 250 mg, 50 mg, 500 mg</i>	Preferred	
<i>niacinamide er oral tablet extended release 500 mg</i>	Preferred	
<i>niacinamide oral tablet 100 mg, 500 mg</i>	Preferred	
NIAVASC 750 ORAL TABLET EXTENDED RELEASE 750 MG (<i>niacin</i>)	Preferred	
NIAVASC ORAL TABLET EXTENDED RELEASE 500 MG (<i>niacin</i>)	Preferred	QL (3 EA per 1 day)
<i>plain niacin oral tablet 250 mg, 500 mg</i>	Preferred	
PUREWAY-C ORAL TABLET 500 MG (<i>ascorbic acid</i>)	Preferred	
<i>px niacin oral tablet 100 mg</i>	Preferred	
<i>px vitamin c oral tablet 500 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>pyridoxine hcl oral tablet 25 mg, 50 mg</i>	Preferred	
<i>qc niacin oral tablet 100 mg</i>	Preferred	
<i>qc vitamin b1 oral tablet 100 mg</i>	Preferred	
<i>qc vitamin b6 oral tablet 100 mg</i>	Preferred	
<i>qc vitamin c oral tablet 1000 mg, 500 mg</i>	Preferred	
<i>qc vitamin c oral tablet chewable 500 mg</i>	Preferred	
<i>qc vitamin c with rose hips oral tablet 500 mg</i>	Preferred	
<i>ra niacin oral tablet 100 mg, 500 mg</i>	Preferred	
<i>ra no flush niacin oral tablet 500 mg</i>	Preferred	
<i>ra vitamin b-1 oral tablet 100 mg</i>	Preferred	
<i>ra vitamin b-6 oral tablet 100 mg, 50 mg</i>	Preferred	
<i>ra vitamin c oral tablet 250 mg, 500 mg</i>	Preferred	
<i>ra vitamin c oral tablet chewable 500 mg</i>	Preferred	
<i>ra vitamin c/acerola oral tablet chewable 500 mg</i>	Preferred	
<i>ra vitamin c/rose hips oral tablet 1000 mg, 500 mg</i>	Preferred	
<i>sb vitamin c oral tablet 500 mg</i>	Preferred	
<i>sm biotin oral capsule 5000 mcg</i>	Preferred	
<i>sm chewable c oral tablet chewable 500 mg</i>	Preferred	
<i>sm chewable vitamin c oral tablet chewable 500 mg</i>	Preferred	
<i>sm niacin cr oral tablet extended release 250 mg</i>	Preferred	
<i>sm vit c/rose hips oral tablet 1000 mg</i>	Preferred	
<i>sm vitamin b1 oral tablet 100 mg</i>	Preferred	
<i>sm vitamin b6 oral tablet 100 mg</i>	Preferred	
<i>sm vitamin b-6 oral tablet 100 mg</i>	Preferred	
<i>sm vitamin c oral tablet 1000 mg, 250 mg, 500 mg</i>	Preferred	
<i>sm vitamin c oral tablet chewable 500 mg</i>	Preferred	
<i>sm vitamin c/rose hips oral tablet 500 mg</i>	Preferred	
SUNKIST VITAMIN C ORAL TABLET CHEWABLE 500 MG (ascorbic acid)	Preferred	
<i>super biotin oral capsule 5000 mcg</i>	Preferred	
<i>thiamine hcl oral tablet 100 mg</i>	Preferred	
<i>thiamine mononitrate oral tablet 100 mg</i>	Preferred	
<i>vitamin b1 oral tablet 100 mg</i>	Preferred	
<i>vitamin b-1 oral tablet 100 mg, 250 mg, 50 mg</i>	Preferred	
<i>vitamin b-2 oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	
<i>vitamin b-6 oral tablet 100 mg, 25 mg, 50 mg</i>	Preferred	
<i>vitamin b6 oral tablet 100 mg, 250 mg, 50 mg</i>	Preferred	
<i>vitamin c (calcium ascorbate) oral solution reconstituted</i>	Preferred	
<i>vitamin c immune health oral tablet chewable 500 mg</i>	Preferred	
<i>vitamin c oral tablet 100 mg, 1000 mg, 250 mg, 500 mg</i>	Preferred	

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Drug Name	Formulary Status	Requirements/Limits
<i>vitamin c oral tablet chewable 500 mg</i>	Preferred	
<i>vitamin c plus wild rose hips oral tablet chewable 500 mg</i>	Preferred	
<i>vitamin c/bioflavonoids/rosehip oral tablet 500 mg</i>	Preferred	
<i>vitamin c/natural rose hips oral tablet 1000 mg</i>	Preferred	
<i>vitamin c/rose hips oral tablet 500 mg</i>	Preferred	
<i>vitamin c-acerola oral tablet chewable 500 mg</i>	Preferred	
<i>vitamin c-rose hips oral tablet 1000 mg, 500 mg</i>	Preferred	
<i>vitamin c-rose hips oral tablet chewable 500 mg</i>	Preferred	
<i>yl vitamin b-6 oral tablet 100 mg</i>	Preferred	
<i>yl vitamin c oral tablet 1000 mg, 500 mg</i>	Preferred	
<i>yl vitamin c-rose hips oral tablet 1000 mg, 500 mg</i>	Preferred	
*WOUND CARE PRODUCTS**		
ATRAPRO DERMAL SPRAY EXTERNAL LIQUID (<i>wound cleansers</i>)	Preferred	
<i>cvs wound wash advanced external liquid</i>	Preferred	
MICROCYN EXTERNAL LIQUID 0.023 % (<i>wound cleansers</i>)	Preferred	
NEXCARE WOUND CLEANSER EXTERNAL LIQUID (<i>wound cleansers</i>)	Preferred	
PURACYN PLUS DUO-CARE EXTERNAL LIQUID (<i>wound cleansers</i>)	Preferred	
RESTA WOUND CLEANSER EXTERNAL LIQUID (<i>wound cleansers</i>)	Preferred	
SAF-CLENS AF EXTERNAL LIQUID (<i>wound cleansers</i>)	Preferred	
SILVERMED EXTERNAL LIQUID (<i>wound cleansers</i>)	Preferred	
<i>wound cleanser external liquid</i>	Preferred	
<i>wound/skin cleanser external liquid</i>	Preferred	
*ZINC**		
<i>cvs zinc gluconate oral tablet 50 mg</i>	Preferred	
ORAZINC ORAL CAPSULE 220 (50 ZN) MG (<i>zinc sulfate</i>)	Preferred	
<i>ra zinc oral tablet 50 mg</i>	Preferred	
<i>sm zinc gluconate oral tablet 50 mg</i>	Preferred	
ZINC 15 ORAL TABLET 66 MG (<i>zinc sulfate</i>)	Preferred	
<i>zinc gluconate oral tablet 50 mg</i>	Preferred	
<i>zinc oral capsule 220 (50 zn) mg</i>	Preferred	
<i>zinc sulfate oral capsule 220 (50 zn) mg</i>	Preferred	
TOPICAL ANTIBIOTICS [OPEN CLASS]		
<i>mupirocin ointment 2 % external</i>	Preferred	
ULCERATIVE COLITIS [OPEN CLASS]		
APRISO CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM ORAL (<i>mesalamine</i>)	Preferred	Max 90-day supply per fill
AZULFIDINE EN-TABS TABLET DELAYED RELEASE 500 MG ORAL (<i>sulfasalazine</i>)	Non Preferred	PA; Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
AZULFIDINE TABLET 500 MG ORAL (<i>sulfasalazine</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>balsalazide disodium capsule 750 mg oral</i>	Preferred	Max 90-day supply per fill
<i>budesonide er tablet extended release 24 hour 9 mg oral</i>	Non Preferred	PA
<i>budesonide foam 2 mg rectal</i>	Non Preferred	PA
CANASA SUPPOSITORY 1000 MG RECTAL (<i>mesalamine</i>)	Non Preferred	PA; Max 90-day supply per fill
COLAZAL CAPSULE 750 MG ORAL (<i>balsalazide disodium</i>)	Non Preferred	PA; Max 90-day supply per fill
DELZICOL CAPSULE DELAYED RELEASE 400 MG ORAL (<i>mesalamine</i>)	Non Preferred	PA
DIPENTUM CAPSULE 250 MG ORAL (<i>olsalazine sodium</i>)	Non Preferred	PA
LIALDA TABLET DELAYED RELEASE 1.2 GM ORAL (<i>mesalamine</i>)	Non Preferred	PA
<i>mesalamine capsule delayed release 400 mg oral</i>	Preferred	
<i>mesalamine enema 4 gm rectal</i>	Preferred	Max 90-day supply per fill
<i>mesalamine er capsule extended release 24 hour 0.375 gm oral</i>	Preferred	Max 90-day supply per fill
<i>mesalamine er capsule extended release 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>mesalamine suppository 1000 mg rectal</i>	Preferred	Max 90-day supply per fill
<i>mesalamine tablet delayed release 1.2 gm oral</i>	Preferred	
<i>mesalamine tablet delayed release 800 mg oral</i>	Preferred	
<i>mesalamine-cleanser kit 4 gm rectal</i>	Non Preferred	PA
PENTASA CAPSULE EXTENDED RELEASE 250 MG ORAL (<i>mesalamine</i>)	Preferred	Max 90-day supply per fill
PENTASA CAPSULE EXTENDED RELEASE 500 MG ORAL (<i>mesalamine</i>)	Preferred	Max 90-day supply per fill
ROWASA KIT 4 GM RECTAL (<i>mesalamine-cleanser</i>)	Non Preferred	PA
SFROWASA ENEMA 4 GM/60ML RECTAL (<i>mesalamine</i>)	Non Preferred	PA
<i>sulfasalazine tablet 500 mg oral</i>	Preferred	Max 90-day supply per fill
<i>sulfasalazine tablet delayed release 500 mg oral</i>	Preferred	Max 90-day supply per fill
UCERIS FOAM 2 MG/ACT RECTAL (<i>budesonide</i>)	Non Preferred	PA
UCERIS TABLET EXTENDED RELEASE 24 HOUR 9 MG ORAL (<i>budesonide</i>)	Non Preferred	PA
URINARY ANTISPASMODIC [OPEN CLASS]		
<i>darifenacin hydrobromide er tablet extended release 24 hour 15 mg oral</i>	Non Preferred	PA

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Drug Name	Formulary Status	Requirements/Limits
<i>darifenacin hydrobromide er tablet extended release 24 hour 7.5 mg oral</i>	Non Preferred	PA
DETROL LA CAPSULE EXTENDED RELEASE 24 HOUR 2 MG ORAL (<i>tolterodine tartrate</i>)	Non Preferred	PA
DETROL LA CAPSULE EXTENDED RELEASE 24 HOUR 4 MG ORAL (<i>tolterodine tartrate</i>)	Non Preferred	PA
DETROL TABLET 1 MG ORAL (<i>tolterodine tartrate</i>)	Non Preferred	PA
DETROL TABLET 2 MG ORAL (<i>tolterodine tartrate</i>)	Non Preferred	PA
DITROPAN XL TABLET EXTENDED RELEASE 24 HOUR 5 MG ORAL (<i>oxybutynin chloride</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>fesoterodine fumarate er tablet extended release 24 hour 4 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>fesoterodine fumarate er tablet extended release 24 hour 8 mg oral</i>	Non Preferred	PA; Max 90-day supply per fill
<i>flavoxate hcl tablet 100 mg oral</i>	Non Preferred	PA
GELNIQUE GEL 10 % TRANSDERMAL (<i>oxybutynin chloride</i>)	Non Preferred	PA
GEMTESA TABLET 75 MG ORAL (<i>vibegron</i>)	Non Preferred	PA
MYRBETRIQ SUSPENSION RECONSTITUTED ER 8 MG/ML ORAL (<i>mirabegron</i>)	Non Preferred	PA
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL (<i>mirabegron</i>)	Non Preferred	PA
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL (<i>mirabegron</i>)	Non Preferred	PA
<i>oxybutynin chloride er tablet extended release 24 hour 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>oxybutynin chloride er tablet extended release 24 hour 15 mg oral</i>	Preferred	Max 90-day supply per fill
<i>oxybutynin chloride er tablet extended release 24 hour 5 mg oral</i>	Preferred	Max 90-day supply per fill
<i>oxybutynin chloride solution 5 mg/5ml oral</i>	Preferred	Max 90-day supply per fill
<i>oxybutynin chloride solution 5 mg/5ml oral</i>	Preferred	
<i>oxybutynin chloride tablet 2.5 mg oral</i>	Preferred	
<i>oxybutynin chloride tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill
OXYTROL FOR WOMEN PATCH TWICE WEEKLY 3.9 MG/24HR TRANSDERMAL (<i>oxybutynin</i>)	Non Preferred	PA; Max 90-day supply per fill
OXYTROL PATCH TWICE WEEKLY 3.9 MG/24HR TRANSDERMAL (<i>oxybutynin</i>)	Non Preferred	PA; Max 90-day supply per fill
<i>solifenacin succinate tablet 10 mg oral</i>	Preferred	Max 90-day supply per fill
<i>solifenacin succinate tablet 5 mg oral</i>	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
<i>tolterodine tartrate er capsule extended release 24 hour 2 mg oral</i>	Non Preferred	PA
<i>tolterodine tartrate er capsule extended release 24 hour 4 mg oral</i>	Non Preferred	PA
<i>tolterodine tartrate tablet 1 mg oral</i>	Non Preferred	PA
<i>tolterodine tartrate tablet 2 mg oral</i>	Non Preferred	PA
TOVIAZ TABLET EXTENDED RELEASE 24 HOUR 4 MG ORAL (<i>fesoterodine fumarate</i>)	Preferred	Max 90-day supply per fill
TOVIAZ TABLET EXTENDED RELEASE 24 HOUR 8 MG ORAL (<i>fesoterodine fumarate</i>)	Preferred	Max 90-day supply per fill
<i>tropium chloride er capsule extended release 24 hour 60 mg oral</i>	Preferred	
<i>tropium chloride tablet 20 mg oral</i>	Non Preferred	PA
VESICARE LS SUSPENSION 5 MG/5ML ORAL (<i>solifenacin succinate</i>)	Non Preferred	PA
VESICARE TABLET 10 MG ORAL (<i>solifenacin succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
VESICARE TABLET 5 MG ORAL (<i>solifenacin succinate</i>)	Non Preferred	PA; Max 90-day supply per fill
VAGINAL ANTIBIOTICS [OPEN CLASS]		
CLEOCIN CREAM 2 % VAGINAL (<i>clindamycin phosphate</i>)	Non Preferred	PA
CLEOCIN SUPPOSITORY 100 MG VAGINAL (<i>clindamycin phosphate</i>)	Preferred	
<i>clindamycin phosphate cream 2 % vaginal</i>	Non Preferred	PA
CLINDESSE CREAM 2 % VAGINAL (<i>clindamycin phosphate (1 dose)</i>)	Preferred	
<i>metronidazole gel 0.75 % vaginal</i>	Preferred	
NUVESSA GEL 1.3 % VAGINAL (<i>metronidazole</i>)	Preferred	
VANAZOLE GEL 0.75 % VAGINAL (<i>metronidazole</i>)	Non Preferred	PA
XACIATO GEL 2 % VAGINAL (<i>clindamycin phosphate</i>)	Non Preferred	PA
VAGINAL ESTROGENS [OPEN CLASS]		
ESTRACE CREAM 0.1 MG/GM VAGINAL (<i>estradiol</i>)	Non Preferred	PA
<i>estradiol cream 0.1 mg/gm vaginal</i>	Preferred	
<i>estradiol tablet 10 mcg vaginal</i>	Preferred	AGE (Min 18 Years)
ESTRING RING 7.5 MCG/24HR VAGINAL (<i>estradiol</i>)	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug **PA** - Prior Authorization **QL** - Quantity Limits **rx** - Prescription Drug

Drug Name	Formulary Status	Requirements/Limits
FEMRING RING 0.05 MG/24HR VAGINAL (<i>estradiol acetate</i>)	Non Preferred	PA
FEMRING RING 0.1 MG/24HR VAGINAL (<i>estradiol acetate</i>)	Non Preferred	PA
IMVEXXY MAINTENANCE PACK INSERT 10 MCG VAGINAL (<i>estradiol</i>)	Non Preferred	PA
IMVEXXY MAINTENANCE PACK INSERT 4 MCG VAGINAL (<i>estradiol</i>)	Non Preferred	PA
IMVEXXY STARTER PACK INSERT 10 MCG VAGINAL (<i>estradiol</i>)	Non Preferred	PA
IMVEXXY STARTER PACK INSERT 4 MCG VAGINAL (<i>estradiol</i>)	Non Preferred	PA
PREMARIN CREAM 0.625 MG/GM VAGINAL (<i>estrogens, conjugated</i>)	Preferred	
VAGIFEM TABLET 10 MCG VAGINAL (<i>estradiol</i>)	Preferred	AGE (Min 18 Years)
<i>estradiol</i> (Yuvaferm Tablet 10 Mcg Vaginal)	Preferred	AGE (Min 18 Years)
WEIGHT MANAGEMENT AGENTS [CLOSED CLASS]		
CONTRACE TABLET EXTENDED RELEASE 12 HOUR 8-90 MG ORAL (<i>naltrexone-bupropion hcl</i>)	Preferred	PA; AGE (Min 18 Years)
IMCIVREE SOLUTION 10 MG/ML SUBCUTANEOUS (<i>setmelanotide acetate</i>)	Non Preferred	PA; AGE (Min 6 Years)
<i>orlistat capsule 120 mg oral</i>	Preferred	PA; AGE (Min 12 Years)
SAXENDA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS (<i>liraglutide -weight management</i>)	Preferred	PA; AGE (Min 12 Years)
WEGOVY SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML SUBCUTANEOUS (<i>semaglutide-weight management</i>)	Preferred	PA; AGE (Min 12 Years)
WEGOVY SOLUTION AUTO-INJECTOR 0.5 MG/0.5ML SUBCUTANEOUS (<i>semaglutide-weight management</i>)	Preferred	PA; AGE (Min 12 Years)
WEGOVY SOLUTION AUTO-INJECTOR 1 MG/0.5ML SUBCUTANEOUS (<i>semaglutide-weight management</i>)	Preferred	PA; AGE (Min 12 Years)
WEGOVY SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML SUBCUTANEOUS (<i>semaglutide-weight management</i>)	Preferred	PA; AGE (Min 12 Years)
WEGOVY SOLUTION AUTO-INJECTOR 2.4 MG/0.75ML SUBCUTANEOUS (<i>semaglutide-weight management</i>)	Preferred	PA; AGE (Min 12 Years)
XENICAL CAPSULE 120 MG ORAL (<i>orlistat</i>)	Preferred	PA; AGE (Min 12 Years)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **otc** - Over-the-Counter Drug
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