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, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(800) 424-4518 (TTY/TDD: 711) 번으로 전화해 주십시오.

Vietnamese
CHÚ Ý: Nếu ban nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho ban. 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 تعمارية ونه ته بينوايان 711)); تعمارية ونه ته بينوايان تماس بگیرید

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል: ወደ ሚከተለው ቁጥር ይደውሉ

Urdu
دعیان دین: اگر آپ اردو بو لیتے ہیں تو مشت زبان کی مدد والی خل ما شت دستیاب ہیں۔ (711 بلس --424-800 (TTY/TDD) : 4518 میڈ لین. پرکریں 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 है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है।
(800) 424-4518 (TTY/TDD: 711) पर कॉल करे ।

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

Bengali
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলেত পারেন, তাহেল নিঃখরচায় ভাষা সহায়তা পা রেষবা উপল আছে ফোন করন।
(800) 424-4518 (TTY/TDD: 711).

Bassa
Dè dɛ nià kɛ dyédé gbo: ɔ jǔ ké m̀ Bàsɔ ɔ-wùdù-po-nyɔ jǔ ní, nií, à wudu kà kò do po-poɔ bɛ́ ìn 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	KONVOMEP 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	ARIPIPRAZOLE 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	ALTUVIIIO 4,000 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIO 250 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIO 2,000 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIO 500 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIO 1,000 UNIT VIAL	Add to formulary, non-preferred	
10/1/2023	ALTUVIIIO 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	PREDNISONE 2.5 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISONE 20 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISONE 10 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISONE 5 MG TABLET	Add to formulary, preferred	
10/1/2023	PREDNISONE 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	DEXTROAMPHETAMINE 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
lowercase	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 dela 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 riego 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 s 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 novel 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, nopreferido	
10/1/2023	DAPSONE 7.5% GEL PUMP	Agregar al formulario, nopreferido	
10/1/2023	BELBUCA 150 MCG FILM	Agregar al formulario, nopreferido	
10/1/2023	BELBUCA 750 MCG FILM	Agregar al formulario, nopreferido	
10/1/2023	BELBUCA 900 MCG FILM	Agregar al formulario, nopreferido	
10/1/2023	BELBUCA 75 MCG FILM	Agregar al formulario, nopreferido	
10/1/2023	BELBUCA 600 MCG FILM	Agregar al formulario, nopreferido	
10/1/2023	BELBUCA 450 MCG FILM	Agregar al formulario, nopreferido	
10/1/2023	BELBUCA 300 MCG FILM	Agregar al formulario, nopreferido	
10/1/2023	TESTOSTERONE 30 MG/1.5 ML PUMP	Agregar al formulario, nopreferido	
10/1/2023	RAGWITEK SUBLINGUAL TABLET	Agregar al formulario, nopreferido	
10/1/2023	ODACTRA 12 SQ-HDM SL TABLET	Agregar al formulario, nopreferido	
10/1/2023	GRASTEK 2,800 BAU SL TABLET	Agregar al formulario, nopreferido	
10/1/2023	VANCOMYCIN 25 MG/ML SOLUTION	Agregar al formulario, nopreferido	
10/1/2023	VANCOMYCIN 50 MG/ML SOLUTION	Agregar al formulario, nopreferido	
10/1/2023	VENLAFAXINE HCL ER 150 MG TAB	Agregar al formulario, nopreferido	
10/1/2023	VENLAFAXINE HCL ER 225 MG TAB	Agregar al formulario, nopreferido	
10/1/2023	VENLAFAXINE HCL ER 75 MG TAB	Agregar al formulario, nopreferido	
10/1/2023	VILAZODONE HCL 10 MG TABLET	Agregar al formulario, nopreferido	
10/1/2023	VILAZODONE HCL 20 MG TABLET	Agregar al formulario, nopreferido	
10/1/2023	VILAZODONE HCL 40 MG TABLET	Agregar al formulario, nopreferido	
10/1/2023	GRANISETRON HCL 1 MG TABLET	Agregar al formulario, nopreferido	
10/1/2023	POSACONAZOLE 200 MG/5 ML SUSP	Agregar al formulario, nopreferido	
10/1/2023	POSACONAZOLE DR 100 MG TABLET	Agregar al formulario, nopreferido	
10/1/2023	ORAVIG 50 MG BUCCAL TABLET	Agregar al formulario, nopreferido	
10/1/2023	MICONAZOLE NITRATE 2% SOLUTION	Agregar al formulario, nopreferido	
10/1/2023	FEBUXOSTAT 40 MG TABLET	Agregar al formulario, nopreferido	

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

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	ARIPIPRAZOLE 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	ALTUVIIIO 4,000 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIIIO 250 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIIIO 2,000 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIIIO 500 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIIIO 1,000 UNIT VIAL	Agregar al formulario, nopreferido	
10/1/2023	ALTUVIIIO 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	PREDNISONE 2.5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONE 20 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONE 10 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONE 5 MG TABLET	Agregar al formulario, privilegiado	
10/1/2023	PREDNISONE 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
minúscula	Indica disponibilidad genérica
MAYÚSCULA	Indica disponibilidad de la marca

Table of Contents

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

Drug Name	Formulary Status	Requirements/Limits
BENZEFOAM FOAM 5.3 % EXTERNAL (OTC) (*benzoyl peroxide*)	Non Preferred	PA; AGE (Max 18 Years)
benzoyl peroxide gel 10 % external (otc)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
benzoyl peroxide gel 2.5 % external (otc)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
benzoyl peroxide gel 5 % external (otc)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
benzoyl peroxide wash liquid 10 % external (otc)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
benzoyl peroxide wash liquid 5 % external (otc)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
benzoyl peroxide-erythromycin gel 5-3 % external	Non Preferred	PA; AGE (Max 18 Years)
bp 10-1 emulsion 10-1 % external	Non Preferred	PA; AGE (Max 18 Years)
bp cleansing wash emulsion 10-4 % external	Non Preferred	PA; AGE (Max 18 Years)
bpo foaming cloths 6 % external (otc)	Non Preferred	PA; AGE (Max 18 Years)
CLEOCIN-T LOTION 1 % EXTERNAL (*clindamycin phosphate*)	Non Preferred	PA; AGE (Max 18 Years)
CLINDACIN ETZ KIT 1 % EXTERNAL (*clindamycin phos & cleanser*)	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate (Clindacin Etz Swab 1 % External)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
clindamycin phosphate (Clindacin Foam 1 % External)	Non Preferred	PA; AGE (Max 18 Years)
CLINDACIN PAC KIT 1 % EXTERNAL (*clindamycin phos & cleanser*)	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate (Clindacin-P Swab 1 % External)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
CLINDAGEL GEL 1 % EXTERNAL (*clindamycin phosphate*)	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phos-benzoyl perox gel 1.2-2.5 % external	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phos-benzoyl perox gel 1.2-5 % external	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
clindamycin phos-benzoyl perox gel 1-5 % external	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate foam 1 % external	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate gel 1 % external	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate lotion 1 % external	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
clindamycin phosphate solution 1 % external	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
clindamycin phosphate swab 1 % external	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
clindamycin-tretinoin gel 1.2-0.025 % external	Non Preferred	PA; AGE (Max 18 Years)
dapsone gel 5 % external	Non Preferred	PA; AGE (Max 18 Years)
dapsone gel 7.5 % external	Non Preferred	PA; AGE (Max 18 Years)
DERMACINRX ATRIX ANTIBAC WASH LIQUID 2 % EXTERNAL (*salicylic acid*)	Non Preferred	PA; AGE (Max 18 Years)
ery pad 2 % external	Non Preferred	PA; AGE (Max 18 Years)
ERYGEL GEL 2 % EXTERNAL (*erythromycin*)	Non Preferred	PA; AGE (Max 18 Years)
erythromycin gel 2 % external	Non Preferred	PA; AGE (Max 18 Years)
erythromycin solution 2 % external	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
FABIOR FOAM 0.1 % EXTERNAL (*tazarotene*)	Non Preferred	PA; AGE (Min 12 Years and Max 18 Years)
clindamycin-benzoyl per (refr) (Neuac Gel 1.2-5 % External)	Non Preferred	PA; AGE (Max 18 Years)
ONEXTON GEL 1.2-3.75 % EXTERNAL (*clindamycin phos-benzoyl perox*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS CREAM 10 % EXTERNAL (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS LOTION 9.8 % EXTERNAL (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS SHAMPOO 10 % EXTERNAL (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS WASH GEL 10 % EXTERNAL (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS WASH LIQUID 10 % EXTERNAL (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE WASH LIQUID 10 % EXTERNAL (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A CREAM 0.025 % EXTERNAL (*tretinoin*)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
RETIN-A CREAM 0.05 % EXTERNAL (*tretinoin*)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
RETIN-A CREAM 0.1 % EXTERNAL (*tretinoin*)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)
RETIN-A GEL 0.01 % EXTERNAL (*tretinoin*)	Preferred	PA (Eligible for auto-PA); AGE (Max 18 Years)

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
TESTIM GEL 50 MG/5GM (1%) TRANSDERMAL (*testosterone*)	Non Preferred	PA; AGE (Min 18 Years)
testosterone gel 1.62 % transdermal	Preferred	
testosterone gel 10 mg/act (2%) transdermal	Non Preferred	PA; AGE (Min 18 Years)
testosterone gel 12.5 mg/act (1%) transdermal	Non Preferred	PA; AGE (Min 18 Years)
testosterone gel 20.25 mg/1.25gm (1.62%) transdermal	Non Preferred	PA; AGE (Min 18 Years)
testosterone gel 20.25 mg/act (1.62%) transdermal	Preferred	
testosterone gel 25 mg/2.5gm (1%) transdermal	Non Preferred	PA; AGE (Min 18 Years)
testosterone gel 40.5 mg/2.5gm (1.62%) transdermal	Non Preferred	PA; AGE (Min 18 Years)
testosterone gel 50 mg/5gm (1%) transdermal	Non Preferred	PA; AGE (Min 18 Years)
testosterone solution 30 mg/act transdermal	Non Preferred	PA; AGE (Min 18 Years)
VOGELXO GEL 50 MG/5GM (1%) TRANSDERMAL (*testosterone*)	Non Preferred	PA; AGE (Min 18 Years)
VOGELXO PUMP GEL 12.5 MG/ACT (1%) TRANSDERMAL (*testosterone*)	Non Preferred	PA; AGE (Min 18 Years)
ANTI-ALLERGENS, ORAL [OPEN CLASS]		
GRASTEK TABLET SUBLINGUAL 2800 BAU SUBLINGUAL (*timothy grass pollen allergen*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 5 Years)
ODACTRA TABLET SUBLINGUAL 12 SQ-HDM SUBLINGUAL (*dust mite mixed allergen ext*)	Non Preferred	PA; AGE (Min 12 Years and Max 65 Years)
ORALAIR TABLET SUBLINGUAL 300 IR SUBLINGUAL (*grass mix pollens allergen ext*)	Non Preferred	PA; AGE (Min 5 Years)
PALFORZIA (12 MG DAILY DOSE) 2 X 1 MG & 10 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (120 MG DAILY DOSE) 20 MG & 100 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (160 MG DAILY DOSE) 3 X 20 MG & 100 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (20 MG DAILY DOSE) 20 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (200 MG DAILY DOSE) 2 X 100 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (240 MG DAILY DOSE) 2 X 20 MG & 2 X 100 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (3 MG DAILY DOSE) 3 X 1 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (300 MG MAINTENANCE) PACKET 300 MG ORAL (*peanut powder-dnfp*)	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 (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (40 MG DAILY DOSE) 2 X 20 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (6 MG DAILY DOSE) 6 X 1 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA (80 MG DAILY DOSE) 4 X 20 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
PALFORZIA INITIAL ESCALATION 0.5 & 1 & 1.5 & 3 & 6 MG ORAL (*peanut powder-dnfp*)	Non Preferred	PA; AGE (Min 4 Years)
RAGWITEK TABLET SUBLINGUAL 12 AMB A 1-U SUBLINGUAL (*short ragweed pollen ext*)	Non Preferred	PA; AGE (Min 5 Years)
ANTIBIOTICS, INHALED [CLOSED CLASS]		
ARIKAYCE SUSPENSION 590 MG/8.4ML INHALATION (*amikacin sulfate liposome*)	Non Preferred	PA; QL (235.2 ML per 28 days); AGE (Min 18 Years)
BETHKIS NEBULIZATION SOLUTION 300 MG/4ML INHALATION (*tobramycin*)	Preferred	QL (224 ML per 28 days); AGE (Min 6 Years)
CAYSTON SOLUTION RECONSTITUTED 75 MG INHALATION (*aztreonam lysine*)	Non Preferred	PA; QL (84 ML per 28 days); AGE (Min 7 Years)
KITABIS PAK NEBULIZATION SOLUTION 300 MG/5ML INHALATION (*tobramycin*)	Preferred	QL (280 ML per 28 days); AGE (Min 6 Years)
TOBI NEBULIZATION SOLUTION 300 MG/5ML INHALATION (*tobramycin*)	Non Preferred	PA; QL (280 ML per 28 days); AGE (Min 6 Years)
TOBI PODHALER CAPSULE 28 MG INHALATION (*tobramycin*)	Preferred	PA; QL (224 EA per 28 days); AGE (Min 6 Years)
tobramycin nebulization solution 300 mg/4ml inhalation	Non Preferred	PA; QL (224 ML per 28 days); AGE (Min 6 Years)
tobramycin nebulization solution 300 mg/5ml inhalation	Non Preferred	PA; QL (280 ML per 28 days); AGE (Min 6 Years)
tobramycin nebulization solution 300 mg/5ml inhalation	Preferred	QL (280 ML per 28 days); AGE (Min 6 Years)
ANTICOAGULANTS [CLOSED CLASS]		
ARIXTRA SOLUTION 10 MG/0.8ML SUBCUTANEOUS (*fondaparinux sodium*)	Non Preferred	PA
ARIXTRA SOLUTION 2.5 MG/0.5ML SUBCUTANEOUS (*fondaparinux sodium*)	Non Preferred	PA
ARIXTRA SOLUTION 5 MG/0.4ML SUBCUTANEOUS (*fondaparinux sodium*)	Non Preferred	PA
ARIXTRA SOLUTION 7.5 MG/0.6ML SUBCUTANEOUS (*fondaparinux sodium*)	Non Preferred	PA
dabigatran etexilate mesylate capsule 150 mg oral	Non Preferred	PA; Max 90-day supply per fill
dabigatran etexilate mesylate capsule 75 mg oral	Non Preferred	PA; Max 90-day supply per fill
ELIQUIS DVT/PE STARTER PACK TABLET THERAPY PACK 5 MG ORAL (*apixaban*)	Preferred	

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
DEPAKOTE ER TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL (*divalproex sodium*)	Non Preferred	PA; Max 90-day supply per fill
DEPAKOTE SPRINKLES CAPSULE DELAYED RELEASE SPRINKLE 125 MG ORAL (*divalproex sodium*)	Non Preferred	PA; Max 90-day supply per fill
DEPAKOTE TABLET DELAYED RELEASE 125 MG ORAL (*divalproex sodium*)	Non Preferred	PA; Max 90-day supply per fill
DEPAKOTE TABLET DELAYED RELEASE 250 MG ORAL (*divalproex sodium*)	Non Preferred	PA; Max 90-day supply per fill
DEPAKOTE TABLET DELAYED RELEASE 500 MG ORAL (*divalproex sodium*)	Non Preferred	PA; Max 90-day supply per fill
DIACOMIT CAPSULE 250 MG ORAL (*stiripentol*)	Non Preferred	PA
DIACOMIT CAPSULE 500 MG ORAL (*stiripentol*)	Non Preferred	PA
DIACOMIT PACKET 250 MG ORAL (*stiripentol*)	Non Preferred	PA
DIACOMIT PACKET 500 MG ORAL (*stiripentol*)	Non Preferred	PA
DIASTAT ACUDIAL GEL 10 MG RECTAL (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DIASTAT ACUDIAL GEL 20 MG RECTAL (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DIASTAT PEDIATRIC GEL 2.5 MG RECTAL (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
diazepam gel 10 mg rectal	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
diazepam gel 2.5 mg rectal	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
diazepam gel 20 mg rectal	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DILANTIN CAPSULE 100 MG ORAL (*phenytoin sodium extended*)	Non Preferred	PA; Max 90-day supply per fill
DILANTIN CAPSULE 30 MG ORAL (*phenytoin sodium extended*)	Preferred	
DILANTIN INFATABS TABLET CHEWABLE 50 MG ORAL (*phenytoin*)	Non Preferred	PA; Max 90-day supply per fill
DILANTIN SUSPENSION 125 MG/5ML ORAL (*phenytoin*)	Non Preferred	PA; Max 90-day supply per fill
divalproex sodium capsule delayed release sprinkle 125 mg oral	Preferred	Max 90-day supply per fill
divalproex sodium er tablet extended release 24 hour 250 mg oral	Preferred	Max 90-day supply per fill
divalproex sodium er tablet extended release 24 hour 500 mg oral	Preferred	Max 90-day supply per fill
divalproex sodium tablet delayed release 125 mg oral	Preferred	Max 90-day supply per fill
divalproex sodium tablet delayed release 250 mg oral	Preferred	Max 90-day supply per fill
divalproex sodium tablet delayed release 500 mg oral	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 (*levetiracetam*)	Non Preferred	PA
ELEPSIA XR TABLET EXTENDED RELEASE 24 HOUR 1500 MG ORAL (*levetiracetam*)	Non Preferred	PA
EPIDIOLEX SOLUTION 100 MG/ML ORAL (*cannabidiol*)	Preferred	PA (Eligible for auto-PA); AGE (Min 1 Years)
carbamazepine (Epitol Tablet 200 Mg Oral)	Preferred	Max 90-day supply per fill
EPRONTIA SOLUTION 25 MG/ML ORAL (*topiramate*)	Non Preferred	PA
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 100 MG ORAL (*carbamazepine (antipsychotic)*)	Non Preferred	PA
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 200 MG ORAL (*carbamazepine (antipsychotic)*)	Non Preferred	PA
EQUETRO CAPSULE EXTENDED RELEASE 12 HOUR 300 MG ORAL (*carbamazepine (antipsychotic)*)	Non Preferred	PA
ethosuximide capsule 250 mg oral	Preferred	Max 90-day supply per fill
ethosuximide solution 250 mg/5ml oral	Preferred	AGE (Min 3 Years); Max 90-day supply per fill
felbamate suspension 600 mg/5ml oral	Non Preferred	PA
felbamate tablet 400 mg oral	Non Preferred	PA
felbamate tablet 600 mg oral	Non Preferred	PA
FELBATOL SUSPENSION 600 MG/5ML ORAL (*felbamate*)	Non Preferred	PA
FELBATOL TABLET 400 MG ORAL (*felbamate*)	Non Preferred	PA
FELBATOL TABLET 600 MG ORAL (*felbamate*)	Non Preferred	PA
FINTEPLA SOLUTION 2.2 MG/ML ORAL (*fenfluramine hcl*)	Non Preferred	PA; AGE (Min 2 Years)
FYCOMPA SUSPENSION 0.5 MG/ML ORAL (*perampanel*)	Non Preferred	PA
FYCOMPA TABLET 10 MG ORAL (*perampanel*)	Non Preferred	PA
FYCOMPA TABLET 12 MG ORAL (*perampanel*)	Non Preferred	PA
FYCOMPA TABLET 2 MG ORAL (*perampanel*)	Non Preferred	PA
FYCOMPA TABLET 4 MG ORAL (*perampanel*)	Non Preferred	PA
FYCOMPA TABLET 6 MG ORAL (*perampanel*)	Non Preferred	PA
FYCOMPA TABLET 8 MG ORAL (*perampanel*)	Non Preferred	PA

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

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

Drug Name	Formulary Status	Requirements/Limits
lamotrigine kit 42 x 50 mg & 14x100 mg oral	Non Preferred	PA
lamotrigine starter kit-blue kit 35 x 25 mg oral	Non Preferred	PA
lamotrigine starter kit-green kit 84 x 25 mg & 14x100 mg oral	Non Preferred	PA
lamotrigine starter kit-orange kit 42 x 25 mg & 7 x 100 mg oral	Non Preferred	PA
lamotrigine tablet 100 mg oral	Preferred	Max 90-day supply per fill
lamotrigine tablet 150 mg oral	Preferred	Max 90-day supply per fill
lamotrigine tablet 200 mg oral	Preferred	Max 90-day supply per fill
lamotrigine tablet 25 mg oral	Preferred	Max 90-day supply per fill
lamotrigine tablet chewable 25 mg oral	Preferred	Max 90-day supply per fill
lamotrigine tablet chewable 5 mg oral	Preferred	Max 90-day supply per fill
lamotrigine tablet dispersible 100 mg oral	Preferred	Maximum 90-day supply per fill
lamotrigine tablet dispersible 200 mg oral	Preferred	Maximum 90-day supply per fill
lamotrigine tablet dispersible 25 mg oral	Preferred	Maximum 90-day supply per fill
lamotrigine tablet dispersible 50 mg oral	Preferred	Maximum 90-day supply per fill
levetiracetam er tablet extended release 24 hour 500 mg oral	Preferred	Max 90-day supply per fill
levetiracetam er tablet extended release 24 hour 750 mg oral	Preferred	Max 90-day supply per fill
levetiracetam solution 100 mg/ml oral	Preferred	Max 90-day supply per fill
levetiracetam tablet 1000 mg oral	Preferred	Max 90-day supply per fill
levetiracetam tablet 250 mg oral	Preferred	Max 90-day supply per fill
levetiracetam tablet 500 mg oral	Preferred	Max 90-day supply per fill
levetiracetam tablet 750 mg oral	Preferred	Max 90-day supply per fill
methsuximide capsule 300 mg oral	Non Preferred	PA
MYSOLINE TABLET 250 MG ORAL (*primidone*)	Non Preferred	PA; Max 90-day supply per fill
MYSOLINE TABLET 50 MG ORAL (*primidone*)	Non Preferred	PA; Max 90-day supply per fill
NAYZILAM SOLUTION 5 MG/0.1ML NASAL (*midazolam (anticonvulsant)*)	Preferred	PA (Eligible for auto-PA); QL (10 EA per 30 days); AGE (Min 12 Years)
ONFI SUSPENSION 2.5 MG/ML ORAL (*clobazam*)	Non Preferred	PA
ONFI TABLET 10 MG ORAL (*clobazam*)	Non Preferred	PA
ONFI TABLET 20 MG ORAL (*clobazam*)	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
oxcarbazepine suspension 300 mg/5ml oral	Non Preferred	PA; Max 90-day supply per fill
oxcarbazepine tablet 150 mg oral	Preferred	Max 90-day supply per fill
oxcarbazepine tablet 300 mg oral	Preferred	Max 90-day supply per fill
oxcarbazepine tablet 600 mg oral	Preferred	Max 90-day supply per fill
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL (*oxcarbazepine*)	Non Preferred	PA
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL (*oxcarbazepine*)	Non Preferred	PA
OXTELLAR XR TABLET EXTENDED RELEASE 24 HOUR 600 MG ORAL (*oxcarbazepine*)	Non Preferred	PA
phenobarbital elixir 20 mg/5ml oral	Preferred	
phenobarbital tablet 100 mg oral	Preferred	
phenobarbital tablet 15 mg oral	Preferred	
phenobarbital tablet 16.2 mg oral	Preferred	
phenobarbital tablet 30 mg oral	Preferred	
phenobarbital tablet 32.4 mg oral	Preferred	
phenobarbital tablet 60 mg oral	Preferred	
phenobarbital tablet 64.8 mg oral	Preferred	
phenobarbital tablet 97.2 mg oral	Preferred	
phenytoin sodium extended (Phenytek Capsule 200 Mg Oral)	Non Preferred	PA; Max 90-day supply per fill
phenytoin sodium extended (Phenytek Capsule 300 Mg Oral)	Non Preferred	PA; Max 90-day supply per fill
phenytoin (Phenytoin Infatabs Tablet Chewable 50 Mg Oral)	Preferred	Max 90-day supply per fill
phenytoin sodium extended capsule 100 mg oral	Preferred	Max 90-day supply per fill
phenytoin sodium extended capsule 200 mg oral	Preferred	Max 90-day supply per fill
phenytoin sodium extended capsule 300 mg oral	Preferred	Max 90-day supply per fill
phenytoin suspension 100 mg/4ml oral	Preferred	Max 90-day supply per fill
phenytoin suspension 125 mg/5ml oral	Preferred	Max 90-day supply per fill
phenytoin tablet chewable 50 mg oral	Preferred	Max 90-day supply per fill
pregabalin capsule 100 mg oral	Preferred	
pregabalin capsule 150 mg oral	Preferred	
pregabalin capsule 200 mg oral	Preferred	
pregabalin capsule 225 mg oral	Preferred	
pregabalin capsule 25 mg oral	Preferred	
pregabalin capsule 300 mg oral	Preferred	
pregabalin capsule 50 mg oral	Preferred	
pregabalin capsule 75 mg oral	Preferred	
primidone tablet 125 mg oral	Preferred	
primidone tablet 250 mg oral	Preferred	Max 90-day supply per fill
primidone tablet 50 mg oral	Preferred	Max 90-day supply per fill

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

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

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

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Drug Name	Formulary Status	Requirements/Limits
VIMPAT TABLET 200 MG ORAL (*lacosamide*)	Non Preferred	PA; Max 90-day supply per fill
VIMPAT TABLET 50 MG ORAL (*lacosamide*)	Non Preferred	PA; Max 90-day supply per fill
XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL (*cenobamate*)	Non Preferred	PA
XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL (*cenobamate*)	Non Preferred	PA
XCOPRI TABLET 100 MG ORAL (*cenobamate*)	Non Preferred	PA
XCOPRI TABLET 150 MG ORAL (*cenobamate*)	Non Preferred	PA
XCOPRI TABLET 200 MG ORAL (*cenobamate*)	Non Preferred	PA
XCOPRI TABLET 50 MG ORAL (*cenobamate*)	Non Preferred	PA
XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL (*cenobamate*)	Non Preferred	PA
XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG ORAL (*cenobamate*)	Non Preferred	PA
XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X100 MG ORAL (*cenobamate*)	Non Preferred	PA
ZARONTIN CAPSULE 250 MG ORAL (*ethosuximide*)	Non Preferred	PA; Max 90-day supply per fill
ZARONTIN SOLUTION 250 MG/5ML ORAL (*ethosuximide*)	Non Preferred	PA; AGE (Min 3 Years); Max 90-day supply per fill
ZONISADE SUSPENSION 100 MG/5ML ORAL (*zonisamide*)	Non Preferred	PA
zonisamide capsule 100 mg oral	Preferred	Max 90-day supply per fill
zonisamide capsule 25 mg oral	Preferred	Max 90-day supply per fill
zonisamide capsule 50 mg oral	Preferred	Max 90-day supply per fill
ZTALMY SUSPENSION 50 MG/ML ORAL (*ganaxolone*)	Non Preferred	PA; AGE (Min 2 Years)
ANTIDEPRESSANTS - OTHER [OPEN CLASS]		
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 174 MG ORAL (*bupropion hbr*)	Non Preferred	PA
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 348 MG ORAL (*bupropion hbr*)	Non Preferred	PA
APLENZIN TABLET EXTENDED RELEASE 24 HOUR 522 MG ORAL (*bupropion hbr*)	Non Preferred	PA
AUVELITY TABLET EXTENDED RELEASE 45-105 MG ORAL (*dextromethorphan-bupropion*)	Non Preferred	PA
bupropion hcl er (sr) tablet extended release 12 hour 100 mg oral	Preferred	Max 90-day supply per fill
bupropion hcl er (sr) tablet extended release 12 hour 150 mg oral	Preferred	Max 90-day supply per fill

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Drug Name	Formulary Status	Requirements/Limits
bupropion hcl er (sr) tablet extended release 12 hour 200 mg oral	Preferred	Max 90-day supply per fill
bupropion hcl er (xl) tablet extended release 24 hour 150 mg oral	Preferred	Max 90-day supply per fill
bupropion hcl er (xl) tablet extended release 24 hour 300 mg oral	Preferred	Max 90-day supply per fill
bupropion hcl er (xl) tablet extended release 24 hour 450 mg oral	Non Preferred	PA; Max 90-day supply per fill
bupropion hcl tablet 100 mg oral	Preferred	Max 90-day supply per fill
bupropion hcl tablet 75 mg oral	Preferred	Max 90-day supply per fill
desvenlafaxine er tablet extended release 24 hour 100 mg oral	Non Preferred	PA; Max 90-day supply per fill
desvenlafaxine er tablet extended release 24 hour 50 mg oral	Non Preferred	PA; Max 90-day supply per fill
desvenlafaxine succinate er tablet extended release 24 hour 100 mg oral	Preferred	Max 90-day supply per fill
desvenlafaxine succinate er tablet extended release 24 hour 25 mg oral	Preferred	Max 90-day supply per fill
desvenlafaxine succinate er tablet extended release 24 hour 50 mg oral	Preferred	Max 90-day supply per fill
duloxetine hcl capsule delayed release particles 20 mg oral	Preferred	
duloxetine hcl capsule delayed release particles 30 mg oral	Preferred	
duloxetine hcl capsule delayed release particles 40 mg oral	Non Preferred	PA
duloxetine hcl capsule delayed release particles 60 mg oral	Preferred	
EFFEXOR XR CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL (*venlafaxine hcl*)	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 (*venlafaxine hcl*)	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 (*venlafaxine hcl*)	Non Preferred	PA; Max 90-day supply per fill
EMSAM PATCH 24 HOUR 12 MG/24HR TRANSDERMAL (*selegiline*)	Non Preferred	PA
EMSAM PATCH 24 HOUR 6 MG/24HR TRANSDERMAL (*selegiline*)	Non Preferred	PA
EMSAM PATCH 24 HOUR 9 MG/24HR TRANSDERMAL (*selegiline*)	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (*levomilnacipran hcl*)	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (*levomilnacipran hcl*)	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL (*levomilnacipran hcl*)	Non Preferred	PA
FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL (*levomilnacipran hcl*)	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 (*levomilnacipran hcl*)	Non Preferred	PA
FORFIVO XL TABLET EXTENDED RELEASE 24 HOUR 450 MG ORAL (*bupropion hcl*)	Non Preferred	PA; Max 90-day supply per fill
MARPLAN TABLET 10 MG ORAL (*isocarboxazid*)	Non Preferred	PA
mirtazapine tablet 15 mg oral	Preferred	Max 90-day supply per fill
mirtazapine tablet 30 mg oral	Preferred	Max 90-day supply per fill
mirtazapine tablet 45 mg oral	Preferred	Max 90-day supply per fill
mirtazapine tablet 7.5 mg oral	Preferred	Max 90-day supply per fill
mirtazapine tablet dispersible 15 mg oral	Preferred	Max 90-day supply per fill
mirtazapine tablet dispersible 30 mg oral	Preferred	Max 90-day supply per fill
mirtazapine tablet dispersible 45 mg oral	Preferred	Max 90-day supply per fill
NARDIL TABLET 15 MG ORAL (*phenelzine sulfate*)	Non Preferred	PA
nefazodone hcl tablet 100 mg oral	Non Preferred	PA
nefazodone hcl tablet 150 mg oral	Non Preferred	PA
nefazodone hcl tablet 200 mg oral	Non Preferred	PA
nefazodone hcl tablet 250 mg oral	Non Preferred	PA
nefazodone hcl tablet 50 mg oral	Non Preferred	PA
phenelzine sulfate tablet 15 mg oral	Preferred	
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL (*desvenlafaxine succinate*)	Non Preferred	PA; Max 90-day supply per fill
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL (*desvenlafaxine succinate*)	Non Preferred	PA; Max 90-day supply per fill
PRISTIQ TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL (*desvenlafaxine succinate*)	Non Preferred	PA; Max 90-day supply per fill
REMERON SOLTAB TABLET DISPERSIBLE 15 MG ORAL (*mirtazapine*)	Non Preferred	PA; Max 90-day supply per fill
REMERON SOLTAB TABLET DISPERSIBLE 30 MG ORAL (*mirtazapine*)	Non Preferred	PA; Max 90-day supply per fill
REMERON SOLTAB TABLET DISPERSIBLE 45 MG ORAL (*mirtazapine*)	Non Preferred	PA; Max 90-day supply per fill
REMERON TABLET 15 MG ORAL (*mirtazapine*)	Non Preferred	PA; Max 90-day supply per fill
REMERON TABLET 30 MG ORAL (*mirtazapine*)	Non Preferred	PA; Max 90-day supply per fill
tranylcypromine sulfate tablet 10 mg oral	Non Preferred	PA
trazodone hcl tablet 100 mg oral	Preferred	Max 90-day supply per fill

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

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

Drug Name	Formulary Status	Requirements/Limits
fluoxetine hcl tablet 10 mg oral	Non Preferred	PA
fluoxetine hcl tablet 20 mg oral	Non Preferred	PA
fluoxetine hcl tablet 60 mg oral	Non Preferred	PA
fluvoxamine maleate er capsule extended release 24 hour 100 mg oral	Non Preferred	PA
fluvoxamine maleate er capsule extended release 24 hour 150 mg oral	Non Preferred	PA
fluvoxamine maleate tablet 100 mg oral	Preferred	Max 90-day supply per fill
fluvoxamine maleate tablet 25 mg oral	Preferred	Max 90-day supply per fill
fluvoxamine maleate tablet 50 mg oral	Preferred	Max 90-day supply per fill
LEXAPRO TABLET 10 MG ORAL (*escitalopram oxalate*)	Non Preferred	PA; Max 90-day supply per fill
LEXAPRO TABLET 20 MG ORAL (*escitalopram oxalate*)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
LEXAPRO TABLET 5 MG ORAL (*escitalopram oxalate*)	Non Preferred	PA; Max 90-day supply per fill
paroxetine hcl er tablet extended release 24 hour 12.5 mg oral	Non Preferred	PA
paroxetine hcl er tablet extended release 24 hour 25 mg oral	Non Preferred	PA
paroxetine hcl er tablet extended release 24 hour 37.5 mg oral	Non Preferred	PA
paroxetine hcl suspension 10 mg/5ml oral	Non Preferred	PA
paroxetine hcl tablet 10 mg oral	Preferred	Max 90-day supply per fill
paroxetine hcl tablet 20 mg oral	Preferred	Max 90-day supply per fill
paroxetine hcl tablet 30 mg oral	Preferred	Max 90-day supply per fill
paroxetine hcl tablet 40 mg oral	Preferred	Max 90-day supply per fill
paroxetine mesylate capsule 7.5 mg oral	Non Preferred	PA
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 12.5 MG ORAL (*paroxetine hcl*)	Non Preferred	PA
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 25 MG ORAL (*paroxetine hcl*)	Non Preferred	PA
PAXIL CR TABLET EXTENDED RELEASE 24 HOUR 37.5 MG ORAL (*paroxetine hcl*)	Non Preferred	PA
PAXIL SUSPENSION 10 MG/5ML ORAL (*paroxetine hcl*)	Non Preferred	PA
PAXIL TABLET 10 MG ORAL (*paroxetine hcl*)	Non Preferred	PA; Max 90-day supply per fill
PAXIL TABLET 20 MG ORAL (*paroxetine hcl*)	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
PAXIL TABLET 30 MG ORAL (*paroxetine hcl*)	Non Preferred	PA; Max 90-day supply per fill
PAXIL TABLET 40 MG ORAL (*paroxetine hcl*)	Non Preferred	PA; Max 90-day supply per fill
PROZAC CAPSULE 10 MG ORAL (*fluoxetine hcl*)	Non Preferred	PA; Max 90-day supply per fill
PROZAC CAPSULE 20 MG ORAL (*fluoxetine hcl*)	Non Preferred	PA; Max 90-day supply per fill
PROZAC CAPSULE 40 MG ORAL (*fluoxetine hcl*)	Non Preferred	PA; Max 90-day supply per fill
sertraline hcl capsule 150 mg oral	Non Preferred	PA
sertraline hcl capsule 200 mg oral	Non Preferred	PA
sertraline hcl concentrate 20 mg/ml oral	Preferred	Max 90-day supply per fill
sertraline hcl tablet 100 mg oral	Preferred	Max 90-day supply per fill
sertraline hcl tablet 25 mg oral	Preferred	Max 90-day supply per fill
sertraline hcl tablet 50 mg oral	Preferred	Max 90-day supply per fill
ZOLOFT CONCENTRATE 20 MG/ML ORAL (*sertraline hcl*)	Non Preferred	PA; Max 90-day supply per fill
ZOLOFT TABLET 100 MG ORAL (*sertraline hcl*)	Non Preferred	PA; Max 90-day supply per fill
ZOLOFT TABLET 25 MG ORAL (*sertraline hcl*)	Non Preferred	PA; Max 90-day supply per fill
ZOLOFT TABLET 50 MG ORAL (*sertraline hcl*)	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 (*fosnetupitant-palonosetron*)	Non Preferred	PA
AKYNZEO (TO-BE-DILUTED) SOLUTION 235-0.25 MG/20ML INTRAVENOUS (*fosnetupitant-palonosetron*)	Non Preferred	PA
AKYNZEO CAPSULE 300-0.5 MG ORAL (*netupitant-palonosetron*)	Non Preferred	PA
AKYNZEO SOLUTION RECONSTITUTED 235-0.25 MG INTRAVENOUS (*fosnetupitant-palonosetron*)	Non Preferred	PA
ANTIVERT TABLET 50 MG ORAL (*meclizine hcl*)	Non Preferred	PA
ANTIVERT TABLET CHEWABLE 25 MG ORAL (*meclizine hcl*)	Non Preferred	PA
ANZEMET TABLET 50 MG ORAL (*dolasetron mesylate*)	Non Preferred	PA; QL (10 EA per 1 Fill)
APONVIE EMULSION 32 MG/4.4ML INTRAVENOUS (*aprepitant*)	Non Preferred	PA; QL (4.4 ML per 1 Fill)
aprepitant 80 & 125 mg oral	Non Preferred	PA; QL (1 EA per 1 Fill)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
valsartan-hydrochlorothiazide tablet 160-25 mg oral	Preferred	Max 90-day supply per fill
valsartan-hydrochlorothiazide tablet 320-12.5 mg oral	Preferred	Max 90-day supply per fill
valsartan-hydrochlorothiazide tablet 320-25 mg oral	Preferred	Max 90-day supply per fill
valsartan-hydrochlorothiazide tablet 80-12.5 mg oral	Preferred	Max 90-day supply per fill
VASERETIC TABLET 10-25 MG ORAL (*enalapril-hydrochlorothiazide*)	Non Preferred	PA; Max 90-day supply per fill
VASOTEC TABLET 10 MG ORAL (*enalapril maleate*)	Non Preferred	PA; Max 90-day supply per fill
VASOTEC TABLET 2.5 MG ORAL (*enalapril maleate*)	Non Preferred	PA; Max 90-day supply per fill
VASOTEC TABLET 20 MG ORAL (*enalapril maleate*)	Non Preferred	PA; Max 90-day supply per fill
VASOTEC TABLET 5 MG ORAL (*enalapril maleate*)	Non Preferred	PA; Max 90-day supply per fill
ZESTORETIC TABLET 10-12.5 MG ORAL (*lisinopril-hydrochlorothiazide*)	Non Preferred	PA; Max 90-day supply per fill
ZESTORETIC TABLET 20-12.5 MG ORAL (*lisinopril-hydrochlorothiazide*)	Non Preferred	PA; Max 90-day supply per fill
ZESTORETIC TABLET 20-25 MG ORAL (*lisinopril-hydrochlorothiazide*)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 10 MG ORAL (*lisinopril*)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 2.5 MG ORAL (*lisinopril*)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 20 MG ORAL (*lisinopril*)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 30 MG ORAL (*lisinopril*)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 40 MG ORAL (*lisinopril*)	Non Preferred	PA; Max 90-day supply per fill
ZESTRIL TABLET 5 MG ORAL (*lisinopril*)	Non Preferred	PA; Max 90-day supply per fill
ANTIHYPERTENSIVES: BETA BLOCKERS [OPEN CLASS]		
acebutolol hcl capsule 200 mg oral	Preferred	
acebutolol hcl capsule 400 mg oral	Preferred	
atenolol tablet 100 mg oral	Preferred	Max 90-day supply per fill
atenolol tablet 25 mg oral	Preferred	Max 90-day supply per fill
atenolol tablet 50 mg oral	Preferred	Max 90-day supply per fill
atenolol-chlorthalidone tablet 100-25 mg oral	Preferred	
atenolol-chlorthalidone tablet 50-25 mg oral	Preferred	
BETAPACE AF TABLET 120 MG ORAL (*sotalol hcl af*)	Non Preferred	PA
BETAPACE AF TABLET 160 MG ORAL (*sotalol hcl af*)	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
BETAPACE AF TABLET 80 MG ORAL (*sotalol hcl af*)	Non Preferred	PA; Max 90-day supply per fill
BETAPACE TABLET 120 MG ORAL (*sotalol hcl*)	Non Preferred	PA; Max 90-day supply per fill
BETAPACE TABLET 160 MG ORAL (*sotalol hcl*)	Non Preferred	PA; Max 90-day supply per fill
BETAPACE TABLET 80 MG ORAL (*sotalol hcl*)	Non Preferred	PA; Max 90-day supply per fill
betaxolol hcl tablet 10 mg oral	Non Preferred	PA
betaxolol hcl tablet 20 mg oral	Non Preferred	PA
bisoprolol fumarate tablet 10 mg oral	Preferred	Max 90-day supply per fill
bisoprolol fumarate tablet 5 mg oral	Preferred	Max 90-day supply per fill
bisoprolol-hydrochlorothiazide tablet 10-6.25 mg oral	Preferred	
bisoprolol-hydrochlorothiazide tablet 2.5-6.25 mg oral	Preferred	
bisoprolol-hydrochlorothiazide tablet 5-6.25 mg oral	Preferred	
BYSTOLIC TABLET 10 MG ORAL (*nebivolol hcl*)	Non Preferred	PA
BYSTOLIC TABLET 2.5 MG ORAL (*nebivolol hcl*)	Non Preferred	PA
BYSTOLIC TABLET 20 MG ORAL (*nebivolol hcl*)	Non Preferred	PA
BYSTOLIC TABLET 5 MG ORAL (*nebivolol hcl*)	Non Preferred	PA
carvedilol phosphate er capsule extended release 24 hour 10 mg oral	Non Preferred	PA; Max 90-day supply per fill
carvedilol phosphate er capsule extended release 24 hour 20 mg oral	Non Preferred	PA; Max 90-day supply per fill
carvedilol phosphate er capsule extended release 24 hour 40 mg oral	Non Preferred	PA; Max 90-day supply per fill
carvedilol phosphate er capsule extended release 24 hour 80 mg oral	Non Preferred	PA; Max 90-day supply per fill
carvedilol tablet 12.5 mg oral	Preferred	Max 90-day supply per fill
carvedilol tablet 25 mg oral	Preferred	Max 90-day supply per fill
carvedilol tablet 3.125 mg oral	Preferred	Max 90-day supply per fill
carvedilol tablet 6.25 mg oral	Preferred	Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (*carvedilol phosphate*)	Non Preferred	PA; Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL (*carvedilol phosphate*)	Non Preferred	PA; Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL (*carvedilol phosphate*)	Non Preferred	PA; Max 90-day supply per fill
COREG CR CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL (*carvedilol phosphate*)	Non Preferred	PA; Max 90-day supply per fill

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
diltiazem hcl er beads capsule extended release 24 hour 120 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er beads capsule extended release 24 hour 180 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er beads capsule extended release 24 hour 240 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er beads capsule extended release 24 hour 300 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er beads capsule extended release 24 hour 360 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er beads capsule extended release 24 hour 420 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er capsule extended release 12 hour 120 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er capsule extended release 12 hour 60 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er capsule extended release 12 hour 90 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er capsule extended release 24 hour 120 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er capsule extended release 24 hour 180 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er capsule extended release 24 hour 240 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er coated beads capsule extended release 24 hour 120 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er coated beads capsule extended release 24 hour 180 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er coated beads capsule extended release 24 hour 240 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er coated beads capsule extended release 24 hour 300 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er coated beads capsule extended release 24 hour 360 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl er tablet extended release 24 hour 120 mg oral	Non Preferred	PA
diltiazem hcl er tablet extended release 24 hour 180 mg oral	Preferred	
diltiazem hcl er tablet extended release 24 hour 240 mg oral	Preferred	
diltiazem hcl er tablet extended release 24 hour 300 mg oral	Preferred	
diltiazem hcl er tablet extended release 24 hour 360 mg oral	Preferred	
diltiazem hcl er tablet extended release 24 hour 420 mg oral	Preferred	
diltiazem hcl tablet 120 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl tablet 30 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl tablet 60 mg oral	Preferred	Max 90-day supply per fill
diltiazem hcl tablet 90 mg oral	Preferred	Max 90-day supply per fill
dilt-xr capsule extended release 24 hour 120 mg oral	Preferred	Max 90-day supply per fill
dilt-xr capsule extended release 24 hour 180 mg oral	Preferred	Max 90-day supply per fill
dilt-xr capsule extended release 24 hour 240 mg oral	Preferred	Max 90-day supply per fill
felodipine er tablet extended release 24 hour 10 mg oral	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
felodipine er tablet extended release 24 hour 2.5 mg oral	Preferred	
felodipine er tablet extended release 24 hour 5 mg oral	Preferred	
isradipine capsule 2.5 mg oral	Non Preferred	PA
isradipine capsule 5 mg oral	Non Preferred	PA
KATERZIA SUSPENSION 1 MG/ML ORAL (*amlodipine benzoate*)	Non Preferred	PA
levamlodipine maleate tablet 2.5 mg oral	Non Preferred	PA
levamlodipine maleate tablet 5 mg oral	Non Preferred	PA
diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 180 Mg Oral)	Non Preferred	PA
diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 240 Mg Oral)	Non Preferred	PA
diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 300 Mg Oral)	Non Preferred	PA
diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 360 Mg Oral)	Non Preferred	PA
diltiazem hcl (Matzim La Tablet Extended Release 24 Hour 420 Mg Oral)	Non Preferred	PA
nicardipine hcl capsule 20 mg oral	Non Preferred	PA
nicardipine hcl capsule 30 mg oral	Non Preferred	PA
nifedipine capsule 10 mg oral	Preferred	Max 90-day supply per fill
nifedipine capsule 20 mg oral	Preferred	Max 90-day supply per fill
nifedipine er osmotic release tablet extended release 24 hour 30 mg oral	Preferred	Max 90-day supply per fill
nifedipine er osmotic release tablet extended release 24 hour 60 mg oral	Preferred	Max 90-day supply per fill
nifedipine er osmotic release tablet extended release 24 hour 90 mg oral	Preferred	Max 90-day supply per fill
nifedipine er tablet extended release 24 hour 30 mg oral	Preferred	Max 90-day supply per fill
nifedipine er tablet extended release 24 hour 60 mg oral	Preferred	Max 90-day supply per fill
nifedipine er tablet extended release 24 hour 90 mg oral	Preferred	Max 90-day supply per fill
nisoldipine er tablet extended release 24 hour 17 mg oral	Non Preferred	PA
nisoldipine er tablet extended release 24 hour 20 mg oral	Non Preferred	PA
nisoldipine er tablet extended release 24 hour 25.5 mg oral	Non Preferred	PA
nisoldipine er tablet extended release 24 hour 30 mg oral	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
nisoldipine er tablet extended release 24 hour 34 mg oral	Non Preferred	PA
nisoldipine er tablet extended release 24 hour 40 mg oral	Non Preferred	PA
nisoldipine er tablet extended release 24 hour 8.5 mg oral	Non Preferred	PA
NORLIQVA SOLUTION 1 MG/ML ORAL (*amlodipine besylate*)	Non Preferred	PA
NORVASC TABLET 10 MG ORAL (*amlodipine besylate*)	Non Preferred	PA; Max 90-day supply per fill
NORVASC TABLET 2.5 MG ORAL (*amlodipine besylate*)	Non Preferred	PA; Max 90-day supply per fill
NORVASC TABLET 5 MG ORAL (*amlodipine besylate*)	Non Preferred	PA; Max 90-day supply per fill
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 30 MG ORAL (*nifedipine*)	Non Preferred	PA; Max 90-day supply per fill
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 60 MG ORAL (*nifedipine*)	Non Preferred	PA; Max 90-day supply per fill
PROCARDIA XL TABLET EXTENDED RELEASE 24 HOUR 90 MG ORAL (*nifedipine*)	Non Preferred	PA; Max 90-day supply per fill
SULAR TABLET EXTENDED RELEASE 24 HOUR 17 MG ORAL (*nisoldipine*)	Non Preferred	PA
SULAR TABLET EXTENDED RELEASE 24 HOUR 34 MG ORAL (*nisoldipine*)	Non Preferred	PA
SULAR TABLET EXTENDED RELEASE 24 HOUR 8.5 MG ORAL (*nisoldipine*)	Non Preferred	PA
diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 120 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 180 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 240 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 300 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Taztia Xt Capsule Extended Release 24 Hour 360 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Tiadylt Er Capsule Extended Release 24 Hour 120 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Tiadylt Er Capsule Extended Release 24 Hour 180 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Tiadylt Er Capsule Extended Release 24 Hour 240 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Tiadylt Er Capsule Extended Release 24 Hour 300 Mg Oral)	Preferred	Max 90-day supply per fill
diltiazem hcl er beads (Tiadylt 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
diltiazem hcl er beads (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 (*diltiazem hcl er beads*)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL (*diltiazem hcl er beads*)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL (*diltiazem hcl er beads*)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL (*diltiazem hcl er beads*)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL (*diltiazem hcl er beads*)	Non Preferred	PA; Max 90-day supply per fill
TIAZAC CAPSULE EXTENDED RELEASE 24 HOUR 420 MG ORAL (*diltiazem hcl er beads*)	Non Preferred	PA; Max 90-day supply per fill
verapamil hcl er capsule extended release 24 hour 100 mg oral	Non Preferred	PA
verapamil hcl er capsule extended release 24 hour 120 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 180 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 200 mg oral	Non Preferred	PA
verapamil hcl er capsule extended release 24 hour 240 mg oral	Preferred	
verapamil hcl er capsule extended release 24 hour 300 mg oral	Non Preferred	PA
verapamil hcl er capsule extended release 24 hour 360 mg oral	Non Preferred	PA
verapamil hcl er tablet extended release 120 mg oral	Preferred	Max 90-day supply per fill
verapamil hcl er tablet extended release 180 mg oral	Preferred	Max 90-day supply per fill
verapamil hcl er tablet extended release 240 mg oral	Preferred	Max 90-day supply per fill
verapamil hcl tablet 120 mg oral	Preferred	Max 90-day supply per fill
verapamil hcl tablet 40 mg oral	Preferred	Max 90-day supply per fill
verapamil hcl tablet 80 mg oral	Preferred	Max 90-day supply per fill
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL (*verapamil hcl*)	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 180 MG ORAL (*verapamil hcl*)	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 240 MG ORAL (*verapamil hcl*)	Non Preferred	PA
VERELAN CAPSULE EXTENDED RELEASE 24 HOUR 360 MG ORAL (*verapamil hcl*)	Non Preferred	PA
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL (*verapamil hcl*)	Non Preferred	PA
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL (*verapamil hcl*)	Non Preferred	PA
VERELAN PM CAPSULE EXTENDED RELEASE 24 HOUR 300 MG ORAL (*verapamil hcl*)	Non Preferred	PA

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

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

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

Drug Name	Formulary Status	Requirements/Limits
ANTIMIGRAINE AGENTS, OTHERS [CLOSED CLASS]		
AIMOVIG SOLUTION AUTO-INJECTOR 140 MG/ML SUBCUTANEOUS (*erenumab-aooe*)	Preferred	PA (Eligible for auto-PA); QL (1 ML per 30 days); AGE (Min 18 Years)
AIMOVIG SOLUTION AUTO-INJECTOR 70 MG/ML SUBCUTANEOUS (*erenumab-aooe*)	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 (*fremanezumab-vfrm*)	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 (*fremanezumab-vfrm*)	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 (*galcanezumab-gnlm*)	Non Preferred	PA; QL (3 ML per 30 days); AGE (Min 18 Years)
EMGALITY SOLUTION AUTO-INJECTOR 120 MG/ML SUBCUTANEOUS (*galcanezumab-gnlm*)	Preferred	PA (Eligible for auto-PA); QL (1 ML per 30 days); AGE (Min 18 Years)
EMGALITY SOLUTION PREFILLED SYRINGE 120 MG/ML SUBCUTANEOUS (*galcanezumab-gnlm*)	Preferred	PA (Eligible for auto-PA); QL (1 ML per 30 days); AGE (Min 18 Years)
NURTEC TABLET DISPERSIBLE 75 MG ORAL (*rimegepant sulfate*)	Preferred	PA (Eligible for auto-PA); QL (18 EA per 30 days); AGE (Min 18 Years)
QULIPTA TABLET 10 MG ORAL (*atogepant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QULIPTA TABLET 30 MG ORAL (*atogepant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QULIPTA TABLET 60 MG ORAL (*atogepant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
REYVOW TABLET 100 MG ORAL (*lasmiditan succinate*)	Non Preferred	PA; QL (8 EA per 30 days); AGE (Min 18 Years)
REYVOW TABLET 50 MG ORAL (*lasmiditan succinate*)	Non Preferred	PA; QL (8 EA per 30 days); AGE (Min 18 Years)
TRUDHESA AEROSOL SOLUTION 0.725 MG/ACT NASAL (*dihydroergotamine mesylate hfa*)	Non Preferred	PA; AGE (Min 18 Years)
UBRELVY TABLET 100 MG ORAL (*ubrogepant*)	Preferred	PA (Eligible for auto-PA); QL (16 EA per 30 days); AGE (Min 18 Years)
UBRELVY TABLET 50 MG ORAL (*ubrogepant*)	Preferred	PA (Eligible for auto-PA); QL (16 EA per 30 days); AGE (Min 18 Years)
ZAVZPRET SOLUTION 10 MG/ACT NASAL (*zavegepant hcl*)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: ATYPICAL [CLOSED CLASS]		
ABILIFY ASIMTUFII PREFILLED SYRINGE 720 MG/2.4ML INTRAMUSCULAR (*aripiprazole*)	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 (*aripiprazole*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 10 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 15 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 2 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 20 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 30 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT TABLET THERAPY PACK 5 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 10 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 15 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 2 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 20 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 30 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT TABLET THERAPY PACK 5 MG ORAL (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY TABLET 10 MG ORAL (*aripiprazole*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 15 MG ORAL (*aripiprazole*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 2 MG ORAL (*aripiprazole*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 20 MG ORAL (*aripiprazole*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 30 MG ORAL (*aripiprazole*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
ABILIFY TABLET 5 MG ORAL (*aripiprazole*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
aripiprazole solution 1 mg/ml oral	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
aripiprazole tablet 10 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
aripiprazole tablet 15 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
aripiprazole tablet 2 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
aripiprazole tablet 20 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
aripiprazole tablet 30 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
aripiprazole tablet 5 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
aripiprazole tablet dispersible 10 mg oral	Non Preferred	PA; AGE (Min 18 Years)
aripiprazole tablet dispersible 15 mg oral	Non Preferred	PA; AGE (Min 18 Years)
asenapine maleate tablet sublingual 10 mg sublingual	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
asenapine maleate tablet sublingual 2.5 mg sublingual	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
asenapine maleate tablet sublingual 5 mg sublingual	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
CAPLYTA CAPSULE 10.5 MG ORAL (*lumateperone tosylate*)	Non Preferred	PA; AGE (Min 18 Years)
CAPLYTA CAPSULE 21 MG ORAL (*lumateperone tosylate*)	Non Preferred	PA; AGE (Min 18 Years)
CAPLYTA CAPSULE 42 MG ORAL (*lumateperone tosylate*)	Non Preferred	PA; AGE (Min 18 Years)
clozapine tablet 100 mg oral	Preferred	AGE (Min 18 Years)
clozapine tablet 200 mg oral	Preferred	AGE (Min 18 Years)
clozapine tablet 25 mg oral	Preferred	AGE (Min 18 Years)
clozapine tablet 50 mg oral	Preferred	AGE (Min 18 Years)
clozapine tablet dispersible 100 mg oral	Non Preferred	PA; AGE (Min 18 Years)
clozapine tablet dispersible 12.5 mg oral	Non Preferred	PA; AGE (Min 18 Years)
clozapine tablet dispersible 150 mg oral	Non Preferred	PA; AGE (Min 18 Years)
clozapine tablet dispersible 200 mg oral	Non Preferred	PA; AGE (Min 18 Years)

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

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

Drug Name	Formulary Status	Requirements/Limits
olanzapine tablet 2.5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
olanzapine tablet 20 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
olanzapine tablet 5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
olanzapine tablet 7.5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
olanzapine tablet dispersible 10 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
olanzapine tablet dispersible 15 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
olanzapine tablet dispersible 20 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
olanzapine tablet dispersible 5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
olanzapine-fluoxetine hcl capsule 12-25 mg oral	Non Preferred	PA; AGE (Min 18 Years)
olanzapine-fluoxetine hcl capsule 12-50 mg oral	Non Preferred	PA; AGE (Min 18 Years)
olanzapine-fluoxetine hcl capsule 3-25 mg oral	Non Preferred	PA; AGE (Min 18 Years)
olanzapine-fluoxetine hcl capsule 6-25 mg oral	Non Preferred	PA; AGE (Min 18 Years)
olanzapine-fluoxetine hcl capsule 6-50 mg oral	Non Preferred	PA; AGE (Min 18 Years)
paliperidone er tablet extended release 24 hour 1.5 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
paliperidone er tablet extended release 24 hour 3 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
paliperidone er tablet extended release 24 hour 6 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
paliperidone er tablet extended release 24 hour 9 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
quetiapine fumarate er tablet extended release 24 hour 150 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate er tablet extended release 24 hour 200 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate er tablet extended release 24 hour 300 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate er tablet extended release 24 hour 400 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate er tablet extended release 24 hour 50 mg oral	Preferred	AGE (Min 18 Years); 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
quetiapine fumarate tablet 100 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate tablet 150 mg oral	Preferred	AGE (Min 18 Years)
quetiapine fumarate tablet 200 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate tablet 25 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate tablet 300 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate tablet 400 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
quetiapine fumarate tablet 50 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
REXULTI TABLET 0.25 MG ORAL (*brexpiprazole*)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 0.5 MG ORAL (*brexpiprazole*)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 1 MG ORAL (*brexpiprazole*)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 2 MG ORAL (*brexpiprazole*)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 3 MG ORAL (*brexpiprazole*)	Non Preferred	PA; AGE (Min 18 Years)
REXULTI TABLET 4 MG ORAL (*brexpiprazole*)	Non Preferred	PA; AGE (Min 18 Years)
RISPERDAL SOLUTION 1 MG/ML ORAL (*risperidone*)	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 (*risperidone*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 1 MG ORAL (*risperidone*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 2 MG ORAL (*risperidone*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 3 MG ORAL (*risperidone*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
RISPERDAL TABLET 4 MG ORAL (*risperidone*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
risperidone solution 1 mg/ml oral	Preferred	QL (2 ML per 1 day); AGE (Min 18 Years); Max 90-day supply per fill

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
CIMZIA STARTER KIT PREFILLED SYRINGE KIT 6 X 200 MG/ML SUBCUTANEOUS (*certolizumab pegol*)	Non Preferred	PA
COSENTYX (300 MG DOSE) SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS (*secukinumab*)	Non Preferred	PA
COSENTYX SENSOREADY (300 MG) SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS (*secukinumab*)	Non Preferred	PA
COSENTYX SENSOREADY PEN SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS (*secukinumab*)	Non Preferred	PA
COSENTYX SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS (*secukinumab*)	Non Preferred	PA
COSENTYX SOLUTION PREFILLED SYRINGE 75 MG/0.5ML SUBCUTANEOUS (*secukinumab*)	Non Preferred	PA
ENBREL MINI SOLUTION CARTRIDGE 50 MG/ML SUBCUTANEOUS (*etanercept*)	Preferred	QL (8 ML per 34 days); AGE (Min 2 Years)
ENBREL SOLUTION 25 MG/0.5ML SUBCUTANEOUS (*etanercept*)	Preferred	QL (4 ML per 34 days); AGE (Min 2 Years)
ENBREL SOLUTION PREFILLED SYRINGE 25 MG/0.5ML SUBCUTANEOUS (*etanercept*)	Preferred	QL (4 ML per 34 days); AGE (Min 2 Years)
ENBREL SOLUTION PREFILLED SYRINGE 50 MG/ML SUBCUTANEOUS (*etanercept*)	Preferred	QL (8 ML per 34 days); AGE (Min 2 Years)
ENBREL SURECLICK SOLUTION AUTO-INJECTOR 50 MG/ML SUBCUTANEOUS (*etanercept*)	Preferred	QL (8 ML per 34 days); AGE (Min 2 Years)
ENSPRYNG SOLUTION PREFILLED SYRINGE 120 MG/ML SUBCUTANEOUS (*satralizumab-mwge*)	Non Preferred	PA
ENTYVIO SOLUTION RECONSTITUTED 300 MG INTRAVENOUS (*vedolizumab*)	Non Preferred	PA
HADLIMA PUSHTOUCH SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-bwwd*)	Non Preferred	PA
HADLIMA PUSHTOUCH SOLUTION AUTO-INJECTOR 40 MG/0.8ML SUBCUTANEOUS (*adalimumab-bwwd*)	Non Preferred	PA
HADLIMA SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-bwwd*)	Non Preferred	PA
HADLIMA SOLUTION PREFILLED SYRINGE 40 MG/0.8ML SUBCUTANEOUS (*adalimumab-bwwd*)	Non Preferred	PA
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PEDIATRIC CROHNS START PREFILLED SYRINGE KIT 80 MG/0.8ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.4ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PEN PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PEN PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PEN-CD/UC/HS STARTER PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS (*adalimumab*)	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 (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PEN-PEDIATRIC UC START PEN-INJECTOR KIT 80 MG/0.8ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PEN-PS/UV/ADOL HS START PEN-INJECTOR KIT 40 MG/0.8ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PEN-PSOR/UVEIT STARTER PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PREFILLED SYRINGE KIT 10 MG/0.1ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PREFILLED SYRINGE KIT 20 MG/0.2ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PREFILLED SYRINGE KIT 40 MG/0.4ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HUMIRA PREFILLED SYRINGE KIT 40 MG/0.8ML SUBCUTANEOUS (*adalimumab*)	Preferred	AGE (Min 2 Years)
HYRIMOZ SOLUTION AUTO-INJECTOR 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
HYRIMOZ SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
HYRIMOZ SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
HYRIMOZ SOLUTION PREFILLED SYRINGE 20 MG/0.2ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
HYRIMOZ SOLUTION PREFILLED SYRINGE 40 MG/0.4ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
HYRIMOZ-CROHNS/UC STARTER PACK SOLUTION AUTO-INJECTOR 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
HYRIMOZ-PED CROHNS STARTER SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
HYRIMOZ-PED CROHNS STARTER SOLUTION PREFILLED SYRINGE 80 MG/0.8ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
HYRIMOZ-PLAQUE PSORIASIS START SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML SUBCUTANEOUS (*adalimumab-adaz*)	Non Preferred	PA
ILARIS SOLUTION 150 MG/ML SUBCUTANEOUS (*canakinumab*)	Non Preferred	PA
ILUMYA SOLUTION PREFILLED SYRINGE 100 MG/ML SUBCUTANEOUS (*tildrakizumab-asmn*)	Non Preferred	PA; AGE (Min 18 Years)
INFLECTRA SOLUTION RECONSTITUTED 100 MG INTRAVENOUS (*infliximab-dyyb*)	Non Preferred	PA
infliximab solution reconstituted 100 mg intravenous	Preferred	
KEVZARA SOLUTION AUTO-INJECTOR 150 MG/1.14ML SUBCUTANEOUS (*sarilumab*)	Non Preferred	PA; AGE (Min 18 Years)

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG ORAL (*saxagliptin-metformin*)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG ORAL (*saxagliptin-metformin*)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
KOMBIGLYZE XR TABLET EXTENDED RELEASE 24 HOUR 5-500 MG ORAL (*saxagliptin-metformin*)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
NESINA TABLET 12.5 MG ORAL (*alogliptin benzoate*)	Non Preferred	PA; AGE (Min 18 Years)
NESINA TABLET 25 MG ORAL (*alogliptin benzoate*)	Non Preferred	PA; AGE (Min 18 Years)
NESINA TABLET 6.25 MG ORAL (*alogliptin benzoate*)	Non Preferred	PA; AGE (Min 18 Years)
ONGLYZA TABLET 2.5 MG ORAL (*saxagliptin hcl*)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
ONGLYZA TABLET 5 MG ORAL (*saxagliptin hcl*)	Preferred	AGE (Min 18 Years); Maximum 90-day supply per fill
OSENI TABLET 12.5-30 MG ORAL (*alogliptin-pioglitazone*)	Non Preferred	PA; AGE (Min 18 Years)
OSENI TABLET 25-15 MG ORAL (*alogliptin-pioglitazone*)	Non Preferred	PA; AGE (Min 18 Years)
OSENI TABLET 25-30 MG ORAL (*alogliptin-pioglitazone*)	Non Preferred	PA; AGE (Min 18 Years)
OSENI TABLET 25-45 MG ORAL (*alogliptin-pioglitazone*)	Non Preferred	PA; AGE (Min 18 Years)
QTERN TABLET 10-5 MG ORAL (*dapagliflozin-saxagliptin*)	Non Preferred	PA; AGE (Min 18 Years)
QTERN TABLET 5-5 MG ORAL (*dapagliflozin-saxagliptin*)	Non Preferred	PA; AGE (Min 18 Years)
STEGLUJAN TABLET 15-100 MG ORAL (*ertugliflozin-sitagliptin*)	Non Preferred	PA; AGE (Min 18 Years)
STEGLUJAN TABLET 5-100 MG ORAL (*ertugliflozin-sitagliptin*)	Non Preferred	PA; AGE (Min 18 Years)
TRADJENTA TABLET 5 MG ORAL (*linagliptin*)	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 (*empagliflozin-linaglip-metform*)	Non Preferred	PA; AGE (Min 18 Years)
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG ORAL (*empagliflozin-linaglip-metform*)	Non Preferred	PA; AGE (Min 18 Years)
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 25-5-1000 MG ORAL (*empagliflozin-linaglip-metform*)	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
TRIJARDY XR TABLET EXTENDED RELEASE 24 HOUR 5-2.5-1000 MG ORAL (*empagliflozin-linaglip-metform*)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: MEGLINITIDES [OPEN CLASS]		
nateglinide tablet 120 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
nateglinide tablet 60 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
repaglinide tablet 0.5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
repaglinide tablet 1 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
repaglinide tablet 2 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
DIABETES ORAL HYPOGLYCEMICS: SECOND GENERATION SULFONYLUREAS [OPEN CLASS]		
glimepiride tablet 1 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glimepiride tablet 2 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glimepiride tablet 4 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glipizide er tablet extended release 24 hour 10 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glipizide er tablet extended release 24 hour 2.5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glipizide er tablet extended release 24 hour 5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glipizide tablet 10 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glipizide tablet 5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glipizide xl tablet extended release 24 hour 10 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glipizide xl tablet extended release 24 hour 2.5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glipizide xl tablet extended release 24 hour 5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 10 MG ORAL (*glipizide*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 2.5 MG ORAL (*glipizide*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GLUCOTROL XL TABLET EXTENDED RELEASE 24 HOUR 5 MG ORAL (*glipizide*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
glyburide micronized tablet 1.5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill

Drug Name	Formulary Status	Requirements/Limits
glyburide micronized tablet 3 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glyburide micronized tablet 6 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glyburide tablet 1.25 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glyburide tablet 2.5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
glyburide tablet 5 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
GLYNASE TABLET 1.5 MG ORAL (*glyburide micronized*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GLYNASE TABLET 3 MG ORAL (*glyburide micronized*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
GLYNASE TABLET 6 MG ORAL (*glyburide micronized*)	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 (*dapagliflozin propanediol*)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
FARXIGA TABLET 5 MG ORAL (*dapagliflozin propanediol*)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill
INPEFA TABLET 200 MG ORAL (*sitagliflozin*)	Non Preferred	PA; AGE (Min 18 Years)
INVOKAMET TABLET 150-1000 MG ORAL (*canagliflozin-metformin hcl*)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET TABLET 150-500 MG ORAL (*canagliflozin-metformin hcl*)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET TABLET 50-1000 MG ORAL (*canagliflozin-metformin hcl*)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET TABLET 50-500 MG ORAL (*canagliflozin-metformin hcl*)	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG ORAL (*canagliflozin-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 150-500 MG ORAL (*canagliflozin-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG ORAL (*canagliflozin-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
INVOKAMET XR TABLET EXTENDED RELEASE 24 HOUR 50-500 MG ORAL (*canagliflozin-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
INVOKANA TABLET 100 MG ORAL (*canagliflozin*)	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); Max 90-day supply per fill

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

Drug Name	Formulary Status	Requirements/Limits
DIABETES ORAL HYPOGLYCEMICS: THIAZOLIDINEDIONES [OPEN CLASS]		
ACTOPLUS MET TABLET 15-850 MG ORAL (*pioglitazone hcl-metformin hcl*)	Non Preferred	PA
ACTOS TABLET 15 MG ORAL (*pioglitazone hcl*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ACTOS TABLET 30 MG ORAL (*pioglitazone hcl*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
ACTOS TABLET 45 MG ORAL (*pioglitazone hcl*)	Non Preferred	PA; AGE (Min 18 Years); Max 90-day supply per fill
DUETACT TABLET 30-2 MG ORAL (*pioglitazone hcl-glimepiride*)	Non Preferred	PA
DUETACT TABLET 30-4 MG ORAL (*pioglitazone hcl-glimepiride*)	Non Preferred	PA
pioglitazone hcl tablet 15 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
pioglitazone hcl tablet 30 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
pioglitazone hcl tablet 45 mg oral	Preferred	AGE (Min 18 Years); Max 90-day supply per fill
pioglitazone hcl-glimepiride tablet 30-2 mg oral	Non Preferred	PA
pioglitazone hcl-glimepiride tablet 30-4 mg oral	Non Preferred	PA
pioglitazone hcl-metformin hcl tablet 15-500 mg oral	Non Preferred	PA
pioglitazone hcl-metformin hcl tablet 15-850 mg oral	Non Preferred	PA
DIABETES: INJECTABLE AMYLIN ANALOGS [CLOSED CLASS]		
SYMLINPEN 120 SOLUTION PEN-INJECTOR 2700 MCG/2.7ML SUBCUTANEOUS (*pramlintide acetate*)	Non Preferred	PA
SYMLINPEN 60 SOLUTION PEN-INJECTOR 1500 MCG/1.5ML SUBCUTANEOUS (*pramlintide acetate*)	Non Preferred	PA
DIABETES: INJECTABLE AND ORAL INCRETIN MIMETICS [CLOSED CLASS]		
BYDUREON BCISE AUTO-INJECTOR 2 MG/0.85ML SUBCUTANEOUS (*exenatide*)	Non Preferred	PA; QL (3.4 ML per 28 days)
BYETTA 10 MCG PEN SOLUTION PEN-INJECTOR 10 MCG/0.04ML SUBCUTANEOUS (*exenatide*)	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 (*exenatide*)	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 (*tirzepatide*)	Non Preferred	PA; QL (2 ML per 28 days); 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
MOUNJARO SOLUTION PEN-INJECTOR 12.5 MG/0.5ML SUBCUTANEOUS (*tirzepatide*)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
MOUNJARO SOLUTION PEN-INJECTOR 15 MG/0.5ML SUBCUTANEOUS (*tirzepatide*)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
MOUNJARO SOLUTION PEN-INJECTOR 2.5 MG/0.5ML SUBCUTANEOUS (*tirzepatide*)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5ML SUBCUTANEOUS (*tirzepatide*)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
MOUNJARO SOLUTION PEN-INJECTOR 7.5 MG/0.5ML SUBCUTANEOUS (*tirzepatide*)	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 (*semaglutide*)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4 MG/3ML SUBCUTANEOUS (*semaglutide*)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8 MG/3ML SUBCUTANEOUS (*semaglutide*)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
RYBELSUS TABLET 14 MG ORAL (*semaglutide*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
RYBELSUS TABLET 3 MG ORAL (*semaglutide*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
RYBELSUS TABLET 7 MG ORAL (*semaglutide*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SOLIQUA SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML SUBCUTANEOUS (*insulin glargine-lixisenatide*)	Non Preferred	PA
TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5ML SUBCUTANEOUS (*dulaglutide*)	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 (*dulaglutide*)	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 (*dulaglutide*)	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 (*dulaglutide*)	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 (*liraglutide*)	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 (*insulin degludec-liraglutide*)	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 (*epinephrine*)	Non Preferred	PA; QL (12 EA per 365 days)

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

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

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

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

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

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

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)
budesonide capsule delayed release particles 3 mg oral	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
cortisone acetate tablet 25 mg oral	Non Preferred	PA
dexamethasone elixir 0.5 mg/5ml oral	Preferred	
DEXAMETHASONE INTENSOL CONCENTRATE 1 MG/ML ORAL (*dexamethasone*)	Preferred	
dexamethasone solution 0.5 mg/5ml oral	Preferred	
dexamethasone tablet 0.5 mg oral	Preferred	
dexamethasone tablet 0.75 mg oral	Preferred	
dexamethasone tablet 1 mg oral	Preferred	
dexamethasone tablet 1.5 mg oral	Preferred	
dexamethasone tablet 2 mg oral	Preferred	
dexamethasone tablet 4 mg oral	Preferred	
dexamethasone tablet 6 mg oral	Preferred	
dexamethasone tablet therapy pack 1.5 mg (21) oral	Non Preferred	PA
dexamethasone tablet therapy pack 1.5 mg (35) oral	Non Preferred	PA
dexamethasone tablet therapy pack 1.5 mg (51) oral	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
hydrocortisone tablet 10 mg oral	Preferred	
hydrocortisone tablet 20 mg oral	Preferred	

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

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

Drug Name	Formulary Status	Requirements/Limits
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.6 MG SUBCUTANEOUS (*somatropin*)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 1.8 MG SUBCUTANEOUS (*somatropin*)	Preferred	PA
GENOTROPIN MINIQUICK PREFILLED SYRINGE 2 MG SUBCUTANEOUS (*somatropin*)	Preferred	PA
HUMATROPE CARTRIDGE 12 MG INJECTION (*somatropin*)	Non Preferred	PA
HUMATROPE CARTRIDGE 24 MG INJECTION (*somatropin*)	Non Preferred	PA
HUMATROPE CARTRIDGE 6 MG INJECTION (*somatropin*)	Non Preferred	PA
NORDITROPIN FLEXPRO SOLUTION PEN-INJECTOR 10 MG/1.5ML SUBCUTANEOUS (*somatropin*)	Preferred	PA
NORDITROPIN FLEXPRO SOLUTION PEN-INJECTOR 15 MG/1.5ML SUBCUTANEOUS (*somatropin*)	Preferred	PA
NORDITROPIN FLEXPRO SOLUTION PEN-INJECTOR 30 MG/3ML SUBCUTANEOUS (*somatropin*)	Preferred	PA
NORDITROPIN FLEXPRO SOLUTION PEN-INJECTOR 5 MG/1.5ML SUBCUTANEOUS (*somatropin*)	Preferred	PA
NUTROPIN AQ NUSPIN 10 SOLUTION PEN-INJECTOR 10 MG/2ML SUBCUTANEOUS (*somatropin*)	Non Preferred	PA
NUTROPIN AQ NUSPIN 20 SOLUTION PEN-INJECTOR 20 MG/2ML SUBCUTANEOUS (*somatropin*)	Non Preferred	PA
NUTROPIN AQ NUSPIN 5 SOLUTION PEN-INJECTOR 5 MG/2ML SUBCUTANEOUS (*somatropin*)	Non Preferred	PA
OMNITROPE SOLUTION CARTRIDGE 10 MG/1.5ML SUBCUTANEOUS (*somatropin*)	Non Preferred	PA
OMNITROPE SOLUTION CARTRIDGE 5 MG/1.5ML SUBCUTANEOUS (*somatropin*)	Non Preferred	PA
OMNITROPE SOLUTION RECONSTITUTED 5.8 MG SUBCUTANEOUS (*somatropin*)	Non Preferred	PA
SAIZEN SOLUTION RECONSTITUTED 5 MG INJECTION (*somatropin (non-refrigerated)*)	Non Preferred	PA
SAIZEN SOLUTION RECONSTITUTED 8.8 MG INJECTION (*somatropin (non-refrigerated)*)	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 4 MG SUBCUTANEOUS (*somatropin (non-refrigerated)*)	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 5 MG SUBCUTANEOUS (*somatropin (non-refrigerated)*)	Non Preferred	PA
SEROSTIM SOLUTION RECONSTITUTED 6 MG SUBCUTANEOUS (*somatropin (non-refrigerated)*)	Non Preferred	PA
SKYTROFA CARTRIDGE 11 MG SUBCUTANEOUS (*lonapegsomatropin-tcgd*)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 13.3 MG SUBCUTANEOUS (*lonapegsomatropin-tcgd*)	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 (*lonapegsomatropin-tcgd*)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 3.6 MG SUBCUTANEOUS (*lonapegsomatropin-tcgd*)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 4.3 MG SUBCUTANEOUS (*lonapegsomatropin-tcgd*)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 5.2 MG SUBCUTANEOUS (*lonapegsomatropin-tcgd*)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 6.3 MG SUBCUTANEOUS (*lonapegsomatropin-tcgd*)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 7.6 MG SUBCUTANEOUS (*lonapegsomatropin-tcgd*)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SKYTROFA CARTRIDGE 9.1 MG SUBCUTANEOUS (*lonapegsomatropin-tcgd*)	Non Preferred	PA; AGE (Min 1 Years and Max 17 Years)
SOGROYA SOLUTION PEN-INJECTOR 10 MG/1.5ML SUBCUTANEOUS (*somapacitan-beco*)	Non Preferred	PA; AGE (Min 2 Years)
SOGROYA SOLUTION PEN-INJECTOR 15 MG/1.5ML SUBCUTANEOUS (*somapacitan-beco*)	Non Preferred	PA; AGE (Min 2 Years)
SOGROYA SOLUTION PEN-INJECTOR 5 MG/1.5ML SUBCUTANEOUS (*somapacitan-beco*)	Non Preferred	PA; AGE (Min 2 Years)
ZOMACTON SOLUTION RECONSTITUTED 10 MG SUBCUTANEOUS (*somatropin*)	Non Preferred	PA
ZOMACTON SOLUTION RECONSTITUTED 5 MG SUBCUTANEOUS (*somatropin*)	Non Preferred	PA
H PYLORI TREATMENT [OPEN CLASS]		
amoxicill-clarithro-lansopraz therapy pack 500 & 500 & 30 mg oral	Non Preferred	PA
bis subcit-metronid-tetracyc capsule 140-125-125 mg oral	Non Preferred	PA
bismuth/metronidaz/tetracyclin capsule 140-125-125 mg oral	Non Preferred	PA
OMECLAMOX-PAK 500-500-20 MG ORAL (*amoxicill-clarithro-omeprazole*)	Non Preferred	PA
PYLERA CAPSULE 140-125-125 MG ORAL (*bis subcit-metronid-tetracyc*)	Preferred	
TALICIA CAPSULE DELAYED RELEASE 250-12.5-10 MG ORAL (*amoxicill-rifabutin-omeprazole*)	Non Preferred	PA
HEMOPHILIA TREATMENT [CLOSED CLASS]		
ADVATE SOLUTION RECONSTITUTED 1000 UNIT INTRAVENOUS (*antihemophil factor (rahf-pfm)*)	Preferred	
ADVATE SOLUTION RECONSTITUTED 1500 UNIT INTRAVENOUS (*antihemophil factor (rahf-pfm)*)	Preferred	
ADVATE SOLUTION RECONSTITUTED 2000 UNIT INTRAVENOUS (*antihemophil factor (rahf-pfm)*)	Preferred	
ADVATE SOLUTION RECONSTITUTED 250 UNIT INTRAVENOUS (*antihemophil factor (rahf-pfm)*)	Preferred	

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

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
heartburn relief tablet 10 mg oral	Preferred	Max 90-day supply per fill
hm dual action complete tablet chewable 10-800-165 mg oral	Non Preferred	PA
nizatidine capsule 150 mg oral	Non Preferred	PA
nizatidine capsule 300 mg oral	Non Preferred	PA
PEPCID TABLET 20 MG ORAL (*famotidine*)	Non Preferred	PA; Max 90-day supply per fill
PEPCID TABLET 40 MG ORAL (*famotidine*)	Non Preferred	PA; Max 90-day supply per fill
sm acid reducer max st tablet 20 mg oral	Preferred	Max 90-day supply per fill
sm acid reducer tablet 10 mg oral	Preferred	Max 90-day supply per fill
HIV/AIDS [CLOSED CLASS]		
abacavir sulfate solution 20 mg/ml oral	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
abacavir sulfate tablet 300 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
abacavir sulfate-lamivudine tablet 600-300 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
APRETUDE SUSPENSION EXTENDED RELEASE 600 MG/3ML INTRAMUSCULAR (*cabotegravir*)	Preferred	QL (3 ML per 28 days); Max 56-day supply per fill
APTIVUS CAPSULE 250 MG ORAL (*tipranavir*)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
atazanavir sulfate capsule 150 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
atazanavir sulfate capsule 200 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
atazanavir sulfate capsule 300 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
ATRIPLA TABLET 600-200-300 MG ORAL (*efavirenz-emtricitab-tenofo df*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
BIKTARVY TABLET 30-120-15 MG ORAL (*bictegravir-emtricitab-tenofov*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
BIKTARVY TABLET 50-200-25 MG ORAL (*bictegravir-emtricitab-tenofov*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
cabenuva suspension extended release 400 & 600 mg/2ml intramuscular	Preferred	QL (12 ML per 84 days); Max 90-day supply per fill
cabenuva suspension extended release 600 & 900 mg/3ml intramuscular	Preferred	Max 90-day supply per fill
CIMDUO TABLET 300-300 MG ORAL (*lamivudine-tenofovir*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
COMBIVIR TABLET 150-300 MG ORAL (*lamivudine-zidovudine*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
COMPLERA TABLET 200-25-300 MG ORAL (*emtricitab-rilpivir-tenofovir*)	Preferred	QL (1 EA per 1 day); 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
darunavir tablet 600 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
darunavir tablet 800 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DELSTRIGO TABLET 100-300-300 MG ORAL (*doravirin-lamivudin-tenofov df*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DESCOVY TABLET 120-15 MG ORAL (*emtricitabine-tenofovir af*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DESCOVY TABLET 200-25 MG ORAL (*emtricitabine-tenofovir af*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
DOVATO TABLET 50-300 MG ORAL (*dolutegravir-lamivudine*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
EDURANT TABLET 25 MG ORAL (*rilpivirine hcl*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
efavirenz capsule 200 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
efavirenz capsule 50 mg oral	Preferred	QL (3 EA per 1 day); Max 90-day supply per fill
efavirenz tablet 600 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
efavirenz-emtricitab-tenofo df tablet 600-200-300 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
efavirenz-lamivudine-tenofovir tablet 400-300-300 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
efavirenz-lamivudine-tenofovir tablet 600-300-300 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
emtricitabine capsule 200 mg oral	Preferred	QL (24 EA per 1 day); Max 90-day supply per fill
emtricitabine-tenofovir df tablet 100-150 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
emtricitabine-tenofovir df tablet 133-200 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
emtricitabine-tenofovir df tablet 167-250 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
emtricitabine-tenofovir df tablet 200-300 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
EMTRIVA CAPSULE 200 MG ORAL (*emtricitabine*)	Preferred	QL (24 EA per 1 day); Max 90-day supply per fill
EMTRIVA SOLUTION 10 MG/ML ORAL (*emtricitabine*)	Preferred	QL (1 ML per 1 day); Max 90-day supply per fill
EPIVIR SOLUTION 10 MG/ML ORAL (*lamivudine*)	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
EPIVIR TABLET 150 MG ORAL (*lamivudine*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
EPIVIR TABLET 300 MG ORAL (*lamivudine*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill

Drug Name	Formulary Status	Requirements/Limits
EPZICOM TABLET 600-300 MG ORAL (*abacavir sulfate-lamivudine*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
etravirine tablet 100 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
etravirine tablet 200 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
EVOTAZ TABLET 300-150 MG ORAL (*atazanavir-cobicistat*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
fosamprenavir calcium tablet 700 mg oral	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
FUZEON SOLUTION RECONSTITUTED 90 MG SUBCUTANEOUS (*enfuvirtide*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
GENVOYA TABLET 150-150-200-10 MG ORAL (*elviteg-cobic-emtricit-tenofaf*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
INTELENCE TABLET 100 MG ORAL (*etravirine*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
INTELENCE TABLET 200 MG ORAL (*etravirine*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
INTELENCE TABLET 25 MG ORAL (*etravirine*)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
ISENTRESS HD TABLET 600 MG ORAL (*raltegravir potassium*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
ISENTRESS PACKET 100 MG ORAL (*raltegravir potassium*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
ISENTRESS TABLET 400 MG ORAL (*raltegravir potassium*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
ISENTRESS TABLET CHEWABLE 100 MG ORAL (*raltegravir potassium*)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
ISENTRESS TABLET CHEWABLE 25 MG ORAL (*raltegravir potassium*)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
JULUCA TABLET 50-25 MG ORAL (*dolutegravir-rilpivirine*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
KALETRA SOLUTION 400-100 MG/5ML ORAL (*lopinavir-ritonavir*)	Preferred	QL (4 ML per 1 day); Max 90-day supply per fill
KALETRA TABLET 100-25 MG ORAL (*lopinavir-ritonavir*)	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
KALETRA TABLET 200-50 MG ORAL (*lopinavir-ritonavir*)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
lamivudine solution 10 mg/ml oral	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
lamivudine tablet 150 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
lamivudine tablet 300 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
lamivudine-zidovudine tablet 150-300 mg oral	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 (*fosamprenavir calcium*)	Preferred	QL (56 ML per 1 day); Max 90-day supply per fill
LEXIVA TABLET 700 MG ORAL (*fosamprenavir calcium*)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
lopinavir-ritonavir solution 400-100 mg/5ml oral	Preferred	QL (4 ML per 1 day); Max 90-day supply per fill
lopinavir-ritonavir tablet 100-25 mg oral	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
lopinavir-ritonavir tablet 200-50 mg oral	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
maraviroc tablet 150 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
maraviroc tablet 300 mg oral	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
nevirapine er tablet extended release 24 hour 100 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
nevirapine er tablet extended release 24 hour 400 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
nevirapine suspension 50 mg/5ml oral	Preferred	QL (40 ML per 1 day); Max 90-day supply per fill
nevirapine tablet 200 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
NORVIR PACKET 100 MG ORAL (*ritonavir*)	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
NORVIR TABLET 100 MG ORAL (*ritonavir*)	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
ODEFSEY TABLET 200-25-25 MG ORAL (*emtricitab-rilpivir-tenofov af*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
PIFELTRO TABLET 100 MG ORAL (*doravirine*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
PREZCOBIX TABLET 800-150 MG ORAL (*darunavir-cobicistat*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
PREZISTA SUSPENSION 100 MG/ML ORAL (*darunavir*)	Preferred	QL (12 ML per 1 day); Max 90-day supply per fill
PREZISTA TABLET 150 MG ORAL (*darunavir*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
PREZISTA TABLET 600 MG ORAL (*darunavir*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
PREZISTA TABLET 75 MG ORAL (*darunavir*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
PREZISTA TABLET 800 MG ORAL (*darunavir*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
RETROVIR CAPSULE 100 MG ORAL (*zidovudine*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
RETROVIR SYRUP 50 MG/5ML ORAL (*zidovudine*)	Preferred	QL (60 ML per 1 day); Max 90-day supply per fill

Drug Name	Formulary Status	Requirements/Limits
REYATAZ CAPSULE 200 MG ORAL (*atazanavir sulfate*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
REYATAZ CAPSULE 300 MG ORAL (*atazanavir sulfate*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
REYATAZ PACKET 50 MG ORAL (*atazanavir sulfate*)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
ritonavir tablet 100 mg oral	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
RUKOBIA TABLET EXTENDED RELEASE 12 HOUR 600 MG ORAL (*fostemsavir tromethamine*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
SELZENTRY SOLUTION 20 MG/ML ORAL (*maraviroc*)	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 150 MG ORAL (*maraviroc*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 25 MG ORAL (*maraviroc*)	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 300 MG ORAL (*maraviroc*)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
SELZENTRY TABLET 75 MG ORAL (*maraviroc*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
stavudine capsule 15 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
stavudine capsule 20 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
stavudine capsule 40 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
STRIBILD TABLET 150-150-200-300 MG ORAL (*elviteg-cobic-emtricit-tenofdf*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SUNLENCA SOLUTION 463.5 MG/1.5ML SUBCUTANEOUS (*lenacapavir sodium*)	Preferred	AGE (Min 18 Years)
SUNLENCA TABLET THERAPY PACK 4 X 300 MG ORAL (*lenacapavir sodium*)	Preferred	AGE (Min 18 Years)
SUNLENCA TABLET THERAPY PACK 5 X 300 MG ORAL (*lenacapavir sodium*)	Preferred	AGE (Min 18 Years)
SYMFI LO TABLET 400-300-300 MG ORAL (*efavirenz-lamivudine-tenofovir*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SYMFI TABLET 600-300-300 MG ORAL (*efavirenz-lamivudine-tenofovir*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
SYMTUZA TABLET 800-150-200-10 MG ORAL (*darun-cobic-emtricit-tenofaf*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
tenofovir disoproxil fumarate tablet 300 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TIVICAY PD TABLET SOLUBLE 5 MG ORAL (*dolutegravir sodium*)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
TIVICAY TABLET 10 MG ORAL (*dolutegravir sodium*)	Preferred	QL (6 EA per 1 day); 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
TIVICAY TABLET 25 MG ORAL (*dolutegravir sodium*)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
TIVICAY TABLET 50 MG ORAL (*dolutegravir sodium*)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
TRIUMEQ PD TABLET SOLUBLE 60-5-30 MG ORAL (*abacavir-dolutegravir-lamivud*)	Preferred	QL (6 EA per 1 day); Max 90-day supply per fill
TRIUMEQ TABLET 600-50-300 MG ORAL (*abacavir-dolutegravir-lamivud*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRIZIVIR TABLET 300-150-300 MG ORAL (*abacavir-lamivudine-zidovudine*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
TROGARZO SOLUTION 200 MG/1.33ML INTRAVENOUS (*ibalizumab-uiyk*)	Non Preferred	PA
TRUVADA TABLET 100-150 MG ORAL (*emtricitabine-tenofovir df*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 133-200 MG ORAL (*emtricitabine-tenofovir df*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 167-250 MG ORAL (*emtricitabine-tenofovir df*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TRUVADA TABLET 200-300 MG ORAL (*emtricitabine-tenofovir df*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
TYBOST TABLET 150 MG ORAL (*cobicistat*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIRACEPT TABLET 250 MG ORAL (*nelfinavir mesylate*)	Preferred	QL (10 EA per 1 day); Max 90-day supply per fill
VIRACEPT TABLET 625 MG ORAL (*nelfinavir mesylate*)	Preferred	QL (4 EA per 1 day); Max 90-day supply per fill
VIREAD POWDER 40 MG/GM ORAL (*tenofovir disoproxil fumarate*)	Preferred	QL (1 GM per 1 day); Max 90-day supply per fill
VIREAD TABLET 150 MG ORAL (*tenofovir disoproxil fumarate*)	Preferred	QL (8 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 200 MG ORAL (*tenofovir disoproxil fumarate*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 250 MG ORAL (*tenofovir disoproxil fumarate*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
VIREAD TABLET 300 MG ORAL (*tenofovir disoproxil fumarate*)	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
ZIAGEN SOLUTION 20 MG/ML ORAL (*abacavir sulfate*)	Preferred	QL (30 ML per 1 day); Max 90-day supply per fill
ZIAGEN TABLET 300 MG ORAL (*abacavir sulfate*)	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
zidovudine capsule 100 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
zidovudine syrup 50 mg/5ml oral	Preferred	QL (60 ML per 1 day); Max 90-day supply per fill
zidovudine tablet 300 mg oral	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
NOVOLIN R SOLUTION 100 UNIT/ML INJECTION (*insulin regular human*)	Non Preferred	PA; Max 90-day supply per fill
INSULINS: LONG-ACTING [OPEN CLASS]		
BASAGLAR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin glargine*)	Preferred	Max 90-day supply per fill
BASAGLAR TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin glargine*)	Non Preferred	PA
insulin degludec flextouch solution pen-injector 100 unit/ml subcutaneous	Non Preferred	PA
insulin degludec flextouch solution pen-injector 200 unit/ml subcutaneous	Non Preferred	PA
insulin degludec solution 100 unit/ml subcutaneous	Non Preferred	PA
insulin glargine solostar solution pen-injector 100 unit/ml subcutaneous	Preferred	Max 90-day supply per fill
insulin glargine solution 100 unit/ml subcutaneous	Preferred	Max 90-day supply per fill
insulin glargine-yfgn solution 100 unit/ml subcutaneous	Preferred	
insulin glargine-yfgn solution pen-injector 100 unit/ml subcutaneous	Preferred	
LANTUS SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin glargine*)	Preferred	Max 90-day supply per fill
LANTUS SOLUTION 100 UNIT/ML SUBCUTANEOUS (*insulin glargine*)	Preferred	Max 90-day supply per fill
LEVEMIR FLEXPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin detemir*)	Preferred	Max 90-day supply per fill
LEVEMIR SOLUTION 100 UNIT/ML SUBCUTANEOUS (*insulin detemir*)	Preferred	Max 90-day supply per fill
REZVOGLAR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin glargine-aglr*)	Preferred	
SEMGLEE (YFGN) SOLUTION 100 UNIT/ML SUBCUTANEOUS (*insulin glargine-yfgn*)	Non Preferred	PA
SEMGLEE (YFGN) SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin glargine-yfgn*)	Non Preferred	PA
TOUJEO MAX SOLOSTAR SOLUTION PEN-INJECTOR 300 UNIT/ML SUBCUTANEOUS (*insulin glargine*)	Non Preferred	PA
TOUJEO SOLOSTAR SOLUTION PEN-INJECTOR 300 UNIT/ML SUBCUTANEOUS (*insulin glargine*)	Non Preferred	PA
TRESIBA FLEXTOUCH SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin degludec*)	Non Preferred	PA
TRESIBA FLEXTOUCH SOLUTION PEN-INJECTOR 200 UNIT/ML SUBCUTANEOUS (*insulin degludec*)	Non Preferred	PA
TRESIBA SOLUTION 100 UNIT/ML SUBCUTANEOUS (*insulin degludec*)	Non Preferred	PA
INSULINS: RAPID-ACTING [OPEN CLASS]		
ADMELOG SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin lispro*)	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
ADMELOG SOLUTION 100 UNIT/ML INJECTION (*insulin lispro*)	Preferred	Max 90-day supply per fill
AFREZZA POWDER 12 UNIT INHALATION (*insulin regular human*)	Non Preferred	PA
AFREZZA POWDER 4 UNIT INHALATION (*insulin regular human*)	Non Preferred	PA
AFREZZA POWDER 60X4 &60X8 & 60X12 UNIT INHALATION (*insulin regular human*)	Non Preferred	PA
AFREZZA POWDER 8 UNIT INHALATION (*insulin regular human*)	Non Preferred	PA
AFREZZA POWDER 90 X 4 UNIT & 90X8 UNIT INHALATION (*insulin regular human*)	Non Preferred	PA
AFREZZA POWDER 90 X 8 UNIT & 90X12 UNIT INHALATION (*insulin regular human*)	Non Preferred	PA
APIDRA SOLOSTAR SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin glulisine*)	Non Preferred	PA
APIDRA SOLUTION 100 UNIT/ML INJECTION (*insulin glulisine*)	Non Preferred	PA
FIASP FLEXTOUCH SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin aspart (w/niacinamide)*)	Non Preferred	PA
FIASP PENFILL SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS (*insulin aspart (w/niacinamide)*)	Non Preferred	PA
FIASP SOLUTION 100 UNIT/ML INJECTION (*insulin aspart (w/niacinamide)*)	Non Preferred	PA
HUMALOG JUNIOR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin lispro*)	Preferred	Max 90-day supply per fill
HUMALOG KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin lispro*)	Preferred	Max 90-day supply per fill
HUMALOG KWIKPEN SOLUTION PEN-INJECTOR 200 UNIT/ML SUBCUTANEOUS (*insulin lispro*)	Non Preferred	PA
HUMALOG SOLUTION 100 UNIT/ML INJECTION (*insulin lispro*)	Preferred	Max 90-day supply per fill
HUMALOG SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS (*insulin lispro*)	Preferred	Max 90-day supply per fill
HUMALOG TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS (*insulin lispro*)	Non Preferred	PA
HUMULIN R U-500 (CONCENTRATED) SOLUTION 500 UNIT/ML SUBCUTANEOUS (*insulin regular human*)	Preferred	Max 90-day supply per fill
HUMULIN R U-500 KWIKPEN SOLUTION PEN-INJECTOR 500 UNIT/ML SUBCUTANEOUS (*insulin regular human*)	Preferred	Max 90-day supply per fill
insulin aspart flexpen solution pen-injector 100 unit/ml subcutaneous	Preferred	Max 90-day supply per fill
insulin aspart penfill solution cartridge 100 unit/ml subcutaneous	Preferred	Max 90-day supply per fill
insulin aspart solution 100 unit/ml injection	Preferred	Max 90-day supply per fill
insulin lispro (1 unit dial) solution pen-injector 100 unit/ml subcutaneous	Preferred	Max 90-day supply per fill

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
EZALLOR SPRINKLE CAPSULE SPRINKLE 40 MG ORAL (*rosuvastatin calcium*)	Non Preferred	PA
EZALLOR SPRINKLE CAPSULE SPRINKLE 5 MG ORAL (*rosuvastatin calcium*)	Non Preferred	PA
ezetimibe-simvastatin tablet 10-10 mg oral	Non Preferred	PA
ezetimibe-simvastatin tablet 10-20 mg oral	Non Preferred	PA
ezetimibe-simvastatin tablet 10-40 mg oral	Non Preferred	PA
ezetimibe-simvastatin tablet 10-80 mg oral	Non Preferred	PA
fluvastatin sodium capsule 20 mg oral	Non Preferred	PA
fluvastatin sodium capsule 40 mg oral	Non Preferred	PA
fluvastatin sodium er tablet extended release 24 hour 80 mg oral	Non Preferred	PA
LESCOL XL TABLET EXTENDED RELEASE 24 HOUR 80 MG ORAL (*fluvastatin sodium*)	Non Preferred	PA
LIPITOR TABLET 10 MG ORAL (*atorvastatin calcium*)	Non Preferred	PA; Max 90-day supply per fill
LIPITOR TABLET 20 MG ORAL (*atorvastatin calcium*)	Non Preferred	PA; Max 90-day supply per fill
LIPITOR TABLET 40 MG ORAL (*atorvastatin calcium*)	Non Preferred	PA; Max 90-day supply per fill
LIPITOR TABLET 80 MG ORAL (*atorvastatin calcium*)	Non Preferred	PA; Max 90-day supply per fill
LIVALO TABLET 1 MG ORAL (*pitavastatin calcium*)	Non Preferred	PA
LIVALO TABLET 2 MG ORAL (*pitavastatin calcium*)	Non Preferred	PA
LIVALO TABLET 4 MG ORAL (*pitavastatin calcium*)	Non Preferred	PA
lovastatin tablet 10 mg oral	Preferred	Max 90-day supply per fill
lovastatin tablet 20 mg oral	Preferred	Max 90-day supply per fill
lovastatin tablet 40 mg oral	Preferred	Max 90-day supply per fill
pravastatin sodium tablet 10 mg oral	Preferred	Max 90-day supply per fill
pravastatin sodium tablet 20 mg oral	Preferred	Max 90-day supply per fill
pravastatin sodium tablet 40 mg oral	Preferred	Max 90-day supply per fill
pravastatin sodium tablet 80 mg oral	Preferred	Max 90-day supply per fill
rosuvastatin calcium tablet 10 mg oral	Preferred	Max 90-day supply per fill
rosuvastatin calcium tablet 20 mg oral	Preferred	Max 90-day supply per fill
rosuvastatin calcium tablet 40 mg oral	Preferred	Max 90-day supply per fill
rosuvastatin calcium tablet 5 mg oral	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
simvastatin tablet 10 mg oral	Preferred	Max 90-day supply per fill
simvastatin tablet 20 mg oral	Preferred	Max 90-day supply per fill
simvastatin tablet 40 mg oral	Preferred	Max 90-day supply per fill
simvastatin tablet 5 mg oral	Preferred	Max 90-day supply per fill
simvastatin tablet 80 mg oral	Preferred	Max 90-day supply per fill
VYTORIN TABLET 10-10 MG ORAL (*ezetimibe-simvastatin*)	Non Preferred	PA
VYTORIN TABLET 10-20 MG ORAL (*ezetimibe-simvastatin*)	Non Preferred	PA
VYTORIN TABLET 10-40 MG ORAL (*ezetimibe-simvastatin*)	Non Preferred	PA
VYTORIN TABLET 10-80 MG ORAL (*ezetimibe-simvastatin*)	Non Preferred	PA
ZOCOR TABLET 10 MG ORAL (*simvastatin*)	Non Preferred	PA; Max 90-day supply per fill
ZOCOR TABLET 20 MG ORAL (*simvastatin*)	Non Preferred	PA; Max 90-day supply per fill
ZOCOR TABLET 40 MG ORAL (*simvastatin*)	Non Preferred	PA; Max 90-day supply per fill
ZYPITAMAG TABLET 2 MG ORAL (*pitavastatin magnesium*)	Non Preferred	PA
ZYPITAMAG TABLET 4 MG ORAL (*pitavastatin magnesium*)	Non Preferred	PA
MACROLIDES, ORAL [OPEN CLASS]		
azithromycin packet 1 gm oral	Preferred	
azithromycin suspension reconstituted 100 mg/5ml oral	Preferred	
azithromycin suspension reconstituted 200 mg/5ml oral	Preferred	
azithromycin tablet 250 mg oral	Preferred	
azithromycin tablet 500 mg oral	Preferred	
azithromycin tablet 600 mg oral	Preferred	
clarithromycin er tablet extended release 24 hour 500 mg oral	Non Preferred	PA
clarithromycin suspension reconstituted 125 mg/5ml oral	Preferred	
clarithromycin suspension reconstituted 250 mg/5ml oral	Preferred	
clarithromycin tablet 250 mg oral	Preferred	
clarithromycin tablet 500 mg oral	Preferred	
E.E.S. 400 TABLET 400 MG ORAL (*erythromycin ethylsuccinate*)	Non Preferred	PA
E.E.S. GRANULES SUSPENSION RECONSTITUTED 200 MG/5ML ORAL (*erythromycin ethylsuccinate*)	Non Preferred	PA
ERYPED 200 SUSPENSION RECONSTITUTED 200 MG/5ML ORAL (*erythromycin ethylsuccinate*)	Non Preferred	PA
ERYPED 400 SUSPENSION RECONSTITUTED 400 MG/5ML ORAL (*erythromycin ethylsuccinate*)	Non Preferred	PA

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

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

Drug Name	Formulary Status	Requirements/Limits
AVONEX PEN AUTO-INJECTOR KIT 30 MCG/0.5ML INTRAMUSCULAR (*interferon beta-1a*)	Preferred	
AVONEX PREFILLED PREFILLED SYRINGE KIT 30 MCG/0.5ML INTRAMUSCULAR (*interferon beta-1a*)	Preferred	
BAFIERTAM CAPSULE DELAYED RELEASE 95 MG ORAL (*monomethyl fumarate*)	Non Preferred	PA
BETASERON KIT 0.3 MG SUBCUTANEOUS (*interferon beta-1b*)	Preferred	
COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS (*glatiramer acetate*)	Preferred	
COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS (*glatiramer acetate*)	Non Preferred	PA
dalfampridine er tablet extended release 12 hour 10 mg oral	Preferred	
dimethyl fumarate capsule delayed release 120 mg oral	Preferred	
dimethyl fumarate capsule delayed release 240 mg oral	Preferred	
dimethyl fumarate starter pack capsule delayed release therapy pack 120 & 240 mg oral	Preferred	
EXTAVIA KIT 0.3 MG SUBCUTANEOUS (*interferon beta-1b*)	Non Preferred	PA
fingolimod hcl capsule 0.5 mg oral	Preferred	AGE (Min 10 Years)
GILENYA CAPSULE 0.25 MG ORAL (*fingolimod hcl*)	Non Preferred	PA; AGE (Min 10 Years)
GILENYA CAPSULE 0.5 MG ORAL (*fingolimod hcl*)	Non Preferred	PA; AGE (Min 10 Years)
glatiramer acetate solution prefilled syringe 20 mg/ml subcutaneous	Non Preferred	PA
glatiramer acetate solution prefilled syringe 40 mg/ml subcutaneous	Non Preferred	PA
glatiramer acetate (Glatopa Solution Prefilled Syringe 20 Mg/Ml Subcutaneous)	Non Preferred	PA
glatiramer acetate (Glatopa Solution Prefilled Syringe 40 Mg/Ml Subcutaneous)	Non Preferred	PA
KESIMPTA SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS (*ofatumumab*)	Preferred	PA (Eligible for auto-PA); AGE (Min 18 Years)
MAVENCLAD (10 TABS) TABLET THERAPY PACK 10 MG ORAL (*cladribine*)	Non Preferred	PA
MAVENCLAD (4 TABS) TABLET THERAPY PACK 10 MG ORAL (*cladribine*)	Non Preferred	PA
MAVENCLAD (5 TABS) TABLET THERAPY PACK 10 MG ORAL (*cladribine*)	Non Preferred	PA
MAVENCLAD (6 TABS) TABLET THERAPY PACK 10 MG ORAL (*cladribine*)	Non Preferred	PA
MAVENCLAD (7 TABS) TABLET THERAPY PACK 10 MG ORAL (*cladribine*)	Non Preferred	PA
MAVENCLAD (8 TABS) TABLET THERAPY PACK 10 MG ORAL (*cladribine*)	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
MAVENCLAD (9 TABS) TABLET THERAPY PACK 10 MG ORAL (*cladribine*)	Non Preferred	PA
MAYZENT STARTER PACK TABLET THERAPY PACK 12 X 0.25 MG ORAL (*siponimod fumarate*)	Non Preferred	PA
MAYZENT STARTER PACK TABLET THERAPY PACK 7 X 0.25 MG ORAL (*siponimod fumarate*)	Non Preferred	PA
MAYZENT TABLET 0.25 MG ORAL (*siponimod fumarate*)	Non Preferred	PA
MAYZENT TABLET 1 MG ORAL (*siponimod fumarate*)	Non Preferred	PA
MAYZENT TABLET 2 MG ORAL (*siponimod fumarate*)	Non Preferred	PA
PLEGRIDY SOLUTION PEN-INJECTOR 125 MCG/0.5ML SUBCUTANEOUS (*peginterferon beta-1a*)	Non Preferred	PA
PLEGRIDY SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML INTRAMUSCULAR (*peginterferon beta-1a*)	Non Preferred	PA
PLEGRIDY SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML SUBCUTANEOUS (*peginterferon beta-1a*)	Non Preferred	PA
PLEGRIDY STARTER PACK SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML SUBCUTANEOUS (*peginterferon beta-1a*)	Non Preferred	PA
PLEGRIDY STARTER PACK SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML SUBCUTANEOUS (*peginterferon beta-1a*)	Non Preferred	PA
PONVORY STARTER PACK TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG ORAL (*ponesimod*)	Non Preferred	PA
PONVORY TABLET 20 MG ORAL (*ponesimod*)	Non Preferred	PA
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 22 MCG/0.5ML SUBCUTANEOUS (*interferon beta-1a*)	Non Preferred	PA
REBIF REBIDOSE SOLUTION AUTO-INJECTOR 44 MCG/0.5ML SUBCUTANEOUS (*interferon beta-1a*)	Non Preferred	PA
REBIF REBIDOSE TITRATION PACK SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG SUBCUTANEOUS (*interferon beta-1a*)	Non Preferred	PA
REBIF SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML SUBCUTANEOUS (*interferon beta-1a*)	Non Preferred	PA
REBIF SOLUTION PREFILLED SYRINGE 44 MCG/0.5ML SUBCUTANEOUS (*interferon beta-1a*)	Non Preferred	PA
REBIF TITRATION PACK SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG SUBCUTANEOUS (*interferon beta-1a*)	Non Preferred	PA
TASCENSO ODT TABLET DISPERSIBLE 0.25 MG ORAL (*fingolimod lauryl sulfate*)	Non Preferred	PA; AGE (Min 10 Years and Max 17 Years)
TASCENSO ODT TABLET DISPERSIBLE 0.5 MG ORAL (*fingolimod lauryl sulfate*)	Non Preferred	PA; AGE (Min 10 Years and Max 17 Years)
TECFIDERA CAPSULE DELAYED RELEASE 120 MG ORAL (*dimethyl fumarate*)	Non Preferred	PA

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
indomethacin capsule 25 mg oral	Preferred	
indomethacin capsule 50 mg oral	Preferred	
indomethacin er capsule extended release 75 mg oral	Non Preferred	PA
indomethacin suppository 50 mg rectal	Preferred	Max 90-day supply per fill
infants ibuprofen suspension 50 mg/1.25ml oral	Preferred	Max 90-day supply per fill
ketoprofen capsule 50 mg oral	Non Preferred	PA
ketoprofen er capsule extended release 24 hour 200 mg oral	Non Preferred	PA
ketorolac tromethamine solution 15.75 mg/spray nasal	Non Preferred	PA
ketorolac tromethamine tablet 10 mg oral	Preferred	
LICART PATCH 24 HOUR 1.3 % EXTERNAL (*diclofenac epolamine*)	Non Preferred	PA; QL (30 EA per 1 Fill)
diclofenac potassium (Lofena Tablet 25 Mg Oral)	Non Preferred	PA
meclofenamate sodium capsule 100 mg oral	Non Preferred	PA
meclofenamate sodium capsule 50 mg oral	Non Preferred	PA
mefenamic acid capsule 250 mg oral	Non Preferred	PA
meloxicam capsule 10 mg oral	Non Preferred	PA
meloxicam capsule 5 mg oral	Non Preferred	PA
meloxicam tablet 15 mg oral	Preferred	Max 90-day supply per fill
meloxicam tablet 7.5 mg oral	Preferred	Max 90-day supply per fill
nabumetone tablet 500 mg oral	Non Preferred	PA
nabumetone tablet 750 mg oral	Non Preferred	PA
NALFON CAPSULE 400 MG ORAL (*fenoprofen calcium*)	Non Preferred	PA
NALFON TABLET 600 MG ORAL (*fenoprofen calcium*)	Non Preferred	PA
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 375 MG ORAL (*naproxen sodium*)	Non Preferred	PA
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 500 MG ORAL (*naproxen sodium*)	Non Preferred	PA
NAPRELAN TABLET EXTENDED RELEASE 24 HOUR 750 MG ORAL (*naproxen sodium*)	Non Preferred	PA
naproxen dr tablet delayed release 500 mg oral	Preferred	Max 90-day supply per fill
naproxen sodium capsule 220 mg oral	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
naproxen sodium er tablet extended release 24 hour 375 mg oral	Non Preferred	PA
naproxen sodium er tablet extended release 24 hour 500 mg oral	Non Preferred	PA
naproxen sodium er tablet extended release 24 hour 750 mg oral	Non Preferred	PA
naproxen sodium tablet 220 mg oral	Preferred	Max 90-day supply per fill
naproxen sodium tablet 275 mg oral	Preferred	Max 90-day supply per fill
naproxen sodium tablet 550 mg oral	Preferred	Max 90-day supply per fill
naproxen suspension 125 mg/5ml oral	Non Preferred	PA
naproxen tablet 250 mg oral	Preferred	Max 90-day supply per fill
naproxen tablet 375 mg oral	Preferred	Max 90-day supply per fill
naproxen tablet 500 mg oral	Preferred	Max 90-day supply per fill
naproxen tablet delayed release 375 mg oral	Preferred	Max 90-day supply per fill
naproxen tablet delayed release 500 mg oral	Preferred	Max 90-day supply per fill
naproxen-esomeprazole mg tablet delayed release 375-20 mg oral	Non Preferred	PA
naproxen-esomeprazole mg tablet delayed release 500-20 mg oral	Non Preferred	PA
oxaprozin tablet 600 mg oral	Non Preferred	PA
PENNSAID SOLUTION 2 % EXTERNAL (*diclofenac sodium*)	Non Preferred	PA
piroxicam capsule 10 mg oral	Non Preferred	PA
piroxicam capsule 20 mg oral	Non Preferred	PA
qc diclofenac sodium gel 1 % external	Preferred	Max 90-day supply per fill
qc ibuprofen capsule 200 mg oral	Preferred	Max 90-day supply per fill
qc ibuprofen tablet 200 mg oral	Preferred	Max 90-day supply per fill
qc naproxen sodium tablet 220 mg oral	Preferred	Max 90-day supply per fill
RELAFEN DS TABLET 1000 MG ORAL (*nabumetone*)	Non Preferred	PA
sm arthritis pain gel 1 % external	Preferred	Max 90-day supply per fill
sm childrens ibuprofen suspension 100 mg/5ml oral	Preferred	Max 90-day supply per fill
sm ibuprofen capsule 200 mg oral	Preferred	Max 90-day supply per fill
sm ibuprofen ib childrens tablet chewable 100 mg oral	Preferred	
sm ibuprofen ib tablet 200 mg oral	Preferred	Max 90-day supply per fill
sm ibuprofen tablet 200 mg oral	Preferred	Max 90-day supply per fill
sm infants ibuprofen suspension 50 mg/1.25ml oral	Preferred	Max 90-day supply per fill
sm naproxen sodium tablet 220 mg oral	Preferred	Max 90-day supply per fill
sulindac tablet 150 mg oral	Preferred	Max 90-day supply per fill

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
olopatadine hcl solution 0.2 % ophthalmic (otc)	Preferred	
olopatadine hcl solution 0.2 % ophthalmic (rx)	Preferred	
PATADAY SOLUTION 0.1 % OPHTHALMIC (*olopatadine hcl*)	Non Preferred	PA
PATADAY SOLUTION 0.2 % OPHTHALMIC (OTC) (*olopatadine hcl*)	Non Preferred	PA
PATADAY SOLUTION 0.7 % OPHTHALMIC (*olopatadine hcl*)	Non Preferred	PA
qc olopatadine hcl solution 0.2 % ophthalmic	Preferred	
sm olopatadine hcl solution 0.2 % ophthalmic	Preferred	
ZADITOR SOLUTION 0.035 % OPHTHALMIC (*ketotifen fumarate*)	Preferred	
ZERVIATE SOLUTION 0.24 % OPHTHALMIC (*cetirizine hcl*)	Non Preferred	PA
OPIOID DEPENDENCY - [CLOSED CLASS]		
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 16 MG/0.32ML SUBCUTANEOUS (*buprenorphine*)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 24 MG/0.48ML SUBCUTANEOUS (*buprenorphine*)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 32 MG/0.64ML SUBCUTANEOUS (*buprenorphine*)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI (WEEKLY) SOLUTION PREFILLED SYRINGE 8 MG/0.16ML SUBCUTANEOUS (*buprenorphine*)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI SOLUTION PREFILLED SYRINGE 128 MG/0.36ML SUBCUTANEOUS (*buprenorphine*)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI SOLUTION PREFILLED SYRINGE 64 MG/0.18ML SUBCUTANEOUS (*buprenorphine*)	Non Preferred	PA; AGE (Min 18 Years)
BRIXADI SOLUTION PREFILLED SYRINGE 96 MG/0.27ML SUBCUTANEOUS (*buprenorphine*)	Non Preferred	PA; AGE (Min 18 Years)
buprenorphine hcl tablet sublingual 2 mg sublingual	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl tablet sublingual 8 mg sublingual	Preferred	QL (2 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl film 12-3 mg sublingual	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
buprenorphine hcl-naloxone hcl film 2-0.5 mg sublingual	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
buprenorphine hcl-naloxone hcl film 4-1 mg sublingual	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
buprenorphine hcl-naloxone hcl film 8-2 mg sublingual	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 16 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
buprenorphine hcl-naloxone hcl tablet sublingual 2-0.5 mg sublingual	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl tablet sublingual 8-2 mg sublingual	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years)
KLOXXADO LIQUID 8 MG/0.1ML NASAL (*naloxone hcl*)	Preferred	
naloxone hcl liquid 4 mg/0.1ml nasal (rx)	Preferred	
naloxone hcl solution 0.4 mg/ml injection	Preferred	
naloxone hcl solution 4 mg/10ml injection	Preferred	
naloxone hcl solution cartridge 0.4 mg/ml injection	Preferred	
naloxone hcl solution prefilled syringe 2 mg/2ml injection	Preferred	
naltrexone hcl tablet 50 mg oral	Preferred	
NARCAN LIQUID 4 MG/0.1ML NASAL (RX) (*naloxone hcl*)	Preferred	
SUBLOCADE SOLUTION PREFILLED SYRINGE 100 MG/0.5ML SUBCUTANEOUS (*buprenorphine*)	Preferred	
SUBLOCADE SOLUTION PREFILLED SYRINGE 300 MG/1.5ML SUBCUTANEOUS (*buprenorphine*)	Preferred	
SUBOXONE FILM 12-3 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Preferred	QL (2 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
SUBOXONE FILM 2-0.5 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
SUBOXONE FILM 4-1 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Preferred	QL (1 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
SUBOXONE FILM 8-2 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Preferred	QL (3 EA per 1 day); AGE (Min 16 Years); Max 90-day supply per fill
VIVITROL SUSPENSION RECONSTITUTED 380 MG INTRAMUSCULAR (*naltrexone*)	Preferred	QL (2 EA per 30 days)
ZIMHI SOLUTION PREFILLED SYRINGE 5 MG/0.5ML INJECTION (*naloxone hcl*)	Preferred	
ZUBSOLV TABLET SUBLINGUAL 0.7-0.18 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 1.4-0.36 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 11.4-2.9 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 2.9-0.71 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 5.7-1.4 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
ZUBSOLV TABLET SUBLINGUAL 8.6-2.1 MG SUBLINGUAL (*buprenorphine hcl-naloxone hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)

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

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

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

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

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

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

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

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

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

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
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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
dexlansoprazole capsule delayed release 30 mg oral	Non Preferred	PA
dexlansoprazole capsule delayed release 60 mg oral	Non Preferred	PA
esomeprazole magnesium capsule delayed release 20 mg oral (otc)	Preferred	QL (2 EA per 1 day)
esomeprazole magnesium capsule delayed release 20 mg oral (rx)	Preferred	QL (2 EA per 1 day)
esomeprazole magnesium capsule delayed release 40 mg oral	Preferred	QL (2 EA per 1 day)
esomeprazole magnesium packet 10 mg oral	Non Preferred	PA; QL (2 EA per 1 day)
esomeprazole magnesium packet 20 mg oral	Non Preferred	PA; QL (2 EA per 1 day)
esomeprazole magnesium packet 40 mg oral	Non Preferred	PA; QL (2 EA per 1 day)
esomeprazole magnesium tablet delayed release 20 mg oral (otc)	Non Preferred	PA; QL (2 EA per 1 day)
gnp esomeprazole magnesium capsule delayed release 20 mg oral	Preferred	QL (2 EA per 1 day)
gnp lansoprazole capsule delayed release 15 mg oral	Preferred	QL (2 EA per 1 day)
gnp omeprazole capsule delayed release 20.6 (20 base) mg oral	Preferred	
gnp omeprazole tablet delayed release 20 mg oral	Non Preferred	PA; QL (4 EA per 1 day)
gnp omeprazole tablet delayed release dispersible 20 mg oral	Preferred	
GOODSENSE ESOMEPRAZOLE CAPSULE DELAYED RELEASE 20 MG ORAL (*esomeprazole magnesium*)	Preferred	QL (2 EA per 1 day)
goodsense lansoprazole capsule delayed release 15 mg oral	Preferred	QL (2 EA per 1 day)
goodsense lansoprazole tablet delayed release dispersible 15 mg oral	Non Preferred	PA; QL (2 EA per 1 day)
hm esomeprazole magnesium dr capsule delayed release 20 mg oral	Preferred	QL (2 EA per 1 day)
KONVOMEP SUSPENSION RECONSTITUTED 2-84 MG/ML ORAL (*omeprazole-sodium bicarbonate*)	Non Preferred	PA
lansoprazole capsule delayed release 15 mg oral (otc)	Preferred	QL (2 EA per 1 day)
lansoprazole capsule delayed release 15 mg oral (rx)	Preferred	QL (2 EA per 1 day)
lansoprazole capsule delayed release 30 mg oral	Preferred	QL (2 EA per 1 day)
lansoprazole tablet delayed release dispersible 15 mg oral (rx)	Non Preferred	PA
lansoprazole tablet delayed release dispersible 30 mg oral	Non Preferred	PA
NEXIUM CAPSULE DELAYED RELEASE 20 MG ORAL (*esomeprazole magnesium*)	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM CAPSULE DELAYED RELEASE 40 MG ORAL (*esomeprazole magnesium*)	Non Preferred	PA; QL (2 EA per 1 day)

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
hm allergy relief tablet 60 mg oral	Non Preferred	PA
hm allergy relief/nasal decong tablet extended release 24 hour 10-240 mg oral	Non Preferred	PA
hm cetirizine hcl tablet 10 mg oral	Preferred	Max 90-day supply per fill
hm loratadine childrens solution 5 mg/5ml oral	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
hm loratadine tablet 10 mg oral	Preferred	Max 90-day supply per fill
levocetirizine dihydrochloride solution 2.5 mg/5ml oral	Non Preferred	PA
levocetirizine dihydrochloride tablet 5 mg oral (rx)	Preferred	Max 90-day supply per fill
loratadine childrens solution 5 mg/5ml oral	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
loratadine childrens tablet chewable 5 mg oral	Non Preferred	PA; AGE (Min 2 Years)
loratadine solution 5 mg/5ml oral	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
loratadine tablet 10 mg oral	Preferred	Max 90-day supply per fill
loratadine tablet dispersible 10 mg oral	Preferred	
loratadine-d 12hr tablet extended release 12 hour 5-120 mg oral	Non Preferred	PA
loratadine-d 24hr tablet extended release 24 hour 10-240 mg oral	Non Preferred	PA
promethazine hcl syrup 6.25 mg/5ml oral	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
qc loratadine allergy relief tablet 10 mg oral	Preferred	Max 90-day supply per fill
sm all day allergy childrens solution 1 mg/ml oral	Preferred	Max 90-day supply per fill
sm all day allergy childrens solution 5 mg/5ml oral	Preferred	Max 90-day supply per fill
sm all day allergy relief tablet 10 mg oral	Preferred	Max 90-day supply per fill
sm all day allergy tablet 10 mg oral	Preferred	Max 90-day supply per fill
sm all day allergy-d tablet extended release 12 hour 5-120 mg oral	Non Preferred	PA
sm allergy childrens solution 5 mg/5ml oral	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
sm allergy relief tablet 60 mg oral	Non Preferred	PA
sm fexofenadine hcl tablet 180 mg oral	Non Preferred	PA
sm loratadine d 12hr tablet extended release 12 hour 5-120 mg oral	Non Preferred	PA
sm lorata-dine d tablet extended release 24 hour 10-240 mg oral	Non Preferred	PA
sm loratadine solution 5 mg/5ml oral	Preferred	AGE (Min 2 Years); Max 90-day supply per fill
sm loratadine tablet 10 mg oral	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 (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN CR TABLET EXTENDED RELEASE 6.25 MG ORAL (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN TABLET 10 MG ORAL (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN TABLET 5 MG ORAL (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA TABLET 10 MG ORAL (*suvorexant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA TABLET 15 MG ORAL (*suvorexant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA TABLET 20 MG ORAL (*suvorexant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA TABLET 5 MG ORAL (*suvorexant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DAYVIGO TABLET 10 MG ORAL (*lemborexant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DAYVIGO TABLET 5 MG ORAL (*lemborexant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DORAL TABLET 15 MG ORAL (*quazepam*)	Non Preferred	PA
doxepin hcl tablet 3 mg oral	Non Preferred	PA; AGE (Min 18 Years)
doxepin hcl tablet 6 mg oral	Non Preferred	PA; AGE (Min 18 Years)
EDLUAR TABLET SUBLINGUAL 10 MG SUBLINGUAL (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
EDLUAR TABLET SUBLINGUAL 5 MG SUBLINGUAL (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
estazolam tablet 1 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
estazolam tablet 2 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
eszopiclone tablet 1 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
eszopiclone tablet 2 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
eszopiclone tablet 3 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
HALCION TABLET 0.25 MG ORAL (*triazolam*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
HETLIOZ CAPSULE 20 MG ORAL (*tasimelteon*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 16 Years)

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

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
halobetasol propionate ointment 0.05 % external	Non Preferred	PA
IMPEKLO LOTION 0.15 MG/ACT (0.05%) EXTERNAL (*clobetasol propionate*)	Non Preferred	PA
LEXETTE FOAM 0.05 % EXTERNAL (*halobetasol propionate*)	Non Preferred	PA
OLUX-E FOAM 0.05 % EXTERNAL (*clobetasol propionate emulsion*)	Non Preferred	PA
clobetasol propionate emulsion (Tovet Foam 0.05 % External)	Non Preferred	PA
TOVET KIT 0.05 % EXTERNAL (*clobetasol emul foam w/moistcr*)	Non Preferred	PA
ULTRAVATE LOTION 0.05 % EXTERNAL (*halobetasol propionate*)	Non Preferred	PA
STIMULANTS AND RELATED AGENTS [CLOSED CLASS]		
ADDERALL TABLET 10 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 12.5 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 15 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 20 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 30 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 5 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL TABLET 7.5 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (*amphetamine-dextroamphetamine*)	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 (*amphetamine-dextroamphetamine*)	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 (*amphetamine-dextroamphetamine*)	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 (*amphetamine-dextroamphetamine*)	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 (*amphetamine-dextroamphetamine*)	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 (*amphetamine-dextroamphetamine*)	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 (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 15.7 MG ORAL (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 18.8 MG ORAL (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 3.1 MG ORAL (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 6.3 MG ORAL (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 9.4 MG ORAL (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
amphetamine sulfate tablet 10 mg oral	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
amphetamine sulfate tablet 5 mg oral	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 10 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 15 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 20 mg oral	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 25 mg oral	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 30 mg oral	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphet er capsule extended release 24 hour 5 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphetamine tablet 10 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphetamine tablet 12.5 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphetamine tablet 15 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphetamine tablet 20 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphetamine tablet 30 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphetamine tablet 5 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)

Drug Name	Formulary Status	Requirements/Limits
amphetamine-dextroamphetamine tablet 7.5 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
APTENSIO XR CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
armodafinil tablet 150 mg oral	Non Preferred	PA; AGE (Min 18 Years)
armodafinil tablet 200 mg oral	Non Preferred	PA; AGE (Min 18 Years)
armodafinil tablet 250 mg oral	Non Preferred	PA; AGE (Min 18 Years)
armodafinil tablet 50 mg oral	Non Preferred	PA; AGE (Min 18 Years)
atomoxetine hcl capsule 10 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
atomoxetine hcl capsule 100 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
atomoxetine hcl capsule 18 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
atomoxetine hcl capsule 25 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
atomoxetine hcl capsule 40 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
atomoxetine hcl capsule 60 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
atomoxetine hcl capsule 80 mg oral	Preferred	QL (1 EA per 1 day); Max 90-day supply per fill
AZSTARYS CAPSULE 26.1-5.2 MG ORAL (*serdexmethylphen-dexmethylphen*)	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 (*serdexmethylphen-dexmethylphen*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
AZSTARYS CAPSULE 52.3-10.4 MG ORAL (*serdexmethylphen-dexmethylphen*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
clonidine hcl er tablet extended release 12 hour 0.1 mg oral	Preferred	Max 90-day supply per fill
CONCERTA TABLET EXTENDED RELEASE 18 MG ORAL (*methylphenidate hcl*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
CONCERTA TABLET EXTENDED RELEASE 27 MG ORAL (*methylphenidate hcl*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
CONCERTA TABLET EXTENDED RELEASE 36 MG ORAL (*methylphenidate hcl*)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
CONCERTA TABLET EXTENDED RELEASE 54 MG ORAL (*methylphenidate hcl*)	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 (*methylphenidate*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
COTEMPLA XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 25.9 MG ORAL (*methylphenidate*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
COTEMPLA XR-ODT TABLET EXTENDED RELEASE DISPERSIBLE 8.6 MG ORAL (*methylphenidate*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DAYTRANA PATCH 10 MG/9HR TRANSDERMAL (*methylphenidate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DAYTRANA PATCH 15 MG/9HR TRANSDERMAL (*methylphenidate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DAYTRANA PATCH 20 MG/9HR TRANSDERMAL (*methylphenidate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DAYTRANA PATCH 30 MG/9HR TRANSDERMAL (*methylphenidate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DESOXYN TABLET 5 MG ORAL (*methamphetamine hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (*dextroamphetamine sulfate*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DEXEDRINE CAPSULE EXTENDED RELEASE 24 HOUR 15 MG ORAL (*dextroamphetamine sulfate*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
dexmethylphenidate hcl er capsule extended release 24 hour 10 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
dexmethylphenidate hcl er capsule extended release 24 hour 15 mg oral	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
methylphenidate hcl er (xr) capsule extended release 24 hour 40 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er (xr) capsule extended release 24 hour 50 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er (xr) capsule extended release 24 hour 60 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er tablet extended release 10 mg oral	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er tablet extended release 20 mg oral	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er tablet extended release 24 hour 18 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er tablet extended release 24 hour 27 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er tablet extended release 24 hour 36 mg oral	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er tablet extended release 24 hour 54 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl solution 10 mg/5ml oral	Preferred	AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl solution 5 mg/5ml oral	Preferred	AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl tablet 10 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl tablet 20 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl tablet 5 mg oral	Preferred	AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl tablet chewable 10 mg oral	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl tablet chewable 2.5 mg oral	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl tablet chewable 5 mg oral	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
methylphenidate patch 10 mg/9hr transdermal	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate patch 15 mg/9hr transdermal	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
methylphenidate patch 20 mg/9hr transdermal	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate patch 30 mg/9hr transdermal	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
modafinil tablet 100 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
modafinil tablet 200 mg oral	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 25 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 37.5 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
MYDAYIS CAPSULE EXTENDED RELEASE 24 HOUR 50 MG ORAL (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
NUVIGIL TABLET 150 MG ORAL (*armodafinil*)	Non Preferred	PA; AGE (Min 18 Years)
NUVIGIL TABLET 200 MG ORAL (*armodafinil*)	Non Preferred	PA; AGE (Min 18 Years)
NUVIGIL TABLET 250 MG ORAL (*armodafinil*)	Non Preferred	PA; AGE (Min 18 Years)
NUVIGIL TABLET 50 MG ORAL (*armodafinil*)	Non Preferred	PA; AGE (Min 18 Years)
dextroamphetamine sulfate (Procentra Solution 5 Mg/5Ml Oral)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
PROVIGIL TABLET 100 MG ORAL (*modafinil*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
PROVIGIL TABLET 200 MG ORAL (*modafinil*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 100 MG ORAL (*viloxazine hcl*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 150 MG ORAL (*viloxazine hcl*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
QELBREE CAPSULE EXTENDED RELEASE 24 HOUR 200 MG ORAL (*viloxazine hcl*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 20 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 30 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
QUILLICHEW ER TABLET CHEWABLE EXTENDED RELEASE 40 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
QUILLIVANT XR SUSPENSION RECONSTITUTED ER 25 MG/5ML ORAL (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)

Drug Name	Formulary Status	Requirements/Limits
RELEXXII TABLET EXTENDED RELEASE 45 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
RELEXXII TABLET EXTENDED RELEASE 63 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
RELEXXII TABLET EXTENDED RELEASE 72 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
RITALIN LA CAPSULE EXTENDED RELEASE 24 HOUR 10 MG ORAL (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	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 (*methylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN TABLET 10 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
RITALIN TABLET 20 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
RITALIN TABLET 5 MG ORAL (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
STRATTERA CAPSULE 10 MG ORAL (*atomoxetine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 100 MG ORAL (*atomoxetine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 18 MG ORAL (*atomoxetine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 25 MG ORAL (*atomoxetine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 40 MG ORAL (*atomoxetine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 60 MG ORAL (*atomoxetine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
STRATTERA CAPSULE 80 MG ORAL (*atomoxetine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); Max 90-day supply per fill
SUNOSI TABLET 150 MG ORAL (*solriamfetol hcl*)	Non Preferred	PA; AGE (Min 18 Years)
SUNOSI TABLET 75 MG ORAL (*solriamfetol hcl*)	Non Preferred	PA; AGE (Min 18 Years)
VYVANSE CAPSULE 10 MG ORAL (*lisdexamfetamine dimesylate*)	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 (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 30 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 40 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 50 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 60 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE CAPSULE 70 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 10 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 20 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 30 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 40 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 50 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
VYVANSE TABLET CHEWABLE 60 MG ORAL (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
WAKIX TABLET 17.8 MG ORAL (*pitolisant hcl*)	Non Preferred	PA; AGE (Min 18 Years)
WAKIX TABLET 4.45 MG ORAL (*pitolisant hcl*)	Non Preferred	PA; AGE (Min 18 Years)
XELSTRYM PATCH 13.5 MG/9HR TRANSDERMAL (*dextroamphetamine*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
XELSTRYM PATCH 18 MG/9HR TRANSDERMAL (*dextroamphetamine*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
XELSTRYM PATCH 4.5 MG/9HR TRANSDERMAL (*dextroamphetamine*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
XELSTRYM PATCH 9 MG/9HR TRANSDERMAL (*dextroamphetamine*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)

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

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

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

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

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

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

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Drug Name	Formulary Status	Requirements/Limits
pain relief childrens oral elixir 160 mg/5ml	Preferred	
pain relief childrens oral suspension 160 mg/5ml	Preferred	
pain relief extra strength oral capsule 500 mg	Preferred	
pain relief extra strength oral tablet 500 mg	Preferred	
pain relief oral liquid 500 mg/15ml	Preferred	
pain relief regular strength oral tablet 325 mg	Preferred	
pain reliever extra strength oral tablet 500 mg	Preferred	
pain reliever for adults oral tablet 500 mg	Preferred	
pain reliever oral liquid 500 mg/15ml	Preferred	
pain reliever oral tablet 325 mg	Preferred	
pain reliever/fever reducer rectal suppository 120 mg	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	
px arthritis pain relief oral tablet extended release 650 mg	Preferred	
px childrens pain relief oral suspension 160 mg/5ml	Preferred	
px pain relief extra strength oral tablet 500 mg	Preferred	
qc 8 hour pain relief oral tablet extended release 650 mg	Preferred	
qc acetaminophen 8 hours oral tablet extended release 650 mg	Preferred	
qc acetaminophen 8hr arth pain oral tablet extended release 650 mg	Preferred	
qc acetaminophen 8hr musc ache oral tablet extended release 650 mg	Preferred	
qc acetaminophen infants oral suspension 160 mg/5ml	Preferred	
qc arthritis pain relief oral tablet extended release 650 mg	Preferred	
qc non-aspirin 8 hour oral tablet extended release 650 mg	Preferred	
qc non-aspirin childrens oral suspension 160 mg/5ml	Preferred	
qc non-aspirin childrens oral tablet chewable 160 mg	Preferred	
qc non-aspirin extra strength oral tablet 500 mg	Preferred	
qc pain relief childrens oral suspension 160 mg/5ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
qc pain relief extra strength oral liquid 500 mg/15ml	Preferred	
qc pain relief extra strength oral tablet 500 mg	Preferred	
qc pain relief oral tablet 325 mg	Preferred	
ra 8 hour pain relief oral tablet extended release 650 mg	Preferred	
ra acetaminophen childrens oral tablet chewable 160 mg	Preferred	
ra acetaminophen ex st oral tablet 500 mg	Preferred	
ra acetaminophen oral tablet 325 mg	Preferred	
ra arthritis pain relief oral tablet extended release 650 mg	Preferred	
ra childrens fever/pain oral suspension 160 mg/5ml	Preferred	
ra fever reducer/pain reliever oral suspension 160 mg/5ml	Preferred	
ra pain relief acetaminophen oral tablet 325 mg, 500 mg	Preferred	
ra pain reliever ex st oral liquid 500 mg/15ml	Preferred	
sb arthritis pain relief oral tablet extended release 650 mg	Preferred	
sb non-aspirin extra strength oral tablet 500 mg	Preferred	
sb non-aspirin jr strength oral tablet dispersible 160 mg	Preferred	
sb non-aspirin oral tablet 325 mg	Preferred	
sb non-aspirin oral tablet chewable 160 mg, 80 mg	Preferred	
sb pain reliever childrens oral suspension 160 mg/5ml	Preferred	
sb pain reliever ex st oral tablet 500 mg	Preferred	
sm 8 hour pain relief oral tablet extended release 650 mg	Preferred	
sm arthritis pain relief oral tablet extended release 650 mg	Preferred	
sm arthritis pain reliever oral tablet extended release 650 mg	Preferred	
sm pain & fever childrens oral suspension 160 mg/5ml	Preferred	
sm pain & fever infants oral suspension 160 mg/5ml	Preferred	
sm pain relief extra strength oral tablet 500 mg	Preferred	
sm pain relief oral tablet 500 mg	Preferred	
sm pain reliever childrens oral suspension 160 mg/5ml	Preferred	
sm pain reliever ex st oral tablet 500 mg	Preferred	
sm pain reliever oral tablet 325 mg	Preferred	
sm rapid melts junior oral tablet dispersible 160 mg	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	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
ACTICON ORAL TABLET 2-60 MG (*dexbrompheniramine-pseudoeph*)	Preferred	
ADVIL COLD/SINUS ORAL TABLET 30-200 MG (*pseudoephedrine-ibuprofen*)	Preferred	
ALKA-SELTZER PLS SINUS & COUGH ORAL CAPSULE 10-5-325 MG (*dm-phenylephrine-acetaminophen*)	Preferred	
ALKA-SELTZER PLUS DAY COLD/FLU ORAL CAPSULE 10-5-325 MG (*dm-phenylephrine-acetaminophen*)	Preferred	
ALKA-SELTZER PLUS MUCUS & CONG ORAL CAPSULE 10-200 MG (*dextromethorphan-guaifenesin*)	Preferred	
ALLEGRA-D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 24 HOUR 180-240 MG (*fexofenadine-pseudoephedrine*)	Preferred	
allergy multi-symptom daytime oral tablet 2-5-325 mg	Preferred	
allergy multi-symptom night oral tablet 25-5-325 mg	Preferred	
allergy multi-symptom oral tablet 2-5-325 mg	Preferred	
allergy relief d oral tablet 4-60 mg	Preferred	
allergy relief d oral tablet extended release 24 hour 180-240 mg	Preferred	
all-nite cold & flu nighttime oral liquid 30-12.5-650 mg/30ml	Preferred	
altarussin dm oral syrup 100-10 mg/5ml	Preferred	
APRODINE ORAL TABLET 2.5-60 MG (*triprolidine-pseudoephedrine*)	Preferred	
biocotron oral liquid 10-100 mg/5ml	Preferred	
bionel oral liquid 30-15-200 mg/5ml	Preferred	
pseudoeph-bromphen-dm (Bromfed Dm Oral Syrup 2-30-10 Mg/5Ml)	Preferred	AGE (Min 2 Years)
capcof oral syrup 5-2-10 mg/5ml	Preferred	
capmist dm oral tablet 60-15-400 mg	Preferred	
capron dm oral liquid 7.5-7.5 mg/5ml	Preferred	
chest congestion relief dm oral syrup 10-100 mg/5ml	Preferred	
chest congestion relief dm oral tablet 20-400 mg	Preferred	
chest congestion/cough relief oral tablet 20-400 mg	Preferred	
childrens cold & allergy oral elixir 1-2.5 mg/5ml	Preferred	
childrens cough oral liquid 5-100 mg/5ml	Preferred	
childrens mucus relief cough oral liquid 5-100 mg/5ml	Preferred	
childrens plus flu oral suspension 2.5-1-5-160 mg/5ml	Preferred	
childrens plus multi-sympt cld oral suspension 2.5-1-5-160 mg/5ml	Preferred	
cold & allergy d oral tablet 2.5-60 mg	Preferred	
cold & allergy oral elixir 1-2.5 mg/5ml	Preferred	
cold & cough childrens oral liquid 1-5-2.5 mg/5ml, 2.5-1-5 mg/5ml	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
cold & flu nighttime oral liquid 15-6.25-325 mg/15ml	Preferred	
cold & flu nighttime relief oral capsule 15-6.25-325 mg	Preferred	
cold & flu relief daytime oral capsule 10-5-325 mg	Preferred	
cold & flu relief nighttime oral capsule 15-6.25-325 mg	Preferred	
cold & flu relief nighttime oral liquid 12.5-5-325 mg/10ml, 15-6.25-325 mg/15ml	Preferred	
cold & flu severe daytime oral liquid 5-10-200-325 mg/15ml	Preferred	
cold & flu severe daytime oral tablet 5-10-200-325 mg	Preferred	QL (1 EA per 1 day)
cold & sinus oral tablet 30-200 mg	Preferred	
cold multi-symptom daytime oral tablet 10-5-325 mg	Preferred	
cold multi-symptom warm night oral liquid 5-6.25-10-325 mg/15ml	Preferred	
cold/cough childrens oral liquid 2.5-1-5 mg/5ml	Preferred	
cold/cough dm childrens oral liquid 2.5-1-5 mg/5ml	Preferred	
cold/flu daytime relief oral capsule 10-5-325 mg	Preferred	
cold/flu relief nighttime oral liquid 15-6.25-325 mg/15ml	Preferred	
COMTREX COLD & COUGH MAX ST ORAL TABLET 10-5-325 MG (*dm-phenylephrine-acetaminophen*)	Preferred	
COMTREX COLD & COUGH NIGHTTIME ORAL TABLET 5-2-10-325 MG (*phenyleph-cpm-dm-apap*)	Preferred	
COMTREX FLU THERAPY DAY/NIGHT ORAL 2-5-325 & 5-325 MG (*chlorphen-pe-acetaminophen*)	Preferred	
COMTREX SEVERE COLD & SINUS ORAL 2-5-325 & 5-325 MG (*chlorphen-pe-acetaminophen*)	Preferred	
CONEX COLD/ALLERGY ORAL SOLUTION 1-30 MG/5ML (*dexbrompheniramine-pseudoeph*)	Preferred	
CONEX COLD/ALLERGY ORAL TABLET 2-60 MG (*dexbrompheniramine-pseudoeph*)	Preferred	
CORICIDIN D COLD/FLU/SINUS ORAL TABLET 2-5-325 MG (*chlorphen-pe-acetaminophen*)	Preferred	
CORICIDIN HBP CONGESTION/COUGH ORAL CAPSULE 10-200 MG (*dextromethorphan-guaifenesin*)	Preferred	
CORICIDIN HBP COUGH/COLD ORAL TABLET 4-30 MG (*chlorpheniramine-dm*)	Preferred	
CORICIDIN HBP NIGHTTIME COLD ORAL LIQUID 15-6.25-325 MG/15ML, 15-6.25-500 MG/15ML (*dm-doxylamine-acetaminophen*)	Preferred	
cough & chest congestion dm oral liquid 5-100 mg/5ml	Preferred	
cough & cold hbp oral tablet 4-30 mg	Preferred	
cough & cold oral tablet 4-30 mg	Preferred	
cough & congestion kids oral liquid 5-100 mg/5ml	Preferred	
cough & sore throat nighttime oral liquid 15-6.25-500 mg/15ml	Preferred	
cough/cold/sore throat child oral liquid 5-10-200-325 mg/10ml	Preferred	

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
MUCINEX D ORAL TABLET EXTENDED RELEASE 12 HOUR 60-600 MG (*pseudoephedrine-guaifenesin*)	Preferred	
MUCINEX DM MAXIMUM STRENGTH ORAL TABLET EXTENDED RELEASE 12 HOUR 60-1200 MG (*dextromethorphan-guaifenesin*)	Preferred	
MUCINEX DM ORAL TABLET EXTENDED RELEASE 12 HOUR 30-600 MG (*dextromethorphan-guaifenesin*)	Preferred	
MUCINEX FAST-MAX CLD FLU THRT ORAL TABLET 5-10-200-325 MG (*phenylephrine-dm-gg-apap*)	Preferred	QL (1 EA per 1 day)
MUCINEX FAST-MAX COLD & SINUS ORAL TABLET 5-325-200 MG (*phenylephrine-apap-guaifenesin*)	Preferred	
MUCINEX FAST-MAX COLD FLU NGHT ORAL LIQUID 12.5-5-325 MG/10ML (*diphenhydramine-pe-apap*)	Preferred	
MUCINEX FAST-MAX COLD FLU ORAL LIQUID 5-10-200-325 MG/10ML (*phenylephrine-dm-gg-apap*)	Preferred	
MUCINEX FAST-MAX COLD/FLU MS ORAL LIQUID 5-10-200-325 MG/10ML (*phenylephrine-dm-gg-apap*)	Preferred	
MUCINEX FAST-MAX COLD/FLU ORAL LIQUID 5-10-200-325 MG/10ML (*phenylephrine-dm-gg-apap*)	Preferred	
MUCINEX FAST-MAX COLD/FLU ORAL TABLET 5-10-200-325 MG (*phenylephrine-dm-gg-apap*)	Preferred	QL (1 EA per 1 day)
MUCINEX FAST-MAX CONG HEADACHE ORAL CAPSULE 10-5-325 MG (*dm-phenylephrine-acetaminophen*)	Preferred	
MUCINEX FAST-MAX CONGEST COUGH ORAL LIQUID 2.5-5-100 MG/5ML (*phenylephrine-dm-gg*)	Preferred	
MUCINEX FAST-MAX DM MAX ORAL LIQUID 20-400 MG/20ML (*dextromethorphan-guaifenesin*)	Preferred	
MUCINEX FAST-MAX ORAL LIQUID 10-650-400 MG/20ML (*phenylephrine-apap-guaifenesin*)	Preferred	
MUCINEX FREEFROM CLD/FLU/CNGST ORAL LIQUID 10-650-400 MG/20ML (*phenylephrine-apap-guaifenesin*)	Preferred	
MUCINEX FREEFROM COLD/FLU DAY ORAL LIQUID 5-10-200-325 MG/10ML (*phenylephrine-dm-gg-apap*)	Preferred	
MUCINEX FREEFROM SEV CNGST/CGH ORAL LIQUID 10-20-400 MG/20ML (*phenylephrine-dm-gg*)	Preferred	
MUCINEX SINUS-MAX CONG & PAIN ORAL LIQUID 10-650-400 MG/20ML (*phenylephrine-apap-guaifenesin*)	Preferred	
MUCINEX SINUS-MAX CONGESTION ORAL LIQUID 10-650-400 MG/20ML (*phenylephrine-apap-guaifenesin*)	Preferred	
MUCINEX SINUS-MAX CONGESTION ORAL TABLET 5-325-200 MG (*phenylephrine-apap-guaifenesin*)	Preferred	
MUCINEX SINUS-MAX NIGHT TIME ORAL LIQUID 12.5-5-325 MG/10ML (*diphenhydramine-pe-apap*)	Preferred	
MUCINEX SINUS-MAX ORAL TABLET 5-10-200-325 MG (*phenylephrine-dm-gg-apap*)	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 (*dm-phenylephrine-acetaminophen*)	Preferred	
MUCINEX SINUS-MAX SEV CONG/PN ORAL TABLET 5-325-200 MG (*phenylephrine-apap-guaifenesin*)	Preferred	
MUCINEX STUFFY NOSE & CHEST ORAL LIQUID 2.5-100 MG/5ML (*phenylephrine-guaifenesin*)	Preferred	
mucus congest & cough child oral liquid 2.5-5-100 mg/5ml	Preferred	
mucus d oral tablet extended release 12 hour 120-1200 mg	Preferred	
mucus dm oral tablet extended release 12 hour 30-600 mg	Preferred	
mucus relief childrens oral liquid 2.5-5-100 mg/5ml	Preferred	
mucus relief cold flu throat oral liquid 5-10-200-325 mg/10ml	Preferred	
mucus relief cold/sinus max st oral liquid 10-650-400 mg/20ml	Preferred	
mucus relief cough childrens oral liquid 5-100 mg/5ml	Preferred	
mucus relief d 12hr er oral tablet extended release 12 hour 60-600 mg	Preferred	
mucus relief d oral tablet extended release 12 hour 120-1200 mg, 60-600 mg	Preferred	
mucus relief dm cough oral tablet 20-400 mg	Preferred	
mucus relief dm max oral liquid 20-400 mg/20ml, 5-100 mg/5ml	Preferred	
mucus relief dm max oral tablet extended release 12 hour 60-1200 mg	Preferred	
mucus relief dm oral liquid 20-400 mg/20ml	Preferred	
mucus relief dm oral tablet 20-400 mg	Preferred	
mucus relief dm oral tablet extended release 12 hour 30-600 mg, 60-1200 mg	Preferred	
mucus relief multi symptom oral liquid 2.5-5-100 mg/5ml	Preferred	
mucus relief plus oral tablet 5-10-200-325 mg	Preferred	QL (1 EA per 1 day)
mucus relief severe cong/cold oral tablet 5-10-200-325 mg	Preferred	QL (1 EA per 1 day)
mucus relief severe congst/cgh oral liquid 10-20-400 mg/20ml, 2.5-5-100 mg/5ml	Preferred	
mucus relief severe sinus oral tablet 5-325-200 mg	Preferred	
mucus-d oral tablet extended release 12 hour 60-600 mg	Preferred	
mucus-dm max oral tablet extended release 12 hour 60-1200 mg	Preferred	
mucus-dm maximum strength oral tablet extended release 12 hour 60-1200 mg	Preferred	
mucus-dm oral tablet extended release 12 hour 30-600 mg	Preferred	
multi-symptom cold childrens oral liquid 2.5-5-100 mg/5ml	Preferred	
multi-symptom cold childrens oral suspension 2.5-1-5-160 mg/5ml	Preferred	
multi-symptom cold plus child oral liquid 2.5-5-100 mg/5ml	Preferred	

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

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

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

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

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

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Drug Name	Formulary Status	Requirements/Limits
SUPRESS-PE PEDIATRIC ORAL LIQUID 2.5-50 MG/ML (*phenylephrine-guaifenesin*)	Preferred	
teo-tus oral liquid 5-10-200 mg/5ml	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	
tusnel diabetic oral liquid 10-100 mg/5ml	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	
tussin cf cough & cold oral liquid 5-10-100 mg/5ml	Preferred	
tussin cf oral liquid 5-10-100 mg/5ml	Preferred	
tussin cf severe multi-symptom oral liquid 5-10-200-325 mg/10ml	Preferred	
tussin cough+chest cong dm sf oral liquid 10-100 mg/5ml	Preferred	
tussin cough+chest congest dm oral liquid 10-100 mg/5ml	Preferred	
tussin dm cough + chest oral liquid 10-100 mg/5ml, 20-400 mg/20ml	Preferred	
tussin dm max adult oral liquid 5-100 mg/5ml	Preferred	
tussin dm max oral liquid 20-400 mg/20ml	Preferred	
tussin dm oral liquid 100-10 mg/5ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
tussin dm oral syrup 100-10 mg/5ml	Preferred	
tussin multi-symptom cold cf oral liquid 5-10-100 mg/5ml	Preferred	
TUSSI-PRES ORAL LIQUID 5-10-200 MG/5ML (*phenylephrine-dm-gg*)	Preferred	
TUSSI-PRES PE PEDIATRIC ORAL LIQUID 2.5-100 MG/5ML (*phenylephrine-guaifenesin*)	Preferred	
TYLENOL CHILDRENS COLD/COUGH ORAL SUSPENSION 160-5 MG/5ML (*acetaminophen-dm*)	Preferred	
TYLENOL CHILDRENS COLD/FLU ORAL SUSPENSION 2.5-1-5-160 MG/5ML (*phenyleph-cpm-dm-apap*)	Preferred	
TYLENOL CHILDRENS PLUS MS COLD ORAL SUSPENSION 2.5-1-5-160 MG/5ML (*phenyleph-cpm-dm-apap*)	Preferred	
TYLENOL COLD & HEAD ORAL TABLET 5-325-200 MG (*phenylephrine-apap-guaifenesin*)	Preferred	
TYLENOL COLD/FLU SEVERE ORAL TABLET 5-10-200-325 MG (*phenylephrine-dm-gg-apap*)	Preferred	QL (1 EA per 1 day)
TYLENOL COLD/FLU/COUGH NIGHT ORAL LIQUID 5-6.25-10-325 MG/15ML (*phenyleph-doxylamine-dm-apap*)	Preferred	
TYLENOL SINUS SEVERE ORAL TABLET 5-325-200 MG (*phenylephrine-apap-guaifenesin*)	Preferred	
TYLENOL SINUS+HEADACHE ORAL TABLET 5-325 MG (*phenylephrine-acetaminophen*)	Preferred	
TYLENOL WARMING COUGH/CONGEST ORAL LIQUID 5-10-200-325 MG/15ML (*phenylephrine-dm-gg-apap*)	Preferred	
VALIHIST ORAL TABLET 2-5-325 MG (*chlorphen-pe-acetaminophen*)	Preferred	
VICKS DAYQUIL COLD & FLU ORAL CAPSULE 10-5-325 MG (*dm-phenylephrine-acetaminophen*)	Preferred	
VICKS DAYQUIL COLD & FLU ORAL LIQUID 10-5-325 MG/15ML (*dm-phenylephrine-acetaminophen*)	Preferred	
VICKS DAYQUIL MUCUS CONTROL DM ORAL LIQUID 10-200 MG/15ML (*dextromethorphan-guaifenesin*)	Preferred	
VICKS DAYQUIL SEVERE COLD/FLU ORAL LIQUID 5-10-200-325 MG/15ML (*phenylephrine-dm-gg-apap*)	Preferred	
VICKS DAYQUIL SEVERE COLD/FLU ORAL TABLET 5-10-200-325 MG (*phenylephrine-dm-gg-apap*)	Preferred	QL (1 EA per 1 day)
VICKS NYQUIL CHILDRENS CLD/CGH ORAL LIQUID 2-15 MG/15ML (*chlorpheniramine-dm*)	Preferred	
VICKS NYQUIL COLD & FLU NIGHT ORAL CAPSULE 15-6.25-325 MG (*dm-doxylamine-acetaminophen*)	Preferred	
VICKS NYQUIL COLD & FLU NIGHT ORAL LIQUID 15-6.25-325 MG/15ML (*dm-doxylamine-acetaminophen*)	Preferred	
VICKS NYQUIL COLD & FLU ORAL CAPSULE 15-6.25-325 MG (*dm-doxylamine-acetaminophen*)	Preferred	
VICKS NYQUIL COLD & FLU ORAL LIQUID 15-6.25-325 MG/15ML (*dm-doxylamine-acetaminophen*)	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 (*doxylamine-dm*)	Preferred	
VICKS NYQUIL SEVERE COLD/FLU ORAL LIQUID 5-6.25-10-325 MG/15ML (*phenyleph-doxylamine-dm-apap*)	Preferred	
VICKS SINEX DAYTIME ORAL CAPSULE 5-325 MG (*phenylephrine-acetaminophen*)	Preferred	
WAL-ACT D ORAL TABLET 2.5-60 MG (*triprolidine-pseudoephedrine*)	Preferred	
WAL-DRYL ALLRGY/SINUS HEADACHE ORAL TABLET 25-5-325 MG (*diphenhydramine-pe-apap*)	Preferred	
WAL-FEX D ALLERGY & CONGESTION ORAL TABLET EXTENDED RELEASE 24 HOUR 180-240 MG (*fexofenadine-pseudoephedrine*)	Preferred	
WAL-FLU SEVERE COLD & COUGH ORAL LIQUID 10-5-325 MG/15ML (*dm-phenylephrine-acetaminophen*)	Preferred	
WAL-FLU SEVERE COLD & COUGH ORAL PACKET 20-10-650 MG (*dm-phenylephrine-acetaminophen*)	Preferred	
WAL-FLU SEVERE COLD DAYTIME ORAL PACKET 10-650 MG (*phenylephrine-acetaminophen*)	Preferred	
wal-flu severe cold nighttime oral liquid 12.5-5-325 mg/15ml	Preferred	
WAL-PHED PE NIGHTTIME COLD ORAL TABLET 25-5-325 MG (*diphenhydramine-pe-apap*)	Preferred	
WAL-PHED PE SINUS/ALLERGY ORAL TABLET 4-10 MG (*chlorpheniramine-phenylephrine*)	Preferred	
WAL-PHED SINUS/ALLERGY ORAL TABLET 4-60 MG (*chlorpheniramine-pseudoeph*)	Preferred	
WAL-PROFEN COLD & SINUS ORAL TABLET 30-200 MG (*pseudoephedrine-ibuprofen*)	Preferred	
wal-tap cold/allergy oral elixir 1-15 mg/5ml	Preferred	
WAL-TUSSIN CF MAX ORAL LIQUID 5-10-200 MG/5ML (*phenylephrine-dm-gg*)	Preferred	
WAL-TUSSIN CF MAX ORAL LIQUID 5-10-200-325 MG/10ML (*phenylephrine-dm-gg-apap*)	Preferred	
WAL-TUSSIN COUGH/CHEST DM ORAL SYRUP 100-10 MG/5ML (*dextromethorphan-guaifenesin*)	Preferred	
WAL-TUSSIN DM CGH/CHEST CONG ORAL LIQUID 100-10 MG/5ML (*dextromethorphan-guaifenesin*)	Preferred	
ZYNCOF ORAL SYRUP 20-400 MG/5ML (*dextromethorphan-guaifenesin*)	Preferred	
CYCLOPLEGIC MYDRIATICS*		
atropine sulfate ophthalmic solution 1 %	Preferred	
cyclopentolate hcl ophthalmic solution 1 %	Preferred	
ISOPTO ATROPINE OPHTHALMIC SOLUTION 1 % (*atropine sulfate*)	Preferred	
tropicamide ophthalmic solution 1 %	Preferred	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
VIVAGUARD LANCING DEVICE (*lancet devices*)	Preferred	
VIVI CAP (*insulin admin supplies*)	Preferred	
VIVI CAP1 (*insulin admin supplies*)	Preferred	
WALGREENS LANCETS (*lancets*)	Preferred	
walgreens lancets micro thin	Preferred	
walgreens lancets super thin	Preferred	
WALGREENS THIN LANCETS (*lancets*)	Preferred	
WALGREENS ULTRA THIN LANCETS (*lancets*)	Preferred	
zevrx twist top lancets 30g	Preferred	
DIAGNOSTIC TESTS*		
RELION TRUE METRIX TEST STRIPS STRIP IN VITRO (*glucose blood*)	Preferred	QL (10 EA per 1 day)
TRUE METRIX BLOOD GLUCOSE TEST STRIP IN VITRO (*glucose blood*)	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 (*diaper rash products*)	Preferred	
cvs diaper external cream 1-10 %	Preferred	
DIETARY MANAGEMENT PRODUCTS*		
CEREFOLIN ORAL TABLET 6-1-50-5 MG (*l-methylfolate-b12-b6-b2*)	Preferred	
DEPLIN 15 ORAL CAPSULE 15-90.314 MG (*l-methylfolate-algae*)	Preferred	
DEPLIN 7.5 ORAL CAPSULE 7.5-90.314 MG (*l-methylfolate-algae*)	Preferred	
ELFOLATE PLUS ORAL TABLET 3-35-2 MG (*l-methylfolate-b6-b12*)	Preferred	
FOLBIC ORAL TABLET 2.5-25-2 MG (*fa-pyridoxine-cyanocobalamin*)	Preferred	
FOLBIC RF ORAL TABLET 1.13-25-2 MG (*l-methylfolate-b6-b12*)	Preferred	
FOLTANX ORAL TABLET 3-35-2 MG (*l-methylfolate-b6-b12*)	Preferred	
FOLTX ORAL TABLET 1.13-25-2 MG (*l-methylfolate-b6-b12*)	Preferred	
l-methylfolate forte oral capsule 15-90.314 mg, 7.5-90.314 mg	Preferred	
l-methylfolate-algae oral capsule 15-90.314 mg	Preferred	
l-methyl-mc oral tablet 6-1-50-5 mg	Preferred	
METAFOLBIC ORAL TABLET 6-1-50-5 MG (*l-methylfolate-b12-b6-b2*)	Preferred	
NIVA-FOL ORAL TABLET 2.5-25-2 MG (*fa-pyridoxine-cyanocobalamin*)	Preferred	
westab max oral tablet 2.5-25-2 mg	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*		
amiloride-hydrochlorothiazide oral tablet 5-50 mg	Preferred	
spironolactone-hctz oral tablet 25-25 mg	Preferred	
triamterene-hctz oral capsule 37.5-25 mg	Preferred	Max 90-day supply per fill
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	Preferred	Max 90-day supply per fill
ELECTROLYTE MIXTURES*		
ADVANTAGE CARE ELECTROLYTE PED ORAL SOLUTION (*oral electrolytes*)	Preferred	
BIOLYTE ORAL SOLUTION (*oral electrolytes*)	Preferred	
CERALYTE 50 ORAL PACKET 1.3-2.2-2.9 GM/L (*oral electrolytes*)	Preferred	
CERALYTE 50 POTASSIUM FREE ORAL PACKET (*oral electrolytes*)	Preferred	
CERALYTE 70 ORAL PACKET , 1.3-2.2-2.9 GM/L (*oral electrolytes*)	Preferred	
CERALYTE 70 ORAL SOLUTION (*oral electrolytes*)	Preferred	
CERALYTE 90 ORAL PACKET 1.3-3.4-2.9 GM/L (*oral electrolytes*)	Preferred	
CERASPORT ENDURANCE ORAL PACKET 160-400 MG (*oral electrolytes*)	Preferred	
CERASPORT EX1 ORAL PACKET (*oral electrolytes*)	Preferred	
CERASPORT EX1 ORAL SOLUTION (*oral electrolytes*)	Preferred	
CERASPORT EX1 ORAL SOLUTION RECONSTITUTED (*oral electrolytes*)	Preferred	
CERASPORT ORAL PACKET (*oral electrolytes*)	Preferred	
CERASPORT ORAL SOLUTION (*oral electrolytes*)	Preferred	
CERASPORT ORAL SOLUTION RECONSTITUTED (*oral electrolytes*)	Preferred	
CERASPORT PLUS ORAL PACKET (*oral electrolytes*)	Preferred	
cvs electrolyte solution oral solution	Preferred	
cvs ped electrolyte freeze pop oral solution	Preferred	
cvs pediatric electrolyte oral solution	Preferred	
DRIPDROP HYDRATION ORAL PACKET (*oral electrolytes*)	Preferred	
DRIPDROP ORAL PACKET (*oral electrolytes*)	Preferred	
EMERGEN-C ELECTRO MIX ORAL PACKET (*oral electrolytes*)	Preferred	
ENFAMIL ENFALYTE ORAL SOLUTION (*oral electrolytes*)	Preferred	
ENSURE RAPID HYDRATION ORAL PACKET (*oral electrolytes*)	Preferred	
EQUALYTE ORAL SOLUTION (*oral electrolytes*)	Preferred	
gnp electrolyte powder oral packet	Preferred	
h-e-b oral electrolyte oral solution	Preferred	
HYDRALYTE FREEZER POPS ORAL SOLUTION (*oral electrolytes*)	Preferred	
HYDRALYTE ORAL PACKET (*oral electrolytes*)	Preferred	

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
PENTRAVAN PLUS EXTERNAL CREAM (*emollient*)	Preferred	
PRETTY FEET/HANDS EXTERNAL CREAM (*emollient*)	Preferred	
ra advanced healing external ointment	Preferred	
ra daylogic healing dry skin external lotion	Preferred	
radiaguard advanced external lotion	Preferred	
refreshing aloe external lotion	Preferred	
RESTA EXTERNAL CREAM (*emollient*)	Preferred	
RESTA LITE EXTERNAL LOTION (*emollient*)	Preferred	
RISABAL-PH EXTERNAL CREAM (*emollient*)	Preferred	
SKIN REPAIR EXTERNAL LOTION (*emollient*)	Preferred	
sm dry skin therapy external lotion	Preferred	
special care external cream	Preferred	
STUDIO 35 EXTRA MOISTURIZING EXTERNAL LOTION (*emollient*)	Preferred	
STUDIO 35 MOISTURIZING SKIN EXTERNAL CREAM (*emollient*)	Preferred	
THERABETIC SKIN CARE EXTERNAL LOTION (*emollient*)	Preferred	
thera-derm external lotion	Preferred	
therapeutic moisturizing external cream	Preferred	
UDDERLY SMOOTH EXTERNAL CREAM (*emollient*)	Preferred	
UDDERLY SMOOTH EXTRA CARE 20 EXTERNAL CREAM (*emollient*)	Preferred	
UDDERLY SMOOTH EXTRA CARE EXTERNAL CREAM (*emollient*)	Preferred	
VANICREAM EXTERNAL CREAM (*emollient*)	Preferred	
VANICREAM EXTERNAL LOTION (*emollient*)	Preferred	
VANICREAM EXTERNAL OINTMENT (*emollient*)	Preferred	
VELVACHOL EXTERNAL CREAM (*emollient*)	Preferred	
vitamin a & d external ointment	Preferred	
vitamin a & d skin protectant external ointment	Preferred	
vitamin e with panthenol external cream	Preferred	
vitamins a & d external ointment	Preferred	
WIBI EXTERNAL LOTION (*emollient*)	Preferred	
ESTROGEN COMBINATIONS*		
estradiol-norethindrone acet (Amabelz Oral Tablet 1-0.5 Mg)	Preferred	QL (1 EA per 1 day)
estradiol-norethindrone acet oral tablet 1-0.5 mg	Preferred	QL (1 EA per 1 day)
estradiol-norethindrone acet (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 (*estradiol*)	Preferred	QL (0.29 EA per 1 day)
estradiol (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)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
BALMEX SKIN PROTECTANT EXTERNAL OINTMENT (*skin protectants, misc.*)	Preferred	
BASIS CLEANSER EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
BASIS FACIAL MOISTURIZER EXTERNAL CREAM (*skin protectants, misc.*)	Preferred	
BASIS OVERNIGHT EXTERNAL CREAM (*skin protectants, misc.*)	Preferred	
benzoin compound external tincture	Preferred	
boro-packs external packet 49-51 %	Preferred	
BOUDREAUXS BUTT BATH EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
BOUDREAUXS BUTT PASTE EXTERNAL OINTMENT 40 % (*zinc oxide*)	Preferred	
B-SURE WITCH HAZEL EXTERNAL PAD 50 % (*witch hazel*)	Preferred	
calamine external lotion 8-8 %	Preferred	
calamine phenolated external lotion	Preferred	
calamine-zinc oxide external lotion , 8-8 %	Preferred	
CALMOSEPTINE EXTERNAL OINTMENT 0.44-20.6 % (*menthol-zinc oxide*)	Preferred	
CALPROTECT EXTERNAL OINTMENT 0.44-20.6 % (*menthol-zinc oxide*)	Preferred	
CARMEX CLASSIC LIP BALM EXTERNAL OINTMENT (*skin protectants, misc.*)	Preferred	
CERAVE FOAMING FACIAL CLEANSER EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
CERAVE HYDRATING CLEANSER EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
CERAVE SA BODY WASH EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
CERAVE THERAPEUTIC HAND CREAM EXTERNAL CREAM 1 % (*dimethicone*)	Preferred	
CETAPHIL DERMACONTROL FOAM WSH EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
CETAPHIL EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
CETAPHIL GENTLE CLEANSER EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
CETAPHIL RESTORADERM EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
CHAPSTICK OVERNIGHT EXTERNAL OINTMENT (*skin protectants, misc.*)	Preferred	
CHAPSTICK ULTRASMOOTH FORTIFY EXTERNAL OINTMENT (*skin protectants, misc.*)	Preferred	
CHAPSTICK ULTRASMOOTH NOURISH EXTERNAL OINTMENT (*skin protectants, misc.*)	Preferred	
CHAPSTICK ULTRASMOOTH REJUVEN EXTERNAL OINTMENT (*skin protectants, misc.*)	Preferred	

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
CERTAVITE/ANTIOXIDANTS ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
CHOICEFUL MULTIVITAMIN ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
CHOICEFUL MULTIVITAMIN ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
companion oral tablet	Preferred	
COMPETE ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
complete multivitamin/mineral oral liquid	Preferred	
coral calcium plus oral capsule	Preferred	
CORVITA ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
CULTURELLE PROBIOTICS + MULTIV ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
cvs adult 50+ eye health oral capsule	Preferred	
CVS AIRSHIELD IMMUNITY SUPPORT ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
CVS AIRSHIELD ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
cvs daily gummies adult oral tablet chewable	Preferred	
cvs daily gummies oral tablet chewable	Preferred	
cvs daily multiple for men oral tablet	Preferred	
cvs daily multiple women 50+ oral tablet	Preferred	
cvs eye health & lutein oral tablet	Preferred	
cvs eye health adult 50+ oral capsule	Preferred	
cvs mens daily gummies oral tablet chewable	Preferred	
cvs one daily essential oral tablet	Preferred	
cvs one daily mens 50+ adv oral tablet	Preferred	
cvs one daily mens formula oral tablet	Preferred	
cvs one daily womens 50+ adv oral tablet	Preferred	
cvs one daily womens formula oral tablet	Preferred	
cvs spectravite adult 50+ oral tablet	Preferred	
cvs spectravite adult 50+ oral tablet chewable	Preferred	
cvs spectravite adults oral tablet	Preferred	
cvs spectravite advanced oral tablet	Preferred	
cvs spectravite men 50+ oral tablet	Preferred	
cvs spectravite men oral tablet	Preferred	
cvs spectravite senior oral tablet	Preferred	
cvs spectravite ultra men 50+ oral tablet	Preferred	
cvs spectravite ultra mens oral tablet	Preferred	
cvs spectravite ultra women oral tablet	Preferred	
cvs spectravite women 50+ oral tablet	Preferred	
cvs spectravite women oral tablet	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
cvs spectravite women oral tablet chewable	Preferred	
cvs spectravite womens senior oral tablet	Preferred	
cvs vision health oral capsule	Preferred	
cvs womens active daily oral tablet	Preferred	
cvs womens daily gummies oral tablet chewable	Preferred	
daily betic oral tablet	Preferred	
daily combo multi vitamins oral tablet	Preferred	
daily mens health formula oral tablet	Preferred	
daily multiple vitamins/min oral tablet	Preferred	
daily multivitamin oral capsule	Preferred	
daily vitamin plus oral capsule	Preferred	
daily womens health formula oral tablet	Preferred	
daily-vitamin maximum formula oral tablet	Preferred	
dayavite oral tablet	Preferred	
DECUBI-VITE ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
dekas bariatric oral tablet chewable	Preferred	
DEKAS PLUS OCEAN ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
DEKAS PLUS ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
DEKAS PLUS ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
DERMACINRX MULTITAM ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
DERMACINRX RIBOTIN-E ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
DERMACINRX ZINTREXYL-C ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
DERMAVITE ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
DEXATRAN ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
diabetes health formula oral tablet	Preferred	
dialyvite 800/ultra d oral tablet	Preferred	
DIALYVITE SUPREME D ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
DRY EYE FORMULA ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
EMERGEN-C IMMUNE PLUS/VIT D ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
EMERGEN-C VITAMIN C ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
eq complete multivit adult 50+ oral tablet	Preferred	
eq complete multivitamin-adult oral tablet	Preferred	
eq multivitamins adult gummy oral tablet chewable	Preferred	

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
ONE-A-DAY MENS VITACRAVES ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY PROACTIVE 65+ ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY TEEN ADVANTAGE/HER ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY TEEN ADVANTAGE/HIM ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY VITACRAVES ADULT ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY VITACRAVES IMMUNITY ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY VITACRAVES ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY VITACRAVES SOUR ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WEIGHT SMART ADVANCE ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WOMENS 50 PLUS ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WOMENS 50+ ADVANTAGE ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WOMENS 50+ ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WOMENS HEALTHY SKIN ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WOMENS MIND & BODY ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WOMENS ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WOMENS PETITES ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ONE-A-DAY WOMENS VITACRAVES ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
one-daily multi caps oral capsule	Preferred	
one-daily multi-vit/mineral oral tablet	Preferred	
onevite oral tablet	Preferred	
optic-vites oral tablet	Preferred	
optic-vites with lutein oral tablet	Preferred	
OPTIFAST POST BARIATRIC ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
optimum airvites oral tablet chewable	Preferred	
optimum pms oral tablet	Preferred	
OPTISOURCE POST BARIATRIC SURG ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	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
OPTIVITE P.M.T. ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
OPURITY BYPASS OPTIMIZED ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
OPURITY ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
OSTEOPRIME PLUS ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
OSTEOPRIME ULTRA ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
parvlex oral tablet	Preferred	
PHYTOMULTI ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
PRESERVISION AREDS 2 ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
PRESERVISION AREDS 2 ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
PRESERVISION AREDS 2+MULTI VIT ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
PRESERVISION AREDS ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
PRESERVISION AREDS ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
PRESERVISION/LUTEIN ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
prevent oral capsule	Preferred	
PRO-CAL ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
PROCERV HP ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
profola oral tablet	Preferred	
PRORENAL + D ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
PRORENAL + D W/ OMEGA-3 ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
PROSIGHT ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
PROTECT CARDIO AF ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
PROTECT PLUS SO ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
PROTEGRA ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
PROVIT ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
px advanced formula multivits oral tablet	Preferred	
px complete senior multivits oral tablet	Preferred	
px mens multivitamins oral tablet	Preferred	
qc daily multivit/multimineral oral tablet	Preferred	
qc hair skin & nails oral tablet	Preferred	
qc mens daily multivitamin oral tablet	Preferred	
qc multi-vite 50 & over oral tablet	Preferred	
qc multi-vite oral tablet	Preferred	

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
womens daily formula oral tablet	Preferred	
WOMENS LIFE PACK ORAL TABLET (*multiple vitamins-minerals*)	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 (*multiple vitamins-minerals*)	Preferred	
YOUR LIFE MULTI ADULT GUMMIES ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
YUMVS MULTI ZERO ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
YUMVS ZERO DIABETIC MULTIVITAM ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
MULTIVITAMINS*		
AMLADEX ORAL TABLET (*multiple vitamin*)	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 (*multiple vitamin*)	Preferred	
GENICIN VITA-Q ORAL TABLET (*multiple vitamin*)	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	

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

Drug Name	Formulary Status	Requirements/Limits
eql saline nasal spray nasal solution 0.65 %	Preferred	
gnp nasal moisturizing nasal solution 0.65 %	Preferred	
meijer saline nasal spray nasal solution 0.65 %	Preferred	
NASAL MOIST NASAL SOLUTION 0.65 % (*saline*)	Preferred	
nasal moisturizing spray nasal solution 0.65 %	Preferred	
NASOGEL NASAL GEL (*saline*)	Preferred	
OCEAN FOR KIDS NASAL SOLUTION 0.65 % (*saline*)	Preferred	
px saline nasal spray nasal solution 0.65 %	Preferred	
qc saline nasal relief nasal solution 0.65 %	Preferred	
qc saline nasal spray nasal solution 0.65 %	Preferred	
ra saline nasal spray nasal solution 0.65 %	Preferred	
ra sterile saline nasal mist nasal solution 0.9 %	Preferred	
saline mist spray nasal solution 0.65 %	Preferred	
saline nasal gel	Preferred	
saline nasal spray nasal solution 0.65 %	Preferred	
sb saline nose nasal solution 0.65 %	Preferred	
SIMPLY SALINE NASAL AEROSOL SOLUTION 0.9 % (*saline*)	Preferred	
sm nasal spray saline nasal solution 0.65 %	Preferred	
NASAL ANTIALLERGY*		
cromolyn sodium nasal aerosol solution 5.2 mg/act	Preferred	
NASALCROM NASAL AEROSOL SOLUTION 5.2 MG/ACT (*cromolyn sodium*)	Preferred	
NASAL STEROIDS*		
FLONASE SENSIMIST NASAL SUSPENSION 27.5 MCG/SPRAY (*fluticasone furoate*)	Preferred	
NATURAL PENICILLINS*		
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	Preferred	
penicillin v potassium oral tablet 250 mg, 500 mg	Preferred	
NITRATES*		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	Preferred	QL (12 EA per 1 day); Max 90-day supply per fill
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
isosorbide mononitrate oral tablet 10 mg, 20 mg	Preferred	QL (2 EA per 1 day); Max 90-day supply per fill
NITRO-BID TRANSDERMAL OINTMENT 2 % (*nitroglycerin*)	Preferred	QL (4 GM per 1 day); Max 90-day supply per fill
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg	Preferred	QL (6 EA per 1 day)
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr	Preferred	QL (1 EA per 1 day); 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
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*		
ADVIL JUNIOR STRENGTH ORAL TABLET 100 MG (*ibuprofen*)	Preferred	
sm ibuprofen jr oral tablet 100 mg	Preferred	
NUTRITIONAL SUPPLEMENTS*		
ADVERA ORAL LIQUID (*nutritional supplements*)	Preferred	
ARGINAID EXTRA ORAL LIQUID (*nutritional supplements*)	Preferred	
balanced nutritional drink oral liquid	Preferred	
balanced nutritional drink pls oral liquid	Preferred	
balanced nutritional shake pls oral liquid	Preferred	
beef/potatoes/spinach oral liquid	Preferred	
BENECALORIE ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST BREEZE ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST GLUCOSE CONTROL ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST GLUCOSE CTRL MAX PROTEIN ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST HIGH PROTEIN ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST KID ESSENTIALS 1.0 CAL ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST KID ESSENTIALS 1.5 CAL ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST KID ESSENTIALS 1.5/FIBER ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST MAX 30G PROTEIN ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST PLUS ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST VERY HIGH CALORIE ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST VHC ORAL LIQUID (*nutritional supplements*)	Preferred	
BOOST WOMEN ORAL LIQUID (*nutritional supplements*)	Preferred	
BRIGHT BEGINNINGS PEDIATRIC ORAL LIQUID (*nutritional supplements*)	Preferred	
CARNATION BREAKFAST ESSENTIALS ORAL LIQUID (*nutritional supplements*)	Preferred	
CFPREOP ORAL LIQUID (*nutritional supplements*)	Preferred	
chicken/carrots/brown rice oral liquid	Preferred	
COMPLEAT ORAL LIQUID (*nutritional supplements*)	Preferred	
COMPLEAT ORGANIC BLENDS ORAL LIQUID (*nutritional supplements*)	Preferred	
COMPLEAT PEDI PEPTIDE 1.5 ORAL LIQUID (*nutritional supplements*)	Preferred	

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

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

Drug Name	Formulary Status	Requirements/Limits
GLUCERNA 1.5 CAL ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA 1.5 CAL/CARBSTEADY ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA ADVANCE SHAKE ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA CARBSTEADY ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA HUNGER SMART SHAKE ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA OS ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA SELECT ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA SHAKE ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA SNACK SHAKE ORAL LIQUID (*nutritional supplements*)	Preferred	
GLUCERNA WEIGHT LOSS SHAKE ORAL LIQUID (*nutritional supplements*)	Preferred	
GLYTACTIN RESTORE 10 ORAL LIQUID (*nutritional supplements*)	Preferred	
GLYTACTIN RESTORE LITE 10 ORAL LIQUID (*nutritional supplements*)	Preferred	
GLYTACTIN RTD 10 ORAL LIQUID (*nutritional supplements*)	Preferred	
GLYTACTIN RTD 15 ORAL LIQUID (*nutritional supplements*)	Preferred	
GLYTACTIN RTD LITE 15 ORAL LIQUID (*nutritional supplements*)	Preferred	
GLYTROL PREBIO1 ORAL LIQUID (*nutritional supplements*)	Preferred	
goodsense nutrisure original oral liquid	Preferred	
goodsense nutrisure plus oral liquid	Preferred	
haelan 951 fermented soy oral liquid	Preferred	
haelan htpi fermented soy oral liquid	Preferred	
HCU COOLER ORAL LIQUID (*nutritional supplements*)	Preferred	
HCU LOPHLEX LQ ORAL LIQUID (*nutritional supplements*)	Preferred	
HEALTHY ACCENTS NUTRA FIT ORAL LIQUID (*nutritional supplements*)	Preferred	
HEALTHY ACCENTS NUTRA FIT PLUS ORAL LIQUID (*nutritional supplements*)	Preferred	
HI-CAL ORAL LIQUID (*nutritional supplements*)	Preferred	
high-protein nutritional shake oral liquid	Preferred	
hm nutrisure oral liquid	Preferred	
hm nutrisure plus oral liquid	Preferred	
HOMACTIN AA PLUS ORAL LIQUID (*nutritional supplements*)	Preferred	
IMPACT ADVANCED RECOVERY ORAL LIQUID (*nutritional supplements*)	Preferred	

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

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

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

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

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

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

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

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

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

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

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

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

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

Drug Name	Formulary Status	Requirements/Limits
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)
bd sharps container home	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
careone unifine pentips plus 33g x 4 mm	Preferred	Max 90-day supply per fill
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"	Preferred	
carepoint poly hub needle 25g x 5/8" , 27g x 1/2" , 30g x 1/2"	Preferred	Max 90-day supply per fill
carepoint safety 1st needle 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"	Preferred	
carepoint safety 1st needle 25g x 5/8"	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	
carepoint syringe luer lock 1 ml	Preferred	

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

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

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

Drug Name	Formulary Status	Requirements/Limits
pen needles 30g x 5 mm , 30g x 8 mm , 32g x 5 mm , 33g x 4 mm	Preferred	Max 90-day supply per fill
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"	Preferred	
poly hub needle 25g x 5/8" , 27g x 1/2" , 30g x 1/2"	Preferred	Max 90-day supply per fill
pro comfort pen needles 32g x 5 mm	Preferred	Max 90-day supply per fill
pure comfort pen needle 32g x 5 mm	Preferred	Max 90-day supply per fill
safety pen needles 30g x 5 mm , 30g x 8 mm	Preferred	Max 90-day supply per fill
SECURESAFE HYPODERMIC NEEDLE 22G X 1" , 25G X 1-1/2" (*needle (disp)*)	Preferred	
SECURESAFE HYPODERMIC NEEDLE 27G X 1/2" (*needle (disp)*)	Preferred	Max 90-day supply per fill
SECURESAFE SAFETY PEN NEEDLES 30G X 8 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
SECURESAFE 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 (*syringe/needle (disp)*)	Preferred	
sharps collector	Preferred	QL (1 EA per 1 day)
sharps container	Preferred	QL (1 EA per 1 day)
sharps disposal by mail system	Preferred	QL (1 EA per 1 day)
sure comfort insulin syringe 31g x 1/4" 0.3 ml	Preferred	Max 90-day supply per fill
sure comfort pen needles 30g x 8 mm	Preferred	Max 90-day supply per fill
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	Preferred	
syringe luer slip 1 ml	Preferred	
techlite insulin syringe 29g x 1/2" 0.3 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 29g x 1/2" 0.5 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 29g x 1/2" 1 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 30g x 1/2" 0.5 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 30g x 1/2" 1 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 30g x 5/16" 0.3 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 30g x 5/16" 0.5 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 31g x 15/64" 0.3 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 31g x 15/64" 0.5 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 31g x 15/64" 1 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 31g x 5/16" 0.3 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 31g x 5/16" 0.5 ml	Preferred	Max 90-day supply per fill
techlite insulin syringe 31g x 5/16" 1 ml	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 29G X 10MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 29G X 12MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 31G X 5 MM (*insulin pen needle*)	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
TECHLITE PEN NEEDLES 31G X 6 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 31G X 8 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 32G X 4 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 32G X 6 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TECHLITE PEN NEEDLES 32G X 8 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
true comfort pro pen needles 32g x 5 mm , 33g x 4 mm	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 1 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 1 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.5 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 1 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 29G X 12MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 31G X 5 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 31G X 6 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 31G X 8 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
TRUEPLUS PEN NEEDLES 32G X 4 MM (*insulin pen needle*)	Preferred	Max 90-day supply per fill
ULTICARE INSULIN SYR 1/2 UNIT 31G X 1/4" 0.3 ML (*insulin syringe-needle u-100*)	Preferred	Max 90-day supply per fill

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 (*docusate sodium*)	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 (*docusate sodium*)	Preferred	
DOCUSOL MINI RECTAL ENEMA 283 MG/5ML (*docusate sodium*)	Preferred	
DOCUSOL PLUS MINI-ENEMA RECTAL ENEMA 20-283 MG (*benzocaine-docusate sodium*)	Preferred	
DOK ORAL TABLET 100 MG (*docusate sodium*)	Preferred	
dss oral capsule 100 mg, 250 mg	Preferred	
DULCOLAX PINK STOOL SOFTENER ORAL CAPSULE 100 MG (*docusate sodium*)	Preferred	
DULCOLAX STOOL SOFTENER ORAL CAPSULE 100 MG (*docusate sodium*)	Preferred	
easy-lax oral capsule 100 mg	Preferred	
ENEMEEZ MINI RECTAL ENEMA 283 MG/5ML (*docusate sodium*)	Preferred	
ENEMEEZ PLUS RECTAL ENEMA 20-283 MG (*benzocaine-docusate sodium*)	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 (*docusate sodium*)	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 (*docusate sodium*)	Preferred	
PEDIA-LAX ORAL LIQUID 50 MG/15ML (*docusate sodium*)	Preferred	
PHILLIPS STOOL SOFTENER ORAL CAPSULE 100 MG (*docusate sodium*)	Preferred	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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