

SHARP Health Plan

2025 Formulary

List of covered prescription drugs

Employer-sponsored plans from Sharp Health Plan

June 2025

This drug list applies to all Large Group HMO and Large Group POS products, and the following Small Group HMO products: Bronze HDHP NG 1, CalChoice Bronze HDHP NG 3, CalChoice Bronze HMO NG 2, CalChoice Gold HMO NG 2, CalChoice Gold HMO NG 3, CalChoice Gold HMO NG 5, CalChoice Platinum HMO NG 1, CalChoice Platinum HMO NG 2, CalChoice Platinum HMO NG 3, CalChoice Silver HMO NG 1, CalChoice Silver HMO NG 2, CalChoice Silver HMO NG 3, Gold HMO NG 1, Gold HMO NG 2, Gold HMO NG 3, Gold HMO NG 4, Gold HMO NG 5, Gold HMO NG 6, Gold HMO NG 7, HDHP NG 1 L, HDHP NG 2 L, HDHP NG 3 L, HDHP NG 4 L, HDHP NG 5 L, HMO GF 1, HMO GF 2, HMO GF 3, HMO GF 4, HMO GF 5, HMO GF 6, HMO GF 7, HMO NG 10 L, HMO NG 11 L, HMO NG 12 L, HMO NG 13 L, HMO NG 14 L, HMO NG 15 L, HMO NG 16 L, HMO NG 17 L, HMO NG 18 L, HMO NG 19 L, HMO NG 20 L, HMO NG 21 L, HMO NG 22 L, HMO NG 23 L, HMO NG 24 L, HMO NG 25 L, HMO NG 26 L, HMO NG 27 L, HMO NG 28 L, HMO NG 29 L, HMO NG 30 L, HMO NG 31 L, HMO NG 32 L, HMO NG 33 L, HMO NG 34 L, HMO NG 35 L, HMO NG 36 L, HMO NG 37 L, HMO NG 38 L, HMO NG 39 L, HMO NG 40 L, HMO NG 41 L, HMO NG 42 L, HMO NG 43 L, HMO NG 44 L, HMO NG 5 L, HMO NG 6 L, HMO NG 7 L, HMO NG 8 L, HMO NG 9 L, Platinum HMO NG 1, Platinum HMO NG 2, Platinum HMO NG 3, Platinum HMO NG 4, Platinum HMO NG 7, Platinum HMO NG 8, POS NG 3 L, Sharp HealthCare HMO NG 1 L (Premium), Silver HMO NG 1, Silver HMO NG 2, Sharp HealthCare HMO NG 2 L (Basic), HMO GF 1 L, HMO GF 3 L, HMO GF 4 L, HMO GF 6 L, HMO GF 14 L, HMO GF 15 L, POS NG 3 L, POS NG 9 L, POS NG 10 L, POS NG 11 L, POS NG 12 L, POS NG 13 L, POS NG 14 L, POS NG 15 L, POS NG 16 L, POS NG 17 L, POS NG 18 L, POS NG 19 L, POS NG 20 L, HDHP POS 21 L, HDHP POS 22 L, HDHP POS 23 L, Platinum POS NG 1, Gold POS NG 1, Silver POS NG 1, Custom Employer Groups

An electronic version of this Prescription Drug List is available on the Sharp Health Plan website, by visiting sharphealthplan.com/search-drug-list. You can find specific cost sharing information in your plan's coverage documents by logging in to your Sharp Connect account on our website by visiting sharphealthplan.com/login. This document is subject to change and all previous versions are no longer in effect. Last updated 06/01/2025.

Table of Contents

INTRODUCTION	13
DEFINITIONS	13
HOW OFTEN DOES THE FORMULARY CHANGE?	15
WILL I BE NOTIFIED OF A FORMULARY CHANGE?	15
HOW DO I LOCATE A PRESCRIPTION DRUG ON THE FORMULARY?	16
HOW DO I KNOW IF THE DRUG LISTED ON THE FORMULARY IS A BRAND OR GENERIC DRUG?	16
WHAT IS A DRUG TIER?	16
ARE THERE ANY COVERAGE REQUIREMENTS OR LIMITS?	17
WHAT IS PRIOR AUTHORIZATION?	18
WHAT IS PA**?	18
WHAT IS QUANTITY LIMIT?	18
WHAT IS STEP THERAPY?	18
WHAT IS MO?	19
WHAT IS A SPECIALTY DRUG?	19
WHAT IS AN ORAL ANTI-CANCER DRUG?	19
WHAT IF A DRUG IS NOT LISTED ON THE FORMULARY? WHAT IS A FORMULARY EXCEPTION?	19
WHERE CAN I FILL MY PRESCRIPTION DRUG?	20
WHAT IS THERAPEUTIC INTERCHANGE?	20
WHAT IS GENERIC SUBSTITUTION?	20
YOU HAVE THE RIGHT TO APPEAL	20
APPEALS DUE TO DENIAL OF COVERAGE FOR A NONFORMULARY DRUG	20
ALL OTHER APPEALS	20
QUESTIONS	21
EXCLUSIONS AND LIMITATIONS TO THE OUTPATIENT PRESCRIPTION DRUG BENEFIT	21
NONDISCRIMINATION NOTICE	23
LANGUAGE ASSISTANCE SERVICES	24
STEP THERAPY CRITERIA	26
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS	27
AMPHETAMINES	27
ANOREXIANTS NON-AMPHETAMINE	31
ANTI-OBESITY AGENTS	32
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS - DRUGS TO TREAT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER	32
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)	33
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS	33
STIMULANTS - MISC.	33
ALLERGENIC EXTRACTS/BIOLOGICALS MISC - DRUGS FOR ALLERGIES	38
ALLERGENIC EXTRACTS	38
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS	38
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS	38
ANALGESICS - ANTI-INFLAMMATORY - DRUGS TO TREAT PAIN AND INFLAMMATION	39

ANTIRHEUMATIC - ENZYME INHIBITORS	39
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	40
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS	41
PYRIMIDINE SYNTHESIS INHIBITORS	41
ANALGESICS - NONNARCOTIC - DRUGS TO TREAT PAIN AND FEVER.....	42
ANALGESIC COMBINATIONS	42
SALICYLATES	42
ANALGESICS - OPIOID - DRUGS TO TREAT PAIN	42
OPIOID AGONISTS	42
OPIOID COMBINATIONS	47
OPIOID PARTIAL AGONISTS	50
ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES	51
ANDROGENS	51
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS.....	51
INTRARECTAL STEROIDS	51
RECTAL COMBINATIONS	51
RECTAL STEROIDS	52
VASODILATING AGENTS	52
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES.....	52
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES	52
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS	52
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS	52
ANTI-INFECTIVE MISC. - COMBINATIONS	52
ANTIPROTOZOAL AGENTS	53
GLYCOPEPTIDES	53
LEPROSTATICS	53
LINCOSAMIDES	53
MONOBACTAMS	53
OXAZOLIDINONES	53
URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS	53
ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS	53
ANTIANGINALS-OTHER	53
NITRATES	53
ANTIANKXIETY AGENTS - DRUGS TO TREAT ANXIETY.....	54
ANTIANKXIETY AGENTS - MISC.	54
BENZODIAZEPINES	54
ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS	55
ANTIARRHYTHMICS TYPE I-A	55
ANTIARRHYTHMICS TYPE I-B.....	55
ANTIARRHYTHMICS TYPE I-C.....	55
ANTIARRHYTHMICS TYPE III	56
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE	56
ANTI-INFLAMMATORY AGENTS	56
BRONCHODILATORS - ANTICHOLINERGICS.....	56

LEUKOTRIENE MODULATORS	56
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS	56
STEROID INHALANTS	57
SYMPATHOMIMETICS.....	57
XANTHINES.....	59
ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS	59
COUMARIN ANTICOAGULANTS	59
DIRECT FACTOR XA INHIBITORS.....	59
THROMBIN INHIBITORS.....	60
ANTICONSULSANTS - DRUGS TO TREAT SEIZURES	60
AMPA GLUTAMATE RECEPTOR ANTAGONISTS	60
ANTICONSULSANTS - BENZODIAZEPINES	60
ANTICONSULSANTS - MISC.	61
CARBAMATES.....	63
GABA MODULATORS	64
HYDANTOINS.....	64
SUCCINIMIDES	64
VALPROIC ACID	64
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION	64
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)	64
ANTIDEPRESSANTS - MISC.	65
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID	65
MONOAMINE OXIDASE INHIBITORS (MAOIS)	65
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	65
SEROTONIN MODULATORS.....	66
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)	66
TRICYCLIC AGENTS	67
ANTIDIABETICS - DRUGS TO TREAT DIABETES.....	68
ALPHA-GLUCOSIDASE INHIBITORS	68
ANTIDIABETIC - AMYLIN ANALOGS	68
ANTIDIABETIC COMBINATIONS	68
BIGUANIDES	69
DIABETIC OTHER	70
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS	70
INCRETIN MIMETIC AGENTS	70
INSULIN.....	70
INSULIN SENSITIZING AGENTS	71
MEGLITINIDE ANALOGUES.....	71
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS	72
SULFONYLUREAS.....	72
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA	72
ANTIPERISTALTIC AGENTS.....	72
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING.....	72
ANTIDOTES - CHELATING AGENTS.....	72
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING	72

OPIOID ANTAGONISTS	73
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING.....	73
5-HT3 RECEPTOR ANTAGONISTS	73
ANTIEMETICS - ANTICHOLINERGIC	73
ANTIEMETICS - MISCELLANEOUS	73
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS	73
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS	73
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS	73
IMIDAZOLE-RELATED ANTIFUNGALS	74
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES	74
ANTIHISTAMINES - ETHANOLAMINES	74
ANTIHISTAMINES - NON-SEDATING	74
ANTIHISTAMINES - PHENOTHIAZINES	74
ANTIHISTAMINES - PIPERIDINES	75
ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE	75
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS.....	75
ANTIHYPERTENSIVES - COMBINATIONS	75
ANTIHYPERTENSIVES - MISC.	75
BILE ACID SEQUESTRANTS	75
FIBRIC ACID DERIVATIVES	75
HMG COA REDUCTASE INHIBITORS.....	76
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS	77
NICOTINIC ACID DERIVATIVES	77
ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE	77
ACE INHIBITORS	77
AGENTS FOR PHEOCHROMOCYTOMA	78
ANGIOTENSIN II RECEPTOR ANTAGONISTS	78
ANTIADRENERGIC ANTIHYPERTENSIVES	79
ANTIHYPERTENSIVE COMBINATIONS.....	79
DIRECT RENIN INHIBITORS	82
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)	82
VASODILATORS	82
ANTIMALARIALS - DRUGS TO TREAT MALARIA	82
ANTIMALARIAL COMBINATIONS	82
ANTIMALARIALS - DRUGS TO TREAT MALARIA	82
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS	82
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS	82
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS	82
ANTI TB COMBINATIONS.....	82
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS.....	83
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER	83
ALKYLATING AGENTS	83
ANTIMETABOLITES	83
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS.....	83
ANTINEOPLASTIC - EGFR INHIBITORS.....	84

ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS	84
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS	84
ANTINEOPLASTIC - IMMUNOMODULATORS	85
ANTINEOPLASTIC COMBINATIONS	85
ANTINEOPLASTIC ENZYME INHIBITORS	85
ANTINEOPLASTICS MISC.....	90
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS	90
MITOTIC INHIBITORS	91
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE..	91
ANTIPARKINSON ADJUNCTIVE THERAPY	91
ANTIPARKINSON ANTICHOLINERGICS	91
ANTIPARKINSON COMT INHIBITORS	91
ANTIPARKINSON DOPAMINERGICS	91
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS	93
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES	93
ANTIMANIC AGENTS.....	93
ANTIPSYCHOTICS - MISC.	93
BENZISOXAZOLES	93
BUTYROPHENONES.....	94
DIBENZAPINES.....	94
DIHYDROINDOLONES	95
PHENOTHIAZINES	95
QUINOLINONE DERIVATIVES	96
THIOXANTHENES	96
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS	96
ANTIRETROVIRALS	96
ANTIVIRAL COMBINATIONS	98
CMV AGENTS.....	98
HEPATITIS AGENTS.....	98
HERPES AGENTS.....	99
INFLUENZA AGENTS.....	99
MISC. ANTIVIRALS.....	99
BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS	100
ALPHA-BETA BLOCKERS	100
BETA BLOCKERS CARDIO-SELECTIVE	100
BETA BLOCKERS NON-SELECTIVE.....	100
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART	
CONDITIONS.....	101
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART	
CONDITIONS.....	101
CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS	103
CARDIAC GLYCOSIDES	103
CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS	
.....	104
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS	104

IMPOTENCE AGENTS - DRUGS TO TREAT ERECTILE DYSFUNCTION	104
PROSTAGLANDIN VASODILATORS	105
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS	105
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS	105
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST	106
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR	106
SINUS NODE INHIBITORS.....	106
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)	106
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS.....	106
CEPHALOSPORINS - 1ST GENERATION	106
CEPHALOSPORINS - 2ND GENERATION	106
CEPHALOSPORINS - 3RD GENERATION	107
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL	107
COMBINATION CONTRACEPTIVES - ORAL	107
COMBINATION CONTRACEPTIVES - TRANSDERMAL	115
COMBINATION CONTRACEPTIVES - VAGINAL	115
EMERGENCY CONTRACEPTIVES	115
PROGESTIN CONTRACEPTIVES - ORAL	115
CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE	116
GLUCOCORTICOSTEROIDS.....	116
MINERALOCORTICIDS	117
COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS	117
ANTITUSSIVES - DRUGS TO TREAT COUGH	117
COUGH/COLD/ALLERGY COMBINATIONS	117
EXPECTORANTS - DRUGS TO TREAT COUGH	117
MISC. RESPIRATORY INHALANTS - DRUGS TO TREAT BREATHING DISORDERS	118
MUCOLYTICS - DRUGS TO TREAT COUGH	118
DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS	118
ACNE PRODUCTS.....	118
ANTI-INFLAMMATORY AGENTS - TOPICAL	120
ANTIBIOTICS - TOPICAL	120
ANTIFUNGALS - TOPICAL.....	120
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL	121
ANTIPSORIATICS	121
ANTISEBORRHEIC PRODUCTS	122
ANTIVIRALS - TOPICAL	122
BURN PRODUCTS	122
CORTICOSTEROIDS - TOPICAL	122
ECZEMA AGENTS.....	124
EMOLLIENTS.....	124
HAIR GROWTH AGENTS.....	124
IMMUNOMODULATING AGENTS - TOPICAL	124
IMMUNOSUPPRESSIVE AGENTS - TOPICAL	124
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS	124
LOCAL ANESTHETICS - TOPICAL	124

PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL.....	124
ROSACEA AGENTS	125
SCABICIDES & PEDICULICIDES	125
DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS	125
DIGESTIVE ENZYMES.....	125
DIURETICS - DRUGS TO TREAT HEART CONDITIONS	126
CARBONIC ANHYDRASE INHIBITORS	126
DIURETIC COMBINATIONS	126
LOOP DIURETICS	126
POTASSIUM SPARING DIURETICS	126
THIAZIDES AND THIAZIDE-LIKE DIURETICS.....	127
ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES.....	127
BONE DENSITY REGULATORS - DRUGS TO TREAT BONE LOSS	127
FERTILITY REGULATORS.....	127
GNRH/LHRH ANTAGONISTS	127
HORMONE RECEPTOR MODULATORS - DRUGS TO TREAT BONE LOSS.....	127
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS	128
METABOLIC MODIFIERS	128
MINERALOCORTICOID RECEPTOR ANTAGONISTS	128
POSTERIOR PITUITARY HORMONES	129
PROGESTERONE RECEPTOR ANTAGONISTS.....	129
PROLACTIN INHIBITORS.....	129
VASOPRESSIN RECEPTOR ANTAGONISTS.....	129
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES	129
ESTROGEN COMBINATIONS.....	129
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES	130
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS	131
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS	131
GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS.....	131
5-HT4 RECEPTOR AGONISTS	131
GALLSTONE SOLUBILIZING AGENTS	131
GASTROINTESTINAL ANTIALLERGY AGENTS	131
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS	131
GASTROINTESTINAL STIMULANTS	132
INFLAMMATORY BOWEL AGENTS	132
INTESTINAL ACIDIFIERS	132
IRRITABLE BOWEL SYNDROME (IBS) AGENTS.....	132
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS	132
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS..	132
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS.....	133
ALKALINIZERS	133
CYSTINOSIS AGENTS	133
PROSTATIC HYPERTROPHY AGENTS	133

URINARY STONE AGENTS	133
GOUT AGENTS - DRUGS TO TREAT GOUT	133
GOUT AGENT COMBINATIONS	133
GOUT AGENTS - DRUGS TO TREAT GOUT	133
URICOSURICS	134
HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS	134
HEMATORHEOLOGIC AGENTS	134
PLASMA KALLIKREIN INHIBITORS	134
PLATELET AGGREGATION INHIBITORS	134
HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS	134
AGENTS FOR GAUCHER DISEASE	134
AGENTS FOR SICKLE CELL DISEASE	134
FOLIC ACID/FOLATES	134
HEMATOPOIETIC GROWTH FACTORS	136
HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS	136
HEMOSTATICS - SYSTEMIC	136
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS	136
BARBITURATE HYPNOTICS	136
HYPNOTICS - TRICYCLIC AGENTS	137
NON-BARBITURATE HYPNOTICS	137
OREXIN RECEPTOR ANTAGONISTS	137
SELECTIVE MELATONIN RECEPTOR AGONISTS	137
LAXATIVES - DRUGS TO TREAT CONSTIPATION	137
LAXATIVE COMBINATIONS	137
LAXATIVES - MISCELLANEOUS	138
MACROLIDES - DRUGS TO TREAT INFECTIONS	138
AZITHROMYCIN	138
CLARITHROMYCIN	138
ERYTHROMYCINS	138
FIDAXOMICIN	139
MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING	139
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL	139
PARENTERAL THERAPY SUPPLIES	139
RESPIRATORY THERAPY SUPPLIES	139
MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES	141
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	141
MIGRAINE COMBINATIONS	141
SEROTONIN AGONISTS	141
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION	142
FLUORIDE	142
PHOSPHATE	143
POTASSIUM	143
MISCELLANEOUS THERAPEUTIC CLASSES	143
CHELATING AGENTS - DRUGS FOR OVERDOSE OR POISONING	143

IMMUNOMODULATORS - DRUGS TO TREAT CANCER	144
IMMUNOSUPPRESSIVE AGENTS - DRUGS FOR TRANSPLANT	144
POTASSIUM REMOVING AGENTS - DRUGS TO LOWER POTASSIUM	145
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT	145
ANESTHETICS TOPICAL ORAL	145
ANTI-INFECTIVES - THROAT	145
STEROIDS - MOUTH/THROAT/DENTAL	146
THROAT PRODUCTS - MISC.	146
MULTIVITAMINS - DRUGS FOR NUTRITION	146
PRENATAL VITAMINS	146
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS	146
CENTRAL MUSCLE RELAXANTS	146
DIRECT MUSCLE RELAXANTS	147
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE	147
NASAL AGENT COMBINATIONS	147
NASAL ANTIALLERGY	147
NASAL ANTICHOLINERGICS	147
NASAL STEROIDS	147
NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES	147
ALS AGENTS	147
OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS	147
BETA-BLOCKERS - OPHTHALMIC	147
CYCLOPLEGIC MYDRIATICS	148
MIOTICS	148
OPHTHALMIC ADRENERGIC AGENTS	148
OPHTHALMIC ANTI-INFECTIVES	148
OPHTHALMIC IMMUNOMODULATORS	149
OPHTHALMIC INTEGRIN ANTAGONISTS	149
OPHTHALMIC STEROIDS	149
OPHTHALMICS - MISC.	150
PROSTAGLANDINS - OPHTHALMIC	150
OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR	150
OTIC AGENTS - MISCELLANEOUS	150
OTIC ANTI-INFECTIVES	150
OTIC COMBINATIONS	150
OTIC STEROIDS	151
OXYTOCICS - DRUGS FOR PREGNANCY	151
OXYTOCICS - DRUGS FOR PREGNANCY	151
PENICILLINS - DRUGS TO TREAT INFECTIONS	151
AMINOPENICILLINS	151
NATURAL PENICILLINS	151
PENICILLIN COMBINATIONS	151
PENICILLINASE-RESISTANT PENICILLINS	152
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES	152
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES	152

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS

SYSTEM DISORDERS.....152

AGENTS FOR CHEMICAL DEPENDENCY	152
ANTI-CATALECTIC AGENTS.....	152
ANTIDEMENTIA AGENTS - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS	152
COMBINATION PSYCHOTHERAPEUTICS	153
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS	154
MOVEMENT DISORDER DRUG THERAPY.....	154
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS.....	154
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS	155
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS.....	155
SMOKING DETERRENTS	155

RESPIRATORY AGENTS - MISC. - DRUGS TO TREAT BREATHING DISORDERS159

CYSTIC FIBROSIS AGENTS	159
PULMONARY FIBROSIS AGENTS	159

SULFONAMIDES - DRUGS TO TREAT INFECTIONS159

SULFONAMIDES - DRUGS TO TREAT INFECTIONS	159
--	-----

TETRACYCLINES - DRUGS TO TREAT INFECTIONS159

TETRACYCLINES - DRUGS TO TREAT INFECTIONS.....	159
--	-----

THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS160

ANTITHYROID AGENTS	160
THYROID HORMONES.....	160

ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH

ACID.....162

ANTISPASMODICS - DRUGS FOR STOMACH SPASMS	162
H-2 ANTAGONISTS	162
MISC. ANTI-ULCER	163
PROTON PUMP INHIBITORS.....	163
ULCER DRUGS - PROSTAGLANDINS	163
ULCER THERAPY COMBINATIONS.....	163

URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE164

URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	164
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS.....	164
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS.....	164
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS	164

VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS164

MISCELLANEOUS VAGINAL PRODUCTS	164
SPERMICIDES.....	164
VAGINAL ANTI-INFECTIVES	165
VAGINAL CONTRACEPTIVE - PH MODULATORS	165
VAGINAL ESTROGENS.....	165
VAGINAL PROGESTINS.....	165

VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS165

ANAPHYLAXIS THERAPY AGENTS - DRUGS FOR ACUTE ALLERGIC REACTION	165
--	-----

NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS	165
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS.....	165
VITAMINS - DRUGS FOR NUTRITION	166
OIL SOLUBLE VITAMINS	166
Index.....	167

INTRODUCTION

This document contains a list of the federal Food and Drug Administration (FDA) approved drugs covered for Sharp Health Plan Members under the pharmacy outpatient prescription drug benefit, and is also known as the Formulary. The outpatient prescription drug benefit covers outpatient drugs provided to Members through a network retail, specialty or mail order pharmacy. Drugs covered under the pharmacy benefit are generally oral or topical medications, unless otherwise listed on the Formulary. The presence of a drug on the Formulary does not guarantee that it will be prescribed by your Prescribing Provider for a particular medical condition. Refer to the end of this Introduction for information about drug benefit exclusions for the outpatient prescription drug benefit.

If you are in an HMO plan, you should contact your provider for information on how to obtain vaccines. If you are in a Point of Service (POS) plan, you can get vaccines at a network retail pharmacy. Please refer to your Evidence of Coverage for additional information. If you have questions regarding your outpatient prescription drug benefit, please call our Customer Service department at 1-855-298-4252.

A Medical Benefit drug is a drug that is physician administered or is self-injectable. Medical Benefit drugs are covered under the Medical Benefit. Refer to the “WHAT ARE YOUR COVERED BENEFITS?” section of the Member Handbook for specific information about the Cost Shares, exclusions and limitations for these drugs covered under your Medical Benefit:

1. Medically Necessary formulas and special food products prescribed by a Plan Physician to treat phenylketonuria (PKU), provided that these formulas and special foods exceed the cost of a normal diet.
2. Medically Necessary injectable and non-injectable drugs and supplies that are administered in a physician's office and self-injectable drugs covered under the medical benefit.
3. FDA-approved medications used to induce spontaneous and non-spontaneous abortions that may only be dispensed by, or under direct supervision of a physician.
4. Immunization or immunological agents, including, but not limited to: biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
5. Equipment and supplies for the management and treatment of diabetes, including insulin pumps and all related necessary supplies, blood glucose monitors, testing strips, lancets and lancet puncture devices. Insulin, glucagon and insulin syringes are covered under the outpatient prescription drug benefit.
6. Items that are approved by the FDA as a medical device. Please refer to the Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning for information about medical devices covered by Sharp Health Plan.

DEFINITIONS

Defined terms are capitalized throughout this Formulary and have the meaning set forth below throughout this Formulary and in the Glossary section of your Member Handbook.

“Appeal” is a written or oral request, by or on behalf of a Member, to re-evaluate a specific determination made by Sharp Health Plan or any of its delegated entities (e.g., Plan Providers).

“Brand-Name Drug” is a drug that is marketed under a proprietary, trademark-protected name. The Brand Name Drug shall be listed in all CAPITAL letters.

“CARE Agreement” means a voluntary settlement agreement entered into by the parties. A CARE Agreement includes the same elements as a CARE Plan to support the respondent in accessing community-based services and supports.

“CARE Plan” means an individualized, appropriate range of community-based services and supports, which include clinically appropriate behavioral health care and stabilization medications, housing and other supportive services, as appropriate.

“Coinsurance” is a percentage of the cost of a Covered Benefit (for example, 20%) that an Enrollee pays after the Enrollee has paid the Deductible, if a Deductible applies to the Covered Benefit, such as the prescription drug benefit.

“Copayment” is a fixed dollar amount (for example, \$20) that an Enrollee pays for a Covered Benefit after the Enrollee has paid the Deductible, if a Deductible applies to the Covered Benefit, such as the prescription drug benefit.

“Deductible” is the amount an Enrollee pays for certain Covered Benefits before Sharp Health Plan begins payment for all or part of the cost of the Covered Benefit under the terms of the policy.

“Drug Tier” is a group of Prescription Drugs that corresponds to a specified cost sharing tier in Sharp Health Plan’s Prescription Drug coverage. The tier in which a Prescription Drug is placed determines the Enrollee’s portion of the cost for the drug.

“Enrollee” is a person enrolled in Sharp Health Plan who is entitled to receive services from the Plan. All references to Enrollees in this Formulary template shall also include Subscribers as defined in this section below. An Enrollee is also referred to as a Member.

“Exception Request” is a request for coverage of a Prescription Drug. If an Enrollee, his or her designee, or prescribing health care provider submits an Exception Request for coverage of a Prescription Drug, Sharp Health Plan must cover the Prescription Drug when the drug is determined to be Medically Necessary to treat the Enrollee’s condition. Drugs and supplies that fall within one of the outpatient prescription drug benefit exclusions described in the Member Handbook are not eligible for an Exception Request.

“Exigent Circumstances” are when an Enrollee is suffering from a health condition that may seriously jeopardize the Enrollee’s life, health, or ability to regain maximum function, or when an Enrollee is undergoing a current course of treatment using a Nonformulary Drug.

“Formulary” is the complete list of drugs preferred for use and eligible for coverage under a Sharp Health Plan product, and includes all drugs covered under the outpatient prescription drug benefit of the Sharp Health Plan product. Formulary is also known as a Prescription Drug list,

“Generic Drug” is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A Generic Drug is listed in bold and italicized lowercase letters.

“Grievance” is a written or oral expression of dissatisfaction regarding Sharp Health Plan, a provider and/or a pharmacy, including quality of care concerns.

“Nonformulary Drug” is a Prescription Drug that is not listed on Sharp Health Plan’s Formulary.

“Out-of-Pocket Cost” are Copayments, Coinsurance, and the applicable Deductible, plus all costs for health care services that are not covered by Sharp Health Plan.

“Prescribing Provider” is a health care provider authorized to write a Prescription to treat a medical condition for a Sharp Health Plan Enrollee.

“Prescription” is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

“Prescription Drug” is a drug that is approved by the federal Food and Drug Administration (FDA) that is prescribed by your Prescribing Provider and requires a prescription under applicable law.

“Prior Authorization” is Sharp Health Plan’s requirement that the Enrollee or the Enrollee's Prescribing Provider obtain the Sharp Health Plan’s Authorization for a Prescription Drug before Sharp Health Plan will cover the drug. Sharp Health Plan shall grant a Prior Authorization when it is Medically Necessary for the Enrollee to obtain the drug.

“Step Therapy” is a process specifying the sequence in which different Prescription Drugs for a given medical condition and medically appropriate for a particular patient are prescribed. Sharp Health Plan may require the Enrollee to try one or more drugs to treat the Enrollee's medical condition before Sharp Health Plan will cover a particular drug for the condition pursuant to a Step Therapy request. If the Enrollee's Prescribing Provider submits a request for Step Therapy exception, Sharp Health Plan shall make exceptions to Step Therapy when the criteria is met.

“Subscriber” means the person who is responsible for payment to Sharp Health Plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

HOW OFTEN DOES THE FORMULARY CHANGE?

The Sharp Health Plan Formulary is developed to identify safe and effective drugs for Members while maintaining affordable benefits. The Formulary and Drug Coverage Requirements and Limits are updated regularly, based on input from the Pharmacy and Therapeutics (P&T) Committee, which meets quarterly. The Formulary and the Drug Coverage Requirements and Limits are subject to change monthly as new clinical information and new drugs become available. The P&T Committee members are clinical pharmacists and actively practicing physicians of various medical specialties. The P&T Committee frequently consults with other medical experts for input to the Committee.

The P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications
- Relevant utilization experience
- Physician recommendations

WILL I BE NOTIFIED OF A FORMULARY CHANGE?

Sharp Health Plan will provide sixty (60) days written notice of a Formulary change to negatively affected Members. The notice will include the date the Member will be impacted by the change. Some examples of Formulary changes that will result in a notice to the member include, but are not limited to:

- A drug or dosage form is moved to a higher Drug Tier that results in an increase in cost sharing
- A drug or dosage form is removed from the Formulary
- Drug Coverage Requirements or Limits for a drug are added or changed

Changes to the Formulary that may occur without prior written notice to the Member include:

- A drug is removed from the Formulary because it is removed from the market by either the drug manufacturer or the FDA
- A drug is added to the Formulary
- A drug is moved to a lower Drug Tier
- A Drug Coverage Requirement or Limit is removed from a drug

- A generic drug is added to the Formulary and the Brand Name drug is moved to a higher Drug Tier or removed from the Formulary

The drug formulary can be accessed by current and prospective Members. To view the most current Formulary, please visit sharphealthplan.com/search-drug-list.

HOW DO I LOCATE A PRESCRIPTION DRUG ON THE FORMULARY?

Covered Prescription Drugs are listed alphabetically by Generic name and Brand-Name in the alphabetical Index.

Within the Formulary, drugs are listed alphabetically under the column titled "Prescription Drug Name" by its Brand or Generic name under the therapeutic category and class to which it belongs. If a generic for a Brand Name Drug is not available or is not covered, the Generic Drug name will not be listed separately by its generic name.

You can find a Prescription Drug on the formulary by looking for its Generic or Brand-Name alphabetically in the Index, or by looking for it in the Formulary, where it is listed alphabetically under the therapeutic category and class to which it belongs. Sharp Health Plan uses the Medispan® classification system for therapeutic category and class. Medispan® maintains the Master Drug Data Base of drug information for professionals in the health sciences. The Master Drug Data Base provides pricing and descriptive drug information on name brand, generic, prescription and OTC medications and herbal products and is updated daily.

HOW DO I KNOW IF THE DRUG LISTED ON THE FORMULARY IS A BRAND OR GENERIC DRUG?

Brand-Name Drugs are listed in all CAPITAL LETTERS followed by the generic name in parentheses in (*lowercase bold italics*).

If a Generic equivalent for a Brand-Name Drug is available and is covered, the Generic Drug will be listed separately from the Brand-Name Drug in all *lowercase bold italics*.

When a Generic Drug is marketed under a Brand-Name, the Brand-Name will be listed in all capital letters after the Generic name in parentheses with the first letter of each word capitalized.

Here is how this is listed on the Formulary:

Drug Type	Listing on the Formulary
Brand-Name Drug and Generic-Name	FIBRICOR TAB 35MG (<i>fenofibric acid</i>)
Generic-Name that is covered on the Formulary	<i>fenofibric acid tab 35mg</i>
Generic Drug marketed with a Brand-Name	(Amiodarone Hcl Tab 100 mg) PACERONE

Some drugs are commercially available as both a Brand-Name and a Generic-Name. Contracted pharmacies are required to dispense the Generic version of the drug, unless Prior Authorization for the Brand-Name Drug is obtained from Sharp Health Plan.

The Brand-Name listed in this document is for reference only and is not an indication that the Brand-Name Drug is covered by Sharp Health Plan, unless Sharp Health Plan has Authorized the Brand-Name Drug due to medical necessity or specifically noted.

WHAT IS A DRUG TIER?

Each covered drug is assigned to a Drug Tier. The Drug Tier is a group of drugs that indicates what your Copayment or Coinsurance is for each drug. A Deductible may also apply. For information about your Copayments, Coinsurance and/or Deductible, please consult your benefits information available online by visiting sharphealthplan.com/login and log in to your Sharp Health Plan online account. When you create a Sharp Health Plan online account, you can easily access your benefit information online 24 hours a day, 7 days a week.

A preferred drug is a drug that the Pharmacy and Therapeutics Committee has determined provides greater value than its alternatives when considering clinical effectiveness, safety and overall value.

The Drug Tier is marked throughout this document by one of the following symbols:

Symbol	Drug Tier	Description
PV	PV	Select drugs covered with no Copayment when recommended for preventive use as indicated under Preventive Care Services, including certain generic and over-the-counter contraceptives for women.
1	Tier 1	Preferred Generic Drugs. These drugs are subject to your Tier 1 Copayment.
2	Tier 2	Preferred Brand-Name Drugs and inhaler spacers. These drugs and inhaler spacers are subject to your Tier 2 Copayment.
3	Tier 3	Non-preferred drugs (may include Brand Name or Generic Drugs). These drugs are subject to your Tier 3 Copayment.

ARE THERE ANY COVERAGE REQUIREMENTS OR LIMITS?

Some covered Generic and Brand-Name Drugs have coverage requirements or limits on coverage. Symbols are used to identify drugs with a Coverage Requirement or Limit. The following symbols are used in this Formulary:

Symbol	Meaning	Description
PA	Prior Authorization	Requires Prior Authorization by Sharp Health Plan based on specific clinical criteria. See “What is Prior Authorization?” below for additional information.
PA**	Prior Authorization if Step Therapy is not met	Requires Prior Authorization by Sharp Health Plan based on specific clinical criteria, if Step Therapy criteria has not been met.
QL	Quantity Limit	Coverage is limited to a specific quantity per Prescription and/or time period. Prior Authorization is required for other quantities.
ST	Step Therapy	Coverage depends on previous use of another drug. Prior Authorization may be required. See “What Is Step Therapy?” below for additional information.
MO	Mail Order	A maintenance drug that is available for up to a 90-day supply and is eligible to be filled through mail order.

SP	Specialty	A specialty drug that must be filled by a pharmacy in the Sharp Health Plan Specialty Pharmacy network and is limited to a 30-day supply per fill.
OAC	Oral Anti-Cancer	An orally administered anticancer medication. Notwithstanding any Deductible, the total amount of Copayments and Coinsurance does not exceed two hundred fifty dollars (\$250) for an individual Prescription of up to a 30-day supply.

WHAT IS PRIOR AUTHORIZATION?

Drugs with a PA symbol in the Coverage Requirements and Limits column of the Formulary are subject to Prior Authorization. Your Prescribing Provider must request Prior Authorization, or approval for coverage, from Sharp Health Plan by calling our Customer Service department, submitting a fax request, or submitting an electronic Prior Authorization Form. Once all the needed supporting information has been received, the Prior Authorization request will be either approved or denied based on our clinical policies within 72 hours for non-urgent requests, or within 24 hours in urgent or Exigent Circumstances. Exigent Circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a Nonformulary Drug. Sharp Health Plan will provide coverage for the Prescription, including refills, for the duration of the Prescription for non-urgent requests, and for the duration of the exigency for requests based on Exigent Circumstances. If Sharp Health Plan fails to respond to a completed Prior Authorization request within 72 hours of receiving a non-urgent request or within 24 hours of receiving a request based on Exigent Circumstances, the request is deemed granted, including refills.

If Sharp Health Plan denies a request for Prior Authorization, the Member, an Authorized Representative, or the Prescribing Provider can file an Appeal or Grievance. Information about this process is described in the section of the Formulary called, "You Have the Right to Appeal."

If Sharp Health Plan approved a Prior Authorization request for your medication and medical condition, Sharp Health Plan will not discontinue or limit coverage if your Prescribing Provider continues to prescribe it for the same medical condition, provided the drug is appropriately prescribed and is safe and effective for treating your medical condition.

WHAT IS PA**?

Drugs with a PA** symbol in the Coverage Requirements and Limits column of the Formulary are subject to Prior Authorization based on specific clinical criteria if Step Therapy has not been met. There may be a situation when it is Medically Necessary for you to receive certain drugs without first trying the alternative drug. In these instances, your doctor may request a Prior Authorization by following the Prior Authorization process described above.

WHAT IS QUANTITY LIMIT?

Drugs with a QL symbol in the Coverage Requirements and Limits column of the Formulary are subject to Quantity Limits. Quantity Limits exist when drugs are limited to a determined number of doses based on criteria, including, but not limited to, safety, potential overdose hazard, abuse potential, or approximation of usual doses per month, not to exceed the FDA maximum approved dose. A Member's Prescribing Provider may submit a request for a quantity of medication that exceeds the Quantity Limit by following the Prior Authorization request procedure stated above. Medical Necessity for the quantity requested must be provided. Once all of the required supporting information has been received, the Prior Authorization request will be either approved or denied within 72 hours for non-urgent requests or within 24 hours in urgent or Exigent Circumstances.

WHAT IS STEP THERAPY?

Drugs with a ST symbol in the Coverage Requirements and Limits column of the Formulary are subject to Step Therapy. The Step Therapy program encourages safe and cost-effective medication use. Under this program, a “step” approach is required to receive coverage for certain drugs. This means that to receive coverage, you may need to first try a proven, cost-effective drug. Remember, treatment decisions are always between you and your doctor. There may be a situation when it is Medically Necessary for you to receive certain drugs without first trying an alternative drug. In these instances, your doctor may request a Step Therapy Exception by following the Prior Authorization process as described above. If Sharp Health Plan fails to respond to a completed Step Therapy Exception request within 72 hours of receiving a non-urgent request or within 24 hours of receiving a request based on Exigent Circumstances, the request is deemed granted, including refills. When a provider determines that the drug required under Step Therapy is inconsistent with good professional practice, the provider should submit their justification and clinical documentation supporting the provider’s determination with a Step Therapy Exception Request, and the Plan will approve the Step Therapy Exception Request.

If a request for prior authorization or a step therapy exception is incomplete or relevant information necessary to make a coverage determination is not included, we will notify your provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or relevant information is needed to approve or deny the prior authorization or step therapy exception request, or to appeal the denial.

If you have moved from another insurance plan to Sharp Health Plan and are taking a medication that your previous insurer covered, Sharp Health Plan will not require you to follow Step Therapy in order to obtain the medication. Your doctor may need to submit a request to Sharp Health Plan in order to provide you with continuity of coverage.

WHAT IS MO?

Drugs with a MO symbol in the Coverage Requirements and Limits column of the Formulary are classified as Maintenance Drugs and can be filled for a 90-day supply at a retail location or through Mail Order.

WHAT IS A SPECIALTY DRUG?

Drugs with a SP symbol in the Coverage Requirements and Limits column of the Formulary are Specialty drugs. A Specialty drug is a drug that the FDA or the manufacturer states must be distributed through a Specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that the Pharmacy and Therapeutics Committee determines to be a Specialty medication.

WHAT IS AN ORAL ANTI-CANCER DRUG?

Drugs with an OAC symbol in the Coverage Requirements and Limits column of the Formulary are Oral Anti-Cancer drugs. Notwithstanding any Deductible, the total amount of Copayments and Coinsurance for these drugs does not exceed two hundred fifty dollars (\$250) for an individual Prescription of up to a 30-day supply.

WHAT IF A DRUG IS NOT LISTED ON THE FORMULARY? WHAT IS A FORMULARY EXCEPTION?

Drugs that are not listed on the Formulary are Nonformulary Drugs and are not covered. There may be times when it is Medically Necessary for you to receive a Nonformulary Drug. In these instances, you, your Authorized Representative or your Prescribing Provider may request a Formulary Exception by following the Prior Authorization Request process described above. Once all of the required supporting information has been received, the Formulary Exception Request will be either approved or denied based on medical necessity within 72 hours for non-urgent requests, or within 24 hours in urgent or Exigent Circumstances. If Sharp Health Plan denies a Formulary Exception Request, the Member, an Authorized Representative, or the Provider can file an Appeal with Sharp Health Plan. Nonformulary Brand-Name Drugs approved for coverage will be subject to the Tier 3 Cost Share. Nonformulary Generic Drugs approved for coverage will be subject to the Tier 1 Cost Share. When approved, Sharp Health Plan shall provide coverage of the Nonformulary non-urgent request for the duration of the Prescription, including refills. Sharp Health Plan shall provide coverage, including refills, pursuant to a request based on Exigent Circumstances for the duration of the exigency.

WHERE CAN I FILL MY PRESCRIPTION DRUG?

To find a pharmacy in our network, use our Pharmacy Locator tool. First, register for an account at www.caremark.com. The Pharmacy Locator tool is available after you log into your account and will allow you to search for a pharmacy that meets your needs. For example, you can search for a pharmacy close to your home, one that is open 24 hours a day, or one that offers drive-thru service.

Specialty drugs can be filled at CVS Specialty® Pharmacy and will be mailed to you. Visit www.CVSSpecialty.com to enroll. You can also take your Specialty drug prescription to a CVS retail pharmacy. Your Prescription will be sent to CVS Specialty® Pharmacy to be filled. You may return to your local CVS pharmacy to pick up your Prescription.

Mail order medications can be filled at CVS Caremark®. You can enroll with CVS Caremark® by visiting info.caremark.com/mailservice.

WHAT IS THERAPEUTIC INTERCHANGE?

Sharp Health Plan employs therapeutic interchange as part of its prescription drug benefit. Therapeutic interchange is the practice of replacing (with the Prescribing Provider's approval) a Prescription Drug originally prescribed for a patient with a Prescription Drug that is preferred on the Formulary. Using therapeutic interchange may offer advantages, such as value through improved convenience, affordability, improved outcomes or fewer side effects. Two or more drugs may be considered appropriate for therapeutic interchange if they can be expected to produce similar levels of clinical effectiveness and sound medical outcomes in patients. If, during the Prior Authorization process, the requested medication has a preferred Formulary alternative that may be considered appropriate for therapeutic interchange, a request to consider the preferred drug(s) may be conveyed to the Prescribing Provider. The Prescribing Provider may choose to use therapeutic interchange and select a pharmaceutical that does not require Prior Authorization or Step Therapy.

WHAT IS GENERIC SUBSTITUTION?

When a Generic Drug is available, the pharmacy is required to switch a Brand-Name Drug to the generic equivalent, unless Sharp Health Plan has authorized the Brand-Name Drug due to medical necessity. If the brand-name drug is Medically Necessary and Prior Authorization is obtained from Sharp Health Plan, you must pay the Cost Share for the corresponding Brand-Name Drug tier. The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their Brand-Name equivalents.

In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share. The enrollee may be required to try an interchangeable product before providing coverage for the equivalent branded prescription drug. Nothing in this section will prohibit or supersede a step therapy exception request.

YOU HAVE THE RIGHT TO APPEAL

If you do not agree with a coverage decision, you, your Authorized Representative or your provider may request an Appeal. You must submit your request within 180 days from the postmark date of the denial notice.

APPEALS DUE TO DENIAL OF COVERAGE FOR A NONFORMULARY DRUG

If an exception request for coverage of a Nonformulary drug is denied, you, your Authorized Representative or your provider may request an external Exception Request review. Sharp Health Plan will ensure that a decision is made within 72 hours of receiving the required supporting information in routine circumstances or within 24 hours of receiving the required supporting information in urgent circumstances.

ALL OTHER APPEALS

If a decision is made to delay, deny or modify coverage of a Formulary Drug, you, your Authorized Representative or your provider may request an Appeal. A decision will be made within 30 days in routine circumstances or 72 hours in urgent circumstances.

For all types of Appeals, the circumstance may be considered urgent if the routine decision-making process might seriously jeopardize your life or health, or when you are experiencing severe pain.

Please refer to your Member Handbook for more information on the Appeal process.

QUESTIONS

If you have any questions, please contact Customer Care by calling 1-855-298-4252. If you or somebody who you are helping have questions about Sharp Health Plan, you have the right to obtain assistance and information in your language without any cost to you.

EXCLUSIONS AND LIMITATIONS TO THE OUTPATIENT PRESCRIPTION DRUG BENEFIT

The services and supplies listed below are exclusions and limitations to your Outpatient Prescription Drug Benefits and are not covered by Sharp Health Plan:

1. Drugs dispensed by a person or entity other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency Medical Condition or urgent care condition or dispensed as medically necessary treatment of a mental health or substance use disorder including, but not limited to, behavioral health crisis services provided by a 988 center or mobile crisis team or other provider of behavioral health crisis services, or required or recommended pursuant to a CARE agreement or a CARE plan approved by a court.
2. Drugs prescribed by non-Plan Providers and not authorized by Sharp Health Plan, except when coverage is otherwise required for treatment of an Emergency Medical Condition or dispensed as medically necessary treatment of a mental health or substance use disorder including, but not limited to, behavioral health crisis services provided by a 988 center or mobile crisis team or other provider of behavioral health crisis services, or required or recommended pursuant to a CARE agreement or a CARE plan approved by a court.
3. Over-the-counter medications or supplies, except for over-the-counter FDA-approved contraceptive drugs, devices and products, even if written on Prescription, except as specifically identified as covered in this Formulary. This exclusion does not apply to over-the-counter products that Sharp Health Plan must cover as a "preventive care" benefit under federal law with a Prescription or if the prescription legend drug is Medically Necessary due to a documented failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.
4. Drugs dispensed in institutional packaging (such as unit dose) and drugs that are repackaged.
5. Drugs that are packaged with over-the-counter medications or other non-prescription items/supplies, except for over-the-counter FDA-approved contraceptive drugs, devices and products.
6. Vitamins (other than pediatric or prenatal vitamins listed in this Formulary).
7. Drugs and supplies prescribed solely for the treatment of hair loss, athletic performance, sexual dysfunction, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease. Drugs for treatment of hair loss or sexual dysfunction are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders.)
8. Herbal, nutritional and dietary supplements.
9. Drugs prescribed solely for the purpose of shortening the duration of the common cold.

10. Dental products and medications prescribed for a dental treatment (such as mouthwash to prevent gum disease) are not covered. Drugs prescribed by a dentist to treat a medical condition (such as antibiotics to treat an infection) are covered.
11. Drugs and supplies prescribed in connection with a service or supply that is not a Covered Benefit, unless required to treat a complication that arises as a result of the service or supply.
12. Travel and/or required work-related immunizations.
13. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.
14. Drugs obtained outside of the United States, unless they are furnished in connection with Urgent Care Services or Emergency Services.
15. Drugs that are prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity or Mental Health and Substance Use Disorders. Members must be enrolled in a Sharp Health Plan-approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug and meet Plan criteria for coverage when prescribed for treatment of morbid obesity.
16. Off-label use of FDA-approved Prescription Drugs, unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in a nationally recognized, major peer-reviewed journal.
17. Replacement of lost, stolen, or destroyed medications.
18. Compounded medications, unless determined to be Medically Necessary and Prior Authorization is obtained.
19. Brand-Name Drugs when a generic equivalent is available.
20. Any Prescription Drug for which there is an over-the-counter product that has the identical active ingredient and dosage as the Prescription Drug, except for over-the-counter FDA-approved contraceptive drugs, devices and products.

The exclusions listed above do not apply to:

1. Coverage of an entire class of Prescription Drugs when one drug within that class becomes available over-the-counter, except for FDA-approved contraceptive drugs, devices and products.
2. Drugs listed in this Formulary.
3. Over-the-counter products that are specifically covered and listed as a preventive care benefit under California State or federal law. Covered preventive drugs include FDA-approved tobacco cessation drugs and FDA-approved contraceptive drugs, including FDA-approved contraceptive drugs, devices and products available over-the-counter. Preventive drugs are provided at \$0 Cost Sharing subject to certain exceptions. For more information regarding coverage of certain over-the-counter drugs as preventive drugs, please see the Plan Formulary and your Member Handbook under Family Planning and Preventive Care Services.
4. Insulin, glucagon and insulin syringes. These items are covered when Medically Necessary, even if they are available without a Prescription. Please see your Formulary and your Member Handbook under Diabetes Treatment.
5. Items that are approved by the FDA as a medical device. Please see your Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning Services for information about medical devices covered by Sharp Health Plan.

Some drugs are commercially available as both a Brand-Name version and a generic version. It is the policy of Sharp Health Plan that when a generic version is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug unless prior Authorization for the Brand-Name Drug is obtained. In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share. When an interchangeable biological product is available, the pharmacy may be required to fill your Prescription with the interchangeable biological product unless prior Authorization is obtained and the reference product is determined to be Medically Necessary.

NONDISCRIMINATION NOTICE

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Information in other formats (such as large print, audio, accessible electronic formats or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / Appeal form on the plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online:
www.dmhca.ca.gov.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

LANGUAGE ASSISTANCE SERVICES

English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (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 1-800-359-2002 (TTY:711)。

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 (Korean):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն (Armenian):

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ) 711)։

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرد (1-800-359-2002 (TTY:711) با. باشد می فراهم.

Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 (Japanese):

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

(Arabic): قبيرعلا

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្បួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002(TTY:711)។

Hmoob (Hmong):

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।कॉल करें।

ภาษาไทย (Thai):

เรียน: ถ้านคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).

STEP THERAPY CRITERIA

Step Therapy Group

Drug Names

Step Therapy Criteria

HPGST ANTIPSYCHOTICS 478-D

VRAYLAR

Coverage will be provided if the member has filled a prescription for a 30 day supply of aripiprazole, clozapine, olanzapine, paliperidone ext-rel, risperidone, quetiapine, quetiapine ext-rel, or ziprasidone within the past 365 days

Step Therapy Group

Drug Names

Step Therapy Criteria

OPIOID ER 2219-M

BELBUCA, BUPRENORPHINE, FENTANYL, HYDROCODONE BITARTRATE ER, HYDROMORPHONE HYDROCHLORI, METHADONE HCL, METHADONE HYDROCHLORIDE, MORPHINE SULFATE ER, TRAMADOL HCL ER, TRAMADOL HYDROCHLORIDE ER

Coverage will be provided if the member has filled a cumulative 7-day or greater supply of an immediate-release opioid agent within the past 90 days OR has been receiving an extended-release opioid agent for a cumulative 30 days or greater within the past 90 days.

Step Therapy Group

Drug Names

Step Therapy Criteria

OPIOID IR COMBO PRODUCTS 1358-E

ACETAMINOPHEN/CAFFEINE/DI, ACETAMINOPHEN/CODEINE, ACETAMINOPHEN/CODEINE PHO, ENDOCET, HYDROCODONE BITARTRATE/AC, HYDROCODONE/IBUPROFEN, OXYCODONE/ACETAMINOPHEN, TRAMADOL HYDROCHLORIDE/AC, TREZIX

Coverage will be provided to the member for up to a 7-day supply of immediate-release opioids if the member does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.

PRESCRIPTION DRUG NAME **DRUG TIER** **COVERAGE REQUIREMENTS AND LIMITS**

ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS

AMPHETAMINES

<i>amphetamine sulfate tab 5 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine sulfate tab 10 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 25 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 50 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	1	PA, QL (270 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	1	PA, QL (270 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine tab 5 mg</i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine tab 10 mg</i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine tab 15 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine tab 20 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine tab 30 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate cap er 24hr 10 mg</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>dextroamphetamine sulfate cap er 24hr 15 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	1	PA, QL (3600 mL every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Oral Solution 5 mg/5ml) PROCENTRA	1	PA, QL (3600 mL every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 2.5 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 2.5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 5 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 7.5 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 7.5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 10 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 10 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>dextroamphetamine sulfate tab 15 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 15 mg) ZENZEDI	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 20 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 20 mg) ZENZEDI	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 30 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 30 mg) ZENZEDI	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 10 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 20 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 30 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 40 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 50 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>lisdexamfetamine dimesylate cap 60 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 70 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 10 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 20 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 30 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 40 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 50 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 60 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methamphetamine hcl tab 5 mg</i>	1	PA, QL (450 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
ANOREXIANTS NON-AMPHETAMINE		
<i>benzphetamine hcl tab 50 mg</i>	1	PA
<i>diethylpropion hcl tab 25 mg</i>	1	PA
<i>diethylpropion hcl tab er 24hr 75 mg</i>	1	PA
<i>phendimetrazine tartrate tab 35 mg</i>	1	PA
<i>phentermine hcl cap 15 mg</i>	1	PA
<i>phentermine hcl cap 30 mg</i>	1	PA
<i>phentermine hcl cap 37.5 mg</i>	1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>phentermine hcl tab 37.5 mg</i>	1	PA
<i>QSYMIA CAP 3.75-23 (phentermine hcl-topiramate)</i>	2	PA
<i>QSYMIA CAP 7.5-46MG (phentermine hcl-topiramate)</i>	2	PA
<i>QSYMIA CAP 11.25-69 (phentermine hcl-topiramate)</i>	2	PA
<i>QSYMIA CAP 15-92MG (phentermine hcl-topiramate)</i>	2	PA
ANTI-OBESITY AGENTS		
<i>orlistat cap 120 mg</i>	1	PA
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS - DRUGS TO TREAT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER		
<i>atomoxetine hcl cap 10 mg (base equiv)</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 18 mg (base equiv)</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 25 mg (base equiv)</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 40 mg (base equiv)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 60 mg (base equiv)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 80 mg (base equiv)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 100 mg (base equiv)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>clonidine hcl tab er 12hr 0.1 mg</i>	1	MO
<i>guanfacine hcl tab er 24hr 1 mg (base equiv)</i>	1	MO
<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i>	1	MO
<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i>	1	MO
QELBREE CAP 100MG ER (<i>viloxazine hcl (adhd)</i>)	2	QL (270 caps every 75 days), MO
QELBREE CAP 150MG ER (<i>viloxazine hcl (adhd)</i>)	2	QL (270 caps every 75 days), MO
QELBREE CAP 200MG ER (<i>viloxazine hcl (adhd)</i>)	2	QL (270 caps every 75 days), MO
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB 75MG (<i>solriamfetol hcl</i>)	2	PA, MO
SUNOSI TAB 150MG (<i>solriamfetol hcl</i>)	2	PA, MO
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB 4.45MG (<i>pitolisant hcl</i>)	2	SP, PA, QL (2 tabs every 1 day)
WAKIX TAB 17.8MG (<i>pitolisant hcl</i>)	2	SP, PA, QL (2 tabs every 1 day)
STIMULANTS - MISC.		
<i>armodafinil tab 50 mg</i>	1	PA, MO
<i>armodafinil tab 150 mg</i>	1	PA, MO
<i>armodafinil tab 200 mg</i>	1	PA, MO
<i>armodafinil tab 250 mg</i>	1	PA, MO
AZSTARYS CAP 26.1-5.2 (<i>serdexmethylphenidate chloride-dexmethylphenidate hcl</i>)	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
AZSTARYS CAP 39.2-7.8 (<i>serdexmethylphenidate chloride-dexmethylphenidate hcl</i>)	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
AZSTARYS CAP 52.3-10. (<i>serdexmethylphenidate chloride-dexmethylphenidate hcl</i>)	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 35 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 40 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl tab 2.5 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl tab 5 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl tab 10 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 10 mg (cd)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 20 mg (cd)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>methylphenidate hcl cap er 30 mg (cd)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 40 mg (cd)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 50 mg (cd)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 60 mg (cd)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl chew tab 2.5 mg</i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl chew tab 5 mg</i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl chew tab 10 mg</i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl soln 5 mg/5ml</i>	1	PA, QL (5400 mL every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl soln 10 mg/5ml</i>	1	PA, QL (2700 mL every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab 5 mg</i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab 10 mg</i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>methylphenidate hcl tab 20 mg</i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er 10 mg</i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er 20 mg</i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er 24hr 18 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er 24hr 27 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er 24hr 36 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er 24hr 54 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>methylphenidate hcl tab er osmotic release (osm) 72 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate td patch 10 mg/9hr</i>	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate td patch 15 mg/9hr</i>	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate td patch 20 mg/9hr</i>	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate td patch 30 mg/9hr</i>	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
<i>modafinil tab 100 mg</i>	1	PA, MO
<i>modafinil tab 200 mg</i>	1	PA, MO
ALLERGENIC EXTRACTS/BIOLOGICALS MISC - DRUGS FOR ALLERGIES		
ALLERGENIC EXTRACTS		
GRASSTK SUB 2800BAU (<i>timothy grass pollen allergen extract</i>)	2	PA, MO
ORALAIR SUB 300 IR (<i>grass mixed pollens allergen extract</i>)	2	PA, MO
RAGWITEK SUB (<i>short ragweed pollen allergen extract</i>)	2	PA, MO
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS		
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS		
<i>neomycin sulfate tab 500 mg</i>	1	
<i>tobramycin nebu soln 300 mg/4ml</i>	1	SP, PA, QL (8 mL every 1 day)
<i>tobramycin nebu soln 300 mg/5ml</i>	1	SP, PA, QL (10 mL every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANALGESICS - ANTI-INFLAMMATORY - DRUGS TO TREAT PAIN AND INFLAMMATION		
ANTIRHEUMATIC - ENZYME INHIBITORS		
RINVOQ LQ SOL 1MG/ML (<i>upadacitinib</i>)	2	SP, PA, QL (12 mL every 1 day); Preferred for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
RINVOQ TAB 15MG ER (<i>upadacitinib</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
RINVOQ TAB 30MG ER (<i>upadacitinib</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
RINVOQ TAB 45MG ER (<i>upadacitinib</i>)	2	SP, PA, QL (56 tabs every 56 days); Preferred for Ankylosing Spondylitis, Atopic Dermatitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ SOL 1MG/ML (<i>tofacitinib citrate</i>)	2	SP, PA, QL (10 mL every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ TAB 5MG (<i>tofacitinib citrate</i>)	2	SP, PA, QL (2 tabs every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ TAB 10MG (<i>tofacitinib citrate</i>)	2	SP, PA, QL (2 tabs every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XELJANZ XR TAB 11MG (<i>tofacitinib citrate</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ XR TAB 22MG (<i>tofacitinib citrate</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
<i>celecoxib cap 50 mg</i>	1	MO
<i>celecoxib cap 100 mg</i>	1	MO
<i>celecoxib cap 200 mg</i>	1	MO
<i>celecoxib cap 400 mg</i>	1	MO
<i>diclofenac potassium tab 50 mg</i>	1	MO
<i>diclofenac sodium tab delayed release 25 mg</i>	1	MO
<i>diclofenac sodium tab delayed release 50 mg</i>	1	MO
<i>diclofenac sodium tab delayed release 75 mg</i>	1	MO
<i>diclofenac sodium tab er 24hr 100 mg</i>	1	MO
<i>diclofenac w/ misoprostol tab delayed release 50-0.2 mg</i>	1	MO
<i>diclofenac w/ misoprostol tab delayed release 75-0.2 mg</i>	1	MO
<i>etodolac cap 200 mg</i>	1	MO
<i>etodolac cap 300 mg</i>	1	MO
<i>etodolac tab 400 mg</i>	1	MO
<i>etodolac tab 500 mg</i>	1	MO
<i>etodolac tab er 24hr 400 mg</i>	1	MO
<i>etodolac tab er 24hr 500 mg</i>	1	MO
<i>etodolac tab er 24hr 600 mg</i>	1	MO
<i>flurbiprofen tab 50 mg</i>	1	MO
<i>flurbiprofen tab 100 mg</i>	1	MO
(Flurbiprofen Tab 100 mg) LURBIPR	1	MO
<i>ibuprofen susp 100 mg/5ml</i>	1	
<i>ibuprofen tab 400 mg</i>	1	MO
(Ibuprofen Tab 400 mg) IBU	1	MO
<i>ibuprofen tab 600 mg</i>	1	MO
(Ibuprofen Tab 600 mg) IBU	1	MO
<i>ibuprofen tab 800 mg</i>	1	MO
(Ibuprofen Tab 800 mg) IBU	1	MO
<i>ibuprofen-famotidine tab 800-26.6 mg</i>	1	PA, MO
<i>indomethacin cap 25 mg</i>	1	MO
<i>indomethacin cap 50 mg</i>	1	MO
<i>indomethacin cap er 75 mg</i>	1	MO
<i>indomethacin suppos 50 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>indomethacin susp 25 mg/5ml</i>	1	MO
<i>ketorolac tromethamine tab 10 mg</i>	1	
<i>meclofenamate sodium cap 50 mg</i>	1	MO
<i>meclofenamate sodium cap 100 mg</i>	1	MO
<i>mefenamic acid cap 250 mg</i>	1	MO
<i>meloxicam susp 7.5 mg/5ml</i>	1	MO
<i>meloxicam tab 7.5 mg</i>	1	MO
<i>meloxicam tab 15 mg</i>	1	MO
<i>nabumetone tab 500 mg</i>	1	MO
<i>nabumetone tab 750 mg</i>	1	MO
<i>naproxen sodium tab 275 mg</i>	1	MO
<i>naproxen sodium tab 550 mg</i>	1	MO
<i>naproxen tab 250 mg</i>	1	MO
<i>naproxen tab 375 mg</i>	1	MO
<i>naproxen tab 500 mg</i>	1	MO
<i>naproxen tab ec 375 mg</i>	1	MO
(Naproxen Tab Ec 375 mg) EC-NAPROXEN	1	MO
<i>naproxen tab ec 500 mg</i>	1	MO
(Naproxen Tab Ec 500 mg) EC-NAPROXEN	1	MO
<i>oxaprozin cap 300 mg</i>	1	MO
<i>oxaprozin tab 600 mg</i>	1	MO
<i>piroxicam cap 10 mg</i>	1	MO
<i>piroxicam cap 20 mg</i>	1	MO
<i>sulindac tab 150 mg</i>	1	MO
<i>sulindac tab 200 mg</i>	1	MO
<i>tolmetin sodium tab 600 mg</i>	1	MO
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA TAB 10/20 (<i>apremilast</i>)	2	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 10/20/30 (<i>apremilast</i>)	2	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 20MG (<i>apremilast</i>)	2	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 30MG (<i>apremilast</i>)	2	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
PYRIMIDINE SYNTHESIS INHIBITORS		
<i>leflunomide tab 10 mg</i>	1	MO
<i>leflunomide tab 20 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANALGESICS - NONNARCOTIC - DRUGS TO TREAT PAIN AND FEVER		
ANALGESIC COMBINATIONS		
<i>butalbital-acetaminophen tab 50-325 mg</i>	1	QL (48 tabs every 25 days)
(Butalbital-Acetaminophen Tab 50-325 mg) TENCON	1	QL (48 tabs every 25 days)
<i>butalbital-acetaminophen-caffeine tab 50-325-40 mg</i>	1	QL (48 tabs every 25 days)
(Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg) BAC	1	QL (48 tabs every 25 days)
<i>butalbital-aspirin-caffeine cap 50-325-40 mg</i>	1	QL (48 caps every 25 days)
SALICYLATES		
(Aspirin Chew Tab 81 mg) ASPIRIN CHILDRENS	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 12-59 years at risk for preeclampsia, otherwise not covered
<i>aspirin tab delayed release 81 mg</i>	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 12-59 years at risk for preeclampsia, otherwise not covered
<i>diflunisal tab 500 mg</i>	1	MO
<i>salsalate tab 750 mg</i>	1	MO
ANALGESICS - OPIOID - DRUGS TO TREAT PAIN		
OPIOID AGONISTS		
<i>codeine sulfate tab 30 mg</i>	1	PA, QL (42 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>fentanyl td patch 72hr 12 mcg/hr</i>	1	ST, QL (10 patches every 25 days); PA**
<i>fentanyl td patch 72hr 25 mcg/hr</i>	1	ST, QL (10 patches every 25 days); PA**
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	1	ST, QL (10 patches every 25 days); PA**
<i>fentanyl td patch 72hr 50 mcg/hr</i>	1	PA; High Strength Requires PA
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	1	PA; High Strength Requires PA
<i>fentanyl td patch 72hr 75 mcg/hr</i>	1	PA; High Strength Requires PA
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	1	PA; High Strength Requires PA
<i>fentanyl td patch 72hr 100 mcg/hr</i>	1	PA; High Strength Requires PA
<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	1	ST, QL (60 caps every 25 days); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>hydrocodone bitartrate cap er 12hr 20 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 30 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 40 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 50 mg</i>	1	PA; High Strength Requires PA
<i>hydrocodone bitartrate tab er 24hr deter 20 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 30 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 40 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 60 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 80 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 100 mg</i>	1	PA; High Strength Requires PA
<i>hydrocodone bitartrate tab er 24hr deter 120 mg</i>	1	PA; High Strength Requires PA
<i>hydromorphone hcl liqd 1 mg/ml</i>	1	PA, QL (600 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydromorphone hcl tab 2 mg</i>	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydromorphone hcl tab 4 mg</i>	1	PA, QL (150 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydromorphone hcl tab 8 mg</i>	1	PA, QL (60 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydromorphone hcl tab er 24hr 8 mg</i>	1	ST, QL (120 tabs every 25 days); PA**
<i>hydromorphone hcl tab er 24hr 12 mg</i>	1	ST, QL (120 tabs every 25 days); PA**
<i>hydromorphone hcl tab er 24hr 16 mg</i>	1	ST, QL (120 tabs every 25 days); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>hydromorphone hcl tab er 24hr 32 mg</i>	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>meperidine hcl oral soln 50 mg/5ml</i>	1	PA, QL (90 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>meperidine hcl tab 50 mg</i>	1	PA, QL (18 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>methadone hcl conc 10 mg/ml</i>	1	QL (30 mL every 25 days); Indicated for opioid addiction
(Methadone Hcl Conc 10 mg/ml) METHADONE HYDROCHLORIDE I	1	PA, QL (30 mL every 25 days); Indicated for opioid addiction
<i>methadone hcl soln 5 mg/5ml</i>	1	ST, QL (450 ml every 25 days); PA**
<i>methadone hcl soln 10 mg/5ml</i>	1	ST, QL (300 mL every 25 days); PA**
<i>methadone hcl tab 5 mg</i>	1	ST, QL (90 tabs every 25 days); PA**
<i>methadone hcl tab 10 mg</i>	1	ST, QL (60 tabs every 25 days); PA**
<i>methadone hcl tab for oral susp 40 mg</i>	1	QL (9 tabs every 25 days); Indicated for opioid addiction
(Methadone Hcl Tab For Oral Susp 40 mg) METHADOSE	1	QL (9 tabs every 25 days); Indicated for opioid addiction
<i>morphine sulfate beads cap er 24hr 30 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 45 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 60 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 75 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 90 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 120 mg</i>	1	PA; High Strength Requires PA
<i>morphine sulfate cap er 24hr 10 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 20 mg</i>	1	ST, QL (60 caps every 25 days); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>morphine sulfate cap er 24hr 30 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 50 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 60 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 80 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 100 mg</i>	1	PA; High Strength Requires PA
<i>morphine sulfate oral soln 10 mg/5ml</i>	1	PA, QL (900 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate oral soln 20 mg/5ml</i>	1	PA, QL (675 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (135 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate tab 15 mg</i>	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate tab 30 mg</i>	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate tab er 15 mg</i>	1	ST, QL (90 tabs every 25 days); PA**
<i>morphine sulfate tab er 30 mg</i>	1	ST, QL (90 tabs every 25 days); PA**
<i>morphine sulfate tab er 60 mg</i>	1	PA; High Strength Requires PA
<i>morphine sulfate tab er 100 mg</i>	1	PA; High Strength Requires PA
<i>morphine sulfate tab er 200 mg</i>	1	PA; High Strength Requires PA
<i>oxycodone hcl cap 5 mg</i>	1	PA, QL (180 caps every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (90 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>oxycodone hcl soln 5 mg/5ml</i>	1	PA, QL (900 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone hcl tab 5 mg</i>	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone hcl tab 10 mg</i>	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone hcl tab 15 mg</i>	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone hcl tab 20 mg</i>	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone hcl tab 30 mg</i>	1	PA, QL (60 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxymorphone hcl tab 5 mg</i>	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxymorphone hcl tab 10 mg</i>	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>tramadol hcl oral soln 5 mg/ml</i>	1	PA, QL (1800 mL every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>tramadol hcl tab 50 mg</i>	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>tramadol hcl tab er 24hr 100 mg</i>	1	ST, QL (30 tabs every 25 days); PA**; Not available under age 12

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>tramadol hcl tab er 24hr 200 mg</i>	1	PA; High Strength Requires PA; Not available under age 12
<i>tramadol hcl tab er 24hr 300 mg</i>	1	PA; High Strength Requires PA; Not available under age 12
<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	1	ST, QL (30 tabs every 25 days); PA**; Not available under age 12
<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	1	PA; High Strength Requires PA; Not available under age 12
<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	1	PA; High Strength Requires PA; Not available under age 12
OPIOID COMBINATIONS		
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	1	ST, QL (2700 mL every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>acetaminophen w/ codeine tab 300-15 mg</i>	1	ST, QL (400 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>acetaminophen w/ codeine tab 300-30 mg</i>	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>acetaminophen w/ codeine tab 300-60 mg</i>	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	1	ST, QL (300 caps every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
(Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg) TREZIX	1	ST, QL (300 caps every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg</i>	1	QL (48 caps every 25 days); Not available under age 12

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i>	1	QL (48 caps every 25 days); Not available under age 12
<i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i>	1	QL (48 caps every 25 days); Not available under age 12
(Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg) ASCOMP/CODEINE	1	QL (48 caps every 25 days); Not available under age 12
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	1	PA, QL (2700 mL every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen soln 10-325 mg/15ml</i>	1	PA, QL (2700 mL every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 2.5-325 mg</i>	1	PA, QL (240 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 5-300 mg</i>	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	1	PA, QL (240 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 7.5-300 mg</i>	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	1	PA, QL (180 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 10-300 mg</i>	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-ibuprofen tab 5-200 mg</i>	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-ibuprofen tab 10-200 mg</i>	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 2.5-325 mg) ENDOCET	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 5-325 mg) ENDOCET	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 7.5-325 mg) ENDOCET	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Oxycodone W/ Acetaminophen Tab 10-325 mg) ENDOCET	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	1	ST, QL (40 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
OPIOID PARTIAL AGONISTS		
BELBUCA MIS 75MCG (<i>buprenorphine hcl</i>)	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 150MCG (<i>buprenorphine hcl</i>)	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 300MCG (<i>buprenorphine hcl</i>)	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 450MCG (<i>buprenorphine hcl</i>)	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 600MCG (<i>buprenorphine hcl</i>)	2	PA; High Strength Requires PA
BELBUCA MIS 750MCG (<i>buprenorphine hcl</i>)	2	PA; High Strength Requires PA
BELBUCA MIS 900MCG (<i>buprenorphine hcl</i>)	2	PA; High Strength Requires PA
<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	1	
<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	1	
<i>buprenorphine td patch weekly 5 mcg/hr</i>	1	ST, QL (4 patches every month); PA**
<i>buprenorphine td patch weekly 7.5 mcg/hr</i>	1	ST, QL (4 patches every month); PA**
<i>buprenorphine td patch weekly 10 mcg/hr</i>	1	ST, QL (4 patches every month); PA**
<i>buprenorphine td patch weekly 15 mcg/hr</i>	1	PA; High Strength Requires PA
<i>buprenorphine td patch weekly 20 mcg/hr</i>	1	PA; High Strength Requires PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	1	
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
ZUBSOLV SUB 0.7-0.18 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 1.4-0.36 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 2.9-0.71 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 5.7-1.4 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 8.6-2.1 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 11.4-2.9 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	

ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES**ANDROGENS**

<i>danazol cap 50 mg</i>	1	
<i>danazol cap 100 mg</i>	1	
<i>danazol cap 200 mg</i>	1	
<i>methyltestosterone cap 10 mg</i>	1	PA, MO
(Methyltestosterone Oral Tab 10 mg) METHITEST	1	PA, MO
NATESTO GEL 5.5MG (<i>testosterone</i>)	2	PA, MO
<i>testosterone td gel 10mg/act (2%)</i>	1	PA, MO
<i>testosterone td gel 12.5 mg/act (1%)</i>	1	PA, MO
<i>testosterone td gel 20.25 mg/1.25gm (1.62%)</i>	1	PA, MO
<i>testosterone td gel 20.25 mg/act (1.62%)</i>	1	PA, MO
<i>testosterone td gel 25 mg/2.5gm (1%)</i>	1	PA, MO
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	1	PA, MO
<i>testosterone td gel 50 mg/5gm (1%)</i>	1	PA, MO
<i>testosterone td soln 30 mg/act</i>	1	PA, MO

ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS**INTRARECTAL STEROIDS**

<i>budesonide rectal foam 2 mg/act</i>	1	
CORTIFOAM AER 90MG (<i>hydrocortisone acetate (intrarectal)</i>)	2	
<i>hydrocortisone enema 100 mg/60ml</i>	1	

RECTAL COMBINATIONS

<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>	1	
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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PROCTOFOAM AER HC 1% (<i>hydrocortisone acetate w/ pramoxine</i>)	2	
RECTAL STEROIDS		
(Hydrocortisone Acetate Suppos 25 mg) ANUCORT-HC	1	
<i>hydrocortisone perianal cream 1%</i>	1	
(Hydrocortisone Perianal Cream 1%) PROCTOCORT	1	
<i>hydrocortisone perianal cream 2.5%</i>	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTO-MED HC	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTOSOL HC	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTOZONE-HC	1	
VASODILATING AGENTS		
<i>nitroglycerin oint 0.4%</i>	1	
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES		
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES		
<i>albendazole tab 200 mg</i>	1	
EMVERM CHW 100MG (<i>mebendazole</i>)	2	
<i>ivermectin tab 3 mg</i>	1	
<i>ivermectin tab 6 mg</i>	1	
<i>praziquantel tab 600 mg</i>	1	
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS		
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS		
IMPAVIDO CAP 50MG (<i>miltefosine</i>)	3	
<i>metronidazole cap 375 mg</i>	1	
<i>metronidazole tab 250 mg</i>	1	
<i>metronidazole tab 500 mg</i>	1	
<i>pentamidine isethionate for nebulization soln 300 mg</i>	1	
<i>tinidazole tab 250 mg</i>	1	
<i>tinidazole tab 500 mg</i>	1	
<i>trimethoprim tab 100 mg</i>	1	
XIFAXAN TAB 550MG (<i>rifaximin</i>)	2	MO
ANTI-INFECTIVE MISC. - COMBINATIONS		
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	1	
(Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml) SULFATRIM PEDIATRIC	1	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIPROTOZOAL AGENTS		
<i>atovaquone susp 750 mg/5ml</i>	1	
<i>nitazoxanide tab 500 mg</i>	1	
GLYCOPEPTIDES		
<i>vancomycin hcl cap 125 mg (base equivalent)</i>	1	
<i>vancomycin hcl cap 250 mg (base equivalent)</i>	1	
<i>vancomycin hcl for oral soln 25 mg/ml (base equivalent)</i>	1	
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	1	
LEPROSTATICS		
<i>dapsone tab 25 mg</i>	1	MO
<i>dapsone tab 100 mg</i>	1	MO
LINCOSAMIDES		
<i>clindamycin hcl cap 75 mg</i>	1	
<i>clindamycin hcl cap 150 mg</i>	1	
<i>clindamycin hcl cap 300 mg</i>	1	
<i>clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)</i>	1	
MONOBACTAMS		
CAYSTON INH 75MG (<i>aztreonam lysine</i>)	3	SP, PA
OXAZOLIDINONES		
<i>linezolid for susp 100 mg/5ml</i>	1	
<i>linezolid tab 600 mg</i>	1	
URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS		
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i>	1	
<i>methenamine hippurate tab 1 gm</i>	1	
<i>methenamine mandelate tab 0.5 gm</i>	1	
<i>nitrofurantoin macrocrystalline cap 25 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 50 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 100 mg</i>	1	
<i>nitrofurantoin monohydrate macrocrystalline cap 100 mg</i>	1	
<i>nitrofurantoin susp 25 mg/5ml</i>	1	
ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS		
ANTIANGINALS-OTHER		
<i>ranolazine tab er 12hr 500 mg</i>	1	MO
<i>ranolazine tab er 12hr 1000 mg</i>	1	MO
NITRATES		
<i>isosorbide dinitrate tab 5 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>isosorbide dinitrate tab 10 mg</i>	1	MO
<i>isosorbide dinitrate tab 20 mg</i>	1	MO
<i>isosorbide dinitrate tab 30 mg</i>	1	MO
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	1	MO
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	1	MO
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	1	MO
<i>nitroglycerin sl tab 0.3 mg</i>	1	MO
<i>nitroglycerin sl tab 0.4 mg</i>	1	MO
<i>nitroglycerin sl tab 0.6 mg</i>	1	MO
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	1	MO
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i>	1	MO
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	1	MO
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	1	MO
<i>nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)</i>	1	MO
ANTIANXIETY AGENTS - DRUGS TO TREAT ANXIETY		
ANTIANXIETY AGENTS - MISC.		
<i>buspirone hcl tab 5 mg</i>	1	
<i>buspirone hcl tab 7.5 mg</i>	1	
<i>buspirone hcl tab 10 mg</i>	1	
<i>buspirone hcl tab 15 mg</i>	1	
<i>buspirone hcl tab 30 mg</i>	1	
<i>hydroxyzine hcl syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl tab 10 mg</i>	1	
<i>hydroxyzine hcl tab 25 mg</i>	1	
<i>hydroxyzine hcl tab 50 mg</i>	1	
<i>hydroxyzine pamoate cap 25 mg</i>	1	
<i>hydroxyzine pamoate cap 50 mg</i>	1	
<i>hydroxyzine pamoate cap 100 mg</i>	1	
<i>meprobamate tab 200 mg</i>	1	
<i>meprobamate tab 400 mg</i>	1	
BENZODIAZEPINES		
<i>alprazolam orally disintegrating tab 0.5 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam orally disintegrating tab 0.25 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam orally disintegrating tab 1 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam orally disintegrating tab 2 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab 0.5 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab 0.25 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab 1 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab 2 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab er 24hr 0.5 mg</i>	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 0.5 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>alprazolam tab er 24hr 1 mg</i>	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 1 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
<i>alprazolam tab er 24hr 2 mg</i>	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 2 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
<i>alprazolam tab er 24hr 3 mg</i>	1	QL (90 tabs every 25 days)
(Alprazolam Tab Er 24hr 3 mg) ALPRAZOLAM XR	1	QL (90 tabs every 25 days)
<i>chlordiazepoxide hcl cap 5 mg</i>	1	QL (360 caps every 25 days)
<i>chlordiazepoxide hcl cap 10 mg</i>	1	QL (360 caps every 25 days)
<i>chlordiazepoxide hcl cap 25 mg</i>	1	QL (360 caps every 25 days)
<i>clorazepate dipotassium tab 3.75 mg</i>	1	QL (180 tabs every 25 days)
<i>clorazepate dipotassium tab 7.5 mg</i>	1	QL (180 tabs every 25 days)
<i>clorazepate dipotassium tab 15 mg</i>	1	QL (180 tabs every 25 days)
<i>diazepam conc 5 mg/ml</i>	1	QL (240 mL every 25 days)
<i>diazepam oral soln 1 mg/ml</i>	1	QL (1200 mL every 25 days)
<i>diazepam tab 2 mg</i>	1	QL (120 tabs every 25 days)
<i>diazepam tab 5 mg</i>	1	QL (120 tabs every 25 days)
<i>diazepam tab 10 mg</i>	1	QL (120 tabs every 25 days)
<i>lorazepam conc 2 mg/ml</i>	1	QL (150 mL every 25 days)
<i>lorazepam tab 0.5 mg</i>	1	QL (150 tabs every 25 days)
<i>lorazepam tab 1 mg</i>	1	QL (150 tabs every 25 days)
<i>lorazepam tab 2 mg</i>	1	QL (150 tabs every 25 days)
<i>oxazepam cap 10 mg</i>	1	QL (120 caps every 25 days)
<i>oxazepam cap 15 mg</i>	1	QL (120 caps every 25 days)
<i>oxazepam cap 30 mg</i>	1	QL (120 caps every 25 days)

ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS**ANTIARRHYTHMICS TYPE I-A**

<i>disopyramide phosphate cap 100 mg</i>	1	MO
<i>disopyramide phosphate cap 150 mg</i>	1	MO
<i>quinidine gluconate tab er 324 mg</i>	1	MO

ANTIARRHYTHMICS TYPE I-B

<i>mexiletine hcl cap 150 mg</i>	1	MO
<i>mexiletine hcl cap 200 mg</i>	1	MO
<i>mexiletine hcl cap 250 mg</i>	1	MO

ANTIARRHYTHMICS TYPE I-C

<i>flecainide acetate tab 50 mg</i>	1	MO
<i>flecainide acetate tab 100 mg</i>	1	MO
<i>flecainide acetate tab 150 mg</i>	1	MO
<i>propafenone hcl cap er 12hr 225 mg</i>	1	MO
<i>propafenone hcl cap er 12hr 325 mg</i>	1	MO
<i>propafenone hcl cap er 12hr 425 mg</i>	1	MO
<i>propafenone hcl tab 150 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>propafenone hcl tab 225 mg</i>	1	MO
<i>propafenone hcl tab 300 mg</i>	1	MO
ANTIARRHYTHMICS TYPE III		
<i>amiodarone hcl tab 100 mg</i>	1	MO
(Amiodarone Hcl Tab 100 mg) PACERONE	1	MO
<i>amiodarone hcl tab 200 mg</i>	1	MO
(Amiodarone Hcl Tab 200 mg) PACERONE	1	MO
<i>amiodarone hcl tab 400 mg</i>	1	MO
(Amiodarone Hcl Tab 400 mg) PACERONE	1	MO
<i>dofetilide cap 125 mcg (0.125 mg)</i>	1	SP, PA
<i>dofetilide cap 250 mcg (0.25 mg)</i>	1	SP, PA
<i>dofetilide cap 500 mcg (0.5 mg)</i>	1	SP, PA
MULTAQ TAB 400MG (<i>dronedarone hcl</i>)	2	MO
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE		
ANTI-INFLAMMATORY AGENTS		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	QL (720 mL every 75 days), MO
BRONCHODILATORS - ANTICHOLINERGICS		
<i>ipratropium bromide inhal soln 0.02%</i>	1	QL (938 mL every 75 days), MO
SPIRIVA AER 1.25MCG (<i>tiotropium bromide monohydrate</i>)	2	QL (3 inhalers every 75 days), MO
SPIRIVA CAP HANDIHLR (<i>tiotropium bromide monohydrate</i>)	2	QL (90 caps every 75 days), MO
SPIRIVA SPR 2.5MCG (<i>tiotropium bromide monohydrate</i>)	2	QL (3 inhalers every 75 days), MO
YUPELRI SOL (<i>revefenacin</i>)	2	QL (270 mL every 75 days), MO
LEUKOTRIENE MODULATORS		
<i>montelukast sodium chew tab 4 mg (base equiv)</i>	1	MO
<i>montelukast sodium chew tab 5 mg (base equiv)</i>	1	MO
<i>montelukast sodium oral granules packet 4 mg (base equiv)</i>	1	MO
<i>montelukast sodium tab 10 mg (base equiv)</i>	1	MO
<i>zafirlukast tab 10 mg</i>	1	MO
<i>zafirlukast tab 20 mg</i>	1	MO
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
<i>roflumilast tab 250 mcg</i>	1	MO
<i>roflumilast tab 500 mcg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
STEROID INHALANTS		
ASMANEX HFA AER 50MCG (<i>mometasone furoate (inhalation)</i>)	2	QL (3 inhalers every 75 days), MO
ASMANEX HFA AER 100 MCG (<i>mometasone furoate (inhalation)</i>)	2	QL (3 inhalers every 75 days), MO
ASMANEX HFA AER 200 MCG (<i>mometasone furoate (inhalation)</i>)	2	QL (3 inhalers every 75 days), MO
<i>budesonide inhalation susp 0.5 mg/2ml</i>	1	QL (360 mL every 75 days), MO
<i>budesonide inhalation susp 0.25 mg/2ml</i>	1	QL (540 mL every 75 days), MO
<i>budesonide inhalation susp 1 mg/2ml</i>	1	QL (180 mL every 75 days), MO
<i>fluticasone propionate hfa inhal aer 110 mcg/act</i>	3	QL (6 inhalers every 75 days), MO
<i>fluticasone propionate hfa inhal aer 220 mcg/act</i>	3	QL (6 inhalers every 75 days), MO
<i>fluticasone propionate hfa inhal aero 44 mcg/act</i>	3	QL (6 inhalers every 75 days), MO
PULMICORT INH 90MCG (<i>budesonide (inhalation)</i>)	2	QL (9 inhalers every 75 days), MO
PULMICORT INH 180MCG (<i>budesonide (inhalation)</i>)	2	QL (6 inhalers every 75 days), MO
SYMPATHOMIMETICS		
AIRSUPRA AER 90-80MCG (<i>albuterol-budesonide</i>)	2	QL (9 inhalers every 75 days)
<i>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)</i>	1	QL (6 inhalers every 75 days), MO
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	1	QL (180 mL every 75 days), MO
<i>albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (1125 mL every 75 days), MO
<i>albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)</i>	1	QL (1125 mL every 75 days), MO
<i>albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (1125 mL every 75 days), MO
<i>albuterol sulfate syrup 2 mg/5ml</i>	1	MO
<i>albuterol sulfate tab 2 mg</i>	1	MO
<i>albuterol sulfate tab 4 mg</i>	1	MO
ANORO ELLIPT AER 62.5-25 (<i>umeclidinium-vilanterol</i>)	2	QL (180 blisters every 75 days), MO
<i>arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)</i>	1	QL (360 mL every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BREO ELLIPTA INH 50-25MCG (<i>fluticasone furoate-vilanterol</i>)	2	QL (3 inhalers every 75 days), MO
BREO ELLIPTA INH 100-25 (<i>fluticasone furoate-vilanterol</i>)	2	QL (180 blisters every 75 days), MO
BREO ELLIPTA INH 200-25 (<i>fluticasone furoate-vilanterol</i>)	2	QL (180 blisters every 75 days), MO
BREZTRI AERO AER SPHERE (<i>budesonide-glycopyrrolate-formoterol fumarate</i>)	2	QL (3 inhalers every 75 days), MO
<i>budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act</i>	1	QL (9 inhalers every 75 days), MO
(Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 mcg/act) BREYNA	1	QL (9 inhalers every 75 days), MO
<i>budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act</i>	1	QL (9 inhalers every 75 days), MO
(Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 mcg/act) BREYNA	1	QL (9 inhalers every 75 days), MO
<i>fluticasone-salmeterol aer powder ba 100-50 mcg/act</i>	1	QL (180 inhalations every 75 days), MO
(Fluticasone-Salmeterol Aer Powder Ba 100-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
<i>fluticasone-salmeterol aer powder ba 250-50 mcg/act</i>	1	QL (180 inhalations every 75 days), MO
(Fluticasone-Salmeterol Aer Powder Ba 250-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
<i>fluticasone-salmeterol aer powder ba 500-50 mcg/act</i>	1	QL (180 inhalations every 75 days), MO
(Fluticasone-Salmeterol Aer Powder Ba 500-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	1	QL (360 mL every 75 days), MO
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	1	QL (1620 mL every 75 days), MO
<i>levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i>	1	QL (900 mL every 75 days), MO
<i>levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (900 mL every 75 days), MO
<i>levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (900 mL every 75 days), MO
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i>	1	QL (270 mL every 75 days), MO
<i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i>	1	QL (6 inhalers every 75 days), MO
SEREVENT DIS AER 50MCG (<i>salmeterol xinafoate</i>)	2	QL (180 inhalations every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
STIOLTO AER 2.5-2.5 (<i>tiotropium bromide-olodaterol hcl</i>)	2	QL (3 inhalers every 75 days), MO
STRIVERDI AER 2.5MCG (<i>olodaterol hcl</i>)	2	QL (3 inhalers every 75 days), MO
<i>terbutaline sulfate tab 2.5 mg</i>	1	MO
<i>terbutaline sulfate tab 5 mg</i>	1	MO
TRELEGY AER 100MCG (<i>fluticasone-umeclidinium-vilanterol</i>)	2	QL (3 inhalers every 75 days), MO
TRELEGY AER 200MCG (<i>fluticasone-umeclidinium-vilanterol</i>)	2	QL (3 inhalers every 75 days), MO
XANTHINES		
<i>theophylline elixir 80 mg/15ml</i>	1	MO
(Theophylline Elixir 80 mg/15ml) ELIXOPHYLLIN	1	MO
<i>theophylline soln 80 mg/15ml</i>	1	MO
<i>theophylline tab er 12hr 300 mg</i>	1	MO
<i>theophylline tab er 12hr 450 mg</i>	1	MO
<i>theophylline tab er 24hr 400 mg</i>	1	MO
<i>theophylline tab er 24hr 600 mg</i>	1	MO
ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS		
COUMARIN ANTICOAGULANTS		
<i>warfarin sodium tab 1 mg</i>	1	MO
(Warfarin Sodium Tab 1 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 2 mg</i>	1	MO
(Warfarin Sodium Tab 2 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 2.5 mg</i>	1	MO
(Warfarin Sodium Tab 2.5 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 3 mg</i>	1	MO
(Warfarin Sodium Tab 3 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 4 mg</i>	1	MO
(Warfarin Sodium Tab 4 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 5 mg</i>	1	MO
(Warfarin Sodium Tab 5 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 6 mg</i>	1	MO
(Warfarin Sodium Tab 6 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 7.5 mg</i>	1	MO
(Warfarin Sodium Tab 7.5 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 10 mg</i>	1	MO
(Warfarin Sodium Tab 10 mg) JANTOVEN	1	MO
DIRECT FACTOR XA INHIBITORS		
ELIQUIS ST P TAB 5MG (<i>apixaban</i>)	2	
ELIQUIS TAB 2.5MG (<i>apixaban</i>)	2	MO
ELIQUIS TAB 5MG (<i>apixaban</i>)	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>rivaroxaban tab 2.5 mg</i>	1	MO
XARELTO STAR TAB 15/20MG (<i>rivaroxaban</i>)	2	
XARELTO SUS 1MG/ML (<i>rivaroxaban</i>)	2	MO
XARELTO TAB 2.5MG (<i>rivaroxaban</i>)	2	MO
XARELTO TAB 10MG (<i>rivaroxaban</i>)	2	MO
XARELTO TAB 15MG (<i>rivaroxaban</i>)	2	MO
XARELTO TAB 20MG (<i>rivaroxaban</i>)	2	MO
THROMBIN INHIBITORS		
<i>dabigatran etexilate mesylate cap 75 mg (etexilate base eq)</i>	1	MO
<i>dabigatran etexilate mesylate cap 110 mg (etexilate base eq)</i>	1	MO
<i>dabigatran etexilate mesylate cap 150 mg (etexilate base eq)</i>	1	MO
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA SUS 0.5MG/ML (<i>perampanel</i>)	2	MO
FYCOMPA TAB 2MG (<i>perampanel</i>)	2	MO
FYCOMPA TAB 4MG (<i>perampanel</i>)	2	MO
FYCOMPA TAB 6MG (<i>perampanel</i>)	2	MO
FYCOMPA TAB 8MG (<i>perampanel</i>)	2	MO
FYCOMPA TAB 10MG (<i>perampanel</i>)	2	MO
FYCOMPA TAB 12MG (<i>perampanel</i>)	2	MO
ANTICONVULSANTS - BENZODIAZEPINES		
<i>clobazam suspension 2.5 mg/ml</i>	1	MO
<i>clobazam tab 10 mg</i>	1	MO
<i>clobazam tab 20 mg</i>	1	MO
<i>clonazepam orally disintegrating tab 0.5 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam orally disintegrating tab 0.25 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam orally disintegrating tab 0.125 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam orally disintegrating tab 1 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam orally disintegrating tab 2 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam tab 0.5 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam tab 1 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam tab 2 mg</i>	1	QL (300 tabs every 25 days)
<i>diazepam rectal gel delivery system 2.5 mg</i>	1	
<i>diazepam rectal gel delivery system 10 mg</i>	1	
<i>diazepam rectal gel delivery system 20 mg</i>	1	
NAYZILAM SPR 5MG (<i>midazolam (anticonvulsant)</i>)	2	
VALTOCO SPR 5MG (<i>diazepam (anticonvulsant)</i>)	2	
VALTOCO SPR 10MG (<i>diazepam (anticonvulsant)</i>)	2	
VALTOCO SPR 15MG (<i>diazepam (anticonvulsant)</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VALTOCO SPR 20MG (<i>diazepam (anticonvulsant)</i>)	2	
ANTICONVULSANTS - MISC.		
APTiom TAB 200MG (<i>eslicarbazepine acetate</i>)	2	MO
APTiom TAB 400MG (<i>eslicarbazepine acetate</i>)	2	MO
APTiom TAB 600MG (<i>eslicarbazepine acetate</i>)	2	MO
APTiom TAB 800MG (<i>eslicarbazepine acetate</i>)	2	MO
BRIVIACT SOL 10MG/ML (<i>brivaracetam</i>)	2	MO
BRIVIACT TAB 10MG (<i>brivaracetam</i>)	2	MO
BRIVIACT TAB 25MG (<i>brivaracetam</i>)	2	MO
BRIVIACT TAB 50MG (<i>brivaracetam</i>)	2	MO
BRIVIACT TAB 75MG (<i>brivaracetam</i>)	2	MO
BRIVIACT TAB 100MG (<i>brivaracetam</i>)	2	MO
<i>carbamazepine cap er 12hr 100 mg</i>	1	MO
<i>carbamazepine cap er 12hr 200 mg</i>	1	MO
<i>carbamazepine cap er 12hr 300 mg</i>	1	MO
<i>carbamazepine chew tab 100 mg</i>	1	MO
<i>carbamazepine chew tab 200 mg</i>	1	MO
<i>carbamazepine susp 100 mg/5ml</i>	1	MO
<i>carbamazepine tab 200 mg</i>	1	MO
(Carbamazepine Tab 200 mg) EPITOL	1	MO
<i>carbamazepine tab er 12hr 100 mg</i>	1	MO
<i>carbamazepine tab er 12hr 200 mg</i>	1	MO
<i>carbamazepine tab er 12hr 400 mg</i>	1	MO
<i>gabapentin cap 100 mg</i>	1	MO
<i>gabapentin cap 300 mg</i>	1	MO
<i>gabapentin cap 400 mg</i>	1	MO
<i>gabapentin oral soln 250 mg/5ml</i>	1	MO
<i>gabapentin tab 600 mg</i>	1	MO
<i>gabapentin tab 800 mg</i>	1	MO
<i>lacosamide oral solution 10 mg/ml</i>	1	MO
<i>lacosamide tab 50 mg</i>	1	MO
<i>lacosamide tab 100 mg</i>	1	MO
<i>lacosamide tab 150 mg</i>	1	MO
<i>lacosamide tab 200 mg</i>	1	MO
<i>lamotrigine orally disintegrating tab 25 mg</i>	1	MO
<i>lamotrigine orally disintegrating tab 50 mg</i>	1	MO
<i>lamotrigine orally disintegrating tab 100 mg</i>	1	MO
<i>lamotrigine orally disintegrating tab 200 mg</i>	1	MO
<i>lamotrigine tab 25 mg</i>	1	MO
(Lamotrigine Tab 25 mg) SUBVENITE	1	MO
<i>lamotrigine tab 25 mg (42) & 100 mg (7) starter kit</i>	1	

PREScription DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit) SUBVENITE STARTER KIT/ORA	1	
lamotrigine tab 35 x 25 mg starter kit	1	
(Lamotrigine Tab 35 X 25 mg Starter Kit) SUBVENITE STARTER KIT/BLU	1	
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit	1	
(Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit) SUBVENITE STARTER KIT/GRE	1	
lamotrigine tab 100 mg	1	MO
(Lamotrigine Tab 100 mg) SUBVENITE	1	MO
lamotrigine tab 150 mg	1	MO
(Lamotrigine Tab 150 mg) SUBVENITE	1	MO
lamotrigine tab 200 mg	1	MO
(Lamotrigine Tab 200 mg) SUBVENITE	1	MO
lamotrigine tab chewable dispersible 5 mg	1	MO
lamotrigine tab chewable dispersible 25 mg	1	MO
lamotrigine tab disint 21 x 25 mg & 7 x 50 mg titration kit	1	
lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit	1	
lamotrigine tab disint 42 x 50mg & 14 x 100mg titration kit	1	
lamotrigine tab er 24hr 25 mg	1	MO
lamotrigine tab er 24hr 50 mg	1	MO
lamotrigine tab er 24hr 100 mg	1	MO
lamotrigine tab er 24hr 200 mg	1	MO
lamotrigine tab er 24hr 250 mg	1	MO
lamotrigine tab er 24hr 300 mg	1	MO
levetiracetam oral soln 100 mg/ml	1	MO
levetiracetam tab 250 mg	1	MO
levetiracetam tab 500 mg	1	MO
(Levetiracetam Tab 500 mg) ROWEEPRA	1	MO
levetiracetam tab 750 mg	1	MO
levetiracetam tab 1000 mg	1	MO
levetiracetam tab er 24hr 500 mg	1	MO
levetiracetam tab er 24hr 750 mg	1	MO
oxcarbazepine susp 300 mg/5ml (60 mg/ml)	1	MO
oxcarbazepine tab 150 mg	1	MO
oxcarbazepine tab 300 mg	1	MO
oxcarbazepine tab 600 mg	1	MO
oxcarbazepine tab er 24hr 150 mg	1	MO
oxcarbazepine tab er 24hr 300 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>oxcarbazepine tab er 24hr 600 mg</i>	1	MO
OXTELLAR XR TAB 150MG (<i>oxcarbazepine</i>)	2	MO
OXTELLAR XR TAB 300MG (<i>oxcarbazepine</i>)	2	MO
OXTELLAR XR TAB 600MG (<i>oxcarbazepine</i>)	2	MO
<i>pregabalin cap 25 mg</i>	1	MO
<i>pregabalin cap 50 mg</i>	1	MO
<i>pregabalin cap 75 mg</i>	1	MO
<i>pregabalin cap 100 mg</i>	1	MO
<i>pregabalin cap 150 mg</i>	1	MO
<i>pregabalin cap 200 mg</i>	1	MO
<i>pregabalin cap 225 mg</i>	1	MO
<i>pregabalin cap 300 mg</i>	1	MO
<i>pregabalin soln 20 mg/ml</i>	1	MO
<i>primidone tab 50 mg</i>	1	MO
<i>primidone tab 250 mg</i>	1	MO
<i>rufinamide susp 40 mg/ml</i>	1	MO
<i>rufinamide tab 200 mg</i>	1	MO
<i>rufinamide tab 400 mg</i>	1	MO
<i>topiramate cap er 24hr 25 mg</i>	1	MO
<i>topiramate cap er 24hr 50 mg</i>	1	MO
<i>topiramate cap er 24hr 100 mg</i>	1	MO
<i>topiramate cap er 24hr 200 mg</i>	1	MO
<i>topiramate sprinkle cap 15 mg</i>	1	MO
<i>topiramate sprinkle cap 25 mg</i>	1	MO
<i>topiramate sprinkle cap 50 mg</i>	1	MO
<i>topiramate tab 25 mg</i>	1	MO
<i>topiramate tab 50 mg</i>	1	MO
<i>topiramate tab 100 mg</i>	1	MO
<i>topiramate tab 200 mg</i>	1	MO
<i>zonisamide cap 25 mg</i>	1	MO
<i>zonisamide cap 50 mg</i>	1	MO
<i>zonisamide cap 100 mg</i>	1	MO
CARBAMATES		
<i>felbamate susp 600 mg/5ml</i>	1	MO
<i>felbamate tab 400 mg</i>	1	MO
<i>felbamate tab 600 mg</i>	1	MO
XCOPRI PAK 12.5-25 (<i>cenobamate</i>)	2	
XCOPRI PAK 50-100MG (<i>cenobamate</i>)	2	
XCOPRI PAK 100-150 (<i>cenobamate</i>)	2	MO
XCOPRI PAK 150-200 (<i>cenobamate</i>)	2	
XCOPRI PAK 150-200 (<i>cenobamate</i>)	2	MO
XCOPRI TAB 25MG (<i>cenobamate</i>)	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XCOPRI TAB 50MG (<i>cenobamate</i>)	2	MO
XCOPRI TAB 100MG (<i>cenobamate</i>)	2	MO
XCOPRI TAB 150MG (<i>cenobamate</i>)	2	MO
XCOPRI TAB 200MG (<i>cenobamate</i>)	2	MO
GABA MODULATORS		
<i>tiagabine hcl tab 2 mg</i>	1	MO
<i>tiagabine hcl tab 4 mg</i>	1	MO
<i>tiagabine hcl tab 12 mg</i>	1	MO
<i>tiagabine hcl tab 16 mg</i>	1	MO
<i>vigabatrin powd pack 500 mg</i>	1	SP, PA, QL (6 packets every 1 day)
(Vigabatrin Powd Pack 500 mg) VIGADRONE	1	SP, PA, QL (6 packets every 1 day)
(Vigabatrin Powd Pack 500 mg) VIGPODER	1	SP, PA, QL (6 packets every 1 day)
<i>vigabatrin tab 500 mg</i>	1	SP, PA, QL (6 tabs every 1 day)
HYDANTOINS		
<i>phenytoin chew tab 50 mg</i>	1	MO
<i>phenytoin sodium extended cap 100 mg</i>	1	MO
<i>phenytoin sodium extended cap 200 mg</i>	1	MO
<i>phenytoin sodium extended cap 300 mg</i>	1	MO
<i>phenytoin susp 125 mg/5ml</i>	1	MO
SUCCINIMIDES		
<i>ethosuximide cap 250 mg</i>	1	MO
<i>ethosuximide soln 250 mg/5ml</i>	1	MO
<i>methsuximide cap 300 mg</i>	1	MO
VALPROIC ACID		
<i>divalproex sodium cap delayed release sprinkle 125 mg</i>	1	MO
<i>divalproex sodium tab delayed release 125 mg</i>	1	MO
<i>divalproex sodium tab delayed release 250 mg</i>	1	MO
<i>divalproex sodium tab delayed release 500 mg</i>	1	MO
<i>divalproex sodium tab er 24 hr 250 mg</i>	1	MO
<i>divalproex sodium tab er 24 hr 500 mg</i>	1	MO
<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	1	MO
<i>valproic acid cap 250 mg</i>	1	MO
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
<i>mirtazapine orally disintegrating tab 15 mg</i>	1	MO
<i>mirtazapine orally disintegrating tab 30 mg</i>	1	MO
<i>mirtazapine orally disintegrating tab 45 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>mirtazapine tab 7.5 mg</i>	1	MO
<i>mirtazapine tab 15 mg</i>	1	MO
<i>mirtazapine tab 30 mg</i>	1	MO
<i>mirtazapine tab 45 mg</i>	1	MO
ANTIDEPRESSANTS - MISC.		
<i>bupropion hcl tab 75 mg</i>	1	MO
<i>bupropion hcl tab 100 mg</i>	1	MO
<i>bupropion hcl tab er 12hr 100 mg</i>	1	MO
<i>bupropion hcl tab er 12hr 150 mg</i>	1	MO
<i>bupropion hcl tab er 12hr 200 mg</i>	1	MO
<i>bupropion hcl tab er 24hr 150 mg</i>	1	MO
<i>bupropion hcl tab er 24hr 300 mg</i>	1	MO
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID		
ZURZUVAE CAP 20MG (<i>zuranolone</i>)	2	SP, PA, QL (2 caps every 1 day)
ZURZUVAE CAP 25MG (<i>zuranolone</i>)	2	SP, PA, QL (2 caps every 1 day)
ZURZUVAE CAP 30MG (<i>zuranolone</i>)	2	SP, PA, QL (1 cap every 1 day)
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
<i>phenelzine sulfate tab 15 mg</i>	1	MO
<i>tranylcypromine sulfate tab 10 mg</i>	1	MO
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
<i>citalopram hydrobromide oral soln 10 mg/5ml</i>	1	MO
<i>citalopram hydrobromide tab 10 mg (base equiv)</i>	1	MO
<i>citalopram hydrobromide tab 20 mg (base equiv)</i>	1	MO
<i>citalopram hydrobromide tab 40 mg (base equiv)</i>	1	MO
<i>escitalopram oxalate soln 5 mg/5ml (base equiv)</i>	1	MO
<i>escitalopram oxalate tab 5 mg (base equiv)</i>	1	MO
<i>escitalopram oxalate tab 10 mg (base equiv)</i>	1	MO
<i>escitalopram oxalate tab 20 mg (base equiv)</i>	1	MO
<i>fluoxetine hcl cap 10 mg</i>	1	MO
<i>fluoxetine hcl cap 20 mg</i>	1	MO
<i>fluoxetine hcl cap 40 mg</i>	1	MO
<i>fluoxetine hcl cap delayed release 90 mg</i>	1	MO
<i>fluoxetine hcl solution 20 mg/5ml</i>	1	MO
<i>fluoxetine hcl tab 10 mg</i>	1	MO
<i>fluoxetine hcl tab 20 mg</i>	1	MO
<i>fluvoxamine maleate cap er 24hr 100 mg</i>	1	MO
<i>fluvoxamine maleate cap er 24hr 150 mg</i>	1	MO
<i>fluvoxamine maleate tab 25 mg</i>	1	MO
<i>fluvoxamine maleate tab 50 mg</i>	1	MO
<i>fluvoxamine maleate tab 100 mg</i>	1	MO
<i>paroxetine hcl oral susp 10 mg/5ml (base equiv)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>paroxetine hcl tab 10 mg</i>	1	MO
<i>paroxetine hcl tab 20 mg</i>	1	MO
<i>paroxetine hcl tab 30 mg</i>	1	MO
<i>paroxetine hcl tab 40 mg</i>	1	MO
<i>paroxetine hcl tab er 24hr 12.5 mg</i>	1	MO
<i>paroxetine hcl tab er 24hr 25 mg</i>	1	MO
<i>paroxetine hcl tab er 24hr 37.5 mg</i>	1	MO
<i>sertraline hcl oral concentrate for solution 20 mg/ml</i>	1	MO
<i>sertraline hcl tab 25 mg</i>	1	MO
<i>sertraline hcl tab 50 mg</i>	1	MO
<i>sertraline hcl tab 100 mg</i>	1	MO
SEROTONIN MODULATORS		
<i>nefazodone hcl tab 50 mg</i>	1	MO
<i>nefazodone hcl tab 100 mg</i>	1	MO
<i>nefazodone hcl tab 150 mg</i>	1	MO
<i>nefazodone hcl tab 200 mg</i>	1	MO
<i>nefazodone hcl tab 250 mg</i>	1	MO
<i>trazodone hcl tab 50 mg</i>	1	MO
<i>trazodone hcl tab 100 mg</i>	1	MO
<i>trazodone hcl tab 150 mg</i>	1	MO
<i>trazodone hcl tab 300 mg</i>	1	MO
TRINTELLIX TAB 5MG (<i>vortioxetine hbr</i>)	2	MO
TRINTELLIX TAB 10MG (<i>vortioxetine hbr</i>)	2	MO
TRINTELLIX TAB 20MG (<i>vortioxetine hbr</i>)	2	MO
<i>vilazodone hcl tab 10 mg</i>	1	MO
<i>vilazodone hcl tab 20 mg</i>	1	MO
<i>vilazodone hcl tab 40 mg</i>	1	MO
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv)</i>	1	MO
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv)</i>	1	MO
<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	1	MO
<i>duloxetine hcl enteric coated pellets cap 20 mg (base eq)</i>	1	MO
<i>duloxetine hcl enteric coated pellets cap 30 mg (base eq)</i>	1	MO
<i>duloxetine hcl enteric coated pellets cap 40 mg (base eq)</i>	1	MO
<i>duloxetine hcl enteric coated pellets cap 60 mg (base eq)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 100 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	1	MO
TRICYCLIC AGENTS		
<i>amitriptyline hcl tab 10 mg</i>	1	MO
<i>amitriptyline hcl tab 25 mg</i>	1	MO
<i>amitriptyline hcl tab 50 mg</i>	1	MO
<i>amitriptyline hcl tab 75 mg</i>	1	MO
<i>amitriptyline hcl tab 100 mg</i>	1	MO
<i>amitriptyline hcl tab 150 mg</i>	1	MO
<i>amoxapine tab 25 mg</i>	1	MO
<i>amoxapine tab 50 mg</i>	1	MO
<i>amoxapine tab 100 mg</i>	1	MO
<i>amoxapine tab 150 mg</i>	1	MO
<i>clomipramine hcl cap 25 mg</i>	1	MO
<i>clomipramine hcl cap 50 mg</i>	1	MO
<i>clomipramine hcl cap 75 mg</i>	1	MO
<i>desipramine hcl tab 10 mg</i>	1	MO
<i>desipramine hcl tab 25 mg</i>	1	MO
<i>desipramine hcl tab 50 mg</i>	1	MO
<i>desipramine hcl tab 75 mg</i>	1	MO
<i>desipramine hcl tab 100 mg</i>	1	MO
<i>desipramine hcl tab 150 mg</i>	1	MO
<i>doxepin hcl cap 10 mg</i>	1	MO
<i>doxepin hcl cap 25 mg</i>	1	MO
<i>doxepin hcl cap 50 mg</i>	1	MO
<i>doxepin hcl cap 75 mg</i>	1	MO
<i>doxepin hcl cap 100 mg</i>	1	MO
<i>doxepin hcl cap 150 mg</i>	1	MO
<i>doxepin hcl conc 10 mg/ml</i>	1	MO
<i>imipramine hcl tab 10 mg</i>	1	MO
<i>imipramine hcl tab 25 mg</i>	1	MO
<i>imipramine hcl tab 50 mg</i>	1	MO
<i>imipramine pamoate cap 75 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>imipramine pamoate cap 100 mg</i>	1	MO
<i>imipramine pamoate cap 125 mg</i>	1	MO
<i>imipramine pamoate cap 150 mg</i>	1	MO
<i>nortriptyline hcl cap 10 mg</i>	1	MO
<i>nortriptyline hcl cap 25 mg</i>	1	MO
<i>nortriptyline hcl cap 50 mg</i>	1	MO
<i>nortriptyline hcl cap 75 mg</i>	1	MO
<i>nortriptyline hcl soln 10 mg/5ml</i>	1	MO
<i>protriptyline hcl tab 5 mg</i>	1	MO
<i>protriptyline hcl tab 10 mg</i>	1	MO
<i>trimipramine maleate cap 25 mg</i>	1	MO
<i>trimipramine maleate cap 50 mg</i>	1	MO
<i>trimipramine maleate cap 100 mg</i>	1	MO
ANTIDIABETICS - DRUGS TO TREAT DIABETES		
ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose tab 25 mg</i>	1	MO
<i>acarbose tab 50 mg</i>	1	MO
<i>acarbose tab 100 mg</i>	1	MO
<i>miglitol tab 25 mg</i>	1	MO
<i>miglitol tab 50 mg</i>	1	MO
<i>miglitol tab 100 mg</i>	1	MO
ANTIDIABETIC - AMYLIN ANALOGS		
SYMLINPEN 60 INJ 1000MCG (<i>pramlintide acetate</i>)	2	MO
SYMLINPEN 120 INJ 1000MCG (<i>pramlintide acetate</i>)	2	MO
ANTIDIABETIC COMBINATIONS		
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	1	MO
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	1	MO
<i>glipizide-metformin hcl tab 5-500 mg</i>	1	MO
<i>glyburide-metformin tab 1.25-250 mg</i>	1	MO
<i>glyburide-metformin tab 2.5-500 mg</i>	1	MO
<i>glyburide-metformin tab 5-500 mg</i>	1	MO
GLYXAMBI TAB 10-5 MG (<i>empagliflozin-linagliptin</i>)	2	MO
GLYXAMBI TAB 25-5 MG (<i>empagliflozin-linagliptin</i>)	2	MO
<i>pioglitazone hcl-glimepiride tab 30-2 mg</i>	1	MO
<i>pioglitazone hcl-glimepiride tab 30-4 mg</i>	1	MO
<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	1	MO
<i>pioglitazone hcl-metformin hcl tab 15-850 mg</i>	1	MO
<i>saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg</i>	1	MO
<i>saxagliptin-metformin hcl tab er 24hr 5-500 mg</i>	1	MO
<i>saxagliptin-metformin hcl tab er 24hr 5-1000 mg</i>	1	MO
SOLIQUA INJ 100/33 (<i>insulin glargine-lixisenatide</i>)	2	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SYNJARDY TAB (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY TAB 5-500MG (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY TAB 5-1000MG (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY TAB 12.5-500 (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY XR TAB (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY XR TAB 5-1000MG (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY XR TAB 10-1000 (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY XR TAB 25-1000 (<i>empagliflozin-metformin hcl</i>)	2	MO
TRIARDY XR TAB (<i>empagliflozin-linagliptin-metformin</i>)	2	MO
XIGDUO XR TAB 2.5-1000 (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XIGDUO XR TAB 5-500MG (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XIGDUO XR TAB 5-1000MG (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XIGDUO XR TAB 10-500MG (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XIGDUO XR TAB 10-1000 (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XULTOPHY INJ 100/3.6 (<i>insulin degludec-liraglutide</i>)	2	PA, MO
ZITUVIMET TAB 50-500MG (<i>sitagliptin free base-metformin hcl</i>)	2	MO
ZITUVIMET TAB 50-1000 (<i>sitagliptin free base-metformin hcl</i>)	2	MO
ZITUVIMET XR TAB 50-500MG (<i>sitagliptin free base-metformin hcl</i>)	2	MO
ZITUVIMET XR TAB 50-1000 (<i>sitagliptin free base-metformin hcl</i>)	2	MO
ZITUVIMET XR TAB 100-1000 (<i>sitagliptin free base-metformin hcl</i>)	2	MO
BIGUANIDES		
<i>metformin hcl oral soln 500 mg/5ml</i>	1	MO
<i>metformin hcl tab 500 mg</i>	1	MO
<i>metformin hcl tab 850 mg</i>	1	MO
<i>metformin hcl tab 1000 mg</i>	1	MO
<i>metformin hcl tab er 24hr 500 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>metformin hcl tab er 24hr 750 mg</i>	1	MO
DIABETIC OTHER		
BAQSIMI ONE POW 3MG/DOSE (<i>glucagon</i>)	2	
BAQSIMI TWO POW 3MG/DOSE (<i>glucagon</i>)	2	
<i>diazoxide susp 50 mg/ml</i>	1	MO
<i>glucagon (rdna) for inj kit 1 mg</i>	1	
GVOKE HYPO 1 INJ 0.5/.1ML (<i>glucagon</i>)	2	
GVOKE HYPO 1 INJ 1/0.2ML (<i>glucagon</i>)	2	
GVOKE HYPO 2 INJ 0.5/.1ML (<i>glucagon</i>)	2	
GVOKE HYPO 2 INJ 1/0.2ML (<i>glucagon</i>)	2	
GVOKE KIT SOL 1/0.2ML (<i>glucagon</i>)	2	
GVOKE PFS INJ 1/0.2ML (<i>glucagon</i>)	2	
<i>mifepristone tab 300 mg</i>	1	SP, PA, QL (4 tabs every 1 day)
ZEGALOGUE INJ 0.6/0.6 (<i>dasiglucagon hcl</i>)	2	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
<i>saxagliptin hcl tab 2.5 mg (base equiv)</i>	1	MO
<i>saxagliptin hcl tab 5 mg (base equiv)</i>	1	MO
ZITUVIO TAB 25MG (<i>sitagliptin</i>)	2	MO
ZITUVIO TAB 50MG (<i>sitagliptin</i>)	2	MO
ZITUVIO TAB 100MG (<i>sitagliptin</i>)	2	MO
INCRETIN MIMETIC AGENTS		
<i>liraglutide soln pen-injector 18 mg/3ml (6 mg/ml)</i>	1	PA, MO
MOUNJARO INJ 2.5/0.5 (<i>tirzepatide</i>)	2	PA
MOUNJARO INJ 5MG/0.5 (<i>tirzepatide</i>)	2	PA, MO
MOUNJARO INJ 7.5/0.5 (<i>tirzepatide</i>)	2	PA, MO
MOUNJARO INJ 10MG/0.5 (<i>tirzepatide</i>)	2	PA, MO
MOUNJARO INJ 12.5/0.5 (<i>tirzepatide</i>)	2	PA, MO
MOUNJARO INJ 15MG/0.5 (<i>tirzepatide</i>)	2	PA, MO
OZEMPIC INJ 2MG/3ML (<i>semaglutide</i>)	2	PA, MO
OZEMPIC INJ 4MG/3ML (<i>semaglutide</i>)	2	PA, MO
OZEMPIC INJ 8MG/3ML (<i>semaglutide</i>)	2	PA, MO
RYBELSUS TAB 3MG (<i>semaglutide</i>)	2	PA, MO
RYBELSUS TAB 7MG (<i>semaglutide</i>)	2	PA, MO
RYBELSUS TAB 14MG (<i>semaglutide</i>)	2	PA, MO
TRULICITY INJ 0.75/0.5 (<i>dulaglutide</i>)	2	PA, MO
TRULICITY INJ 1.5/0.5 (<i>dulaglutide</i>)	2	PA, MO
TRULICITY INJ 3/0.5 (<i>dulaglutide</i>)	2	PA, MO
TRULICITY INJ 4.5/0.5 (<i>dulaglutide</i>)	2	PA, MO
INSULIN		
FIASP FLEX INJ TOUCH (<i>insulin aspart (with niacinamide)</i>)	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FIASP INJ 100/ML (<i>insulin aspart (with niacinamide)</i>)	2	MO
FIASP PENFIL INJ U-100 (<i>insulin aspart (with niacinamide)</i>)	2	MO
GLARGIN YFGN INJ 100U/ML	2	MO
GLARGIN YFGN SOL 100U/ML	2	MO
HUMULIN R INJ U-500 (<i>insulin regular (human)</i>)	2	MO
LANTUS INJ 100/ML (<i>insulin glargine</i>)	2	MO
LANTUS SOLOS INJ 100/ML (<i>insulin glargine</i>)	2	MO
NOVOLIN INJ 70/30 (<i>insulin nph isophane & reg (human)</i>)	2	MO; RELION not covered
NOVOLIN INJ 70/30 FP (<i>insulin nph isophane & reg (human)</i>)	2	MO; RELION not covered
NOVOLIN N INJ 100 UNIT (<i>insulin nph (human) (isophane)</i>)	2	MO; RELION not covered
NOVOLIN N INJ U-100 (<i>insulin nph (human) (isophane)</i>)	2	MO; RELION not covered
NOVOLIN R INJ 100 UNIT (<i>insulin regular (human)</i>)	2	MO; RELION not covered
NOVOLIN R INJ U-100 (<i>insulin regular (human)</i>)	2	MO; RELION not covered
NOVOLOG INJ 100/ML (<i>insulin aspart</i>)	2	MO; RELION not covered
NOVOLOG INJ FLEXPEN (<i>insulin aspart</i>)	2	MO; RELION not covered
NOVOLOG INJ PENFILL (<i>insulin aspart</i>)	2	MO; RELION not covered
NOVOLOG MIX INJ 70/30 (<i>insulin aspart protamine & aspart (human)</i>)	2	MO; RELION not covered
NOVOLOG MIX INJ FLEXPEN (<i>insulin aspart protamine & aspart (human)</i>)	2	MO; RELION not covered
TOUJEO MAX INJ 300/ML (<i>insulin glargine</i>)	2	MO
TOUJEO SOLO INJ 300/ML (<i>insulin glargine</i>)	2	MO
TRESIBA FLEX INJ 100UNIT (<i>insulin degludec</i>)	2	MO
TRESIBA FLEX INJ 200UNIT (<i>insulin degludec</i>)	2	MO
TRESIBA INJ 100UNIT (<i>insulin degludec</i>)	2	MO
INSULIN SENSITIZING AGENTS		
<i>pioglitazone hcl tab 15 mg (base equiv)</i>	1	MO
<i>pioglitazone hcl tab 30 mg (base equiv)</i>	1	MO
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	1	MO
MEGLITINIDE ANALOGUES		
<i>nateglinide tab 60 mg</i>	1	MO
<i>nateglinide tab 120 mg</i>	1	MO
<i>repaglinide tab 0.5 mg</i>	1	MO
<i>repaglinide tab 1 mg</i>	1	MO
<i>repaglinide tab 2 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB 5MG (<i>dapagliflozin propanediol</i>)	2	MO
FARXIGA TAB 10MG (<i>dapagliflozin propanediol</i>)	2	MO
JARDIANCE TAB 10MG (<i>empagliflozin</i>)	2	MO
JARDIANCE TAB 25MG (<i>empagliflozin</i>)	2	MO
SULFONYLUREAS		
<i>glimepiride tab 1 mg</i>	1	MO
<i>glimepiride tab 2 mg</i>	1	MO
<i>glimepiride tab 4 mg</i>	1	MO
<i>glipizide tab 5 mg</i>	1	MO
<i>glipizide tab 10 mg</i>	1	MO
<i>glipizide tab er 24hr 2.5 mg</i>	1	MO
<i>glipizide tab er 24hr 5 mg</i>	1	MO
<i>glipizide tab er 24hr 10 mg</i>	1	MO
<i>glyburide micronized tab 1.5 mg</i>	1	MO
<i>glyburide micronized tab 3 mg</i>	1	MO
<i>glyburide micronized tab 6 mg</i>	1	MO
<i>glyburide tab 1.25 mg</i>	1	MO
<i>glyburide tab 2.5 mg</i>	1	MO
<i>glyburide tab 5 mg</i>	1	MO
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA		
ANTIPERISTALTIC AGENTS		
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	1	
<i>loperamide hcl cap 2 mg</i>	1	
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
ANTIDOTES - CHELATING AGENTS		
<i>deferasirox granules packet 90 mg</i>	1	SP, PA
<i>deferasirox granules packet 180 mg</i>	1	SP, PA
<i>deferasirox granules packet 360 mg</i>	1	SP, PA
<i>deferasirox tab 90 mg</i>	1	SP, PA
<i>deferasirox tab 180 mg</i>	1	SP, PA
<i>deferasirox tab 360 mg</i>	1	SP, PA
<i>deferasirox tab for oral susp 125 mg</i>	1	SP, PA
<i>deferasirox tab for oral susp 250 mg</i>	1	SP, PA
<i>deferasirox tab for oral susp 500 mg</i>	1	SP, PA
<i>deferiprone tab 500 mg</i>	1	SP, PA
<i>deferiprone tab 1000 mg</i>	1	SP, PA
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
VISTOGARD PAK 10GM (<i>uridine triacetate (emergency treatment)</i>)	2	QL (20 packets every 5 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPIOID ANTAGONISTS		
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	1	QL (4 sprays every 25 days)
<i>naltrexone hcl tab 50 mg</i>	1	
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
5-HT3 RECEPTOR ANTAGONISTS		
<i>granisetron hcl tab 1 mg</i>	1	QL (12 tabs every 21 days)
<i>ondansetron hcl oral soln 4 mg/5ml</i>	1	QL (200 mL every 21 days)
<i>ondansetron hcl tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 8 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 24 mg</i>	1	QL (2 tabs every 21 days)
<i>ondansetron orally disintegrating tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron orally disintegrating tab 8 mg</i>	1	QL (18 tabs every 21 days)
<i>SANCUSO DIS 3.1MG (granisetron)</i>	2	QL (2 patches every 21 days)
ANTIEMETICS - ANTICHOLINERGIC		
<i>meclizine hcl tab 12.5 mg</i>	1	
<i>meclizine hcl tab 25 mg</i>	1	
<i>meclizine hcl tab 50 mg</i>	1	
<i>scopolamine td patch 72hr 1 mg/3days</i>	1	
<i>trimethobenzamide hcl cap 300 mg</i>	1	
ANTIEMETICS - MISCELLANEOUS		
<i>doxylamine-pyridoxine tab delayed release 10-10 mg</i>	1	
<i>dronabinol cap 2.5 mg</i>	1	QL (60 caps every 25 days)
<i>dronabinol cap 5 mg</i>	1	QL (60 caps every 25 days)
<i>dronabinol cap 10 mg</i>	1	QL (60 caps every 25 days)
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
<i>aprepitant capsule 40 mg</i>	1	QL (3 caps every 180 days)
<i>aprepitant capsule 80 mg</i>	1	QL (4 caps every 21 days)
<i>aprepitant capsule 125 mg</i>	1	QL (2 caps every 21 days)
<i>aprepitant capsule therapy pack 80 & 125 mg</i>	1	QL (6 caps every 21 days)
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
<i>flucytosine cap 250 mg</i>	1	
<i>griseofulvin microsize susp 125 mg/5ml</i>	1	
<i>griseofulvin microsize tab 500 mg</i>	1	
<i>griseofulvin ultramicrosize tab 125 mg</i>	1	
<i>griseofulvin ultramicrosize tab 165 mg</i>	1	
<i>griseofulvin ultramicrosize tab 250 mg</i>	1	
<i>nystatin tab 500000 unit</i>	1	
<i>terbinafine hcl tab 250 mg</i>	1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IMIDAZOLE-RELATED ANTIFUNGALS		
<i>fluconazole for susp 10 mg/ml</i>	1	
<i>fluconazole for susp 40 mg/ml</i>	1	
<i>fluconazole tab 50 mg</i>	1	
<i>fluconazole tab 100 mg</i>	1	
<i>fluconazole tab 150 mg</i>	1	
<i>fluconazole tab 200 mg</i>	1	
<i>itraconazole cap 100 mg</i>	1	PA
<i>itraconazole oral soln 10 mg/ml</i>	1	PA
<i>ketoconazole tab 200 mg</i>	1	
<i>posaconazole susp 40 mg/ml</i>	1	MO
<i>voriconazole for susp 40 mg/ml</i>	1	
<i>voriconazole tab 50 mg</i>	1	
<i>voriconazole tab 200 mg</i>	1	
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
ANTIHISTAMINES - ETHANOLAMINES		
<i>carbinoxamine maleate extended release susp 4 mg/5ml</i>	1	
<i>carbinoxamine maleate soln 4 mg/5ml</i>	1	
<i>carbinoxamine maleate tab 4 mg</i>	1	
<i>clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)</i>	1	
(Clemastine Fumarate Tab 2.68 mg) CLEMASZ	1	
ANTIHISTAMINES - NON-SEDATING		
<i>cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)</i>	1	
<i>desloratadine tab 5 mg</i>	1	
<i>desloratadine tab orally disintegrating 2.5 mg</i>	1	
<i>desloratadine tab orally disintegrating 5 mg</i>	1	
<i>levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)</i>	1	
<i>levocetirizine dihydrochloride tab 5 mg</i>	1	
<i>loratadine tab 10 mg</i>	1	
ANTIHISTAMINES - PHENOTHIAZINES		
<i>promethazine hcl oral soln 6.25 mg/5ml</i>	1	
<i>promethazine hcl suppos 12.5 mg</i>	1	
(Promethazine Hcl Suppos 12.5 mg) PROMETHEGAN	1	
<i>promethazine hcl suppos 25 mg</i>	1	
(Promethazine Hcl Suppos 25 mg) PROMETHEGAN	1	
(Promethazine Hcl Suppos 50 mg) PROMETHEGAN	1	
<i>promethazine hcl tab 12.5 mg</i>	1	
<i>promethazine hcl tab 25 mg</i>	1	

PREScription DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>promethazine hcl tab 50 mg</i>	1	
ANTI-HISTAMINES - PIPERIDINES		
<i>cyproheptadine hcl syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl tab 4 mg</i>	1	
ANTI-HYPERLIPIDEMICS - DRUGS TO TREAT HIGH CHOLESTEROL		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB 180MG (<i>bempedoic acid</i>)	2	MO
ANTI-HYPERLIPIDEMICS - COMBINATIONS		
<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	MO
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	MO
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	MO
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	MO
NEXLIZET TAB 180/10MG (<i>bempedoic acid-ezetimibe</i>)	2	MO
ANTI-HYPERLIPIDEMICS - MISC.		
<i>icosapent ethyl cap 0.5 gm</i>	1	MO
<i>icosapent ethyl cap 1 gm</i>	1	MO
<i>omega-3-acid ethyl esters cap 1 gm</i>	1	MO
BILE ACID SEQUESTRANTS		
<i>cholestyramine light powder 4 gm/dose</i>	1	MO
(Cholestyramine Light Powder 4 gm/dose)	1	MO
PREVALITE		
<i>cholestyramine light powder packets 4 gm</i>	1	MO
(Cholestyramine Light Powder Packets 4 gm)	1	MO
PREVALITE		
<i>cholestyramine powder 4 gm/dose</i>	1	MO
<i>cholestyramine powder packets 4 gm</i>	1	MO
<i>colesevelam hcl packet for susp 3.75 gm</i>	1	MO
<i>colesevelam hcl tab 625 mg</i>	1	MO
<i>colestipol hcl granule packets 5 gm</i>	1	MO
<i>colestipol hcl granules 5 gm</i>	1	MO
<i>colestipol hcl tab 1 gm</i>	1	MO
FIBRIC ACID DERIVATIVES		
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i>	1	MO
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</i>	1	MO
<i>fenofibrate cap 150 mg</i>	1	MO
<i>fenofibrate micronized cap 43 mg</i>	1	MO
<i>fenofibrate micronized cap 67 mg</i>	1	MO
<i>fenofibrate micronized cap 134 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>fenofibrate micronized cap 200 mg</i>	1	MO
<i>fenofibrate tab 48 mg</i>	1	MO
<i>fenofibrate tab 54 mg</i>	1	MO
<i>fenofibrate tab 145 mg</i>	1	MO
<i>fenofibrate tab 160 mg</i>	1	MO
<i>fenofibric acid tab 35 mg</i>	1	MO
<i>fenofibric acid tab 105 mg</i>	1	MO
<i>gemfibrozil tab 600 mg</i>	1	MO
HMG COA REDUCTASE INHIBITORS		
<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>atorvastatin calcium tab 20 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>atorvastatin calcium tab 40 mg (base equivalent)</i>	1	MO
<i>atorvastatin calcium tab 80 mg (base equivalent)</i>	1	MO
<i>fluvastatin sodium cap 20 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>fluvastatin sodium cap 40 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>fluvastatin sodium tab er 24 hr 80 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>lovastatin tab 10 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>lovastatin tab 20 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>lovastatin tab 40 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pitavastatin calcium tab 1 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pitavastatin calcium tab 2 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pitavastatin calcium tab 4 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pravastatin sodium tab 10 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pravastatin sodium tab 20 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pravastatin sodium tab 40 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pravastatin sodium tab 80 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 5 mg</i>	1	MO; \$0 copay for members age 40 through 75

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>rosuvastatin calcium tab 10 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 20 mg</i>	1	MO
<i>rosuvastatin calcium tab 40 mg</i>	1	MO
<i>simvastatin tab 5 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>simvastatin tab 10 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>simvastatin tab 20 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>simvastatin tab 40 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>simvastatin tab 80 mg</i>	1	MO
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
<i>ezetimibe tab 10 mg</i>	1	MO
NICOTINIC ACID DERIVATIVES		
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	1	MO
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	1	MO
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	1	MO
ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE		
ACE INHIBITORS		
<i>benazepril hcl tab 5 mg</i>	1	MO
<i>benazepril hcl tab 10 mg</i>	1	MO
<i>benazepril hcl tab 20 mg</i>	1	MO
<i>benazepril hcl tab 40 mg</i>	1	MO
<i>captopril tab 12.5 mg</i>	1	MO
<i>captopril tab 25 mg</i>	1	MO
<i>captopril tab 50 mg</i>	1	MO
<i>captopril tab 100 mg</i>	1	MO
<i>enalapril maleate oral soln 1 mg/ml</i>	1	MO
<i>enalapril maleate tab 2.5 mg</i>	1	MO
<i>enalapril maleate tab 5 mg</i>	1	MO
<i>enalapril maleate tab 10 mg</i>	1	MO
<i>enalapril maleate tab 20 mg</i>	1	MO
<i>fosinopril sodium tab 10 mg</i>	1	MO
<i>fosinopril sodium tab 20 mg</i>	1	MO
<i>fosinopril sodium tab 40 mg</i>	1	MO
<i>lisinopril tab 2.5 mg</i>	1	MO
<i>lisinopril tab 5 mg</i>	1	MO
<i>lisinopril tab 10 mg</i>	1	MO
<i>lisinopril tab 20 mg</i>	1	MO
<i>lisinopril tab 30 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>lisinopril tab 40 mg</i>	1	MO
<i>moexipril hcl tab 7.5 mg</i>	1	MO
<i>moexipril hcl tab 15 mg</i>	1	MO
<i>perindopril erbumine tab 2 mg</i>	1	MO
<i>perindopril erbumine tab 4 mg</i>	1	MO
<i>perindopril erbumine tab 8 mg</i>	1	MO
<i>quinapril hcl tab 5 mg</i>	1	MO
<i>quinapril hcl tab 10 mg</i>	1	MO
<i>quinapril hcl tab 20 mg</i>	1	MO
<i>quinapril hcl tab 40 mg</i>	1	MO
<i>ramipril cap 1.25 mg</i>	1	MO
<i>ramipril cap 2.5 mg</i>	1	MO
<i>ramipril cap 5 mg</i>	1	MO
<i>ramipril cap 10 mg</i>	1	MO
<i>trandolapril tab 1 mg</i>	1	MO
<i>trandolapril tab 2 mg</i>	1	MO
<i>trandolapril tab 4 mg</i>	1	MO
AGENTS FOR PHEOCHROMOCYTOMA		
<i>metyrosine cap 250 mg</i>	1	SP, PA, QL (16 caps every 1 day)
<i>phenoxybenzamine hcl cap 10 mg</i>	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil tab 4 mg</i>	1	MO
<i>candesartan cilexetil tab 8 mg</i>	1	MO
<i>candesartan cilexetil tab 16 mg</i>	1	MO
<i>candesartan cilexetil tab 32 mg</i>	1	MO
<i>irbesartan tab 75 mg</i>	1	MO
<i>irbesartan tab 150 mg</i>	1	MO
<i>irbesartan tab 300 mg</i>	1	MO
<i>losartan potassium tab 25 mg</i>	1	MO
<i>losartan potassium tab 50 mg</i>	1	MO
<i>losartan potassium tab 100 mg</i>	1	MO
<i>olmesartan medoxomil tab 5 mg</i>	1	MO
<i>olmesartan medoxomil tab 20 mg</i>	1	MO
<i>olmesartan medoxomil tab 40 mg</i>	1	MO
<i>telmisartan tab 20 mg</i>	1	MO
<i>telmisartan tab 40 mg</i>	1	MO
<i>telmisartan tab 80 mg</i>	1	MO
<i>valsartan oral soln 4 mg/ml</i>	1	MO
<i>valsartan tab 40 mg</i>	1	MO
<i>valsartan tab 80 mg</i>	1	MO
<i>valsartan tab 160 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>valsartan tab 320 mg</i>	1	MO
ANTIADRENERGIC ANTIHYPERTENSIVES		
<i>clonidine hcl tab 0.1 mg</i>	1	MO
<i>clonidine hcl tab 0.2 mg</i>	1	MO
<i>clonidine hcl tab 0.3 mg</i>	1	MO
<i>clonidine tab er 24hr 0.17 mg</i>	1	MO
<i>clonidine td patch weekly 0.1 mg/24hr</i>	1	MO
<i>clonidine td patch weekly 0.2 mg/24hr</i>	1	MO
<i>clonidine td patch weekly 0.3 mg/24hr</i>	1	MO
<i>doxazosin mesylate tab 1 mg</i>	1	MO
<i>doxazosin mesylate tab 2 mg</i>	1	MO
<i>doxazosin mesylate tab 4 mg</i>	1	MO
<i>doxazosin mesylate tab 8 mg</i>	1	MO
<i>guanfacine hcl tab 1 mg</i>	1	MO
<i>guanfacine hcl tab 2 mg</i>	1	MO
<i>methyldopa tab 250 mg</i>	1	MO
<i>methyldopa tab 500 mg</i>	1	MO
<i>prazosin hcl cap 1 mg</i>	1	MO
<i>prazosin hcl cap 2 mg</i>	1	MO
<i>prazosin hcl cap 5 mg</i>	1	MO
<i>terazosin hcl cap 1 mg (base equivalent)</i>	1	MO
<i>terazosin hcl cap 2 mg (base equivalent)</i>	1	MO
<i>terazosin hcl cap 5 mg (base equivalent)</i>	1	MO
<i>terazosin hcl cap 10 mg (base equivalent)</i>	1	MO
ANTIHYPERTENSIVE COMBINATIONS		
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	1	MO
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	1	MO
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	1	MO
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	1	MO
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	1	MO
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	MO
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	MO
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i>	1	MO
<i>atenolol & chlorthalidone tab 50-25 mg</i>	1	MO
<i>atenolol & chlorthalidone tab 100-25 mg</i>	1	MO
<i>benazepril & hydrochlorothiazide tab 5-6.25 mg</i>	1	MO
<i>benazepril & hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>benazepril & hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>benazepril & hydrochlorothiazide tab 20-25 mg</i>	1	MO
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	1	MO
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	1	MO
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	1	MO
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	1	MO
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	1	MO
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	1	MO
<i>captopril & hydrochlorothiazide tab 25-15 mg</i>	1	MO
<i>captopril & hydrochlorothiazide tab 25-25 mg</i>	1	MO
<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	1	MO
<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	1	MO
<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	1	MO
<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	1	MO
<i>fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	MO
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	MO
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	1	MO
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	1	MO
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	1	MO
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	1	MO
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	1	MO
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	1	MO
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	1	MO
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	MO
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>telmisartan-amlodipine tab 40-5 mg</i>	1	MO
<i>telmisartan-amlodipine tab 40-10 mg</i>	1	MO
<i>telmisartan-amlodipine tab 80-5 mg</i>	1	MO
<i>telmisartan-amlodipine tab 80-10 mg</i>	1	MO
<i>telmisartan-hydrochlorothiazide tab 40-12.5 mg</i>	1	MO
<i>telmisartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	MO
<i>telmisartan-hydrochlorothiazide tab 80-25 mg</i>	1	MO
<i>trandolapril-verapamil hcl tab er 1-240 mg</i>	1	MO
<i>trandolapril-verapamil hcl tab er 2-180 mg</i>	1	MO
<i>trandolapril-verapamil hcl tab er 2-240 mg</i>	1	MO
<i>trandolapril-verapamil hcl tab er 4-240 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>DIRECT RENIN INHIBITORS</i>		
<i>aliskiren fumarate tab 150 mg (base equivalent)</i>	1	MO
<i>aliskiren fumarate tab 300 mg (base equivalent)</i>	1	MO
<i>SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)</i>		
<i>eplerenone tab 25 mg</i>	1	MO
<i>eplerenone tab 50 mg</i>	1	MO
<i>VASODILATORS</i>		
<i>hydralazine hcl tab 10 mg</i>	1	MO
<i>hydralazine hcl tab 25 mg</i>	1	MO
<i>hydralazine hcl tab 50 mg</i>	1	MO
<i>hydralazine hcl tab 100 mg</i>	1	MO
<i>minoxidil tab 2.5 mg</i>	1	MO
<i>minoxidil tab 10 mg</i>	1	MO
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
<i>ANTIMALARIAL COMBINATIONS</i>		
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	1	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	1	
<i>COARTEM TAB 20-120MG (artemether-lumefantrine)</i>	3	
<i>ANTIMALARIALS - DRUGS TO TREAT MALARIA</i>		
<i>chloroquine phosphate tab 250 mg</i>	1	MO
<i>chloroquine phosphate tab 500 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 100 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 200 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 300 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 400 mg</i>	1	MO
<i>mefloquine hcl tab 250 mg</i>	1	MO
<i>primaquine phosphate tab 26.3 mg (15 mg base)</i>	1	
<i>pyrimethamine tab 25 mg</i>	1	
<i>quinine sulfate cap 324 mg</i>	1	
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS		
<i>ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS</i>		
<i>GUANIDINE TAB 125MG</i>	3	PA
<i>pyridostigmine bromide oral soln 60 mg/5ml</i>	1	
<i>pyridostigmine bromide tab 60 mg</i>	1	
<i>pyridostigmine bromide tab er 180 mg</i>	1	
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS		
<i>ANTI TB COMBINATIONS</i>		
<i>RIFATER TAB (isoniazid-rifampin w/ pyrazinamide)</i>	3	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS		
<i>cycloserine cap 250 mg</i>	1	
<i>ethambutol hcl tab 100 mg</i>	1	
<i>ethambutol hcl tab 400 mg</i>	1	
<i>isoniazid syrup 50 mg/5ml</i>	1	MO
<i>isoniazid tab 100 mg</i>	1	MO
<i>isoniazid tab 300 mg</i>	1	MO
PASER GRA 4GM (<i>aminosalicylic acid</i>)	3	
<i>pyrazinamide tab 500 mg</i>	1	
<i>rifabutin cap 150 mg</i>	1	
<i>rifampin cap 150 mg</i>	1	
<i>rifampin cap 300 mg</i>	1	
SIRTURO TAB 20MG (<i>bedaquiline fumarate</i>)	3	
SIRTURO TAB 100MG (<i>bedaquiline fumarate</i>)	3	
TRECTOR TAB 250MG (<i>ethionamide</i>)	3	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
<i>cyclophosphamide cap 25 mg</i>	1	OAC
<i>cyclophosphamide cap 50 mg</i>	1	OAC
GLEOSTINE CAP 10MG (<i>lomustine</i>)	3	SP; OAC
GLEOSTINE CAP 40MG (<i>lomustine</i>)	3	SP; OAC
GLEOSTINE CAP 100MG (<i>lomustine</i>)	3	SP; OAC
<i>temozolomide cap 5 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 20 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 100 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 140 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 180 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 250 mg</i>	1	SP, PA; OAC
ANTIMETABOLITES		
<i>capecitabine tab 150 mg</i>	1	SP, PA; OAC
<i>capecitabine tab 500 mg</i>	1	SP, PA; OAC
<i>mercaptopurine susp 2000 mg/100ml (20 mg/ml)</i>	1	SP, PA; OAC
<i>mercaptopurine tab 50 mg</i>	1	OAC
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	1	OAC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
INLYTA TAB 1MG (<i>axitinib</i>)	2	SP, PA, QL (8 tabs every 1 day); OAC
INLYTA TAB 5MG (<i>axitinib</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
LENVIMA CAP 4MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (1 cap every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LENVIMA CAP 8 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 10 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
LENVIMA CAP 12MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (3 caps every 1 day); OAC
LENVIMA CAP 14 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 18 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (3 caps every 1 day); OAC
LENVIMA CAP 20 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 24 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (3 caps every 1 day); OAC
ANTINEOPLASTIC - EGFR INHIBITORS		
<i>erlotinib hcl tab 25 mg (base equivalent)</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
<i>erlotinib hcl tab 100 mg (base equivalent)</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>erlotinib hcl tab 150 mg (base equivalent)</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>gefitinib tab 250 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
TAGRISSO TAB 40MG (<i>osimertinib mesylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
TAGRISSO TAB 80MG (<i>osimertinib mesylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP 150MG (<i>vismodegib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
ODOMZO CAP 200MG (<i>sonidegib phosphate</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
<i>abiraterone acetate tab 250 mg</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
(Abiraterone Acetate Tab 250 mg) ABIRTEGA	1	SP, PA, QL (4 tabs every 1 day); OAC
<i>abiraterone acetate tab 500 mg</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
<i>anastrozole tab 1 mg</i>	PV	MO; OAC, \$0 copay ages 35 and older for the primary prevention of breast cancer
<i>bicalutamide tab 50 mg</i>	1	OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ERLEADA TAB 60MG (<i>apalutamide</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
ERLEADA TAB 240MG (<i>apalutamide</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
<i>exemestane tab 25 mg</i>	PV	MO; OAC, \$0 copay ages 35 and older for the primary prevention of breast cancer
<i>letrozole tab 2.5 mg</i>	1	MO; OAC
<i>megestrol acetate susp 40 mg/ml</i>	1	OAC
<i>megestrol acetate tab 20 mg</i>	1	OAC
<i>megestrol acetate tab 40 mg</i>	1	OAC
<i>nilutamide tab 150 mg</i>	1	OAC
NUBEQA TAB 300MG (<i>darolutamide</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
<i>tamoxifen citrate tab 10 mg (base equivalent)</i>	1	MO; OAC, \$0 copay ages 35 and older for the primary prevention of breast cancer
<i>tamoxifen citrate tab 20 mg (base equivalent)</i>	1	MO; OAC, \$0 copay ages 35 and older for the primary prevention of breast cancer
<i>toremifene citrate tab 60 mg (base equivalent)</i>	1	MO; OAC
XTANDI CAP 40MG (<i>enzalutamide</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
XTANDI TAB 40MG (<i>enzalutamide</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
XTANDI TAB 80MG (<i>enzalutamide</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
YONSA TAB 125MG (<i>abiraterone acetate micronized</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP 1MG (<i>pomalidomide</i>)	3	SP, PA; OAC
POMALYST CAP 2MG (<i>pomalidomide</i>)	3	SP, PA; OAC
POMALYST CAP 3MG (<i>pomalidomide</i>)	3	SP, PA; OAC
POMALYST CAP 4MG (<i>pomalidomide</i>)	3	SP, PA; OAC
ANTINEOPLASTIC COMBINATIONS		
LONSURF TAB 15-6.14 (<i>trifluridine-tipiracil</i>)	2	SP, PA, QL (100 tabs every 28 days); OAC
LONSURF TAB 20-8.19 (<i>trifluridine-tipiracil</i>)	2	SP, PA, QL (80 tabs every 28 days); OAC
ANTINEOPLASTIC ENZYME INHIBITORS		
ALECENSA CAP 150MG (<i>alectinib hcl</i>)	2	SP, PA, QL (8 caps every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ALUNBRIG PAK (<i>brigatinib</i>)	2	PA, QL (1 tab every 1 day); OAC
ALUNBRIG TAB 30MG (<i>brigatinib</i>)	2	PA, QL (4 tabs every 1 day); OAC
ALUNBRIG TAB 90MG (<i>brigatinib</i>)	2	PA, QL (1 tab every 1 day); OAC
ALUNBRIG TAB 180MG (<i>brigatinib</i>)	2	PA, QL (1 tab every 1 day); OAC
AUGTYRO CAP 40MG (<i>repotrectinib</i>)	2	SP, PA, QL (8 caps every 1 day); OAC
AUGTYRO CAP 160MG (<i>repotrectinib</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
BOSULIF CAP 50MG (<i>bosutinib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
BOSULIF CAP 100MG (<i>bosutinib</i>)	2	SP, PA, QL (10 caps every 1 day); OAC
BOSULIF TAB 100MG (<i>bosutinib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
BOSULIF TAB 400MG (<i>bosutinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
BOSULIF TAB 500MG (<i>bosutinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
BRAFTOVI CAP 75MG (<i>encorafenib</i>)	2	SP, PA, QL (6 caps every 1 day); OAC
BRUKINSA CAP 80MG (<i>zanubrutinib</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
CABOMETYX TAB 20MG (<i>cabozantinib s-malate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
CABOMETYX TAB 40MG (<i>cabozantinib s-malate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
CABOMETYX TAB 60MG (<i>cabozantinib s-malate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
CALQUENCE TAB 100MG (<i>acalabrutinib maleate</i>)	2	PA, QL (2 tabs every 1 day); OAC
COPIKTRA CAP 15MG (<i>duvelisib</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
COPIKTRA CAP 25MG (<i>duvelisib</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
<i>dasatinib tab 20 mg</i>	1	SP, PA, QL (3 tabs every 1 day); OAC
<i>dasatinib tab 50 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>dasatinib tab 70 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>dasatinib tab 80 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>dasatinib tab 100 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>dasatinib tab 140 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab 2.5 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
(Everolimus Tab 2.5 mg) TORPENZ	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab 5 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
(Everolimus Tab 5 mg) TORPENZ	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab 7.5 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
(Everolimus Tab 7.5 mg) TORPENZ	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab 10 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
(Everolimus Tab 10 mg) TORPENZ	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab for oral susp 2 mg</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
<i>everolimus tab for oral susp 3 mg</i>	1	SP, PA, QL (3 tabs every 1 day); OAC
<i>everolimus tab for oral susp 5 mg</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
GAVRETO CAP 100MG (<i>pralsetinib</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
GOMEKLI CAP 1MG (<i>mirdametinib</i>)	2	SP, PA, QL (42 caps every 21 days); OAC
GOMEKLI CAP 2MG (<i>mirdametinib</i>)	2	SP, PA, QL (84 caps every 21 days); OAC
GOMEKLI TAB 1MG (<i>mirdametinib</i>)	2	SP, PA, QL (168 tabs every 21 days); OAC
IBRANCE CAP 75MG (<i>palbociclib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE CAP 100MG (<i>palbociclib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE CAP 125MG (<i>palbociclib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE TAB 75MG (<i>palbociclib</i>)	2	SP, PA, QL (42 tabs every 28 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IBRANCE TAB 100MG (<i>palbociclib</i>)	2	SP, PA, QL (42 tabs every 28 days); OAC
IBRANCE TAB 125MG (<i>palbociclib</i>)	2	SP, PA, QL (42 tabs every 28 days); OAC
<i>imatinib mesylate tab 100 mg (base equivalent)</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
<i>imatinib mesylate tab 400 mg (base equivalent)</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
KISQALI TAB 200DOSE (<i>ribociclib succinate</i>)	2	SP, PA, QL (42 tabs every 28 days); OAC
KISQALI TAB 400DOSE (<i>ribociclib succinate</i>)	2	SP, PA, QL (84 tabs every 28 days); OAC
KISQALI TAB 600DOSE (<i>ribociclib succinate</i>)	2	SP, PA, QL (126 tabs every 28 days); OAC
KOSELUGO CAP 10MG (<i>selumetinib sulfate</i>)	2	PA, QL (8 caps every 1 day); OAC
KOSELUGO CAP 25MG (<i>selumetinib sulfate</i>)	2	PA, QL (4 caps every 1 day); OAC
KRAZATI TAB 200MG (<i>adagrasib</i>)	2	PA, QL (6 tabs every 1 day); OAC
<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	1	SP, PA, QL (6 tabs every 1 day); OAC
LUMAKRAS TAB 120MG (<i>sotorasib</i>)	2	SP, PA, QL (8 tabs every 1 day); OAC
LUMAKRAS TAB 240MG (<i>sotorasib</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
LUMAKRAS TAB 320MG (<i>sotorasib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
LYNPARZA TAB 100MG (<i>olaparib</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
LYNPARZA TAB 150MG (<i>olaparib</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
MEKINIST SOL 0.05/ML (<i>trametinib dimethyl sulfoxide</i>)	2	SP, PA, QL (38 mL every 1 day); OAC
MEKINIST TAB 0.5MG (<i>trametinib dimethyl sulfoxide</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
MEKINIST TAB 2MG (<i>trametinib dimethyl sulfoxide</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
MEKTOVI TAB 15MG (<i>binimetinib</i>)	2	SP, PA, QL (6 tabs every 1 day); OAC
NINLARO CAP 2.3MG (<i>ixazomib citrate</i>)	2	SP, PA, QL (3 caps every 21 days); OAC
NINLARO CAP 3MG (<i>ixazomib citrate</i>)	2	SP, PA, QL (3 caps every 21 days); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NINLARO CAP 4MG (<i>ixazomib citrate</i>)	2	SP, PA, QL (3 caps every 21 days); OAC
<i>pazopanib hcl tab 200 mg (base equiv)</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
PIQRAY 200MG TAB DOSE (<i>alpelisib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
PIQRAY 250MG TAB DOSE (<i>alpelisib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
PIQRAY 300MG TAB DOSE (<i>alpelisib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
RETEVMO TAB 40MG (<i>selpercatinib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
RETEVMO TAB 80MG (<i>selpercatinib</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
RETEVMO TAB 120MG (<i>selpercatinib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
RETEVMO TAB 160MG (<i>selpercatinib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
ROZLYTREK CAP 100MG (<i>entrectinib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
ROZLYTREK CAP 200MG (<i>entrectinib</i>)	2	SP, PA, QL (3 caps every 1 day); OAC
ROZLYTREK PAK 50MG (<i>entrectinib</i>)	2	SP, PA, QL (12 packets every 1 day); OAC
RYDAPT CAP 25MG (<i>midostaurin</i>)	2	SP, PA, QL (8 caps every 1 day); OAC
SCEMBLIX TAB 20MG (<i>asciminib hcl</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
SCEMBLIX TAB 40MG (<i>asciminib hcl</i>)	2	SP, PA, QL (10 tabs every 1 day); OAC
SCEMBLIX TAB 100MG (<i>asciminib hcl</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
<i>sorafenib tosylate tab 200 mg (base equivalent)</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
STIVARGA TAB 40MG (<i>regorafenib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>sunitinib malate cap 25 mg (base equivalent)</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>sunitinib malate cap 50 mg (base equivalent)</i>	1	SP, PA, QL (1 cap every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TAFINLAR CAP 50MG (<i>dabrafenib mesylate</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
TAFINLAR CAP 75MG (<i>dabrafenib mesylate</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
TAFINLAR TAB 10MG (<i>dabrafenib mesylate</i>)	2	SP, PA, QL (30 tabs every 1 day); OAC
TRUQAP PAK 160MG (<i>capivasertib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
TRUQAP PAK 200MG (<i>capivasertib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
TRUQAP TAB 200MG (<i>capivasertib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
VITRAKVI CAP 25MG (<i>larotrectinib sulfate</i>)	2	SP, PA, QL (6 caps every 1 day); OAC
VITRAKVI CAP 100MG (<i>larotrectinib sulfate</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
VITRAKVI SOL 20MG/ML (<i>larotrectinib sulfate</i>)	2	SP, PA, QL (10 mL every 1 day); OAC
XOSPATA TAB 40MG (<i>gilteritinib fumarate</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
ZEJULA TAB 100MG (<i>niraparib tosylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
ZEJULA TAB 200MG (<i>niraparib tosylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
ZEJULA TAB 300MG (<i>niraparib tosylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
ZYDELIG TAB 100MG (<i>idelalisib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
ZYDELIG TAB 150MG (<i>idelalisib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
ZYKADIA TAB 150MG (<i>ceritinib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
ANTINEOPLASTICS MISC.		
<i>bexarotene cap 75 mg</i>	1	SP, PA; OAC
<i>hydroxyurea cap 500 mg</i>	1	OAC
<i>tretinoin cap 10 mg</i>	1	OAC
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
<i>leucovorin calcium tab 5 mg</i>	1	OAC
<i>leucovorin calcium tab 10 mg</i>	1	OAC
<i>leucovorin calcium tab 15 mg</i>	1	OAC
<i>leucovorin calcium tab 25 mg</i>	1	OAC
<i>mesna tab 400 mg</i>	1	OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MITOTIC INHIBITORS		
<i>etoposide cap 50 mg</i>	1	OAC
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
ANTIPARKINSON ADJUNCTIVE THERAPY		
<i>carbidopa tab 25 mg</i>	1	MO
ANTIPARKINSON ANTICHOLINERGICS		
<i>benztropine mesylate tab 0.5 mg</i>	1	MO
<i>benztropine mesylate tab 1 mg</i>	1	MO
<i>benztropine mesylate tab 2 mg</i>	1	MO
<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i>	1	MO
<i>trihexyphenidyl hcl tab 2 mg</i>	1	MO
<i>trihexyphenidyl hcl tab 5 mg</i>	1	MO
ANTIPARKINSON COMT INHIBITORS		
<i>entacapone tab 200 mg</i>	1	MO
<i>tolcapone tab 100 mg</i>	1	MO
ANTIPARKINSON DOPAMINERGICS		
<i>amantadine hcl cap 100 mg</i>	1	MO
<i>amantadine hcl soln 50 mg/5ml</i>	1	MO
<i>amantadine hcl tab 100 mg</i>	1	MO
<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	1	MO
<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i>	1	MO
<i>carbidopa & levodopa orally disintegrating tab 10-100 mg</i>	1	MO
<i>carbidopa & levodopa orally disintegrating tab 25-100 mg</i>	1	MO
<i>carbidopa & levodopa orally disintegrating tab 25-250 mg</i>	1	MO
<i>carbidopa & levodopa tab 10-100 mg</i>	1	MO
<i>carbidopa & levodopa tab 25-100 mg</i>	1	MO
<i>carbidopa & levodopa tab 25-250 mg</i>	1	MO
<i>carbidopa & levodopa tab er 25-100 mg</i>	1	MO
<i>carbidopa & levodopa tab er 50-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	1	MO
DHIVY TAB 25-100MG (<i>carbidopa-levodopa</i>)	3	MO
INBRIJA CAP 42MG (<i>levodopa</i>)	2	PA, QL (10 caps every 1 day), MO
NEUPRO DIS 1MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 2MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 3MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 4MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 6MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 8MG/24HR (<i>rotigotine</i>)	2	MO
<i>pramipexole dihydrochloride tab 0.5 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 0.25 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 0.75 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 0.125 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 1 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 1.5 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 0.75 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 0.375 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 1.5 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 2.25 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 3 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 3.75 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 4.5 mg</i>	1	MO
<i>ropinirole hydrochloride tab 0.5 mg</i>	1	MO
<i>ropinirole hydrochloride tab 0.25 mg</i>	1	MO
<i>ropinirole hydrochloride tab 1 mg</i>	1	MO
<i>ropinirole hydrochloride tab 2 mg</i>	1	MO
<i>ropinirole hydrochloride tab 3 mg</i>	1	MO
<i>ropinirole hydrochloride tab 4 mg</i>	1	MO
<i>ropinirole hydrochloride tab 5 mg</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
RYTARY CAP 95MG (<i>carbidopa-levodopa</i>)	2	MO
RYTARY CAP 145MG (<i>carbidopa-levodopa</i>)	2	MO
RYTARY CAP 195MG (<i>carbidopa-levodopa</i>)	2	MO
RYTARY CAP 245MG (<i>carbidopa-levodopa</i>)	2	MO
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
<i>rasagiline mesylate tab 0.5 mg (base equiv)</i>	1	MO
<i>rasagiline mesylate tab 1 mg (base equiv)</i>	1	MO
<i>selegiline hcl cap 5 mg</i>	1	MO
<i>selegiline hcl tab 5 mg</i>	1	MO
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES		
ANTIMANIC AGENTS		
<i>lithium carbonate cap 150 mg</i>	1	MO
<i>lithium carbonate cap 300 mg</i>	1	MO
<i>lithium carbonate cap 600 mg</i>	1	MO
<i>lithium carbonate tab 300 mg</i>	1	MO
<i>lithium carbonate tab er 300 mg</i>	1	MO
<i>lithium carbonate tab er 450 mg</i>	1	MO
<i>lithium oral solution 8 meq/5ml</i>	1	MO
ANTIPSYCHOTICS - MISC.		
<i>lurasidone hcl tab 20 mg</i>	1	MO
<i>lurasidone hcl tab 40 mg</i>	1	MO
<i>lurasidone hcl tab 60 mg</i>	1	MO
<i>lurasidone hcl tab 80 mg</i>	1	MO
<i>lurasidone hcl tab 120 mg</i>	1	MO
VRAYLAR CAP 1.5MG (<i>cariprazine hcl</i>)	2	ST, MO; PA**
VRAYLAR CAP 3MG (<i>cariprazine hcl</i>)	2	ST, MO; PA**
VRAYLAR CAP 4.5MG (<i>cariprazine hcl</i>)	2	ST, MO; PA**
VRAYLAR CAP 6MG (<i>cariprazine hcl</i>)	2	ST, MO; PA**
<i>ziprasidone hcl cap 20 mg</i>	1	MO
<i>ziprasidone hcl cap 40 mg</i>	1	MO
<i>ziprasidone hcl cap 60 mg</i>	1	MO
<i>ziprasidone hcl cap 80 mg</i>	1	MO
BENZISOXAZOLES		
<i>paliperidone tab er 24hr 1.5 mg</i>	1	MO
<i>paliperidone tab er 24hr 3 mg</i>	1	MO
<i>paliperidone tab er 24hr 6 mg</i>	1	MO
<i>paliperidone tab er 24hr 9 mg</i>	1	MO
<i>risperidone orally disintegrating tab 0.5 mg</i>	1	MO
<i>risperidone orally disintegrating tab 0.25 mg</i>	1	MO
<i>risperidone orally disintegrating tab 1 mg</i>	1	MO
<i>risperidone orally disintegrating tab 2 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>risperidone orally disintegrating tab 3 mg</i>	1	MO
<i>risperidone orally disintegrating tab 4 mg</i>	1	MO
<i>risperidone soln 1 mg/ml</i>	1	MO
<i>risperidone tab 0.5 mg</i>	1	MO
<i>risperidone tab 0.25 mg</i>	1	MO
<i>risperidone tab 1 mg</i>	1	MO
<i>risperidone tab 2 mg</i>	1	MO
<i>risperidone tab 3 mg</i>	1	MO
<i>risperidone tab 4 mg</i>	1	MO
BUTYROPHENONES		
<i>haloperidol lactate oral conc 2 mg/ml</i>	1	MO
<i>haloperidol tab 0.5 mg</i>	1	MO
<i>haloperidol tab 1 mg</i>	1	MO
<i>haloperidol tab 2 mg</i>	1	MO
<i>haloperidol tab 5 mg</i>	1	MO
<i>haloperidol tab 10 mg</i>	1	MO
<i>haloperidol tab 20 mg</i>	1	MO
DIBENZAPINES		
<i>asenapine maleate sl tab 2.5 mg (base equiv)</i>	1	MO
<i>asenapine maleate sl tab 5 mg (base equiv)</i>	1	MO
<i>asenapine maleate sl tab 10 mg (base equiv)</i>	1	MO
<i>clozapine orally disintegrating tab 12.5 mg</i>	1	
<i>clozapine orally disintegrating tab 25 mg</i>	1	
<i>clozapine orally disintegrating tab 100 mg</i>	1	
<i>clozapine orally disintegrating tab 150 mg</i>	1	
<i>clozapine orally disintegrating tab 200 mg</i>	1	
<i>clozapine tab 25 mg</i>	1	
<i>clozapine tab 50 mg</i>	1	
<i>clozapine tab 100 mg</i>	1	
<i>clozapine tab 200 mg</i>	1	
<i>loxapine succinate cap 5 mg</i>	1	MO
<i>loxapine succinate cap 10 mg</i>	1	MO
<i>loxapine succinate cap 25 mg</i>	1	MO
<i>loxapine succinate cap 50 mg</i>	1	MO
<i>olanzapine orally disintegrating tab 5 mg</i>	1	MO
<i>olanzapine orally disintegrating tab 10 mg</i>	1	MO
<i>olanzapine orally disintegrating tab 15 mg</i>	1	MO
<i>olanzapine orally disintegrating tab 20 mg</i>	1	MO
<i>olanzapine tab 2.5 mg</i>	1	MO
<i>olanzapine tab 5 mg</i>	1	MO
<i>olanzapine tab 7.5 mg</i>	1	MO
<i>olanzapine tab 10 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>olanzapine tab 15 mg</i>	1	MO
<i>olanzapine tab 20 mg</i>	1	MO
<i>quetiapine fumarate tab 25 mg</i>	1	MO
<i>quetiapine fumarate tab 50 mg</i>	1	MO
<i>quetiapine fumarate tab 100 mg</i>	1	MO
<i>quetiapine fumarate tab 150 mg</i>	1	MO
<i>quetiapine fumarate tab 200 mg</i>	1	MO
<i>quetiapine fumarate tab 300 mg</i>	1	MO
<i>quetiapine fumarate tab 400 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 50 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 150 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 200 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 300 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 400 mg</i>	1	MO
DIHYDROINDOLONES		
<i>molindone hcl tab 5 mg</i>	1	MO
<i>molindone hcl tab 10 mg</i>	1	MO
<i>molindone hcl tab 25 mg</i>	1	MO
PHENOTHIAZINES		
<i>chlorpromazine hcl tab 10 mg</i>	1	MO
<i>chlorpromazine hcl tab 25 mg</i>	1	MO
<i>chlorpromazine hcl tab 50 mg</i>	1	MO
<i>chlorpromazine hcl tab 100 mg</i>	1	MO
<i>chlorpromazine hcl tab 200 mg</i>	1	MO
<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	1	MO
<i>fluphenazine hcl oral conc 5 mg/ml</i>	1	MO
<i>fluphenazine hcl tab 1 mg</i>	1	MO
<i>fluphenazine hcl tab 2.5 mg</i>	1	MO
<i>fluphenazine hcl tab 5 mg</i>	1	MO
<i>fluphenazine hcl tab 10 mg</i>	1	MO
<i>perphenazine tab 2 mg</i>	1	MO
<i>perphenazine tab 4 mg</i>	1	MO
<i>perphenazine tab 8 mg</i>	1	MO
<i>perphenazine tab 16 mg</i>	1	MO
<i>prochlorperazine maleate tab 5 mg (base equivalent)</i>	1	MO
<i>prochlorperazine maleate tab 10 mg (base equivalent)</i>	1	MO
<i>prochlorperazine suppos 25 mg</i>	1	
(Prochlorperazine Suppos 25 mg) COMPRO	1	
<i>thioridazine hcl tab 10 mg</i>	1	MO
<i>thioridazine hcl tab 25 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>thioridazine hcl tab 50 mg</i>	1	MO
<i>thioridazine hcl tab 100 mg</i>	1	MO
<i>trifluoperazine hcl tab 1 mg (base equivalent)</i>	1	MO
<i>trifluoperazine hcl tab 2 mg (base equivalent)</i>	1	MO
<i>trifluoperazine hcl tab 5 mg (base equivalent)</i>	1	MO
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	1	MO
QUINOLINONE DERIVATIVES		
<i>aripiprazole oral solution 1 mg/ml</i>	1	MO
<i>aripiprazole orally disintegrating tab 10 mg</i>	1	MO
<i>aripiprazole orally disintegrating tab 15 mg</i>	1	MO
<i>aripiprazole tab 2 mg</i>	1	MO
<i>aripiprazole tab 5 mg</i>	1	MO
<i>aripiprazole tab 10 mg</i>	1	MO
<i>aripiprazole tab 15 mg</i>	1	MO
<i>aripiprazole tab 20 mg</i>	1	MO
<i>aripiprazole tab 30 mg</i>	1	MO
THIOXANTHENES		
<i>thiothixene cap 1 mg</i>	1	MO
<i>thiothixene cap 2 mg</i>	1	MO
<i>thiothixene cap 5 mg</i>	1	MO
<i>thiothixene cap 10 mg</i>	1	MO
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
ANTIRETROVIRALS		
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	1	SP, QL (30 mL every 1 day)
<i>abacavir sulfate tab 300 mg (base equiv)</i>	1	SP, QL (2 tabs every 1 day)
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>APTIVUS CAP 250MG (tipranavir)</i>	2	SP, QL (4 caps every 1 day)
<i>atazanavir sulfate cap 150 mg (base equiv)</i>	1	SP, QL (1 cap every 1 day)
<i>atazanavir sulfate cap 200 mg (base equiv)</i>	1	SP, QL (2 caps every 1 day)
<i>atazanavir sulfate cap 300 mg (base equiv)</i>	1	SP, QL (1 cap every 1 day)
<i>BIKTARVY TAB (bictegravir-emtricitabine-tenofovir alafenamide fumarate)</i>	2	SP, QL (1 tab every 1 day); (30-120-15 mg)
<i>BIKTARVY TAB (bictegravir-emtricitabine-tenofovir alafenamide fumarate)</i>	2	SP, QL (1 tab every 1 day); (50-200-25 mg)
<i>CIMDUO TAB 300-300 (lamivudine-tenofovir disoproxil fumarate)</i>	2	SP, QL (1 tab every 1 day)
<i>CRIXIVAN CAP 200MG (indinavir sulfate)</i>	3	SP, PA
<i>CRIXIVAN CAP 400MG (indinavir sulfate)</i>	3	SP, PA
<i>darunavir tab 600 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>darunavir tab 800 mg</i>	1	SP, QL (1 tab every 1 day)
<i>DESCOVY TAB 120-15MG (emtricitabine-tenofovir alafenamide fumarate)</i>	2	SP, QL (1 tab every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
DESCOVY TAB 200/25MG (<i>emtricitabine-tenofovir alafenamide fumarate</i>)	2	SP, QL (1 tab every 1 day); \$0 copay for PrEP
DOVATO TAB 50-300MG (<i>dolutegravir sodium-lamivudine</i>)	2	SP, QL (1 tab every 1 day)
<i>efavirenz tab 600 mg</i>	1	SP, QL (1 tab every 1 day)
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>emtricitabine caps 200 mg</i>	1	SP, QL (1 cap every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	1	SP, QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	1	SP, QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	1	SP, QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	1	SP, QL (1 tab every 1 day); \$0 copay for PrEP
<i>etravirine tab 100 mg</i>	1	SP, QL (4 tabs every 1 day)
<i>etravirine tab 200 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>fosamprenavir calcium tab 700 mg (base equiv)</i>	1	SP, QL (4 tabs every 1 day)
GENVOYA TAB (<i>elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide</i>)	2	SP, QL (1 tab every 1 day)
ISENTRESS CHW 25MG (<i>raltegravir potassium</i>)	2	SP, QL (6 tabs every 1 day)
ISENTRESS CHW 100MG (<i>raltegravir potassium</i>)	2	SP, QL (6 tabs every 1 day)
ISENTRESS HD TAB 600MG (<i>raltegravir potassium</i>)	2	SP, QL (2 tabs every 1 day)
ISENTRESS POW 100MG (<i>raltegravir potassium</i>)	2	SP, QL (2 packets every 1 day)
ISENTRESS TAB 400MG (<i>raltegravir potassium</i>)	2	SP, QL (4 tabs every 1 day)
<i>lamivudine oral soln 10 mg/ml</i>	1	SP, QL (32 mL every 1 day)
<i>lamivudine tab 150 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>lamivudine tab 300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>lamivudine-zidovudine tab 150-300 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>lopinavir-ritonavir tab 100-25 mg</i>	1	SP, QL (10 tabs every 1 day)
<i>lopinavir-ritonavir tab 200-50 mg</i>	1	SP, QL (4 tabs every 1 day)
<i>maraviroc tab 150 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>maraviroc tab 300 mg</i>	1	SP, QL (4 tabs every 1 day)
<i>nevirapine susp 50 mg/5ml</i>	1	SP, QL (40 mL every 1 day)
<i>nevirapine tab 200 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>nevirapine tab er 24hr 400 mg</i>	1	SP, QL (1 tab every 1 day)
ODEFSEY TAB (<i>emtricitabine-rilpivirine-tenofovir alafenamide fumarate</i>)	2	SP, QL (1 tab every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PREZCOBIX TAB 800-150 (<i>darunavir-cobicistat</i>)	3	SP, QL (1 tab every 1 day)
<i>ritonavir tab 100 mg</i>	1	SP, QL (12 tabs every 1 day)
SYM TUZA TAB (<i>darunavir-cobicistat-emtricitabine-tenofovir alafenamide</i>)	2	SP, QL (1 tab every 1 day)
<i>tenofovir disoproxil fumarate tab 300 mg</i>	1	SP, QL (1 tab every 1 day)
TIVICAY PD TAB 5MG (<i>dolutegravir sodium</i>)	2	SP, QL (12 tabs every 1 day)
TIVICAY TAB 50MG (<i>dolutegravir sodium</i>)	2	SP, QL (2 tabs every 1 day)
TRIUMEQ PD TAB (<i>abacavir-dolutegravir-lamivudine</i>)	2	SP, QL (6 tabs every 1 day)
TRIUMEQ TAB (<i>abacavir-dolutegravir-lamivudine</i>)	2	SP, QL (1 tab every 1 day)
VIRACEPT TAB 250MG (<i>nelfinavir mesylate</i>)	3	SP, PA
VIRACEPT TAB 625MG (<i>nelfinavir mesylate</i>)	3	SP, PA
<i>zidovudine cap 100 mg</i>	1	SP, QL (6 caps every 1 day)
<i>zidovudine syrup 10 mg/ml</i>	1	SP, QL (64 mL every 1 day)
<i>zidovudine tab 300 mg</i>	1	SP, QL (2 tabs every 1 day)
ANTIVIRAL COMBINATIONS		
PAXLOVID PAK (<i>nirmatrelvir-ritonavir</i>)	2	
PAXLOVID TAB 150-100 (<i>nirmatrelvir-ritonavir</i>)	PV	QL (1 carton every 90 days)
PAXLOVID TAB 300-100 (<i>nirmatrelvir-ritonavir</i>)	PV	QL (1 carton every 90 days)
CMV AGENTS		
<i>valganciclovir hcl for soln 50 mg/ml (base equiv)</i>	1	QL (1000 mL every 30 days), MO
<i>valganciclovir hcl tab 450 mg (base equivalent)</i>	1	QL (4 tabs every 1 day), MO
HEPATITIS AGENTS		
<i>adefovir dipivoxil tab 10 mg</i>	1	SP
<i>entecavir tab 0.5 mg</i>	1	SP, QL (1 tab every 1 day)
<i>entecavir tab 1 mg</i>	1	SP, QL (1 tab every 1 day)
EPCLUSA PAK 150-37.5 (<i>sofosbuvir-velpatasvir</i>)	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA PAK 200-50MG (<i>sofosbuvir-velpatasvir</i>)	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 200-50MG (<i>sofosbuvir-velpatasvir</i>)	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 400-100 (<i>sofosbuvir-velpatasvir</i>)	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 2, 3, 4, 5, 6
HARVONI PAK (<i>ledipasvir-sofosbuvir</i>)	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
HARVONI PAK 45-200MG (<i>ledipasvir-sofosbuvir</i>)	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
HARVONI TAB 45-200MG (<i>ledipasvir-sofosbuvir</i>)	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 4, 5, 6

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HARVONI TAB 90-400MG (<i>ledipasvir-sofosbuvir</i>)	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 4, 5, 6
<i>lamivudine tab 100 mg (hbv)</i>	1	SP
MAVYRET PAK 50-20MG (<i>glecaprevir-pibrentasvir</i>)	3	SP, PA
MAVYRET TAB 100-40MG (<i>glecaprevir-pibrentasvir</i>)	3	SP, PA
<i>ribavirin cap 200 mg</i>	1	SP, PA
<i>ribavirin tab 200 mg</i>	1	SP, PA
SOVALDI PAK 150MG (<i>sofosbuvir</i>)	3	SP, PA
SOVALDI PAK 200MG (<i>sofosbuvir</i>)	3	SP, PA
SOVALDI TAB 200MG (<i>sofosbuvir</i>)	3	SP, PA
SOVALDI TAB 400MG (<i>sofosbuvir</i>)	3	SP, PA
VEMLIDY TAB 25MG (<i>tenofovir alafenamide fumarate</i>)	2	SP, QL (1 tab every 1 day)
VOSEVI TAB (<i>sofosbuvir-velpatasvir-voxilaprevir</i>)	2	SP, PA, QL (1 tab every 1 day); For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).
ZEPATIER TAB 50-100MG (<i>elbasvir-grazoprevir</i>)	3	SP, PA
HERPES AGENTS		
<i>acyclovir cap 200 mg</i>	1	
<i>acyclovir susp 200 mg/5ml</i>	1	
<i>acyclovir tab 400 mg</i>	1	
<i>acyclovir tab 800 mg</i>	1	
<i>famciclovir tab 125 mg</i>	1	
<i>famciclovir tab 250 mg</i>	1	
<i>famciclovir tab 500 mg</i>	1	
<i>valacyclovir hcl tab 1 gm</i>	1	
<i>valacyclovir hcl tab 500 mg</i>	1	
INFLUENZA AGENTS		
<i>oseltamivir phosphate cap 30 mg (base equiv)</i>	1	
<i>oseltamivir phosphate cap 45 mg (base equiv)</i>	1	
<i>oseltamivir phosphate cap 75 mg (base equiv)</i>	1	
<i>oseltamivir phosphate for susp 6 mg/ml (base equiv)</i>	1	
RELENZA MIS DISKHALE (<i>zanamivir</i>)	2	
<i>rimantadine hydrochloride tab 100 mg</i>	1	
MISC. ANTIVIRALS		
LAGEVRIO CAP 200MG (<i>molnupiravir</i>)	PV	QL (40 caps every 90 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		

ALPHA-BETA BLOCKERS

<i>carvedilol phosphate cap er 24hr 10 mg</i>	1	MO
<i>carvedilol phosphate cap er 24hr 20 mg</i>	1	MO
<i>carvedilol phosphate cap er 24hr 40 mg</i>	1	MO
<i>carvedilol phosphate cap er 24hr 80 mg</i>	1	MO
<i>carvedilol tab 3.125 mg</i>	1	MO
<i>carvedilol tab 6.25 mg</i>	1	MO
<i>carvedilol tab 12.5 mg</i>	1	MO
<i>carvedilol tab 25 mg</i>	1	MO
<i>labetalol hcl tab 100 mg</i>	1	MO
<i>labetalol hcl tab 200 mg</i>	1	MO
<i>labetalol hcl tab 300 mg</i>	1	MO

BETA BLOCKERS CARDIO-SELECTIVE

<i>acebutolol hcl cap 200 mg</i>	1	MO
<i>acebutolol hcl cap 400 mg</i>	1	MO
<i>atenolol tab 25 mg</i>	1	MO
<i>atenolol tab 50 mg</i>	1	MO
<i>atenolol tab 100 mg</i>	1	MO
<i>betaxolol hcl tab 10 mg</i>	1	MO
<i>betaxolol hcl tab 20 mg</i>	1	MO
<i>bisoprolol fumarate tab 5 mg</i>	1	MO
<i>bisoprolol fumarate tab 10 mg</i>	1	MO
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv)</i>	1	MO
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv)</i>	1	MO
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv)</i>	1	MO
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv)</i>	1	MO
<i>metoprolol tartrate tab 25 mg</i>	1	MO
<i>metoprolol tartrate tab 37.5 mg</i>	1	MO
<i>metoprolol tartrate tab 50 mg</i>	1	MO
<i>metoprolol tartrate tab 75 mg</i>	1	MO
<i>metoprolol tartrate tab 100 mg</i>	1	MO
<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	1	MO
<i>nebivolol hcl tab 5 mg (base equivalent)</i>	1	MO
<i>nebivolol hcl tab 10 mg (base equivalent)</i>	1	MO
<i>nebivolol hcl tab 20 mg (base equivalent)</i>	1	MO

BETA BLOCKERS NON-SELECTIVE

<i>nadolol tab 20 mg</i>	1	MO
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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>nadolol tab 40 mg</i>	1	MO
<i>nadolol tab 80 mg</i>	1	MO
<i>pindolol tab 5 mg</i>	1	MO
<i>pindolol tab 10 mg</i>	1	MO
<i>propranolol hcl cap er 24hr 60 mg</i>	1	MO
<i>propranolol hcl cap er 24hr 80 mg</i>	1	MO
<i>propranolol hcl cap er 24hr 120 mg</i>	1	MO
<i>propranolol hcl cap er 24hr 160 mg</i>	1	MO
<i>propranolol hcl oral soln 20 mg/5ml</i>	1	MO
<i>propranolol hcl oral soln 40 mg/5ml</i>	1	MO
<i>propranolol hcl tab 10 mg</i>	1	MO
<i>propranolol hcl tab 20 mg</i>	1	MO
<i>propranolol hcl tab 40 mg</i>	1	MO
<i>propranolol hcl tab 60 mg</i>	1	MO
<i>propranolol hcl tab 80 mg</i>	1	MO
<i>sotalol hcl (afib/afi) tab 80 mg</i>	1	MO
<i>sotalol hcl (afib/afi) tab 120 mg</i>	1	MO
<i>sotalol hcl (afib/afi) tab 160 mg</i>	1	MO
<i>sotalol hcl tab 80 mg</i>	1	MO
<i>sotalol hcl tab 120 mg</i>	1	MO
<i>sotalol hcl tab 160 mg</i>	1	MO
<i>sotalol hcl tab 240 mg</i>	1	MO
<i>timolol maleate tab 5 mg</i>	1	MO
<i>timolol maleate tab 10 mg</i>	1	MO
<i>timolol maleate tab 20 mg</i>	1	MO

CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS

CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS

<i>amlodipine besylate tab 2.5 mg (base equivalent)</i>	1	MO
<i>amlodipine besylate tab 5 mg (base equivalent)</i>	1	MO
<i>amlodipine besylate tab 10 mg (base equivalent)</i>	1	MO
<i>diltiazem hcl cap er 12hr 60 mg</i>	1	MO
<i>diltiazem hcl cap er 12hr 90 mg</i>	1	MO
<i>diltiazem hcl cap er 12hr 120 mg</i>	1	MO
<i>diltiazem hcl cap er 24hr 120 mg</i>	1	MO
(Diltiazem Hcl Cap Er 24hr 120 mg) DILT-XR	1	MO
<i>diltiazem hcl cap er 24hr 180 mg</i>	1	MO
(Diltiazem Hcl Cap Er 24hr 180 mg) DILT-XR	1	MO
<i>diltiazem hcl cap er 24hr 240 mg</i>	1	MO
(Diltiazem Hcl Cap Er 24hr 240 mg) DILT-XR	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>diltiazem hcl coated beads cap er 24hr 120 mg</i>	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg) CARTIA XT	1	MO
<i>diltiazem hcl coated beads cap er 24hr 180 mg</i>	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg) CARTIA XT	1	MO
<i>diltiazem hcl coated beads cap er 24hr 240 mg</i>	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg) CARTIA XT	1	MO
<i>diltiazem hcl coated beads cap er 24hr 300 mg</i>	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg) CARTIA XT	1	MO
<i>diltiazem hcl coated beads cap er 24hr 360 mg</i>	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 120 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 180 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 240 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 300 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 360 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 420 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 420 mg) TIADYLT ER	1	MO
<i>diltiazem hcl tab 30 mg</i>	1	MO
<i>diltiazem hcl tab 60 mg</i>	1	MO
<i>diltiazem hcl tab 90 mg</i>	1	MO
<i>diltiazem hcl tab 120 mg</i>	1	MO
<i>felodipine tab er 24hr 2.5 mg</i>	1	MO
<i>felodipine tab er 24hr 5 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>felodipine tab er 24hr 10 mg</i>	1	MO
<i>isradipine cap 2.5 mg</i>	1	MO
<i>isradipine cap 5 mg</i>	1	MO
<i>levamlodipine maleate tab 2.5 mg</i>	1	MO
<i>levamlodipine maleate tab 5 mg</i>	1	MO
<i>nicardipine hcl cap 20 mg</i>	1	MO
<i>nicardipine hcl cap 30 mg</i>	1	MO
<i>nifedipine cap 10 mg</i>	1	MO
<i>nifedipine cap 20 mg</i>	1	MO
<i>nifedipine tab er 24hr 30 mg</i>	1	MO
<i>nifedipine tab er 24hr 60 mg</i>	1	MO
<i>nifedipine tab er 24hr 90 mg</i>	1	MO
<i>nifedipine tab er 24hr osmotic release 30 mg</i>	1	MO
<i>nifedipine tab er 24hr osmotic release 60 mg</i>	1	MO
<i>nifedipine tab er 24hr osmotic release 90 mg</i>	1	MO
<i>nimodipine cap 30 mg</i>	1	
<i>nimodipine oral soln 60 mg/20ml (3 mg/ml)</i>	1	
<i>nisoldipine tab er 24hr 8.5 mg</i>	1	MO
<i>nisoldipine tab er 24hr 17 mg</i>	1	MO
<i>nisoldipine tab er 24hr 20 mg</i>	1	MO
<i>nisoldipine tab er 24hr 25.5 mg</i>	1	MO
<i>nisoldipine tab er 24hr 30 mg</i>	1	MO
<i>nisoldipine tab er 24hr 34 mg</i>	1	MO
<i>nisoldipine tab er 24hr 40 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 100 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 120 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 180 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 200 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 240 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 300 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 360 mg</i>	1	MO
<i>verapamil hcl tab 40 mg</i>	1	MO
<i>verapamil hcl tab 80 mg</i>	1	MO
<i>verapamil hcl tab 120 mg</i>	1	MO
<i>verapamil hcl tab er 120 mg</i>	1	MO
<i>verapamil hcl tab er 180 mg</i>	1	MO
<i>verapamil hcl tab er 240 mg</i>	1	MO
CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS		
CARDIAC GLYCOSIDES		
<i>digoxin oral soln 0.05 mg/ml</i>	1	MO
<i>digoxin tab 62.5 mcg (0.0625 mg)</i>	1	MO
<i>digoxin tab 125 mcg (0.125 mg)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>digoxin tab 250 mcg (0.25 mg)</i>	1	MO
CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i>	1	MO
ENTRESTO CAP 6-6MG (<i>sacubitril-valsartan</i>)	2	PA, MO
ENTRESTO CAP 15-16MG (<i>sacubitril-valsartan</i>)	2	PA, MO
ENTRESTO TAB 24-26MG (<i>sacubitril-valsartan</i>)	2	PA, MO
ENTRESTO TAB 49-51MG (<i>sacubitril-valsartan</i>)	2	PA, MO
ENTRESTO TAB 97-103MG (<i>sacubitril-valsartan</i>)	2	PA, MO
<i>isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg</i>	1	MO
OPSYNVI TAB 10-20MG (<i>macitentan-tadalafil</i>)	2	SP, PA, QL (1 tab every 1 day)
OPSYNVI TAB 10-40MG (<i>macitentan-tadalafil</i>)	2	SP, PA, QL (1 tab every 1 day)
IMPOTENCE AGENTS - DRUGS TO TREAT ERECTILE DYSFUNCTION		
<i>sildenafil citrate tab 25 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>sildenafil citrate tab 50 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>sildenafil citrate tab 100 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>tadalafil tab 2.5 mg</i>	1	PA, QL (1 tab every 1 day), MO
<i>tadalafil tab 5 mg</i>	1	PA, QL (1 tab every 1 day), MO
<i>tadalafil tab 10 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>tadalafil tab 20 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>vardeafil hcl orally disintegrating tab 10 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>vardeafil hcl tab 2.5 mg</i>	1	PA, QL (8 tabs every 21 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>varafenafil hcl tab 5 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>varafenafil hcl tab 10 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>varafenafil hcl tab 20 mg</i>	1	PA, QL (8 tabs every 21 days)
PROSTAGLANDIN VASODILATORS		
<i>ORENITRAM TAB 0.25MG (treprostiniol diolamine)</i>	2	SP, PA
<i>ORENITRAM TAB 0.125MG (treprostiniol diolamine)</i>	2	SP, PA
<i>ORENITRAM TAB 1MG (treprostiniol diolamine)</i>	2	SP, PA
<i>ORENITRAM TAB 2.5MG (treprostiniol diolamine)</i>	2	SP, PA
<i>ORENITRAM TAB 5MG (treprostiniol diolamine)</i>	2	SP, PA
<i>ORENITRAM TAB MONTH 1 (treprostiniol diolamine)</i>	2	SP, PA
<i>ORENITRAM TAB MONTH 2 (treprostiniol diolamine)</i>	2	SP, PA
<i>ORENITRAM TAB MONTH 3 (treprostiniol diolamine)</i>	2	SP, PA
<i>TYVASO DPI POW 16-32-48 (treprostiniol)</i>	2	SP, PA, QL (9 cartridges every 1 day)
<i>TYVASO DPI POW 16MCG (treprostiniol)</i>	2	SP, PA, QL (4 cartridges every 1 day)
<i>TYVASO DPI POW 32MCG (treprostiniol)</i>	2	SP, PA, QL (4 cartridges every 1 day)
<i>TYVASO DPI POW 48MCG (treprostiniol)</i>	2	SP, PA, QL (4 cartridges every 1 day)
<i>TYVASO DPI POW 64MCG (treprostiniol)</i>	2	SP, PA, QL (4 cartridges every 1 day)
<i>TYVASO RF KT SOL 0.6MG/ML (treprostiniol)</i>	2	SP, PA, QL (2.9 mL every 1 day)
<i>TYVASO SOL 0.6MG/ML (treprostiniol)</i>	2	SP, PA, QL (2.9 mL every 1 day)
<i>TYVASO ST KT SOL 0.6MG/ML (treprostiniol)</i>	2	SP, PA, QL (2.9 mL every 1 day)
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
<i>ambrisentan tab 5 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>ambrisentan tab 10 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>bosentan tab 62.5 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>bosentan tab 125 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>OPSUMIT TAB 10MG (macitentan)</i>	2	SP, PA, QL (1 tab every 1 day)
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
<i>sildenafil citrate for suspension 10 mg/ml</i>	1	SP, PA, QL (224 mL every 30 days)
<i>sildenafil citrate tab 20 mg</i>	1	SP, PA, QL (12 tabs every 1 day)
<i>tadalafil tab 20 mg (pah)</i>	1	SP, PA, QL (2 tabs every 1 day)
(Tadalafil Tab 20 mg (Pah)) ALYQ	1	SP, PA, QL (2 tabs every 1 day)
<i>TADLIQ SUS 20MG/5ML (tadalafil (pulmonary hypertension))</i>	2	SP, PA, QL (10 mL every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI PACK TAB 200/800 (<i>selexipag</i>)	2	SP, PA, QL (1 pack every 28 days)
UPTRAVI TAB 200MCG (<i>selexipag</i>)	2	SP, PA, QL (5 tabs every 1 day)
UPTRAVI TAB 400MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 600MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 800MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1000MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1200MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1400MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1600MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB 0.5MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 1.5MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 1MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 2.5MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 2MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
SINUS NODE INHIBITORS		
<i>ivabradine hcl tab 5 mg (base equiv)</i>	1	MO
<i>ivabradine hcl tab 7.5 mg (base equiv)</i>	1	MO
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB 2.5MG (<i>vericiguat</i>)	2	MO
VERQUVO TAB 5MG (<i>vericiguat</i>)	2	MO
VERQUVO TAB 10MG (<i>vericiguat</i>)	2	MO
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
CEPHALOSPORINS - 1ST GENERATION		
<i>cefadroxil cap 500 mg</i>	1	
<i>cefadroxil for susp 250 mg/5ml</i>	1	
<i>cefadroxil for susp 500 mg/5ml</i>	1	
<i>cefadroxil tab 1 gm</i>	1	
<i>cephalexin cap 250 mg</i>	1	
<i>cephalexin cap 500 mg</i>	1	
<i>cephalexin cap 750 mg</i>	1	
<i>cephalexin for susp 125 mg/5ml</i>	1	
<i>cephalexin for susp 250 mg/5ml</i>	1	
<i>cephalexin tab 250 mg</i>	1	
<i>cephalexin tab 500 mg</i>	1	
CEPHALOSPORINS - 2ND GENERATION		
<i>cefaclor cap 250 mg</i>	1	
<i>cefaclor cap 500 mg</i>	1	
<i>cefaclor for susp 250 mg/5ml</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>cefprozil for susp 125 mg/5ml</i>	1	
<i>cefprozil for susp 250 mg/5ml</i>	1	
<i>cefprozil tab 250 mg</i>	1	
<i>cefprozil tab 500 mg</i>	1	
<i>cefuroxime axetil tab 250 mg</i>	1	
<i>cefuroxime axetil tab 500 mg</i>	1	
CEPHALOSPORINS - 3RD GENERATION		
<i>cefdinir cap 300 mg</i>	1	
<i>cefdinir for susp 125 mg/5ml</i>	1	
<i>cefdinir for susp 250 mg/5ml</i>	1	
<i>cefixime cap 400 mg</i>	1	
<i>cefixime for susp 100 mg/5ml</i>	1	
<i>cefixime for susp 200 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	1	
<i>cefpodoxime proxetil tab 100 mg</i>	1	
<i>cefpodoxime proxetil tab 200 mg</i>	1	
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
COMBINATION CONTRACEPTIVES - ORAL		
<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) AZURETTE	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) KARIVA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) PIMTREA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) SIMLIYA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VIORELE	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VOLNEA	PV	MO
(Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg) VELIVET	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) APRI	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) CYRED EQ	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ENSKYCE	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ISIBLOOM	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) JULEBER	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) KALLIGA	PV	MO
(Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) RECLIPSEN	PV	MO
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg</i>	PV	MO
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</i>	PV	MO
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) JASMIEL	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) LO-ZUMANDIMINE	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) LORYNA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) NIKKI	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) VESTURA	PV	MO
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) OCELLA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) SYEDA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) ZUMANDIMINE	PV	MO
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) KELNOR 1/35	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) ZOVIA 1/35	PV	MO
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg) KELNOR 1/50	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg) VALTYA 1/50	PV	MO
FALESSA KIT (<i>levonorgestrel-ethinyl estradiol & folic acid</i>)	PV	MO
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg</i>	PV	MO

PREScription DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg ð Est 0.01 mg) RIVELSA	PV	MO
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	PV	MO
(Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7)) CAMRESE LO	PV	MO
(Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7)) LOJAIMIESS	PV	MO
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) ASHLYNA	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) CAMRESE	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) DAYSEE	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) JAIMIESS	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) SIMPESS	PV	MO
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) ICLEVIA	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) INTROVALE	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) JOLESSA	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) SETLAKIN	PV	MO
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AFIRMELLE	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AUBRA EQ	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AVIANE	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) DELYLA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) FALMINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LESSINA	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LUTERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) SRONYX	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) VIENVA	PV	MO
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ALTAVERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) AYUNA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) CHATEAL EQ	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) KURVELO	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) LEVORA 0.15/30-28	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) MARLISSA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) PORTIA-28	PV	MO
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) ENPRESSE-28	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) LEVONEST	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) TRIVORA-28	PV	MO
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) AMETHYST	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) DOLISHALE	PV	MO
levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)	PV	MO
(Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)) JOYEAUX	PV	MO
(Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)) MINZOYA	PV	MO
LO LOESTRIN TAB 1-10-10 (norethindrone acetate-ethinyl estradiol-fe fum (biphasic))	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NATAZIA TAB (<i>estradiol valerate-dienogest</i>)	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) BALZIVA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) BRIELLYN	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) PHILITH	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) VYFEMLA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) NECON 0.5/35-28	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) NORTREL 0.5/35 (28)	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) WERA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) ALYACEN 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) DASETTA 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NORTREL 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NYLIA 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg) WYMZYA FE	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg) XELRIA FE	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg) KAITLIB FE	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg) LAYOLIS FE	PV	MO
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg) TILIA FE	PV	MO
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg) TRI-LEGEST FE	PV	MO
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg) XARAH FE	PV	MO
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) AUROVELA 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) JUNEL 1/20	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) LARIN 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) LOESTRIN 1/20-21	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) MICROGESTIN 1/20	PV	MO
<i>norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg</i>	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) AUROVELA 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) HAILEY 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) JUNEL 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) LARIN 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) LOESTRIN 1.5/30-21	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) MICROGESTIN 1.5/30	PV	MO
<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) AUROVELA FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) BLISOVI FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) FEIRZA 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) HAILEY FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) JUNEL FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) LARIN FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) LOESTRIN FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) MICROGESTIN FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) TARINA FE 1/20 EQ	PV	MO
<i>norethindrone ace & ethinyl estradiol-fe tab 1.5 mg-30 mcg</i>	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) AUROVELA FE 1.5/30	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) BLISOVI FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) FEIRZA 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) HAILEY FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) JUNEL FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) LARIN FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) LOESTRIN FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) MICROGESTIN FE 1.5/30	PV	MO
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	PV	MO
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) CHARLOTTE 24 FE	PV	MO
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) FINZALA	PV	MO
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) MIBELAS 24 FE	PV	MO
<i>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)</i>	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) GEMMILY	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) MERZEE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) TAYSOFY	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) AUROVELA 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) BLISOVI 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) HAILEY 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) JUNEL FE 24	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) LARIN 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) TARINA 24 FE	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) ALYACEN 7/7/7	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) DASETTA 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) NORTREL 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) NYLIA 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg) ARANELLE	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg) LEENA	PV	MO
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) ESTARYLLA	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) MILI	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) MONO-LINYAH	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) SPRINTEC 28	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) VYLIBRA	PV	MO
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-ESTARYLLA	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-MARZIA	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-MILI	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-SPRINTEC	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-VYLIBRA LO	PV	MO
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-ESTARYLLA	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-LINYAH	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-MILI	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-SPRINTEC	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-VYLIBRA	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) CRYSELLE-28	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) ELINEST	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) LOW-OGESTREL	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) TURQOZ	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.5 mg-50 mcg) OGESTREL	PV	MO
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	PV	MO
(Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) XULANE	PV	MO
(Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) ZAFEMY	PV	MO
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA MIS (segesterone acetate-ethinyl estradiol)	PV	QL (1 ring every 300 days), MO; Quantity max 1 per fill; Quantity max 1 per 300 days
etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr	PV	QL (13 rings every 300 days), MO
(Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr) ELURYNG	PV	QL (13 rings every 300 days), MO
(Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr) ENILLORING	PV	QL (13 rings every 300 days), MO
(Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr) HALOETTE	PV	QL (13 rings every 300 days), MO
EMERGENCY CONTRACEPTIVES		
ELLA TAB 30MG (ulipristal acetate)	PV	
(Levonorgestrel Tab 1.5 mg) OPTION 2	PV	MO
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab 0.35 mg	PV	MO
(Norethindrone Tab 0.35 mg) CAMILA	PV	MO
(Norethindrone Tab 0.35 mg) DEBLITANE	PV	MO
(Norethindrone Tab 0.35 mg) EMZAHH	PV	MO
(Norethindrone Tab 0.35 mg) ERRIN	PV	MO
(Norethindrone Tab 0.35 mg) HEATHER	PV	MO
(Norethindrone Tab 0.35 mg) INCASSIA	PV	MO
(Norethindrone Tab 0.35 mg) JENCYCLA	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Tab 0.35 mg) LYLEQ	PV	MO
(Norethindrone Tab 0.35 mg) LYZA	PV	MO
(Norethindrone Tab 0.35 mg) NORA-BE	PV	MO
(Norethindrone Tab 0.35 mg) NORLYROC	PV	MO
(Norethindrone Tab 0.35 mg) SHAROBEL	PV	MO

CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE**GLUCOCORTICOSTEROIDS**

<i>budesonide delayed release particles cap 3 mg</i>	1	
<i>deflazacort susp 22.75 mg/ml</i>	1	SP, PA, QL (54 mL every 30 days)
<i>deflazacort tab 6 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>deflazacort tab 18 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>deflazacort tab 30 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>deflazacort tab 36 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>dexamethasone elixir 0.5 mg/5ml</i>	1	
<i>dexamethasone soln 0.5 mg/5ml</i>	1	
<i>dexamethasone tab 0.5 mg</i>	1	
<i>dexamethasone tab 0.75 mg</i>	1	
<i>dexamethasone tab 1 mg</i>	1	
<i>dexamethasone tab 1.5 mg</i>	1	
<i>dexamethasone tab 2 mg</i>	1	
<i>dexamethasone tab 4 mg</i>	1	
<i>dexamethasone tab 6 mg</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (21)</i>	1	
(Dexamethasone Tab Therapy Pack 1.5 mg (21)) HIDEX 6-DAY	1	
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	1	
EMFLAZA SUS 22.75/ML (<i>deflazacort</i>)	3	SP, PA
<i>hydrocortisone tab 5 mg</i>	1	
<i>hydrocortisone tab 10 mg</i>	1	
<i>hydrocortisone tab 20 mg</i>	1	
MEDROL TAB 2MG (<i>methylprednisolone</i>)	3	
<i>methylprednisolone tab 4 mg</i>	1	
<i>methylprednisolone tab 8 mg</i>	1	
<i>methylprednisolone tab 16 mg</i>	1	
<i>methylprednisolone tab 32 mg</i>	1	
<i>methylprednisolone tab therapy pack 4 mg (21)</i>	1	
<i>prednisolone sod phos orally disintegr tab 10 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 15 mg (base eq)</i>	1	

PREScription DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>prednisolone sod phos orally disintegr tab 30 mg (base eq)</i>	1	
<i>prednisolone sod phosphate oral soln 5 mg/5ml (base equiv)</i>	1	
<i>prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)</i>	1	
<i>prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)</i>	1	
<i>prednisolone soln 15 mg/5ml</i>	1	
<i>prednisolone tab 5 mg</i>	1	
<i>prednisone oral soln 5 mg/5ml</i>	1	
<i>prednisone tab 1 mg</i>	1	
<i>prednisone tab 2.5 mg</i>	1	
<i>prednisone tab 5 mg</i>	1	
<i>prednisone tab 10 mg</i>	1	
<i>prednisone tab 20 mg</i>	1	
<i>prednisone tab 50 mg</i>	1	
<i>prednisone tab therapy pack 5 mg (21)</i>	1	
<i>prednisone tab therapy pack 5 mg (48)</i>	1	
<i>prednisone tab therapy pack 10 mg (21)</i>	1	
<i>prednisone tab therapy pack 10 mg (48)</i>	1	
MINERALOCORTICIDS		
<i>fludrocortisone acetate tab 0.1 mg</i>	1	MO
COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS		
ANTITUSSIVES - DRUGS TO TREAT COUGH		
<i>benzonatate cap 100 mg</i>	1	
<i>benzonatate cap 150 mg</i>	1	
<i>benzonatate cap 200 mg</i>	1	
<i>hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml</i>	1	Not available under age 6
(Hydrocodone Bitart-Homatropine Methylbrom Soln 5-1.5 mg/5ml) HYDROMET	1	Not available under age 6
<i>hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg</i>	1	Not available under age 6
COUGH/COLD/ALLERGY COMBINATIONS		
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>	1	Not available under age 12
<i>promethazine & phenylephrine syrup 6.25-5 mg/5ml</i>	1	
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	1	Not available under age 12
<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	1	
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	1	
EXPECTORANTS - DRUGS TO TREAT COUGH		
<i>potassium iodide oral soln 1 gm/ml</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MISC. RESPIRATORY INHALANTS - DRUGS TO TREAT BREATHING DISORDERS		
<i>sodium chloride soln nebu 0.9%</i>	1	
<i>sodium chloride soln nebu 3%</i>	1	
(Sodium Chloride Soln Nebu 3%) NEBUSAL	1	
<i>sodium chloride soln nebu 7%</i>	1	
(Sodium Chloride Soln Nebu 7%) PULMOSAL	1	
<i>sodium chloride soln nebu 10%</i>	1	
MUCOLYTICS - DRUGS TO TREAT COUGH		
<i>acetylcysteine inhal soln 10%</i>	1	
<i>acetylcysteine inhal soln 20%</i>	1	
DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS		
ACNE PRODUCTS		
<i>adapalene cream 0.1%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>adapalene gel 0.1%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>adapalene gel 0.3%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	1	
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	1	
AKLIEF CRE 0.005% (<i>trifarotene</i>)	2	PA
<i>benzoyl peroxide foam 9.8%</i>	1	
<i>benzoyl peroxide gel 8%</i>	1	
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	1	
<i>benzoyl peroxide-hydrocortisone lotion 5-0.5%</i>	1	
<i>clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%</i>	1	
(Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5%) NEUAC	1	
<i>clindamycin phosphate foam 1%</i>	1	
(Clindamycin Phosphate Foam 1%) CLINDACIN	1	
<i>clindamycin phosphate gel 1% (twice-daily)</i>	1	
<i>clindamycin phosphate lotion 1%</i>	1	
<i>clindamycin phosphate soln 1%</i>	1	
<i>clindamycin phosphate swab 1%</i>	1	
(Clindamycin Phosphate Swab 1%) CLINDACIN ETZ PLEDGETS	1	
(Clindamycin Phosphate Swab 1%) CLINDACIN-P	1	
<i>clindamycin phosphate-benzoyl peroxide gel 1-5%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%</i>	1	
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-3.75%</i>	1	
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>dapsone gel 5%</i>	1	
<i>dapsone gel 7.5%</i>	1	
EPIDUO FORTE GEL 0.3-2.5% (<i>adapalene-benzoyl peroxide</i>)	2	
EPIDUO GEL 0.1-2.5% (<i>adapalene-benzoyl peroxide</i>)	2	
<i>erythromycin gel 2%</i>	1	
(Erythromycin Pads 2%) ERY	1	
<i>erythromycin soln 2%</i>	1	
<i>isotretinoin cap 10 mg</i>	1	PA
(Isotretinoin Cap 10 mg) ACCUTANE	1	PA
(Isotretinoin Cap 10 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 10 mg) CLARAVIS	1	PA
(Isotretinoin Cap 10 mg) ZENATANE	1	PA
<i>isotretinoin cap 20 mg</i>	1	PA
(Isotretinoin Cap 20 mg) ACCUTANE	1	PA
(Isotretinoin Cap 20 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 20 mg) CLARAVIS	1	PA
(Isotretinoin Cap 20 mg) ZENATANE	1	PA
<i>isotretinoin cap 30 mg</i>	1	PA
(Isotretinoin Cap 30 mg) ACCUTANE	1	PA
(Isotretinoin Cap 30 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 30 mg) CLARAVIS	1	PA
(Isotretinoin Cap 30 mg) ZENATANE	1	PA
<i>isotretinoin cap 40 mg</i>	1	PA
(Isotretinoin Cap 40 mg) ACCUTANE	1	PA
(Isotretinoin Cap 40 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 40 mg) CLARAVIS	1	PA
(Isotretinoin Cap 40 mg) ZENATANE	1	PA
<i>sulfacetamide sodium lotion 10% (acne)</i>	1	
<i>sulfacetamide sodium w/ sulfur cleanser 10-5%</i>	1	
(Sulfacetamide Sodium W/ Sulfur Emulsion 10-1%) SULFAMEZ WASH	1	
<i>tretinoin cream 0.1%</i>	1	PA; PA Required for age greater than or equal to age 35

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>tretinoin cream 0.05%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin cream 0.025%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin gel 0.01%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin gel 0.05%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin gel 0.025%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin microsphere gel 0.1%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin microsphere gel 0.04%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin microsphere gel 0.08%</i>	1	PA; PA Required for age greater than or equal to age 35
TWYNEO CRE 0.1-3% (<i>tretinoin-benzoyl peroxide</i>)	2	PA; PA Required for age greater than or equal to age 35
WINLEVI CRE 1% (<i>clascoterone</i>)	2	PA
ANTI-INFLAMMATORY AGENTS - TOPICAL		
<i>diclofenac epolamine patch 1.3%</i>	1	
<i>diclofenac sodium soln 1.5%</i>	1	
ANTIBIOTICS - TOPICAL		
<i>gentamicin sulfate cream 0.1%</i>	1	
<i>gentamicin sulfate oint 0.1%</i>	1	
<i>mupirocin oint 2%</i>	1	
ANTIFUNGALS - TOPICAL		
<i>ciclopirox gel 0.77%</i>	1	
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	1	
<i>ciclopirox olamine susp 0.77% (base equiv)</i>	1	
<i>ciclopirox shampoo 1%</i>	1	
<i>ciclopirox solution 8%</i>	1	PA
(Ciclopirox Solution 8%) CICLODAN	1	PA
<i>clotrimazole cream 1%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>clotrimazole soln 1%</i>	1	
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	1	
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	1	
<i>econazole nitrate cream 1%</i>	1	
(Iodoquinol-Hydrocortisone In Aloe Vehicle Cream 1-1.9%) IODOQUIMEZ-HC	1	
<i>ketoconazole cream 2%</i>	1	
<i>ketoconazole shampoo 2%</i>	1	
<i>naftifine hcl cream 1%</i>	1	
<i>naftifine hcl cream 2%</i>	1	
<i>naftifine hcl gel 2%</i>	1	
NAFTIN GEL 2% (<i>naftifine hcl</i>)	2	
<i>nystatin cream 100000 unit/gm</i>	1	
<i>nystatin oint 100000 unit/gm</i>	1	
<i>nystatin topical powder 100000 unit/gm</i>	1	
(Nystatin Topical Powder 100000 unit/gm) KLAYESTA	1	
(Nystatin Topical Powder 100000 unit/gm) NYAMYC	1	
(Nystatin Topical Powder 100000 unit/gm) NYSTOP	1	
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	1	
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	1	
<i>oxiconazole nitrate cream 1%</i>	1	
<i>sulconazole nitrate cream 1%</i>	1	
<i>sulconazole nitrate solution 1%</i>	1	
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
<i>bexarotene gel 1%</i>	1	SP, PA
<i>diclofenac sodium (actinic keratoses) gel 3%</i>	1	
<i>fluorouracil cream 5%</i>	1	
<i>fluorouracil soln 2%</i>	1	
<i>fluorouracil soln 5%</i>	1	
ANTIPSORIATICS		
<i>acitretin cap 10 mg</i>	1	PA
<i>acitretin cap 17.5 mg</i>	1	PA
<i>acitretin cap 25 mg</i>	1	PA
<i>calcipotriene oint 0.005%</i>	1	
(Calcipotriene Oint 0.005%) CALCITRENE	1	
<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	1	
<i>methoxsalen rapid cap 10 mg</i>	1	
SOTYKTU TAB 6MG (<i>deucravacitinib</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Psoriasis
<i>tazarotene cream 0.1%</i>	1	PA
<i>tazarotene cream 0.05%</i>	1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>tazarotene gel 0.1%</i>	1	PA
<i>tazarotene gel 0.05%</i>	1	PA
ANTISEBORRHEIC PRODUCTS		
<i>selenium sulfide lotion 2.5%</i>	1	
<i>sulfacetamide sodium liquid 10%</i>	1	
ANTIVIRALS - TOPICAL		
<i>acyclovir oint 5%</i>	1	
<i>penciclovir cream 1%</i>	1	
BURN PRODUCTS		
<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	1	
<i>silver sulfadiazine cream 1%</i>	1	
(Silver Sulfadiazine Cream 1%) SSD	1	
CORTICOSTEROIDS - TOPICAL		
<i>alclometasone dipropionate cream 0.05%</i>	1	
<i>alclometasone dipropionate oint 0.05%</i>	1	
<i>betamethasone dipropionate augmented cream 0.05%</i>	1	
<i>betamethasone dipropionate augmented gel 0.05%</i>	1	
<i>betamethasone dipropionate augmented lotion 0.05%</i>	1	
<i>betamethasone dipropionate augmented oint 0.05%</i>	1	
<i>betamethasone dipropionate cream 0.05%</i>	1	
<i>betamethasone dipropionate lotion 0.05%</i>	1	
<i>betamethasone valerate aerosol foam 0.12%</i>	1	
<i>betamethasone valerate cream 0.1% (base equivalent)</i>	1	
<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	1	
<i>betamethasone valerate oint 0.1% (base equivalent)</i>	1	
BRYHALI LOT 0.01% (<i>halobetasol propionate</i>)	2	
<i>clobetasol propionate cream 0.05%</i>	1	
<i>clobetasol propionate cream 0.025%</i>	1	
<i>clobetasol propionate emollient base cream 0.05%</i>	1	
<i>clobetasol propionate foam 0.05%</i>	1	
<i>clobetasol propionate gel 0.05%</i>	1	
<i>clobetasol propionate lotion 0.05%</i>	1	
<i>clobetasol propionate oint 0.05%</i>	1	
<i>clobetasol propionate shampoo 0.05%</i>	1	
(Clobetasol Propionate Shampoo 0.05%) CLODAN	1	
<i>clobetasol propionate soln 0.05%</i>	1	
<i>desonide cream 0.05%</i>	1	
<i>desonide lotion 0.05%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>desonide oint 0.05%</i>	1	
<i>desoximetasone cream 0.05%</i>	1	
<i>desoximetasone cream 0.25%</i>	1	
<i>desoximetasone gel 0.05%</i>	1	
<i>desoximetasone oint 0.25%</i>	1	
<i>desoximetasone spray 0.25%</i>	1	
ENSTILAR AER (<i>calcipotriene-betamethasone dipropionate</i>)	2	
<i>fluocinolone acetonide cream 0.01%</i>	1	
<i>fluocinolone acetonide cream 0.025%</i>	1	
<i>fluocinolone acetonide oil 0.01% (body oil)</i>	1	
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	1	
<i>fluocinolone acetonide oint 0.025%</i>	1	
<i>fluocinolone acetonide soln 0.01%</i>	1	
<i>fluocinonide cream 0.05%</i>	1	
<i>fluocinonide emulsified base cream 0.05%</i>	1	
<i>fluocinonide gel 0.05%</i>	1	
<i>fluocinonide oint 0.05%</i>	1	
<i>fluocinonide soln 0.05%</i>	1	
<i>fluticasone propionate cream 0.05%</i>	1	
<i>fluticasone propionate lotion 0.05%</i>	1	
<i>fluticasone propionate oint 0.005%</i>	1	
<i>halcinonide soln 0.1%</i>	1	
<i>halobetasol propionate cream 0.05%</i>	1	
<i>halobetasol propionate oint 0.05%</i>	1	
<i>hydrocortisone butyrate cream 0.1%</i>	1	
<i>hydrocortisone butyrate oint 0.1%</i>	1	
<i>hydrocortisone butyrate soln 0.1%</i>	1	
<i>hydrocortisone cream 1%</i>	1	
(Hydrocortisone Cream 1%) ALA-CORT	1	
<i>hydrocortisone cream 2.5%</i>	1	
<i>hydrocortisone lotion 2.5%</i>	1	
<i>hydrocortisone oint 1%</i>	1	
<i>hydrocortisone oint 2.5%</i>	1	
(Hydrocortisone Soln 2.5%) TEXACORT	1	
<i>hydrocortisone valerate cream 0.2%</i>	1	
<i>hydrocortisone valerate oint 0.2%</i>	1	
<i>lidocaine-hydrocortisone acetate cream 1-1%</i>	1	
<i>mometasone furoate cream 0.1%</i>	1	
<i>mometasone furoate oint 0.1%</i>	1	
<i>mometasone furoate solution 0.1% (lotion)</i>	1	
<i>triamcinolone acetonide cream 0.1%</i>	1	

PREScription DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>triamcinolone acetonide cream 0.5%</i>	1	
(Triamcinolone Acetonide Cream 0.5%) TRIDERM	1	
<i>triamcinolone acetonide cream 0.025%</i>	1	
<i>triamcinolone acetonide lotion 0.1%</i>	1	
<i>triamcinolone acetonide lotion 0.025%</i>	1	
<i>triamcinolone acetonide oint 0.1%</i>	1	
<i>triamcinolone acetonide oint 0.5%</i>	1	
<i>triamcinolone acetonide oint 0.025%</i>	1	
ECZEMA AGENTS		
CIBINQO TAB 50MG (<i>abrocitinib</i>)	2	SP, PA, QL (1 tab every 1 day)
CIBINQO TAB 100MG (<i>abrocitinib</i>)	2	SP, PA, QL (1 tab every 1 day)
CIBINQO TAB 200MG (<i>abrocitinib</i>)	2	SP, PA, QL (1 tab every 1 day)
OPZELURA CRE 1.5% (<i>ruxolitinib phosphate (topical)</i>)	2	PA
EMOLLIENTS		
<i>lactic acid (ammonium lactate) cream 12%</i>	1	
<i>lactic acid (ammonium lactate) lotion 12%</i>	1	
HAIR GROWTH AGENTS		
LITFULO CAP 50MG (<i>ritlecitinib tosylate</i>)	2	SP, PA, QL (1 cap every 1 day)
IMMUNOMODULATING AGENTS - TOPICAL		
<i>imiquimod cream 3.75%</i>	1	
<i>imiquimod cream 5%</i>	1	
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
<i>pimecrolimus cream 1%</i>	1	PA
<i>tacrolimus oint 0.1%</i>	1	PA
<i>tacrolimus oint 0.03%</i>	1	PA
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS		
<i>podofilox gel 0.5%</i>	1	
<i>podofilox soln 0.5%</i>	1	
LOCAL ANESTHETICS - TOPICAL		
<i>ethyl chloride aerosol spray</i>	1	
(Lidocaine Hcl Cream 3%) LIDOPIN	1	
<i>lidocaine hcl lotion 3%</i>	1	
<i>lidocaine hcl soln 4%</i>	1	QL (50 mL every 25 days)
<i>lidocaine oint 5%</i>	1	QL (50 gm every 25 days)
<i>lidocaine patch 5%</i>	1	PA
(Lidocaine Patch 5%) LIDOCAN	1	PA
(Lidocaine Patch 5%) TRIDACAINE II	1	PA
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	1	QL (30 gm every 25 days)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OIN 2% (<i>crisaborole</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZORYVE CRE 0.3% (<i>roflumilast (topical)</i>)	2	
ZORYVE CRE 0.15% (<i>roflumilast (topical)</i>)	2	
ZORYVE MIS 0.3% (<i>roflumilast (topical)</i>)	2	
ROSACEA AGENTS		
<i>azelaic acid gel 15%</i>	1	
<i>brimonidine tartrate gel 0.33% (base equivalent)</i>	1	
FINACEA AER 15% (<i>azelaic acid</i>)	2	
<i>metronidazole cream 0.75%</i>	1	
<i>metronidazole gel 0.75%</i>	1	
<i>metronidazole gel 1%</i>	1	
<i>metronidazole lotion 0.75%</i>	1	
ORACEA CAP 40MG (<i>doxycycline (rosacea)</i>)	1	
SOOLANTRA CRE 1% (<i>ivermectin (rosacea)</i>)	1	
SCABICIDES & PEDICULICIDES		
(Crotamiton Lotion 10%) CROTAN	1	
<i>malathion lotion 0.5%</i>	1	
<i>permethrin cream 5%</i>	1	
<i>spinosad susp 0.9%</i>	1	
DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
DIGESTIVE ENZYMES		
CREON CAP 3000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
CREON CAP 6000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
CREON CAP 12000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
CREON CAP 24000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
CREON CAP 36000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
VIOKACE TAB 10440 (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
VIOKACE TAB 20880 (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 3000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 5000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 10000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 15000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZENPEP CAP 20000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 25000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 40000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 60000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
CARBONIC ANHYDRASE INHIBITORS		
<i>acetazolamide cap er 12hr 500 mg</i>	1	MO
<i>acetazolamide tab 125 mg</i>	1	MO
<i>acetazolamide tab 250 mg</i>	1	MO
<i>dichlorphenamide tab 50 mg</i>	1	SP, PA, QL (4 tabs every 1 day)
(Dichlorphenamide Tab 50 mg) ORMALVI	1	SP, PA, QL (4 tabs every 1 day)
<i>methazolamide tab 25 mg</i>	1	MO
<i>methazolamide tab 50 mg</i>	1	MO
DIURETIC COMBINATIONS		
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	1	MO
<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	1	MO
<i>triamterene & hydrochlorothiazide cap 37.5-25 mg</i>	1	MO
<i>triamterene & hydrochlorothiazide tab 37.5-25 mg</i>	1	MO
<i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	1	MO
LOOP DIURETICS		
<i>bumetanide tab 0.5 mg</i>	1	MO
<i>bumetanide tab 1 mg</i>	1	MO
<i>bumetanide tab 2 mg</i>	1	MO
<i>ethacrynic acid tab 25 mg</i>	1	MO
<i>furosemide oral soln 8 mg/ml</i>	1	MO
<i>furosemide oral soln 10 mg/ml</i>	1	MO
<i>furosemide tab 20 mg</i>	1	MO
<i>furosemide tab 40 mg</i>	1	MO
<i>furosemide tab 80 mg</i>	1	MO
<i>torsemide tab 5 mg</i>	1	MO
<i>torsemide tab 10 mg</i>	1	MO
<i>torsemide tab 20 mg</i>	1	MO
<i>torsemide tab 100 mg</i>	1	MO
POTASSIUM SPARING DIURETICS		
<i>amiloride hcl tab 5 mg</i>	1	MO
<i>spironolactone susp 25 mg/5ml</i>	1	MO
<i>spironolactone tab 25 mg</i>	1	MO
<i>spironolactone tab 50 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>spironolactone tab 100 mg</i>	1	MO
<i>triamterene cap 50 mg</i>	1	MO
<i>triamterene cap 100 mg</i>	1	MO
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
<i>chlorthalidone tab 25 mg</i>	1	MO
<i>chlorthalidone tab 50 mg</i>	1	MO
<i>hydrochlorothiazide cap 12.5 mg</i>	1	MO
<i>hydrochlorothiazide tab 12.5 mg</i>	1	MO
<i>hydrochlorothiazide tab 25 mg</i>	1	MO
<i>hydrochlorothiazide tab 50 mg</i>	1	MO
<i>indapamide tab 1.25 mg</i>	1	MO
<i>indapamide tab 2.5 mg</i>	1	MO
<i>metolazone tab 2.5 mg</i>	1	MO
<i>metolazone tab 5 mg</i>	1	MO
<i>metolazone tab 10 mg</i>	1	MO
ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES		
BONE DENSITY REGULATORS - DRUGS TO TREAT BONE LOSS		
<i>alendronate sodium oral soln 70 mg/75ml</i>	1	MO
<i>alendronate sodium tab 5 mg</i>	1	MO
<i>alendronate sodium tab 10 mg</i>	1	MO
<i>alendronate sodium tab 35 mg</i>	1	MO
<i>alendronate sodium tab 70 mg</i>	1	MO
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	1	MO
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	1	MO
<i>risedronate sodium tab 5 mg</i>	1	MO
<i>risedronate sodium tab 30 mg</i>	1	
<i>risedronate sodium tab 35 mg</i>	1	MO
<i>risedronate sodium tab 150 mg</i>	1	MO
<i>risedronate sodium tab delayed release 35 mg</i>	1	MO
FERTILITY REGULATORS		
<i>clomiphene citrate tab 50 mg</i>	1	Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
GNRH/LHRH ANTAGONISTS		
ORILISSA TAB 150MG (<i>elagolix sodium</i>)	2	
ORILISSA TAB 200MG (<i>elagolix sodium</i>)	2	
HORMONE RECEPTOR MODULATORS - DRUGS TO TREAT BONE LOSS		
<i>raloxifene hcl tab 60 mg</i>	1	MO; \$0 copay ages 35 and older for the primary prevention of breast cancer

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL SOL 2MG/ML (<i>nafarelin acetate</i>)	3	
METABOLIC MODIFIERS		
<i>betaine powder for oral solution</i>	1	SP, PA
<i>calcitriol cap 0.5 mcg</i>	1	MO
<i>calcitriol cap 0.25 mcg</i>	1	MO
<i>calcitriol oral soln 1 mcg/ml</i>	1	MO
<i>carglumic acid soluble tab 200 mg</i>	1	SP, PA
<i>cinacalcet hcl tab 30 mg (base equiv)</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>cinacalcet hcl tab 60 mg (base equiv)</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>cinacalcet hcl tab 90 mg (base equiv)</i>	1	SP, PA, QL (4 tabs every 1 day)
<i>doxercalciferol cap 0.5 mcg</i>	1	MO
<i>doxercalciferol cap 1 mcg</i>	1	MO
<i>doxercalciferol cap 2.5 mcg</i>	1	MO
GALAFOLD CAP 123MG (<i>migalastat hcl</i>)	2	SP, PA
<i>levocarnitine oral soln 1 gm/10ml (10%)</i>	1	MO
<i>levocarnitine tab 330 mg</i>	1	MO
<i>nitisinone cap 2 mg</i>	1	SP, PA
<i>nitisinone cap 5 mg</i>	1	SP, PA
<i>nitisinone cap 10 mg</i>	1	SP, PA
<i>nitisinone cap 20 mg</i>	1	SP, PA
ORFADIN SUS 4MG/ML (<i>nitisinone</i>)	2	SP, PA
<i>paricalcitol cap 1 mcg</i>	1	MO
<i>paricalcitol cap 2 mcg</i>	1	MO
<i>paricalcitol cap 4 mcg</i>	1	MO
PHEBURANE MIS 483/GM (<i>sodium phenylbutyrate</i>)	2	SP, PA, QL (46.4 gm every 1 day)
<i>sapropterin dihydrochloride powder packet 100 mg</i>	1	SP, PA
(Sapropterin Dihydrochloride Powder Packet 100 mg) JAVYGTOR	1	SP, PA
<i>sapropterin dihydrochloride powder packet 500 mg</i>	1	SP, PA
(Sapropterin Dihydrochloride Powder Packet 500 mg) JAVYGTOR	1	SP, PA
<i>sapropterin dihydrochloride tab 100 mg</i>	1	SP, PA
(Sapropterin Dihydrochloride Tab 100 mg) JAVYGTOR	1	SP, PA
<i>sodium phenylbutyrate oral powder 3 gm/teaspoonful</i>	1	SP, PA, QL (26.6 gm every 1 day)
<i>sodium phenylbutyrate tab 500 mg</i>	1	SP, PA, QL (40 tabs every 1 day)
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB 10MG (<i>finerenone</i>)	2	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
KERENDIA TAB 20MG (<i>finerenone</i>)	2	PA, MO
POSTERIOR PITUITARY HORMONES		
<i>desmopressin acetate nasal spray soln 0.01%</i>	1	MO
<i>desmopressin acetate nasal spray soln 0.01% (refrigerated)</i>	1	MO
<i>desmopressin acetate tab 0.1 mg</i>	1	MO
<i>desmopressin acetate tab 0.2 mg</i>	1	MO
PROGESTERONE RECEPTOR ANTAGONISTS		
<i>mifepristone tab 200 mg</i>	1	
PROLACTIN INHIBITORS		
<i>cabergoline tab 0.5 mg</i>	1	
VASOPRESSIN RECEPTOR ANTAGONISTS		
<i>tolvaptan tab 15 mg</i>	1	SP, PA
<i>tolvaptan tab 30 mg</i>	1	SP, PA
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
ESTROGEN COMBINATIONS		
BIJUVA CAP 0.5-100 (<i>estradiol-progesterone</i>)	2	MO
BIJUVA CAP 1-100MG (<i>estradiol-progesterone</i>)	2	MO
CLIMARA PRO DIS WEEKLY (<i>estradiol-levonorgestrel</i>)	2	MO
COMBIPATCH DIS (<i>estradiol & norethindrone acetate</i>)	2	MO
DUAVEE TAB 0.45-20 (<i>conjugated estrogens-bazedoxifene</i>)	2	MO
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	1	MO
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	1	MO
(Estradiol & Norethindrone Acetate Tab 1-0.5 mg) MIMVEY	1	MO
MYFEMBREE TAB (<i>relugolix-estradiol-norethindrone acetate</i>)	2	
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg) FYAVOLV	1	MO
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg) FYAVOLV	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg) JINTELI	1	MO
ORIAHNN CAP (<i>elagolix sodium-estradiol-norethindrone acetate</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PREMPHASE TAB (<i>conjugated estrogens-medroxyprogesterone acetate</i>)	2	MO
PREMPRO TAB (<i>conjugated estrogens-medroxyprogesterone acetate</i>)	2	MO
PREMPRO TAB 0.3-1.5 (<i>conjugated estrogens-medroxyprogesterone acetate</i>)	2	MO
PREMPRO TAB 0.45-1.5 (<i>conjugated estrogens-medroxyprogesterone acetate</i>)	2	MO
PREMPRO TAB 0.625-5 (<i>conjugated estrogens-medroxyprogesterone acetate</i>)	2	MO
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
<i>estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump)</i>	1	MO
<i>estradiol tab 0.5 mg</i>	1	MO
<i>estradiol tab 1 mg</i>	1	MO
<i>estradiol tab 2 mg</i>	1	MO
<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i>	1	MO
<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i>	1	MO
<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i>	1	MO
<i>estradiol td gel 1 mg/gm (0.1%)</i>	1	MO
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i>	1	MO
<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.1 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.1 mg/24hr) LYLLANA	1	MO
<i>estradiol td patch twice weekly 0.05 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.05 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.05 mg/24hr) LYLLANA	1	MO
<i>estradiol td patch twice weekly 0.025 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.025 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.025 mg/24hr) LYLLANA	1	MO
<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.075 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.075 mg/24hr) LYLLANA	1	MO
<i>estradiol td patch twice weekly 0.0375 mg/24hr</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Estradiol Td Patch Twice Weekly 0.0375 mg/24hr) DOTI	1	MO
(Estradiol Td Patch Twice Weekly 0.0375 mg/24hr) LYLLANA	1	MO
<i>estradiol td patch weekly 0.1 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.05 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.06 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.025 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.075 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i>	1	MO
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
CIPRO (5%) SUS 250MG/5 (<i>ciprofloxacin</i>)	3	
CIPRO (10%) SUS 500MG/5 (<i>ciprofloxacin</i>)	3	
<i>ciprofloxacin hcl tab 250 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 500 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	1	
<i>levofloxacin oral soln 25 mg/ml</i>	1	
<i>levofloxacin tab 250 mg</i>	1	
<i>levofloxacin tab 500 mg</i>	1	
<i>levofloxacin tab 750 mg</i>	1	
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	1	
<i>ofloxacin tab 300 mg</i>	1	
<i>ofloxacin tab 400 mg</i>	1	
GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
5-HT4 RECEPTOR AGONISTS		
<i>prucalopride succinate tab 1 mg (base equivalent)</i>	1	MO
<i>prucalopride succinate tab 2 mg (base equivalent)</i>	1	MO
GALLSTONE SOLUBILIZING AGENTS		
(Chenodiol Tab 250 mg) CHENODAL	1	PA
<i>ursodiol cap 300 mg</i>	1	MO
<i>ursodiol tab 250 mg</i>	1	MO
<i>ursodiol tab 500 mg</i>	1	MO
GASTROINTESTINAL ANTIALLERGY AGENTS		
<i>cromolyn sodium oral conc 100 mg/5ml</i>	1	MO
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
<i>lubiprostone cap 8 mcg</i>	1	PA, MO
<i>lubiprostone cap 24 mcg</i>	1	PA, MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
GASTROINTESTINAL STIMULANTS		
<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>	1	
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i>	1	
<i>metoclopramide hcl tab 5 mg (base equivalent)</i>	1	
<i>metoclopramide hcl tab 10 mg (base equivalent)</i>	1	
INFLAMMATORY BOWEL AGENTS		
<i>balsalazide disodium cap 750 mg</i>	1	
<i>mesalamine cap dr 400 mg</i>	1	MO
<i>mesalamine cap er 24hr 0.375 gm</i>	1	MO
<i>mesalamine enema 4 gm</i>	1	
<i>mesalamine suppos 1000 mg</i>	1	
<i>mesalamine tab delayed release 1.2 gm</i>	1	MO
<i>mesalamine tab delayed release 800 mg</i>	1	
<i>sulfasalazine tab 500 mg</i>	1	MO
<i>sulfasalazine tab delayed release 500 mg</i>	1	MO
VELSIPITY TAB 2MG (<i>etrasimod arginine</i>)	2	SP, PA, QL (1 tab every 1 day)
INTESTINAL ACIDIFIERS		
<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	1	MO
(Lactulose (Encephalopathy) Solution 10 gm/15ml) ENULOSE	1	MO
(Lactulose (Encephalopathy) Solution 10 gm/15ml) GENERLAC	1	MO
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
<i>alosetron hcl tab 0.5 mg (base equiv)</i>	1	PA, MO
<i>alosetron hcl tab 1 mg (base equiv)</i>	1	PA, MO
LINZESS CAP 72MCG (<i>linaclotide</i>)	2	PA, MO
LINZESS CAP 145MCG (<i>linaclotide</i>)	2	PA, MO
LINZESS CAP 290MCG (<i>linaclotide</i>)	2	PA, MO
VIBERZI TAB 75MG (<i>eluxadoline</i>)	2	PA, MO
VIBERZI TAB 100MG (<i>eluxadoline</i>)	2	PA, MO
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
MOVANTIK TAB 12.5MG (<i>naloxegol oxalate</i>)	2	
MOVANTIK TAB 25MG (<i>naloxegol oxalate</i>)	2	
SYMPROIC TAB 0.2MG (<i>naldemedine tosylate</i>)	2	
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	1	MO
<i>calcium acetate (phosphate binder) tab 667 mg</i>	1	MO
<i>ferric citrate tab 1 gm (210 mg ferric iron)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>sevelamer carbonate packet 0.8 gm</i>	1	MO
<i>sevelamer carbonate packet 2.4 gm</i>	1	MO
<i>sevelamer carbonate tab 800 mg</i>	1	MO
<i>sevelamer hcl tab 400 mg</i>	1	MO
<i>sevelamer hcl tab 800 mg</i>	1	MO
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
ALKALINIZERS		
(Potassium Citrate & Citric Acid Powder Pack 3300-1002 mg) CYTRA K CRYSTALS	1	
<i>potassium citrate tab er 5 meq (540 mg)</i>	1	
<i>potassium citrate tab er 10 meq (1080 mg)</i>	1	
<i>potassium citrate tab er 15 meq (1620 mg)</i>	1	
CYSTINOSIS AGENTS		
CYSTAGON CAP 50MG (<i>cysteamine bitartrate</i>)	2	SP, PA
CYSTAGON CAP 150MG (<i>cysteamine bitartrate</i>)	2	SP, PA
PROSTATIC HYPERTROPHY AGENTS		
<i>alfuzosin hcl tab er 24hr 10 mg</i>	1	MO
<i>dutasteride cap 0.5 mg</i>	1	MO
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	1	MO
<i>finasteride tab 5 mg</i>	1	MO
<i>silodosin cap 4 mg</i>	1	MO
<i>silodosin cap 8 mg</i>	1	MO
<i>tamsulosin hcl cap 0.4 mg</i>	1	MO
URINARY STONE AGENTS		
<i>tiopronin tab 100 mg</i>	1	SP, PA
<i>tiopronin tab delayed release 100 mg</i>	1	SP, PA
(Tiopronin Tab Delayed Release 100 mg) VENXXIVA	1	SP, PA
<i>tiopronin tab delayed release 300 mg</i>	1	SP, PA
(Tiopronin Tab Delayed Release 300 mg) VENXXIVA	1	SP, PA
GOUT AGENTS - DRUGS TO TREAT GOUT		
GOUT AGENT COMBINATIONS		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	MO
GOUT AGENTS - DRUGS TO TREAT GOUT		
<i>allopurinol tab 100 mg</i>	1	MO
<i>allopurinol tab 200 mg</i>	1	MO
<i>allopurinol tab 300 mg</i>	1	MO
<i>colchicine tab 0.6 mg</i>	1	
<i>febuxostat tab 40 mg</i>	1	MO
<i>febuxostat tab 80 mg</i>	1	MO
MITIGARE CAP 0.6MG (<i>colchicine</i>)	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
URICOSURICS		
<i>probenecid tab 500 mg</i>	1	MO
HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS		
HEMATORHEOLOGIC AGENTS		
<i>pentoxifylline tab er 400 mg</i>	1	MO
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO CAP 110MG (<i>berotralstat hcl</i>)	2	PA, QL (1 cap every 1 day), MO
ORLADEYO CAP 150MG (<i>berotralstat hcl</i>)	2	PA, QL (1 cap every 1 day), MO
PLATELET AGGREGATION INHIBITORS		
<i>anagrelide hcl cap 0.5 mg</i>	1	MO
<i>anagrelide hcl cap 1 mg</i>	1	MO
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	1	MO
BRILINTA TAB 60MG (<i>ticagrelor</i>)	2	MO
BRILINTA TAB 90MG (<i>ticagrelor</i>)	2	MO
<i>cilostazol tab 50 mg</i>	1	MO
<i>cilostazol tab 100 mg</i>	1	MO
<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	1	MO
<i>clopidogrel bisulfate tab 300 mg (base equiv)</i>	1	
<i>dipyridamole tab 25 mg</i>	1	MO
<i>dipyridamole tab 50 mg</i>	1	MO
<i>dipyridamole tab 75 mg</i>	1	MO
<i>prasugrel hcl tab 5 mg (base equiv)</i>	1	MO
<i>prasugrel hcl tab 10 mg (base equiv)</i>	1	MO
<i>ticagrelor tab 90 mg</i>	1	MO
HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP 84MG (<i>eliglustat tartrate</i>)	2	SP, PA, QL (2 caps every 1 day)
<i>miglustat cap 100 mg</i>	1	SP, PA, QL (3 caps every 1 day)
(Miglustat Cap 100 mg) YARGESA	1	SP, PA, QL (3 caps every 1 day)
AGENTS FOR SICKLE CELL DISEASE		
SIKLOS TAB 100MG (<i>hydroxyurea (sickle cell disease)</i>)	2	
SIKLOS TAB 1000MG (<i>hydroxyurea (sickle cell disease)</i>)	2	
FOLIC ACID/FOLATES		
<i>folic acid cap 0.8 mg</i>	PV	QL (100 caps every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Folic Acid Cap 0.8 mg) FA-8	PV	QL (100 caps every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
<i>folic acid tab 1 mg</i>	1	MO
<i>folic acid tab 400 mcg</i>	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) FOLATE	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) GNP FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) RA FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) SM FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 400 mcg) YL FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
<i>folic acid tab 800 mcg</i>	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 800 mcg) CVS FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 800 mcg) KP FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Folic Acid Tab 800 mcg) QC FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
(Folic Acid Tab 800 mcg) RA FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered

HEMATOPOIETIC GROWTH FACTORS

ALVAIZ TAB 9MG (<i>eltrombopag choline</i>)	2	SP, PA, QL (2 tabs every 1 day)
ALVAIZ TAB 18MG (<i>eltrombopag choline</i>)	2	SP, PA, QL (3 tabs every 1 day)
ALVAIZ TAB 36MG (<i>eltrombopag choline</i>)	2	SP, PA, QL (3 tabs every 1 day)
ALVAIZ TAB 54MG (<i>eltrombopag choline</i>)	2	SP, PA, QL (2 tabs every 1 day)
DOPTELET TAB 20MG (<i>avatrombopag maleate</i>)	2	SP, PA; OAC
DOPTELET TAB 20MG (<i>avatrombopag maleate</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC; 1 carton of 1 blister card (10 tabs)
DOPTELET TAB 20MG (<i>avatrombopag maleate</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC; 1 carton of 2 blister card (15 tabs)
DOPTELET TAB 20MG (<i>avatrombopag maleate</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC; 1 carton of 1 blister card (15 tabs)

HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS**HEMOSTATICS - SYSTEMIC**

<i>aminocaproic acid oral soln 0.25 gm/ml</i>	1	
<i>aminocaproic acid tab 500 mg</i>	1	
<i>aminocaproic acid tab 1000 mg</i>	1	
<i>tranexamic acid tab 650 mg</i>	1	

HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS**BARBITURATE HYPNOTICS**

<i>phenobarbital elixir 20 mg/5ml</i>	1	MO
<i>phenobarbital tab 15 mg</i>	1	MO
<i>phenobarbital tab 16.2 mg</i>	1	MO
<i>phenobarbital tab 30 mg</i>	1	MO
<i>phenobarbital tab 32.4 mg</i>	1	MO
<i>phenobarbital tab 60 mg</i>	1	MO
<i>phenobarbital tab 64.8 mg</i>	1	MO
<i>phenobarbital tab 97.2 mg</i>	1	MO
<i>phenobarbital tab 100 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HYPNOTICS - TRICYCLIC AGENTS		
<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	1	
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	1	
NON-BARBITURATE HYPNOTICS		
<i>estazolam tab 1 mg</i>	1	QL (15 tabs every 25 days)
<i>estazolam tab 2 mg</i>	1	QL (15 tabs every 25 days)
<i>eszopiclone tab 1 mg</i>	1	QL (15 tabs every 25 days)
<i>eszopiclone tab 2 mg</i>	1	QL (15 tabs every 25 days)
<i>eszopiclone tab 3 mg</i>	1	QL (15 tabs every 25 days)
<i>midazolam hcl syrup 2 mg/ml (base equivalent)</i>	1	
<i>temazepam cap 7.5 mg</i>	1	QL (15 caps every 25 days)
<i>temazepam cap 15 mg</i>	1	QL (15 caps every 25 days)
<i>temazepam cap 22.5 mg</i>	1	QL (15 caps every 25 days)
<i>temazepam cap 30 mg</i>	1	QL (15 caps every 25 days)
<i>triazolam tab 0.25 mg</i>	1	QL (10 tabs every 25 days)
<i>triazolam tab 0.125 mg</i>	1	QL (10 tabs every 25 days)
<i>zaleplon cap 5 mg</i>	1	QL (15 caps every 25 days)
<i>zaleplon cap 10 mg</i>	1	QL (15 caps every 25 days)
<i>zolpidem tartrate tab 5 mg</i>	1	QL (15 tabs every 25 days)
<i>zolpidem tartrate tab 10 mg</i>	1	QL (15 tabs every 25 days)
<i>zolpidem tartrate tab er 6.25 mg</i>	1	QL (15 tabs every 25 days)
<i>zolpidem tartrate tab er 12.5 mg</i>	1	QL (15 tabs every 25 days)
OREXIN RECEPTOR ANTAGONISTS		
<i>BELSOMRA TAB 5MG (suvorexant)</i>	2	PA
<i>BELSOMRA TAB 10MG (suvorexant)</i>	2	PA
<i>BELSOMRA TAB 15MG (suvorexant)</i>	2	PA
<i>BELSOMRA TAB 20MG (suvorexant)</i>	2	PA
<i>DAYVIGO TAB 5MG (lemborexant)</i>	2	PA
<i>DAYVIGO TAB 10MG (lemborexant)</i>	2	PA
<i>QUVIVIQ TAB 25MG (daridorexant hcl)</i>	2	PA
<i>QUVIVIQ TAB 50MG (daridorexant hcl)</i>	2	PA
SELECTIVE MELATONIN RECEPTOR AGONISTS		
<i>ramelteon tab 8 mg</i>	1	QL (15 tabs every 25 days)
<i>tasimelteon capsule 20 mg</i>	1	SP, PA, QL (1 cap every 1 day)
LAXATIVES - DRUGS TO TREAT CONSTIPATION		
LAXATIVE COMBINATIONS		
<i>CLENPIQ SOL (sodium picosulfate-magnesium oxide-anhydrous citric acid)</i>	PV	\$0 copay for members age 45 through 75
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 236 gm) GAVILYTE-G	1	
(Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm) GAVILYTE-C	1	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1	
(Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm) GAVILYTE-N/FLAVOR PACK	1	
PREPOPIK PAK (<i>sodium picosulfate-magnesium oxide-anhydrous citric acid</i>)	PV	\$0 copay for members age 45 through 75
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	PV	\$0 copay for members age 45 through 75
LAXATIVES - MISCELLANEOUS		
lactulose oral crystal packet 10 gm	1	MO
(Lactulose Oral Crystal Packet 10 gm) KRISTALOSE	1	MO
lactulose oral crystal packet 20 gm	1	MO
(Lactulose Oral Crystal Packet 20 gm) KRISTALOSE	1	MO
lactulose solution 10 gm/15ml	1	MO
(Lactulose Solution 10 gm/15ml) CONSTULOSE	1	MO
MACROLIDES - DRUGS TO TREAT INFECTIONS		
AZITHROMYCIN		
azithromycin for susp 100 mg/5ml	1	
azithromycin for susp 200 mg/5ml	1	
azithromycin tab 250 mg	1	
azithromycin tab 500 mg	1	
azithromycin tab 600 mg	1	
CLARITHROMYCIN		
clarithromycin for susp 125 mg/5ml	1	
clarithromycin for susp 250 mg/5ml	1	
clarithromycin tab 250 mg	1	
clarithromycin tab 500 mg	1	
clarithromycin tab er 24hr 500 mg	1	
ERYTHROMYCINS		
erythromycin ethylsuccinate for susp 200 mg/5ml	1	
erythromycin ethylsuccinate for susp 400 mg/5ml	1	
(Erythromycin Ethylsuccinate Tab 400 mg) E.E.S. 400	1	
erythromycin tab 250 mg	1	
erythromycin tab 500 mg	1	
erythromycin tab delayed release 250 mg	1	
erythromycin tab delayed release 333 mg	1	
erythromycin tab delayed release 500 mg	1	
erythromycin w/ delayed release particles cap 250 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FIDAXOMICIN		
DIFICID SUS (<i>fidaxomicin</i>)	2	
DIFICID TAB 200MG (<i>fidaxomicin</i>)	2	
MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING		
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
CONDOMS MIS	PV	QL (36 condoms every 75 days), MO
DUREX MIS REALFEEL (<i>condoms non-latex lubricated - male</i>)	PV	QL (36 condoms every 75 days), MO
FC2 FEMALE MIS CONDOM (<i>condoms - female</i>)	PV	QL (36 condoms every 75 days)
FC FEMALE MIS CONDOM (<i>condoms - female</i>)	PV	QL (36 condoms every 75 days)
MALE MIS CONDOM (<i>condoms latex lubricated - male</i>)	PV	QL (36 condoms every 75 days)
TRUSTEX MIS FLAVORS (<i>condoms latex non-lubricated - male</i>)	PV	QL (36 condoms every 75 days), MO
PARENTERAL THERAPY SUPPLIES		
BD INSULIN PEN NEEDLES - OTC (<i>insulin pen needle</i>)	2	
BD INSULIN SYRINGE - OTC (<i>insulin syringe/needle u-100</i>)	2	
BD INSULIN SYRINGE - OTC (<i>insulin syringes (disposable)</i>)	2	
BD INSULIN SYRINGE - RX (<i>insulin syringe/needle u-100</i>)	2	
BD INSULIN SYRINGE - RX (<i>insulin syringe/needle u-500</i>)	2	
RESPIRATORY THERAPY SUPPLIES		
AERCHMBR PLS MIS LRG MASK (<i>spacer/aerosol-holding chambers</i>)	2	
AERCHMBR PLS MIS MED MASK (<i>spacer/aerosol-holding chambers</i>)	2	
AERCHMBR PLS MIS SM MASK (<i>spacer/aerosol-holding chambers</i>)	2	
AERCHMBR Z- MIS STAT PLS (<i>spacer/aerosol-holding chambers</i>)	2	
AEROCHAMBER MIS CHAMBER (<i>spacer/aerosol-holding chambers</i>)	2	
AEROCHAMBER MIS FLOSIGNA (<i>spacer/aerosol-holding chambers</i>)	2	
AEROCHAMBER MIS MV (<i>spacer/aerosol-holding chambers</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
AEROCHAMBER MIS PLUS (<i>spacer/aerosol-holding chambers</i>)	2	
AEROVENT MIS PLUS (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHE EASE MIS LG MASK (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHE EASE MIS MED MASK (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHE EASE MIS SM MASK (<i>spacer/aerosol-holding chambers</i>)	2	
COMPACT SPAC MIS CHAMBER (<i>spacer/aerosol-holding chambers</i>)	2	
COMPACT SPAC MIS LG MASK (<i>spacer/aerosol-holding chambers</i>)	2	
COMPACT SPAC MIS MD MASK (<i>spacer/aerosol-holding chambers</i>)	2	
COMPACT SPAC MIS SM MASK (<i>spacer/aerosol-holding chambers</i>)	2	
EASIVENT MIS (<i>spacer/aerosol-holding chambers</i>)	2	
EASIVENT MIS MASK LG (<i>spacer/aerosol-holding chambers</i>)	2	
EASIVENT MIS MASK MED (<i>spacer/aerosol-holding chambers</i>)	2	
EASIVENT MIS MASK SM (<i>spacer/aerosol-holding chambers</i>)	2	
FLEXICHAMBER MIS (<i>spacer/aerosol-holding chambers</i>)	2	
FLEXICHAMBER MIS MASK LRG (<i>spacer/aerosol-holding chamber supplies - masks</i>)	2	
FLEXICHAMBER MIS MASK SM (<i>spacer/aerosol-holding chamber supplies - masks</i>)	2	
HOLD CHAMBER MIS ADLT LG (<i>spacer/aerosol-holding chambers</i>)	2	
HOLD CHAMBER MIS MEDIUM (<i>spacer/aerosol-holding chambers</i>)	2	
HOLD CHAMBER MIS SMALL (<i>spacer/aerosol-holding chambers</i>)	2	
INSPIREASE MIS DD SYST (<i>spacer/aerosol-holding chambers</i>)	2	
MICROCHAMBER MIS (<i>spacer/aerosol-holding chambers</i>)	2	
MICROSPACER MIS (<i>spacer/aerosol-holding chambers</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPTICHAMBER MIS DIA LG (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS DIA MD (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS DIA SM (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS DIAMOND (<i>spacer/aerosol-holding chambers</i>)	2	
POCKET CHAMB MIS (<i>spacer/aerosol-holding chambers</i>)	2	
POCKET SPACE MIS (<i>spacer/aerosol-holding chambers</i>)	2	
PROCHAMBER MIS VHC (<i>spacer/aerosol-holding chambers</i>)	2	
RITEFLO MIS (<i>spacer/aerosol-holding chambers</i>)	2	
VORTEX VALVE MIS CHAMBER (<i>spacer/aerosol-holding chambers</i>)	2	
MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
NURTEC TAB 75MG ODT (<i>rimegepant sulfate</i>)	2	
QULIPTA TAB 10MG (<i>atogepant</i>)	2	MO
QULIPTA TAB 30MG (<i>atogepant</i>)	2	MO
QULIPTA TAB 60MG (<i>atogepant</i>)	2	MO
UBRELVEY TAB 50MG (<i>ubrogepant</i>)	2	
UBRELVEY TAB 100MG (<i>ubrogepant</i>)	2	
MIGRAINE COMBINATIONS		
<i>ergotamine w/ caffeine tab 1-100 mg</i>	3	
SEROTONIN AGONISTS		
<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 tabs every 25 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 tabs every 25 days)
<i>eletriptan hydrobromide tab 20 mg (base equivalent)</i>	1	QL (12 tabs every 25 days)
<i>eletriptan hydrobromide tab 40 mg (base equivalent)</i>	1	QL (12 tabs every 25 days)
<i>frovatriptan succinate tab 2.5 mg (base equivalent)</i>	1	QL (18 tabs every 25 days)
<i>naratriptan hcl tab 1 mg (base equiv)</i>	1	QL (12 tabs every 25 days)
<i>naratriptan hcl tab 2.5 mg (base equiv)</i>	1	QL (12 tabs every 25 days)
ONZETRA XSAI MIS 11MG (<i>sumatriptan succinate</i>)	2	QL (16 nosepieces (8 pouches) every 25 days)
REYVOW TAB 50MG (<i>lasmiditan succinate</i>)	3	
REYVOW TAB 100MG (<i>lasmiditan succinate</i>)	3	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>rizatriptan benzoate oral disintegrating tab 5 mg (base eq)</i>	1	QL (18 tabs every 25 days)
<i>rizatriptan benzoate oral disintegrating tab 10 mg (base eq)</i>	1	QL (18 tabs every 25 days)
<i>rizatriptan benzoate tab 5 mg (base equivalent)</i>	1	QL (18 tabs every 25 days)
<i>rizatriptan benzoate tab 10 mg (base equivalent)</i>	1	QL (18 tabs every 25 days)
<i>sumatriptan nasal spray 5 mg/act</i>	1	QL (24 sprays (4 boxes) every 25 days)
<i>sumatriptan nasal spray 20 mg/act</i>	1	QL (12 sprays (2 boxes) every 25 days)
<i>sumatriptan succinate inj 6 mg/0.5ml</i>	1	QL (12 injections every 25 days)
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml</i>	1	QL (18 injections every 25 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml</i>	1	QL (12 injections every 25 days)
<i>sumatriptan succinate solution cartridge 4 mg/0.5ml</i>	1	QL (18 injections every 25 days)
<i>sumatriptan succinate solution cartridge 6 mg/0.5ml</i>	1	QL (12 injections every 25 days)
<i>sumatriptan succinate tab 25 mg</i>	1	QL (12 tabs every 25 days)
<i>sumatriptan succinate tab 50 mg</i>	1	QL (12 tabs every 25 days)
<i>sumatriptan succinate tab 100 mg</i>	1	QL (12 tabs every 25 days)
ZEMBRACE SYM INJ 3/0.5ML (<i>sumatriptan succinate</i>)	2	QL (24 injections every 25 days)
<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>	1	QL (12 inhalers every 25 days)
<i>zolmitriptan nasal spray 5 mg/spray unit</i>	1	QL (12 bottles every 25 days)
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	1	QL (12 tabs every 25 days)
<i>zolmitriptan orally disintegrating tab 5 mg</i>	1	QL (12 tabs every 25 days)
<i>zolmitriptan tab 2.5 mg</i>	1	QL (12 tabs every 25 days)
<i>zolmitriptan tab 5 mg</i>	1	QL (12 tabs every 25 days)

MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION**FLUORIDE**

FLUORABON DRO (<i>sodium fluoride</i>)	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)</i>	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)</i>	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride chew tab 1 mg f (from 2.2 mg naf)</i>	1	MO
<i>sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)</i>	PV	MO; \$0 applies for ages 5 and under

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Sodium Fluoride Soln 0.25 mg/drop F (From 0.55 mg/drop Naf)) FLURA-DROPS	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride tab 0.5 mg f (from 1.1 mg naf)</i>	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride tab 1 mg f (from 2.2 mg naf)</i>	1	MO
PHOSPHATE		
(Potassium Phosphate Monobasic Tab 500 mg) PHOSPHO-TRIN K500	1	MO
POTASSIUM		
(Potassium Bicarbonate Effer Tab 25 meq) EFFER-K	1	MO
(Potassium Bicarbonate Effer Tab 25 meq) K-PRIME	1	MO
(Potassium Bicarbonate Effer Tab 25 meq) KLOR-CON/EF	1	MO
<i>potassium chloride cap er 8 meq</i>	1	MO
<i>potassium chloride cap er 10 meq</i>	1	MO
<i>potassium chloride microencapsulated crys er tab 10 meq</i>	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 10 meq) KLOR-CON M10	1	MO
<i>potassium chloride microencapsulated crys er tab 15 meq</i>	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 15 meq) KLOR-CON M15	1	MO
<i>potassium chloride microencapsulated crys er tab 20 meq</i>	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 20 meq) KLOR-CON M20	1	MO
<i>potassium chloride oral soln 10% (20 meq/15ml)</i>	1	MO
<i>potassium chloride oral soln 20% (40 meq/15ml)</i>	1	MO
<i>potassium chloride powder packet 20 meq</i>	1	MO
(Potassium Chloride Powder Packet 20 meq) KLOR-CON	1	MO
<i>potassium chloride tab er 8 meq (600 mg)</i>	1	MO
(Potassium Chloride Tab Er 8 meq (600 mg)) KLOR-CON 8	1	MO
<i>potassium chloride tab er 10 meq</i>	1	MO
(Potassium Chloride Tab Er 10 meq) KLOR-CON 10	1	MO
<i>potassium chloride tab er 15 meq</i>	1	MO
<i>potassium chloride tab er 20 meq (1500 mg)</i>	1	MO
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS - DRUGS FOR OVERDOSE OR POISONING		
<i>penicillamine cap 250 mg</i>	1	SP

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>penicillamine tab 250 mg</i>	1	SP
<i>trientine hcl cap 250 mg</i>	1	SP
IMMUNOMODULATORS - DRUGS TO TREAT CANCER		
<i>lenalidomide cap 5 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>lenalidomide cap 10 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>lenalidomide cap 15 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>lenalidomide cap 20 mg</i>	1	SP, PA, QL (42 caps every 28 days); OAC
<i>lenalidomide cap 25 mg</i>	1	SP, PA, QL (42 caps every 28 days); OAC
<i>lenalidomide caps 2.5 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 2.5MG (<i>lenalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 5MG (<i>lenalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 10MG (<i>lenalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 15MG (<i>lenalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 20MG (<i>lenalidomide</i>)	2	SP, PA, QL (42 caps every 28 days); OAC
REVLIMID CAP 25MG (<i>lenalidomide</i>)	2	SP, PA, QL (42 caps every 28 days); OAC
THALOMID CAP 50MG (<i>thalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
THALOMID CAP 100MG (<i>thalidomide</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
IMMUNOSUPPRESSIVE AGENTS - DRUGS FOR TRANSPLANT		
<i>azathioprine tab 50 mg</i>	1	MO
<i>azathioprine tab 75 mg</i>	1	MO
(Azathioprine Tab 75 mg) AZASAN	1	MO
<i>azathioprine tab 100 mg</i>	1	MO
(Azathioprine Tab 100 mg) AZASAN	1	MO
<i>cyclosporine cap 25 mg</i>	1	SP
<i>cyclosporine cap 100 mg</i>	1	SP
<i>cyclosporine modified cap 25 mg</i>	1	SP
(Cyclosporine Modified Cap 25 mg) GENGRAF	1	SP
<i>cyclosporine modified cap 50 mg</i>	1	SP
<i>cyclosporine modified cap 100 mg</i>	1	SP

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Cyclosporine Modified Cap 100 mg) GENGRAF	1	SP
<i>cyclosporine modified oral soln 100 mg/ml</i>	1	SP
(Cyclosporine Modified Oral Soln 100 mg/ml) GENGRAF	1	SP
<i>everolimus tab 0.5 mg</i>	1	SP
<i>everolimus tab 0.25 mg</i>	1	SP
<i>everolimus tab 0.75 mg</i>	1	SP
<i>everolimus tab 1 mg</i>	1	SP
<i>mycophenolate mofetil cap 250 mg</i>	1	SP
<i>mycophenolate mofetil for oral susp 200 mg/ml</i>	1	SP
<i>mycophenolate mofetil tab 500 mg</i>	1	SP
<i>mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)</i>	1	SP
<i>mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)</i>	1	SP
<i>sirolimus oral soln 1 mg/ml</i>	1	SP
<i>sirolimus tab 0.5 mg</i>	1	SP
<i>sirolimus tab 1 mg</i>	1	SP
<i>sirolimus tab 2 mg</i>	1	SP
<i>tacrolimus cap 0.5 mg</i>	1	SP
<i>tacrolimus cap 1 mg</i>	1	SP
<i>tacrolimus cap 5 mg</i>	1	SP
POTASSIUM REMOVING AGENTS - DRUGS TO LOWER POTASSIUM		
<i>sodium polystyrene sulfonate powder</i>	1	
(Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml) SPS	1	
(Sodium Polystyrene Sulfonate Susp 15 gm/60ml) KIONEX	1	
(Sodium Polystyrene Sulfonate Susp 15 gm/60ml) SPS	1	
VELTASSA POW 1GM (<i>patiomer sorbitex calcium</i>)	2	MO
VELTASSA POW 8.4GM (<i>patiomer sorbitex calcium</i>)	2	MO
VELTASSA POW 16.8GM (<i>patiomer sorbitex calcium</i>)	2	MO
VELTASSA POW 25.2GM (<i>patiomer sorbitex calcium</i>)	2	MO
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT		
ANESTHETICS TOPICAL ORAL		
<i>lidocaine hcl viscous soln 2%</i>	1	
ANTI-INFECTIVES - THROAT		
<i>clotrimazole troche 10 mg</i>	1	
<i>nystatin susp 100000 unit/ml</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>STEROIDS - MOUTH/THROAT/DENTAL</i>		
<i>triamcinolone acetonide dental paste 0.1%</i>	1	
(Triamcinolone Acetonide Dental Paste 0.1%) KOURZEQ	1	
(Triamcinolone Acetonide Dental Paste 0.1%) ORALONE DENTAL PASTE	1	
<i>THROAT PRODUCTS - MISC.</i>		
<i>cevimeline hcl cap 30 mg</i>	1	MO
<i>pilocarpine hcl tab 5 mg</i>	1	MO
<i>pilocarpine hcl tab 7.5 mg</i>	1	MO
MULTIVITAMINS - DRUGS FOR NUTRITION		
<i>PRENATAL VITAMINS</i>		
(Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg) PNV-DHA	1	
(Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab 90-1 mg) INATAL GT	1	
(Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27-0.6-0.4 mg) PNV-SELECT	1	
(Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg) PRENATAL 19	1	
(Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg) TRINATE	1	
(Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg) ELITE-OB	1	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
<i>CENTRAL MUSCLE RELAXANTS</i>		
<i>baclofen oral soln 5 mg/5ml</i>	1	
<i>baclofen oral soln 10 mg/5ml</i>	1	
<i>baclofen tab 5 mg</i>	1	
<i>baclofen tab 10 mg</i>	1	
<i>baclofen tab 15 mg</i>	1	
<i>baclofen tab 20 mg</i>	1	
<i>carisoprodol tab 350 mg</i>	1	PA
<i>chlorzoxazone tab 500 mg</i>	1	
<i>cyclobenzaprine hcl tab 5 mg</i>	1	
<i>cyclobenzaprine hcl tab 10 mg</i>	1	
LYVISPAH GRA 5MG (<i>baclofen</i>)	2	
LYVISPAH GRA 10MG (<i>baclofen</i>)	2	
LYVISPAH GRA 20MG (<i>baclofen</i>)	2	
<i>metaxalone tab 800 mg</i>	1	
<i>methocarbamol tab 500 mg</i>	1	
<i>methocarbamol tab 750 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>methocarbamol tab 1000 mg</i>	1	
(Methocarbamol Tab 1000 mg) TANLOR	1	
<i>orphenadrine citrate tab er 12hr 100 mg</i>	1	
<i>tizanidine hcl cap 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 4 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 6 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 4 mg (base equivalent)</i>	1	
DIRECT MUSCLE RELAXANTS		
<i>dantrolene sodium cap 25 mg</i>	1	
<i>dantrolene sodium cap 50 mg</i>	1	
<i>dantrolene sodium cap 100 mg</i>	1	
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE		
NASAL AGENT COMBINATIONS		
<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act</i>	1	QL (1 bottle every 25 days)
NASAL ANTIALLERGY		
<i>azelastine hcl nasal spray 0.1% (137 mcg/spray)</i>	1	QL (2 bottles every 25 days)
<i>olopatadine hcl nasal soln 0.6%</i>	1	QL (1 bottle every 25 days)
NASAL ANTICHOLINERGICS		
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	1	MO
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	1	MO
NASAL STEROIDS		
<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	1	QL (3 bottles every 25 days)
<i>fluticasone propionate nasal susp 50 mcg/act</i>	1	QL (1 bottle every 25 days)
<i>mometasone furoate nasal susp 50 mcg/act</i>	1	QL (34 gm every 25 days)
NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES		
ALS AGENTS		
RADICAVA ORS SUS 105/5ML (<i>edaravone</i>)	2	SP, PA, QL (75 mL every 30 days)
RADICAVA ORS SUS STARTER (<i>edaravone</i>)	2	SP, PA, QL (75 mL every 30 days)
<i>riluzole tab 50 mg</i>	1	MO
OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS		
BETA-BLOCKERS - OPHTHALMIC		
<i>betaxolol hcl ophth soln 0.5%</i>	1	MO
BETOPTIC-S SUS 0.25% OP (<i>betaxolol hcl (ophth)</i>)	2	MO
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>carteolol hcl ophth soln 1%</i>	1	MO
<i>dorzolamide hcl-timolol maleate ophth soln 2-0.5%</i>	1	MO
<i>dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%</i>	1	MO
<i>levobunolol hcl ophth soln 0.5%</i>	1	MO
<i>timolol maleate ophth gel forming soln 0.5%</i>	1	MO
<i>timolol maleate ophth gel forming soln 0.25%</i>	1	MO
<i>timolol maleate ophth soln 0.5%</i>	1	MO
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	1	MO
<i>timolol maleate ophth soln 0.25%</i>	1	MO
<i>timolol maleate preservative free ophth soln 0.5%</i>	1	MO
<i>timolol maleate preservative free ophth soln 0.25%</i>	1	MO
CYCLOPLEGIC MYDRIATICS		
<i>atropine sulfate ophth soln 1%</i>	1	MO
<i>cyclopentolate hcl ophth soln 1%</i>	1	MO
<i>phenylephrine hcl ophth soln 2.5%</i>	1	
(Phenylephrine Hcl Ophth Soln 2.5%) ALTAFRIN	1	
<i>phenylephrine hcl ophth soln 10%</i>	1	
(Phenylephrine Hcl Ophth Soln 10%) ALTAFRIN	1	
<i>tropicamide ophth soln 0.5%</i>	1	MO
<i>tropicamide ophth soln 1%</i>	1	MO
MIOTICS		
<i>pilocarpine hcl ophth soln 1%</i>	1	MO
<i>pilocarpine hcl ophth soln 2%</i>	1	MO
<i>pilocarpine hcl ophth soln 4%</i>	1	MO
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P SOL 0.1% (<i>brimonidine tartrate</i>)	2	MO
ALPHAGAN P SOL 0.15% (<i>brimonidine tartrate</i>)	2	MO
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	1	
<i>brimonidine tartrate ophth soln 0.1%</i>	1	MO
<i>brimonidine tartrate ophth soln 0.2%</i>	1	MO
<i>brimonidine tartrate ophth soln 0.15%</i>	1	MO
SIMBRINZA SUS 1-0.2% (<i>brinzolamide-brimonidine tartrate</i>)	2	MO
OPHTHALMIC ANTI-INFECTIVES		
<i>bacitracin ophth oint 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophth oint</i>	1	
(Bacitracin-Polymyxin B Ophth Oint) POLYCIN	1	
BESIVANCE SUS 0.6% (<i>besifloxacin hcl</i>)	2	
<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i>	1	
<i>erythromycin ophth oint 5 mg/gm</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>gatifloxacin ophth soln 0.5%</i>	1	
<i>gentamicin sulfate ophth soln 0.3%</i>	1	
<i>levofloxacin ophth soln 0.5%</i>	3	
<i>levofloxacin ophth soln 1.5%</i>	1	
<i>moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)</i>	1	
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	1	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	1	
(Neomycin-Bacitrac Zn-Polymyx 5(3.5)mg-400unt-10000unt Op Oin) NEO-POLYCIN	1	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	1	
<i>ofloxacin ophth soln 0.3%</i>	1	
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	1	
<i>sulfacetamide sodium ophth oint 10%</i>	1	
<i>sulfacetamide sodium ophth soln 10%</i>	1	
<i>tobramycin ophth soln 0.3%</i>	1	
TOBREX OIN 0.3% OP (<i>tobramycin (ophth)</i>)	3	
<i>trifluridine ophth soln 1%</i>	1	
XDEMVY DRO 0.25% (<i>lotilaner</i>)	2	
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS EMU 0.05% OP (<i>cyclosporine (ophth)</i>)	1	MO
RESTASIS MUL EMU 0.05% OP (<i>cyclosporine (ophth)</i>)	2	MO
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA DRO 5% (<i>lifitegrast</i>)	2	MO
OPHTHALMIC STEROIDS		
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
(Bacitracin-Polymyxin-Neomycin-Hc Ophth Oint 1%) NEO-POLYCIN HC	1	
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	1	
<i>difluprednate ophth emulsion 0.05%</i>	1	
<i>fluorometholone ophth susp 0.1%</i>	1	
<i>loteprednol etabonate ophth gel 0.5%</i>	1	
<i>loteprednol etabonate ophth susp 0.2%</i>	1	
<i>loteprednol etabonate ophth susp 0.5%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	1	
<i>neomycin-polymyxin-hc ophth susp</i>	1	

PREScription DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PRED SOD PHO SOL 1% OP	3	
<i>prednisolone acetate ophth susp 1%</i>	1	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	1	
TOBRADEX OIN 0.3-0.1% (<i>tobramycin-dexamethasone</i>)	2	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	1	
OPHTHALMICS - MISC.		
<i>azelastine hcl ophth soln 0.05%</i>	1	
<i>bepotastine besilate ophth soln 1.5%</i>	1	
<i>brinzolamide ophth susp 1%</i>	1	MO
<i>bromfenac sodium ophth soln 0.07% (base equivalent)</i>	1	
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	1	
<i>bromfenac sodium ophth soln 0.075% (base equivalent)</i>	1	
<i>cromolyn sodium ophth soln 4%</i>	1	
<i>diclofenac sodium ophth soln 0.1%</i>	1	
<i>dorzolamide hcl ophth soln 2%</i>	1	MO
<i>epinastine hcl ophth soln 0.05%</i>	1	
<i>flurbiprofen sodium ophth soln 0.03%</i>	1	
ILEVRO DRO 0.3% OP (<i>nepafenac</i>)	2	
<i>ketorolac tromethamine ophth soln 0.4%</i>	1	
<i>ketorolac tromethamine ophth soln 0.5%</i>	1	
<i>olopatadine hcl ophth soln 0.1% (base equivalent)</i>	1	
<i>olopatadine hcl ophth soln 0.2% (base equivalent)</i>	1	
PROSTAGLANDINS - OPHTHALMIC		
<i>bimatoprost ophth soln 0.03%</i>	1	MO
<i>latanoprost ophth soln 0.005%</i>	1	MO
<i>tafluprost preservative free (pf) ophth soln 0.0015%</i>	1	MO
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	1	MO
OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR		
OTIC AGENTS - MISCELLANEOUS		
<i>acetic acid otic soln 2%</i>	1	
OTIC ANTI-INFECTIVES		
<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i>	1	
<i>ofloxacin otic soln 0.3%</i>	1	
OTIC COMBINATIONS		
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	1	
<i>neomycin-polymyxin-hc otic soln 1%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%</i>	1	
OTIC STEROIDS		
<i>fluocinolone acetonide (otic) oil 0.01%</i>	1	
(Fluocinolone Acetonide (Otic) Oil 0.01%) FLAC	1	
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>	1	
OXYTOCICS - DRUGS FOR PREGNANCY		
OXYTOCICS - DRUGS FOR PREGNANCY		
<i>methylergonovine maleate tab 0.2 mg</i>	1	
(Methylergonovine Maleate Tab 0.2 mg) METHERGINE	1	
PENICILLINS - DRUGS TO TREAT INFECTIONS		
AMINOPENICILLINS		
<i>amoxicillin (trihydrate) cap 250 mg</i>	1	
<i>amoxicillin (trihydrate) cap 500 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	1	
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) tab 500 mg</i>	1	
<i>amoxicillin (trihydrate) tab 875 mg</i>	1	
<i>ampicillin cap 500 mg</i>	1	
NATURAL PENICILLINS		
<i>penicillin v potassium for soln 125 mg/5ml</i>	1	
<i>penicillin v potassium for soln 250 mg/5ml</i>	1	
<i>penicillin v potassium tab 250 mg</i>	1	
<i>penicillin v potassium tab 500 mg</i>	1	
PENICILLIN COMBINATIONS		
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	1	
AUGMENTIN SUS 125/5ML (<i>amoxicillin & pot clavulanate</i>)	3	
PENICILLINASE-RESISTANT PENICILLINS		
<i>dicloxacillin sodium cap 250 mg</i>	1	
<i>dicloxacillin sodium cap 500 mg</i>	1	
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
<i>medroxyprogesterone acetate tab 2.5 mg</i>	1	MO
<i>medroxyprogesterone acetate tab 5 mg</i>	1	MO
<i>medroxyprogesterone acetate tab 10 mg</i>	1	MO
<i>megestrol acetate susp 625 mg/5ml</i>	1	MO
<i>norethindrone acetate tab 5 mg</i>	1	MO
(Norethindrone Acetate Tab 5 mg) GALLIFREY	1	MO
<i>progesterone cap 100 mg</i>	1	MO
<i>progesterone cap 200 mg</i>	1	MO
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
AGENTS FOR CHEMICAL DEPENDENCY		
<i>acamprosate calcium tab delayed release 333 mg</i>	1	MO
<i>disulfiram tab 250 mg</i>	1	MO
<i>disulfiram tab 500 mg</i>	1	MO
<i>lofexidine hcl tab 0.18 mg (base equivalent)</i>	1	
ANTI-CATALECTIC AGENTS		
LUMRYZ PAK 6GM (<i>sodium oxybate</i>)	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK 7.5GM (<i>sodium oxybate</i>)	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK 9GM (<i>sodium oxybate</i>)	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK STARTER (<i>sodium oxybate</i>)	2	SP, PA, QL (1 packet every 1 day); 28-day starter pack
LUMRYZ PKG 4.5GM (<i>sodium oxybate</i>)	2	SP, PA, QL (1 packet every 1 day)
XYWAV SOL 0.5GM/ML (<i>calcium, magnesium, potassium, & sodium oxybates</i>)	2	PA, QL (18 mL every 1 day)
ANTIDEMENTIA AGENTS - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
<i>donepezil hydrochloride orally disintegrating tab 5 mg</i>	1	MO
<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>donepezil hydrochloride tab 5 mg</i>	1	MO
<i>donepezil hydrochloride tab 10 mg</i>	1	MO
<i>donepezil hydrochloride tab 23 mg</i>	1	MO
<i>galantamine hydrobromide cap er 24hr 8 mg</i>	1	MO
<i>galantamine hydrobromide cap er 24hr 16 mg</i>	1	MO
<i>galantamine hydrobromide cap er 24hr 24 mg</i>	1	MO
<i>galantamine hydrobromide oral soln 4 mg/ml</i>	1	MO
<i>galantamine hydrobromide tab 4 mg</i>	1	MO
<i>galantamine hydrobromide tab 8 mg</i>	1	MO
<i>galantamine hydrobromide tab 12 mg</i>	1	MO
<i>memantine hcl cap er 24hr 7 mg</i>	1	MO
<i>memantine hcl cap er 24hr 14 mg</i>	1	MO
<i>memantine hcl cap er 24hr 21 mg</i>	1	MO
<i>memantine hcl cap er 24hr 28 mg</i>	1	MO
<i>memantine hcl oral solution 2 mg/ml</i>	1	MO
<i>memantine hcl tab 5 mg</i>	1	MO
<i>memantine hcl tab 10 mg</i>	1	MO
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>	1	
<i>memantine hcl-donepezil hcl cap er 24hr 14-10 mg</i>	1	MO
<i>memantine hcl-donepezil hcl cap er 24hr 21-10 mg</i>	1	MO
<i>memantine hcl-donepezil hcl cap er 24hr 28-10 mg</i>	1	MO
NAMZARIC CAP 7-10MG (<i>memantine hcl-donepezil hcl</i>)	2	MO
NAMZARIC CAP 14-10MG (<i>memantine hcl-donepezil hcl</i>)	2	MO
NAMZARIC CAP 21-10MG (<i>memantine hcl-donepezil hcl</i>)	2	MO
NAMZARIC CAP 28-10MG (<i>memantine hcl-donepezil hcl</i>)	2	MO
<i>rivastigmine tartrate cap 1.5 mg (base equivalent)</i>	1	MO
<i>rivastigmine tartrate cap 3 mg (base equivalent)</i>	1	MO
<i>rivastigmine tartrate cap 4.5 mg (base equivalent)</i>	1	MO
<i>rivastigmine tartrate cap 6 mg (base equivalent)</i>	1	MO
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	1	MO
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	1	MO
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	1	MO
COMBINATION PSYCHOTHERAPEUTICS		
<i>chlordiazepoxide-amitriptyline tab 5-12.5 mg</i>	1	MO
<i>chlordiazepoxide-amitriptyline tab 10-25 mg</i>	1	MO
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i>	1	MO
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	1	MO
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	1	MO
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 2-10 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 2-25 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 4-10 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 4-25 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 4-50 mg</i>	1	MO
<i>HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS</i>		
<i>ADDYI TAB 100MG (flibanserin)</i>	3	PA, MO
<i>MOVEMENT DISORDER DRUG THERAPY</i>		
<i>AUSTEDO TAB 6MG (deutetrabenazine)</i>	2	SP, PA, QL (2 tabs every 1 day)
<i>AUSTEDO TAB 9MG (deutetrabenazine)</i>	2	SP, PA, QL (4 tabs every 1 day)
<i>AUSTEDO TAB 12MG (deutetrabenazine)</i>	2	SP, PA, QL (4 tabs every 1 day)
<i>AUSTEDO XR TAB 6MG (deutetrabenazine)</i>	2	SP, PA, QL (3 tabs every 1 day)
<i>AUSTEDO XR TAB 12MG (deutetrabenazine)</i>	2	SP, PA, QL (4 tabs every 1 day)
<i>AUSTEDO XR TAB 18MG (deutetrabenazine)</i>	2	SP, PA, QL (1 tab every 1 day)
<i>AUSTEDO XR TAB 24MG (deutetrabenazine)</i>	2	SP, PA, QL (2 tabs every 1 day)
<i>AUSTEDO XR TAB 30MG ER (deutetrabenazine)</i>	2	SP, PA, QL (1 tab every 1 day)
<i>AUSTEDO XR TAB 36MG ER (deutetrabenazine)</i>	2	SP, PA, QL (1 tab every 1 day)
<i>AUSTEDO XR TAB 42MG ER (deutetrabenazine)</i>	2	SP, PA, QL (1 tab every 1 day)
<i>AUSTEDO XR TAB 48MG ER (deutetrabenazine)</i>	2	SP, PA, QL (1 tab every 1 day)
<i>AUSTEDO XR TAB TITR KIT (deutetrabenazine)</i>	2	SP, PA, QL (1 kit every 28 days)
<i>INGREZZA CAP 40-80MG (valbenazine tosylate)</i>	2	SP, PA, QL (1 cap every 1 day)
<i>INGREZZA CAP 40MG (valbenazine tosylate)</i>	2	SP, PA, QL (1 cap every 1 day)
<i>INGREZZA CAP 60MG (valbenazine tosylate)</i>	2	SP, PA, QL (1 cap every 1 day)
<i>INGREZZA CAP 80MG (valbenazine tosylate)</i>	2	SP, PA, QL (1 cap every 1 day)
<i>tetrabenazine tab 12.5 mg</i>	1	SP, PA, QL (4 tabs every 1 day)
<i>tetrabenazine tab 25 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS</i>		
<i>BAFIERTAM CAP 95MG (monomethyl fumarate)</i>	2	SP, PA, QL (4 caps every 1 day)
<i>dalfampridine tab er 12hr 10 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>dimethyl fumarate capsule delayed release 120 mg</i>	1	SP, PA, QL (14 caps every 28 days)
<i>dimethyl fumarate capsule delayed release 240 mg</i>	1	SP, PA, QL (2 caps every 1 day)
<i>dimethyl fumarate capsule dr starter pack 120 mg & 240 mg</i>	1	SP, PA, QL (60 caps every 30 days)
<i>fingolimod hcl cap 0.5 mg (base equiv)</i>	1	SP, PA, QL (1 cap every 1 day)
<i>MAYZENT PAK STARTER (siponimod fumarate)</i>	2	SP, PA, QL (12 tablet starter pack)
<i>MAYZENT PAK STARTER (siponimod fumarate)</i>	2	SP, PA, QL (7 tabs every 4 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MAYZENT TAB 0.25MG (<i>siponimod fumarate</i>)	2	SP, PA, QL (12 tabs every 5 days)
MAYZENT TAB 1MG (<i>siponimod fumarate</i>)	2	SP, PA, QL (1 tab every 1 day)
MAYZENT TAB 2MG (<i>siponimod fumarate</i>)	2	SP, PA, QL (1 tab every 1 day)
<i>teriflunomide tab 7 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>teriflunomide tab 14 mg</i>	1	SP, PA, QL (1 tab every 1 day)
ZEPOSIA 7DAY CAP STR PACK (<i>ozanimod hcl</i>)	2	SP, PA, QL (7 caps every 7 days); Preferred for Multiple Sclerosis Agents, Ulcerative Colitis
ZEPOSIA CAP 0.92MG (<i>ozanimod hcl</i>)	2	SP, PA, QL (1 cap every 1 day); Preferred for Multiple Sclerosis Agents, Ulcerative Colitis
ZEPOSIA CAP STR KIT (<i>ozanimod hcl</i>)	2	SP, PA, QL (28 caps every 28 days); Preferred for Multiple Sclerosis Agents, Ulcerative Colitis
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
<i>gabapentin (once-daily) tab 300 mg</i>	1	MO
<i>gabapentin (once-daily) tab 600 mg</i>	1	MO
GRALISE TAB 450MG (<i>gabapentin (once-daily)</i>)	2	MO
GRALISE TAB 750MG (<i>gabapentin (once-daily)</i>)	2	MO
GRALISE TAB 900MG (<i>gabapentin (once-daily)</i>)	2	MO
<i>pregabalin tab er 24hr 82.5 mg</i>	1	MO
<i>pregabalin tab er 24hr 165 mg</i>	1	MO
<i>pregabalin tab er 24hr 330 mg</i>	1	MO
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
<i>pimozide tab 1 mg</i>	1	MO
<i>pimozide tab 2 mg</i>	1	MO
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 2 mg</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE POLACRILEX S	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Polacrilex Gum 2 mg) EQ NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) GNP NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) GOODSENSE NICOTINE POLACR	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) HM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) KLS QUIT2	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) NICORELIEF	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) RA NICOTINE GUM	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) SM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) THRIVE	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 4 mg</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE GUM	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) EQ NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) GNP NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) GOODSENSE NICOTINE POLACR	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) HM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) KLS QUIT4	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) RA NICOTINE GUM	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) SM NICOTINE	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Polacrilex Gum 4 mg) SM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 2 mg</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) CVS NICOTINE LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) CVS NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) EQ NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GNP NICOTINE MINI LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GNP NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GOODSENSE NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) HM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) KLS QUIT2	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) NICOTINE MINI LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) RA MINI NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) RA NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) SM NICOTINE	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 4 mg</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) CVS NICOTINE LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) CVS NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) EQ NICOTINE LOZENGES	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) EQ NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GNP NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GNP NICOTINE POLACRILEX M	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GOODSENSE NICOTINE	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Polacrilex Lozenge 4 mg) GOODSENSE NICOTINE POLACR	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) KLS QUIT4	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) NICOTINE MINI LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) RA MINI NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) RA NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) SM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 7 mg/24hr</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) EQ NICOTINE STEP 3	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) GNP NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) NICOTINE STEP 3	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 14 mg/24hr</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) EQ NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) GNP NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 21 mg/24hr</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Td Patch 24hr 21 mg/24hr) EQ NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) NICOTINE STEP 1	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) RA NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
NICOTROL INH (<i>nicotine</i>)	PV	\$0 limited to 2 treatment cycles/year
NICOTROL NS SPR 10MG/ML (<i>nicotine</i>)	PV	\$0 limited to 2 treatment cycles/year
<i>varenicline tartrate tab 0.5 mg (base equiv)</i>	PV	\$0 limited to 2 treatment cycles/year
<i>varenicline tartrate tab 1 mg (base equiv)</i>	PV	\$0 limited to 2 treatment cycles/year
<i>varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack</i>	PV	\$0 limited to 2 treatment cycles/year
RESPIRATORY AGENTS - MISC. - DRUGS TO TREAT BREATHING DISORDERS		
<i>CYSTIC FIBROSIS AGENTS</i>		
KALYDECO PAK 25MG (<i>ivacaftor</i>)	3	SP, PA
KALYDECO PAK 50MG (<i>ivacaftor</i>)	3	SP, PA
KALYDECO PAK 75MG (<i>ivacaftor</i>)	3	SP, PA
KALYDECO TAB 150MG (<i>ivacaftor</i>)	3	SP, PA
<i>PULMONARY FIBROSIS AGENTS</i>		
OFEV CAP 100MG (<i>nintedanib esylate</i>)	2	SP, PA, QL (2 caps every 1 day)
OFEV CAP 150MG (<i>nintedanib esylate</i>)	2	SP, PA, QL (2 caps every 1 day)
<i>pirfenidone cap 267 mg</i>	1	SP, PA, QL (9 caps every 1 day)
<i>pirfenidone tab 267 mg</i>	1	SP, PA, QL (9 tabs every 1 day)
<i>pirfenidone tab 801 mg</i>	1	SP, PA, QL (3 tabs every 1 day)
SULFONAMIDES - DRUGS TO TREAT INFECTIONS		
<i>SULFONAMIDES - DRUGS TO TREAT INFECTIONS</i>		
<i>sulfadiazine tab 500 mg</i>	1	
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
<i>TETRACYCLINES - DRUGS TO TREAT INFECTIONS</i>		
<i>demeclocycline hcl tab 150 mg</i>	1	
<i>demeclocycline hcl tab 300 mg</i>	1	
<i>doxycycline hyclate cap 50 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>doxycycline hyclate cap 100 mg</i>	1	
<i>doxycycline hyclate tab 100 mg</i>	1	
<i>doxycycline monohydrate cap 50 mg</i>	1	
<i>doxycycline monohydrate cap 100 mg</i>	1	
(Doxycycline Monohydrate Cap 100 mg) MONDOXYNE NL	1	
<i>doxycycline monohydrate for susp 25 mg/5ml</i>	1	
<i>doxycycline monohydrate tab 50 mg</i>	1	
<i>doxycycline monohydrate tab 75 mg</i>	1	
<i>doxycycline monohydrate tab 100 mg</i>	1	
(Doxycycline Monohydrate Tab 100 mg) AVIDOXY	1	
<i>doxycycline monohydrate tab 150 mg</i>	1	
<i>minocycline hcl cap 50 mg</i>	1	
<i>minocycline hcl cap 75 mg</i>	1	
<i>minocycline hcl cap 100 mg</i>	1	
<i>minocycline hcl tab 50 mg</i>	1	
<i>minocycline hcl tab 75 mg</i>	1	
<i>minocycline hcl tab 100 mg</i>	1	
<i>tetracycline hcl cap 250 mg</i>	1	
<i>tetracycline hcl cap 500 mg</i>	1	

THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS**ANTITHYROID AGENTS**

<i>methimazole tab 5 mg</i>	1	MO
<i>methimazole tab 10 mg</i>	1	MO
<i>propylthiouracil tab 50 mg</i>	1	MO

THYROID HORMONES

<i>levothyroxine sodium tab 25 mcg</i>	1	MO
(Levothyroxine Sodium Tab 25 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 25 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 25 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 25 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 50 mcg</i>	1	MO
(Levothyroxine Sodium Tab 50 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 50 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 50 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 50 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 75 mcg</i>	1	MO
(Levothyroxine Sodium Tab 75 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 75 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 75 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 75 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 88 mcg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levothyroxine Sodium Tab 88 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 88 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 88 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 88 mcg) UNITHROID	1	MO
levothyroxine sodium tab 100 mcg	1	MO
(Levothyroxine Sodium Tab 100 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 100 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 100 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 100 mcg) UNITHROID	1	MO
levothyroxine sodium tab 112 mcg	1	MO
(Levothyroxine Sodium Tab 112 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 112 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 112 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 112 mcg) UNITHROID	1	MO
levothyroxine sodium tab 125 mcg	1	MO
(Levothyroxine Sodium Tab 125 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 125 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 125 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 125 mcg) UNITHROID	1	MO
levothyroxine sodium tab 137 mcg	1	MO
(Levothyroxine Sodium Tab 137 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 137 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 137 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 137 mcg) UNITHROID	1	MO
levothyroxine sodium tab 150 mcg	1	MO
(Levothyroxine Sodium Tab 150 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 150 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 150 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 150 mcg) UNITHROID	1	MO
levothyroxine sodium tab 175 mcg	1	MO
(Levothyroxine Sodium Tab 175 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 175 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 175 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 175 mcg) UNITHROID	1	MO
levothyroxine sodium tab 200 mcg	1	MO
(Levothyroxine Sodium Tab 200 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 200 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 200 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 200 mcg) UNITHROID	1	MO
levothyroxine sodium tab 300 mcg	1	MO
(Levothyroxine Sodium Tab 300 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 300 mcg) UNITHROID	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>liothyronine sodium tab 5 mcg</i>	1	MO
<i>liothyronine sodium tab 25 mcg</i>	1	MO
<i>liothyronine sodium tab 50 mcg</i>	1	MO
SYNTHROID TAB 25MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 50MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 75MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 88MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 100MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 112MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 125MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 137MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 150MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 175MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 200MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 300MCG (<i>levothyroxine sodium</i>)	2	MO

ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH ACID

ANTISPASMODICS - DRUGS FOR STOMACH SPASMS

<i>chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg</i>	1	
<i>dicyclomine hcl cap 10 mg</i>	1	
<i>dicyclomine hcl oral soln 10 mg/5ml</i>	1	
<i>dicyclomine hcl tab 20 mg</i>	1	
<i>glycopyrrolate oral soln 1 mg/5ml</i>	1	MO
<i>glycopyrrolate tab 1 mg</i>	1	
<i>glycopyrrolate tab 2 mg</i>	1	
<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>	1	MO
(Hyoscyamine Sulfate Elixir 0.125 mg/5ml) HYOSYNE	1	MO
<i>hyoscyamine sulfate sl tab 0.125 mg</i>	1	MO
(Hyoscyamine Sulfate Sl Tab 0.125 mg) OSCIMIN	1	MO
<i>hyoscyamine sulfate soln 0.125 mg/ml</i>	1	MO
(Hyoscyamine Sulfate Soln 0.125 mg/ml) HYOSYNE	1	MO
<i>hyoscyamine sulfate tab 0.125 mg</i>	1	MO
(Hyoscyamine Sulfate Tab 0.125 mg) OSCIMIN	1	MO
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	1	MO
(Hyoscyamine Sulfate Tab Disint 0.125 mg) NULEV	1	MO
<i>methscopolamine bromide tab 2.5 mg</i>	1	
<i>methscopolamine bromide tab 5 mg</i>	1	

H-2 ANTAGONISTS

<i>cimetidine hcl soln 300 mg/5ml</i>	1	MO
<i>cimetidine tab 200 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>cimetidine tab 300 mg</i>	1	MO
<i>cimetidine tab 400 mg</i>	1	MO
<i>cimetidine tab 800 mg</i>	1	MO
<i>famotidine for susp 40 mg/5ml</i>	1	MO
<i>famotidine tab 20 mg</i>	1	MO
<i>famotidine tab 40 mg</i>	1	MO
<i>nizatidine cap 150 mg</i>	1	MO
<i>nizatidine cap 300 mg</i>	1	MO
MISC. ANTI-ULCER		
<i>sucralfate tab 1 gm</i>	1	MO
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	1	QL (90 caps every year), MO
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	1	QL (90 caps every year), MO
<i>esomeprazole magnesium for delayed release susp pack 2.5 mg</i>	1	QL (90 packets every year), MO
<i>esomeprazole magnesium for delayed release susp packet 5 mg</i>	1	QL (90 packets every year), MO
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i>	1	QL (90 packets every year), MO
<i>esomeprazole magnesium for delayed release susp packet 20 mg</i>	1	QL (90 packets every year), MO
<i>esomeprazole magnesium for delayed release susp packet 40 mg</i>	1	QL (90 packets every year), MO
<i>lansoprazole cap delayed release 15 mg</i>	1	QL (90 caps every year), MO
<i>lansoprazole cap delayed release 30 mg</i>	1	QL (90 caps every year), MO
<i>omeprazole cap delayed release 10 mg</i>	1	QL (90 caps every year), MO
<i>omeprazole cap delayed release 20 mg</i>	1	QL (90 caps every year), MO
<i>omeprazole cap delayed release 40 mg</i>	1	QL (90 caps every year), MO
<i>pantoprazole sodium ec tab 20 mg (base equiv)</i>	1	QL (90 tabs every year), MO
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1	QL (90 tabs every year), MO
<i>rabeprazole sodium ec tab 20 mg</i>	1	QL (90 tabs every year), MO
ULCER DRUGS - PROSTAGLANDINS		
<i>misoprostol tab 100 mcg</i>	1	MO
<i>misoprostol tab 200 mcg</i>	1	MO
ULCER THERAPY COMBINATIONS		
<i>amoxicil cap & clarithro tab & lansopraz cap dr 500 & 500 & 30mg</i>	1	
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	1	
<i>TALICIA CAP (amoxicillin-rifabutin-omeprazole)</i>	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
<i>darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)</i>	1	MO
<i>darifenacin hydrobromide tab er 24hr 15 mg (base equiv)</i>	1	MO
<i>fesoterodine fumarate tab er 24hr 4 mg</i>	1	MO
<i>fesoterodine fumarate tab er 24hr 8 mg</i>	1	MO
<i>oxybutynin chloride solution 5 mg/5ml</i>	1	MO
<i>oxybutynin chloride tab 5 mg</i>	1	MO
<i>oxybutynin chloride tab er 24hr 5 mg</i>	1	MO
<i>oxybutynin chloride tab er 24hr 10 mg</i>	1	MO
<i>oxybutynin chloride tab er 24hr 15 mg</i>	1	MO
<i>solifenacin succinate tab 5 mg</i>	1	MO
<i>solifenacin succinate tab 10 mg</i>	1	MO
<i>tolterodine tartrate cap er 24hr 2 mg</i>	1	MO
<i>tolterodine tartrate cap er 24hr 4 mg</i>	1	MO
<i>tolterodine tartrate tab 1 mg</i>	1	MO
<i>tolterodine tartrate tab 2 mg</i>	1	MO
<i>trospium chloride cap er 24hr 60 mg</i>	1	MO
<i>trospium chloride tab 20 mg</i>	1	MO
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
<i>GEMTESA TAB 75MG (vibegron)</i>	2	MO
<i>mirabegron tab er 24 hr 25 mg</i>	1	MO
<i>mirabegron tab er 24 hr 50 mg</i>	1	MO
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
<i>bethanechol chloride tab 5 mg</i>	1	
<i>bethanechol chloride tab 10 mg</i>	1	
<i>bethanechol chloride tab 25 mg</i>	1	
<i>bethanechol chloride tab 50 mg</i>	1	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS		
<i>flavoxate hcl tab 100 mg</i>	1	MO
VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS		
MISCELLANEOUS VAGINAL PRODUCTS		
<i>INTRAROSA SUP 6.5MG (prasterone vaginal)</i>	3	MO
SPERMICIDES		
<i>ENCARE SUP 100MG (nonoxynol-9)</i>	PV	
<i>GYNOL II GEL 3% (nonoxynol-9)</i>	PV	
<i>SHUR-SEAL GEL 2% (nonoxynol-9)</i>	PV	
<i>TODAY SPONGE MIS (nonoxynol-9)</i>	PV	
<i>VCF VAGINAL AER CONTRACP (nonoxynol-9)</i>	PV	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VCF VAGINAL GEL CONTRACE (<i>nonoxynol-9</i>)	PV	
VCF VAGINAL MIS CONTRACP (<i>nonoxynol-9</i>)	PV	
VAGINAL ANTI-INFECTIVES		
<i>clindamycin phosphate vaginal cream 2%</i>	1	
<i>metronidazole vaginal gel 0.75%</i>	1	
(Miconazole Nitrate Vaginal Suppos 200 mg) MICONAZOLE 3	1	
<i>terconazole vaginal cream 0.4%</i>	1	
<i>terconazole vaginal cream 0.8%</i>	1	
<i>terconazole vaginal suppos 80 mg</i>	1	
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXXI GEL (<i>lactic acid-citric acid-potassium bitartrate</i>)	PV	
VAGINAL ESTROGENS		
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	MO
IMVEXXY MAIN SUP 4MCG (<i>estradiol vaginal</i>)	2	MO
IMVEXXY MAIN SUP 10MCG (<i>estradiol vaginal</i>)	2	MO
IMVEXXY STRT SUP 4MCG (<i>estradiol vaginal</i>)	2	MO
IMVEXXY STRT SUP 10MCG (<i>estradiol vaginal</i>)	2	MO
VAGIFEM TAB 10MCG (<i>estradiol vaginal</i>)	1	MO
VAGINAL PROGESTINS		
CRINONE GEL 4% VAG (<i>progesterone (vaginal)</i>)	2	
CRINONE GEL 8% VAG (<i>progesterone (vaginal)</i>)	2	PA
ENDOMETRIN SUP 100MG (<i>progesterone (vaginal)</i>)	2	
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
ANAPHYLAXIS THERAPY AGENTS - DRUGS FOR ACUTE ALLERGIC REACTION		
AUVI-Q INJ 0.1MG (<i>epinephrine (anaphylaxis)</i>)	2	
AUVI-Q INJ 0.3MG (<i>epinephrine (anaphylaxis)</i>)	2	
AUVI-Q INJ 0.15MG (<i>epinephrine (anaphylaxis)</i>)	2	
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i>	1	
<i>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</i>	1	
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
<i>droxidopa cap 100 mg</i>	1	SP, PA, QL (6 caps every 1 day)
<i>droxidopa cap 200 mg</i>	1	SP, PA, QL (6 caps every 1 day)
<i>droxidopa cap 300 mg</i>	1	SP, PA, QL (6 caps every 1 day)
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
<i>midodrine hcl tab 2.5 mg</i>	1	
<i>midodrine hcl tab 5 mg</i>	1	
<i>midodrine hcl tab 10 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VITAMINS - DRUGS FOR NUTRITION		
<i>OIL SOLUBLE VITAMINS</i>		
<i>ergocalciferol cap 1.25 mg (50000 unit)</i>	1	MO
<i>phytonadione tab 5 mg</i>	1	

Index

A	
abacavir sulfate soln 20 mg/ml (base equiv) ...	96
abacavir sulfate tab 300 mg (base equiv)	96
abacavir sulfate-lamivudine tab 600-300 mg..	96
abacavir-dolutegravir-lamivudine	
see TRIUMEQ PD TAB	98
see TRIUMEQ TAB	98
abiraterone acetate micronized	
see YONSA TAB 125MG	85
abiraterone acetate tab 250 mg	84
Abiraterone Acetate Tab 250 mg	84
abiraterone acetate tab 500 mg	84
ABIRTEGA	
see Abiraterone Acetate Tab 250 mg	84
abrocitinib	
see CIBINQO TAB 100MG	124
see CIBINQO TAB 200MG	124
see CIBINQO TAB 50MG	124
acalabrutinib maleate	
see CALQUENCE TAB 100MG	86
acamprosate calcium tab delayed release 333 mg.....	
	152
acarbose tab 100 mg	68
acarbose tab 25 mg	68
acarbose tab 50 mg	68
ACCUTANE	
see Isotretinoin Cap 10 mg	119
see Isotretinoin Cap 20 mg	119
see Isotretinoin Cap 30 mg	119
see Isotretinoin Cap 40 mg	119
acebutolol hcl cap 200 mg	100
acebutolol hcl cap 400 mg	100
acetaminophen w/ codeine soln 120-12 mg/5ml	
	47
acetaminophen w/ codeine tab 300-15 mg	47
acetaminophen w/ codeine tab 300-30 mg	47
acetaminophen w/ codeine tab 300-60 mg	47
acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg	
	47
Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg	
	47
acetazolamide cap er 12hr 500 mg	126
acetazolamide tab 125 mg	126
acetazolamide tab 250 mg	126
acetic acid otic soln 2%	
	150
acetylcysteine inhal soln 10%	
	118
acetylcysteine inhal soln 20%	
	118
acitretin cap 10 mg	121
acitretin cap 17.5 mg	121
acitretin cap 25 mg	121
acyclovir cap 200 mg	99
acyclovir oint 5%	122
acyclovir susp 200 mg/5ml	99
acyclovir tab 400 mg	99
acyclovir tab 800 mg	99
adagrasib	
see KRAZATI TAB 200MG	88
adapalene cream 0.1%	118
adapalene gel 0.1%	118
adapalene gel 0.3%	118
adapalene-benzoyl peroxide	
see EPIDUO FORTE GEL 0.3-2.5%	119
see EPIDUO GEL 0.1-2.5%	119
adapalene-benzoyl peroxide gel 0.1-2.5%	118
adapalene-benzoyl peroxide gel 0.3-2.5%	118
ADDYI TAB 100MG	154
adefovir dipivoxil tab 10 mg	98
ADEMPAS TAB 0.5MG	106
ADEMPAS TAB 1.5MG	106
ADEMPAS TAB 1MG	106
ADEMPAS TAB 2.5MG	106
ADEMPAS TAB 2MG	106
AERCHMBR PLS MIS LRG MASK	139
AERCHMBR PLS MIS MED MASK	139
AERCHMBR PLS MIS SM MASK	139
AERCHMBR Z- MIS STAT PLS	139
AEROCHAMBER MIS CHAMBER	139
AEROCHAMBER MIS FLOSIGNA	139
AEROCHAMBER MIS MV	139
AEROCHAMBER MIS PLUS	140
AEROVENT MIS PLUS	140
AFIRMELLE	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	109
AIRSUPRA AER 90-80MCG	57
AKLIEF CRE 0.005%	118
ALA-CORT	
see Hydrocortisone Cream 1%	123

albendazole tab 200 mg	52	alprazolam tab 0.25 mg	54
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)	57	alprazolam tab 0.5 mg	54
albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)	57	alprazolam tab 1 mg	54
albuterol sulfate soln nebu 0.5% (5 mg/ml)	57	alprazolam tab 2 mg	54
albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)	57	alprazolam tab er 24hr 0.5 mg	54
albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)	57	Alprazolam Tab Er 24hr 0.5 mg	54
albuterol sulfate syrup 2 mg/5ml	57	alprazolam tab er 24hr 1 mg	55
albuterol sulfate tab 2 mg	57	Alprazolam Tab Er 24hr 1 mg	55
albuterol sulfate tab 4 mg	57	alprazolam tab er 24hr 2 mg	55
albuterol-budesonide		Alprazolam Tab Er 24hr 2 mg	55
see AIRSUPRA AER 90-80MCG	57	alprazolam tab er 24hr 3 mg	55
alclometasone dipropionate cream 0.05%	122	Alprazolam Tab Er 24hr 3 mg	55
alclometasone dipropionate oint 0.05%	122	ALPRAZOLAM XR	
ALECENSA CAP 150MG	85	see Alprazolam Tab Er 24hr 0.5 mg	54
alectinib hcl		see Alprazolam Tab Er 24hr 1 mg	55
see ALECENSA CAP 150MG	85	see Alprazolam Tab Er 24hr 2 mg	55
alendronate sodium oral soln 70 mg/75ml	127	see Alprazolam Tab Er 24hr 3 mg	55
alendronate sodium tab 10 mg	127	ALTAFRIN	
alendronate sodium tab 35 mg	127	see Phenylephrine Hcl Ophth Soln 10%	148
alendronate sodium tab 5 mg	127	see Phenylephrine Hcl Ophth Soln 2.5%	148
alendronate sodium tab 70 mg	127	ALTAVERA	
alfuzosin hcl tab er 24hr 10 mg	133	see Levonorgestrel & Ethinyl Estradiol Tab	
aliskiren fumarate tab 150 mg (base equivalent)	82	0.15 mg-30 mcg	110
aliskiren fumarate tab 300 mg (base equivalent)	82	ALUNBRIG PAK	86
allopurinol tab 100 mg	133	ALUNBRIG TAB 180MG	86
allopurinol tab 200 mg	133	ALUNBRIG TAB 30MG	86
allopurinol tab 300 mg	133	ALUNBRIG TAB 90MG	86
almotriptan malate tab 12.5 mg	141	ALVAIZ TAB 18MG	136
almotriptan malate tab 6.25 mg	141	ALVAIZ TAB 36MG	136
alosetron hcl tab 0.5 mg (base equiv)	132	ALVAIZ TAB 54MG	136
alosetron hcl tab 1 mg (base equiv)	132	ALVAIZ TAB 9MG	136
alpelisib		ALYACEN 1/35	
see PIQRAY 200MG TAB DOSE	89	see Norethindrone & Ethinyl Estradiol Tab 1	
see PIQRAY 250MG TAB DOSE	89	mg-35 mcg	111
see PIQRAY 300MG TAB DOSE	89	ALYACEN 7/7/7	
ALPHAGAN P SOL 0.1%	148	see Norethindrone-Eth Estradiol Tab 0.5-	
ALPHAGAN P SOL 0.15%	148	35/0.75-35/1-35 mg-Mcg	113
alprazolam orally disintegrating tab 0.25 mg .	54	ALYQ	
alprazolam orally disintegrating tab 0.5 mg ...	54	see Tadalafil Tab 20 mg (Pah)	105
alprazolam orally disintegrating tab 1 mg	54	amantadine hcl cap 100 mg	91
alprazolam orally disintegrating tab 2 mg	54	amantadine hcl soln 50 mg/5ml	91
		amantadine hcl tab 100 mg	91
		ambrisentan tab 10 mg	105
		ambrisentan tab 5 mg	105
		AMETHYST	
		see Levonorgestrel-Ethinyl Estradiol	
		(Continuous) Tab 90-20 mcg	110

amiloride & hydrochlorothiazide tab 5-50 mg	126
amiloride hcl tab 5 mg	126
aminocaproic acid oral soln 0.25 gm/ml	136
aminocaproic acid tab 1000 mg	136
aminocaproic acid tab 500 mg	136
aminosalicylic acid	
see PASER GRA 4GM	83
amiodarone hcl tab 100 mg	56
Amiodarone Hcl Tab 100 mg	16, 56
amiodarone hcl tab 200 mg	56
Amiodarone Hcl Tab 200 mg	56
amiodarone hcl tab 400 mg	56
Amiodarone Hcl Tab 400 mg	56
amitriptyline hcl tab 10 mg	67
amitriptyline hcl tab 100 mg	67
amitriptyline hcl tab 150 mg	67
amitriptyline hcl tab 25 mg	67
amitriptyline hcl tab 50 mg	67
amitriptyline hcl tab 75 mg	67
amlodipine besylate tab 10 mg (base equivalent)	101
amlodipine besylate tab 2.5 mg (base equivalent)	101
amlodipine besylate tab 5 mg (base equivalent)	101
amlodipine besylate-atorvastatin calcium tab 10-10 mg	104
amlodipine besylate-atorvastatin calcium tab 10-20 mg	104
amlodipine besylate-atorvastatin calcium tab 10-40 mg	104
amlodipine besylate-atorvastatin calcium tab 10-80 mg	104
amlodipine besylate-atorvastatin calcium tab 2.5-10 mg	104
amlodipine besylate-atorvastatin calcium tab 2.5-20 mg	104
amlodipine besylate-atorvastatin calcium tab 2.5-40 mg	104
amlodipine besylate-atorvastatin calcium tab 5-10 mg	104
amlodipine besylate-atorvastatin calcium tab 5-20 mg	104
amlodipine besylate-atorvastatin calcium tab 5-40 mg	104

amlodipine besylate-atorvastatin calcium tab 5-80 mg	104
amlodipine besylate-benazepril hcl cap 10-20 mg	79
amlodipine besylate-benazepril hcl cap 10-40 mg	79
amlodipine besylate-benazepril hcl cap 2.5-10 mg	79
amlodipine besylate-benazepril hcl cap 5-10 mg	79
amlodipine besylate-benazepril hcl cap 5-20 mg	79
amlodipine besylate-benazepril hcl cap 5-40 mg	79
amlodipine besylate-olmesartan medoxomil tab 10-20 mg	79
amlodipine besylate-olmesartan medoxomil tab 10-40 mg	79
amlodipine besylate-olmesartan medoxomil tab 5-20 mg	79
amlodipine besylate-olmesartan medoxomil tab 5-40 mg	79
amlodipine besylate-valsartan tab 10-160 mg	79
amlodipine besylate-valsartan tab 10-320 mg	80
amlodipine besylate-valsartan tab 5-160 mg	79
amlodipine besylate-valsartan tab 5-320 mg	79
amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg	80
amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg	80
amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg	80
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg	80
amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	80
AMNESTEEM	
see Isotretinoin Cap 10 mg	119
see Isotretinoin Cap 20 mg	119
see Isotretinoin Cap 30 mg	119
see Isotretinoin Cap 40 mg	119
amoxapine tab 100 mg	67
amoxapine tab 150 mg	67
amoxapine tab 25 mg	67
amoxapine tab 50 mg	67
amoxicil cap & clarithro tab & lansopraz cap dr 500 & 500 & 30mg	163

amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	151
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	151
amoxicillin & k clavulanate for susp 400-57 mg/5ml	151
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	151
amoxicillin & k clavulanate tab 250-125 mg .	151
amoxicillin & k clavulanate tab 500-125 mg .	151
amoxicillin & k clavulanate tab 875-125 mg .	151
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	152
amoxicillin & pot clavulanate see AUGMENTIN SUS 125/5ML	152
amoxicillin (trihydrate) cap 250 mg	151
amoxicillin (trihydrate) cap 500 mg	151
amoxicillin (trihydrate) chew tab 125 mg	151
amoxicillin (trihydrate) chew tab 250 mg	151
amoxicillin (trihydrate) for susp 125 mg/5ml	151
amoxicillin (trihydrate) for susp 200 mg/5ml	151
amoxicillin (trihydrate) for susp 250 mg/5ml	151
amoxicillin (trihydrate) for susp 400 mg/5ml	151
amoxicillin (trihydrate) tab 500 mg	151
amoxicillin (trihydrate) tab 875 mg	151
amoxicillin-rifabutin-omeprazole see TALICIA CAP	163
amphetamine sulfate tab 10 mg	27
amphetamine sulfate tab 5 mg	27
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5 mg	27
amphetamine-dextroamphetamine 3-bead cap er 24hr 25 mg	27
amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5 mg	27
amphetamine-dextroamphetamine 3-bead cap er 24hr 50 mg	27
amphetamine-dextroamphetamine cap er 24hr 10 mg	27
amphetamine-dextroamphetamine cap er 24hr 15 mg	27
amphetamine-dextroamphetamine cap er 24hr 20 mg	27
amphetamine-dextroamphetamine cap er 24hr 25 mg	28
amphetamine-dextroamphetamine cap er 24hr 30 mg	28

amphetamine-dextroamphetamine cap er 24hr 5 mg	27
amphetamine-dextroamphetamine tab 10 mg	28
amphetamine-dextroamphetamine tab 12.5 mg	28
amphetamine-dextroamphetamine tab 15 mg	28
amphetamine-dextroamphetamine tab 20 mg	28
amphetamine-dextroamphetamine tab 30 mg	28
amphetamine-dextroamphetamine tab 5 mg .	28
amphetamine-dextroamphetamine tab 7.5 mg	28
ampicillin cap 500 mg	151
anagrelide hcl cap 0.5 mg	134
anagrelide hcl cap 1 mg	134
anastrozole tab 1 mg	84
ANNOVERA MIS	115
ANORO ELLIPT AER 62.5-25	57
ANUCORT-HC see Hydrocortisone Acetate Suppos 25 mg ..	52
apalutamide see ERLEADA TAB 240MG	85
see ERLEADA TAB 60MG	85
apixaban see ELIQUIS ST P TAB 5MG	59
see ELIQUIS TAB 2.5MG	59
see ELIQUIS TAB 5MG	59
apraclonidine hcl ophth soln 0.5% (base equivalent)	148
apremilast see OTEZLA TAB 10/20	41
see OTEZLA TAB 10/20/30	41
see OTEZLA TAB 20MG	41
see OTEZLA TAB 30MG	41
aprepitant capsule 125 mg	73
aprepitant capsule 40 mg	73
aprepitant capsule 80 mg	73
aprepitant capsule therapy pack 80 & 125 mg ..	73
APRI see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	107
APTOM TAB 200MG	61
APTOM TAB 400MG	61
APTOM TAB 600MG	61

APTOM TAB 800MG	61	atenolol & chlorthalidone tab 50-25 mg	80
APTIVUS CAP 250MG	96	atenolol tab 100 mg	100
ARANELLE		atenolol tab 25 mg	100
see Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg	114	atenolol tab 50 mg	100
arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)	57	atogepant	
aripiprazole oral solution 1 mg/ml	96	see QULIPTA TAB 10MG	141
aripiprazole orally disintegrating tab 10 mg ...	96	see QULIPTA TAB 30MG	141
aripiprazole orally disintegrating tab 15 mg ...	96	see QULIPTA TAB 60MG	141
aripiprazole tab 10 mg	96	atomoxetine hcl cap 10 mg (base equiv)	32
aripiprazole tab 15 mg	96	atomoxetine hcl cap 100 mg (base equiv)	32
aripiprazole tab 2 mg	96	atomoxetine hcl cap 18 mg (base equiv)	32
aripiprazole tab 20 mg	96	atomoxetine hcl cap 25 mg (base equiv)	32
aripiprazole tab 30 mg	96	atomoxetine hcl cap 40 mg (base equiv)	32
aripiprazole tab 5 mg	96	atomoxetine hcl cap 60 mg (base equiv)	32
armodafinil tab 150 mg	33	atomoxetine hcl cap 80 mg (base equiv)	32
armodafinil tab 200 mg	33	atorvastatin calcium tab 10 mg (base equivalent)	76
armodafinil tab 250 mg	33	atorvastatin calcium tab 20 mg (base equivalent)	76
armodafinil tab 50 mg	33	atorvastatin calcium tab 40 mg (base equivalent)	76
artemether-lumefantrine		atorvastatin calcium tab 80 mg (base equivalent)	76
see COARTEM TAB 20-120MG	82	atovaquone susp 750 mg/5ml	53
asciminib hcl		atovaquone-proguanil hcl tab 250-100 mg	82
see SCEMBLIX TAB 100MG	89	atovaquone-proguanil hcl tab 62.5-25 mg	82
see SCEMBLIX TAB 20MG	89	atropine sulfate ophth soln 1%	148
see SCEMBLIX TAB 40MG	89	AUBRA EQ	
ASCOMP/CODEINE		see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	109
see Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg	48	AUGMENTIN SUS 125/5ML	152
asenapine maleate sl tab 10 mg (base equiv) .	94	AUGTYRO CAP 160MG	86
asenapine maleate sl tab 2.5 mg (base equiv) 94		AUGTYRO CAP 40MG	86
asenapine maleate sl tab 5 mg (base equiv) ...	94	AUROVELA 1.5/30	
ASHLYNA		see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg	112
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)	109	AUROVELA 1/20	
ASMANEX HFA AER 100 MCG	57	see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg	111
ASMANEX HFA AER 200 MCG	57	AUROVELA 24 FE	
ASMANEX HFA AER 50MCG	57	see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)	113
Aspirin Chew Tab 81 mg	42	AUROVELA FE 1.5/30	
ASPIRIN CHILDRENS		see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg	112
see Aspirin Chew Tab 81 mg	42	AUROVELA FE 1/20	
aspirin tab delayed release 81 mg	42		
aspirin-dipyridamole cap er 12hr 25-200 mg .	134		
atazanavir sulfate cap 150 mg (base equiv)	96		
atazanavir sulfate cap 200 mg (base equiv)	96		
atazanavir sulfate cap 300 mg (base equiv)	96		
atenolol & chlorthalidone tab 100-25 mg	80		

see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg	112
AUSTEDO TAB 12MG	154
AUSTEDO TAB 6MG	154
AUSTEDO TAB 9MG	154
AUSTEDO XR TAB 12MG	154
AUSTEDO XR TAB 18MG	154
AUSTEDO XR TAB 24MG	154
AUSTEDO XR TAB 30MG ER	154
AUSTEDO XR TAB 36MG ER	154
AUSTEDO XR TAB 42MG ER	154
AUSTEDO XR TAB 48MG ER	154
AUSTEDO XR TAB 6MG	154
AUSTEDO XR TAB TITR KIT	154
AUVI-Q INJ 0.15MG	165
AUVI-Q INJ 0.1MG	165
AUVI-Q INJ 0.3MG	165
avatrombopag maleate	
see DOPTELET TAB 20MG	136
AVIANE	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	109
AVIDOXY	
see Doxycycline Monohydrate Tab 100 mg	160
axitinib	
see INLYTA TAB 1MG	83
see INLYTA TAB 5MG	83
AYUNA	
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	110
AZASAN	
see Azathioprine Tab 100 mg	144
see Azathioprine Tab 75 mg	144
azathioprine tab 100 mg	144
Azathioprine Tab 100 mg	144
azathioprine tab 50 mg	144
azathioprine tab 75 mg	144
Azathioprine Tab 75 mg	144
azelaic acid	
see FINACEA AER 15%	125
azelaic acid gel 15%	125
azelastine hcl nasal spray 0.1% (137 mcg/spray)	147
azelastine hcl ophth soln 0.05%	150
azelastine hcl-fluticasone prop nasal spray 137- 50 mcg/act	147
azithromycin for susp 100 mg/5ml	138

azithromycin for susp 200 mg/5ml	138
azithromycin tab 250 mg	138
azithromycin tab 500 mg	138
azithromycin tab 600 mg	138
AZSTARYS CAP 26.1-5.2	33
AZSTARYS CAP 39.2-7.8	33
AZSTARYS CAP 52.3-10	33
aztreonam lysine	
see CAYSTON INH 75MG	53
AZURETTE	
see Desogest-Eth Estrad & Eth Estrad Tab 0.15- 0.02/0.01 mg(21/5)	107
B	
BAC	
see Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg	42
bacitracin ophth oint 500 unit/gm	148
bacitracin-polymyxin b ophth oint	148
Bacitracin-Polymyxin B Ophth Oint	148
bacitracin-polymyxin-neomycin-hc ophth oint 1%	149
Bacitracin-Polymyxin-Neomycin-Hc Ophth Oint 1%	149
baclofen	
see LYVISPAH GRA 10MG	146
see LYVISPAH GRA 20MG	146
see LYVISPAH GRA 5MG	146
baclofen oral soln 10 mg/5ml	146
baclofen oral soln 5 mg/5ml	146
baclofen tab 10 mg	146
baclofen tab 15 mg	146
baclofen tab 20 mg	146
baclofen tab 5 mg	146
BAFIERTAM CAP 95MG	154
balsalazide disodium cap 750 mg	132
BALZIVA	
see Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg	111
BAQSIMI ONE POW 3MG/DOSE	70
BAQSIMI TWO POW 3MG/DOSE	70
BD INSULIN PEN NEEDLES - OTC	139
BD INSULIN SYRINGE - OTC	139
BD INSULIN SYRINGE - RX	139
bedaquiline fumarate	
see SIRTURO TAB 100MG	83
see SIRTURO TAB 20MG	83
BELBUCA MIS 150MCG	50

BELBUCA MIS 300MCG	50	<i>betamethasone dipropionate augmented cream</i>	
BELBUCA MIS 450MCG	50	0.05%	122
BELBUCA MIS 600MCG	50	<i>betamethasone dipropionate augmented gel</i>	
BELBUCA MIS 750MCG	50	0.05%	122
BELBUCA MIS 75MCG.....	50	<i>betamethasone dipropionate augmented lotion</i>	
BELBUCA MIS 900MCG	50	0.05%	122
BELSOMRA TAB 10MG	137	<i>betamethasone dipropionate augmented oint</i>	
BELSOMRA TAB 15MG	137	0.05%	122
BELSOMRA TAB 20MG	137	<i>betamethasone dipropionate cream 0.05% ..</i>	122
BELSOMRA TAB 5MG	137	<i>betamethasone dipropionate lotion 0.05% ...</i>	122
<i>bempedoic acid</i>		<i>betamethasone valerate aerosol foam 0.12%</i>	
see NEXLETOL TAB 180MG	75	.....	122
<i>bempedoic acid-ezetimibe</i>		<i>betamethasone valerate cream 0.1% (base</i>	
see NEXLIZET TAB 180/10MG.....	75	<i>equivalent)</i>	122
<i>benazepril & hydrochlorothiazide tab 10-12.5</i>		<i>betamethasone valerate lotion 0.1% (base</i>	
<i>mg</i>	80	<i>equivalent)</i>	122
<i>benazepril & hydrochlorothiazide tab 20-12.5</i>		<i>betamethasone valerate oint 0.1% (base</i>	
<i>mg</i>	80	<i>equivalent)</i>	122
<i>benazepril & hydrochlorothiazide tab 20-25 mg</i>		<i>betaxolol hcl (ophth)</i>	
.....	80	see BETOPTIC-S SUS 0.25% OP	147
<i>benazepril & hydrochlorothiazide tab 5-6.25 mg</i>		<i>betaxolol hcl ophth soln 0.5%</i>	147
.....	80	<i>betaxolol hcl tab 10 mg</i>	100
<i>benazepril hcl tab 10 mg</i>	77	<i>betaxolol hcl tab 20 mg</i>	100
<i>benazepril hcl tab 20 mg</i>	77	<i>bethanechol chloride tab 10 mg</i>	164
<i>benazepril hcl tab 40 mg</i>	77	<i>bethanechol chloride tab 25 mg</i>	164
<i>benazepril hcl tab 5 mg</i>	77	<i>bethanechol chloride tab 5 mg</i>	164
<i>benzonatate cap 100 mg</i>	117	<i>bethanechol chloride tab 50 mg</i>	164
<i>benzonatate cap 150 mg</i>	117	BETOPTIC-S SUS 0.25% OP	147
<i>benzonatate cap 200 mg</i>	117	<i>bexarotene cap 75 mg</i>	90
<i>benzoyl peroxide foam 9.8%</i>	118	<i>bexarotene gel 1%</i>	121
<i>benzoyl peroxide gel 8%</i>	118	<i>bicalutamide tab 50 mg</i>	84
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	118	<i>bictegravir-emtricitabine-tenofovir alafenamide</i>	
<i>benzoyl peroxide-hydrocortisone lotion 5-0.5%</i>		<i>fumarate</i>	
.....	118	see BIKTARVY TAB	96
<i>benzphetamine hcl tab 50 mg</i>	31	BIJUVA CAP 0.5-100	129
<i>benztropine mesylate tab 0.5 mg</i>	91	BIJUVA CAP 1-100MG	129
<i>benztropine mesylate tab 1 mg</i>	91	BIKTARVY TAB	96
<i>benztropine mesylate tab 2 mg</i>	91	<i>bimatoprost ophth soln 0.03%</i>	150
<i>bepotastine besilate ophth soln 1.5%</i>	150	<i>binimetinib</i>	
<i>berotralstat hcl</i>		see MEKTOVI TAB 15MG	88
see ORLADEYO CAP 110MG.....	134	<i>bismuth subcit-metronidazole-tetracycline cap</i>	
see ORLADEYO CAP 150MG	134	140-125-125 mg	163
<i>besifloxacin hcl</i>		<i>bisoprolol & hydrochlorothiazide tab 10-6.25</i>	
see BESIVANCE SUS 0.6%.....	148	<i>mg</i>	80
BESIVANCE SUS 0.6%.....	148	<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25</i>	
<i>betaine powder for oral solution</i>	128	<i>mg</i>	80

bisoprolol & hydrochlorothiazide tab 5-6.25 mg	
.....	80
bisoprolol fumarate tab 10 mg	100
bisoprolol fumarate tab 5 mg	100
BLISOVI 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24)	113
BLISOVI FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1.5 mg-30 mcg	113
BLISOVI FE 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg	112
bosentan tab 125 mg	105
bosentan tab 62.5 mg	105
BOSULIF CAP 100MG	86
BOSULIF CAP 50MG	86
BOSULIF TAB 100MG	86
BOSULIF TAB 400MG	86
BOSULIF TAB 500MG	86
bosutinib	
see BOSULIF CAP 100MG	86
see BOSULIF CAP 50MG	86
see BOSULIF TAB 100MG	86
see BOSULIF TAB 400MG	86
see BOSULIF TAB 500MG	86
BRAFTOVI CAP 75MG	86
BREATHE EASE MIS LG MASK	140
BREATHE EASE MIS MED MASK	140
BREATHE EASE MIS SM MASK	140
BREO ELLIPTA INH 100-25	58
BREO ELLIPTA INH 200-25	58
BREO ELLIPTA INH 50-25MCG	58
BREYNA	
see Budesonide-Formoterol Fumarate Dihy	
Aerosol 160-4.5 mcg/act	58
see Budesonide-Formoterol Fumarate Dihy	
Aerosol 80-4.5 mcg/act	58
BREZTRI AERO AER SPHERE	58
BRIELLYN	
see Norethindrone & Ethinyl Estradiol Tab 0.4	
mg-35 mcg	111
brigatinib	
see ALUNBRIG PAK	86
see ALUNBRIG TAB 180MG	86
see ALUNBRIG TAB 30MG	86
see ALUNBRIG TAB 90MG	86
BRILINTA TAB 60MG	134
BRILINTA TAB 90MG	134
brimonidine tartrate	
see ALPHAGAN P SOL 0.1%	148
see ALPHAGAN P SOL 0.15%	148
brimonidine tartrate gel 0.33% (base equivalent)	125
brimonidine tartrate ophth soln 0.1%	148
brimonidine tartrate ophth soln 0.15%	148
brimonidine tartrate ophth soln 0.2%	148
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	147
brinzolamide ophth susp 1%	150
brinzolamide-brimonidine tartrate	
see SIMBRINZA SUS 1-0.2%	148
brivaracetam	
see BRIVIACT SOL 10MG/ML	61
see BRIVIACT TAB 100MG	61
see BRIVIACT TAB 10MG	61
see BRIVIACT TAB 25MG	61
see BRIVIACT TAB 50MG	61
see BRIVIACT TAB 75MG	61
BRIVIACT SOL 10MG/ML	61
BRIVIACT TAB 100MG	61
BRIVIACT TAB 10MG	61
BRIVIACT TAB 25MG	61
BRIVIACT TAB 50MG	61
BRIVIACT TAB 75MG	61
bromfenac sodium ophth soln 0.07% (base equivalent)	150
bromfenac sodium ophth soln 0.075% (base equivalent)	150
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)	150
bromocriptine mesylate cap 5 mg (base equivalent)	91
bromocriptine mesylate tab 2.5 mg (base equivalent)	91
BRUKINSA CAP 80MG	86
BRYHALI LOT 0.01%	122
budesonide (inhalation)	
see PULMICORT INH 180MCG	57
see PULMICORT INH 90MCG	57
budesonide delayed release particles cap 3 mg	116
budesonide inhalation susp 0.25 mg/2ml	57
budesonide inhalation susp 0.5 mg/2ml	57

budesonide inhalation susp 1 mg/2ml	57
budesonide rectal foam 2 mg/act	51
budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act	58
Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 mcg/act	58
budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act	58
Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 mcg/act.....	58
budesonide-glycopyrrolate-formoterol fumarate see BREZTRI AERO AER SPHERE.....	58
bumetanide tab 0.5 mg	126
bumetanide tab 1 mg	126
bumetanide tab 2 mg	126
buprenorphine hcl see BELBUCA MIS 150MCG.....	50
see BELBUCA MIS 300MCG.....	50
see BELBUCA MIS 450MCG.....	50
see BELBUCA MIS 600MCG.....	50
see BELBUCA MIS 750MCG.....	50
see BELBUCA MIS 75MCG.....	50
see BELBUCA MIS 900MCG.....	50
buprenorphine hcl sl tab 2 mg (base equiv)	50
buprenorphine hcl sl tab 8 mg (base equiv)	50
buprenorphine hcl-naloxone hcl dihydrate see ZUBSOLV SUB 0.7-0.18.....	51
see ZUBSOLV SUB 1.4-0.36.....	51
see ZUBSOLV SUB 11.4-2.9.....	51
see ZUBSOLV SUB 2.9-0.71.....	51
see ZUBSOLV SUB 5.7-1.4.....	51
see ZUBSOLV SUB 8.6-2.1.....	51
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	50
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	50
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	50
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	50
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	50
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	50
buprenorphine td patch weekly 10 mcg/hr	50
buprenorphine td patch weekly 15 mcg/hr	50
buprenorphine td patch weekly 20 mcg/hr	50
buprenorphine td patch weekly 5 mcg/hr	50
buprenorphine td patch weekly 7.5 mcg/hr	50
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	155
bupropion hcl tab 100 mg	65
bupropion hcl tab 75 mg	65
bupropion hcl tab er 12hr 100 mg	65
bupropion hcl tab er 12hr 150 mg	65
bupropion hcl tab er 12hr 200 mg	65
bupropion hcl tab er 24hr 150 mg	65
bupropion hcl tab er 24hr 300 mg	65
buspirone hcl tab 10 mg	54
buspirone hcl tab 15 mg	54
buspirone hcl tab 30 mg	54
buspirone hcl tab 5 mg	54
buspirone hcl tab 7.5 mg	54
butalbital-acetaminophen tab 50-325 mg	42
Butalbital-Acetaminophen Tab 50-325 mg	42
butalbital-acetaminophen-caff w/ cod cap 50- 300-40-30 mg	47
butalbital-acetaminophen-caff w/ cod cap 50- 325-40-30 mg	48
butalbital-acetaminophen-cafeine tab 50-325- 40 mg	42
Butalbital-Acetaminophen-Caffeine Tab 50-325- 40 mg	42
butalbital-aspirin-caff w/ codeine cap 50-325- 40-30 mg	48
Butalbital-Aspirin-Caff W/ Codeine Cap 50-325- 40-30 mg	48
butalbital-aspirin-cafeine cap 50-325-40 mg .	42
butorphanol tartrate nasal soln 10 mg/ml	51
C	
cabergoline tab 0.5 mg	129
CABOMETYX TAB 20MG.....	86
CABOMETYX TAB 40MG.....	86
CABOMETYX TAB 60MG.....	86
cabozantinib s-malate see CABOMETYX TAB 20MG	86
see CABOMETYX TAB 40MG	86
see CABOMETYX TAB 60MG	86
calcipotriene oint 0.005%	121
Calcipotriene Oint 0.005%	121
calcipotriene soln 0.005% (50 mcg/ml)	121
calcipotriene-betamethasone dipropionate see ENSTILAR AER	123
calcitonin (salmon) nasal soln 200 unit/act...	127

CALCITRENE	
see Calcipotriene Oint 0.005%	121
calcitriol cap 0.25 mcg	128
calcitriol cap 0.5 mcg	128
calcitriol oral soln 1 mcg/ml	128
calcium acetate (phosphate binder) cap 667 mg (169 mg ca)	132
calcium acetate (phosphate binder) tab 667 mg	132
calcium, magnesium, potassium, & sodium oxybates	
see XYWAV SOL 0.5GM/ML	152
CALQUENCE TAB 100MG	86
CAMILA	
see Norethindrone Tab 0.35 mg	115
CAMRESE	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)	109
CAMRESE LO	
see Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7)	109
candesartan cilexetil tab 16 mg	78
candesartan cilexetil tab 32 mg	78
candesartan cilexetil tab 4 mg	78
candesartan cilexetil tab 8 mg	78
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg	80
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg	80
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg	80
capecitabine tab 150 mg	83
capecitabine tab 500 mg	83
capivasertib	
see TRUQAP PAK 160MG	90
see TRUQAP PAK 200MG	90
see TRUQAP TAB 200MG	90
captopril & hydrochlorothiazide tab 25-15 mg	80
captopril & hydrochlorothiazide tab 25-25 mg	80
captopril & hydrochlorothiazide tab 50-15 mg	80
captopril & hydrochlorothiazide tab 50-25 mg	80
captopril tab 100 mg	77
captopril tab 12.5 mg	77
captopril tab 25 mg	77
captopril tab 50 mg	77
carbamazepine cap er 12hr 100 mg	61
carbamazepine cap er 12hr 200 mg	61
carbamazepine cap er 12hr 300 mg	61
carbamazepine chew tab 100 mg	61
carbamazepine chew tab 200 mg	61
carbamazepine susp 100 mg/5ml	61
carbamazepine tab 200 mg	61
Carbamazepine Tab 200 mg	61
carbamazepine tab er 12hr 100 mg	61
carbamazepine tab er 12hr 200 mg	61
carbamazepine tab er 12hr 400 mg	61
carbidopa & levodopa orally disintegrating tab 10-100 mg	91
carbidopa & levodopa orally disintegrating tab 25-100 mg	91
carbidopa & levodopa orally disintegrating tab 25-250 mg	91
carbidopa & levodopa tab 10-100 mg	91
carbidopa & levodopa tab 25-100 mg	91
carbidopa & levodopa tab 25-250 mg	91
carbidopa & levodopa tab er 25-100 mg	91
carbidopa & levodopa tab er 50-200 mg	91
carbidopa tab 25 mg	91
carbidopa-levodopa	
see DHIVY TAB 25-100MG	92
see RYTARY CAP 145MG	93
see RYTARY CAP 195MG	93
see RYTARY CAP 245MG	93
see RYTARY CAP 95MG	93
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	91
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	91
carbidopa-levodopa-entacapone tabs 25-100-200 mg	91
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	91
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	92
carbidopa-levodopa-entacapone tabs 50-200-200 mg	92
carbinoxamine maleate extended release susp 4 mg/5ml	74
carbinoxamine maleate soln 4 mg/5ml	74
carbinoxamine maleate tab 4 mg	74
carglumic acid soluble tab 200 mg	128
cariprazine hcl	
see VRAYLAR CAP 1.5MG	93
see VRAYLAR CAP 3MG	93

see VRAYLAR CAP 4.5MG	93
see VRAYLAR CAP 6MG	93
carisoprodol tab 350 mg	146
carteolol hcl ophth soln 1%	148
CARTIA XT	
see Diltiazem Hcl Coated Beads Cap Er 24hr	
120 mg	102
see Diltiazem Hcl Coated Beads Cap Er 24hr	
180 mg	102
see Diltiazem Hcl Coated Beads Cap Er 24hr	
240 mg	102
see Diltiazem Hcl Coated Beads Cap Er 24hr	
300 mg	102
carvedilol phosphate cap er 24hr 10 mg	100
carvedilol phosphate cap er 24hr 20 mg	100
carvedilol phosphate cap er 24hr 40 mg	100
carvedilol phosphate cap er 24hr 80 mg	100
carvedilol tab 12.5 mg	100
carvedilol tab 25 mg	100
carvedilol tab 3.125 mg	100
carvedilol tab 6.25 mg	100
CAYSTON INH 75MG	53
cefaclor cap 250 mg	106
cefaclor cap 500 mg	106
cefaclor for susp 250 mg/5ml	106
cefadroxil cap 500 mg	106
cefadroxil for susp 250 mg/5ml	106
cefadroxil for susp 500 mg/5ml	106
cefadroxil tab 1 gm	106
cefдинир cap 300 mg	107
cefдинир for susp 125 mg/5ml	107
cefдинир for susp 250 mg/5ml	107
cefіxime cap 400 mg	107
cefіxime for susp 100 mg/5ml	107
cefіxime for susp 200 mg/5ml	107
cefpodoxime proxetil for susp 100 mg/5ml ..	107
cefpodoxime proxetil for susp 50 mg/5ml	107
cefpodoxime proxetil tab 100 mg	107
cefpodoxime proxetil tab 200 mg	107
cefprozil for susp 125 mg/5ml	107
cefprozil for susp 250 mg/5ml	107
cefprozil tab 250 mg	107
cefprozil tab 500 mg	107
cefuroxime axetil tab 250 mg	107
cefuroxime axetil tab 500 mg	107
celecoxib cap 100 mg	40
celecoxib cap 200 mg	40

celecoxib cap 400 mg	40
celecoxib cap 50 mg	40
cenobamate	
see XCOPRI PAK 100-150	63
see XCOPRI PAK 12.5-25	63
see XCOPRI PAK 150-200	63
see XCOPRI PAK 50-100MG	63
see XCOPRI TAB 100MG	64
see XCOPRI TAB 150MG	64
see XCOPRI TAB 200MG	64
see XCOPRI TAB 25MG	63
see XCOPRI TAB 50MG	64
cephalexin cap 250 mg	106
cephalexin cap 500 mg	106
cephalexin cap 750 mg	106
cephalexin for susp 125 mg/5ml	106
cephalexin for susp 250 mg/5ml	106
cephalexin tab 250 mg	106
cephalexin tab 500 mg	106
CERDELGA CAP 84MG	134
ceritinib	
see ZYKADIA TAB 150MG	90
cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)	74
cevimeline hcl cap 30 mg	146
CHARLOTTE 24 FE	
see Norethindrone Ace-Eth Estradiol-Fe Chew	
Tab 1 mg-20 mcg (24)	113
CHATEAL EQ	
see Levonorgestrel & Ethinyl Estradiol Tab	
0.15 mg-30 mcg	110
CHENODAL	
see Chenodiol Tab 250 mg	131
Chenodiol Tab 250 mg	131
chlordiazepoxide hcl cap 10 mg	55
chlordiazepoxide hcl cap 25 mg	55
chlordiazepoxide hcl cap 5 mg	55
chlordiazepoxide hcl-clidinium bromide cap 5-	
2.5 mg	162
chlordiazepoxide-amitriptyline tab 10-25 mg	153
chlordiazepoxide-amitriptyline tab 5-12.5 mg	
.....	153
chloroquine phosphate tab 250 mg	82
chloroquine phosphate tab 500 mg	82
chlorpromazine hcl tab 10 mg	95
chlorpromazine hcl tab 100 mg	95
chlorpromazine hcl tab 200 mg	95
chlorpromazine hcl tab 25 mg	95

chlorpromazine hcl tab 50 mg	95
chlorthalidone tab 25 mg	127
chlorthalidone tab 50 mg	127
chlorzoxazone tab 500 mg	146
cholestyramine light powder 4 gm/dose	75
Cholestyramine Light Powder 4 gm/dose	75
cholestyramine light powder packets 4 gm	75
Cholestyramine Light Powder Packets 4 gm	75
cholestyramine powder 4 gm/dose	75
cholestyramine powder packets 4 gm	75
choline fenofibrate cap dr 135 mg (fenofibric acid equiv)	75
choline fenofibrate cap dr 45 mg (fenofibric acid equiv)	75
CIBINQO TAB 100MG	124
CIBINQO TAB 200MG	124
CIBINQO TAB 50MG	124
CICLODAN	
see Ciclopirox Solution 8%	120
ciclopirox gel 0.77%	120
ciclopirox olamine cream 0.77% (base equiv)	120
ciclopirox olamine susp 0.77% (base equiv) ...	120
ciclopirox shampoo 1%	120
ciclopirox solution 8%	120
Ciclopirox Solution 8%	120
cilostazol tab 100 mg	134
cilostazol tab 50 mg	134
CIMDUO TAB 300-300	96
cimetidine hcl soln 300 mg/5ml	162
cimetidine tab 200 mg	162
cimetidine tab 300 mg	163
cimetidine tab 400 mg	163
cimetidine tab 800 mg	163
cinacalcet hcl tab 30 mg (base equiv)	128
cinacalcet hcl tab 60 mg (base equiv)	128
cinacalcet hcl tab 90 mg (base equiv)	128
CIPRO (10%) SUS 500MG/5	131
CIPRO (5%) SUS 250MG/5	131
ciprofloxacin	
see CIPRO (10%) SUS 500MG/5	131
see CIPRO (5%) SUS 250MG/5	131
ciprofloxacin hcl ophth soln 0.3% (base equivalent)	148
ciprofloxacin hcl otic soln 0.2% (base equivalent)	150
ciprofloxacin hcl tab 250 mg (base equiv)	131
ciprofloxacin hcl tab 500 mg (base equiv)	131

ciprofloxacin hcl tab 750 mg (base equiv)	131
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	150
citalopram hydrobromide oral soln 10 mg/5ml	65
citalopram hydrobromide tab 10 mg (base equiv)	65
citalopram hydrobromide tab 20 mg (base equiv)	65
citalopram hydrobromide tab 40 mg (base equiv)	65
CLARAVIS	
see Isotretinoin Cap 10 mg	119
see Isotretinoin Cap 20 mg	119
see Isotretinoin Cap 30 mg	119
see Isotretinoin Cap 40 mg	119
clarithromycin for susp 125 mg/5ml	138
clarithromycin for susp 250 mg/5ml	138
clarithromycin tab 250 mg	138
clarithromycin tab 500 mg	138
clarithromycin tab er 24hr 500 mg	138
clascoterone	
see WINLEVI CRE 1%	120
clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)	74
Clemastine Fumarate Tab 2.68 mg	74
CLEMASZ	
see Clemastine Fumarate Tab 2.68 mg	74
CLENPIQ SOL	137
CLIMARA PRO DIS WEEKLY	129
CLINDACIN	
see Clindamycin Phosphate Foam 1%	118
CLINDACIN ETZ PLEDGETS	
see Clindamycin Phosphate Swab 1%	118
CLINDACIN-P	
see Clindamycin Phosphate Swab 1%	118
clindamycin hcl cap 150 mg	53
clindamycin hcl cap 300 mg	53
clindamycin hcl cap 75 mg	53
clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)	53
clindamycin phosphate foam 1%	118
Clindamycin Phosphate Foam 1%	118
clindamycin phosphate gel 1% (twice-daily)	118
clindamycin phosphate lotion 1%	118
clindamycin phosphate soln 1%	118
clindamycin phosphate swab 1%	118

Clindamycin Phosphate Swab 1%.....	118	<i>clonidine tab er 24hr 0.17 mg</i>	79
<i>clindamycin phosphate vaginal cream 2%</i>	165	<i>clonidine td patch weekly 0.1 mg/24hr</i>	79
<i>clindamycin phosphate-benzoyl peroxide gel</i>		<i>clonidine td patch weekly 0.2 mg/24hr</i>	79
1.2-2.5%	119	<i>clonidine td patch weekly 0.3 mg/24hr</i>	79
<i>clindamycin phosphate-benzoyl peroxide gel</i>		<i>clopidogrel bisulfate tab 300 mg (base equiv)</i>	
1.2-3.75%	119	.....	134
<i>clindamycin phosphate-benzoyl peroxide gel 1-</i>		<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	134
5%	118	<i>clorazepate dipotassium tab 15 mg</i>	55
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i>		<i>clorazepate dipotassium tab 3.75 mg</i>	55
.....	119	<i>clorazepate dipotassium tab 7.5 mg</i>	55
<i>clindamycin phosph-benzoyl peroxide (refrig)</i>		<i>clotrimazole cream 1%</i>	120
gel 1.2 (1)-5%	118	<i>clotrimazole soln 1%</i>	121
Clindamycin Phosph-Benzoyl Peroxide (Refrig)		<i>clotrimazole troche 10 mg</i>	145
Gel 1.2 (1)-5%	118	<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	
<i>clobazam suspension 2.5 mg/ml</i>	60	.....	121
<i>clobazam tab 10 mg</i>	60	<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	
<i>clobazam tab 20 mg</i>	60	.....	121
<i>clobetasol propionate cream 0.025%</i>	122	<i>clozapine orally disintegrating tab 100 mg</i>	94
<i>clobetasol propionate cream 0.05%</i>	122	<i>clozapine orally disintegrating tab 12.5 mg</i>	94
<i>clobetasol propionate emollient base cream</i>		<i>clozapine orally disintegrating tab 150 mg</i>	94
0.05%	122	<i>clozapine orally disintegrating tab 200 mg</i>	94
<i>clobetasol propionate foam 0.05%</i>	122	<i>clozapine orally disintegrating tab 25 mg</i>	94
<i>clobetasol propionate gel 0.05%</i>	122	<i>clozapine tab 100 mg</i>	94
<i>clobetasol propionate lotion 0.05%</i>	122	<i>clozapine tab 200 mg</i>	94
<i>clobetasol propionate oint 0.05%</i>	122	<i>clozapine tab 25 mg</i>	94
<i>clobetasol propionate shampoo 0.05%</i>	122	<i>clozapine tab 50 mg</i>	94
Clobetasol Propionate Shampoo 0.05%	122	COARTEM TAB 20-120MG	82
<i>clobetasol propionate soln 0.05%</i>	122	<i>codeine sulfate tab 30 mg</i>	42
CLODAN		<i>colchicine</i>	
see Clobetasol Propionate Shampoo 0.05% 122		see MITIGARE CAP 0.6MG	133
<i>clomiphene citrate tab 50 mg</i>	127	<i>colchicine tab 0.6 mg</i>	133
<i>clomipramine hcl cap 25 mg</i>	67	<i>colchicine w/ probenecid tab 0.5-500 mg</i>	133
<i>clomipramine hcl cap 50 mg</i>	67	<i>colesevelam hcl packet for susp 3.75 gm</i>	75
<i>clomipramine hcl cap 75 mg</i>	67	<i>colesevelam hcl tab 625 mg</i>	75
<i>clonazepam orally disintegrating tab 0.125 mg</i>		<i>colestipol hcl granule packets 5 gm</i>	75
.....	60	<i>colestipol hcl granules 5 gm</i>	75
<i>clonazepam orally disintegrating tab 0.25 mg</i>	60	<i>colestipol hcl tab 1 gm</i>	75
<i>clonazepam orally disintegrating tab 0.5 mg</i> ..	60	COMBIPATCH DIS	129
<i>clonazepam orally disintegrating tab 1 mg</i>	60	COMPACT SPAC MIS CHAMBER	140
<i>clonazepam orally disintegrating tab 2 mg</i>	60	COMPACT SPAC MIS LG MASK	140
<i>clonazepam tab 0.5 mg</i>	60	COMPACT SPAC MIS MD MASK	140
<i>clonazepam tab 1 mg</i>	60	COMPACT SPAC MIS SM MASK	140
<i>clonazepam tab 2 mg</i>	60	COMPRO	
<i>clonidine hcl tab 0.1 mg</i>	79	see Prochlorperazine Suppos 25 mg	95
<i>clonidine hcl tab 0.2 mg</i>	79	<i>condoms - female</i>	
<i>clonidine hcl tab 0.3 mg</i>	79	see FC FEMALE MIS CONDOM	139
<i>clonidine hcl tab er 12hr 0.1 mg</i>	32	see FC2 FEMALE MIS CONDOM	139

condoms latex lubricated - male	
see MALE MIS CONDOM.....	139
condoms latex non-lubricated - male	
see TRUSTEX MIS FLAVORS	139
CONDOMS MIS	139
condoms non-latex lubricated - male	
see DUREX MIS REALFEEL	139
conjugated estrogens-bazedoxifene	
see DUAVEE TAB 0.45-20	129
conjugated estrogens-medroxyprogesterone acetate	
see PREMPHASE TAB.....	130
see PREMPRO TAB.....	130
see PREMPRO TAB 0.3-1.5.....	130
see PREMPRO TAB 0.45-1.5.....	130
see PREMPRO TAB 0.625-5.....	130
CONSTULOSE	
see Lactulose Solution 10 gm/15ml	138
COPIKTRA CAP 15MG	86
COPIKTRA CAP 25MG	86
CORTIFOAM AER 90MG	51
CREON CAP 12000UNT.....	125
CREON CAP 24000UNT.....	125
CREON CAP 3000UNIT.....	125
CREON CAP 36000UNT.....	125
CREON CAP 6000UNIT.....	125
CRINONE GEL 4% VAG	165
CRINONE GEL 8% VAG	165
crisaborole	
see EUCRISA OIN 2%	124
CRIXIVAN CAP 200MG	96
CRIXIVAN CAP 400MG	96
cromolyn sodium ophth soln 4%	150
cromolyn sodium oral conc 100 mg/5ml	131
cromolyn sodium soln nebu 20 mg/2ml	56
Crotamiton Lotion 10%	125
CROTAN	
see Crotamiton Lotion 10%	125
CRYSELLE-28	
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg.....	115
CVS FOLIC ACID	
see Folic Acid Tab 800 mcg.....	135
CVS NICOTINE	
see Nicotine Polacrilex Gum 2 mg.....	155
see Nicotine Polacrilex Gum 4 mg.....	156
CVS NICOTINE GUM	
see Nicotine Polacrilex Gum 4 mg	156
CVS NICOTINE LOZENGE	
see Nicotine Polacrilex Lozenge 2 mg.....	157
see Nicotine Polacrilex Lozenge 4 mg.....	157
CVS NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg	155
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Polacrilex Lozenge 2 mg.....	157
see Nicotine Polacrilex Lozenge 4 mg.....	157
CVS NICOTINE POLACRILEX S	
see Nicotine Polacrilex Gum 2 mg	155
CVS NICOTINE TRANSDERMAL	
see Nicotine Td Patch 24hr 14 mg/24hr	158
see Nicotine Td Patch 24hr 21 mg/24hr	158
see Nicotine Td Patch 24hr 7 mg/24hr	158
cyclobenzaprine hcl tab 10 mg	146
cyclobenzaprine hcl tab 5 mg	146
cyclopentolate hcl ophth soln 1%	148
cyclophosphamide cap 25 mg	83
cyclophosphamide cap 50 mg	83
cycloserine cap 250 mg	83
cyclosporine (ophth)	
see RESTASIS EMU 0.05% OP	149
see RESTASIS MUL EMU 0.05% OP	149
cyclosporine cap 100 mg	144
cyclosporine cap 25 mg	144
cyclosporine modified cap 100 mg	144
Cyclosporine Modified Cap 100 mg	145
cyclosporine modified cap 25 mg	144
Cyclosporine Modified Cap 25 mg	144
cyclosporine modified cap 50 mg	144
cyclosporine modified oral soln 100 mg/ml ... 145	
Cyclosporine Modified Oral Soln 100 mg/ml .. 145	
cyproheptadine hcl syrup 2 mg/5ml	75
cyproheptadine hcl tab 4 mg	75
CYRED EQ	
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg.....	107
CYSTAGON CAP 150MG	133
CYSTAGON CAP 50MG	133
cysteamine bitartrate	
see CYSTAGON CAP 150MG	133
see CYSTAGON CAP 50MG	133
CYTRA K CRYSTALS	
see Potassium Citrate & Citric Acid Powder Pack 3300-1002 mg.....	133

D	
dabigatran etexilate mesylate cap 110 mg (etexilate base eq)	60
dabigatran etexilate mesylate cap 150 mg (etexilate base eq)	60
dabigatran etexilate mesylate cap 75 mg (etexilate base eq)	60
dabrafenib mesylate	
see TAFINLAR CAP 50MG	90
see TAFINLAR CAP 75MG	90
see TAFINLAR TAB 10MG	90
dalfampridine tab er 12hr 10 mg	154
danazol cap 100 mg	51
danazol cap 200 mg	51
danazol cap 50 mg	51
dantrolene sodium cap 100 mg	147
dantrolene sodium cap 25 mg	147
dantrolene sodium cap 50 mg	147
dapagliflozin propanediol	
see FARXIGA TAB 10MG	72
see FARXIGA TAB 5MG	72
dapagliflozin propanediol-metformin hcl	
see XIGDUO XR TAB 10-1000	69
see XIGDUO XR TAB 10-500MG	69
see XIGDUO XR TAB 2.5-1000	69
see XIGDUO XR TAB 5-1000MG	69
see XIGDUO XR TAB 5-500MG	69
dapsone gel 5%	119
dapsone gel 7.5%	119
dapsone tab 100 mg	53
dapsone tab 25 mg	53
daridorexant hcl	
see QUVIVIQ TAB 25MG	137
see QUVIVIQ TAB 50MG	137
darifenacin hydrobromide tab er 24hr 15 mg (base equiv)	164
darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)	164
darolutamide	
see NUBEQA TAB 300MG	85
darunavir tab 600 mg	96
darunavir tab 800 mg	96
darunavir-cobicistat	
see PREZCOBIX TAB 800-150	98
darunavir-cobicistat-emtricitabine-tenofovir alafenamide	
see SYMTUZA TAB	98
dasatinib tab 100 mg	87
dasatinib tab 140 mg	87
dasatinib tab 20 mg	86
dasatinib tab 50 mg	86
dasatinib tab 70 mg	86
dasatinib tab 80 mg	87
DASETTA 1/35	
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg	111
DASETTA 7/7/7	
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg	114
dasiglucagon hcl	
see ZEGALOGUE INJ 0.6/0.6	70
DAYSEE	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)	109
DAYVIGO TAB 10MG	137
DAYVIGO TAB 5MG	137
DEBLITANE	
see Norethindrone Tab 0.35 mg	115
deferasirox granules packet 180 mg	72
deferasirox granules packet 360 mg	72
deferasirox granules packet 90 mg	72
deferasirox tab 180 mg	72
deferasirox tab 360 mg	72
deferasirox tab 90 mg	72
deferasirox tab for oral susp 125 mg	72
deferasirox tab for oral susp 250 mg	72
deferasirox tab for oral susp 500 mg	72
deferiprone tab 1000 mg	72
deferiprone tab 500 mg	72
deflazacort	
see EMFLAZA SUS 22.75/ML	116
deflazacort susp 22.75 mg/ml	116
deflazacort tab 18 mg	116
deflazacort tab 30 mg	116
deflazacort tab 36 mg	116
deflazacort tab 6 mg	116
DELYLA	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	109
demeclocycline hcl tab 150 mg	159
demeclocycline hcl tab 300 mg	159
DESCOVY TAB 120-15MG	96
DESCOVY TAB 200/25MG	97
desipramine hcl tab 10 mg	67

desipramine hcl tab 100 mg	67	see AUSTEDO XR TAB 36MG ER	154
desipramine hcl tab 150 mg	67	see AUSTEDO XR TAB 42MG ER	154
desipramine hcl tab 25 mg	67	see AUSTEDO XR TAB 48MG ER	154
desipramine hcl tab 50 mg	67	see AUSTEDO XR TAB 6MG	154
desipramine hcl tab 75 mg	67	see AUSTEDO XR TAB TITR KIT	154
desloratadine tab 5 mg	74	dexamethasone elixir 0.5 mg/5ml	116
desloratadine tab orally disintegrating 2.5 mg	74	dexamethasone sodium phosphate ophth soln 0.1%	149
desloratadine tab orally disintegrating 5 mg ..	74	dexamethasone soln 0.5 mg/5ml	116
desmopressin acetate nasal spray soln 0.01%	129	dexamethasone tab 0.5 mg	116
desmopressin acetate nasal spray soln 0.01% (refrigerated)	129	dexamethasone tab 0.75 mg	116
desmopressin acetate tab 0.1 mg	129	dexamethasone tab 1 mg	116
desmopressin acetate tab 0.2 mg	129	dexamethasone tab 1.5 mg	116
desogest-eth estrad & eth estrad tab 0.15- 0.02/0.01 mg(21/5)	107	dexamethasone tab 2 mg	116
Desogest-Eth Estrad & Eth Estrad Tab 0.15- 0.02/0.01 mg(21/5)	107	dexamethasone tab 4 mg	116
Desogest-Ethin Est Tab 0.1-0.025/0.125- 0.025/0.15-0.025mg-Mg	107	dexamethasone tab 6 mg	116
Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	107, 108	dexamethasone tab therapy pack 1.5 mg (21)	116
desonide cream 0.05%	122	Dexamethasone Tab Therapy Pack 1.5 mg (21)	116
desonide lotion 0.05%	122	dexamethasone tab therapy pack 1.5 mg (35)	116
desonide oint 0.05%	123	dexamethasone tab therapy pack 1.5 mg (51)	116
desoximetasone cream 0.05%	123	dexmethylphenidate hcl cap er 24 hr 10 mg	33
desoximetasone cream 0.25%	123	dexmethylphenidate hcl cap er 24 hr 15 mg	33
desoximetasone gel 0.05%	123	dexmethylphenidate hcl cap er 24 hr 20 mg	34
desoximetasone oint 0.25%	123	dexmethylphenidate hcl cap er 24 hr 25 mg	34
desoximetasone spray 0.25%	123	dexmethylphenidate hcl cap er 24 hr 30 mg	34
desvenlafaxine succinate tab er 24hr 100 mg (base equiv)	66	dexmethylphenidate hcl cap er 24 hr 35 mg	34
desvenlafaxine succinate tab er 24hr 25 mg (base equiv)	66	dexmethylphenidate hcl cap er 24 hr 40 mg	34
desvenlafaxine succinate tab er 24hr 50 mg (base equiv)	66	dexmethylphenidate hcl cap er 24 hr 5 mg	33
deucravacitinib see SOTYKTU TAB 6MG	121	dexmethylphenidate hcl tab 10 mg	34
deutetrabenazine see AUSTEDO TAB 12MG	154	dexmethylphenidate hcl tab 2.5 mg	34
see AUSTEDO TAB 6MG	154	dexmethylphenidate hcl tab 5 mg	34
see AUSTEDO TAB 9MG	154	dextroamphetamine sulfate cap er 24hr 10 mg	28
see AUSTEDO XR TAB 12MG	154	dextroamphetamine sulfate cap er 24hr 15 mg	29
see AUSTEDO XR TAB 18MG	154	dextroamphetamine sulfate cap er 24hr 5 mg 28	
see AUSTEDO XR TAB 24MG	154	dextroamphetamine sulfate oral solution 5 mg/5ml	29
see AUSTEDO XR TAB 30MG ER	154	Dextroamphetamine Sulfate Oral Solution 5 mg/5ml	29
		dextroamphetamine sulfate tab 10 mg	29
		Dextroamphetamine Sulfate Tab 10 mg	29
		dextroamphetamine sulfate tab 15 mg	30

Dextroamphetamine Sulfate Tab 15 mg	30	<i>diethylpropion hcl tab er 24hr 75 mg</i>	31
dextroamphetamine sulfate tab 2.5 mg	29	DIFICID SUS	139
Dextroamphetamine Sulfate Tab 2.5 mg	29	DIFICID TAB 200MG	139
dextroamphetamine sulfate tab 20 mg	30	<i>diflunisal tab 500 mg</i>	42
Dextroamphetamine Sulfate Tab 20 mg	30	<i>difluprednate ophth emulsion 0.05%</i>	149
dextroamphetamine sulfate tab 30 mg	30	<i>digoxin oral soln 0.05 mg/ml</i>	103
Dextroamphetamine Sulfate Tab 30 mg	30	<i>digoxin tab 125 mcg (0.125 mg)</i>	103
dextroamphetamine sulfate tab 5 mg	29	<i>digoxin tab 250 mcg (0.25 mg)</i>	104
Dextroamphetamine Sulfate Tab 5 mg	29	<i>digoxin tab 62.5 mcg (0.0625 mg)</i>	103
dextroamphetamine sulfate tab 7.5 mg	29	<i>diltiazem hcl cap er 12hr 120 mg</i>	101
Dextroamphetamine Sulfate Tab 7.5 mg	29	<i>diltiazem hcl cap er 12hr 60 mg</i>	101
DHIVY TAB 25-100MG	92	<i>diltiazem hcl cap er 12hr 90 mg</i>	101
diazepam (anticonvulsant)		<i>diltiazem hcl cap er 24hr 120 mg</i>	101
see VALTOCO SPR 10MG	60	Diltiazem Hcl Cap Er 24hr 120 mg	101
see VALTOCO SPR 15MG	60	<i>diltiazem hcl cap er 24hr 180 mg</i>	101
see VALTOCO SPR 20MG	61	Diltiazem Hcl Cap Er 24hr 180 mg	101
see VALTOCO SPR 5MG	60	<i>diltiazem hcl cap er 24hr 240 mg</i>	101
diazepam conc 5 mg/ml	55	Diltiazem Hcl Cap Er 24hr 240 mg	101
diazepam oral soln 1 mg/ml	55	<i>diltiazem hcl coated beads cap er 24hr 120 mg</i>	
diazepam rectal gel delivery system 10 mg	60	.....	102
diazepam rectal gel delivery system 2.5 mg	60	Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg	
diazepam rectal gel delivery system 20 mg	60	.....	102
diazepam tab 10 mg	55	<i>diltiazem hcl coated beads cap er 24hr 180 mg</i>	
diazepam tab 2 mg	55	.....	102
diazepam tab 5 mg	55	Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg	
diazoxide susp 50 mg/ml	70	.....	102
dichlorphenamide tab 50 mg	126	<i>diltiazem hcl coated beads cap er 24hr 240 mg</i>	
Dichlorphenamide Tab 50 mg	126	.....	102
diclofenac epolamine patch 1.3%	120	Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg	
diclofenac potassium tab 50 mg	40	.....	102
diclofenac sodium (actinic keratoses) gel 3%	121	<i>diltiazem hcl coated beads cap er 24hr 300 mg</i>	
diclofenac sodium ophth soln 0.1%	150	.....	102
diclofenac sodium soln 1.5%	120	Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg	
diclofenac sodium tab delayed release 25 mg	40	.....	102
diclofenac sodium tab delayed release 50 mg	40	<i>diltiazem hcl coated beads cap er 24hr 360 mg</i>	
diclofenac sodium tab delayed release 75 mg	40	.....	102
diclofenac sodium tab er 24hr 100 mg	40	<i>diltiazem hcl extended release beads cap er</i>	
diclofenac w/ misoprostol tab delayed release		24hr 120 mg	102
50-0.2 mg	40	Diltiazem Hcl Extended Release Beads Cap Er	
diclofenac w/ misoprostol tab delayed release		24hr 120 mg	102
75-0.2 mg	40	<i>diltiazem hcl extended release beads cap er</i>	
dicloxacillin sodium cap 250 mg	152	24hr 180 mg	102
dicloxacillin sodium cap 500 mg	152	Diltiazem Hcl Extended Release Beads Cap Er	
dicyclomine hcl cap 10 mg	162	24hr 180 mg	102
dicyclomine hcl oral soln 10 mg/5ml	162	<i>diltiazem hcl extended release beads cap er</i>	
dicyclomine hcl tab 20 mg	162	24hr 240 mg	102
diethylpropion hcl tab 25 mg	31		

Diltiazem Hcl Extended Release Beads Cap Er 24hr 240 mg	102
diltiazem hcl extended release beads cap er 24hr 300 mg	102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 300 mg	102
diltiazem hcl extended release beads cap er 24hr 360 mg	102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 360 mg	102
diltiazem hcl extended release beads cap er 24hr 420 mg	102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 420 mg	102
diltiazem hcl tab 120 mg	102
diltiazem hcl tab 30 mg	102
diltiazem hcl tab 60 mg	102
diltiazem hcl tab 90 mg	102
DILT-XR see Diltiazem Hcl Cap Er 24hr 120 mg	101
see Diltiazem Hcl Cap Er 24hr 180 mg	101
see Diltiazem Hcl Cap Er 24hr 240 mg	101
dimethyl fumarate capsule delayed release 120 mg.....	154
dimethyl fumarate capsule delayed release 240 mg.....	154
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	154
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	72
diphenoxylate w/ atropine tab 2.5-0.025 mg..	72
dipyridamole tab 25 mg	134
dipyridamole tab 50 mg	134
dipyridamole tab 75 mg	134
disopyramide phosphate cap 100 mg.....	55
disopyramide phosphate cap 150 mg.....	55
disulfiram tab 250 mg	152
disulfiram tab 500 mg	152
divalproex sodium cap delayed release sprinkle 125 mg	64
divalproex sodium tab delayed release 125 mg	64
divalproex sodium tab delayed release 250 mg	64
divalproex sodium tab delayed release 500 mg	64
divalproex sodium tab er 24 hr 250 mg	64
divalproex sodium tab er 24 hr 500 mg.....	64
dofetilide cap 125 mcg (0.125 mg)	56
dofetilide cap 250 mcg (0.25 mg).....	56
dofetilide cap 500 mcg (0.5 mg).....	56
DOLISHALE see Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg	110
dolutegravir sodium see TIVICAY PD TAB 5MG.....	98
see TIVICAY TAB 50MG	98
dolutegravir sodium-lamivudine see DOVATO TAB 50-300MG.....	97
donepezil hydrochloride orally disintegrating tab 10 mg	152
donepezil hydrochloride orally disintegrating tab 5 mg.....	152
donepezil hydrochloride tab 10 mg	153
donepezil hydrochloride tab 23 mg	153
donepezil hydrochloride tab 5 mg	153
DOPTLET TAB 20MG.....	136
dorzolamide hcl opth soln 2%	150
dorzolamide hcl-timolol maleate opth soln 2- 0.5%.....	148
dorzolamide hcl-timolol maleate pf opth soln 2-0.5%	148
DOTTI see Estradiol Td Patch Twice Weekly 0.025 mg/24hr	130
see Estradiol Td Patch Twice Weekly 0.0375 mg/24hr	131
see Estradiol Td Patch Twice Weekly 0.05 mg/24hr	130
see Estradiol Td Patch Twice Weekly 0.075 mg/24hr	130
see Estradiol Td Patch Twice Weekly 0.1 mg/24hr	130
DOVATO TAB 50-300MG.....	97
doxazosin mesylate tab 1 mg	79
doxazosin mesylate tab 2 mg	79
doxazosin mesylate tab 4 mg	79
doxazosin mesylate tab 8 mg	79
doxepin hcl (sleep) tab 3 mg (base equiv).....	137
doxepin hcl (sleep) tab 6 mg (base equiv).....	137
doxepin hcl cap 10 mg.....	67
doxepin hcl cap 100 mg.....	67
doxepin hcl cap 150 mg.....	67
doxepin hcl cap 25 mg.....	67

doxepin hcl cap 50 mg	67
doxepin hcl cap 75 mg	67
doxepin hcl conc 10 mg/ml	67
doxercalciferol cap 0.5 mcg	128
doxercalciferol cap 1 mcg	128
doxercalciferol cap 2.5 mcg	128
doxycycline (rosacea)	
see ORACEA CAP 40MG	125
doxycycline hyclate cap 100 mg	160
doxycycline hyclate cap 50 mg	159
doxycycline hyclate tab 100 mg	160
doxycycline monohydrate cap 100 mg	160
Doxycycline Monohydrate Cap 100 mg	160
doxycycline monohydrate cap 50 mg	160
doxycycline monohydrate for susp 25 mg/5ml	
.....	160
doxycycline monohydrate tab 100 mg	160
Doxycycline Monohydrate Tab 100 mg	160
doxycycline monohydrate tab 150 mg	160
doxycycline monohydrate tab 50 mg	160
doxycycline monohydrate tab 75 mg	160
doxylamine-pyridoxine tab delayed release 10-10 mg	73
dronabinol cap 10 mg	73
dronabinol cap 2.5 mg	73
dronabinol cap 5 mg	73
dronedarone hcl	
see MULTAQ TAB 400MG	56
drospirenone-ethinyl estradiol tab 3-0.02 mg	108
Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg	108
drospirenone-ethinyl estradiol tab 3-0.03 mg	108
Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg	108
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	108
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	108
droxidopa cap 100 mg	165
droxidopa cap 200 mg	165
droxidopa cap 300 mg	165
DUAVEE TAB 0.45-20	129
dulaglutide	
see TRULICITY INJ 0.75/0.5	70
see TRULICITY INJ 1.5/0.5	70
see TRULICITY INJ 3/0.5	70
see TRULICITY INJ 4.5/0.5	70
duloxetine hcl enteric coated pellets cap 20 mg (base eq)	66
duloxetine hcl enteric coated pellets cap 30 mg (base eq)	66
duloxetine hcl enteric coated pellets cap 40 mg (base eq)	66
duloxetine hcl enteric coated pellets cap 60 mg (base eq)	66
DUREX MIS REALFEEL	139
dutasteride cap 0.5 mg	133
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	133
duvelisib	
see COPIKTRA CAP 15MG	86
see COPIKTRA CAP 25MG	86
E	
E.E.S. 400	
see Erythromycin Ethylsuccinate Tab 400 mg	
.....	138
EASIVENT MIS	140
EASIVENT MIS MASK LG	140
EASIVENT MIS MASK MED	140
EASIVENT MIS MASK SM	140
EC-NAPROXEN	
see Naproxen Tab Ec 375 mg	41
see Naproxen Tab Ec 500 mg	41
econazole nitrate cream 1%	121
edaravone	
see RADICAVA ORS SUS 105/5ML	147
see RADICAVA ORS SUS STARTER	147
efavirenz tab 600 mg	97
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	97
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	97
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	97
EFFER-K	
see Potassium Bicarbonate Effer Tab 25 meq	
.....	143
elagolix sodium	
see ORILISSA TAB 150MG	127
see ORILISSA TAB 200MG	127
elagolix sodium-estradiol-norethindrone acetate	
see ORIAHNN CAP	129
elbasvir-grazoprevir	
see ZEPATIER TAB 50-100MG	99
eletriptan hydrobromide tab 20 mg (base equivalent)	141

eletriptan hydrobromide tab 40 mg (base equivalent)	141
eliglustat tartrate see CERDELGA CAP 84MG	134
ELINEST see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg	115
ELIQUIS ST P TAB 5MG	59
ELIQUIS TAB 2.5MG	59
ELIQUIS TAB 5MG	59
ELITE-OB see Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg	146
ELIXOPHYLLIN see Theophylline Elixir 80 mg/15ml	59
ELLA TAB 30MG	115
eltrombopag choline see ALVAIZ TAB 18MG	136
see ALVAIZ TAB 36MG	136
see ALVAIZ TAB 54MG	136
see ALVAIZ TAB 9MG	136
ELURYNG see Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr	115
eluxadoline see VIBERZI TAB 100MG	132
see VIBERZI TAB 75MG	132
elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide see GENVOYA TAB	97
EMFLAZA SUS 22.75/ML	116
empagliflozin see JARDIANCE TAB 10MG	72
see JARDIANCE TAB 25MG	72
empagliflozin-linagliptin see GLYXAMBI TAB 10-5 MG	68
see GLYXAMBI TAB 25-5 MG	68
empagliflozin-linagliptin-metformin see TRIJARDY XR TAB	69
empagliflozin-metformin hcl see SYNJARDY TAB	69
see SYNJARDY TAB 12.5-500	69
see SYNJARDY TAB 5-1000MG	69
see SYNJARDY TAB 5-500MG	69
see SYNJARDY XR TAB	69
see SYNJARDY XR TAB 10-1000	69
see SYNJARDY XR TAB 25-1000	69
see SYNJARDY XR TAB 5-1000MG	69
emtricitabine caps 200 mg	97
emtricitabine-rilpivirine-tenofovir alafenamide fumarate see ODEFSEY TAB	97
emtricitabine-tenofovir alafenamide fumarate see DESCOVY TAB 120-15MG	96
see DESCOVY TAB 200/25MG	97
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg	97
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg	97
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg	97
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg	97
EMVERM CHW 100MG	52
EMZAHN see Norethindrone Tab 0.35 mg	115
enalapril maleate & hydrochlorothiazide tab 10-25 mg	80
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	80
enalapril maleate oral soln 1 mg/ml	77
enalapril maleate tab 10 mg	77
enalapril maleate tab 2.5 mg	77
enalapril maleate tab 20 mg	77
enalapril maleate tab 5 mg	77
ENCARE SUP 100MG	164
encorafenib see BRAFTOVI CAP 75MG	86
ENDOCET see Oxycodone W/ Acetaminophen Tab 10-325 mg	50
see Oxycodone W/ Acetaminophen Tab 2.5-325 mg	49
see Oxycodone W/ Acetaminophen Tab 5-325 mg	49
see Oxycodone W/ Acetaminophen Tab 7.5-325 mg	49
ENDOMETRIN SUP 100MG	165
ENILLORING see Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr	115
ENPRESSE-28 see Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg	110

ENSKYCE	
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	107
ENSTILAR AER	123
entacapone tab 200 mg	91
entecavir tab 0.5 mg	98
entecavir tab 1 mg	98
entrectinib	
see ROZLYTREK CAP 100MG	89
see ROZLYTREK CAP 200MG	89
see ROZLYTREK PAK 50MG	89
ENTRESTO CAP 15-16MG	104
ENTRESTO CAP 6-6MG	104
ENTRESTO TAB 24-26MG	104
ENTRESTO TAB 49-51MG	104
ENTRESTO TAB 97-103MG	104
ENULOSE	
see Lactulose (Encephalopathy) Solution 10 gm/15ml	132
enzalutamide	
see XTANDI CAP 40MG	85
see XTANDI TAB 40MG	85
see XTANDI TAB 80MG	85
EPCLUSA PAK 150-37.5	98
EPCLUSA PAK 200-50MG	98
EPCLUSA TAB 200-50MG	98
EPCLUSA TAB 400-100	98
EPIDUO FORTE GEL 0.3-2.5%	119
EPIDUO GEL 0.1-2.5%	119
epinastine hcl ophth soln 0.05%	150
epinephrine (anaphylaxis)	
see AUVI-Q INJ 0.15MG	165
see AUVI-Q INJ 0.1MG	165
see AUVI-Q INJ 0.3MG	165
epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)	165
epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)	165
EPITOL	
see Carbamazepine Tab 200 mg	61
eplerenone tab 25 mg	82
eplerenone tab 50 mg	82
EQ NICOTINE	
see Nicotine Td Patch 24hr 14 mg/24hr	158
see Nicotine Td Patch 24hr 21 mg/24hr	159
EQ NICOTINE LOZENGES	
see Nicotine Polacrilex Lozenge 4 mg	157
EQ NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Polacrilex Lozenge 2 mg	157
see Nicotine Polacrilex Lozenge 4 mg	157
EQ NICOTINE STEP 3	
see Nicotine Td Patch 24hr 7 mg/24hr	158
ergocalciferol cap 1.25 mg (50000 unit)	166
ergotamine w/ caffeine tab 1-100 mg	141
ERIVEDGE CAP 150MG	84
ERLEADA TAB 240MG	85
ERLEADA TAB 60MG	85
erlotinib hcl tab 100 mg (base equivalent)	84
erlotinib hcl tab 150 mg (base equivalent)	84
erlotinib hcl tab 25 mg (base equivalent)	84
ERRIN	
see Norethindrone Tab 0.35 mg	115
ERY	
see Erythromycin Pads 2%	119
erythromycin ethylsuccinate for susp 200 mg/5ml	138
erythromycin ethylsuccinate for susp 400 mg/5ml	138
Erythromycin Ethylsuccinate Tab 400 mg	138
erythromycin gel 2%	119
erythromycin ophth oint 5 mg/gm	148
Erythromycin Pads 2%	119
erythromycin soln 2%	119
erythromycin tab 250 mg	138
erythromycin tab 500 mg	138
erythromycin tab delayed release 250 mg ...	138
erythromycin tab delayed release 333 mg ...	138
erythromycin tab delayed release 500 mg ...	138
erythromycin w/ delayed release particles cap 250 mg	138
escitalopram oxalate soln 5 mg/5ml (base equiv)	65
escitalopram oxalate tab 10 mg (base equiv) .	65
escitalopram oxalate tab 20 mg (base equiv) .	65
escitalopram oxalate tab 5 mg (base equiv) ...	65
eslicarbazepine acetate	
see APTIOM TAB 200MG	61
see APTIOM TAB 400MG	61
see APTIOM TAB 600MG	61
see APTIOM TAB 800MG	61
esomeprazole magnesium cap delayed release 20 mg (base eq)	163

esomeprazole magnesium cap delayed release	
40 mg (base eq)	163
esomeprazole magnesium for delayed release	
susp pack 2.5 mg	163
esomeprazole magnesium for delayed release	
susp packet 10 mg	163
esomeprazole magnesium for delayed release	
susp packet 20 mg	163
esomeprazole magnesium for delayed release	
susp packet 40 mg	163
esomeprazole magnesium for delayed release	
susp packet 5 mg	163
ESTARYLLA	
see Norgestimate & Ethinyl Estradiol Tab 0.25	
mg-35 mcg	114
estazolam tab 1 mg	137
estazolam tab 2 mg	137
estradiol & norethindrone acetate	
see COMBIPATCH DIS.....	129
estradiol & norethindrone acetate tab 0.5-0.1	
mg	129
estradiol & norethindrone acetate tab 1-0.5 mg	
.....	129
Estradiol & Norethindrone Acetate Tab 1-0.5 mg	
.....	129
estradiol gel 0.06% (0.75 mg/1.25 gm metered-	
dose pump)	130
estradiol tab 0.5 mg	130
estradiol tab 1 mg	130
estradiol tab 2 mg	130
estradiol td gel 0.25 mg/0.25gm (0.1%)	130
estradiol td gel 0.5 mg/0.5gm (0.1%)	130
estradiol td gel 0.75 mg/0.75gm (0.1%)	130
estradiol td gel 1 mg/gm (0.1%)	130
estradiol td gel 1.25 mg/1.25gm (0.1%)	130
estradiol td patch twice weekly 0.025 mg/24hr	
.....	130
Estradiol Td Patch Twice Weekly 0.025 mg/24hr	
.....	130
estradiol td patch twice weekly 0.0375 mg/24hr	
.....	130
Estradiol Td Patch Twice Weekly 0.0375 mg/24hr	
.....	131
estradiol td patch twice weekly 0.05 mg/24hr	
.....	130
Estradiol Td Patch Twice Weekly 0.05 mg/24hr	
.....	130

estradiol td patch twice weekly 0.075 mg/24hr	
.....	130
Estradiol Td Patch Twice Weekly 0.075 mg/24hr	
.....	130
estradiol td patch twice weekly 0.1 mg/24hr	130
Estradiol Td Patch Twice Weekly 0.1 mg/24hr	130
estradiol td patch weekly 0.025 mg/24hr	131
estradiol td patch weekly 0.0375 mg/24hr (37.5	
mcg/24hr)	131
estradiol td patch weekly 0.05 mg/24hr	131
estradiol td patch weekly 0.06 mg/24hr	131
estradiol td patch weekly 0.075 mg/24hr	131
estradiol td patch weekly 0.1 mg/24hr	131
estradiol vaginal	
see IMVEXXY MAIN SUP 10MCG	165
see IMVEXXY MAIN SUP 4MCG	165
see IMVEXXY STRT SUP 10MCG	165
see IMVEXXY STRT SUP 4MCG	165
see VAGIFEM TAB 10MCG	165
estradiol vaginal cream 0.1 mg/gm	165
estradiol valerate-dienogest	
see NATAZIA TAB.....	111
estradiol-levonorgestrel	
see CLIMARA PRO DIS WEEKLY	129
estradiol-progesterone	
see BIJUVA CAP 0.5-100.....	129
see BIJUVA CAP 1-100MG	129
eszopiclone tab 1 mg	137
eszopiclone tab 2 mg	137
eszopiclone tab 3 mg	137
ethacrynic acid tab 25 mg	126
ethambutol hcl tab 100 mg	83
ethambutol hcl tab 400 mg	83
ethionamide	
see TRECATOR TAB 250MG	83
ethosuximide cap 250 mg	64
ethosuximide soln 250 mg/5ml	64
ethyl chloride aerosol spray	124
ethynodiol diacetate & ethinyl estradiol tab 1	
mg-35 mcg	108
Ethynodiol Diacetate & Ethinyl Estradiol Tab 1	
mg-35 mcg	108
ethynodiol diacetate & ethinyl estradiol tab 1	
mg-50 mcg	108
Ethynodiol Diacetate & Ethinyl Estradiol Tab 1	
mg-50 mcg	108
etodolac cap 200 mg	40

etodolac cap 300 mg	40
etodolac tab 400 mg	40
etodolac tab 500 mg	40
etodolac tab er 24hr 400 mg	40
etodolac tab er 24hr 500 mg	40
etodolac tab er 24hr 600 mg	40
etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr	115
Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr	115
etoposide cap 50 mg	91
etrasimod arginine	
see VELSIPITY TAB 2MG	132
etravirine tab 100 mg	97
etravirine tab 200 mg	97
EUCRISA OIN 2%	124
EUTHYROX	
see Levothyroxine Sodium Tab 100 mcg	161
see Levothyroxine Sodium Tab 112 mcg	161
see Levothyroxine Sodium Tab 125 mcg	161
see Levothyroxine Sodium Tab 137 mcg	161
see Levothyroxine Sodium Tab 150 mcg	161
see Levothyroxine Sodium Tab 175 mcg	161
see Levothyroxine Sodium Tab 200 mcg	161
see Levothyroxine Sodium Tab 25 mcg	160
see Levothyroxine Sodium Tab 50 mcg	160
see Levothyroxine Sodium Tab 75 mcg	160
see Levothyroxine Sodium Tab 88 mcg	161
everolimus tab 0.25 mg	145
everolimus tab 0.5 mg	145
everolimus tab 0.75 mg	145
everolimus tab 1 mg	145
everolimus tab 10 mg	87
Everolimus Tab 10 mg	87
everolimus tab 2.5 mg	87
Everolimus Tab 2.5 mg	87
everolimus tab 5 mg	87
Everolimus Tab 5 mg	87
everolimus tab 7.5 mg	87
Everolimus Tab 7.5 mg	87
everolimus tab for oral susp 2 mg	87
everolimus tab for oral susp 3 mg	87
everolimus tab for oral susp 5 mg	87
exemestane tab 25 mg	85
ezetimibe tab 10 mg	77
ezetimibe-simvastatin tab 10-10 mg	75
ezetimibe-simvastatin tab 10-20 mg	75

ezetimibe-simvastatin tab 10-40 mg	75
ezetimibe-simvastatin tab 10-80 mg	75
F	
FA-8	
see Folic Acid Cap 0.8 mg	135
FALESSA KIT	108
FALMINA	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	109
famciclovir tab 125 mg	99
famciclovir tab 250 mg	99
famciclovir tab 500 mg	99
famotidine for susp 40 mg/5ml	163
famotidine tab 20 mg	163
famotidine tab 40 mg	163
FARXIGA TAB 10MG	72
FARXIGA TAB 5MG	72
FC FEMALE MIS CONDOM	139
FC2 FEMALE MIS CONDOM	139
febuxostat tab 40 mg	133
febuxostat tab 80 mg	133
FEIRZA 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg	113
FEIRZA 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg	112
felbamate susp 600 mg/5ml	63
felbamate tab 400 mg	63
felbamate tab 600 mg	63
felodipine tab er 24hr 10 mg	103
felodipine tab er 24hr 2.5 mg	102
felodipine tab er 24hr 5 mg	102
fenofibrate cap 150 mg	75
fenofibrate micronized cap 134 mg	75
fenofibrate micronized cap 200 mg	76
fenofibrate micronized cap 43 mg	75
fenofibrate micronized cap 67 mg	75
fenofibrate tab 145 mg	76
fenofibrate tab 160 mg	76
fenofibrate tab 48 mg	76
fenofibrate tab 54 mg	76
fenofibric acid tab 105 mg	76
fenofibric acid tab 35 mg	76
fentanyl td patch 72hr 100 mcg/hr	42
fentanyl td patch 72hr 12 mcg/hr	42
fentanyl td patch 72hr 25 mcg/hr	42

fentanyl td patch 72hr 37.5 mcg/hr	42
fentanyl td patch 72hr 50 mcg/hr	42
fentanyl td patch 72hr 62.5 mcg/hr	42
fentanyl td patch 72hr 75 mcg/hr	42
fentanyl td patch 72hr 87.5 mcg/hr	42
ferric citrate tab 1 gm (210 mg ferric iron)	132
fesoterodine fumarate tab er 24hr 4 mg	164
fesoterodine fumarate tab er 24hr 8 mg	164
FIASP FLEX INJ TOUCH	70
FIASP INJ 100/ML	71
FIASP PENFIL INJ U-100	71
fidaxomicin	
see DIFICID SUS	139
see DIFICID TAB 200MG	139
FINACEA AER 15%	125
finasteride tab 5 mg	133
finerenone	
see KERENDIA TAB 10MG	128
see KERENDIA TAB 20MG	129
fingolimod hcl cap 0.5 mg (base equiv)	154
FINZALA	
see Norethindrone Ace-Eth Estradiol-Fe Chew	
Tab 1 mg-20 mcg (24)	113
FLAC	
see Fluocinolone Acetonide (Otic) Oil 0.01%	
.....	151
flavoxate hcl tab 100 mg	164
flecainide acetate tab 100 mg	55
flecainide acetate tab 150 mg	55
flecainide acetate tab 50 mg	55
FLEXICHAMBER MIS	140
FLEXICHAMBER MIS MASK LRG	140
FLEXICHAMBER MIS MASK SM	140
flibanserin	
see ADDYI TAB 100MG	154
fluconazole for susp 10 mg/ml	74
fluconazole for susp 40 mg/ml	74
fluconazole tab 100 mg	74
fluconazole tab 150 mg	74
fluconazole tab 200 mg	74
fluconazole tab 50 mg	74
flucytosine cap 250 mg	73
fludrocortisone acetate tab 0.1 mg	117
flunisolide nasal soln 25 mcg/act (0.025%) ...	147
fluocinolone acetonide (otic) oil 0.01%	151
Fluocinolone Acetonide (Otic) Oil 0.01%	151
fluocinolone acetonide cream 0.01%	123
fluocinolone acetonide cream 0.025%	123
fluocinolone acetonide oil 0.01% (body oil) ...	123
fluocinolone acetonide oil 0.01% (scalp oil) ...	123
fluocinolone acetonide oint 0.025%	123
fluocinolone acetonide soln 0.01%	123
fluocinonide cream 0.05%	123
fluocinonide emulsified base cream 0.05%	123
fluocinonide gel 0.05%	123
fluocinonide oint 0.05%	123
fluocinonide soln 0.05%	123
FLUORABON DRO	142
fluorometholone ophth susp 0.1%	149
fluorouracil cream 5%	121
fluorouracil soln 2%	121
fluorouracil soln 5%	121
fluoxetine hcl cap 10 mg	65
fluoxetine hcl cap 20 mg	65
fluoxetine hcl cap 40 mg	65
fluoxetine hcl cap delayed release 90 mg	65
fluoxetine hcl solution 20 mg/5ml	65
fluoxetine hcl tab 10 mg	65
fluoxetine hcl tab 20 mg	65
fluphenazine hcl elixir 2.5 mg/5ml	95
fluphenazine hcl oral conc 5 mg/ml	95
fluphenazine hcl tab 1 mg	95
fluphenazine hcl tab 10 mg	95
fluphenazine hcl tab 2.5 mg	95
fluphenazine hcl tab 5 mg	95
FLURA-DROPS	
see Sodium Fluoride Soln 0.25 mg/drop F	
(From 0.55 mg/drop Naf)	143
flurbiprofen sodium ophth soln 0.03%	150
flurbiprofen tab 100 mg	40
Flurbiprofen Tab 100 mg	40
flurbiprofen tab 50 mg	40
fluticasone furoate-vilanterol	
see BREO ELLIPTA INH 100-25	58
see BREO ELLIPTA INH 200-25	58
see BREO ELLIPTA INH 50-25MCG	58
fluticasone propionate cream 0.05%	123
fluticasone propionate hfa inhal aer 110	
mcg/act	57
fluticasone propionate hfa inhal aer 220	
mcg/act	57
fluticasone propionate hfa inhal aero 44	
mcg/act	57
fluticasone propionate lotion 0.05%	123

fluticasone propionate nasal susp 50 mcg/act	147
fluticasone propionate oint 0.005%	123
fluticasone-salmeterol aer powder ba 100-50 mcg/act	58
Fluticasone-Salmeterol Aer Powder Ba 100-50 mcg/act	58
fluticasone-salmeterol aer powder ba 250-50 mcg/act	58
Fluticasone-Salmeterol Aer Powder Ba 250-50 mcg/act	58
fluticasone-salmeterol aer powder ba 500-50 mcg/act	58
Fluticasone-Salmeterol Aer Powder Ba 500-50 mcg/act	58
fluticasone-umeclidinium-vilanterol	
see TRELEGY AER 100MCG	59
see TRELEGY AER 200MCG	59
fluvastatin sodium cap 20 mg (base equivalent)	76
fluvastatin sodium cap 40 mg (base equivalent)	76
fluvastatin sodium tab er 24 hr 80 mg (base equivalent)	76
fluvoxamine maleate cap er 24hr 100 mg	65
fluvoxamine maleate cap er 24hr 150 mg	65
fluvoxamine maleate tab 100 mg	65
fluvoxamine maleate tab 25 mg	65
fluvoxamine maleate tab 50 mg	65
FOLATE	
see Folic Acid Tab 400 mcg	135
folic acid cap 0.8 mg	134
Folic Acid Cap 0.8 mg	135
folic acid tab 1 mg	135
folic acid tab 400 mcg	135
Folic Acid Tab 400 mcg	135
folic acid tab 800 mcg	135
Folic Acid Tab 800 mcg	135, 136
formoterol fumarate soln nebu 20 mcg/2ml	58
fosamprenavir calcium tab 700 mg (base equiv)	97
fosfomycin tromethamine powd pack 3 gm (base equivalent)	53
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	80
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	80

fosinopril sodium tab 10 mg	77
fosinopril sodium tab 20 mg	77
fosinopril sodium tab 40 mg	77
frovatriptan succinate tab 2.5 mg (base equivalent)	141
furosemide oral soln 10 mg/ml	126
furosemide oral soln 8 mg/ml	126
furosemide tab 20 mg	126
furosemide tab 40 mg	126
furosemide tab 80 mg	126
FYAVOLV	
see Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg	129
see Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg	129
FYCOMPA SUS 0.5MG/ML	60
FYCOMPA TAB 10MG	60
FYCOMPA TAB 12MG	60
FYCOMPA TAB 2MG	60
FYCOMPA TAB 4MG	60
FYCOMPA TAB 6MG	60
FYCOMPA TAB 8MG	60
G	
gabapentin (once-daily)	
see GRALISE TAB 450MG	155
see GRALISE TAB 750MG	155
see GRALISE TAB 900MG	155
gabapentin (once-daily) tab 300 mg	155
gabapentin (once-daily) tab 600 mg	155
gabapentin cap 100 mg	61
gabapentin cap 300 mg	61
gabapentin cap 400 mg	61
gabapentin oral soln 250 mg/5ml	61
gabapentin tab 600 mg	61
gabapentin tab 800 mg	61
GALAFOLD CAP 123MG	128
galantamine hydrobromide cap er 24hr 16 mg	153
galantamine hydrobromide cap er 24hr 24 mg	153
galantamine hydrobromide cap er 24hr 8 mg	153
galantamine hydrobromide oral soln 4 mg/ml	153
galantamine hydrobromide tab 12 mg	153
galantamine hydrobromide tab 4 mg	153
galantamine hydrobromide tab 8 mg	153

GALLIFREY	
see Norethindrone Acetate Tab 5 mg	152
gatifloxacin ophth soln 0.5%	149
GAVILYTE-C	
see Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate	
For Soln 240 gm.....	138
GAVILYTE-G	
see Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate	
For Soln 236 gm.....	138
GAVILYTE-N/FLAVOR PACK	
see Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420	
gm.....	138
GAVRETO CAP 100MG	87
gefitinib tab 250 mg	84
gemfibrozil tab 600 mg	76
GEMMILY	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Cap 1 mg-20 mcg (24)	113
GEMTESA TAB 75MG.....	164
GENERLAC	
see Lactulose (Encephalopathy) Solution 10	
gm/15ml	132
GENGRAF	
see Cyclosporine Modified Cap 100 mg	145
see Cyclosporine Modified Cap 25 mg.....	144
see Cyclosporine Modified Oral Soln 100	
mg/ml.....	145
gentamicin sulfate cream 0.1%	120
gentamicin sulfate oint 0.1%	120
gentamicin sulfate ophth soln 0.3%	149
GENVOYA TAB.....	97
gilteritinib fumarate	
see XOSPATA TAB 40MG.....	90
GLARGIN YFGN INJ 100U/ML.....	71
GLARGIN YFGN SOL 100U/ML	71
glecaprevir-pibrentasvir	
see MAVYRET PAK 50-20MG	99
see MAVYRET TAB 100-40MG	99
GLEOSTINE CAP 100MG	83
GLEOSTINE CAP 10MG	83
GLEOSTINE CAP 40MG	83
glimepiride tab 1 mg	72
glimepiride tab 2 mg	72
glimepiride tab 4 mg	72
glipizide tab 10 mg	72
glipizide tab 5 mg	72
glipizide tab er 24hr 10 mg	72
glipizide tab er 24hr 2.5 mg	72
glipizide tab er 24hr 5 mg	72
glipizide-metformin hcl tab 2.5-250 mg	68
glipizide-metformin hcl tab 2.5-500 mg	68
glipizide-metformin hcl tab 5-500 mg	68
glucagon	
see BAQSIMI ONE POW 3MG/DOSE	70
see BAQSIMI TWO POW 3MG/DOSE	70
see GVOKE HYPO 1 INJ 0.5/.1ML	70
see GVOKE HYPO 1 INJ 1/0.2ML	70
see GVOKE HYPO 2 INJ 0.5/.1ML	70
see GVOKE HYPO 2 INJ 1/0.2ML	70
see GVOKE KIT SOL 1/0.2ML	70
see GVOKE PFS INJ 1/0.2ML	70
glucagon (rdna) for inj kit 1 mg	70
glyburide micronized tab 1.5 mg	72
glyburide micronized tab 3 mg	72
glyburide micronized tab 6 mg	72
glyburide tab 1.25 mg	72
glyburide tab 2.5 mg	72
glyburide tab 5 mg	72
glyburide-metformin tab 1.25-250 mg	68
glyburide-metformin tab 2.5-500 mg	68
glyburide-metformin tab 5-500 mg	68
glycopyrrolate oral soln 1 mg/5ml	162
glycopyrrolate tab 1 mg	162
glycopyrrolate tab 2 mg	162
GLYXAMBI TAB 10-5 MG	68
GLYXAMBI TAB 25-5 MG	68
GNP FOLIC ACID	
see Folic Acid Tab 400 mcg	135
GNP NICOTINE MINI LOZENGE	
see Nicotine Polacrilex Lozenge 2 mg	157
GNP NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Polacrilex Lozenge 2 mg.....	157
see Nicotine Polacrilex Lozenge 4 mg.....	157
GNP NICOTINE POLACRILEX M	
see Nicotine Polacrilex Lozenge 4 mg.....	157
GNP NICOTINE TRANSDERMAL	
see Nicotine Td Patch 24hr 14 mg/24hr	158
see Nicotine Td Patch 24hr 7 mg/24hr	158
GOMEKLI CAP 1MG	87
GOMEKLI CAP 2MG	87
GOMEKLI TAB 1MG	87
GOODSENSE NICOTINE	

see Nicotine Polacrilex Lozenge 2 mg	157
see Nicotine Polacrilex Lozenge 4 mg	157
GOODSENSE NICOTINE POLACR	
see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Polacrilex Lozenge 4 mg	158
GRALISE TAB 450MG	155
GRALISE TAB 750MG	155
GRALISE TAB 900MG	155
granisetron	
see SANCUSO DIS 3.1MG	73
granisetron hcl tab 1 mg	73
grass mixed pollens allergen extract	
see ORALAIR SUB 300 IR	38
GRASTEK SUB 2800BAU	38
griseofulvin microsize susp 125 mg/5ml	73
griseofulvin microsize tab 500 mg	73
griseofulvin ultramicrosize tab 125 mg	73
griseofulvin ultramicrosize tab 165 mg	73
griseofulvin ultramicrosize tab 250 mg	73
guanfacine hcl tab 1 mg	79
guanfacine hcl tab 2 mg	79
guanfacine hcl tab er 24hr 1 mg (base equiv) .	32
guanfacine hcl tab er 24hr 2 mg (base equiv) .	32
guanfacine hcl tab er 24hr 3 mg (base equiv) .	32
guanfacine hcl tab er 24hr 4 mg (base equiv) .	33
GUANIDINE TAB 125MG	82
GVOKE HYPO 1 INJ 0.5/.1ML	70
GVOKE HYPO 1 INJ 1/0.2ML	70
GVOKE HYPO 2 INJ 0.5/.1ML	70
GVOKE HYPO 2 INJ 1/0.2ML	70
GVOKE KIT SOL 1/0.2ML	70
GVOKE PFS INJ 1/0.2ML	70
GYNOL II GEL 3%	164
H	
HAILEY 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol Tab	
1.5 mg-30 mcg	112
HAILEY 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24)	113
HAILEY FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1.5 mg-30 mcg	113
HAILEY FE 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg	112

halcinonide soln 0.1%	123
halobetasol propionate	
see BRYHALI LOT 0.01%	122
halobetasol propionate cream 0.05%	123
halobetasol propionate oint 0.05%	123
HALOETTE	
see Etonogestrel-Ethinyl Estradiol Va Ring	
0.12-0.015 mg/24hr	115
haloperidol lactate oral conc 2 mg/ml	94
haloperidol tab 0.5 mg	94
haloperidol tab 1 mg	94
haloperidol tab 10 mg	94
haloperidol tab 2 mg	94
haloperidol tab 20 mg	94
haloperidol tab 5 mg	94
HARVONI PAK	98
HARVONI PAK 45-200MG	98
HARVONI TAB 45-200MG	98
HARVONI TAB 90-400MG	99
HEATHER	
see Norethindrone Tab 0.35 mg	115
HIDEX 6-DAY	
see Dexamethasone Tab Therapy Pack 1.5 mg	
(21)	116
HM NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Polacrilex Lozenge 2 mg	157
HOLD CHAMBER MIS ADLT LG	140
HOLD CHAMBER MIS MEDIUM	140
HOLD CHAMBER MIS SMALL	140
HUMULIN R INJ U-500	71
hydralazine hcl tab 10 mg	82
hydralazine hcl tab 100 mg	82
hydralazine hcl tab 25 mg	82
hydralazine hcl tab 50 mg	82
hydrochlorothiazide cap 12.5 mg	127
hydrochlorothiazide tab 12.5 mg	127
hydrochlorothiazide tab 25 mg	127
hydrochlorothiazide tab 50 mg	127
hydrocod polst-chlorphen polst er susp 10-8	
mg/5ml	117
hydrocodone bitart-homatropine methylbrom	
soln 5-1.5 mg/5ml	117
Hydrocodone Bitart-Homatropine Methylbrom	
Soln 5-1.5 mg/5ml	117

hydrocodone bitart-homatropine	
methylbromide tab 5-1.5 mg	117
hydrocodone bitartrate cap er 12hr 10 mg	42
hydrocodone bitartrate cap er 12hr 15 mg	42
hydrocodone bitartrate cap er 12hr 20 mg	43
hydrocodone bitartrate cap er 12hr 30 mg	43
hydrocodone bitartrate cap er 12hr 40 mg	43
hydrocodone bitartrate cap er 12hr 50 mg	43
hydrocodone bitartrate tab er 24hr deter 100 mg	43
hydrocodone bitartrate tab er 24hr deter 120 mg	43
hydrocodone bitartrate tab er 24hr deter 20 mg	43
hydrocodone bitartrate tab er 24hr deter 30 mg	43
hydrocodone bitartrate tab er 24hr deter 40 mg	43
hydrocodone bitartrate tab er 24hr deter 60 mg	43
hydrocodone bitartrate tab er 24hr deter 80 mg	43
hydrocodone-acetaminophen soln 10-325 mg/15ml	48
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	48
hydrocodone-acetaminophen tab 10-300 mg ..	48
hydrocodone-acetaminophen tab 10-325 mg ..	48
hydrocodone-acetaminophen tab 2.5-325 mg ..	48
hydrocodone-acetaminophen tab 5-300 mg ...	48
hydrocodone-acetaminophen tab 5-325 mg ...	48
hydrocodone-acetaminophen tab 7.5-300 mg ..	48
hydrocodone-acetaminophen tab 7.5-325 mg ..	48
hydrocodone-ibuprofen tab 10-200 mg	49
hydrocodone-ibuprofen tab 5-200 mg	48
hydrocodone-ibuprofen tab 7.5-200 mg	49
hydrocortisone acetate (intrarectal)	
see CORTIFOAM AER 90MG	51
Hydrocortisone Acetate Suppos 25 mg	52
hydrocortisone acetate w/ pramoxine	
see PROCTOFOAM AER HC 1%	52
hydrocortisone acetate w/ pramoxine perianal cream 1-1%	51
hydrocortisone butyrate cream 0.1%	123
hydrocortisone butyrate oint 0.1%	123
hydrocortisone butyrate soln 0.1%	123
hydrocortisone cream 1%	123

Hydrocortisone Cream 1%	123
hydrocortisone cream 2.5%	123
hydrocortisone enema 100 mg/60ml	51
hydrocortisone lotion 2.5%	123
hydrocortisone oint 1%	123
hydrocortisone oint 2.5%	123
hydrocortisone perianal cream 1%	52
Hydrocortisone Perianal Cream 1%	52
hydrocortisone perianal cream 2.5%	52
Hydrocortisone Perianal Cream 2.5%	52
Hydrocortisone Soln 2.5%	123
hydrocortisone tab 10 mg	116
hydrocortisone tab 20 mg	116
hydrocortisone tab 5 mg	116
hydrocortisone valerate cream 0.2%	123
hydrocortisone valerate oint 0.2%	123
hydrocortisone w/ acetic acid otic soln 1-2% ..	151
HYDROMET	
see Hydrocodone Bitart-Homatropine	
Methylbrom Soln 5-1.5 mg/5ml	117
hydromorphone hcl liqd 1 mg/ml	43
hydromorphone hcl tab 2 mg	43
hydromorphone hcl tab 4 mg	43
hydromorphone hcl tab 8 mg	43
hydromorphone hcl tab er 24hr 12 mg	43
hydromorphone hcl tab er 24hr 16 mg	43
hydromorphone hcl tab er 24hr 32 mg	44
hydromorphone hcl tab er 24hr 8 mg	43
hydroxychloroquine sulfate tab 100 mg	82
hydroxychloroquine sulfate tab 200 mg	82
hydroxychloroquine sulfate tab 300 mg	82
hydroxychloroquine sulfate tab 400 mg	82
hydroxyurea (sickle cell disease)	
see SIKLOS TAB 1000MG	134
see SIKLOS TAB 100MG	134
hydroxyurea cap 500 mg	90
hydroxyzine hcl syrup 10 mg/5ml	54
hydroxyzine hcl tab 10 mg	54
hydroxyzine hcl tab 25 mg	54
hydroxyzine hcl tab 50 mg	54
hydroxyzine pamoate cap 100 mg	54
hydroxyzine pamoate cap 25 mg	54
hydroxyzine pamoate cap 50 mg	54
hyoscyamine sulfate elixir 0.125 mg/5ml	162
Hyoscyamine Sulfate Elixir 0.125 mg/5ml	162
hyoscyamine sulfate sl tab 0.125 mg	162
Hyoscyamine Sulfate Sl Tab 0.125 mg	162

hyoscyamine sulfate soln 0.125 mg/ml	162
Hyoscyamine Sulfate Soln 0.125 mg/ml	162
hyoscyamine sulfate tab 0.125 mg	162
Hyoscyamine Sulfate Tab 0.125 mg	162
hyoscyamine sulfate tab disint 0.125 mg	162
Hyoscyamine Sulfate Tab Disint 0.125 mg	162
HYOSYNE	
see Hyoscyamine Sulfate Elixir 0.125 mg/5ml	162
see Hyoscyamine Sulfate Soln 0.125 mg/ml	162
I	
ibandronate sodium tab 150 mg (base equivalent)	127
IBRANCE CAP 100MG	87
IBRANCE CAP 125MG	87
IBRANCE CAP 75MG	87
IBRANCE TAB 100MG	88
IBRANCE TAB 125MG	88
IBRANCE TAB 75MG	87
IBU	
see Ibuprofen Tab 400 mg	40
see Ibuprofen Tab 600 mg	40
see Ibuprofen Tab 800 mg	40
ibuprofen susp 100 mg/5ml	40
ibuprofen tab 400 mg	40
Ibuprofen Tab 400 mg	40
ibuprofen tab 600 mg	40
Ibuprofen Tab 600 mg	40
ibuprofen tab 800 mg	40
Ibuprofen Tab 800 mg	40
ibuprofen-famotidine tab 800-26.6 mg	40
ICLEVIA	
see Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg	109
icosapent ethyl cap 0.5 gm	75
icosapent ethyl cap 1 gm	75
idelalisib	
see ZYDELIG TAB 100MG	90
see ZYDELIG TAB 150MG	90
ILEVRO DRO 0.3% OP	150
imatinib mesylate tab 100 mg (base equivalent)	88
imatinib mesylate tab 400 mg (base equivalent)	88
imipramine hcl tab 10 mg	67
imipramine hcl tab 25 mg	67
imipramine hcl tab 50 mg	67

imipramine pamoate cap 100 mg	68
imipramine pamoate cap 125 mg	68
imipramine pamoate cap 150 mg	68
imipramine pamoate cap 75 mg	67
imiquimod cream 3.75%	124
imiquimod cream 5%	124
IMPAVIDO CAP 50MG	52
IMVEXXY MAIN SUP 10MCG	165
IMVEXXY MAIN SUP 4MCG	165
IMVEXXY STRT SUP 10MCG	165
IMVEXXY STRT SUP 4MCG	165
INATAL GT	
see Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab 90-1 mg	146
INBRIJA CAP 42MG	92
INCASSIA	
see Norethindrone Tab 0.35 mg	115
indapamide tab 1.25 mg	127
indapamide tab 2.5 mg	127
indinavir sulfate	
see CRIXIVAN CAP 200MG	96
see CRIXIVAN CAP 400MG	96
indomethacin cap 25 mg	40
indomethacin cap 50 mg	40
indomethacin cap er 75 mg	40
indomethacin suppos 50 mg	40
indomethacin susp 25 mg/5ml	41
INGREZZA CAP 40-80MG	154
INGREZZA CAP 40MG	154
INGREZZA CAP 60MG	154
INGREZZA CAP 80MG	154
INLYTA TAB 1MG	83
INLYTA TAB 5MG	83
INSPIREASE MIS DD SYST	140
insulin aspart	
see NOVOLOG INJ 100/ML	71
see NOVOLOG INJ FLEXPEN	71
see NOVOLOG INJ PENFILL	71
insulin aspart (with niacinamide)	
see FIASP FLEX INJ TOUCH	70
see FIASP INJ 100/ML	71
see FIASP PENFIL INJ U-100	71
insulin aspart protamine & aspart (human)	
see NOVOLOG MIX INJ 70/30	71
see NOVOLOG MIX INJ FLEXPEN	71
insulin degludec	
see TRESIBA FLEX INJ 100UNIT	71

see TRESIBA FLEX INJ 200UNIT	71
see TRESIBA INJ 100UNIT	71
insulin degludec-liraglutide	
see XULTOPHY INJ 100/3.6	69
insulin glargine	
see LANTUS INJ 100/ML	71
see LANTUS SOLOS INJ 100/ML	71
see TOUJEO MAX INJ 300/ML	71
see TOUJEO SOLO INJ 300/ML	71
insulin glargine-lixisenatide	
see SOLIQUA INJ 100/33	68
insulin nph (human) (isophane)	
see NOVOLIN N INJ 100 UNIT	71
see NOVOLIN N INJ U-100	71
insulin nph isophane & reg (human)	
see NOVOLIN INJ 70/30	71
see NOVOLIN INJ 70/30 FP	71
insulin pen needle	
see BD INSULIN PEN NEEDLES - OTC	139
insulin regular (human)	
see HUMULIN R INJ U-500	71
see NOVOLIN R INJ 100 UNIT	71
see NOVOLIN R INJ U-100	71
insulin syringe/needle u-100	
see BD INSULIN SYRINGE - OTC	139
see BD INSULIN SYRINGE - RX	139
insulin syringe/needle u-500	
see BD INSULIN SYRINGE - RX	139
insulin syringes (disposable)	
see BD INSULIN SYRINGE - OTC	139
INTRAROSA SUP 6.5MG	164
INTROVALE	
see Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg	109
ODOQUIMEZ-HC	
see Iodoquinol-Hydrocortisone In Aloe Vehicle Cream 1-1.9%	121
Iodoquinol-Hydrocortisone In Aloe Vehicle Cream 1-1.9%	121
ipratropium bromide inhal soln 0.02%	56
ipratropium bromide nasal soln 0.03% (21 mcg/spray)	147
ipratropium bromide nasal soln 0.06% (42 mcg/spray)	147
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	58
irbesartan tab 150 mg	78

irbesartan tab 300 mg	78
irbesartan tab 75 mg	78
irbesartan-hydrochlorothiazide tab 150-12.5 mg	80
irbesartan-hydrochlorothiazide tab 300-12.5 mg	80
ISENTRESS CHW 100MG	97
ISENTRESS CHW 25MG	97
ISENTRESS HD TAB 600MG	97
ISENTRESS POW 100MG	97
ISENTRESS TAB 400MG	97
ISIBLOOM	
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	107
isoniazid syrup 50 mg/5ml	83
isoniazid tab 100 mg	83
isoniazid tab 300 mg	83
isoniazid-rifampin w/ pyrazinamide	
see RIFATER TAB	82
isosorbide dinitrate tab 10 mg	54
isosorbide dinitrate tab 20 mg	54
isosorbide dinitrate tab 30 mg	54
isosorbide dinitrate tab 5 mg	53
isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg	104
isosorbide mononitrate tab er 24hr 120 mg	54
isosorbide mononitrate tab er 24hr 30 mg	54
isosorbide mononitrate tab er 24hr 60 mg	54
isotretinoin cap 10 mg	119
Isotretinoin Cap 10 mg	119
isotretinoin cap 20 mg	119
Isotretinoin Cap 20 mg	119
isotretinoin cap 30 mg	119
Isotretinoin Cap 30 mg	119
isotretinoin cap 40 mg	119
Isotretinoin Cap 40 mg	119
isradipine cap 2.5 mg	103
isradipine cap 5 mg	103
itraconazole cap 100 mg	74
itraconazole oral soln 10 mg/ml	74
ivabradine hcl tab 5 mg (base equiv)	106
ivabradine hcl tab 7.5 mg (base equiv)	106
ivacaftor	
see KALYDECO PAK 25MG	159
see KALYDECO PAK 50MG	159
see KALYDECO PAK 75MG	159
see KALYDECO TAB 150MG	159

ivermectin (rosacea)	
see SOOLANTRA CRE 1%	125
ivermectin tab 3 mg	52
ivermectin tab 6 mg	52
ixazomib citrate	
see NINLARO CAP 2.3MG	88
see NINLARO CAP 3MG	88
see NINLARO CAP 4MG	89
J	
JAIMESS	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)	109
JANTOVEN	
see Warfarin Sodium Tab 1 mg	59
see Warfarin Sodium Tab 10 mg	59
see Warfarin Sodium Tab 2 mg	59
see Warfarin Sodium Tab 2.5 mg	59
see Warfarin Sodium Tab 3 mg	59
see Warfarin Sodium Tab 4 mg	59
see Warfarin Sodium Tab 5 mg	59
see Warfarin Sodium Tab 6 mg	59
see Warfarin Sodium Tab 7.5 mg	59
JARDIANCE TAB 10MG	72
JARDIANCE TAB 25MG	72
JASMIEL	
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg	108
JAVYGTOR	
see Sapropterin Dihydrochloride Powder Packet 100 mg	128
see Sapropterin Dihydrochloride Powder Packet 500 mg	128
see Sapropterin Dihydrochloride Tab 100 mg	128
JENCYCLA	
see Norethindrone Tab 0.35 mg	115
JINTELI	
see Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg	129
JOLESSA	
see Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg	109
JOYEAX	
see Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)	110
JULEBER	

see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	108
JUNEL 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg	112
JUNEL 1/20	
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg	111
JUNEL FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg	113
JUNEL FE 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg	112
JUNEL FE 24	
see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)	113
K	
KAITLIB FE	
see Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg	111
KALLIGA	
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	108
KALYDECO PAK 25MG	159
KALYDECO PAK 50MG	159
KALYDECO PAK 75MG	159
KALYDECO TAB 150MG	159
KARIVA	
see Desogest-Eth Estrad & Eth Estrad Tab 0.15- 0.02/0.01 mg(21/5)	107
KELNOR 1/35	
see Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg	108
KELNOR 1/50	
see Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg	108
KERENDIA TAB 10MG	128
KERENDIA TAB 20MG	129
ketoconazole cream 2%	121
ketoconazole shampoo 2%	121
ketoconazole tab 200 mg	74
ketorolac tromethamine ophth soln 0.4%	150
ketorolac tromethamine ophth soln 0.5%	150
ketorolac tromethamine tab 10 mg	41
KIONEX	

see Sodium Polystyrene Sulfonate Susp 15 gm/60ml	145
KISQALI TAB 200DOSE	88
KISQALI TAB 400DOSE	88
KISQALI TAB 600DOSE	88
KLAYESTA	
see Nystatin Topical Powder 100000 unit/gm	121
KLOR-CON	
see Potassium Chloride Powder Packet 20 meq	143
KLOR-CON 10	
see Potassium Chloride Tab Er 10 meq	143
KLOR-CON 8	
see Potassium Chloride Tab Er 8 meq (600 mg)	143
KLOR-CON M10	
see Potassium Chloride Microencapsulated Crys Er Tab 10 meq	143
KLOR-CON M15	
see Potassium Chloride Microencapsulated Crys Er Tab 15 meq	143
KLOR-CON M20	
see Potassium Chloride Microencapsulated Crys Er Tab 20 meq	143
KLOR-CON/EF	
see Potassium Bicarbonate Effer Tab 25 meq	143
KLS QUIT2	
see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Lozenge 2 mg	157
KLS QUIT4	
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Polacrilex Lozenge 4 mg	158
KOSELUGO CAP 10MG	88
KOSELUGO CAP 25MG	88
KOURZEQ	
see Triamcinolone Acetonide Dental Paste 0.1%	146
KP FOLIC ACID	
see Folic Acid Tab 800 mcg	135
K-PRIME	
see Potassium Bicarbonate Effer Tab 25 meq	143
KRAZATI TAB 200MG	88
KRISTALOSE	
see Lactulose Oral Crystal Packet 10 gm	138

see Lactulose Oral Crystal Packet 20 gm	138
KURVELO	
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	110

L

labetalol hcl tab 100 mg	100
labetalol hcl tab 200 mg	100
labetalol hcl tab 300 mg	100
lacosamide oral solution 10 mg/ml	61
lacosamide tab 100 mg	61
lacosamide tab 150 mg	61
lacosamide tab 200 mg	61
lacosamide tab 50 mg	61
lactic acid (ammonium lactate) cream 12% ...	124
lactic acid (ammonium lactate) lotion 12% ...	124
lactic acid-citric acid-potassium bitartrate	
see PHEXXI GEL	165
lactulose (encephalopathy) solution 10 gm/15ml	132
Lactulose (Encephalopathy) Solution 10 gm/15ml	132
lactulose oral crystal packet 10 gm	138
Lactulose Oral Crystal Packet 10 gm	138
lactulose oral crystal packet 20 gm	138
Lactulose Oral Crystal Packet 20 gm	138
lactulose solution 10 gm/15ml	138
Lactulose Solution 10 gm/15ml	138
LAGEVRIO CAP 200MG	99
lamivudine oral soln 10 mg/ml	97
lamivudine tab 100 mg (hbv)	99
lamivudine tab 150 mg	97
lamivudine tab 300 mg	97
lamivudine-tenofovir disoproxil fumarate	
see CIMDUO TAB 300-300	96
lamivudine-zidovudine tab 150-300 mg	97
lamotrigine orally disintegrating tab 100 mg .	61
lamotrigine orally disintegrating tab 200 mg .	61
lamotrigine orally disintegrating tab 25 mg ...	61
lamotrigine orally disintegrating tab 50 mg ...	61
lamotrigine tab 100 mg	62
Lamotrigine Tab 100 mg	62
lamotrigine tab 150 mg	62
Lamotrigine Tab 150 mg	62
lamotrigine tab 200 mg	62
Lamotrigine Tab 200 mg	62
lamotrigine tab 25 mg	61
Lamotrigine Tab 25 mg	61

lamotrigine tab 25 mg (42) & 100 mg (7) starter kit	61
Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit.....	62
lamotrigine tab 35 x 25 mg starter kit	62
Lamotrigine Tab 35 X 25 mg Starter Kit	62
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit	62
Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit	62
lamotrigine tab chewable dispersible 25 mg ...	62
lamotrigine tab chewable dispersible 5 mg	62
lamotrigine tab disint 21 x 25 mg & 7 x 50 mg titration kit	62
lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit	62
lamotrigine tab disint 42 x 50mg & 14 x 100mg titration kit	62
lamotrigine tab er 24hr 100 mg	62
lamotrigine tab er 24hr 200 mg	62
lamotrigine tab er 24hr 25 mg	62
lamotrigine tab er 24hr 250 mg	62
lamotrigine tab er 24hr 300 mg	62
lamotrigine tab er 24hr 50 mg	62
lansoprazole cap delayed release 15 mg	163
lansoprazole cap delayed release 30 mg	163
LANTUS INJ 100/ML.....	71
LANTUS SOLOS INJ 100/ML	71
lapatinib ditosylate tab 250 mg (base equiv) ..	88
LARIN 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg	112
LARIN 1/20	
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg	112
LARIN 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)	113
LARIN FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg.....	113
LARIN FE 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg	112
larotrectinib sulfate	
see VITRAKVI CAP 100MG	90
see VITRAKVI CAP 25MG	90
see VITRAKVI SOL 20MG/ML	90
lasmiditan succinate	
see REYVOW TAB 100MG	141
see REYVOW TAB 50MG	141
latanoprost ophth soln 0.005%	150
LAYOLIS FE	
see Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg	111
ledipasvir-sofosbuvir	
see HARVONI PAK	98
see HARVONI PAK 45-200MG	98
see HARVONI TAB 45-200MG	98
see HARVONI TAB 90-400MG	99
LEENA	
see Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg	114
leflunomide tab 10 mg	41
leflunomide tab 20 mg	41
lemborexant	
see DAYVIGO TAB 10MG	137
see DAYVIGO TAB 5MG.....	137
lenalidomide	
see REVLIMID CAP 10MG.....	144
see REVLIMID CAP 15MG.....	144
see REVLIMID CAP 2.5MG	144
see REVLIMID CAP 20MG.....	144
see REVLIMID CAP 25MG.....	144
see REVLIMID CAP 5MG.....	144
lenalidomide cap 10 mg	144
lenalidomide cap 15 mg	144
lenalidomide cap 20 mg	144
lenalidomide cap 25 mg	144
lenalidomide cap 5 mg	144
lenalidomide caps 2.5 mg	144
lenvatinib mesylate	
see LENVIMA CAP 10 MG	84
see LENVIMA CAP 12MG	84
see LENVIMA CAP 14 MG	84
see LENVIMA CAP 18 MG	84
see LENVIMA CAP 20 MG	84
see LENVIMA CAP 24 MG	84
see LENVIMA CAP 4MG	83
see LENVIMA CAP 8 MG	84
LENVIMA CAP 10 MG	84
LENVIMA CAP 12MG	84
LENVIMA CAP 14 MG	84
LENVIMA CAP 18 MG	84

LENVIMA CAP 20 MG	84
LENVIMA CAP 24 MG	84
LENVIMA CAP 4MG	83
LENVIMA CAP 8 MG	84
LESSINA	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1	
mg-20 mcg	109
letrozole tab 2.5 mg	85
leucovorin calcium tab 10 mg	90
leucovorin calcium tab 15 mg	90
leucovorin calcium tab 25 mg	90
leucovorin calcium tab 5 mg	90
levalbuterol hcl soln nebu 0.31 mg/3ml (base	
equiv)	58
levalbuterol hcl soln nebu 0.63 mg/3ml (base	
equiv)	58
levalbuterol hcl soln nebu 1.25 mg/3ml (base	
equiv)	58
levalbuterol hcl soln nebu conc 1.25 mg/0.5ml	
(base equiv)	58
levalbuterol tartrate inhal aerosol 45 mcg/act	
(base equiv)	58
levamlodipine maleate tab 2.5 mg	103
levamlodipine maleate tab 5 mg	103
levetiracetam oral soln 100 mg/ml	62
levetiracetam tab 1000 mg	62
levetiracetam tab 250 mg	62
levetiracetam tab 500 mg	62
Levetiracetam Tab 500 mg	62
levetiracetam tab 750 mg	62
levetiracetam tab er 24hr 500 mg	62
levetiracetam tab er 24hr 750 mg	62
levobunolol hcl ophth soln 0.5%	148
levocarnitine oral soln 1 gm/10ml (10%)	128
levocarnitine tab 330 mg	128
levocetirizine dihydrochloride soln 2.5 mg/5ml	
(0.5 mg/ml)	74
levocetirizine dihydrochloride tab 5 mg	74
levodopa	
see INBRIJA CAP 42MG	92
levofloxacin ophth soln 0.5%	149
levofloxacin ophth soln 1.5%	149
levofloxacin oral soln 25 mg/ml	131
levofloxacin tab 250 mg	131
levofloxacin tab 500 mg	131
levofloxacin tab 750 mg	131
LEVONEST	

see Levonorgestrel-Eth Estra Tab 0.05-	
30/0.075-40/0.125-30mg-Mcg	110
levonor-eth est tab 0.15-0.02/0.025/0.03 mg	
&eth est 0.01 mg	108
Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg	
ð Est 0.01 mg	109
levonorgestrel & ethinyl estradiol (91-day) tab	
0.15-0.03 mg	109
Levonorgestrel & Ethinyl Estradiol (91-Day) Tab	
0.15-0.03 mg.....	109
levonorgestrel & ethinyl estradiol tab 0.1 mg-20	
mcg	109
Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20	
mcg	109, 110
levonorgestrel & ethinyl estradiol tab 0.15 mg-	
30 mcg	110
Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-	
30 mcg.....	110
Levonorgestrel Tab 1.5 mg	115
levonorgestrel-eth estra tab 0.05-30/0.075-	
40/0.125-30mg-mcg	110
Levonorgestrel-Eth Estra Tab 0.05-30/0.075-	
40/0.125-30mg-Mcg	110
levonorgestrel-ethinyl estradiol & folic acid	
see FALESSA KIT.....	108
levonorgestrel-ethinyl estradiol (continuous) tab	
90-20 mcg	110
Levonorgestrel-Ethinyl Estradiol (Continuous)	
Tab 90-20 mcg	110
levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-	
20 mcg (21)	110
Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-	
20 mcg (21)	110
levonorg-eth est tab 0.1-0.02mg(84) & eth est	
tab 0.01mg(7)	109
Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est	
Tab 0.01mg(7)	109
levonorg-eth est tab 0.15-0.03mg(84) & eth est	
tab 0.01mg(7)	109
Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est	
Tab 0.01mg(7)	109
LEVORA 0.15/30-28	
see Levonorgestrel & Ethinyl Estradiol Tab	
0.15 mg-30 mcg.....	110
LEVO-T	
see Levothyroxine Sodium Tab 100 mcg	161
see Levothyroxine Sodium Tab 112 mcg	161

see Levothyroxine Sodium Tab 125 mcg 161
 see Levothyroxine Sodium Tab 137 mcg 161
 see Levothyroxine Sodium Tab 150 mcg 161
 see Levothyroxine Sodium Tab 175 mcg 161
 see Levothyroxine Sodium Tab 200 mcg 161
 see Levothyroxine Sodium Tab 25 mcg 160
 see Levothyroxine Sodium Tab 300 mcg 161
 see Levothyroxine Sodium Tab 50 mcg 160
 see Levothyroxine Sodium Tab 75 mcg 160
 see Levothyroxine Sodium Tab 88 mcg 161

levothyroxine sodium

see SYNTHROID TAB 100MCG 162
 see SYNTHROID TAB 112MCG 162
 see SYNTHROID TAB 125MCG 162
 see SYNTHROID TAB 137MCG 162
 see SYNTHROID TAB 150MCG 162
 see SYNTHROID TAB 175MCG 162
 see SYNTHROID TAB 200MCG 162
 see SYNTHROID TAB 25MCG 162
 see SYNTHROID TAB 300MCG 162
 see SYNTHROID TAB 50MCG 162
 see SYNTHROID TAB 75MCG 162
 see SYNTHROID TAB 88MCG 162

levothyroxine sodium tab 100 mcg 161

Levothyroxine Sodium Tab 100 mcg 161

levothyroxine sodium tab 112 mcg 161

Levothyroxine Sodium Tab 112 mcg 161

levothyroxine sodium tab 125 mcg 161

Levothyroxine Sodium Tab 125 mcg 161

levothyroxine sodium tab 137 mcg 161

Levothyroxine Sodium Tab 137 mcg 161

levothyroxine sodium tab 150 mcg 161

Levothyroxine Sodium Tab 150 mcg 161

levothyroxine sodium tab 175 mcg 161

Levothyroxine Sodium Tab 175 mcg 161

levothyroxine sodium tab 200 mcg 161

Levothyroxine Sodium Tab 200 mcg 161

levothyroxine sodium tab 25 mcg 160

Levothyroxine Sodium Tab 25 mcg 160

levothyroxine sodium tab 300 mcg 161

Levothyroxine Sodium Tab 300 mcg 161

levothyroxine sodium tab 50 mcg 160

Levothyroxine Sodium Tab 50 mcg 160

levothyroxine sodium tab 75 mcg 160

Levothyroxine Sodium Tab 75 mcg 160

levothyroxine sodium tab 88 mcg 160

Levothyroxine Sodium Tab 88 mcg 161

LEVOXYL

see Levothyroxine Sodium Tab 100 mcg 161

see Levothyroxine Sodium Tab 112 mcg 161

see Levothyroxine Sodium Tab 125 mcg 161

see Levothyroxine Sodium Tab 137 mcg 161

see Levothyroxine Sodium Tab 150 mcg 161

see Levothyroxine Sodium Tab 175 mcg 161

see Levothyroxine Sodium Tab 200 mcg 161

see Levothyroxine Sodium Tab 25 mcg 160

see Levothyroxine Sodium Tab 50 mcg 160

see Levothyroxine Sodium Tab 75 mcg 160

see Levothyroxine Sodium Tab 88 mcg 161

Lidocaine Hcl Cream 3% 124

lidocaine hcl lotion 3% 124

lidocaine hcl soln 4% 124

lidocaine hcl viscous soln 2% 145

lidocaine oint 5% 124

lidocaine patch 5% 124

Lidocaine Patch 5% 124

lidocaine-hydrocortisone acetate cream 1-1%

..... 123

lidocaine-prilocaine cream 2.5-2.5% 124

LIDOCAN

see Lidocaine Patch 5% 124

LIDOPIN

see Lidocaine Hcl Cream 3% 124

lifitegrast

see XIIDRA DRO 5% 149

linaclotide

see LINZESS CAP 145MCG 132

see LINZESS CAP 290MCG 132

see LINZESS CAP 72MCG 132

linezolid for susp 100 mg/5ml 53

linezolid tab 600 mg 53

LINZESS CAP 145MCG 132

LINZESS CAP 290MCG 132

LINZESS CAP 72MCG 132

liothyronine sodium tab 25 mcg 162

liothyronine sodium tab 5 mcg 162

liothyronine sodium tab 50 mcg 162

liraglutide soln pen-injector 18 mg/3ml (6 mg/ml) 70

lisdexamphetamine dimesylate cap 10 mg 30

lisdexamphetamine dimesylate cap 20 mg 30

lisdexamphetamine dimesylate cap 30 mg 30

lisdexamphetamine dimesylate cap 40 mg 30

lisdexamphetamine dimesylate cap 50 mg 30

lisdexamfetamine dimesylate cap 60 mg	31
lisdexamfetamine dimesylate cap 70 mg	31
lisdexamfetamine dimesylate chew tab 10 mg	31
lisdexamfetamine dimesylate chew tab 20 mg	31
lisdexamfetamine dimesylate chew tab 30 mg	31
lisdexamfetamine dimesylate chew tab 40 mg	31
lisdexamfetamine dimesylate chew tab 50 mg	31
lisdexamfetamine dimesylate chew tab 60 mg	31
lisinopril & hydrochlorothiazide tab 10-12.5 mg	80
lisinopril & hydrochlorothiazide tab 20-12.5 mg	80
lisinopril & hydrochlorothiazide tab 20-25 mg	80
lisinopril tab 10 mg	77
lisinopril tab 2.5 mg	77
lisinopril tab 20 mg	77
lisinopril tab 30 mg	77
lisinopril tab 40 mg	78
lisinopril tab 5 mg	77
LITFULO CAP 50MG	124
lithium carbonate cap 150 mg	93
lithium carbonate cap 300 mg	93
lithium carbonate cap 600 mg	93
lithium carbonate tab 300 mg	93
lithium carbonate tab er 300 mg	93
lithium carbonate tab er 450 mg	93
lithium oral solution 8 meq/5ml	93
LO LOESTRIN TAB 1-10-10.....	110
LOESTRIN 1.5/30-21 see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg.....	112
LOESTRIN 1/20-21 see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg.....	112
LOESTRIN FE 1.5/30 see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg.....	113
LOESTRIN FE 1/20 see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg.....	112
lofexidine hcl tab 0.18 mg (base equivalent) .	152
LOJAIMIESS see Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7).....	109
lomustine see GLEOSTINE CAP 100MG	83
see GLEOSTINE CAP 10MG	83
see GLEOSTINE CAP 40MG	83
LONSURF TAB 15-6.14.....	85
LONSURF TAB 20-8.19.....	85
loperamide hcl cap 2 mg	72
lopinavir-ritonavir tab 100-25 mg	97
lopinavir-ritonavir tab 200-50 mg	97
loratadine tab 10 mg	74
lorazepam conc 2 mg/ml	55
lorazepam tab 0.5 mg	55
lorazepam tab 1 mg	55
lorazepam tab 2 mg	55
LORYNA see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg	108
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	81
losartan potassium & hydrochlorothiazide tab 100-25 mg	81
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	81
losartan potassium tab 100 mg	78
losartan potassium tab 25 mg	78
losartan potassium tab 50 mg	78
loteprednol etabonate ophth gel 0.5%	149
loteprednol etabonate ophth susp 0.2%	149
loteprednol etabonate ophth susp 0.5%	149
lotilaner see XDEMVY DRO 0.25%.....	149
lovastatin tab 10 mg	76
lovastatin tab 20 mg	76
lovastatin tab 40 mg	76
LOW-OGESTREL see Norgestrel & Ethinyl Estradiol Tab 0.3 mg- 30 mcg	115
loxapine succinate cap 10 mg	94
loxapine succinate cap 25 mg	94
loxapine succinate cap 5 mg	94
loxapine succinate cap 50 mg	94
LO-ZUMANDIMINE see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg	108
lubiprostone cap 24 mcg	131
lubiprostone cap 8 mcg	131
LUMAKRAS TAB 120MG	88
LUMAKRAS TAB 240MG	88
LUMAKRAS TAB 320MG	88
LUMRYZ PAK 6GM	152

LUMRYZ PAK 7.5GM	152
LUMRYZ PAK 9GM	152
LUMRYZ PAK STARTER	152
LUMRYZ PKG 4.5GM	152
<i>lurasidone hcl tab 120 mg</i>	93
<i>lurasidone hcl tab 20 mg</i>	93
<i>lurasidone hcl tab 40 mg</i>	93
<i>lurasidone hcl tab 60 mg</i>	93
<i>lurasidone hcl tab 80 mg</i>	93
LURBIPR	
see Flurbiprofen Tab 100 mg	40
LUTERA	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	110
LYLEQ	
see Norethindrone Tab 0.35 mg	116
LYLLANA	
see Estradiol Td Patch Twice Weekly 0.025 mg/24hr	130
see Estradiol Td Patch Twice Weekly 0.0375 mg/24hr	131
see Estradiol Td Patch Twice Weekly 0.05 mg/24hr	130
see Estradiol Td Patch Twice Weekly 0.075 mg/24hr	130
see Estradiol Td Patch Twice Weekly 0.1 mg/24hr	130
LYNPARZA TAB 100MG	88
LYNPARZA TAB 150MG	88
LYVISPAH GRA 10MG	146
LYVISPAH GRA 20MG	146
LYVISPAH GRA 5MG	146
LYZA	
see Norethindrone Tab 0.35 mg	116
M	
<i>macitentan</i>	
see OPSUMIT TAB 10MG	105
<i>macitentan-tadalafil</i>	
see OPSYNVI TAB 10-20MG	104
see OPSYNVI TAB 10-40MG	104
<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	122
<i>malathion lotion 0.5%</i>	125
MALE MIS CONDOM	139
<i>maraviroc tab 150 mg</i>	97
<i>maraviroc tab 300 mg</i>	97
MARLISSA	

see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	110
MAVYRET PAK 50-20MG	99
MAVYRET TAB 100-40MG	99
MAYZENT PAK STARTER	154
MAYZENT TAB 0.25MG	155
MAYZENT TAB 1MG	155
MAYZENT TAB 2MG	155
<i>mebendazole</i>	
see EMVERM CHW 100MG	52
<i>meclizine hcl tab 12.5 mg</i>	73
<i>meclizine hcl tab 25 mg</i>	73
<i>meclizine hcl tab 50 mg</i>	73
<i>meclofenamate sodium cap 100 mg</i>	41
<i>meclofenamate sodium cap 50 mg</i>	41
MEDROL TAB 2MG	116
<i>medroxyprogesterone acetate tab 10 mg</i>	152
<i>medroxyprogesterone acetate tab 2.5 mg</i>	152
<i>medroxyprogesterone acetate tab 5 mg</i>	152
<i>mefenamic acid cap 250 mg</i>	41
<i>mefloquine hcl tab 250 mg</i>	82
<i>megestrol acetate susp 40 mg/ml</i>	85
<i>megestrol acetate susp 625 mg/5ml</i>	152
<i>megestrol acetate tab 20 mg</i>	85
<i>megestrol acetate tab 40 mg</i>	85
MEKINIST SOL 0.05/ML	88
MEKINIST TAB 0.5MG	88
MEKINIST TAB 2MG	88
MEKTOVI TAB 15MG	88
<i>meloxicam susp 7.5 mg/5ml</i>	41
<i>meloxicam tab 15 mg</i>	41
<i>meloxicam tab 7.5 mg</i>	41
<i>memantine hcl cap er 24hr 14 mg</i>	153
<i>memantine hcl cap er 24hr 21 mg</i>	153
<i>memantine hcl cap er 24hr 28 mg</i>	153
<i>memantine hcl cap er 24hr 7 mg</i>	153
<i>memantine hcl oral solution 2 mg/ml</i>	153
<i>memantine hcl tab 10 mg</i>	153
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>	153
<i>memantine hcl tab 5 mg</i>	153
<i>memantine hcl-donepezil hcl</i>	
see NAMZARIC CAP 14-10MG	153
see NAMZARIC CAP 21-10MG	153
see NAMZARIC CAP 28-10MG	153
see NAMZARIC CAP 7-10MG	153

memantine hcl-donepezil hcl cap er 24hr 14-10 mg	153
memantine hcl-donepezil hcl cap er 24hr 21-10 mg	153
memantine hcl-donepezil hcl cap er 24hr 28-10 mg	153
meperidine hcl oral soln 50 mg/5ml	44
meperidine hcl tab 50 mg	44
meprobamate tab 200 mg	54
meprobamate tab 400 mg	54
mercaptopurine susp 2000 mg/100ml (20 mg/ml)	83
mercaptopurine tab 50 mg	83

MERZEE

see Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)	113
mesalamine cap dr 400 mg	132
mesalamine cap er 24hr 0.375 gm	132
mesalamine enema 4 gm	132
mesalamine suppos 1000 mg	132
mesalamine tab delayed release 1.2 gm	132
mesalamine tab delayed release 800 mg	132
mesna tab 400 mg	90
metaxalone tab 800 mg	146
metformin hcl oral soln 500 mg/5ml	69
metformin hcl tab 1000 mg	69
metformin hcl tab 500 mg	69
metformin hcl tab 850 mg	69
metformin hcl tab er 24hr 500 mg	69
metformin hcl tab er 24hr 750 mg	70
methadone hcl conc 10 mg/ml	44
Methadone Hcl Conc 10 mg/ml	44
methadone hcl soln 10 mg/5ml	44
methadone hcl soln 5 mg/5ml	44
methadone hcl tab 10 mg	44
methadone hcl tab 5 mg	44
methadone hcl tab for oral susp 40 mg	44
Methadone Hcl Tab For Oral Susp 40 mg	44

METHADONE HYDROCHLORIDE I

see Methadone Hcl Conc 10 mg/ml	44
---------------------------------------	----

METHADOSE

see Methadone Hcl Tab For Oral Susp 40 mg	44
methamphetamine hcl tab 5 mg	31
methazolamide tab 25 mg	126
methazolamide tab 50 mg	126
methenamine hippurate tab 1 gm	53
methenamine mandelate tab 0.5 gm	53

METHERGINE

see Methylergonovine Maleate Tab 0.2 mg	151
methimazole tab 10 mg	160
methimazole tab 5 mg	160

METHITEST

see Methyltestosterone Oral Tab 10 mg	51
methocarbamol tab 1000 mg	147
Methocarbamol Tab 1000 mg	147
methocarbamol tab 500 mg	146
methocarbamol tab 750 mg	146
methotrexate sodium tab 2.5 mg (base equiv)	83
methoxsalen rapid cap 10 mg	121
methscopolamine bromide tab 2.5 mg	162
methscopolamine bromide tab 5 mg	162
methsuximide cap 300 mg	64
methyl dopa tab 250 mg	79
methyl dopa tab 500 mg	79
methylergonovine maleate tab 0.2 mg	151
Methylergonovine Maleate Tab 0.2 mg	151
methylphenidate hcl cap er 10 mg (cd)	34
methylphenidate hcl cap er 20 mg (cd)	34
methylphenidate hcl cap er 24hr 10 mg (la)	34
methylphenidate hcl cap er 24hr 10 mg (xr)	35
methylphenidate hcl cap er 24hr 15 mg (xr)	35
methylphenidate hcl cap er 24hr 20 mg (la)	35
methylphenidate hcl cap er 24hr 20 mg (xr)	35
methylphenidate hcl cap er 24hr 30 mg (la)	35
methylphenidate hcl cap er 24hr 30 mg (xr)	35
methylphenidate hcl cap er 24hr 40 mg (la)	35
methylphenidate hcl cap er 24hr 40 mg (xr)	35
methylphenidate hcl cap er 24hr 50 mg (xr)	35
methylphenidate hcl cap er 24hr 60 mg (la)	35
methylphenidate hcl cap er 24hr 60 mg (xr)	35
methylphenidate hcl cap er 30 mg (cd)	36
methylphenidate hcl cap er 40 mg (cd)	36
methylphenidate hcl cap er 50 mg (cd)	36
methylphenidate hcl cap er 60 mg (cd)	36
methylphenidate hcl chew tab 10 mg	36
methylphenidate hcl chew tab 2.5 mg	36
methylphenidate hcl chew tab 5 mg	36
methylphenidate hcl soln 10 mg/5ml	36
methylphenidate hcl soln 5 mg/5ml	36
methylphenidate hcl tab 10 mg	36
methylphenidate hcl tab 20 mg	37
methylphenidate hcl tab 5 mg	36
methylphenidate hcl tab er 10 mg	37
methylphenidate hcl tab er 20 mg	37

methylphenidate hcl tab er 24hr 18 mg	37
methylphenidate hcl tab er 24hr 27 mg	37
methylphenidate hcl tab er 24hr 36 mg	37
methylphenidate hcl tab er 24hr 54 mg	37
methylphenidate hcl tab er osmotic release (osm) 18 mg	37
methylphenidate hcl tab er osmotic release (osm) 27 mg	37
methylphenidate hcl tab er osmotic release (osm) 36 mg	37
methylphenidate hcl tab er osmotic release (osm) 54 mg	37
methylphenidate hcl tab er osmotic release (osm) 72 mg	38
methylphenidate td patch 10 mg/9hr	38
methylphenidate td patch 15 mg/9hr	38
methylphenidate td patch 20 mg/9hr	38
methylphenidate td patch 30 mg/9hr	38
methylprednisolone see MEDROL TAB 2MG	116
methylprednisolone tab 16 mg	116
methylprednisolone tab 32 mg	116
methylprednisolone tab 4 mg	116
methylprednisolone tab 8 mg	116
methylprednisolone tab therapy pack 4 mg (21)	116
methyltestosterone cap 10 mg	51
Methyltestosterone Oral Tab 10 mg	51
metoclopramide hcl orally disintegrating tab 5 mg (base eq)	132
metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)	132
metoclopramide hcl tab 10 mg (base equivalent)	132
metoclopramide hcl tab 5 mg (base equivalent)	132
metolazone tab 10 mg	127
metolazone tab 2.5 mg	127
metolazone tab 5 mg	127
metoprolol & hydrochlorothiazide tab 100-25 mg	81
metoprolol & hydrochlorothiazide tab 100-50 mg	81
metoprolol & hydrochlorothiazide tab 50-25 mg	81
metoprolol succinate tab er 24hr 100 mg (tartrate equiv)	100
metoprolol succinate tab er 24hr 200 mg (tartrate equiv)	100
metoprolol succinate tab er 24hr 25 mg (tartrate equiv)	100
metoprolol succinate tab er 24hr 50 mg (tartrate equiv)	100
metoprolol tartrate tab 100 mg	100
metoprolol tartrate tab 25 mg	100
metoprolol tartrate tab 37.5 mg	100
metoprolol tartrate tab 50 mg	100
metoprolol tartrate tab 75 mg	100
metronidazole cap 375 mg	52
metronidazole cream 0.75%	125
metronidazole gel 0.75%	125
metronidazole gel 1%	125
metronidazole lotion 0.75%	125
metronidazole tab 250 mg	52
metronidazole tab 500 mg	52
metronidazole vaginal gel 0.75%	165
metyrosine cap 250 mg	78
mexiletine hcl cap 150 mg	55
mexiletine hcl cap 200 mg	55
mexiletine hcl cap 250 mg	55
MIBELAS 24 FE see Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)	113
MICONAZOLE 3 see Miconazole Nitrate Vaginal Suppos 200 mg	165
Miconazole Nitrate Vaginal Suppos 200 mg	165
MICROCHAMBER MIS	140
MICROGESTIN 1.5/30 see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg	112
MICROGESTIN 1/20 see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg	112
MICROGESTIN FE 1.5/30 see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg	113
MICROGESTIN FE 1/20 see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg	112
MICROSPACER MIS	140
midazolam (anticonvulsant) see NAYZILAM SPR 5MG	60

midazolam hcl syrup 2 mg/ml (base equivalent)	
.....	137
midodrine hcl tab 10 mg	165
midodrine hcl tab 2.5 mg	165
midodrine hcl tab 5 mg	165
midostaurin	
see RYDAPT CAP 25MG	89
mifepristone tab 200 mg	129
mifepristone tab 300 mg	70
migalastat hcl	
see GALAFOLD CAP 123MG	128
miglitol tab 100 mg	68
miglitol tab 25 mg	68
miglitol tab 50 mg	68
miglustat cap 100 mg	134
Miglustat Cap 100 mg	134
MILI	
see Norgestimate & Ethinyl Estradiol Tab 0.25	
mg-35 mcg	114
miltefosine	
see IMPAVIDO CAP 50MG	52
MIMVEY	
see Estradiol & Norethindrone Acetate Tab 1-	
0.5 mg	129
minocycline hcl cap 100 mg	160
minocycline hcl cap 50 mg	160
minocycline hcl cap 75 mg	160
minocycline hcl tab 100 mg	160
minocycline hcl tab 50 mg	160
minocycline hcl tab 75 mg	160
minoxidil tab 10 mg	82
minoxidil tab 2.5 mg	82
MINZOYA	
see Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1	
mg-20 mcg (21)	110
mirabegron tab er 24 hr 25 mg	164
mirabegron tab er 24 hr 50 mg	164
mirdametinib	
see GOMEKLI CAP 1MG	87
see GOMEKLI CAP 2MG	87
see GOMEKLI TAB 1MG	87
mirtazapine orally disintegrating tab 15 mg	64
mirtazapine orally disintegrating tab 30 mg	64
mirtazapine orally disintegrating tab 45 mg	64
mirtazapine tab 15 mg	65
mirtazapine tab 30 mg	65
mirtazapine tab 45 mg	65
mirtazapine tab 7.5 mg	65
misoprostol tab 100 mcg	163
misoprostol tab 200 mcg	163
MITIGARE CAP 0.6MG	133
modafinil tab 100 mg	38
modafinil tab 200 mg	38
moexipril hcl tab 15 mg	78
moexipril hcl tab 7.5 mg	78
molindone hcl tab 10 mg	95
molindone hcl tab 25 mg	95
molindone hcl tab 5 mg	95
molnupiravir	
see LAGEVRIO CAP 200MG	99
mometasone furoate (inhalation)	
see ASMANEX HFA AER 100 MCG	57
see ASMANEX HFA AER 200 MCG	57
see ASMANEX HFA AER 50MCG	57
mometasone furoate cream 0.1%	123
mometasone furoate nasal susp 50 mcg/act	147
mometasone furoate oint 0.1%	123
mometasone furoate solution 0.1% (lotion)	123
MONDOXYNE NL	
see Doxycycline Monohydrate Cap 100 mg	160
MONO-LINYAH	
see Norgestimate & Ethinyl Estradiol Tab 0.25	
mg-35 mcg	114
monomethyl fumarate	
see BAFIERTAM CAP 95MG	154
montelukast sodium chew tab 4 mg (base equiv)	
.....	56
montelukast sodium chew tab 5 mg (base equiv)	
.....	56
montelukast sodium oral granules packet 4 mg (base equiv)	56
montelukast sodium tab 10 mg (base equiv)	56
morphine sulfate beads cap er 24hr 120 mg	44
morphine sulfate beads cap er 24hr 30 mg	44
morphine sulfate beads cap er 24hr 45 mg	44
morphine sulfate beads cap er 24hr 60 mg	44
morphine sulfate beads cap er 24hr 75 mg	44
morphine sulfate beads cap er 24hr 90 mg	44
morphine sulfate cap er 24hr 10 mg	44
morphine sulfate cap er 24hr 100 mg	45
morphine sulfate cap er 24hr 20 mg	44
morphine sulfate cap er 24hr 30 mg	45
morphine sulfate cap er 24hr 50 mg	45
morphine sulfate cap er 24hr 60 mg	45

morphine sulfate cap er 24hr 80 mg	45
morphine sulfate oral soln 10 mg/5ml	45
morphine sulfate oral soln 100 mg/5ml (20 mg/ml)	45
morphine sulfate oral soln 20 mg/5ml	45
morphine sulfate tab 15 mg	45
morphine sulfate tab 30 mg	45
morphine sulfate tab er 100 mg	45
morphine sulfate tab er 15 mg	45
morphine sulfate tab er 200 mg	45
morphine sulfate tab er 30 mg	45
morphine sulfate tab er 60 mg	45
MOUNJARO INJ 10MG/0.5	70
MOUNJARO INJ 12.5/0.5	70
MOUNJARO INJ 15MG/0.5	70
MOUNJARO INJ 2.5/0.5	70
MOUNJARO INJ 5MG/0.5	70
MOUNJARO INJ 7.5/0.5	70
MOVANTIK TAB 12.5MG	132
MOVANTIK TAB 25MG	132
moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)	149
moxifloxacin hcl ophth soln 0.5% (base equiv)	149
moxifloxacin hcl tab 400 mg (base equiv)	131
MULTAQ TAB 400MG	56
mupirocin oint 2%	120
mycophenolate mofetil cap 250 mg	145
mycophenolate mofetil for oral susp 200 mg/ml	145
mycophenolate mofetil tab 500 mg	145
mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)	145
mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)	145
MYFEMBREE TAB	129
N	
nabumetone tab 500 mg	41
nabumetone tab 750 mg	41
nadolol tab 20 mg	100
nadolol tab 40 mg	101
nadolol tab 80 mg	101
nafarelin acetate	
see SYNAREL SOL 2MG/ML.....	128
naftifine hcl	
see NAFTIN GEL 2%	121
naftifine hcl cream 1%	121

naftifine hcl cream 2%	121
naftifine hcl gel 2%	121
NAFTIN GEL 2%	121
naldemedine tosylate	
see SYMPROIC TAB 0.2MG	132
naloxegol oxalate	
see MOVANTIK TAB 12.5MG	132
see MOVANTIK TAB 25MG	132
naloxone hcl nasal spray 4 mg/0.1ml	73
naltrexone hcl tab 50 mg	73
NAMZARIC CAP 14-10MG	153
NAMZARIC CAP 21-10MG	153
NAMZARIC CAP 28-10MG	153
NAMZARIC CAP 7-10MG	153
naproxen sodium tab 275 mg	41
naproxen sodium tab 550 mg	41
naproxen tab 250 mg	41
naproxen tab 375 mg	41
naproxen tab 500 mg	41
naproxen tab ec 375 mg	41
Naproxen Tab Ec 375 mg	41
naproxen tab ec 500 mg	41
Naproxen Tab Ec 500 mg	41
naratriptan hcl tab 1 mg (base equiv)	141
naratriptan hcl tab 2.5 mg (base equiv)	141
NATAZIA TAB	111
nateglinide tab 120 mg	71
nateglinide tab 60 mg	71
NATESTO GEL 5.5MG	51
NAYZILAM SPR 5MG	60
nebivolol hcl tab 10 mg (base equivalent)	100
nebivolol hcl tab 2.5 mg (base equivalent)	100
nebivolol hcl tab 20 mg (base equivalent)	100
nebivolol hcl tab 5 mg (base equivalent)	100
NEBUSAL	
see Sodium Chloride Soln Nebu 3%	118
NECON 0.5/35-28	
see Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg	111
nefazodone hcl tab 100 mg	66
nefazodone hcl tab 150 mg	66
nefazodone hcl tab 200 mg	66
nefazodone hcl tab 250 mg	66
nefazodone hcl tab 50 mg	66
nelfinavir mesylate	
see VIRACEPT TAB 250MG.....	98
see VIRACEPT TAB 625MG.....	98

neomycin sulfate tab 500 mg	38
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	149
Neomycin-Bacitrac Zn-Polymyx 5(3.5)mg-400unt-10000unt Op Oin	149
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	149
neomycin-polymyxin-dexamethasone ophth oint 0.1%	149
neomycin-polymyxin-dexamethasone ophth susp 0.1%	149
neomycin-polymyxin-hc ophth susp	149
neomycin-polymyxin-hc otic soln 1%	150
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	151
NEO-POLYCIN	
see Neomycin-Bacitrac Zn-Polymyx 5(3.5)mg-400unt-10000unt Op Oin	149
NEO-POLYCIN HC	
see Bacitracin-Polymyxin-Neomycin-Hc Ophth Oint 1%	149
nepafenac	
see ILEVRO DRO 0.3% OP	150
NEUAC	
see Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5%	118
NEUPRO DIS 1MG/24HR	92
NEUPRO DIS 2MG/24HR	92
NEUPRO DIS 3MG/24HR	92
NEUPRO DIS 4MG/24HR	92
NEUPRO DIS 6MG/24HR	92
NEUPRO DIS 8MG/24HR	92
nevirapine susp 50 mg/5ml	97
nevirapine tab 200 mg	97
nevirapine tab er 24hr 400 mg	97
NEXLETOL TAB 180MG	75
NEXLIZET TAB 180/10MG	75
niacin tab er 1000 mg (antihyperlipidemic)	77
niacin tab er 500 mg (antihyperlipidemic)	77
niacin tab er 750 mg (antihyperlipidemic)	77
nicardipine hcl cap 20 mg	103
nicardipine hcl cap 30 mg	103
NICORELIEF	
see Nicotine Polacrilex Gum 2 mg	156
nicotine	
see NICOTROL INH	159
see NICOTROL NS SPR 10MG/ML	159

NICOTINE MINI LOZENGE	
see Nicotine Polacrilex Lozenge 2 mg	157
see Nicotine Polacrilex Lozenge 4 mg	158
nicotine polacrilex gum 2 mg	155
Nicotine Polacrilex Gum 2 mg	155, 156
nicotine polacrilex gum 4 mg	156
Nicotine Polacrilex Gum 4 mg	156, 157
nicotine polacrilex lozenge 2 mg	157
Nicotine Polacrilex Lozenge 2 mg	157
nicotine polacrilex lozenge 4 mg	157
Nicotine Polacrilex Lozenge 4 mg	157, 158
NICOTINE STEP 1	
see Nicotine Td Patch 24hr 21 mg/24hr	159
NICOTINE STEP 3	
see Nicotine Td Patch 24hr 7 mg/24hr	158
nicotine td patch 24hr 14 mg/24hr	158
Nicotine Td Patch 24hr 14 mg/24hr	158
nicotine td patch 24hr 21 mg/24hr	158
Nicotine Td Patch 24hr 21 mg/24hr	158, 159
nicotine td patch 24hr 7 mg/24hr	158
Nicotine Td Patch 24hr 7 mg/24hr	158
NICOTINE TRANSDERMAL SYST	
see Nicotine Td Patch 24hr 14 mg/24hr	158
see Nicotine Td Patch 24hr 21 mg/24hr	159
see Nicotine Td Patch 24hr 7 mg/24hr	158
NICOTROL INH	159
NICOTROL NS SPR 10MG/ML	159
nifedipine cap 10 mg	103
nifedipine cap 20 mg	103
nifedipine tab er 24hr 30 mg	103
nifedipine tab er 24hr 60 mg	103
nifedipine tab er 24hr 90 mg	103
nifedipine tab er 24hr osmotic release 30 mg	103
nifedipine tab er 24hr osmotic release 60 mg	103
nifedipine tab er 24hr osmotic release 90 mg	103
NIKKI	
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg	108
nilutamide tab 150 mg	85
nimodipine cap 30 mg	103
nimodipine oral soln 60 mg/20ml (3 mg/ml)	103
NINLARO CAP 2.3MG	88
NINLARO CAP 3MG	88
NINLARO CAP 4MG	89
nintedanib esylate	
see OFEV CAP 100MG	159
see OFEV CAP 150MG	159

niraparib tosylate	
see ZEJULA TAB 100MG	90
see ZEJULA TAB 200MG	90
see ZEJULA TAB 300MG	90
nirmatrelvir-ritonavir	
see PAXLOVID PAK	98
see PAXLOVID TAB 150-100.....	98
see PAXLOVID TAB 300-100.....	98
nisoldipine tab er 24hr 17 mg	103
nisoldipine tab er 24hr 20 mg	103
nisoldipine tab er 24hr 25.5 mg	103
nisoldipine tab er 24hr 30 mg	103
nisoldipine tab er 24hr 34 mg	103
nisoldipine tab er 24hr 40 mg	103
nisoldipine tab er 24hr 8.5 mg	103
nitazoxanide tab 500 mg	53
nitisinone	
see ORFADIN SUS 4MG/ML	128
nitisinone cap 10 mg	128
nitisinone cap 2 mg	128
nitisinone cap 20 mg	128
nitisinone cap 5 mg	128
nitrofurantoin macrocrystalline cap 100 mg ...	53
nitrofurantoin macrocrystalline cap 25 mg	53
nitrofurantoin macrocrystalline cap 50 mg	53
nitrofurantoin monohydrate macrocrystalline	
cap 100 mg	53
nitrofurantoin susp 25 mg/5ml	53
nitroglycerin oint 0.4%	52
nitroglycerin sl tab 0.3 mg	54
nitroglycerin sl tab 0.4 mg	54
nitroglycerin sl tab 0.6 mg	54
nitroglycerin td patch 24hr 0.1 mg/hr	54
nitroglycerin td patch 24hr 0.2 mg/hr	54
nitroglycerin td patch 24hr 0.4 mg/hr	54
nitroglycerin td patch 24hr 0.6 mg/hr	54
nitroglycerin tl soln 0.4 mg/spray (400	
mcg/spray)	54
nizatidine cap 150 mg	163
nizatidine cap 300 mg	163
nonoxynol-9	
see ENCARE SUP 100MG.....	164
see GYNOL II GEL 3%	164
see SHUR-SEAL GEL 2%	164
see TODAY SPONGE MIS	164
see VCF VAGINAL AER CONTRACP	164
see VCF VAGINAL GEL CONTRACE	165
see VCF VAGINAL MIS CONTRACP	165
NORA-BE	
see Norethindrone Tab 0.35 mg	116
norelgestromin-ethinyl estradiol td ptwk 150-35	
mcg/24hr	115
Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35	
mcg/24hr	115
Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35	
mcg	111
Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35	
mcg	111
Norethindrone & Ethinyl Estradiol Tab 1 mg-35	
mcg	111
Norethindrone & Ethinyl Estradiol-Fe Chew Tab	
0.4 mg-35 mcg	111
Norethindrone & Ethinyl Estradiol-Fe Chew Tab	
0.8 mg-25 mcg	111
norethindrone ace & ethinyl estradiol tab 1 mg-	
20 mcg	111
Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-	
20 mcg	111, 112
norethindrone ace & ethinyl estradiol tab 1.5	
mg-30 mcg	112
Norethindrone Ace & Ethinyl Estradiol Tab 1.5	
mg-30 mcg	112
norethindrone ace & ethinyl estradiol-fe tab 1	
mg-20 mcg	112
Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1	
mg-20 mcg	112
norethindrone ace & ethinyl estradiol-fe tab 1.5	
mg-30 mcg	112
Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5	
mg-30 mcg	112, 113
norethindrone ace-eth estradiol-fe chew tab 1	
mg-20 mcg (24)	113
Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1	
mg-20 mcg (24)	113
norethindrone ace-ethinyl estradiol-fe cap 1 mg-	
20 mcg (24)	113
Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1	
mg-20 mcg (24)	113
Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1	
mg-20 mcg (24)	113
norethindrone acetate tab 5 mg	152
Norethindrone Acetate Tab 5 mg	152
norethindrone acetate-ethinyl estradiol tab 0.5	
mg-2.5 mcg	129

Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg	129	nortriptyline hcl cap 75 mg	68
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	129	nortriptyline hcl soln 10 mg/5ml	68
Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg	129	NOVOLIN INJ 70/30	71
norethindrone acetate-ethinyl estradiol-fe fum (biphasic)		NOVOLIN INJ 70/30 FP	71
see LO LOESTRIN TAB 1-10-10	110	NOVOLIN N INJ 100 UNIT	71
Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg	111	NOVOLIN N INJ U-100	71
norethindrone tab 0.35 mg	115	NOVOLIN R INJ 100 UNIT	71
Norethindrone Tab 0.35 mg	115, 116	NOVOLIN R INJ U-100	71
Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg	113, 114	NOVOLOG INJ 100/ML	71
Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg	114	NOVOLOG INJ FLEXPEN	71
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	114	NOVOLOG INJ PENFILL	71
Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg	114	NOVOLOG MIX INJ 70/30	71
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	114	NOVOLOG MIX INJ FLEXPEN	71
Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	114	NUBEQA TAB 300MG	85
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	114	NULEV	
Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	114, 115	see Hyoscyamine Sulfate Tab Disint 0.125 mg	162
Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg	115	NURTEC TAB 75MG ODT	141
Norgestrel & Ethinyl Estradiol Tab 0.5 mg-50 mcg	115	NYAMYC	
NORLYROC		see Nystatin Topical Powder 100000 unit/gm	121
see Norethindrone Tab 0.35 mg	116	NYLIA 1/35	
NORTREL 0.5/35 (28)		see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg	111
see Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg	111	NYLIA 7/7/7	
NORTREL 1/35		see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg	114
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg	111	nystatin cream 100000 unit/gm	121
NORTREL 7/7/7		nystatin oint 100000 unit/gm	121
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg	114	nystatin susp 100000 unit/ml	145
nortriptyline hcl cap 10 mg	68	nystatin tab 500000 unit	73
nortriptyline hcl cap 25 mg	68	nystatin topical powder 100000 unit/gm	121
nortriptyline hcl cap 50 mg	68	Nystatin Topical Powder 100000 unit/gm	121
		nystatin-triamcinolone cream 100000-0.1 unit/gm-%	121
		nystatin-triamcinolone oint 100000-0.1 unit/gm-%	121
		NYSTOP	
		see Nystatin Topical Powder 100000 unit/gm	121
		O	
		OCELLA	
		see Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg	108
		ODEFSEY TAB	97
		ODOMZO CAP 200MG	84
		OFEV CAP 100MG	159

OFEV CAP 150MG	159
<i>ofloxacin ophth soln 0.3%</i>	149
<i>ofloxacin otic soln 0.3%</i>	150
<i>ofloxacin tab 300 mg</i>	131
<i>ofloxacin tab 400 mg</i>	131
OGESTREL	
see Norgestrel & Ethinyl Estradiol Tab 0.5 mg- 50 mcg	115
<i>olanzapine orally disintegrating tab 10 mg</i>	94
<i>olanzapine orally disintegrating tab 15 mg</i>	94
<i>olanzapine orally disintegrating tab 20 mg</i>	94
<i>olanzapine orally disintegrating tab 5 mg</i>	94
<i>olanzapine tab 10 mg</i>	94
<i>olanzapine tab 15 mg</i>	95
<i>olanzapine tab 2.5 mg</i>	94
<i>olanzapine tab 20 mg</i>	95
<i>olanzapine tab 5 mg</i>	94
<i>olanzapine tab 7.5 mg</i>	94
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	154
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i>	154
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i>	153
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i>	153
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	154
<i>olaparib</i>	
see LYNPARZA TAB 100MG	88
see LYNPARZA TAB 150MG	88
<i>olmesartan medoxomil tab 20 mg</i>	78
<i>olmesartan medoxomil tab 40 mg</i>	78
<i>olmesartan medoxomil tab 5 mg</i>	78
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	81
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	81
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	81
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	81
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	81
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	81
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	81
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	81
<i>olodaterol hcl</i>	
see STRIVERDI AER 2.5MCG	59

<i>olopatadine hcl nasal soln 0.6%</i>	147
<i>olopatadine hcl ophth soln 0.1% (base equivalent)</i>	150
<i>olopatadine hcl ophth soln 0.2% (base equivalent)</i>	150
<i>omega-3-acid ethyl esters cap 1 gm</i>	75
<i>omeprazole cap delayed release 10 mg</i>	163
<i>omeprazole cap delayed release 20 mg</i>	163
<i>omeprazole cap delayed release 40 mg</i>	163
<i>ondansetron hcl oral soln 4 mg/5ml</i>	73
<i>ondansetron hcl tab 24 mg</i>	73
<i>ondansetron hcl tab 4 mg</i>	73
<i>ondansetron hcl tab 8 mg</i>	73
<i>ondansetron orally disintegrating tab 4 mg</i>	73
<i>ondansetron orally disintegrating tab 8 mg</i>	73
ONZETRA XSAI MIS 11MG	141
OPSUMIT TAB 10MG	105
OPSYNVI TAB 10-20MG	104
OPSYNVI TAB 10-40MG	104
OPTICHAMBER MIS DIA LG	141
OPTICHAMBER MIS DIA MD	141
OPTICHAMBER MIS DIA SM	141
OPTICHAMBER MIS DIAMOND	141
OPTION 2	
see Levonorgestrel Tab 1.5 mg	115
OPZELURA CRE 1.5%	124
ORACEA CAP 40MG	125
ORALAIR SUB 300 IR	38
ORALONE DENTAL PASTE	
see Triamcinolone Acetonide Dental Paste 0.1%	146
ORENITRAM TAB 0.125MG	105
ORENITRAM TAB 0.25MG	105
ORENITRAM TAB 1MG	105
ORENITRAM TAB 2.5MG	105
ORENITRAM TAB 5MG	105
ORENITRAM TAB MONTH 1	105
ORENITRAM TAB MONTH 2	105
ORENITRAM TAB MONTH 3	105
ORFADIN SUS 4MG/ML	128
ORIAHNN CAP	129
ORLISSA TAB 150MG	127
ORLISSA TAB 200MG	127
ORLADEYO CAP 110MG	134
ORLADEYO CAP 150MG	134
<i>orlistat cap 120 mg</i>	32
ORMALVI	

see Dichlorphenamide Tab 50 mg.....	126
orphenadrine citrate tab er 12hr 100 mg	147
OSCIMIN	
see Hyoscyamine Sulfate SI Tab 0.125 mg ..	162
see Hyoscyamine Sulfate Tab 0.125 mg	162
oseltamivir phosphate cap 30 mg (base equiv) 99	
oseltamivir phosphate cap 45 mg (base equiv) 99	
oseltamivir phosphate cap 75 mg (base equiv) 99	
oseltamivir phosphate for susp 6 mg/ml (base equiv)	99
osimertinib mesylate	
see TAGRISSO TAB 40MG	84
see TAGRISSO TAB 80MG	84
OTEZLA TAB 10/20	41
OTEZLA TAB 10/20/30	41
OTEZLA TAB 20MG	41
OTEZLA TAB 30MG	41
oxaprozin cap 300 mg	41
oxaprozin tab 600 mg	41
oxazepam cap 10 mg	55
oxazepam cap 15 mg	55
oxazepam cap 30 mg	55
oxcarbazepine	
see OXTELLAR XR TAB 150MG	63
see OXTELLAR XR TAB 300MG	63
see OXTELLAR XR TAB 600MG	63
oxcarbazepine susp 300 mg/5ml (60 mg/ml) ..	62
oxcarbazepine tab 150 mg	62
oxcarbazepine tab 300 mg	62
oxcarbazepine tab 600 mg	62
oxcarbazepine tab er 24hr 150 mg	62
oxcarbazepine tab er 24hr 300 mg	62
oxcarbazepine tab er 24hr 600 mg	63
oxiconazole nitrate cream 1%	121
OXTELLAR XR TAB 150MG	63
OXTELLAR XR TAB 300MG	63
OXTELLAR XR TAB 600MG	63
oxybutynin chloride solution 5 mg/5ml	164
oxybutynin chloride tab 5 mg	164
oxybutynin chloride tab er 24hr 10 mg	164
oxybutynin chloride tab er 24hr 15 mg	164
oxybutynin chloride tab er 24hr 5 mg	164
oxycodone hcl cap 5 mg	45
oxycodone hcl conc 100 mg/5ml (20 mg/ml) ..	45
oxycodone hcl soln 5 mg/5ml	46
oxycodone hcl tab 10 mg	46
oxycodone hcl tab 15 mg	46

oxycodone hcl tab 20 mg	46
oxycodone hcl tab 30 mg	46
oxycodone hcl tab 5 mg	46
oxycodone w/ acetaminophen tab 10-325 mg 49	
Oxycodone W/ Acetaminophen Tab 10-325 mg50	
oxycodone w/ acetaminophen tab 2.5-325 mg	49
Oxycodone W/ Acetaminophen Tab 2.5-325 mg	49
oxycodone w/ acetaminophen tab 5-325 mg ..	49
Oxycodone W/ Acetaminophen Tab 5-325 mg.	49
oxycodone w/ acetaminophen tab 7.5-325 mg	49
Oxycodone W/ Acetaminophen Tab 7.5-325 mg	49
oxymorphone hcl tab 10 mg	46
oxymorphone hcl tab 5 mg	46
ozanimod hcl	
see ZEPOSIA 7DAY CAP STR PACK	155
see ZEPOSIA CAP 0.92MG	155
see ZEPOSIA CAP STR KIT	155
OZEMPIC INJ 2MG/3ML	70
OZEMPIC INJ 4MG/3ML	70
OZEMPIC INJ 8MG/3ML	70
P	
PACERONE	
see Amiodarone Hcl Tab 100 mg	16, 56
see Amiodarone Hcl Tab 200 mg	56
see Amiodarone Hcl Tab 400 mg	56
palbociclib	
see IBRANCE CAP 100MG	87
see IBRANCE CAP 125MG	87
see IBRANCE CAP 75MG	87
see IBRANCE TAB 100MG	88
see IBRANCE TAB 125MG	88
see IBRANCE TAB 75MG	87
paliperidone tab er 24hr 1.5 mg	93
paliperidone tab er 24hr 3 mg	93
paliperidone tab er 24hr 6 mg	93
paliperidone tab er 24hr 9 mg	93
pancrelipase (lipase-protease-amylase)	
see CREON CAP 12000UNT	125
see CREON CAP 24000UNT	125
see CREON CAP 3000UNIT	125
see CREON CAP 36000UNT	125
see CREON CAP 6000UNIT	125
see VIOKACE TAB 10440	125

see VIOKACE TAB 20880	125
see ZENPEP CAP 10000UNT	125
see ZENPEP CAP 15000UNT	125
see ZENPEP CAP 20000UNT	126
see ZENPEP CAP 25000UNT	126
see ZENPEP CAP 3000UNIT	125
see ZENPEP CAP 40000UNT	126
see ZENPEP CAP 5000UNIT	125
see ZENPEP CAP 60000UNT	126
pantoprazole sodium ec tab 20 mg (base equiv)	163
pantoprazole sodium ec tab 40 mg (base equiv)	163
paricalcitol cap 1 mcg	128
paricalcitol cap 2 mcg	128
paricalcitol cap 4 mcg	128
paroxetine hcl oral susp 10 mg/5ml (base equiv)	65
paroxetine hcl tab 10 mg	66
paroxetine hcl tab 20 mg	66
paroxetine hcl tab 30 mg	66
paroxetine hcl tab 40 mg	66
paroxetine hcl tab er 24hr 12.5 mg	66
paroxetine hcl tab er 24hr 25 mg	66
paroxetine hcl tab er 24hr 37.5 mg	66
PASER GRA 4GM	83
patiomer sorbitex calcium see VELTASSA POW 16.8GM	145
see VELTASSA POW 1GM	145
see VELTASSA POW 25.2GM	145
see VELTASSA POW 8.4GM	145
PAXLOVID PAK	98
PAXLOVID TAB 150-100	98
PAXLOVID TAB 300-100	98
pazopanib hcl tab 200 mg (base equiv)	89
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	137
Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 236 gm	138
Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm	138
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	138
Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm	138
penciclovir cream 1%	122
penicillamine cap 250 mg	143
penicillamine tab 250 mg	144

penicillin v potassium for soln 125 mg/5ml ...	151
penicillin v potassium for soln 250 mg/5ml ...	151
penicillin v potassium tab 250 mg	151
penicillin v potassium tab 500 mg	151
pentamidine isethionate for nebulization soln 300 mg	52
pentazocine w/ naloxone hcl tab 50-0.5 mg ...	51
pentoxifylline tab er 400 mg	134
perampanel see FYCOMPA SUS 0.5MG/ML	60
see FYCOMPA TAB 10MG	60
see FYCOMPA TAB 12MG	60
see FYCOMPA TAB 2MG	60
see FYCOMPA TAB 4MG	60
see FYCOMPA TAB 6MG	60
see FYCOMPA TAB 8MG	60
perindopril erbumine tab 2 mg	78
perindopril erbumine tab 4 mg	78
perindopril erbumine tab 8 mg	78
permethrin cream 5%	125
perphenazine tab 16 mg	95
perphenazine tab 2 mg	95
perphenazine tab 4 mg	95
perphenazine tab 8 mg	95
perphenazine-amitriptyline tab 2-10 mg	154
perphenazine-amitriptyline tab 2-25 mg	154
perphenazine-amitriptyline tab 4-10 mg	154
perphenazine-amitriptyline tab 4-25 mg	154
perphenazine-amitriptyline tab 4-50 mg	154
PHEBURANE MIS 483/GM	128
phendimetrazine tartrate tab 35 mg	31
phenelzine sulfate tab 15 mg	65
phenobarbital elixir 20 mg/5ml	136
phenobarbital tab 100 mg	136
phenobarbital tab 15 mg	136
phenobarbital tab 16.2 mg	136
phenobarbital tab 30 mg	136
phenobarbital tab 32.4 mg	136
phenobarbital tab 60 mg	136
phenobarbital tab 64.8 mg	136
phenobarbital tab 97.2 mg	136
phenoxybenzamine hcl cap 10 mg	78
phentermine hcl cap 15 mg	31
phentermine hcl cap 30 mg	31
phentermine hcl cap 37.5 mg	31
phentermine hcl tab 37.5 mg	32
phentermine hcl-topiramate	

see QSYMIA CAP 11.25-69	32	piroxicam cap 10 mg	41
see QSYMIA CAP 15-92MG	32	piroxicam cap 20 mg	41
see QSYMIA CAP 3.75-23	32	pitavastatin calcium tab 1 mg	76
see QSYMIA CAP 7.5-46MG	32	pitavastatin calcium tab 2 mg	76
phenylephrine hcl ophth soln 10%	148	pitavastatin calcium tab 4 mg	76
Phenylephrine Hcl Ophth Soln 10%	148	pitolisant hcl	
phenylephrine hcl ophth soln 2.5%	148	see WAKIX TAB 17.8MG	33
Phenylephrine Hcl Ophth Soln 2.5%	148	see WAKIX TAB 4.45MG	33
phenytoin chew tab 50 mg	64	PNV-DHA	
phenytoin sodium extended cap 100 mg	64	see Prenat W/o A W/fefum-Methfol-Fa-Dha	
phenytoin sodium extended cap 200 mg	64	Cap 27-0.6-0.4-300 mg	146
phenytoin sodium extended cap 300 mg	64	PNV-SELECT	
phenytoin susp 125 mg/5ml	64	see Prenatal Vit W/ Fe Fum-Methylfolate-Fa	
PHEXXI GEL	165	Tab 27-0.6-0.4 mg	146
PHILITH		POCKET CHAMB MIS	141
see Norethindrone & Ethinyl Estradiol Tab 0.4		POCKET SPACE MIS	141
mg-35 mcg	111	podofilox gel 0.5%	124
PHOSPHO-TRIN K500		podofilox soln 0.5%	124
see Potassium Phosphate Monobasic Tab 500		POLYCIN	
mg	143	see Bacitracin-Polymyxin B Ophth Oint	148
phytonadione tab 5 mg	166	polymyxin b-trimethoprim ophth soln 10000	
pilocarpine hcl ophth soln 1%	148	unit/ml-0.1%	149
pilocarpine hcl ophth soln 2%	148	pomalidomide	
pilocarpine hcl ophth soln 4%	148	see POMALYST CAP 1MG	85
pilocarpine hcl tab 5 mg	146	see POMALYST CAP 2MG	85
pilocarpine hcl tab 7.5 mg	146	see POMALYST CAP 3MG	85
pimecrolimus cream 1%	124	see POMALYST CAP 4MG	85
pimozide tab 1 mg	155	POMALYST CAP 1MG	85
pimozide tab 2 mg	155	POMALYST CAP 2MG	85
PIMTREA		POMALYST CAP 3MG	85
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-		POMALYST CAP 4MG	85
0.02/0.01 mg(21/5)	107	PORTIA-28	
pindolol tab 10 mg	101	see Levonorgestrel & Ethinyl Estradiol Tab	
pindolol tab 5 mg	101	0.15 mg-30 mcg	110
pioglitazone hcl tab 15 mg (base equiv)	71	posaconazole susp 40 mg/ml	74
pioglitazone hcl tab 30 mg (base equiv)	71	Potassium Bicarbonate Effer Tab 25 meq	143
pioglitazone hcl tab 45 mg (base equiv)	71	potassium chloride cap er 10 meq	143
pioglitazone hcl-glimepiride tab 30-2 mg	68	potassium chloride cap er 8 meq	143
pioglitazone hcl-glimepiride tab 30-4 mg	68	potassium chloride microencapsulated crys er	
pioglitazone hcl-metformin hcl tab 15-500 mg	68	tab 10 meq	143
pioglitazone hcl-metformin hcl tab 15-850 mg	68	Potassium Chloride Microencapsulated Crys Er	
PIQRAY 200MG TAB DOSE	89	Tab 10 meq	143
PIQRAY 250MG TAB DOSE	89	potassium chloride microencapsulated crys er	
PIQRAY 300MG TAB DOSE	89	tab 15 meq	143
pirfenidone cap 267 mg	159	Potassium Chloride Microencapsulated Crys Er	
pirfenidone tab 267 mg	159	Tab 15 meq	143
pirfenidone tab 801 mg	159		

potassium chloride microencapsulated crys er	
tab 20 meq	143
Potassium Chloride Microencapsulated Crys Er	
Tab 20 meq	143
potassium chloride oral soln 10% (20 meq/15ml)	
.....	143
potassium chloride oral soln 20% (40 meq/15ml)	
.....	143
potassium chloride powder packet 20 meq ...	143
Potassium Chloride Powder Packet 20 meq....	143
potassium chloride tab er 10 meq	143
Potassium Chloride Tab Er 10 meq	143
potassium chloride tab er 15 meq	143
potassium chloride tab er 20 meq (1500 mg)	143
potassium chloride tab er 8 meq (600 mg)	143
Potassium Chloride Tab Er 8 meq (600 mg)	143
Potassium Citrate & Citric Acid Powder Pack	
3300-1002 mg.....	133
potassium citrate tab er 10 meq (1080 mg) ...	133
potassium citrate tab er 15 meq (1620 mg) ...	133
potassium citrate tab er 5 meq (540 mg)	133
potassium iodide oral soln 1 gm/ml	117
Potassium Phosphate Monobasic Tab 500 mg	143
pralsetinib	
see GAVRETO CAP 100MG	87
pramipexole dihydrochloride tab 0.125 mg	92
pramipexole dihydrochloride tab 0.25 mg	92
pramipexole dihydrochloride tab 0.5 mg	92
pramipexole dihydrochloride tab 0.75 mg	92
pramipexole dihydrochloride tab 1 mg	92
pramipexole dihydrochloride tab 1.5 mg	92
pramipexole dihydrochloride tab er 24hr 0.375	
mg	92
pramipexole dihydrochloride tab er 24hr 0.75	
mg	92
pramipexole dihydrochloride tab er 24hr 1.5 mg	
.....	92
pramipexole dihydrochloride tab er 24hr 2.25	
mg	92
pramipexole dihydrochloride tab er 24hr 3 mg	92
pramipexole dihydrochloride tab er 24hr 3.75	
mg	92
pramipexole dihydrochloride tab er 24hr 4.5 mg	
.....	92
pramlintide acetate	
see SYMLINPEN 60 INJ 1000MCG.....	68
see SYMLINPEN 120 INJ 1000MCG	68

prasterone vaginal	
see INTRAROSA SUP 6.5MG	164
prasugrel hcl tab 10 mg (base equiv)	134
prasugrel hcl tab 5 mg (base equiv)	134
pravastatin sodium tab 10 mg	76
pravastatin sodium tab 20 mg	76
pravastatin sodium tab 40 mg	76
pravastatin sodium tab 80 mg	76
praziquantel tab 600 mg	52
prazosin hcl cap 1 mg	79
prazosin hcl cap 2 mg	79
prazosin hcl cap 5 mg	79
PRED SOD PHO SOL 1% OP	150
prednisolone acetate ophth susp 1%	150
prednisolone sod phos orally disintegr tab 10	
mg (base eq)	116
prednisolone sod phos orally disintegr tab 15	
mg (base eq)	116
prednisolone sod phos orally disintegr tab 30	
mg (base eq)	117
prednisolone sod phosphate oral soln 15	
mg/5ml (base equiv)	117
prednisolone sod phosphate oral soln 5 mg/5ml	
(base equiv)	117
prednisolone sodium phosphate oral soln 25	
mg/5ml (base eq)	117
prednisolone soln 15 mg/5ml	117
prednisolone tab 5 mg	117
prednisone oral soln 5 mg/5ml	117
prednisone tab 1 mg	117
prednisone tab 10 mg	117
prednisone tab 2.5 mg	117
prednisone tab 20 mg	117
prednisone tab 5 mg	117
prednisone tab 50 mg	117
prednisone tab therapy pack 10 mg (21)	117
prednisone tab therapy pack 10 mg (48)	117
prednisone tab therapy pack 5 mg (21)	117
prednisone tab therapy pack 5 mg (48)	117
pregabalin cap 100 mg	63
pregabalin cap 150 mg	63
pregabalin cap 200 mg	63
pregabalin cap 225 mg	63
pregabalin cap 25 mg	63
pregabalin cap 300 mg	63
pregabalin cap 50 mg	63
pregabalin cap 75 mg	63

pregabalin soln 20 mg/ml	63
pregabalin tab er 24hr 165 mg	155
pregabalin tab er 24hr 330 mg	155
pregabalin tab er 24hr 82.5 mg	155
PREMPHASE TAB	130
PREMPRO TAB	130
PREMPRO TAB 0.3-1.5.....	130
PREMPRO TAB 0.45-1.5	130
PREMPRO TAB 0.625-5.....	130
Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27- 0.6-0.4-300 mg	146
PRENATAL 19 see Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg	146
Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab 90-1 mg.....	146
Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg.....	146
Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg.	146
Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27- 0.6-0.4 mg	146
Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg	146
PREPOPIK PAK.....	138
PREVALITE see Cholestyramine Light Powder 4 gm/dose	75
see Cholestyramine Light Powder Packets 4 gm.....	75
PREZCOBIX TAB 800-150.....	98
primaquine phosphate tab 26.3 mg (15 mg base)	82
primidone tab 250 mg	63
primidone tab 50 mg	63
probenecid tab 500 mg	134
PROCENTRA see Dextroamphetamine Sulfate Oral Solution 5 mg/5ml	29
PROCHAMBER MIS VHC	141
prochlorperazine maleate tab 10 mg (base equivalent)	95
prochlorperazine maleate tab 5 mg (base equivalent)	95
prochlorperazine suppos 25 mg	95
Prochlorperazine Suppos 25 mg.....	95
PROCTOCORT see Hydrocortisone Perianal Cream 1%	52

PROCTOFOAM AER HC 1%.....	52
PROCTO-MED HC see Hydrocortisone Perianal Cream 2.5%	52
PROCTOSOL HC see Hydrocortisone Perianal Cream 2.5%	52
PROCTOZONE-HC see Hydrocortisone Perianal Cream 2.5%	52
progesterone (vaginal) see CRINONE GEL 4% VAG	165
see CRINONE GEL 8% VAG	165
see ENDOMETRIN SUP 100MG	165
progesterone cap 100 mg	152
progesterone cap 200 mg	152
promethazine & phenylephrine syrup 6.25-5 mg/5ml	117
promethazine hcl oral soln 6.25 mg/5ml	74
promethazine hcl suppos 12.5 mg	74
Promethazine Hcl Suppos 12.5 mg	74
promethazine hcl suppos 25 mg	74
Promethazine Hcl Suppos 25 mg.....	74
Promethazine Hcl Suppos 50 mg.....	74
promethazine hcl tab 12.5 mg	74
promethazine hcl tab 25 mg	74
promethazine hcl tab 50 mg	75
promethazine w/ codeine syrup 6.25-10 mg/5ml	117
promethazine-dm syrup 6.25-15 mg/5ml	117
PROMETHEGAN see Promethazine Hcl Suppos 12.5 mg.....	74
see Promethazine Hcl Suppos 25 mg.....	74
see Promethazine Hcl Suppos 50 mg.....	74
propafenone hcl cap er 12hr 225 mg	55
propafenone hcl cap er 12hr 325 mg	55
propafenone hcl cap er 12hr 425 mg	55
propafenone hcl tab 150 mg	55
propafenone hcl tab 225 mg	56
propafenone hcl tab 300 mg	56
propranolol hcl cap er 24hr 120 mg	101
propranolol hcl cap er 24hr 160 mg	101
propranolol hcl cap er 24hr 60 mg	101
propranolol hcl cap er 24hr 80 mg	101
propranolol hcl oral soln 20 mg/5ml	101
propranolol hcl oral soln 40 mg/5ml	101
propranolol hcl tab 10 mg	101
propranolol hcl tab 20 mg	101
propranolol hcl tab 40 mg	101
propranolol hcl tab 60 mg	101

propranolol hcl tab 80 mg	101
propylthiouracil tab 50 mg	160
protriptyline hcl tab 10 mg	68
protriptyline hcl tab 5 mg	68
prucalopride succinate tab 1 mg (base equivalent)	131
prucalopride succinate tab 2 mg (base equivalent)	131
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	117
PULMICORT INH 180MCG	57
PULMICORT INH 90MCG	57
PULMOSAL see Sodium Chloride Soln Nebu 7%	118
pyrazinamide tab 500 mg	83
pyridostigmine bromide oral soln 60 mg/5ml .	82
pyridostigmine bromide tab 60 mg	82
pyridostigmine bromide tab er 180 mg	82
pyrimethamine tab 25 mg	82
Q	
QC FOLIC ACID see Folic Acid Tab 800 mcg	136
QELBREE CAP 100MG ER.....	33
QELBREE CAP 150MG ER.....	33
QELBREE CAP 200MG ER.....	33
QSYMIA CAP 11.25-69.....	32
QSYMIA CAP 15-92MG	32
QSYMIA CAP 3.75-23.....	32
QSYMIA CAP 7.5-46MG	32
quetiapine fumarate tab 100 mg	95
quetiapine fumarate tab 150 mg	95
quetiapine fumarate tab 200 mg	95
quetiapine fumarate tab 25 mg	95
quetiapine fumarate tab 300 mg	95
quetiapine fumarate tab 400 mg	95
quetiapine fumarate tab 50 mg	95
quetiapine fumarate tab er 24hr 150 mg	95
quetiapine fumarate tab er 24hr 200 mg	95
quetiapine fumarate tab er 24hr 300 mg	95
quetiapine fumarate tab er 24hr 400 mg	95
quetiapine fumarate tab er 24hr 50 mg	95
quinapril hcl tab 10 mg	78
quinapril hcl tab 20 mg	78
quinapril hcl tab 40 mg	78
quinapril hcl tab 5 mg	78
quinapril-hydrochlorothiazide tab 10-12.5 mg	81
quinidine gluconate tab er 324 mg	55

quinine sulfate cap 324 mg	82
QULIPTA TAB 10MG	141
QULIPTA TAB 30MG	141
QULIPTA TAB 60MG	141
QUVIVIQ TAB 25MG	137
QUVIVIQ TAB 50MG	137
R	
RA FOLIC ACID see Folic Acid Tab 400 mcg	135
see Folic Acid Tab 800 mcg	136
RA MINI NICOTINE see Nicotine Polacrilex Lozenge 2 mg	157
see Nicotine Polacrilex Lozenge 4 mg	158
RA NICOTINE see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Td Patch 24hr 14 mg/24hr	158
see Nicotine Td Patch 24hr 21 mg/24hr	159
RA NICOTINE GUM see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Gum 4 mg	156
RA NICOTINE POLACRILEX see Nicotine Polacrilex Lozenge 2 mg	157
see Nicotine Polacrilex Lozenge 4 mg	158
RA NICOTINE TRANSDERMAL S see Nicotine Td Patch 24hr 21 mg/24hr	159
rabeprazole sodium ec tab 20 mg	163
RADICAVA ORS SUS 105/5ML.....	147
RADICAVA ORS SUS STARTER	147
RAGWITEK SUB	38
raloxifene hcl tab 60 mg	127
raltegravir potassium see ISENTRESS CHW 100MG	97
see ISENTRESS CHW 25MG.....	97
see ISENTRESS HD TAB 600MG	97
see ISENTRESS POW 100MG	97
see ISENTRESS TAB 400MG	97
ramelteon tab 8 mg	137
ramipril cap 1.25 mg	78
ramipril cap 10 mg	78
ramipril cap 2.5 mg	78
ramipril cap 5 mg	78
ranolazine tab er 12hr 1000 mg	53
ranolazine tab er 12hr 500 mg	53
rasagiline mesylate tab 0.5 mg (base equiv) ...	93
rasagiline mesylate tab 1 mg (base equiv)	93
RECLIPSEN	

see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	108
regorafenib	
see STIVARGA TAB 40MG	89
RELENZA MIS DISKHALE	99
relugolix-estradiol-norethindrone acetate	
see MYFEMBREE TAB	129
repaglinide tab 0.5 mg	71
repaglinide tab 1 mg	71
repaglinide tab 2 mg	71
repotrectinib	
see AUGTYRO CAP 160MG	86
see AUGTYRO CAP 40MG	86
RESTASIS EMU 0.05% OP	149
RESTASIS MUL EMU 0.05% OP	149
RETEVMO TAB 120MG	89
RETEVMO TAB 160MG	89
RETEVMO TAB 40MG	89
RETEVMO TAB 80MG	89
revefenacin	
see YUPELRI SOL	56
REVLIMID CAP 10MG	144
REVLIMID CAP 15MG	144
REVLIMID CAP 2.5MG	144
REVLIMID CAP 20MG	144
REVLIMID CAP 25MG	144
REVLIMID CAP 5MG	144
REYVOW TAB 100MG	141
REYVOW TAB 50MG	141
ribavirin cap 200 mg	99
ribavirin tab 200 mg	99
ribociclib succinate	
see KISQALI TAB 200DOSE	88
see KISQALI TAB 400DOSE	88
see KISQALI TAB 600DOSE	88
rifabutin cap 150 mg	83
rifampin cap 150 mg	83
rifampin cap 300 mg	83
RIFATER TAB	82
rifaximin	
see XIFAXAN TAB 550MG	52
riluzole tab 50 mg	147
rimantadine hydrochloride tab 100 mg	99
rimegepant sulfate	
see NURTEC TAB 75MG ODT	141
RINVOQ LQ SOL 1MG/ML	39
RINVOQ TAB 15MG ER	39

RINVOQ TAB 30MG ER	39
RINVOQ TAB 45MG ER	39
riociguat	
see ADEMPAS TAB 0.5MG	106
see ADEMPAS TAB 1.5MG	106
see ADEMPAS TAB 1MG	106
see ADEMPAS TAB 2.5MG	106
see ADEMPAS TAB 2MG	106
risedronate sodium tab 150 mg	127
risedronate sodium tab 30 mg	127
risedronate sodium tab 35 mg	127
risedronate sodium tab 5 mg	127
risedronate sodium tab delayed release 35 mg	127
risperidone orally disintegrating tab 0.25 mg ..	93
risperidone orally disintegrating tab 0.5 mg ...	93
risperidone orally disintegrating tab 1 mg	93
risperidone orally disintegrating tab 2 mg	93
risperidone orally disintegrating tab 3 mg	94
risperidone orally disintegrating tab 4 mg	94
risperidone soln 1 mg/ml	94
risperidone tab 0.25 mg	94
risperidone tab 0.5 mg	94
risperidone tab 1 mg	94
risperidone tab 2 mg	94
risperidone tab 3 mg	94
risperidone tab 4 mg	94
RITEFLO MIS	141
ritlecitinib tosylate	
see LITFULO CAP 50MG	124
ritonavir tab 100 mg	98
rivaroxaban	
see XARELTO STAR TAB 15/20MG	60
see XARELTO SUS 1MG/ML	60
see XARELTO TAB 10MG	60
see XARELTO TAB 15MG	60
see XARELTO TAB 2.5MG	60
see XARELTO TAB 20MG	60
rivaroxaban tab 2.5 mg	60
rivastigmine tartrate cap 1.5 mg (base equivalent)	153
rivastigmine tartrate cap 3 mg (base equivalent)	153
rivastigmine tartrate cap 4.5 mg (base equivalent)	153
rivastigmine tartrate cap 6 mg (base equivalent)	153

rivastigmine td patch 24hr 13.3 mg/24hr	153
rivastigmine td patch 24hr 4.6 mg/24hr	153
rivastigmine td patch 24hr 9.5 mg/24hr	153
RIVELSA	
see Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg & eth Est 0.01 mg	109
rizatriptan benzoate oral disintegrating tab 10 mg (base eq)	142
rizatriptan benzoate oral disintegrating tab 5 mg (base eq)	142
rizatriptan benzoate tab 10 mg (base equivalent)	142
rizatriptan benzoate tab 5 mg (base equivalent)	142
roflumilast (topical)	
see ZORYVE CRE 0.15%	125
see ZORYVE CRE 0.3%	125
see ZORYVE MIS 0.3%	125
roflumilast tab 250 mcg	56
roflumilast tab 500 mcg	56
ropinirole hydrochloride tab 0.25 mg	92
ropinirole hydrochloride tab 0.5 mg	92
ropinirole hydrochloride tab 1 mg	92
ropinirole hydrochloride tab 2 mg	92
ropinirole hydrochloride tab 3 mg	92
ropinirole hydrochloride tab 4 mg	92
ropinirole hydrochloride tab 5 mg	92
ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)	92
ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)	92
ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)	92
ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)	92
ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)	92
rosuvastatin calcium tab 10 mg	77
rosuvastatin calcium tab 20 mg	77
rosuvastatin calcium tab 40 mg	77
rosuvastatin calcium tab 5 mg	76
rotigotine	
see NEUPRO DIS 1MG/24HR	92
see NEUPRO DIS 2MG/24HR	92
see NEUPRO DIS 3MG/24HR	92
see NEUPRO DIS 4MG/24HR	92
see NEUPRO DIS 6MG/24HR	92

see NEUPRO DIS 8MG/24HR	92
ROWEEPRA	
see Levetiracetam Tab 500 mg	62
ROZLYTREK CAP 100MG	89
ROZLYTREK CAP 200MG	89
ROZLYTREK PAK 50MG	89
rufinamide susp 40 mg/ml	63
rufinamide tab 200 mg	63
rufinamide tab 400 mg	63
ruxolitinib phosphate (topical)	
see OPZELURA CRE 1.5%	124
RYBELSUS TAB 14MG	70
RYBELSUS TAB 3MG	70
RYBELSUS TAB 7MG	70
RYDAPT CAP 25MG	89
RYTARY CAP 145MG	93
RYTARY CAP 195MG	93
RYTARY CAP 245MG	93
RYTARY CAP 95MG	93
S	
sacubitril-valsartan	
see ENTRESTO CAP 15-16MG	104
see ENTRESTO CAP 6-6MG	104
see ENTRESTO TAB 24-26MG	104
see ENTRESTO TAB 49-51MG	104
see ENTRESTO TAB 97-103MG	104
salmeterol xinafoate	
see SEREVENT DIS AER 50MCG	58
salsalate tab 750 mg	42
SANCUSO DIS 3.1MG	73
sapropterin dihydrochloride powder packet 100 mg	
Sapropterin Dihydrochloride Powder Packet 100 mg	128
sapropterin dihydrochloride powder packet 500 mg	
Sapropterin Dihydrochloride Powder Packet 500 mg	128
sapropterin dihydrochloride tab 100 mg	128
Sapropterin Dihydrochloride Tab 100 mg	128
saxagliptin hcl tab 2.5 mg (base equiv)	70
saxagliptin hcl tab 5 mg (base equiv)	70
saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg	
saxagliptin-metformin hcl tab er 24hr 5-1000 mg	68

saxagliptin-metformin hcl tab er 24hr 5-500 mg	68
SCEMBLIX TAB 100MG	89
SCEMBLIX TAB 20MG	89
SCEMBLIX TAB 40MG	89
scopolamine td patch 72hr 1 mg/3days	73
segesterone acetate-ethinyl estradiol	
see ANNOVERA MIS	115
selegiline hcl cap 5 mg	93
selegiline hcl tab 5 mg	93
selenium sulfide lotion 2.5%	122
selexipag	
see UPTRAVI PACK TAB 200/800	106
see UPTRAVI TAB 1000MCG	106
see UPTRAVI TAB 1200MCG	106
see UPTRAVI TAB 1400MCG	106
see UPTRAVI TAB 1600MCG	106
see UPTRAVI TAB 200MCG	106
see UPTRAVI TAB 400MCG	106
see UPTRAVI TAB 600MCG	106
see UPTRAVI TAB 800MCG	106
sempercatinib	
see RETEVMO TAB 120MG	89
see RETEVMO TAB 160MG	89
see RETEVMO TAB 40MG	89
see RETEVMO TAB 80MG	89
selumetinib sulfate	
see KOSELUGO CAP 10MG	88
see KOSELUGO CAP 25MG	88
semaglutide	
see OZEMPIC INJ 2MG/3ML	70
see OZEMPIC INJ 4MG/3ML	70
see OZEMPIC INJ 8MG/3ML	70
see RYBELSUS TAB 14MG	70
see RYBELSUS TAB 3MG	70
see RYBELSUS TAB 7MG	70
serdexmethylphenidate chloride-	
dexmethylphenidate hcl	
see AZSTARYS CAP 26.1-5.2	33
see AZSTARYS CAP 39.2-7.8	33
see AZSTARYS CAP 52.3-10	33
SEREVENT DIS AER 50MCG	58
sertraline hcl oral concentrate for solution 20 mg/ml	66
sertraline hcl tab 100 mg	66
sertraline hcl tab 25 mg	66
sertraline hcl tab 50 mg	66

SETLAKIN	
see Levonorgestrel & Ethinyl Estradiol (91-Day)	
Tab 0.15-0.03 mg	109
sevelamer carbonate packet 0.8 gm	133
sevelamer carbonate packet 2.4 gm	133
sevelamer carbonate tab 800 mg	133
sevelamer hcl tab 400 mg	133
sevelamer hcl tab 800 mg	133
SHAROBEL	
see Norethindrone Tab 0.35 mg	116
short ragweed pollen allergen extract	
see RAGWITEK SUB	38
SHUR-SEAL GEL 2%	164
SIKLOS TAB 1000MG	134
SIKLOS TAB 100MG	134
sildenafil citrate for suspension 10 mg/ml	105
sildenafil citrate tab 100 mg	104
sildenafil citrate tab 20 mg	105
sildenafil citrate tab 25 mg	104
sildenafil citrate tab 50 mg	104
silodosin cap 4 mg	133
silodosin cap 8 mg	133
silver sulfadiazine cream 1%	122
Silver Sulfadiazine Cream 1%	122
SIMBRINZA SUS 1-0.2%	148
SIMLIYA	
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)	107
SIMPESSE	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)	109
simvastatin tab 10 mg	77
simvastatin tab 20 mg	77
simvastatin tab 40 mg	77
simvastatin tab 5 mg	77
simvastatin tab 80 mg	77
siponimod fumarate	
see MAYZENT PAK STARTER	154
see MAYZENT TAB 0.25MG	155
see MAYZENT TAB 1MG	155
see MAYZENT TAB 2MG	155
sirolimus oral soln 1 mg/ml	145
sirolimus tab 0.5 mg	145
sirolimus tab 1 mg	145
sirolimus tab 2 mg	145
SIRTURO TAB 100MG	83
SIRTURO TAB 20MG	83

sitagliptin	
see ZITUVIO TAB 100MG	70
see ZITUVIO TAB 25MG	70
see ZITUVIO TAB 50MG	70
sitagliptin free base-metformin hcl	
see ZITUVIMET TAB 50-1000	69
see ZITUVIMET TAB 50-500MG	69
see ZITUVIMET XR TAB 100-1000.....	69
see ZITUVIMET XR TAB 50-1000.....	69
see ZITUVIMET XR TAB 50-500MG.....	69
SM FOLIC ACID	
see Folic Acid Tab 400 mcg	135
SM NICOTINE	
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Polacrilex Lozenge 2 mg	157
SM NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Gum 4 mg	157
see Nicotine Polacrilex Lozenge 4 mg	158
SM NICOTINE TRANSDERMAL S	
see Nicotine Td Patch 24hr 14 mg/24hr	158
see Nicotine Td Patch 24hr 21 mg/24hr	159
see Nicotine Td Patch 24hr 7 mg/24hr	158
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml.....	138
sodium chloride soln nebu 0.9%	118
sodium chloride soln nebu 10%	118
sodium chloride soln nebu 3%	118
Sodium Chloride Soln Nebu 3%	118
sodium chloride soln nebu 7%	118
Sodium Chloride Soln Nebu 7%	118
sodium fluoride	
see FLUORABON DRO	142
sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf).....	142
sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)	142
sodium fluoride chew tab 1 mg f (from 2.2 mg naf)	142
Sodium Fluoride Soln 0.25 mg/drop F (From 0.55 mg/drop Naf)	143
sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)	142
sodium fluoride tab 0.5 mg f (from 1.1 mg naf)	143
sodium fluoride tab 1 mg f (from 2.2 mg naf)	143
sodium oxybate	
see LUMRYZ PAK 6GM	152
see LUMRYZ PAK 7.5GM	152
see LUMRYZ PAK 9GM	152
see LUMRYZ PAK STARTER	152
see LUMRYZ PKG 4.5GM.....	152
sodium phenylbutyrate	
see PHEBURANE MIS 483/GM.....	128
sodium phenylbutyrate oral powder 3 gm/teaspoonful	128
sodium phenylbutyrate tab 500 mg	128
sodium picosulfate-magnesium oxide-anhydrous citric acid	
see CLENPIQ SOL	137
see PREPOPIK PAK.....	138
sodium polystyrene sulfonate powder	145
Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml	145
Sodium Polystyrene Sulfonate Susp 15 gm/60ml	145
sofosbuvir	
see SOVALDI PAK 150MG	99
see SOVALDI PAK 200MG	99
see SOVALDI TAB 200MG	99
see SOVALDI TAB 400MG	99
sofosbuvir-velpatasvir	
see EPCLUSA PAK 150-37.5	98
see EPCLUSA PAK 200-50MG	98
see EPCLUSA TAB 200-50MG	98
see EPCLUSA TAB 400-100.....	98
sofosbuvir-velpatasvir-voxilaprevir	
see VOSEVI TAB	99
solifenacin succinate tab 10 mg	164
solifenacin succinate tab 5 mg	164
SOLQUA INJ 100/33.....	68
solriamfetol hcl	
see SUNOSI TAB 150MG	33
see SUNOSI TAB 75MG	33
sonidegib phosphate	
see ODOMZO CAP 200MG	84
SOOLANTRA CRE 1%.....	125
sorafenib tosylate tab 200 mg (base equivalent)	89
sotalol hcl (afib/afl) tab 120 mg	101
sotalol hcl (afib/afl) tab 160 mg	101
sotalol hcl (afib/afl) tab 80 mg	101
sotalol hcl tab 120 mg	101
sotalol hcl tab 160 mg	101

sotalol hcl tab 240 mg	101
sotalol hcl tab 80 mg	101
sotorasib	
see LUMAKRAS TAB 120MG	88
see LUMAKRAS TAB 240MG	88
see LUMAKRAS TAB 320MG	88
SOTYKTU TAB 6MG	121
SOVALDI PAK 150MG	99
SOVALDI PAK 200MG	99
SOVALDI TAB 200MG	99
SOVALDI TAB 400MG	99
spacer/aerosol-holding chamber supplies - masks	
see FLEXICHAMBER MIS MASK LRG	140
see FLEXICHAMBER MIS MASK SM	140
spacer/aerosol-holding chambers	
see AERCHMBR PLS MIS LRG MASK	139
see AERCHMBR PLS MIS MED MASK	139
see AERCHMBR PLS MIS SM MASK	139
see AERCHMBR Z- MIS STAT PLS	139
see AEROCHAMBER MIS CHAMBER	139
see AEROCHAMBER MIS FLOSIGNA	139
see AEROCHAMBER MIS MV	139
see AEROCHAMBER MIS PLUS	140
see AEROVENT MIS PLUS	140
see BREATHE EASE MIS LG MASK	140
see BREATHE EASE MIS MED MASK	140
see BREATHE EASE MIS SM MASK	140
see COMPACT SPAC MIS CHAMBER	140
see COMPACT SPAC MIS LG MASK	140
see COMPACT SPAC MIS MD MASK	140
see COMPACT SPAC MIS SM MASK	140
see EASIVENT MIS	140
see EASIVENT MIS MASK LG	140
see EASIVENT MIS MASK MED	140
see EASIVENT MIS MASK SM	140
see FLEXICHAMBER MIS	140
see HOLD CHAMBER MIS ADLT LG	140
see HOLD CHAMBER MIS MEDIUM	140
see HOLD CHAMBER MIS SMALL	140
see INSPIREASE MIS DD SYST	140
see MICROCHAMBER MIS	140
see MICROSPACER MIS	140
see OPTICHAMBER MIS DIA LG	141
see OPTICHAMBER MIS DIA MD	141
see OPTICHAMBER MIS DIA SM	141
see OPTICHAMBER MIS DIAMOND	141
see POCKET CHAMB MIS	141
see POCKET SPACE MIS	141
see PROCHAMBER MIS VHC	141
see RITEFLO MIS	141
see VORTEX VALVE MIS CHAMBER	141
spinosad susp 0.9%	125
SPIRIVA AER 1.25MCG	56
SPIRIVA CAP HANDIHLR	56
SPIRIVA SPR 2.5MCG	56
spironolactone & hydrochlorothiazide tab 25-25 mg	126
spironolactone susp 25 mg/5ml	126
spironolactone tab 100 mg	127
spironolactone tab 25 mg	126
spironolactone tab 50 mg	126
SPRINTEC 28	
see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg	114
SPS	
see Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml	145
see Sodium Polystyrene Sulfonate Susp 15 gm/60ml	145
SRONYX	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	110
SSD	
see Silver Sulfadiazine Cream 1%	122
STIOLTO AER 2.5-2.5	59
STIVARGA TAB 40MG	89
STRIVERDI AER 2.5MCG	59
SUBVENITE	
see Lamotrigine Tab 100 mg	62
see Lamotrigine Tab 150 mg	62
see Lamotrigine Tab 200 mg	62
see Lamotrigine Tab 25 mg	61
SUBVENITE STARTER KIT/BLU	
see Lamotrigine Tab 35 X 25 mg Starter Kit ..	62
SUBVENITE STARTER KIT/GRE	
see Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit	62
SUBVENITE STARTER KIT/ORA	
see Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit	62
sucralfate tab 1 gm	163
sulconazole nitrate cream 1%	121
sulconazole nitrate solution 1%	121

sulfacetamide sodium liquid 10%	122
sulfacetamide sodium lotion 10% (acne)	119
sulfacetamide sodium ophth oint 10%	149
sulfacetamide sodium ophth soln 10%	149
sulfacetamide sodium w/ sulfur cleanser 10-5%	119
Sulfacetamide Sodium W/ Sulfur Emulsion 10-1%	119
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	150
sulfadiazine tab 500 mg	159
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	52
Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml	52
sulfamethoxazole-trimethoprim tab 400-80 mg	52
sulfamethoxazole-trimethoprim tab 800-160 mg	52
SULFAMEZ WASH see Sulfacetamide Sodium W/ Sulfur Emulsion 10-1%	119
sulfasalazine tab 500 mg	132
sulfasalazine tab delayed release 500 mg	132
SULFATRIM PEDIATRIC see Sulfamethoxazole-Trimethoprim Susp 200- 40 mg/5ml	52
sulindac tab 150 mg	41
sulindac tab 200 mg	41
sumatriptan nasal spray 20 mg/act	142
sumatriptan nasal spray 5 mg/act	142
sumatriptan succinate see ONZETRA XSAI MIS 11MG	141
see ZEMBRACE SYM INJ 3/0.5ML	142
sumatriptan succinate inj 6 mg/0.5ml	142
sumatriptan succinate solution auto-injector 4 mg/0.5ml	142
sumatriptan succinate solution auto-injector 6 mg/0.5ml	142
sumatriptan succinate solution cartridge 4 mg/0.5ml	142
sumatriptan succinate solution cartridge 6 mg/0.5ml	142
sumatriptan succinate tab 100 mg	142
sumatriptan succinate tab 25 mg	142
sumatriptan succinate tab 50 mg	142

sunitinib malate cap 12.5 mg (base equivalent)	89
sunitinib malate cap 25 mg (base equivalent)	89
sunitinib malate cap 37.5 mg (base equivalent)	89
sunitinib malate cap 50 mg (base equivalent)	89
SUNOSI TAB 150MG	33
SUNOSI TAB 75MG	33
suvorexant see BELSOMRA TAB 10MG	137
see BELSOMRA TAB 15MG	137
see BELSOMRA TAB 20MG	137
see BELSOMRA TAB 5MG	137
SYEDA see Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg	108
SYMLINPEN 60 INJ 1000MCG	68
SYMLNPN 120 INJ 1000MCG	68
SYMPROIC TAB 0.2MG	132
SYMTUZA TAB	98
SYNAREL SOL 2MG/ML	128
SYNJARDY TAB	69
SYNJARDY TAB 12.5-500	69
SYNJARDY TAB 5-1000MG	69
SYNJARDY TAB 5-500MG	69
SYNJARDY XR TAB	69
SYNJARDY XR TAB 10-1000	69
SYNJARDY XR TAB 25-1000	69
SYNJARDY XR TAB 5-1000MG	69
SYNTHROID TAB 100MCG	162
SYNTHROID TAB 112MCG	162
SYNTHROID TAB 125MCG	162
SYNTHROID TAB 137MCG	162
SYNTHROID TAB 150MCG	162
SYNTHROID TAB 175MCG	162
SYNTHROID TAB 200MCG	162
SYNTHROID TAB 25MCG	162
SYNTHROID TAB 300MCG	162
SYNTHROID TAB 50MCG	162
SYNTHROID TAB 75MCG	162
SYNTHROID TAB 88MCG	162
T	
tacrolimus cap 0.5 mg	145
tacrolimus cap 1 mg	145
tacrolimus cap 5 mg	145
tacrolimus oint 0.03%	124
tacrolimus oint 0.1%	124

tadalafil (pulmonary hypertension)	
see TADLIQ SUS 20MG/5ML	105
tadalafil tab 10 mg	104
tadalafil tab 2.5 mg	104
tadalafil tab 20 mg	104
tadalafil tab 20 mg (pah)	105
Tadalafil Tab 20 mg (Pah)	105
tadalafil tab 5 mg	104
TADLIQ SUS 20MG/5ML	105
TAFINLAR CAP 50MG	90
TAFINLAR CAP 75MG	90
TAFINLAR TAB 10MG	90
tafluprost preservative free (pf) ophth soln	
0.0015%	150
TAGRISSO TAB 40MG	84
TAGRISSO TAB 80MG	84
TALICIA CAP	163
tamoxifen citrate tab 10 mg (base equivalent)	85
tamoxifen citrate tab 20 mg (base equivalent)	85
tamsulosin hcl cap 0.4 mg	133
TANLOR	
see Methocarbamol Tab 1000 mg	147
TARINA 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24)	113
TARINA FE 1/20 EQ	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg	112
tasimelteon capsule 20 mg	137
TAYSOFY	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Cap 1 mg-20 mcg (24)	113
tazarotene cream 0.05%	121
tazarotene cream 0.1%	121
tazarotene gel 0.05%	122
tazarotene gel 0.1%	122
telmisartan tab 20 mg	78
telmisartan tab 40 mg	78
telmisartan tab 80 mg	78
telmisartan-amlodipine tab 40-10 mg	81
telmisartan-amlodipine tab 40-5 mg	81
telmisartan-amlodipine tab 80-10 mg	81
telmisartan-amlodipine tab 80-5 mg	81
telmisartan-hydrochlorothiazide tab 40-12.5 mg	
.....	81
telmisartan-hydrochlorothiazide tab 80-12.5 mg	
.....	81

telmisartan-hydrochlorothiazide tab 80-25 mg	
.....	81
temazepam cap 15 mg	137
temazepam cap 22.5 mg	137
temazepam cap 30 mg	137
temazepam cap 7.5 mg	137
temozolomide cap 100 mg	83
temozolomide cap 140 mg	83
temozolomide cap 180 mg	83
temozolomide cap 20 mg	83
temozolomide cap 250 mg	83
temozolomide cap 5 mg	83
TENCON	
see Butalbital-Acetaminophen Tab 50-325 mg	
.....	42
tenofovir alafenamide fumarate	
see VEMLIDY TAB 25MG	99
tenofovir disoproxil fumarate tab 300 mg	98
terazosin hcl cap 1 mg (base equivalent)	79
terazosin hcl cap 10 mg (base equivalent)	79
terazosin hcl cap 2 mg (base equivalent)	79
terazosin hcl cap 5 mg (base equivalent)	79
terbinafine hcl tab 250 mg	73
terbutaline sulfate tab 2.5 mg	59
terbutaline sulfate tab 5 mg	59
terconazole vaginal cream 0.4%	165
terconazole vaginal cream 0.8%	165
terconazole vaginal suppos 80 mg	165
teriflunomide tab 14 mg	155
teriflunomide tab 7 mg	155
testosterone	
see NATESTO GEL 5.5MG	51
testosterone td gel 10mg/act (2%)	51
testosterone td gel 12.5 mg/act (1%)	51
testosterone td gel 20.25 mg/1.25gm (1.62%)	51
testosterone td gel 20.25 mg/act (1.62%)	51
testosterone td gel 25 mg/2.5gm (1%)	51
testosterone td gel 40.5 mg/2.5gm (1.62%)	51
testosterone td gel 50 mg/5gm (1%)	51
testosterone td soln 30 mg/act	51
tetrabenazine tab 12.5 mg	154
tetrabenazine tab 25 mg	154
tetracycline hcl cap 250 mg	160
tetracycline hcl cap 500 mg	160
TEXACORT	
see Hydrocortisone Soln 2.5%	123
thalidomide	

see THALOMID CAP 100MG	144
see THALOMID CAP 50MG	144
THALOMID CAP 100MG	144
THALOMID CAP 50MG	144
theophylline elixir 80 mg/15ml	59
Theophylline Elixir 80 mg/15ml	59
theophylline soln 80 mg/15ml	59
theophylline tab er 12hr 300 mg	59
theophylline tab er 12hr 450 mg	59
theophylline tab er 24hr 400 mg	59
theophylline tab er 24hr 600 mg	59
thioridazine hcl tab 10 mg	95
thioridazine hcl tab 100 mg	96
thioridazine hcl tab 25 mg	95
thioridazine hcl tab 50 mg	96
thiothixene cap 1 mg	96
thiothixene cap 10 mg	96
thiothixene cap 2 mg	96
thiothixene cap 5 mg	96
THRIVE	
see Nicotine Polacrilex Gum 2 mg	156
TIADYL ER	
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 120 mg	102
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 180 mg	102
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 240 mg	102
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 300 mg	102
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 360 mg	102
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 420 mg	102
tiagabine hcl tab 12 mg	64
tiagabine hcl tab 16 mg	64
tiagabine hcl tab 2 mg	64
tiagabine hcl tab 4 mg	64
ticagrelor	
see BRILINTA TAB 60MG	134
see BRILINTA TAB 90MG	134
ticagrelor tab 90 mg	134
TILIA FE	
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-	
20/1-30/1-35 mg-Mcg	111
timolol maleate ophth gel forming soln 0.25%	
.....	148

timolol maleate ophth gel forming soln 0.5%	148
timolol maleate ophth soln 0.25%	148
timolol maleate ophth soln 0.5%	148
timolol maleate ophth soln 0.5% (once-daily)	
.....	148
timolol maleate preservative free ophth soln	
0.25%	148
timolol maleate preservative free ophth soln	
0.5%	148
timolol maleate tab 10 mg	101
timolol maleate tab 20 mg	101
timolol maleate tab 5 mg	101
timothy grass pollen allergen extract	
see GRASTEK SUB 2800BAU	38
tinidazole tab 250 mg	52
tinidazole tab 500 mg	52
tiopronin tab 100 mg	133
tiopronin tab delayed release 100 mg	133
Tiopronin Tab Delayed Release 100 mg	133
tiopronin tab delayed release 300 mg	133
Tiopronin Tab Delayed Release 300 mg	133
tiotropium bromide monohydrate	
see SPIRIVA AER 1.25MCG	56
see SPIRIVA CAP HANDIHLR	56
see SPIRIVA SPR 2.5MCG	56
tiotropium bromide-olodaterol hcl	
see STIOLTO AER 2.5-2.5	59
tipranavir	
see APTIVUS CAP 250MG	96
tirzepatide	
see MOUNJARO INJ 10MG/0.5	70
see MOUNJARO INJ 12.5/0.5	70
see MOUNJARO INJ 15MG/0.5	70
see MOUNJARO INJ 2.5/0.5	70
see MOUNJARO INJ 5MG/0.5	70
see MOUNJARO INJ 7.5/0.5	70
TIVICAY PD TAB 5MG	98
TIVICAY TAB 50MG	98
tizanidine hcl cap 2 mg (base equivalent)	147
tizanidine hcl cap 4 mg (base equivalent)	147
tizanidine hcl cap 6 mg (base equivalent)	147
tizanidine hcl tab 2 mg (base equivalent)	147
tizanidine hcl tab 4 mg (base equivalent)	147
TOBRADEX OIN 0.3-0.1%	150
tobramycin (ophth)	
see TOBREX OIN 0.3% OP	149
tobramycin nebu soln 300 mg/4ml	38

tobramycin nebu soln 300 mg/5ml	38	tramadol hcl tab 50 mg	46
tobramycin ophth soln 0.3%	149	tramadol hcl tab er 24hr 100 mg	46
tobramycin-dexamethasone		tramadol hcl tab er 24hr 200 mg	47
see TOBRADEX OIN 0.3-0.1%	150	tramadol hcl tab er 24hr 300 mg	47
tobramycin-dexamethasone ophth susp 0.3-0.1%	150	tramadol hcl tab er 24hr biphasic release 100 mg	47
TOBREX OIN 0.3% OP	149	tramadol hcl tab er 24hr biphasic release 200 mg	47
TODAY SPONGE MIS	164	tramadol hcl tab er 24hr biphasic release 300 mg	47
tofacitinib citrate		tramadol-acetaminophen tab 37.5-325 mg	50
see XELJANZ SOL 1MG/ML	39	trametinib dimethyl sulfoxide	
see XELJANZ TAB 10MG	39	see MEKINIST SOL 0.05/ML	88
see XELJANZ TAB 5MG	39	see MEKINIST TAB 0.5MG	88
see XELJANZ XR TAB 11MG	40	see MEKINIST TAB 2MG	88
see XELJANZ XR TAB 22MG	40	trandolapril tab 1 mg	78
tolcapone tab 100 mg	91	trandolapril tab 2 mg	78
tolmetin sodium tab 600 mg	41	trandolapril tab 4 mg	78
tolterodine tartrate cap er 24hr 2 mg	164	trandolapril-verapamil hcl tab er 1-240 mg	81
tolterodine tartrate cap er 24hr 4 mg	164	trandolapril-verapamil hcl tab er 2-180 mg	81
tolterodine tartrate tab 1 mg	164	trandolapril-verapamil hcl tab er 2-240 mg	81
tolterodine tartrate tab 2 mg	164	trandolapril-verapamil hcl tab er 4-240 mg	81
tolvaptan tab 15 mg	129	tranexamic acid tab 650 mg	136
tolvaptan tab 30 mg	129	tranylcypromine sulfate tab 10 mg	65
topiramate cap er 24hr 100 mg	63	travoprost ophth soln 0.004% (benzalkonium free) (bak free)	150
topiramate cap er 24hr 200 mg	63	trazodone hcl tab 100 mg	66
topiramate cap er 24hr 25 mg	63	trazodone hcl tab 150 mg	66
topiramate cap er 24hr 50 mg	63	trazodone hcl tab 300 mg	66
topiramate sprinkle cap 15 mg	63	trazodone hcl tab 50 mg	66
topiramate sprinkle cap 25 mg	63	TRECTOR TAB 250MG	83
topiramate sprinkle cap 50 mg	63	TRELEGY AER 100MCG	59
topiramate tab 100 mg	63	TRELEGY AER 200MCG	59
topiramate tab 200 mg	63	treprostinil	
topiramate tab 25 mg	63	see TYVASO DPI POW 16-32-48	105
topiramate tab 50 mg	63	see TYVASO DPI POW 16MCG	105
toremifene citrate tab 60 mg (base equivalent)	85	see TYVASO DPI POW 32MCG	105
TORPENZ		see TYVASO DPI POW 48MCG	105
see Everolimus Tab 10 mg	87	see TYVASO DPI POW 64MCG	105
see Everolimus Tab 2.5 mg	87	see TYVASO RF KT SOL 0.6MG/ML	105
see Everolimus Tab 5 mg	87	see TYVASO SOL 0.6MG/ML	105
see Everolimus Tab 7.5 mg	87	see TYVASO ST KT SOL 0.6MG/ML	105
torsemide tab 10 mg	126	treprostinil diolamine	
torsemide tab 100 mg	126	see ORENITRAM TAB 0.125MG	105
torsemide tab 20 mg	126	see ORENITRAM TAB 0.25MG	105
torsemide tab 5 mg	126	see ORENITRAM TAB 1MG	105
TOUJEO MAX INJ 300/ML	71	see ORENITRAM TAB 2.5MG	105
TOUJEO SOLO INJ 300/ML	71		
tramadol hcl oral soln 5 mg/ml	46		

see ORENITRAM TAB 5MG	105
see ORENITRAM TAB MONTH 1	105
see ORENITRAM TAB MONTH 2	105
see ORENITRAM TAB MONTH 3	105
TRESIBA FLEX INJ 100UNIT	71
TRESIBA FLEX INJ 200UNIT	71
TRESIBA INJ 100UNIT	71
tretinoin cap 10 mg	90
tretinoin cream 0.025%	120
tretinoin cream 0.05%	120
tretinoin cream 0.1%	119
tretinoin gel 0.01%	120
tretinoin gel 0.025%	120
tretinoin gel 0.05%	120
tretinoin microsphere gel 0.04%	120
tretinoin microsphere gel 0.08%	120
tretinoin microsphere gel 0.1%	120
tretinoin-benzoyl peroxide	
see TWYNEO CRE 0.1-3%	120
TREZIX	
see Acetaminophen-Caffeine-Dihydrocodeine	
Cap 320.5-30-16 mg	47
triamcinolone acetonide cream 0.025%	124
triamcinolone acetonide cream 0.1%	123
triamcinolone acetonide cream 0.5%	124
Triamcinolone Acetonide Cream 0.5%	124
triamcinolone acetonide dental paste 0.1% ..	146
Triamcinolone Acetonide Dental Paste 0.1% ..	146
triamcinolone acetonide lotion 0.025%	124
triamcinolone acetonide lotion 0.1%	124
triamcinolone acetonide oint 0.025%	124
triamcinolone acetonide oint 0.1%	124
triamcinolone acetonide oint 0.5%	124
triamterene & hydrochlorothiazide cap 37.5-25	
mg	126
triamterene & hydrochlorothiazide tab 37.5-25	
mg	126
triamterene & hydrochlorothiazide tab 75-50	
mg	126
triamterene cap 100 mg	127
triamterene cap 50 mg	127
triazolam tab 0.125 mg	137
triazolam tab 0.25 mg	137
TRIDACAINE II	
see Lidocaine Patch 5%	124
TRIDERM	
see Triamcinolone Acetonide Cream 0.5% ..	124

trientine hcl cap 250 mg	144
TRI-ESTARYLLA	
see Norgestimate-Eth Estrad Tab 0.18-	
35/0.215-35/0.25-35 mg-Mcg	114
trifarotene	
see AKLIEF CRE 0.005%	118
trifluoperazine hcl tab 1 mg (base equivalent)	96
trifluoperazine hcl tab 10 mg (base equivalent)	
.....	96
trifluoperazine hcl tab 2 mg (base equivalent)	96
trifluoperazine hcl tab 5 mg (base equivalent)	96
trifluridine ophth soln 1%	149
trifluridine-tipiracil	
see LONSURF TAB 15-6.14	85
see LONSURF TAB 20-8.19	85
trihexyphenidyl hcl oral soln 0.4 mg/ml	91
trihexyphenidyl hcl tab 2 mg	91
trihexyphenidyl hcl tab 5 mg	91
TRIJARDY XR TAB	69
TRI-LEGEST FE	
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-	
20/1-30/1-35 mg-Mcg	111
TRI-LINYAH	
see Norgestimate-Eth Estrad Tab 0.18-	
35/0.215-35/0.25-35 mg-Mcg	114
TRI-LO-ESTARYLLA	
see Norgestimate-Eth Estrad Tab 0.18-	
25/0.215-25/0.25-25 mg-Mcg	114
TRI-LO-MARZIA	
see Norgestimate-Eth Estrad Tab 0.18-	
25/0.215-25/0.25-25 mg-Mcg	114
TRI-LO-MILI	
see Norgestimate-Eth Estrad Tab 0.18-	
25/0.215-25/0.25-25 mg-Mcg	114
TRI-LO-SPRINTEC	
see Norgestimate-Eth Estrad Tab 0.18-	
25/0.215-25/0.25-25 mg-Mcg	114
trimethobenzamide hcl cap 300 mg	73
trimethoprim tab 100 mg	52
TRI-MILI	
see Norgestimate-Eth Estrad Tab 0.18-	
35/0.215-35/0.25-35 mg-Mcg	114
trimipramine maleate cap 100 mg	68
trimipramine maleate cap 25 mg	68
trimipramine maleate cap 50 mg	68
TRINATE	

see Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg.....	146
TRINTELLIX TAB 10MG	66
TRINTELLIX TAB 20MG	66
TRINTELLIX TAB 5MG	66
TRI-SPRINTEC	
see Norgestimate-Eth Estrad Tab 0.18- 35/0.215-35/0.25-35 mg-Mcg.....	114
TRIUMEQ PD TAB	98
TRIUMEQ TAB	98
TRIVORA-28	
see Levonorgestrel-Eth Estra Tab 0.05- 30/0.075-40/0.125-30mg-Mcg.....	110
TRI-VYLIBRA	
see Norgestimate-Eth Estrad Tab 0.18- 35/0.215-35/0.25-35 mg-Mcg.....	115
TRI-VYLIBRA LO	
see Norgestimate-Eth Estrad Tab 0.18- 25/0.215-25/0.25-25 mg-Mcg.....	114
tropicamide ophth soln 0.5%	148
tropicamide ophth soln 1%	148
trospium chloride cap er 24hr 60 mg	164
trospium chloride tab 20 mg	164
TRULICITY INJ 0.75/0.5	70
TRULICITY INJ 1.5/0.5	70
TRULICITY INJ 3/0.5	70
TRULICITY INJ 4.5/0.5	70
TRUQAP PAK 160MG.....	90
TRUQAP PAK 200MG.....	90
TRUQAP TAB 200MG.....	90
TRUSTEX MIS FLAVORS	139
TURQOZ	
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg- 30 mcg.....	115
TWYNEO CRE 0.1-3%.....	120
TYVASO DPI POW 16-32-48	105
TYVASO DPI POW 16MCG	105
TYVASO DPI POW 32MCG	105
TYVASO DPI POW 48MCG	105
TYVASO DPI POW 64MCG	105
TYVASO RF KT SOL 0.6MG/ML.....	105
TYVASO SOL 0.6MG/ML.....	105
TYVASO ST KT SOL 0.6MG/ML.....	105
U	
UBRELVY TAB 100MG.....	141
UBRELVY TAB 50MG.....	141
ubrogepant	

see UBRELVY TAB 100MG.....	141
see UBRELVY TAB 50MG	141
ulipristal acetate	
see ELLA TAB 30MG	115
umeclidinium-vilanterol	
see ANORO ELLIPT AER 62.5-25	57
UNITHROID	
see Levothyroxine Sodium Tab 100 mcg	161
see Levothyroxine Sodium Tab 112 mcg	161
see Levothyroxine Sodium Tab 125 mcg	161
see Levothyroxine Sodium Tab 137 mcg	161
see Levothyroxine Sodium Tab 150 mcg	161
see Levothyroxine Sodium Tab 175 mcg	161
see Levothyroxine Sodium Tab 200 mcg	161
see Levothyroxine Sodium Tab 25 mcg	160
see Levothyroxine Sodium Tab 300 mcg	161
see Levothyroxine Sodium Tab 50 mcg	160
see Levothyroxine Sodium Tab 75 mcg	160
see Levothyroxine Sodium Tab 88 mcg	161
upadacitinib	
see RINVOQ LQ SOL 1MG/ML	39
see RINVOQ TAB 15MG ER	39
see RINVOQ TAB 30MG ER	39
see RINVOQ TAB 45MG ER	39
UPTRAVI PACK TAB 200/800	106
UPTRAVI TAB 1000MCG.....	106
UPTRAVI TAB 1200MCG.....	106
UPTRAVI TAB 1400MCG.....	106
UPTRAVI TAB 1600MCG.....	106
UPTRAVI TAB 200MCG.....	106
UPTRAVI TAB 400MCG.....	106
UPTRAVI TAB 600MCG.....	106
UPTRAVI TAB 800MCG.....	106
uridine triacetate (emergency treatment)	
see VISTOGARD PAK 10GM	72
ursodiol cap 300 mg	131
ursodiol tab 250 mg	131
ursodiol tab 500 mg	131
V	
VAGIFEM TAB 10MCG	165
valacyclovir hcl tab 1 gm	99
valacyclovir hcl tab 500 mg	99
valbenazine tosylate	
see INGREZZA CAP 40-80MG.....	154
see INGREZZA CAP 40MG	154
see INGREZZA CAP 60MG	154
see INGREZZA CAP 80MG	154

valganciclovir hcl for soln 50 mg/ml (base equiv)	98
valganciclovir hcl tab 450 mg (base equivalent)	98
valproate sodium oral soln 250 mg/5ml (base equiv)	64
valproic acid cap 250 mg	64
valsartan oral soln 4 mg/ml	78
valsartan tab 160 mg	78
valsartan tab 320 mg	79
valsartan tab 40 mg	78
valsartan tab 80 mg	78
valsartan-hydrochlorothiazide tab 160-12.5 mg	81
valsartan-hydrochlorothiazide tab 160-25 mg	81
valsartan-hydrochlorothiazide tab 320-12.5 mg	81
valsartan-hydrochlorothiazide tab 320-25 mg	81
valsartan-hydrochlorothiazide tab 80-12.5 mg	81
VALTOCO SPR 10MG	60
VALTOCO SPR 15MG	60
VALTOCO SPR 20MG	61
VALTOCO SPR 5MG	60
VALTYA 1/50	
see Ethynodiol Diacetate & Ethinyl Estradiol	
Tab 1 mg-50 mcg	108
vancomycin hcl cap 125 mg (base equivalent)	53
vancomycin hcl cap 250 mg (base equivalent)	53
vancomycin hcl for oral soln 25 mg/ml (base equivalent)	53
vancomycin hcl for oral soln 50 mg/ml (base equivalent)	53
varafenafil hcl orally disintegrating tab 10 mg	104
varafenafil hcl tab 10 mg	105
varafenafil hcl tab 2.5 mg	104
varafenafil hcl tab 20 mg	105
varafenafil hcl tab 5 mg	105
varenicline tartrate tab 0.5 mg (base equiv)	159
varenicline tartrate tab 1 mg (base equiv)	159
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	159
VCF VAGINAL AER CONTRACP	164
VCF VAGINAL GEL CONTRACE	165
VCF VAGINAL MIS CONTRACP	165
VELIVET	
see Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg	107
VELSIPITY TAB 2MG	132
VELTASSA POW 16.8GM	145
VELTASSA POW 1GM	145
VELTASSA POW 25.2GM	145
VELTASSA POW 8.4GM	145
VEMLIDY TAB 25MG	99
venlafaxine hcl cap er 24hr 150 mg (base equivalent)	67
venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)	67
venlafaxine hcl cap er 24hr 75 mg (base equivalent)	67
venlafaxine hcl tab 100 mg (base equivalent)	67
venlafaxine hcl tab 25 mg (base equivalent)	67
venlafaxine hcl tab 37.5 mg (base equivalent)	67
venlafaxine hcl tab 50 mg (base equivalent)	67
venlafaxine hcl tab 75 mg (base equivalent)	67
venlafaxine hcl tab er 24hr 225 mg (base equivalent)	67
VENXXIVA	
see Tiopronin Tab Delayed Release 100 mg	133
see Tiopronin Tab Delayed Release 300 mg	133
verapamil hcl cap er 24hr 100 mg	103
verapamil hcl cap er 24hr 120 mg	103
verapamil hcl cap er 24hr 180 mg	103
verapamil hcl cap er 24hr 200 mg	103
verapamil hcl cap er 24hr 240 mg	103
verapamil hcl cap er 24hr 300 mg	103
verapamil hcl cap er 24hr 360 mg	103
verapamil hcl tab 120 mg	103
verapamil hcl tab 40 mg	103
verapamil hcl tab 80 mg	103
verapamil hcl tab er 120 mg	103
verapamil hcl tab er 180 mg	103
verapamil hcl tab er 240 mg	103
vericiguat	
see VERQUVO TAB 10MG	106
see VERQUVO TAB 2.5MG	106
see VERQUVO TAB 5MG	106
VERQUVO TAB 10MG	106
VERQUVO TAB 2.5MG	106
VERQUVO TAB 5MG	106
VESTURA	
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg	108

vibegron	
see GEMTESA TAB 75MG	164
VIBERZI TAB 100MG	132
VIBERZI TAB 75MG	132
VIENVA	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1	
mg-20 mcg	110
vigabatrin powd pack 500 mg	64
Vigabatrin Powd Pack 500 mg	64
vigabatrin tab 500 mg	64
VIGADRONE	
see Vigabatrin Powd Pack 500 mg	64
VIGPODER	
see Vigabatrin Powd Pack 500 mg	64
vilazodone hcl tab 10 mg	66
vilazodone hcl tab 20 mg	66
vilazodone hcl tab 40 mg	66
viloxazine hcl (adhd)	
see QELBREE CAP 100MG ER	33
see QELBREE CAP 150MG ER	33
see QELBREE CAP 200MG ER	33
VIOKACE TAB 10440	125
VIOKACE TAB 20880	125
VIORELE	
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
0.02/0.01 mg(21/5)	107
VIRACEPT TAB 250MG	98
VIRACEPT TAB 625MG	98
vismodegib	
see ERIVEDGE CAP 150MG	84
VISTOGARD PAK 10GM	72
VITRAKVI CAP 100MG	90
VITRAKVI CAP 25MG	90
VITRAKVI SOL 20MG/ML	90
VOLNEA	
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
0.02/0.01 mg(21/5)	107
voriconazole for susp 40 mg/ml	74
voriconazole tab 200 mg	74
voriconazole tab 50 mg	74
VORTEX VALVE MIS CHAMBER	141
vortioxetine hbr	
see TRINTELLIX TAB 10MG	66
see TRINTELLIX TAB 20MG	66
see TRINTELLIX TAB 5MG	66
VOSEVI TAB	99
VRAYLAR CAP 1.5MG	93
VRAYLAR CAP 3MG	93
VRAYLAR CAP 4.5MG	93
VRAYLAR CAP 6MG	93
VYFEMLA	
see Norethindrone & Ethinyl Estradiol Tab 0.4	
mg-35 mcg	111
VYLIBRA	
see Norgestimate & Ethinyl Estradiol Tab 0.25	
mg-35 mcg	114
W	
WAKIX TAB 17.8MG	33
WAKIX TAB 4.45MG	33
warfarin sodium tab 1 mg	59
Warfarin Sodium Tab 1 mg	59
warfarin sodium tab 10 mg	59
Warfarin Sodium Tab 10 mg	59
warfarin sodium tab 2 mg	59
Warfarin Sodium Tab 2 mg	59
warfarin sodium tab 2.5 mg	59
Warfarin Sodium Tab 2.5 mg	59
warfarin sodium tab 3 mg	59
Warfarin Sodium Tab 3 mg	59
warfarin sodium tab 4 mg	59
Warfarin Sodium Tab 4 mg	59
warfarin sodium tab 5 mg	59
Warfarin Sodium Tab 5 mg	59
warfarin sodium tab 6 mg	59
Warfarin Sodium Tab 6 mg	59
warfarin sodium tab 7.5 mg	59
Warfarin Sodium Tab 7.5 mg	59
WERA	
see Norethindrone & Ethinyl Estradiol Tab 0.5	
mg-35 mcg	111
WINLEVI CRE 1%	120
WIXELA INHUB	
see Fluticasone-Salmeterol Aer Powder Ba	
100-50 mcg/act	58
see Fluticasone-Salmeterol Aer Powder Ba	
250-50 mcg/act	58
see Fluticasone-Salmeterol Aer Powder Ba	
500-50 mcg/act	58
WYMZYA FE	
see Norethindrone & Ethinyl Estradiol-Fe	
Chew Tab 0.4 mg-35 mcg	111
X	
XARAH FE	

see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1- 20/1-30/1-35 mg-Mcg	111
XARELTO STAR TAB 15/20MG	60
XARELTO SUS 1MG/ML	60
XARELTO TAB 10MG	60
XARELTO TAB 15MG	60
XARELTO TAB 2.5MG	60
XARELTO TAB 20MG	60
XCOPRI PAK 100-150	63
XCOPRI PAK 12.5-25	63
XCOPRI PAK 150-200	63
XCOPRI PAK 50-100MG	63
XCOPRI TAB 100MG	64
XCOPRI TAB 150MG	64
XCOPRI TAB 200MG	64
XCOPRI TAB 25MG	63
XCOPRI TAB 50MG	64
XDEMVI DRO 0.25%	149
XELJANZ SOL 1MG/ML	39
XELJANZ TAB 10MG	39
XELJANZ TAB 5MG	39
XELJANZ XR TAB 11MG	40
XELJANZ XR TAB 22MG	40
XELRIA FE	
see Norethindrone & Ethinyl Estradiol-Fe	
Chew Tab 0.4 mg-35 mcg	111
XIFAXAN TAB 550MG	52
XIGDUO XR TAB 10-1000	69
XIGDUO XR TAB 10-500MG	69
XIGDUO XR TAB 2.5-1000	69
XIGDUO XR TAB 5-1000MG	69
XIGDUO XR TAB 5-500MG	69
XIIDRA DRO 5%	149
XOSPATA TAB 40MG	90
XTANDI CAP 40MG	85
XTANDI TAB 40MG	85
XTANDI TAB 80MG	85
XULANE	
see Norelgestromin-Ethinyl Estradiol Td Ptwk	
150-35 mcg/24hr	115
XULTOPHY INJ 100/3.6	69
XYWAV SOL 0.5GM/ML	152
Y	
YARGESA	
see Miglustat Cap 100 mg	134
YL FOLIC ACID	
see Folic Acid Tab 400 mcg	135

YONSA TAB 125MG	85
YUPELRI SOL	56
Z	
ZAFEMY	
see Norelgestromin-Ethinyl Estradiol Td Ptwk	
150-35 mcg/24hr	115
zafirlukast tab 10 mg	56
zafirlukast tab 20 mg	56
zaleplon cap 10 mg	137
zaleplon cap 5 mg	137
zanamivir	
see RELENZA MIS DISKHALE	99
zanubrutinib	
see BRUKINSA CAP 80MG	86
ZEGALOGUE INJ 0.6/0.6	70
ZEJULA TAB 100MG	90
ZEJULA TAB 200MG	90
ZEJULA TAB 300MG	90
ZEMBRACE SYM INJ 3/0.5ML	142
ZENATANE	
see Isotretinoin Cap 10 mg	119
see Isotretinoin Cap 20 mg	119
see Isotretinoin Cap 30 mg	119
see Isotretinoin Cap 40 mg	119
ZENPEP CAP 10000UNT	125
ZENPEP CAP 15000UNT	125
ZENPEP CAP 20000UNT	126
ZENPEP CAP 25000UNT	126
ZENPEP CAP 3000UNIT	125
ZENPEP CAP 40000UNT	126
ZENPEP CAP 5000UNIT	125
ZENPEP CAP 60000UNT	126
ZENZEDI	
see Dextroamphetamine Sulfate Tab 10 mg .	29
see Dextroamphetamine Sulfate Tab 15 mg .	30
see Dextroamphetamine Sulfate Tab 2.5 mg .	29
see Dextroamphetamine Sulfate Tab 20 mg .	30
see Dextroamphetamine Sulfate Tab 30 mg .	30
see Dextroamphetamine Sulfate Tab 5 mg ...	29
see Dextroamphetamine Sulfate Tab 7.5 mg .	29
ZEPATIER TAB 50-100MG	99
ZEPOSIA 7DAY CAP STR PACK	155
ZEPOSIA CAP 0.92MG	155
ZEPOSIA CAP STR KIT	155
zidovudine cap 100 mg	98
zidovudine syrup 10 mg/ml	98
zidovudine tab 300 mg	98

ziprasidone hcl cap 20 mg	93	ZORYVE CRE 0.15%	125
ziprasidone hcl cap 40 mg	93	ZORYVE CRE 0.3%	125
ziprasidone hcl cap 60 mg	93	ZORYVE MIS 0.3%	125
ziprasidone hcl cap 80 mg	93	ZOVIA 1/35	
ZITUVIMET TAB 50-1000	69	see Ethynodiol Diacetate & Ethinyl Estradiol	
ZITUVIMET TAB 50-500MG	69	Tab 1 mg-35 mcg	108
ZITUVIMET XR TAB 100-1000	69	ZUBSOLV SUB 0.7-0.18	51
ZITUVIMET XR TAB 50-1000	69	ZUBSOLV SUB 1.4-0.36	51
ZITUVIMET XR TAB 50-500MG	69	ZUBSOLV SUB 11.4-2.9	51
ZITUVIO TAB 100MG	70	ZUBSOLV SUB 2.9-0.71	51
ZITUVIO TAB 25MG	70	ZUBSOLV SUB 5.7-1.4	51
ZITUVIO TAB 50MG	70	ZUBSOLV SUB 8.6-2.1	51
zolmitriptan nasal spray 2.5 mg/spray unit ...	142	ZUMANDIMINE	
zolmitriptan nasal spray 5 mg/spray unit	142	see Drospirenone-Ethinyl Estradiol Tab 3-0.03	
zolmitriptan orally disintegrating tab 2.5 mg	142	mg	108
zolmitriptan orally disintegrating tab 5 mg	142	zuranolone	
zolmitriptan tab 2.5 mg	142	see ZURZUVAE CAP 20MG	65
zolmitriptan tab 5 mg	142	see ZURZUVAE CAP 25MG	65
zolpidem tartrate tab 10 mg	137	see ZURZUVAE CAP 30MG	65
zolpidem tartrate tab 5 mg	137	ZURZUVAE CAP 20MG	65
zolpidem tartrate tab er 12.5 mg	137	ZURZUVAE CAP 25MG	65
zolpidem tartrate tab er 6.25 mg	137	ZURZUVAE CAP 30MG	65
zonisamide cap 100 mg	63	ZYDELIG TAB 100MG	90
zonisamide cap 25 mg	63	ZYDELIG TAB 150MG	90
zonisamide cap 50 mg	63	ZYKADIA TAB 150MG	90

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