Health Plan of San Joaquin (HPSJ) Medi-Cal Formulary

Introduction:

All medications listed in the HPSJ formulary are Tier 1 medications. They are covered by HPSJ at no cost to members when there are no restrictions or if the restriction(s) is/are met.

HPSJ covers generic formulations of medications where available. If a member is unsuccessfully treated with, or is allergic to, generics, a brand may be covered.

HPSJ has edits in place for medications at the point of service. These are listed below under the Legend. If a provider believes a medication is medically necessary for a member who does not meet the edits, they may submit a request for prior authorization. Prior authorization forms can be found at https://www.hpsj.com/forms-documents/under Pharmacy Tools & Resources → Medication Prior Authorization Form. In addition there may be additional causes of a medication to reject at the pharmacy such as drug-drug interactions, or drug-disease interactions. These should be discussed with the pharmacist and the prescriber to ensure patient safety.

Legend:

AL = Age Limit	PL = Provider Limit	GL = Gender Limit	PA = Prior Authorization
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Carve-Out Medications:

Some types of medications are considered carve-outs from HPSJ's formulary. This means these medications are paid for by Medi-Cal Fee-For-Service and billing should be submitted to them directly. Carve-out medications include those used to treat Anti-psychotics, Drug Dependency, Hemophilia Blood Factors, Human Immunodeficiency Virus (HIV), and Mood Disorders. Some of the medications may require a Treatment Authorization Request (TAR) to be completed. TAR forms can be found at https://files.medi-cal.ca.gov/pubsdoco/forms.asp. The completed form should be faxed to 1-800-829-4325 or 1-800-641-1021.

Intravenous Solution of Unlisted Antibiotics/ Intravenous Solution of Unlisted Drugs:

These are restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when I.V. therapy with the same antibiotic/drug was started before discharge. There is a maximum of 10 days supply per dispensing within the 10-day period.

Parenteral Nutrition Solutions (TPN or Hyperalimentation)/Separately Administered Intravenous Lipids:

These are restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when I.V. therapy with the same product was started before discharge. There is a maximum of 10 days supply per dispensing within this 10-day period.

THERAPEUTIC CATEGORY
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DRUG CLASS: Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY - PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Invokamet Xr	Canagliflozin/Metformin Hcl	Tab Bp 24H	150-1000Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.
Invokamet Xr	Canagliflozin/Metformin Hcl	Tab Bp 24H	150-500 Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.

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Invokamet Xr	Canagliflozin/Metformin Hcl	Tab Bp 24H	50-1000 Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.
Invokamet Xr	Canagliflozin/Metformin Hcl	Tab Bp 24H	50Mg-500Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.
Invokamet	Canagliflozin/Metformin Hcl	Tablet	150-1000Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.

Invokamet	Canagliflozin/Metformin Hcl	Tablet	150-500 Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.
Invokamet	Canagliflozin/Metformin Hcl	Tablet	50-1000 Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.
Invokamet	Canagliflozin/Metformin Hcl	Tablet	50Mg-500Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.

Striverdi Respimat	Olodaterol Hcl	Mist Inhal	2.5 Mcg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to concurrent use of ICS is required. Limit 1 package per month.

THERAPEUTIC CATEGORY
Allergy

DRUG CLASS: 1St Gen Antihistamine & Decongestant Combinati					CATEGORY Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Dimetapp	Phenylephrine/Bro	Solution	2.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp	Phenylephrine/Bro	Solution	2.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp	Phenylephrine/Bro	Solution	2.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp	Phenylephrine/Bro	Solution	2.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp	Phenylephrine/Bro	Solution	2.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp	Phenylephrine/Bro	Solution	2.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp	Phenylephrine/Bro	Solution	2.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cardec	Phenylephrine/Chlo	Drops	3.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cardec	Phenylephrine/Chlo	Drops	3.5-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenergan Vc	Promethazine/Phenylephrine	Syrup	6.25-5-10	1	☐	☐	☐	☑	☑	☐	☐	☐	Restricted to patients ≥2 years of age. For ages 2 to 6, limited to 1 fill per 365 days.

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Triaminic Cold & All	Pseudoephed/Chlor	Syrup	15-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Wal-Tap	Pseudoephedrine/Br	Liquid	15-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Wal-Tap	Pseudoephedrine/Br	Liquid	15-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Wal-Tap	Pseudoephedrine/Br	Liquid	15-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Wal-Tap	Pseudoephedrine/Br	Liquid	15-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Wal-Tap	Pseudoephedrine/Br	Liquid	15-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Allerfrim	Pseudoephedrine/Tr	Syrup	30-1.25	1	☐	☐	☐	☐	☐	☐	☐	☐
Allerfrim	Pseudoephedrine/Tr	Syrup	30-1.25	1	☐	☐	☐	☐	☐	☐	☐	☐
Allerfrim	Pseudoephedrine/Tr	Syrup	30-1.25	1	☐	☐	☐	☐	☐	☐	☐	☐
Genac	Pseudoephedrine/Tr	Tablet	60MG-2.	1	☐	☐	☐	☐	☐	☐	☐	☐
Genac	Pseudoephedrine/Tr	Tablet	60MG-2.	1	☐	☐	☐	☐	☐	☐	☐	☐
Genac	Pseudoephedrine/Tr	Tablet	60MG-2.	1	☐	☐	☐	☐	☐	☐	☐	☐
Genac	Pseudoephedrine/Tr	Tablet	60MG-2.	1	☐	☐	☐	☐	☐	☐	☐	☐
Genac	Pseudoephedrine/Tr	Tablet	60MG-2.	1	☐	☐	☐	☐	☐	☐	☐	☐
Genac	Pseudoephedrine/Tr	Tablet	60MG-2.	1	☐	☐	☐	☐	☐	☐	☐	☐

Genac	Pseudoephedrine/Tr	Tablet	60MG-2.	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	2Nd Gen Antihistamine & Decongestant				**CATEGORY**	Allergy							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Nucala	Mepolizumab	Vial	100 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: Poorly controlled, severe eosinophilic asthma with baseline serum eosinophil counts of either ≥ 150 cells/µL at initiation of treatment or ≥ 300 cells/µL in the past 12 months; AND 2 or more exacerbations i

DRUG CLASS:	2Nd Gen Antihistamine & Decongestant Combinati				**CATEGORY**	Allergy							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	

All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
All Day Allergy-D	Cetirizine Hcl/Pseud	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
Allegra-D 12 Hour	Fexofenadine/Pseudoephedrine	Tab Er 12H	60MG-120MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra-D 24 Hour	Fexofenadine/Pseudoephedrine	Tab Er 24H	180-240MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra-D 24 Hour	Fexofenadine/Pseudoephedrine	Tab Er 24H	180-240MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra-D 24 Hour	Fexofenadine/Pseudoephedrine	Tab Er 24H	180-240MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allergy & Congestio	Loratadine/Pseudoe	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐	

Allergy & Congestio	Loratadine/Pseudoe	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy & Congestio	Loratadine/Pseudoe	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy & Congestio	Loratadine/Pseudoe	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy & Congestio	Loratadine/Pseudoe	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy & Congestio	Loratadine/Pseudoe	Tab Er 12H	5 MG-12	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy-Congestion	Loratadine/Pseudoe	Tab Er 24H	10MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐

DRUG CLASS: Adrenergic Agents,Catecholamines					CATEGORY Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Epinephrine	Epinephrine	Ampul	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adrenalin Chloride	Epinephrine	Vial	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Antihistamines - 1St Generation					CATEGORY Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ed Chlorped Jr	Chlorpheniramine M	Syrup	2 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Chlor-Trimeton	Chlorpheniramine M	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Chlor-Trimeton Alle	Chlorpheniramine M	Tablet Er	12 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Chlor-Trimeton Alle	Chlorpheniramine M	Tablet Er	12 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Clemastine Fumarat	Clemastine Fumarat	Tablet	2.68 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Cyproheptadine Hcl	Cyproheptadine Hcl	Syrup	4 MG/1	1	☐	☐	☐	☐	☐	☐	☐	☐
Cyproheptadine Hcl	Cyproheptadine Hcl	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

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Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diphenhydramine H	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diphenhydramine H	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diphenhydramine H	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diphenhydramine H	Diphenhydramine H	Elixir	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diphenhydramine H	Diphenhydramine H	Elixir	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diphenhydramine H	Diphenhydramine H	Elixir	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diphenhydramine H	Diphenhydramine H	Elixir	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐

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Benadryl Allergy	Diphenhydramine H	Liquid	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Quenalin	Diphenhydramine H	Syrup	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Quenalin	Diphenhydramine H	Syrup	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Quenalin	Diphenhydramine H	Syrup	12.5MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl	Diphenhydramine H	Tab Chew	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Allergy R	Diphenhydramine H	Tab Rapdis	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Benadryl Allergy	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diphenhist	Diphenhydramine H	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diphenhydramine H	Diphenhydramine H	Vial	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydroxyzine Hcl	Hydroxyzine Hcl	Syrup	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydroxyzine Hcl	Hydroxyzine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydroxyzine Hcl	Hydroxyzine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydroxyzine Hcl	Hydroxyzine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydroxyzine Pamoa	Hydroxyzine Pamoat	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vistaril	Hydroxyzine Pamoat	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vistaril	Hydroxyzine Pamoat	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Promethazine Hcl	Promethazine Hcl	Syrup	6.25MG /5ML	1	☐	☐	☐	☑	☑	☐	☐	☐	Restricted to patients ≥2 years of age. For ages 2 to 6, limited to 1 fill per 365 days.
Promethazine Hcl	Promethazine Hcl	Tablet	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Promethazine Hcl	Promethazine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Promethazine Hcl	Promethazine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Antihistamines - 2Nd Generation				**CATEGORY** Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zyrtec	Cetirizine Hcl	Solution	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aller-Tec	Cetirizine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Aller-Tec	Cetirizine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aller-Tec	Cetirizine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aller-Tec	Cetirizine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aller-Tec	Cetirizine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aller-Tec	Cetirizine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cetirizine Hcl	Cetirizine Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Allegra	Fexofenadine Hcl	Oral Susp	30 MG/5 ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra Odt	Fexofenadine Hcl	Tab Rapdis	30 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra Odt	Fexofenadine Hcl	Tab Rapdis	30 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra	Fexofenadine Hcl	Tablet	180 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.

Allegra	Fexofenadine Hcl	Tablet	180 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra	Fexofenadine Hcl	Tablet	180 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra	Fexofenadine Hcl	Tablet	180 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra	Fexofenadine Hcl	Tablet	180 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra	Fexofenadine Hcl	Tablet	60 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra	Fexofenadine Hcl	Tablet	60 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Allegra	Fexofenadine Hcl	Tablet	60 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.

Allegra	Fexofenadine Hcl	Tablet	60 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of both Loratadine and Cetirizine.
Wal-Itin	Loratadine	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Itin	Loratadine	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Itin	Loratadine	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Itin	Loratadine	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist Nd	Loratadine	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist Nd	Loratadine	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist Nd	Loratadine	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist Nd	Loratadine	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist Nd	Loratadine	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Histamine H2-Receptor Inhibitors				**CATEGORY** Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Heartburn Relief	Cimetidine	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heartburn Relief	Cimetidine	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Heartburn Relief	Cimetidine	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heartburn Relief	Cimetidine	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cimetidine	Cimetidine	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cimetidine	Cimetidine	Tablet	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cimetidine	Cimetidine	Tablet	800 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cimetidine	Cimetidine Hcl	Solution	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pepcid	Famotidine	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pepcid	Famotidine	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pepcid	Famotidine	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pepcid	Famotidine	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pepcid	Famotidine	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pepcid	Famotidine	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zantac	Ranitidine Hcl	Capsule	150 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who have tried and failed treatment with Ranitidine tablets.

Ranitidine Hcl	Ranitidine Hcl	Capsule	300 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who have tried and failed treatment with Ranitidine tablets.
Ranitidine Hcl	Ranitidine Hcl	Syrup	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ranitidine Hcl	Ranitidine Hcl	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acid Reducer	Ranitidine Hcl	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Nasal Antihistamine					**CATEGORY** Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Astelin	Azelastine Hcl	Spray/Pump	137 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	Step therapy to failure of an adequate trial of fluticasone or flunisolide nasal spray.

DRUG CLASS: Nasal Anti-Inflammatory Steroids					**CATEGORY** Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Rhinocort Aqua	Budesonide	Spray/Pump	32MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Flunisolide	Flunisolide	Spray	25 MCG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to an adequate trial (7-14 days) of any 2 (two) first-line agents (fluticasone, budesonide, triamcinolone).
Flonase	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nasonex	Mometasone Furoate	Spray/Pump	50 MCG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to an adequate trial (7-14 days) of any 2 (two) first-line agents (fluticasone, budesonide, triamcinolone) AND flunisolide.

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Nasacort OTC	Triamcinolone Aceto	Spray	55 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐		
DRUG CLASS:	Nasal Mast Cell Stabilizers Agents				**CATEGORY**	Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Nasalcrom	Cromolyn Sodium	Spray/Pump	5.2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐		
Nasalcrom	Cromolyn Sodium	Spray/Pump	5.2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐		
DRUG CLASS:	Nose Preparations, Vasoconstrictors (Rx)				**CATEGORY**	Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Adrenalin Chloride	Epinephrine Hcl	Solution	0.73611	1	☐	☐	☐	☐	☐	☐	☐	☐		
DRUG CLASS:	Nose Preparations, Vasoconstrictors(Otc)				**CATEGORY**	Allergy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Afrin	Oxymetazoline Hcl	Spray	0.0005	1	☐	☐	☐	☐	☐	☐	☐	☐		
Little Noses	Phenylephrine Hcl	Drops	0.00125	1	☐	☐	☐	☐	☐	☐	☐	☐		
Neo-Synephrine	Phenylephrine Hcl	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐		
Neo-Synephrine	Phenylephrine Hcl	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐		
Neo-Synephrine	Phenylephrine Hcl	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐		
Neo-Synephrine	Phenylephrine Hcl	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐		

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Neo-Synephrine	Phenylephrine Hcl	Spray	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐
Neo-Synephrine	Phenylephrine Hcl	Spray	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐
Neo-Synephrine	Phenylephrine Hcl	Spray	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Neo-Synephrine	Phenylephrine Hcl	Spray	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Neo-Synephrine	Phenylephrine Hcl	Spray	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Neo-Synephrine	Phenylephrine Hcl	Spray	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Anethetics Local Topical

DRUG CLASS: Topical Local Anesthetics					CATEGORY Anethetics Local Topical								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Lidocaine	Lidocaine	Cream (G)	4 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Anecream	Lidocaine	Cream (G)	4 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lc-4	Lidocaine	Cream (G)	4 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lmx 4	Lidocaine	Cream (G)	4 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cidaleaze	Lidocaine Hcl	Cream (G)	3 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lidopin	Lidocaine Hcl	Cream (G)	3 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lidocaine Hcl	Lidocaine Hcl	Cream (G)	3 %	1	☐	☐	☐	☐	☐	☐	☐	☐	

THERAPEUTIC CATEGORY
Anticoagulants

DRUG CLASS: HEPARIN AND RELATED PREPARATIONS					CATEGORY Anticoagulants								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Heparin Flush	Heparin Sodium,Por	SYRINGE	500/5 M	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Platelet Aggregation Inhibitors					CATEGORY Anticoagulants								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Brilinta	Ticagrelor	Tablet	60 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Pa Required. Reserved For Patients Post 12 Months Of Dual Oral Antiplatelet Therapy With Clopidogrel, Ticagrelor, Or Prasugrel.

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THERAPEUTIC CATEGORY
Anticonvulsants

DRUG CLASS: ANTICONVULSANTS					CATEGORY Anticonvulsants								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Diazepam	Diazepam	KIT	12.5-15-20	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 kit per 30 days.
Diazepam	Diazepam	KIT	2.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 kit per 30 days.
Diazepam	Diazepam	KIT	5-7.5-10MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 kit per 30 days.
Sabril	Vigabatrin	Powd Pack	500 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. RESTRICTED TO USE BY NEUROLOGISTS ONLY. See See HPSJ Epilepsy coverage policy for more details.
Sabril	Vigabatrin	Tablet	500 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. RESTRICTED TO USE BY NEUROLOGISTS ONLY. See See HPSJ Epilepsy coverage policy for more details.

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THERAPEUTIC CATEGORY
Antidotes

DRUG CLASS: Metallic Poison,Agents To Treat					CATEGORY Antidotes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Chemet	Succimer	Capsule	100 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Antineoplastics

DRUG CLASS: Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Antineoplastics PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Tecentriq	Atezolizumab	Vial	1200 Mg/20	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Bavencio	Avelumab	Vial	200Mg/ 10Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Cotellic	Cobimetinib Fumarate	Tablet	20 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Imfinzi	Durvalumab	Vial	120 Mg/2.4	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Imfinzi	Durvalumab	Vial	500Mg/ 10Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Mekinist	Trametinib Dimethyl Sulfoxide	Tablet	0.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Mekinist	Trametinib Dimethyl Sulfoxide	Tablet	2 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS:	Antibiotic Antineoplastics				**CATEGORY**	Antineoplastics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Bleomycin Sulfate	Bleomycin Sulfate	Vial	15 Unit	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Bleomycin Sulfate	Bleomycin Sulfate	Vial	30 Unit	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dactinomycin	Dactinomycin	Vial	0.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Cosmegen	Dactinomycin	Vial	0.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Daunorubicin Hcl	Daunorubicin Hcl	Vial	20 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Daunorubicin Hcl	Daunorubicin Hcl	Vial	5 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Daunorubicin Hcl	Daunorubicin Hcl	Vial	5 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Doxorubicin Hcl	Doxorubicin Hcl	Vial	10 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Adriamycin	Doxorubicin Hcl	Vial	10 Mg/5 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Adriamycin	Doxorubicin Hcl	Vial	2 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Doxorubicin Hcl	Doxorubicin Hcl	Vial	2 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Adriamycin	Doxorubicin Hcl	Vial	20 Mg/10Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Doxorubicin Hcl	Doxorubicin Hcl	Vial	50 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Adriamycin	Doxorubicin Hcl	Vial	50 Mg/25Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Lipodox	Doxorubicin Hcl Peg-Liposomal	Vial	2 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Doxil	Doxorubicin Hcl Peg-Liposomal	Vial	2 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Lipodox 50	Doxorubicin Hcl Peg-Liposomal	Vial	2 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Epirubicin Hcl	Epirubicin Hcl	Vial	200 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Ellence	Epirubicin Hcl	Vial	200Mg/ 0.1L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Epirubicin Hcl	Epirubicin Hcl	Vial	50 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Ellence	Epirubicin Hcl	Vial	50 Mg/25Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Idamycin Pfs	Idarubicin Hcl	Vial	1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Idarubicin Hcl	Idarubicin Hcl	Vial	1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Idarubicin Hcl	Idarubicin Hcl	Vial	1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Idarubicin Hcl	Idarubicin Hcl	Vial	1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Mitomycin-Sterile Water	Mitomycin	Syringe	20 Mg/40Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Mutamycin	Mitomycin	Vial	20 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Mutamycin	Mitomycin	Vial	40 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Mutamycin	Mitomycin	Vial	5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Zanosar	Streptozocin	Vial	1 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Valstar	Valrubicin	Vial	40 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
DRUG CLASS:	Antineoplast Egf Receptor Blocker Rcmb Mc Antib				**CATEGORY**	Antineoplastics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Erbitux	Cetuximab	Vial	100Mg/ 50Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

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Erbitux	Cetuximab	Vial	200Mg/ 0.1L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Portrazza	Necitumumab	Vial	800Mg/ 50Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Vectibix	Panitumumab	Vial	100 Mg/5Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Vectibix	Panitumumab	Vial	400Mg/ 20Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Perjeta	Pertuzumab	Vial	420Mg/ 14Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Herceptin	Trastuzumab	Vial	150 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Herceptin	Trastuzumab	Vial	440 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
DRUG CLASS:	Antineoplast Hum Vegf Inhibitor Recomb Mc Anti				**CATEGORY**	Antineoplastics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Avastin	Bevacizumab	Vial	25 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

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Avastin	Bevacizumab	Vial	25 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
DRUG CLASS:	Antineoplastic - Epothilones And Analogs				**CATEGORY**	Antineoplastics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ixempra	Ixabepilone	Vial	15 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

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Ixempra	Ixabepilone	Vial	45 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
DRUG CLASS:	Antineoplastic - Topoisomerase I Inhibitors				**CATEGORY**	Antineoplastics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Camptosar	Irinotecan Hcl	Vial	100 Mg/5Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

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Camptosar	Irinotecan Hcl	Vial	300Mg/ 15Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Camptosar	Irinotecan Hcl	Vial	40 Mg/2 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Irinotecan Hcl	Irinotecan Hcl	Vial	500Mg/ 25Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Onivyde	Irinotecan Liposomal	Vial	43 Mg/10Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Hycamtin	Topotecan Hcl	Capsule	0.25 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Hycamtin	Topotecan Hcl	Capsule	1 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Hycamtin	Topotecan Hcl	Vial	4 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Topotecan Hcl	Topotecan Hcl	Vial	4 Mg/4 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS:	Antineoplastics,Miscellaneous				**CATEGORY**	Antineoplastics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Erwinaze	Asparaginase (Erwinia Chrysan)	Vial	10000 Unit	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. Restricted To Specialty Pharmacy

DRUG CLASS:	Selective Retinoid X Receptor Agonists (Rxr)				**CATEGORY** Antineoplastics								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Targretin	Bexarotene	Capsule	75 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Bexarotene	Bexarotene	Capsule	75 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
DRUG CLASS:	Vinca Alkaloids				**CATEGORY**	Antineoplastics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Vinblastine Sulfate	Vinblastine Sulfate	Vial	1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Vincasar Pfs	Vincristine Sulfate	Vial	1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Vincasar Pfs	Vincristine Sulfate	Vial	2 Mg/2 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Marqibo	Vincristine Sulfate Liposomal	Kit	Fnl 5Mg/31	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Navelbine	Vinorelbine Tartrate	Vial	10 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Navelbine	Vinorelbine Tartrate	Vial	50 Mg/5 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

THERAPEUTIC CATEGORY
Antiobesity Prep, All Oth

DRUG CLASS: Fat Absorption Decreasing Agents					CATEGORY Antiobesity Prep, All Oth								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Alli	Orlistat	Capsule	60 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for individuals who have received exercise and dietary counseling at least twice by a registered dietitian AND one of the following: [1] BMI of ≥ 27 with 2 or more comorbidities OR [2] BMI > 30.

THERAPEUTIC CATEGORY
Antiparasitics

DRUG CLASS: Topical Antiparasitics					CATEGORY Antiparasitics								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Nix	Permethrin	Liquid	1 %	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Antiparkinson

DRUG CLASS:	Antiparkinsonism Drugs,Other				CATEGORY	Antiparkinson							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Comtan	Entacapone	Tablet	200 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

THERAPEUTIC CATEGORY
Antispasmodics-Anticholig

DRUG CLASS:	Urinary Tract Antispasmodic/Antiincontinence Ag				CATEGORY	Antispasmodics-Anticholig							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Trospium Chloride	Trospium Chloride	Tablet	20 Mg	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of or intolerance to Oxybutynin IR/ER in the past 365 days.

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THERAPEUTIC CATEGORY
Anti-Ulcer Preps/Gastrointestinal Preps

DRUG CLASS: Histamine H2-Receptor Inhibitors					CATEGORY Anti-Ulcer Preps/Gastrointestinal Preps								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Famotidine	Famotidine	Vial	10 Mg/Ml	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to a 7 day supply fill at at time.
Famotidine	Famotidine	Vial	10 Mg/Ml	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to a 7 day supply fill at at time.
Famotidine	Famotidine	Vial	10 Mg/Ml	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to a 7 day supply fill at at time.
Famotidine	Famotidine	Vial	10 Mg/Ml	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to a 7 day supply fill at at time.
DRUG CLASS: Brand Name	Proton-Pump Inhibitors **Generic Name**	**Formulation**	**Strength**	**Tier**	CATEGORY Anti-Ulcer Preps/Gastrointestinal Preps **PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Prilosec	Omeprazole Magnesium	Suspdr Pkt	10 Mg	1	☐	☑	☑	☐	☑	☐	☐	☐	Step therapy to ranitidine syrup for children <6 years old.
Prilosec	Omeprazole Magnesium	Suspdr Pkt	2.5 Mg	1	☐	☑	☑	☐	☑	☐	☐	☐	Step therapy to ranitidine syrup for children <6 years old.

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THERAPEUTIC CATEGORY
Antivirals

DRUG CLASS: Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Antivirals PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Zepatier	Elbasvir/Grazoprevir	Tablet	50Mg-100Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. This medication is restricted to Diplomat Specialty Pharmacy. Please see the Hepatitis C Coverage Policy for preferred regimens.
Mavyret	Glecaprevir/Pibrentasvir	Tablet	100Mg-40Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. This medication is restricted to Diplomat Specialty Pharmacy. Please see the Hepatitis C Coverage Policy for preferred regimens. The AASLD guidelines were updated on 9/21/17.

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Vosevi	Sofosbuvir/Velpatas /Voxilaprev	Tablet	400-100 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. This medication is restricted to Diplomat Specialty Pharmacy. Please see the Hepatitis C Coverage Policy for preferred regimens. The AASLD guidelines were updated on 9/21/17.

DRUG CLASS:	Antivirals, General				**CATEGORY** Antivirals								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Xofluza	Baloxavir Marboxil	Tablet	20 Mg	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients who meet all of the following criteria: [a] 12 years of age or older;[b] Treatment of acute, uncomplicated influenza (defined as patient's with influenza who can be treated outpatient and do not require hospitalization)

Xofluza	Baloxavir Marboxil	Tablet	40 Mg	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients who meet all of the following criteria: [a] 12 years of age or older;[b] Treatment of acute, uncomplicated influenza (defined as patient's with influenza who can be treated outpatient and do not require hospitalization)
DRUG CLASS:	Hepatitis C Treatment Agents				**CATEGORY** Antivirals								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Viekira Xr	Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir	Tab Bp 24H	8.33-50 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. This medication is restricted to Diplomat Specialty Pharmacy. Please see the Hepatitis C Coverage Policy for preferred regimens.

Epclusa	Sofosbuvir/Velpatasvir	Tablet	400-100Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. This medication is restricted to Diplomat Specialty Pharmacy. Please see the Hepatitis C Coverage Policy for preferred regimens.

THERAPEUTIC CATEGORY
Biologicals

DRUG CLASS: - / Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Biologicals PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Zinplava	Bezlotoxumab	Vial	1000 MG/40	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients with positive C. difficile toxin presence who are currently receiving standard of care for C. difficile and are at high risk of C. difficile infection recurrence.

DRUG CLASS: Gram Negative Cocci Vaccines / Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Biologicals PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Menveo A-C-Y-W-135-Dip	Mening Vac A,C,Y,W-135 Dip/Pf	Kit	10-5/0.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Menactra	Mening Vac A,C,Y,W-135 Dip/Pf	Vial	4Mcg/0.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

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Menomune-A-C-Y-W-135	Meningococ Vac A,C,Y,W-135/Pf	Vial	50 Mcg	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Menomune-A-C-Y-W-135	Meningococ Vac A,C,Y,W-135/Pf	Vial	50 Mcg	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Bexsero	Meningococcal B Vacc,4-Comp/Pf	Syringe	50-50/0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Menomune-A-C-Y-W-135	Meningococcal Vac A,C,Y,W-135	Vial	50 Mcg	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Menomune-A-C-Y-W-135	Meningococcal Vac A,C,Y,W-135	Vial	50 Mcg	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

Trumenba	N.Meningitidis B,Lipid Fhbp Rc	Syringe	120Mcg /0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
DRUG CLASS: Gram Positive Cocci Vaccines					**CATEGORY** Biologicals								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Prevnar 13	Pneumoc 13-Val Conj-Dip Crm/Pf	Syringe	0.5 Ml	1	☐	☐	☐	☑	☐	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Pneumovax 23	Pneumococcal 23-Val P-Sac Vac	Syringe	25Mcg/ 0.5	1	☐	☐	☐	☑	☐	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Pneumovax 23	Pneumococcal 23-Val P-Sac Vac	Vial	25Mcg/ 0.5	1	☐	☐	☐	☑	☐	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
DRUG CLASS: Influenza Virus Vaccines					**CATEGORY** Biologicals								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Flucelvax Quad 2017-2018	Flu Vac Qs 17-18 (4Yr Up) Cell	Vial	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Flucelvax Quad 2017-2018	Flu Vac Qs 17-18(4Yr Up)Cel/Pf	Syringe	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Flublok Quad 2017-2018	Flu Vac Qv 2017(18Yr Up)Rcm/Pf	Syringe	180Mcg/0.5	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Fluvirin 2017-2018	Flu Vac Ts 2017-18(4 Yr Up)/Pf	Syringe	45Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Flublok 2017-2018	Flu Vac Tv 2017(18Yr Up)Rcm/Pf	Vial	135Mcg/0.5	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.

Fluzone Intraderm Quad 2017-18	Flu Vacc Qs 2017 (18-64Yrs)/Pf	Syringe	36Mcg/.1Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Fluzone Quad Pedi 2017-2018	Flu Vacc Qs 2017 (6-35Mos)/Pf	Syringe	30Mcg/0.25	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Fluzone Quad 2017-2018	Flu Vacc Qs2017-18 36Mos Up/Pf	Syringe	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Fluzone Quad 2017-2018	Flu Vacc Qs2017-18 36Mos Up/Pf	Vial	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Flulaval Quad 2017-2018	Flu Vacc Qs2017-18(6Mos Up)/Pf	Syringe	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.

Fluarix Quad 2017-2018	Flu Vacc Qs2017-18(6Mos Up)/Pf	Syringe	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Afluria Quad 2017-2018	Flu Vacc Quad 2017(5 Yr Up)/Pf	Syringe	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Afluria Quad 2017-2018	Flu Vacc Quad 2017-18(5 Yr Up)	Vial	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Flulaval Quad 2017-2018	Flu Vacc Quad 2017-18(6Mos Up)	Vial	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Fluzone Quad 2017-2018	Flu Vacc Quad 2017-18(6Mos Up)	Vial	60Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.

Flumist Quad 2017-2018	Flu Vacc Qv Live 2017(2-49Yrs)	Nas Sp Syr	10E6.5-7.5	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Fluad 2017-2018	Flu Vacc Ts2017(65Up)/Mf59 C/Pf	Syringe	45Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Fluzone High-Dose 2017-2018	Flu Vacc Ts2017-18(65Yr Up)/Pf	Syringe	180Mcg /0.5	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Afluria 2017-2018	Flu Vaccin Ts2017-18 5Yr Up/Pf	Syringe	45Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.
Fluvirin 2017-2018	Flu Vaccine Ts2017-18(4 Yr Up)	Vial	45Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.

Afluria 2017-2018	Flu Vaccine Ts2017-18(5 Yr Up)	Vial	45Mcg/.5Ml	1	☐	☐	☐	☐	☑	☐	☐	☐	Anyone Under The Age Of 19 Can Only Obtain This Vaccine At A Vaccines For Children (Vfc) Facility.

DRUG CLASS: Neurotoxic Virus Vaccines					**CATEGORY** Biologicals								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Imovax Rabies Vaccine	Rabies Vacc, Human Diploid/Pf	Vial	2.5 Unit	1	☑	☐	☐	☐	☐	☐	☐	☐	Prior Authorization Required.
Rabavert	Rabies Vaccine (Pcec)/Pf	Vial	2.5 Unit	1	☑	☐	☐	☐	☐	☐	☐	☐	Prior Authorization Required.

DRUG CLASS: Vaccine/Toxoid Preparations,Combinations					**CATEGORY** Biologicals								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Adacel Tdap	Diph,Pertuss(Acell), Tet Vac/Pf	Syringe	2-2.5-5/.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Adacel Tdap	Diph,Pertuss(Acell), Tet Vac/Pf	Vial	2-2.5-5/.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

Boostrix Tdap	Diphth,Pertuss(Acell),Tet Vac	Syringe	2.5-8-5/.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Boostrix Tdap	Diphth,Pertuss(Acell),Tet Vac	Vial	2.5-8-5/.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Acthib	Haemoph B Poly Conj-Tet Tox/Pf	Vial	10 Mcg/0.5	1	☑	☐	☐	☐	☐	☐	☐	☐	Prior Authorization required.
Hiberix	Haemoph B Poly Conj-Tet Tox/Pf	Vial	10 Mcg/0.5	1	☑	☐	☐	☐	☐	☐	☐	☐	Prior Authorization required.
Acthib	Haemoph B Poly Conj-Tet Tox/Pf	Vial	10 Mcg/0.5	1	☑	☐	☐	☐	☐	☐	☐	☐	Prior Authorization required.
Pedvaxhib	Haemph B Polysac Conj-Menin/Pf	Vial	7.5Mcg/0.5	1	☑	☐	☐	☐	☐	☐	☐	☐	Prior Authorization required.
M-M-R Ii Vaccine	Measles,Mumps,Rubella Vacc/Pf	Vial	12500/0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

Tenivac	Tetanus And Diphtheria Tox/Pf	Syringe	5-2/0.5Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Tenivac	Tetanus And Diphtheria Tox/Pf	Vial	5-2/0.5Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Tetanus Diphtheria Toxoids	Tetanus, Diphtheria Tox,Adult	Vial	2-2 Lf/0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
DRUG CLASS:	Viral/Tumorigenic Vaccines				**CATEGORY**			Biologicals					
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Twinrix	Hepatitis A And B Vaccine/Pf	Syringe	720-20/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Twinrix	Hepatitis A And B Vaccine/Pf	Vial	720-20/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

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Havrix	Hepatitis A Virus Vaccine/Pf	Syringe	1440/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Vaqta	Hepatitis A Virus Vaccine/Pf	Syringe	25/0.5Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Vaqta	Hepatitis A Virus Vaccine/Pf	Syringe	50 Unit/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Havrix	Hepatitis A Virus Vaccine/Pf	Syringe	720/0.5 Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Havrix	Hepatitis A Virus Vaccine/Pf	Vial	1440/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

Vaqta	Hepatitis A Virus Vaccine/Pf	Vial	25/0.5Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Vaqta	Hepatitis A Virus Vaccine/Pf	Vial	50 Unit/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Havrix	Hepatitis A Virus Vaccine/Pf	Vial	720/0.5 Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Heplisav-B	Hepatitis B Vaccine/	Syringe	20 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heplisav-B	Hepatitis B Vaccine/	Vial	20 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Engerix-B Pediatric-Adolescent	Hepatitis B Virus Vaccine/Pf	Syringe	10 Mcg/0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

Recombivax Hb	Hepatitis B Virus Vaccine/Pf	Syringe	10 Mcg/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Engerix-B Adult	Hepatitis B Virus Vaccine/Pf	Syringe	20 Mcg/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Recombivax Hb	Hepatitis B Virus Vaccine/Pf	Syringe	5Mcg/0.5Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Engerix-B Pediatric-Adolescent	Hepatitis B Virus Vaccine/Pf	Vial	10 Mcg/0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Recombivax Hb	Hepatitis B Virus Vaccine/Pf	Vial	10 Mcg/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

Engerix-B Adult	Hepatitis B Virus Vaccine/Pf	Vial	20 Mcg/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Recombivax Hb	Hepatitis B Virus Vaccine/Pf	Vial	40 Mcg/Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Recombivax Hb	Hepatitis B Virus Vaccine/Pf	Vial	5Mcg/0.5Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Gardasil 9	Hpv Vaccine 9-Valent/Pf	Syringe	0.5 Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Gardasil 9	Hpv Vaccine 9-Valent/Pf	Vial	0.5 Ml	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.

Cervarix	Human Papillomav Vacc Bival/Pf	Syringe	20-20/0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Gardasil	Human Papilomvirus Vac,Qval/Pf	Syringe	20-40/0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Gardasil	Human Papilomvirus Vac,Qval/Pf	Vial	20-40/0.5	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Varivax Vaccine	Varicella Vaccine Live/Pf	Vial	1350 Unit	1	☐	☐	☐	☑	☑	☐	☐	☐	Anyone under the age of 19 can only obtain that vaccine at a Vaccines for Children (VFC) facility.
Shingrix	Varicella-Zoster Ge/As01B/Pf	KIT	50 MCG/0.	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to patients ≥50 years of age.
Zostavax	Zoster Vaccine Live/Pf	Vial	19400 Unit	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to patients ≥50 years of age.

THERAPEUTIC CATEGORY
Bronchial Dilators

DRUG CLASS: -ADRENERGIC AND GLUCOCORTICOID COMBO, IN					CATEGORY Bronchial Dilators								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Airduo Respiclick	Fluticasone/Salmeterol	AER POW BA	113-14 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 inhaler per 30 days.
Airduo Respiclick	Fluticasone/Salmeterol	AER POW BA	232-14 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 inhaler per 30 days.
Airduo Respiclick	Fluticasone/Salmeterol	AER POW BA	55-14 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 inhaler per 30 days.
DRUG CLASS: Brand Name	Cholinergics, Orally Inhaled Long Acting **Generic Name**	**Formulation**	**Strength**	**Tier**	CATEGORY Bronchial Dilators **PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Spiriva Respimat	Tiotropium Bromide	Mist Inhal	1.25 Mcg	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy To Montelukast 10Mg And One Of The Following: Symbicort 160-4.5, AirDuo Respiclick 232/14, Or Dulera 200/5 Within The Last 30 Days

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THERAPEUTIC CATEGORY
Cardiology, Anticoagulation

DRUG CLASS: Brand Name	Direct Factor Xa Inhibitors Generic Name	Formulation	Strength	Tier	CATEGORY Cardiology, Anticoagulation PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Eliquis	Apixaban	Tablet	2.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 70 tablets per 365 days.
Eliquis	Apixaban	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 74 tablets per month.
Xarelto	Rivaroxaban	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 35 tablets per 365 days.
Xarelto	Rivaroxaban	Tablet	15 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 42 tablets per three months.
Xarelto	Rivaroxaban	Tablet	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 30 tablets per month.

DRUG CLASS: Brand Name	Heparin And Related Preparations Generic Name	Formulation	Strength	Tier	CATEGORY Cardiology, Anticoagulation PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)

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Lovenox	Enoxaparin Sodium	Syringe	100 MG/ML	1	☐	☐	☑	☑	☐	☐	☐	☐	No PA is required if <= 10 days supply as bridge therapy. Maximum of 2 syringes per day, 3 courses per 180 days. For longer duration, please fax prior auth to HPSJ at (209)942-6302
Lovenox	Enoxaparin Sodium	Syringe	120MG/ .8ML	1	☐	☐	☑	☑	☐	☐	☐	☐	No PA is required if <= 10 days supply as bridge therapy. Maximum of 2 syringes per day, 3 courses per 180 days. For longer duration, please fax prior auth to HPSJ at (209)942-6302
Lovenox	Enoxaparin Sodium	Syringe	150 MG/ML	1	☐	☐	☑	☑	☐	☐	☐	☐	No PA is required if <= 10 days supply as bridge therapy. Maximum of 2 syringes per day, 3 courses per 180 days. For longer duration, please fax prior auth to HPSJ at (209)942-6302

Lovenox	Enoxaparin Sodium	Syringe	30MG/0.3ML	1	☐	☐	☑	☑	☐	☐	☐	☐	No PA is required if <= 10 days supply as bridge therapy. Maximum of 2 syringes per day, 3 courses per 180 days. For longer duration, please fax prior auth to HPSJ at (209)942-6302
Lovenox	Enoxaparin Sodium	Syringe	40MG/0.4ML	1	☐	☐	☑	☑	☐	☐	☐	☐	No PA is required if <= 10 days supply as bridge therapy. Maximum of 2 syringes per day, 3 courses per 180 days. For longer duration, please fax prior auth to HPSJ at (209)942-6302
Lovenox	Enoxaparin Sodium	Syringe	60MG/0.6ML	1	☐	☐	☑	☑	☐	☐	☐	☐	No PA is required if <= 10 days supply as bridge therapy. Maximum of 2 syringes per day, 3 courses per 180 days. For longer duration, please fax prior auth to HPSJ at (209)942-6302

Lovenox	Enoxaparin Sodium	Syringe	80MG/0.8ML	1	☐	☐	☑	☑	☐	☐	☐	☐	No PA is required if <= 10 days supply as bridge therapy. Maximum of 2 syringes per day, 3 courses per 180 days. For longer duration, please fax prior auth to HPSJ at (209)942-6302
Heparin Flush	Heparin Sod,Porcine	Kit	10 UNIT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Lock	Heparin Sodium,Por	Syringe	10 UNIT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Lock	Heparin Sodium,Por	Syringe	10 UNIT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Lock	Heparin Sodium,Por	Syringe	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Lock	Heparin Sodium,Por	Vial	10 UNIT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Lock	Heparin Sodium,Por	Vial	10 UNIT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Lock	Heparin Sodium,Por	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Lock	Heparin Sodium,Por	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Sodium	Heparin Sodium,Por	Vial	1000/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Sodium	Heparin Sodium,Por	Vial	10000/	1	☐	☐	☐	☐	☐	☐	☐	☐	

Heparin Sodium	Heparin Sodium,Por	Vial	20000/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Sodium	Heparin Sodium,Por	Vial	5000/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Flush	Heparin Sodium,Por	Syringe	10 UNIT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Flush	Heparin Sodium,Por	Syringe	10 UNIT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Flush	Heparin Sodium,Por	Syringe	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Heparin Flush	Heparin Sodium,Por	Syringe	200/2 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hep-Lock	Heparin Sodium,Por	Vial	10 UNIT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hep-Lock	Heparin Sodium,Por	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Oral Anticoagulants,Coumarin Type				**CATEGORY**	Cardiology, Anticoagulation							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Coumadin	Warfarin Sodium	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Coumadin	Warfarin Sodium	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Coumadin	Warfarin Sodium	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Coumadin	Warfarin Sodium	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Coumadin	Warfarin Sodium	Tablet	3 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Coumadin	Warfarin Sodium	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Coumadin	Warfarin Sodium	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Coumadin	Warfarin Sodium	Tablet	6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Coumadin	Warfarin Sodium	Tablet	7.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Platelet Aggregation Inhibitors				**CATEGORY**	Cardiology, Anticoagulation							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Aggrenox	Aspirin/Dipyridamole	Cpmp 12Hr	25MG-200MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Restricted to secondary CVA prevention.
Cilostazol	Cilostazol	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cilostazol	Cilostazol	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Clopidogrel	Clopidogrel Bisulfate	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dipyridamole	Dipyridamole	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dipyridamole	Dipyridamole	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dipyridamole	Dipyridamole	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Effient	Prasugrel Hcl	Tablet	10 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required. Reserved for patients status-post stent placement or medical management of ACS for patients intolerant of Clopidogrel or Ticagrelor, or who have concomitant Diabetes.
Effient	Prasugrel Hcl	Tablet	5 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required. For use in patients with weight <60 kg. Reserved for patients status-post stent placement or medical management of ACS for patients intolerant of Clopidogrel or Ticagrelor, or who have concomitant Diabetes.
Brilinta	Ticagrelor	Tablet	90 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tablets per month. Total concurrent Aspirin dose should not exceed 100 mg per day.

DRUG CLASS:	Thrombin Inhibitors,Selective,Direct, & Reversible				**CATEGORY**	Cardiology, Anticoagulation							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pradaxa	Dabigatran Etexilate Mesylate	Capsule	150 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 capsules per month.
DRUG CLASS:	Thrombolytic Enzymes				**CATEGORY**	Cardiology, Anticoagulation							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Activase	Alteplase	Vial	100 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Activase	Alteplase	Vial	50 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Thrombopoietin Receptor Agonists				**CATEGORY**	Cardiology, Anticoagulation							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Promacta	Eltrombopag Olamine	Tablet	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Promacta	Eltrombopag Olamine	Tablet	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Nplate	Romiplostim	Vial	250 MCG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Nplate	Romiplostim	Vial	500 MCG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

THERAPEUTIC CATEGORY
Cardiology, Hypertension

DRUG CLASS: Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
DRUG CLASS: Ace Inhibitor/Thiazide & Thiazide-Like Diuretic					**CATEGORY** Cardiology, Hypertension								
Lotensin Hct	Benazepril/Hydrochl	Tablet	10-12.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lotensin Hct	Benazepril/Hydrochl	Tablet	20-12.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lotensin Hct	Benazepril/Hydrochl	Tablet	20-25M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lotensin Hct	Benazepril/Hydrochl	Tablet	5-6.25M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Enalapril-Hydrochlo	Enalapril/Hydrochlo	Tablet	10 MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
Enalapril-Hydrochlo	Enalapril/Hydrochlo	Tablet	5MG-12.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prinzide	Lisinopril/Hydrochl	Tablet	10-12.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prinzide	Lisinopril/Hydrochl	Tablet	20-12.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lisinopril-Hctz	Lisinopril/Hydrochl	Tablet	20-25M	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Alpha/Beta-Adrenergic Blocking Agents					**CATEGORY** Cardiology, Hypertension								

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Coreg	Carvedilol	Tablet	12.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Coreg	Carvedilol	Tablet	25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 4 tablets per day.
Coreg	Carvedilol	Tablet	3.125 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Coreg	Carvedilol	Tablet	6.25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Labetalol Hcl	Labetalol Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Labetalol Hcl	Labetalol Hcl	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Labetalol Hcl	Labetalol Hcl	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Alpha-Adrenergic Blocking Agents				**CATEGORY** Cardiology, Hypertension								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cardura	Doxazosin Mesylate	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cardura	Doxazosin Mesylate	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cardura	Doxazosin Mesylate	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cardura	Doxazosin Mesylate	Tablet	8 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Minipress	Prazosin Hcl	Capsule	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Minipress	Prazosin Hcl	Capsule	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Minipress	Prazosin Hcl	Capsule	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Terazosin Hcl	Terazosin Hcl	Capsule	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Terazosin Hcl	Terazosin Hcl	Capsule	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hytrin	Terazosin Hcl	Capsule	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Terazosin Hcl	Terazosin Hcl	Capsule	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Angiotensin Receptr Antg./Thiazide & Related Co				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Hyzaar	Losartan/Hydrochlo	Tablet	100-12.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyzaar	Losartan/Hydrochlo	Tablet	100MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyzaar	Losartan/Hydrochlo	Tablet	50-12.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diovan Hct	Valsartan/Hydrochlorothiazide	Tablet	160-12.5MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).

Diovan Hct	Valsartan/Hydrochlorothiazide	Tablet	160-25MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).
Diovan Hct	Valsartan/Hydrochlorothiazide	Tablet	320-12.5MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).
Diovan Hct	Valsartan/Hydrochlorothiazide	Tablet	320MG-25MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).
Diovan Hct	Valsartan/Hydrochlorothiazide	Tablet	80-12.5MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).
DRUG CLASS:	Beta-Adrenergic Blocking Agents				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Atenolol	Atenolol	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Atenolol	Atenolol	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Atenolol	Atenolol	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Bisoprolol Fumarate	Bisoprolol Fumarate	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Bisoprolol Fumarate	Bisoprolol Fumarate	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Metoprolol Succinat	Metoprolol Succinate	Tab Er 24H	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Metoprolol Succinat	Metoprolol Succinate	Tab Er 24H	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Metoprolol Succinat	Metoprolol Succinate	Tab Er 24H	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Metoprolol Succinat	Metoprolol Succinate	Tab Er 24H	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lopressor	Metoprolol Tartrate	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Metoprolol Tartrate	Metoprolol Tartrate	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lopressor	Metoprolol Tartrate	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nadolol	Nadolol	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nadolol	Nadolol	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nadolol	Nadolol	Tablet	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Bystolic	Nebivolol Hcl	Tablet	10 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for intolerance or treatment failure of dose optimized metoprolol and carvedilol; restricted to 1 tablet per day
Bystolic	Nebivolol Hcl	Tablet	2.5 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for intolerance or treatment failure of dose optimized metoprolol and carvedilol; restricted to 1 tablet per day
Bystolic	Nebivolol Hcl	Tablet	20 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for intolerance or treatment failure of dose optimized metoprolol and carvedilol; restricted to 1 tablet per day
Bystolic	Nebivolol Hcl	Tablet	5 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for intolerance or treatment failure of dose optimized metoprolol and carvedilol; restricted to 1 tablet per day
Pindolol	Pindolol	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pindolol	Pindolol	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Innopran Xl	Propranolol Hcl	Cap Er 24H	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Innopran Xl	Propranolol Hcl	Cap Er 24H	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Inderal La	Propranolol Hcl	Cap Sa 24H	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Inderal La	Propranolol Hcl	Cap Sa 24H	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Propranolol Hcl	Propranolol Hcl	Cap Sa 24H	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Inderal La	Propranolol Hcl	Cap Sa 24H	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Propranolol Hcl	Propranolol Hcl	Solution	20 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Propranolol Hcl	Propranolol Hcl	Solution	40MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐
Propranolol Hcl	Propranolol Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Propranolol Hcl	Propranolol Hcl	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Propranolol Hcl	Propranolol Hcl	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Propranolol Hcl	Propranolol Hcl	Tablet	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Propranolol Hcl	Propranolol Hcl	Tablet	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Sotalol	Sotalol Hcl	Tablet	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Sotalol	Sotalol Hcl	Tablet	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Sotalol	Sotalol Hcl	Tablet	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sotalol	Sotalol Hcl	Tablet	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sotalol	Sotalol Hcl	Tablet	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sotalol	Sotalol Hcl	Tablet	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sotalol	Sotalol Hcl	Tablet	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sotalol	Sotalol Hcl	Tablet	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sotalol	Sotalol Hcl	Tablet	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sotalol	Sotalol Hcl	Tablet	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sotalol	Sotalol Hcl	Tablet	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Timolol Maleate	Timolol Maleate	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Timolol Maleate	Timolol Maleate	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Timolol Maleate	Timolol Maleate	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Beta-Adrenergic Blocking Agents/Thiazide & Rela				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Tenoretic 100	Atenolol/Chlorthalid	Tablet	100MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Tenoretic 50	Atenolol/Chlorthalid	Tablet	50 MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Calcium Channel Blocking Agents				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Amlodipine Besylate	Amlodipine Besylate	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Amlodipine Besylate	Amlodipine Besylate	Tablet	2.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Amlodipine Besylate	Amlodipine Besylate	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem 24Hr Er	Diltiazem Hcl	Cap Er 24H	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Cap Er Deg	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Cap Er Deg	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Cap Er Deg	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Cap Er Deg	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Cap Er Deg	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Cap Er Deg	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Cap Er Deg	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Cap Er Deg	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Diltiazem Er	Diltiazem Hcl	Capsule Er	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Er	Diltiazem Hcl	Capsule Er	420MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Hcl	Diltiazem Hcl	Tablet	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Hcl	Diltiazem Hcl	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Hcl	Diltiazem Hcl	Tablet	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Diltiazem Hcl	Diltiazem Hcl	Tablet	90 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Plendil	Felodipine	Tab Er 24H	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Plendil	Felodipine	Tab Er 24H	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Plendil	Felodipine	Tab Er 24H	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Procardia	Nifedipine	Capsule	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nifedipine	Nifedipine	Capsule	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Procardia Xl	Nifedipine	Tab Er 24	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Procardia Xl	Nifedipine	Tab Er 24	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Procardia Xl	Nifedipine	Tab Er 24	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Procardia Xl	Nifedipine	Tab Er 24	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Procardia Xl	Nifedipine	Tab Er 24	90 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Adalat Cc	Nifedipine	Tablet Er	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Adalat Cc	Nifedipine	Tablet Er	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Adalat Cc	Nifedipine	Tablet Er	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Adalat Cc	Nifedipine	Tablet Er	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Adalat Cc	Nifedipine	Tablet Er	90 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Adalat Cc	Nifedipine	Tablet Er	90 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Verelan Pm	Verapamil Hcl	Cap24H Pct	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Verelan Pm	Verapamil Hcl	Cap24H Pct	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Verelan Pm	Verapamil Hcl	Cap24H Pct	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Verelan	Verapamil Hcl	Cap24H Pel	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Verelan	Verapamil Hcl	Cap24H Pel	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Verelan	Verapamil Hcl	Cap24H Pel	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Verelan	Verapamil Hcl	Cap24H Pel	360 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calan	Verapamil Hcl	Tablet	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calan	Verapamil Hcl	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calan	Verapamil Hcl	Tablet	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calan Sr	Verapamil Hcl	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calan Sr	Verapamil Hcl	Tablet Er	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calan Sr	Verapamil Hcl	Tablet Er	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Hypotensives, Ace Inhibitors				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Lotensin	Benazepril Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lotensin	Benazepril Hcl	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lotensin	Benazepril Hcl	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lotensin	Benazepril Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Enalapril Maleate	Enalapril Maleate	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Enalapril Maleate	Enalapril Maleate	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Enalapril Maleate	Enalapril Maleate	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Enalapril Maleate	Enalapril Maleate	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prinivil	Lisinopril	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lisinopril	Lisinopril	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prinivil	Lisinopril	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lisinopril	Lisinopril	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lisinopril	Lisinopril	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prinivil	Lisinopril	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Accupril	Quinapril Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Accupril	Quinapril Hcl	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Accupril	Quinapril Hcl	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Accupril	Quinapril Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ramipril	Ramipril	Capsule	1.25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 capsule per day.
Ramipril	Ramipril	Capsule	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 capsules per day.
Ramipril	Ramipril	Capsule	2.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 capsule per day.
Ramipril	Ramipril	Capsule	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 capsule per day.

DRUG CLASS:	Hypotensives,Angiotensin Receptor Antagonist				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Avapro	Irbesartan	Tablet	150 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 30 tablets per 30 days.

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Avapro	Irbesartan	Tablet	300 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 30 tablets per 30 days.
Avapro	Irbesartan	Tablet	75 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 30 tablets per 30 days.
Cozaar	Losartan Potassium	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cozaar	Losartan Potassium	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cozaar	Losartan Potassium	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diovan	Valsartan	Tablet	160 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).
Diovan	Valsartan	Tablet	320 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).

Diovan	Valsartan	Tablet	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).
Diovan	Valsartan	Tablet	80 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Valsartan is reserved for heart failure patients intolerant of ACE inhbIItors (e.g., Lisinopril).
DRUG CLASS:	Hypotensives,Sympatholytic				**CATEGORY**		Cardiology, Hypertension						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Clonidine	Clonidine	Patch Tdwk	0.1MG/ 24HR	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to take medications by mouth. Limited to 4 patches per 28 days.
Clonidine	Clonidine	Patch Tdwk	0.2MG/ 24HR	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to take medications by mouth. Limited to 4 patches per 28 days.

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Clonidine	Clonidine	Patch Tdwk	0.3MG/ 24HR	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to take medications by mouth. Limited to 4 patches per 28 days.
Clonidine Hcl	Clonidine Hcl	Tablet	0.1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Clonidine Hcl	Clonidine Hcl	Tablet	0.2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Clonidine Hcl	Clonidine Hcl	Tablet	0.3 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Guanfacine Hcl	Guanfacine Hcl	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Guanfacine Hcl	Guanfacine Hcl	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methyldopa	Methyldopa	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methyldopa	Methyldopa	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methyldopa-Hydroc	Methyldopa/Hydroc	Tablet	250MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methyldopa-Hydroc	Methyldopa/Hydroc	Tablet	250MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Hypotensives,Vasodilators				**CATEGORY**		Cardiology, Hypertension						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Hydralazine Hcl	Hydralazine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Hydralazine Hcl	Hydralazine Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydralazine Hcl	Hydralazine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydralazine Hcl	Hydralazine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Minoxidil	Minoxidil	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Minoxidil	Minoxidil	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Potassium Sparing Diuretics				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Aldactone	Spironolactone	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aldactone	Spironolactone	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aldactone	Spironolactone	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dyrenium	Triamterene	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dyrenium	Triamterene	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Renin Inhibitor, Direct				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Tekturna	Aliskiren Hemifumarate	Tablet	150 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of at least 3 formulary antihypertensives, including a thiazide, ACE/ARB and beta-blocker/calcium channel blocker
Tekturna	Aliskiren Hemifumarate	Tablet	300 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of at least 3 formulary antihypertensives, including a thiazide, ACE/ARB and beta-blocker/calcium channel blocker
DRUG CLASS:	Thiazide And Related Diuretics				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Chlorthalidone	Chlorthalidone	Tablet	25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Chlorthalidone	Chlorthalidone	Tablet	50 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.

Hydrochlorothiazid	Hydrochlorothiazide	Capsule	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydrochlorothiazid	Hydrochlorothiazide	Tablet	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydrochlorothiazid	Hydrochlorothiazide	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydrochlorothiazid	Hydrochlorothiazide	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Metolazone	Metolazone	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Metolazone	Metolazone	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Metolazone	Metolazone	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Vasodilators,Coronary				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Isosorbide Dinitrate	Isosorbide Dinitrate	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isosorbide Dinitrate	Isosorbide Dinitrate	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isosorbide Dinitrate	Isosorbide Dinitrate	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isordil	Isosorbide Dinitrate	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isordil	Isosorbide Dinitrate	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isosorbide Dinitrate	Isosorbide Dinitrate	Tablet Er	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Imdur	Isosorbide Mononitr	Tab Er 24H	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Imdur	Isosorbide Mononitr	Tab Er 24H	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Imdur	Isosorbide Mononitr	Tab Er 24H	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Monoket	Isosorbide Mononitr	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Monoket	Isosorbide Mononitr	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Time	Nitroglycerin	Capsule Er	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Time	Nitroglycerin	Capsule Er	6.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Time	Nitroglycerin	Capsule Er	9 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Bid	Nitroglycerin	Oint. (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Dur	Nitroglycerin	Patch Td24	0.1MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Dur	Nitroglycerin	Patch Td24	0.2MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Dur	Nitroglycerin	Patch Td24	0.3 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Dur	Nitroglycerin	Patch Td24	0.4MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Dur	Nitroglycerin	Patch Td24	0.6MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Nitro-Dur	Nitroglycerin	Patch Td24	0.8MG/	1	☐	☐	☐	☐	☐	☐	☐	☐

Nitrostat	Nitroglycerin	Tab Subl	0.3 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nitrostat	Nitroglycerin	Tab Subl	0.4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nitrostat	Nitroglycerin	Tab Subl	0.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Vasodilators,Peripheral				**CATEGORY**	Cardiology, Hypertension							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ergoloid Mesylates	Ergoloid Mesylates	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Cardiology, Lipotropics

DRUG CLASS: Antihyperlip.Hmg Coa Reduct Inhib&Cholest.Ab.In **CATEGORY** Cardiology, Lipotropics

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Vytorin	Ezetimibe/Simvastatin	Tablet	10 MG-10MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for uncontrolled hyperlipidemia despite compliant use of (or intolerance to) dose optimized atorvastatin (Lipitor) and rosuvastatin (Crestor).
Vytorin	Ezetimibe/Simvastatin	Tablet	10 MG-20MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for uncontrolled hyperlipidemia despite compliant use of (or intolerance to) dose optimized atorvastatin (Lipitor) and rosuvastatin (Crestor).

Vytorin	Ezetimibe/Simvastatin	Tablet	10 MG-40MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for uncontrolled hyperlipidemia despite compliant use of (or intolerance to) dose optimized atorvastatin (Lipitor) and rosuvastatin (Crestor).
Vytorin	Ezetimibe/Simvastatin	Tablet	10 MG-80MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for uncontrolled hyperlipidemia despite compliant use of (or intolerance to) dose optimized atorvastatin (Lipitor) and rosuvastatin (Crestor).
DRUG CLASS: Antihyperlipidemic-Hmg-Coa Reductase Inhibitor					**CATEGORY** Cardiology, Lipotropics								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Lipitor	Atorvastatin Calcium	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 30 tablets per month
Lipitor	Atorvastatin Calcium	Tablet	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 30 tablets per month
Lipitor	Atorvastatin Calcium	Tablet	40 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 30 tablets per month

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Lipitor	Atorvastatin Calcium	Tablet	80 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 30 tablets per month
Lovastatin	Lovastatin	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Mevacor	Lovastatin	Tablet	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Mevacor	Lovastatin	Tablet	40 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Pravachol	Pravastatin Sodium	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Pravachol	Pravastatin Sodium	Tablet	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Pravachol	Pravastatin Sodium	Tablet	40 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Pravachol	Pravastatin Sodium	Tablet	80 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Crestor	Rosuvastatin Calcium	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 30 tablets per 30 days.

Crestor	Rosuvastatin Calcium	Tablet	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 30 tablets per 30 days.
Crestor	Rosuvastatin Calcium	Tablet	40 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 30 tablets per 30 days.
Crestor	Rosuvastatin Calcium	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 30 tablets per 30 days.
Zocor	Simvastatin	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day
Zocor	Simvastatin	Tablet	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day
Zocor	Simvastatin	Tablet	40 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day
Zocor	Simvastatin	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day
Zocor	Simvastatin	Tablet	80 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day
DRUG CLASS:	Bile Salt Sequestrants				**CATEGORY**		Cardiology, Lipotropics						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cholestyramine	Cholestyramine (Wit	Powd Pack	4 G	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Cholestyramine	Cholestyramine (Wit	Powd Pack	4 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cholestyramine	Cholestyramine (Wit	Powder	4 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cholestyramine Ligh	Cholestyramine/Asp	Powd Pack	4 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cholestyramine Ligh	Cholestyramine/Asp	Powd Pack	4 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cholestyramine Ligh	Cholestyramine/Asp	Powd Pack	4 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cholestyramine Ligh	Cholestyramine/Asp	Powder	4 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cholestyramine Ligh	Cholestyramine/Asp	Powder	4 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Welchol	Colesevelam Hcl	Tablet	625 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who are intolerant to 2 formulary statins.

DRUG CLASS:	Lipotropics				**CATEGORY**	Cardiology, Lipotropics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Zetia	Ezetimibe	Tablet	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who meet one of the following criteria: [1] Concurrently on a high intensity statin, [2] Concurrently on a maximally tolerated statin with ASCVD risk, OR[3] Has contraindication/intoleranc e to three (3) formulary 1st line statins, t
Fenofibrate	Fenofibrate	Tablet	160 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment with statin; only 54mg, 67mg, 134mg 160mg and 200mg are covered strengths; consider Gemfibrozil if not used with statin

Fenofibrate	Fenofibrate	Tablet	54 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment with statin; only 54mg, 67mg, 134mg 160mg and 200mg are covered strengths; consider Gemfibrozil if not used with statin
Fenofibrate	Fenofibrate,Micronized	Capsule	134MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment with statin; only 54mg, 67mg, 134mg 160mg and 200mg are covered strengths; consider Gemfibrozil if not used with statin
Fenofibrate	Fenofibrate,Micronized	Capsule	200 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment with statin; only 54mg, 67mg, 134mg 160mg and 200mg are covered strengths; consider Gemfibrozil if not used with statin

Fenofibrate	Fenofibrate,Micronized	Capsule	67 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment with statin; only 54mg, 67mg, 134mg 160mg and 200mg are covered strengths; consider Gemfibrozil if not used with statin
Lopid	Gemfibrozil	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Niaspan	Niacin	Tab Er 24H	1000 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niaspan	Niacin	Tab Er 24H	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niaspan	Niacin	Tab Er 24H	750 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niacor	Niacin	Tablet	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.

Omega-3 Acid Ethyl Esters	Omega-3 Acid Ethyl Esters	Capsule	1 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with elevated triglycerides >500 mg/dl despite dose-optimized treatment with both a statin and Fenofibrate.

THERAPEUTIC CATEGORY
Cardiology, Other

DRUG CLASS: - / Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Cardiology, Other PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Entresto	Sacubitril/Valsartan	Tablet	24 Mg-26Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who meet ALL of the following criteria:a. LVEF ≤40%;b. Currently on dose optimized or maximally tolerated doses of all of the following: Beta blockers, ACE-I or ARB, and Aldosterone Antagonist;c. An ARB must be tried

Entresto	Sacubitril/Valsartan	Tablet	49 Mg-51Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who meet ALL of the following criteria:a. LVEF ≤40%;b. Currently on dose optimized or maximally tolerated doses of all of the following: Beta blockers, ACE-I or ARB, and Aldosterone Antagonist;c. An ARB must be tried
Entresto	Sacubitril/Valsartan	Tablet	97Mg-103Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who meet ALL of the following criteria:a. LVEF ≤40%;b. Currently on dose optimized or maximally tolerated doses of all of the following: Beta blockers, ACE-I or ARB, and Aldosterone Antagonist;c. An ARB must be tried

DRUG CLASS:	Adrenergic Vasopressor Agents				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Midodrine Hcl	Midodrine Hcl	Tablet	10 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for symptomatic orthostatic hypotension secondary to autonomic failure caused by neurodegenerative disease or neuropathy. Limited to 3 tablets per day.
Midodrine Hcl	Midodrine Hcl	Tablet	2.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for symptomatic orthostatic hypotension secondary to autonomic failure caused by neurodegenerative disease or neuropathy. Limited to 3 tablets per day.
Midodrine Hcl	Midodrine Hcl	Tablet	5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for symptomatic orthostatic hypotension secondary to autonomic failure caused by neurodegenerative disease or neuropathy. Limited to 3 tablets per day.

DRUG CLASS:	Antianginal & Anti-Ischemic Agents,Non-Hemodyn				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Ranexa	Ranolazine	Tab Er 12H	1000 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to 3 formulary alternatives including a beta-blocker, calcium channel blocker and long-acting nitrate.
Ranexa	Ranolazine	Tab Er 12H	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to 3 formulary alternatives including a beta-blocker, calcium channel blocker and long-acting nitrate.
DRUG CLASS:	Antianginal, Heart Rate Reducing, I(F) Inhibitor				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Corlanor	Ivabradine Hcl	Tablet	5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with LVEF<35%, NYHA Stage II-IV, resting HR greater than 70 bpm, and compliant use or contraindication to use of dose-optimized beta-blocker, ACE-I/ARB, and Aldosterone Antagonist.

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Corlanor	Ivabradine Hcl	Tablet	7.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with LVEF<35%, NYHA Stage II-IV, resting HR greater than 70 bpm, and compliant use or contraindication to use of dose-optimized beta-blocker, ACE-I/ARB, and Aldosterone Antagonist.
DRUG CLASS:	Antiarrhythmics				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cordarone	Amiodarone Hcl	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norpace	Disopyramide Phosp	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norpace	Disopyramide Phosp	Capsule	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norpace Cr	Disopyramide Phosp	Capsule Er	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norpace Cr	Disopyramide Phosp	Capsule Er	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Multaq	Dronedarone Hcl	Tablet	400 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Reserved for patients <55yo or treatment failure or intolerant to amiodarone or for patients with high risk of pulmonary fibrosis or high risk of optic neuropathy, AND without NYHA Class II or III heart failure with exacerbation/hospitalization within th
Flecainide Acetate	Flecainide Acetate	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Flecainide Acetate	Flecainide Acetate	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Flecainide Acetate	Flecainide Acetate	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mexiletine Hcl	Mexiletine Hcl	Capsule	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mexiletine Hcl	Mexiletine Hcl	Capsule	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mexiletine Hcl	Mexiletine Hcl	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rythmol Sr	Propafenone Hcl	Cap Er 12H	225 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rythmol Sr	Propafenone Hcl	Cap Er 12H	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Rythmol Sr	Propafenone Hcl	Cap Er 12H	425 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rythmol	Propafenone Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rythmol	Propafenone Hcl	Tablet	225 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Propafenone Hcl	Propafenone Hcl	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Quinidine Gluconate	Quinidine Gluconate	Tablet Er	324 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Quinidine Gluconate	Quinidine Gluconate	Vial	80 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Quinidine Sulfate	Quinidine Sulfate	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Quinidine Sulfate	Quinidine Sulfate	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Quinidine Sulfate	Quinidine Sulfate	Tablet Er	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Digitalis Glycosides				**CATEGORY** Cardiology, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Digoxin	Digoxin	Solution	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Digoxin	Digoxin	Tablet	125 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Digoxin	Digoxin	Tablet	125 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Digoxin	Digoxin	Tablet	250 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	

Digoxin	Digoxin	Tablet	250 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Electrolyte Depleters				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Calcium Acetate	Calcium Acetate	Capsule	667 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of Calcium Acetate Tablets.
Calcium Acetate	Calcium Acetate	Tablet	667 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calcium Acetate	Calcium Acetate	Tablet	667 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calcium Acetate	Calcium Acetate	Tablet	667 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fosrenol	Lanthanum Carbonate	Tab Chew	1000 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Third line therapy for patients with treatment failure of Calcium Acetate (PhosLo) and Sevelamer (Renagel/Renvela) tablets.
Fosrenol	Lanthanum Carbonate	Tab Chew	500 MG	1	☑	☐	☑	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure of calcium acetate and sevelamer. Limited to 90 tablets per 30 days.

Fosrenol	Lanthanum Carbonate	Tab Chew	750 Mg	1	☑	☐	☑	☐	☐	☐	☐	☑	Third line therapy for patientswith treatment failure of calcium acetate and sevelamer. Limited to 90 tablets per 30 days.
Veltassa	Patiromer Calcium Sorbitex	Powd Pack	16.8 Gram	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients with [1] Potassium (K+) > 5.5 mEq/L AND one of the followng: [2] Diagnosis of heart failure, OR hypernatremia, OR risk for colonic necrosis (impaction, chronic constipation, inflammatory bowel disease, ischemic colitis, vascular inte

Veltassa	Patiromer Calcium Sorbitex	Powd Pack	25.2 Gram	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients with [1] Potassium (K+) > 5.5 mEq/L AND one of the followng: [2] Diagnosis of heart failure, OR hypernatremia, OR risk for colonic necrosis (impaction, chronic constipation, inflammatory bowel disease, ischemic colitis, vascular inte
Veltassa	Patiromer Calcium Sorbitex	Powd Pack	8.4 Gram	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients with [1] Potassium (K+) > 5.5 mEq/L AND one of the followng: [2] Diagnosis of heart failure, OR hypernatremia, OR risk for colonic necrosis (impaction, chronic constipation, inflammatory bowel disease, ischemic colitis, vascular inte

Renvela	Sevelamer Carbonate	Powd Pack	0.8 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Second line after PhosLo (calcium acetate), unless on dialysis, corrected serum calcium > 10.2 mg/dl, or evidence of soft tissue calcification
Renvela	Sevelamer Carbonate	Powd Pack	2.4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Second line after PhosLo (calcium acetate), unless on dialysis, corrected serum calcium > 10.2 mg/dl, or evidence of soft tissue calcification
Sevelamer Carbonate	Sevelamer Carbonate	Tablet	800 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Second line after PhosLo (calcium acetate), unless on dialysis, corrected serum calcium > 10.2 mg/dl, or evidence of soft tissue calcification
Renagel	Sevelamer Hcl	Tablet	400 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Sevelamer Carbonate (Renvela).

Renagel	Sevelamer Hcl	Tablet	800 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Sevelamer Carbonate (Renvela).
Sodium Polystyrene Sulfonate	Sodium Polystyrene Sulfonate	Enema	30G/120ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. For hyperkalemia in patients with vomiting not successfully treated by oral anti-nausea medications, or have upper GI problems.
Sodium Polystyrene	Sodium Polystyrene	Oral Susp	15 G/60	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Polystyrene	Sodium Polystyrene	Oral Susp	15 G/60	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Polystyrene	Sodium Polystyrene	Oral Susp	15 G/60	1	☐	☐	☐	☐	☐	☐	☐	☐	
Kayexalate	Sodium Polystyrene Sulfonate	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. For hyperkalemia in patients with vomiting not successfully treated by oral anti-nausea medications, or have upper GI problems.

Kayexalate	Sodium Polystyrene Sulfonate	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. For hyperkalemia in patients with vomiting not successfully treated by oral anti-nausea medications, or have upper GI problems.
Kayexalate	Sodium Polystyrene Sulfonate	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. For hyperkalemia in patients with vomiting not successfully treated by oral anti-nausea medications, or have upper GI problems.
DRUG CLASS:	Electrolyte Maintenance				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pedialyte	Electrolyte,Oral	Solution		1	☐	☐	☐	☐	☐	☐	☐	☐	
Pedialyte	Electrolyte,Oral	Solution		1	☐	☐	☐	☐	☐	☐	☐	☐	
Pedialyte	Electrolyte,Oral	Solution		1	☐	☐	☐	☐	☐	☐	☐	☐	
Pedialyte	Electrolyte,Oral	Solution		1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Folic Acid Preparations				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Folic Acid	Folic Acid	Tablet	0.4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Folic Acid	Folic Acid	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Hemorrheologic Agents				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Trental	Pentoxifylline	Tablet Er	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Iron Replacement				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Iron	Ferrous Sulfate	Capsule Er	325(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fer-In-Sol	Ferrous Sulfate	Drops	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fer-In-Sol	Ferrous Sulfate	Drops	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fer-In-Sol	Ferrous Sulfate	Drops	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Liquid	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Solution	220(44)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Solution	220(44)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Tablet	325(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Tablet	325(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	

Ferrous Sulfate	Ferrous Sulfate	Tablet	325(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Tablet	325(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Tablet	325(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Tablet	325(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Tablet Dr	324(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ferrous Sulfate	Ferrous Sulfate	Tablet Dr	325(65)	1	☐	☐	☐	☐	☐	☐	☐	☐	
Venofer	Iron Sucrose Complex	Vial	100 MG/5ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Documentation required if on dialysis: Recent labs showing TSAT ≤30% AND ferritin ≤500 ng/mL. If not on dialysis, same labs required but also documentation that non IV iron supplementation is insufficient.
DRUG CLASS:	Loop Diuretics				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Bumetanide	Bumetanide	Tablet	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Bumetanide	Bumetanide	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Edecrin	Ethacrynic Acid	Tablet	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Restricted to patients w/sulfa-allergy or tx failure to 3 formulary loop diuretics.
Furosemide	Furosemide	Solution	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Furosemide	Furosemide	Solution	40MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lasix	Furosemide	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lasix	Furosemide	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lasix	Furosemide	Tablet	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Demadex	Torsemide	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Demadex	Torsemide	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Demadex	Torsemide	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Demadex	Torsemide	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Magnesium Salts Replacement				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Magox	Magnesium Oxide	Tablet	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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DRUG CLASS: Medical Supplies,Miscellaneous **CATEGORY** Cardiology, Other

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Blood Pressure Kit	Blood Pressure Kit	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Blood Pressure Monitor Kit	Blood Pressure Monitor Kit	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Blood Pressure Test Kit-Large Cuff	Blood Pressure Test Kit-Large Cuff	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Condoms-Prem Lub	Condoms	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 24 per month
Fora Normal Control	Control Solution	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per year
Fora D20 Kit	Glucometer	Liquid		1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients in the Diabetes disease management program
Test N'Go Blood Glucose System	Glucometer	Liquid		1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients in the Diabetes disease management program
Fora V30A Kit	Glucometer	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken ; only NDC 16042-0010-39 is covered.

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Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Relion Thin Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Safety Lancets 21 Ga	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Safety Lancets 26 Ga	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Renew Advanced Mi	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Single-Let Misc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Renew Advanced Lancing System Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Reliamed Twist & Ca	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Safety Seal Lancets 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Safety Seal Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Safety-Let Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Rightest Gl300 Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Rightest Gd500 Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Smart Sense Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Relion Ultra Thin Pl	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Safety Lancets 28 Ga	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Nova Safety Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Pressure Activated L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
On Call Plus Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
On Call Plus Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
On Call Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
On Call Lancet 30 Ga	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
One Touch Delica La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Nova Safety Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
One Touch Delica Lancing Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Myglucohealth Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Multi-Lancet Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken

Smart Sense Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultilet Lancets 28 Ga	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Monolet Thin Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Monolet Lancets 21	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Nova Sureflex Lance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Prodigy Lancets 28	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Reliamed Safety Seal	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Reliamed Mini Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Reliamed Lancet 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Reliamed Lancet 28	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Reliamed Lancet 23	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
One Touch Delica La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Prodigy Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Reliamed Safety Seal	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

RESTRICTION KEY

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | FL = Fill Limit | AL = Age Limit
PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Pressure Activated L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Penlet Plus Blood Sampler Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
On-The-Go Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Onetouch Finepoint	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
One Touch Ultrasoft	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
One Touch Suresoft	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Prodigy Twist Top L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultralance Lancets 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultilet Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unilet Gp Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unilet Excelite Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unilet Excelite Ii Lan	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unilet Comfortouch	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unilet Comfortouch	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Ultra-Thin Ii Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unilet Lancet 28 Gau	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultralance Lancets 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unilet Lancets 30 Ga	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Ultra Tlc Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultra Thin Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultra Thin Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultra Thin Lancets 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultra Thin Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultra Thin Ii Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultilet Lancets 30 Ga	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultilet Classic Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultra-Thin Ii Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unistik 3 Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken

Universal 1 Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Universal 1 Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Universal 1 Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unistik Czt Lancet 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unistik Czt Lancet 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unistik 3 Normal La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unistik 3 Neonatal Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Unilet Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unistik 3 Lancets 21	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Mini Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Unistik 3 Gentle 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Unistik 3 Extra Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unistik 3 Comfort La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Unistik 3 Comfort Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Unistik 2 Normal Lancet&Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Unistik 2 Extra Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Unistik 2 Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Unilet Super Thin La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Unistik 3 Neonatal Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Sterilance Tl 32 Gau	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Freestyle Lancets 28	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Sureflex Lancing Device With	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Sureflex Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken

Sure Comfort Lancing Pen	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Sure Comfort Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Sure Comfort Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Super Thin Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Sure-Lance 26 Gaug	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Super Thin Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Sure-Lance 28 Gaug	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Sterilance Tl 30 Gau	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Solus V2 Lancing Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Solus V2 Lancets 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Solus V2 Lancets 28	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Soft Touch Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Smartest Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Smartdiabetes Vant	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Smartdiabetes Vantage	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Super Thin Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Topcare Universal1	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultilet Classic Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultilet Classic Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ultilet Basic Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Ulti-Lance Misc	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Ulti-Lance Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Trueplus Lancets 33	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Trueplus Lancets 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Sure-Lance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Trueplus Lancets 26	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Smart Sense Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Thin Lancets 26 Gau	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Telcare Lancets 30 G	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Techlite Lancets 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Techlite Lancets 28	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Techlite Lancets 25	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Sure-Touch Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Sure-Pen Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Sure-Lance Ultra Thi	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Trueplus Lancets 28	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bullseye Mini Safety	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Safety L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Caresens Premium Comfort Lancing	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Careone Ultra Thin	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Careone Thin Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Careone Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Carelance Ultimate Comfort Lancing	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Coaguchek Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bullseye Mini Safety	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Color Lancets 21 Ga	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bd Ultra-Fine Ii Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bd Ultra Fine Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bd Microtainer Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bd Microtainer Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bd Microtainer Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bd Lancet Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Bullseye Mini Safety	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Easy Click Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Gentle Draw Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Easy Touch Safety L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Safety L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Safety L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Safety L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Clever Chek Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Comfort Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Auto-Lancet Mini	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Droplet Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Droplet Lancets 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Comfort Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Comfort Ez Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Comfort Ez Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Comfort Ez Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Easy Touch Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Accu-Chek Safe-T-Pr	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Adjustable Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Acti-Lance Lancets 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Acti-Lance Lancets 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Acti-Lance Lancets 1	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Accu-Chek Softclix Lancing	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Accu-Chek Softclix L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Autolet Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken

Accu-Chek Safe-T-Pr	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Advocate Lancet 26	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Accu-Chek Multiclix Lancet Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Accu-Chek Multiclix	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Accu-Chek Fastclix Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Accu-Chek Fastclix	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
1St Tier Unilet Comf	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
1St Tier Unilet Comf	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Accu-Chek Softclix Lancet Dev	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Assure Haemolance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Twist La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Aurora Super Thin L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Assure Lance 28 Gau	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Assure Lance 25 Gau	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Assure Haemolance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Assure Haemolance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Advanced Lancing Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Assure Haemolance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Advanced Travel La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Aqua Lance Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Alternate Site Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Alternate Site Lance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Advocate Rapid-Safe Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Advocate Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Advocate Lancet 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Autolet Impression Lancing Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Assure Haemolance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets 21 Gauge	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Safety L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets,Thin 23 Gau	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets,Thin	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets, Super Thin	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets 33 Gauge	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets 30 Gauge	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Lancets,Ultra Thin	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets 26 Gauge	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets,Ultra Thin 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Kinney Brand Lance	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Invacare Lancets 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Inject Ease Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Inject Ease Lancets 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Incontrol Ultra Thin	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets 28 Gauge	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lite Touch Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Microlet 2 Lancing Device Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Micro Thin Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Medlance Plus Speci	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Medlance Plus Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Medlance Plus Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Medlance Plus Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancets,Thin 28 Gau	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Medi-Lance Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Hypolance Ast Lancing Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Lite Touch Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lite Touch Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Lancing System	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Lancing Device With Lancets Kit	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Lancing Device With Lancets	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Medisense Thin Lan	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
E-Z Ject Lancets 26 G	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Fine 30 Universal La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Fifty50 Safety Seal L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Fifty50 Safety Seal L	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Ez Smart Lancets 28	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
E-Z Ject Thin Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
E-Z Ject Lancets 33 G	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Incontrol Super Thi	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
E-Z Ject Lancets 30 G	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Fora Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
E-Z Ject Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Embrace Lancets 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Easy Twist & Cap La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Twist La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Twist La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Easy Touch Twist La	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
E-Z Ject Lancets 32 G	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Glucocom Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Microlet Lancet	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Healthy Accents Unil	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Healthy Accents Autolet Impression	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Gmate Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Gmate Lancets 30 G	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Glucosource Misc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Fingerstix Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Glucolet 2 Automatic Lancing	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
First Choice Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Glucocom Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Glucocom Lancets 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Universal 1 Lancets	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Freestyle Unistik 2	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	

Ultra Thin Plus Lanc	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Foracare Lancets 30	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days
Incontrol Lancing Device	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Glucolet 2 Automatic Lancing	Lancets/Lancing Device	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Ultra Thin Lancets 3	Lancets/Lancing Dev	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	
Bubbles The Fish Pedi Mask	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Optichamber Adult	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 2 per year
Optichamber Diamo	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 2 per year
Optichamber Diamo	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 2 per year
Optichamber Diamo	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 2 per year
Vortex Holding Cha	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 2 per year
Vortex Holding Cha	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 2 per year
Vortex Holding Cha	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 2 per year

Vortex Vhc Frog Mas	Mask/Spacer	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 2 per year
Personal Best Full R	Peak Flow meter	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	
Peak Air Peak Flow Meter	Peak Flow meter	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per lifetime, submit PA for lost/broken
Bd Insulin Pen Need	Pen Needles	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sharps Container	Sharps Container	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per 30 days
Integra Syringe 1 Ml	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

RESTRICTION KEY

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | FL = Fill Limit | AL = Age Limit
PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe Micr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Insulin Syringe 1/2	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Exel Insulin 1 Ml 27	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Exel Insulin 1 Ml 30	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Exel Insulin 1/2 Ml 2	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Exel Insulin 1/2 Ml 3	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Freestyle Precision	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Freestyle Precision	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Freestyle Precision	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Freestyle Precision	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe 1 Ml	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe 1 Ml	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe Ultra	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe 1/2	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe 1/2	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Insulin Syringe Micr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Magellan Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe Micr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe/Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe-Nee	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Insulin Syringe 1 Ml	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Tb 1 Ml 28	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Magellan S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Syringe 1/	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Tb Safety S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Tb Safety S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Tuberculi	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Tuberculi	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Tuberculi	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Tuberculi	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Monoject Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Prodigy Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Prodigy Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Prodigy Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Magellan S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Magellan Syringe 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Exel Insulin 0.3 Ml 2	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Magellan Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Magellan Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Magellan Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Magellan Syringe 0.5	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Lite Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Maxi-Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Maxi-Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Medsaver Syringe 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Monoject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Magellan Syringe 0.3	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Bd Luer-Lok Syringe	Syringes/Needles	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Safety-Lok Tuber	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Integra Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Lo-Dose Micro-Fi	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Lo-Dose Ultra-Fi	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Luer-Lok Syringe	Syringes/Needles	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Bd Luer-Lok Syringe	Syringes/Needles	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Luer-Lok Syringe	Syringes/Needles	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bd Safetyglide Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Safetyglide Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Safetyglide Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Safetyglide Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Safetyglide Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Safetyglide Syrin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Lo-Dose Micro-Fi	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Advocate Syringes 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Advocate Syringes 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Advocate Syringes 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Advocate Syringes 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

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Advocate Syringes 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Advocate Syringes 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Assure Id Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Assure Id Insulin Saf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Eclipse Luer-Lok	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Slip Tip Syringe 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe H	Syringes/Needles	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe H	Syringes/Needles	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe M	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe M	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe M	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Bd Insulin Syringe Sl	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe U	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Insulin Syringe 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Safetyglide Tube	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch 1 Ml 25	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Fluringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Fluringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Luer-Lok Syringe	Syringes/Needles	Liquid	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch Insulin S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

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Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Tuberculin Slip-	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Tuberculin Syrin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Tuberculin Syrin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Tuberculin Syrin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Tuberculin Syrin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Tuberculin Syrin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Touch 1 Ml 25	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Eclipse Syringe 1 Ml	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Easy Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Comfort Ez Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 1/	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ulticare 0.3 Ml 30 X	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 1/	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 1/	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Tuberculin Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Tuberculin Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Tuberculin Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultilet Insulin Syring	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Tuberculin-Allergy S	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ulticare 0.3 Ml 31 X	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ulticare 1 Ml 25 X 5/	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ulticare 1 Ml 30 X 1/	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ulticare 1 Ml 31 X 5/	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ulticare 1/2 Ml 30 X	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ulticare 1/2 Ml 31 X	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Tuberculin Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Vanishpoint Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultracomfort 1/2 Ml	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra-Thin Ii (Short)	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Ultra-Thin Ii (Short)	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra-Thin Ii (Short)	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra-Thin Ii Insulin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra-Thin Ii Insulin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultracomfort 1 Ml 3	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Vanishpoint Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Vanishpoint Syringe	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Vanishpoint Tuberc	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Vanishpoint Tuberc	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Bd Lo-Dose Ultra-Fi	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra-Thin Ii Insulin	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra-Thin Ii (Short)	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultracomfort 1/2 Ml	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultracomfort 1/2 Ml	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultracomfort 1 Ml 2	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultracomfort 1 Ml 3	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Surguard2 Safety 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Terumo Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Surguard2 Safety 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Surguard2 Safety 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Syringe With Needle	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Terumo Allergy Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Terumo Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Terumo Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Ultra-Thin Ii (Short)	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 1/	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

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Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure Comfort Insuli	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Sure-Ject Insulin Syr	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Topcare Ultra Comf	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 0.3	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 0.3	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Trueplus Insulin 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 1	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Terumo Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Terumo Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Terumo Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Trueplus Insulin 0.3	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Terumo Insulin Syri	Syringes/Needles	Liquid	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days

Terumo Insulin Syri	Syringes/Needles	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Thinpro Insulin Syri	Syringes/Needles	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 200 per 30 days
Tablet Cutter Misc	Tablet Cutter Misc	Liquid		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 per year
DRUG CLASS:	Niacin Preparations				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Niacin	Niacin	Capsule Er	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niacin	Niacin	Tablet	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niacin	Niacin	Tablet	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.

Niacin	Niacin	Tablet	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niacin	Niacin	Tablet	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Slo-Niacin	Niacin	Tablet Er	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Slo-Niacin	Niacin	Tablet Er	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niacin	Niacin	Tablet Er	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niacin	Niacin	Tablet Er	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.
Niacin	Niacin	Tablet Er	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Restricted to patients intolerant to two formulary 1st line statins.

DRUG CLASS: Potassium Replacement					**CATEGORY** Cardiology, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Potassium Chloride	Potassium Chloride	Capsule Er	10 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Potassium Chloride	Potassium Chloride	Capsule Er	8 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Potassium Chloride	Potassium Chloride	Liquid	20MEQ/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Potassium Chloride	Potassium Chloride	Liquid	40MEQ/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klor-Con	Potassium Chloride	Packet	20 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klor-Con	Potassium Chloride	Packet	25 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Potassium Chloride	Potassium Chloride	Tab Er Prt	10 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Potassium Chloride	Potassium Chloride	Tab Er Prt	10 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klor-Con M15	Potassium Chloride	Tab Er Prt	15 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Potassium Chloride	Potassium Chloride	Tab Er Prt	20 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Potassium Chloride	Potassium Chloride	Tab Er Prt	20 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
K-Tab Er	Potassium Chloride	Tablet Er	10 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
K-Tab Er	Potassium Chloride	Tablet Er	10 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	

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K-Tab Er	Potassium Chloride	Tablet Er	10 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
K-Tab Er	Potassium Chloride	Tablet Er	20 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klor-Con 8	Potassium Chloride	Tablet Er	8 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klor-Con 8	Potassium Chloride	Tablet Er	8 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Potassium Sparing Diuretics In Combination				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Aldactazide	Spironolact/Hydroch	Tablet	25 MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aldactazide	Spironolact/Hydroch	Tablet	50 MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dyazide	Triamterene/Hydroc	Capsule	37.5-25	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamterene-Hctz	Triamterene/Hydroc	Capsule	50 MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maxzide-25 Mg	Triamterene/Hydroc	Tablet	37.5-25	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamterene-Hydro	Triamterene/Hydroc	Tablet	75 MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Sodium/Saline Preparations				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Sodium Chloride	0.9 % Sodium Chlori	Syringe	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	0.9 % Sodium Chlori	Syringe	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Sodium Chloride	0.9 % Sodium Chlori	Syringe	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	0.9 % Sodium Chlori	Syringe	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	0.9 % Sodium Chlori	Syringe	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	0.9 % Sodium Chlori	Syringe	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	0.9 % Sodium Chlori	Syringe	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	0.9 % Sodium Chlori	Vial	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Vitamin K Preparations				**CATEGORY**	Cardiology, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Vitamin K	Phytonadione	Tablet	100 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mephyton	Phytonadione	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

THERAPEUTIC CATEGORY
CNS, ADHD

DRUG CLASS: Brand Name	Adrenergics, Aromatic, Non-Catecholamine Generic Name	Formulation	Strength	Tier	CATEGORY CNS, ADHD PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Dexedrine XR	Dextroamphetamine Sulfate	Capsule Er	10 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Dexedrine XR	Dextroamphetamine Sulfate	Capsule Er	15 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Dexedrine XR	Dextroamphetamine Sulfate	Capsule Er	5 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Dexedrine	Dextroamphetamine	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dexedrine	Dextroamphetamine	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adderall XR	Dextroamphetamine /Amphetamine	Cap Er 24H	10 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Adderall XR	Dextroamphetamine /Amphetamine	Cap Er 24H	15 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Adderall XR	Dextroamphetamine /Amphetamine	Cap Er 24H	20 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.

Adderall XR	Dextroamphetamine /Amphetamine	Cap Er 24H	25 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Adderall XR	Dextroamphetamine /Amphetamine	Cap Er 24H	30 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Adderall XR	Dextroamphetamine /Amphetamine	Cap Er 24H	5 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Adderall	Dextroamphetamine	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adderall	Dextroamphetamine	Tablet	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adderall	Dextroamphetamine	Tablet	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adderall	Dextroamphetamine	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adderall	Dextroamphetamine	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adderall	Dextroamphetamine	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adderall	Dextroamphetamine	Tablet	7.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Vyvanse	Lisdexamfetamine Dimesylate	Capsule	10 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documentation of treatment failure or intolerance to one Methylphenidate ER-based and one Amphetamine ER-based stimulant medication. Limited to persons ≥ 4 years of age.
Vyvanse	Lisdexamfetamine Dimesylate	Capsule	20 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documentation of treatment failure or intolerance to one Methylphenidate ER-based and one Amphetamine ER-based stimulant medication. Limited to persons ≥ 4 years of age.

Vyvanse	Lisdexamfetamine Dimesylate	Capsule	30 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documentation of treatment failure or intolerance to one Methylphenidate ER-based and one Amphetamine ER-based stimulant medication. Limited to persons ≥ 4 years of age.
Vyvanse	Lisdexamfetamine Dimesylate	Capsule	40 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documentation of treatment failure or intolerance to one Methylphenidate ER-based and one Amphetamine ER-based stimulant medication. Limited to persons ≥ 4 years of age.

Vyvanse	Lisdexamfetamine Dimesylate	Capsule	50 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documentation of treatment failure or intolerance to one Methylphenidate ER-based and one Amphetamine ER-based stimulant medication. Limited to persons ≥ 4 years of age.
Vyvanse	Lisdexamfetamine Dimesylate	Capsule	60 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documentation of treatment failure or intolerance to one Methylphenidate ER-based and one Amphetamine ER-based stimulant medication. Limited to persons ≥ 4 years of age.

Vyvanse	Lisdexamfetamine Dimesylate	Capsule	70 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documentation of treatment failure or intolerance to one Methylphenidate ER-based and one Amphetamine ER-based stimulant medication. Limited to persons ≥ 4 years of age.
DRUG CLASS:	treatment For Adhd - Selective Alpha-2A Receptor				**CATEGORY**	CNS, ADHD							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Intuniv	Guanfacine Hcl	Tab Er 24H	1 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure, intolerance or contraindication to stimulants (e.g., Adderall XR, Concerta, Ritalin ER/LA).
Intuniv	Guanfacine Hcl	Tab Er 24H	2 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure, intolerance or contraindication to stimulants (e.g., Adderall XR, Concerta, Ritalin ER/LA).

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Intuniv	Guanfacine Hcl	Tab Er 24H	3 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure, intolerance or contraindication to stimulants (e.g., Adderall XR, Concerta, Ritalin ER/LA).
Intuniv	Guanfacine Hcl	Tab Er 24H	4 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure, intolerance or contraindication to stimulants (e.g., Adderall XR, Concerta, Ritalin ER/LA).
DRUG CLASS: treatment For Attention Deficit-Hyperact(Adhd)/					**CATEGORY** CNS, ADHD								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Focalin Xr	Dexmethylphenidate Hcl	Cpbp 50-50	10 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.

Focalin Xr	Dexmethylphenidate Hcl	Cpbp 50-50	15 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Focalin Xr	Dexmethylphenidate Hcl	Cpbp 50-50	20 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Focalin Xr	Dexmethylphenidate Hcl	Cpbp 50-50	25 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.

Focalin Xr	Dexmethylphenidate Hcl	Cpbp 50-50	30 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Focalin Xr	Dexmethylphenidate Hcl	Cpbp 50-50	35 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Focalin Xr	Dexmethylphenidate Hcl	Cpbp 50-50	40 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.

Focalin Xr	Dexmethylphenidate Hcl	Cpbp 50-50	5 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Focalin	Dexmethylphenidate Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Focalin	Dexmethylphenidate Hcl	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.

Focalin	Dexmethylphenidate Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Daytrana	Methylphenidate	Patch Td24	10MG/9 HR	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for patients with documented inability to swallow tabs, caps, chewables, solutions, or suspensions. Limited to persons ≥ 4 years of age.
Daytrana	Methylphenidate	Patch Td24	15MG/9 HR	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for patients with documented inability to swallow tabs, caps, chewables, solutions, or suspensions. Limited to persons ≥ 4 years of age.

Daytrana	Methylphenidate	Patch Td24	20 MG/9 HR	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for patients with documented inability to swallow tabs, caps, chewables, solutions, or suspensions. Limited to persons ≥ 4 years of age.
Daytrana	Methylphenidate	Patch Td24	30MG/9 HR	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for patients with documented inability to swallow tabs, caps, chewables, solutions, or suspensions. Limited to persons ≥ 4 years of age.
Methylphenidate Hcl Cd	Methylphenidate Hcl	Cpbp 30-70	10 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Methylphenidate Hcl Cd	Methylphenidate Hcl	Cpbp 30-70	20 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Methylphenidate Hcl Cd	Methylphenidate Hcl	Cpbp 30-70	30 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Methylphenidate Hcl Cd	Methylphenidate Hcl	Cpbp 30-70	40 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.

Methylphenidate Hcl Cd	Methylphenidate Hcl	Cpbp 30-70	50 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Methylphenidate Hcl Cd	Methylphenidate Hcl	Cpbp 30-70	60 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Ritalin La	Methylphenidate Hcl	Cpbp 50-50	10 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Ritalin La	Methylphenidate Hcl	Cpbp 50-50	20 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Ritalin La	Methylphenidate Hcl	Cpbp 50-50	30 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Ritalin La	Methylphenidate Hcl	Cpbp 50-50	40 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Limited to persons ≥ 4 years of age.
Methylphenidate Hc	Methylphenidate Hcl	Solution	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methylin	Methylphenidate Hcl	Tab Chew	10 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documented inability to take methylphenidate IR solution by mouth. Limited to persons ≥ 4 years of age.

Methylin	Methylphenidate Hcl	Tab Chew	2.5 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documented inability to take methylphenidate IR solution by mouth. Limited to persons ≥ 4 years of age.
Methylin	Methylphenidate Hcl	Tab Chew	5 MG	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documented inability to take methylphenidate IR solution by mouth. Limited to persons ≥ 4 years of age.
Methylphenidate Er	Methylphenidate Hcl	Tab Er 24	18 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Methylphenidate Er	Methylphenidate Hcl	Tab Er 24	27 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.

Methylphenidate Er	Methylphenidate Hcl	Tab Er 24	36 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Methylphenidate Er	Methylphenidate Hcl	Tab Er 24	54 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
Ritalin	Methylphenidate Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ritalin	Methylphenidate Hcl	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ritalin	Methylphenidate Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methylin Er	Methylphenidate Hcl	Tablet Er	10 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.

Ritalin-Sr	Methylphenidate Hcl	Tablet Er	20 MG	1	☐	☑	☐	☐	☑	☐	☐	☐	Step therapy to at least one ER tier 1 formulary stimulant medication within the last 120 days. Limited to persons ≥ 4 years of age.
DRUG CLASS:	Tx For Attention Deficit-Hyperact(Adhd)/Narcole				**CATEGORY**	Cns, Adhd							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Quillivant Xr	Methylphenidate Hcl	Su Er Rc24	5 Mg/Ml	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documented inability to take methylphenidate ER capsules by mouth with or without applesauce. Limited to persons ≥ 4 years of age.
Quillichew Er	Methylphenidate Hcl	Tab Cbp24H	20 Mg	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documented inability to take methylphenidate ER capsules by mouth with or without applesauce. Limited to persons ≥ 4 years of age.

THERAPEUTIC CATEGORY
CNS, Mental Health

DRUG CLASS: Alpha-2 Receptor Antagonist Antidepressants **CATEGORY** CNS, Mental Health

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Remeron	Mirtazapine	Tab Rapdis	15 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients with a documented inability to swallow tablets or capsules; limited to 1 tab per day
Remeron	Mirtazapine	Tab Rapdis	30 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients with a documented inability to swallow tablets or capsules; limited to 1 tab per day
Remeron	Mirtazapine	Tab Rapdis	45 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients with a documented inability to swallow tablets or capsules; limited to 1 tab per day
Remeron	Mirtazapine	Tablet	15 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day

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Remeron	Mirtazapine	Tablet	30 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day
Remeron	Mirtazapine	Tablet	45 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day
Mirtazapine	Mirtazapine	Tablet	7.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day

DRUG CLASS:	Norepinephrine And Dopamine Reuptake Inhib (N				**CATEGORY**	CNS, Mental Health							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Budeprion Xl	Bupropion Hcl	Tab Er 24H	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Budeprion Xl	Bupropion Hcl	Tab Er 24H	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bupropion Hcl	Bupropion Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bupropion Hcl	Bupropion Hcl	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Budeprion Sr	Bupropion Hcl	Tablet Er	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Budeprion Sr	Bupropion Hcl	Tablet Er	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Budeprion Sr	Bupropion Hcl	Tablet Er	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Budeprion Sr	Bupropion Hcl	Tablet Er	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bupropion Hcl Sr	Bupropion Hcl	Tablet Er	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Selective Serotonin Reuptake Inhibitor (Ssris) **CATEGORY** CNS, Mental Health

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Citalopram Hbr	Citalopram Hydrobromide	Solution	10 MG/5 ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to consume capsules or tablets by mouth.
Citalopram Hbr	Citalopram Hydrobr	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Citalopram Hbr	Citalopram Hydrobr	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Citalopram Hbr	Citalopram Hydrobr	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lexapro	Escitalopram Oxalate	Solution	5 MG/5 ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to consume capsules or tablets by mouth.
Escitalopram Oxalat	Escitalopram Oxalat	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Escitalopram Oxalat	Escitalopram Oxalat	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Escitalopram Oxalat	Escitalopram Oxalat	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prozac	Fluoxetine Hcl	Capsule	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prozac	Fluoxetine Hcl	Capsule	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Fluoxetine Hcl	Fluoxetine Hcl	Capsule	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prozac	Fluoxetine Hcl	Solution	20 MG/5 ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to consume capsules or tablets by mouth.
Fluvoxamine Maleat	Fluvoxamine Maleat	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluvoxamine Maleat	Fluvoxamine Maleat	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluvoxamine Maleat	Fluvoxamine Maleat	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Paxil	Paroxetine Hcl	Oral Susp	10 MG/5 ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to consume capsules or tablets by mouth.
Paxil Cr	Paroxetine Hcl	Tab Er 24H	12.5 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for failure of 2 months of dose optimized paroxetine; limit 1 tab per day.
Paxil Cr	Paroxetine Hcl	Tab Er 24H	25 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for failure of 2 months of dose optimized paroxetine; limit 1 tab per day.

Paxil Cr	Paroxetine Hcl	Tab Er 24H	37.5 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for failure of 2 months of dose optimized paroxetine; limit 1 tab per day.
Paxil	Paroxetine Hcl	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Paxil	Paroxetine Hcl	Tablet	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Paxil	Paroxetine Hcl	Tablet	30 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Paxil	Paroxetine Hcl	Tablet	40 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Zoloft	Sertraline Hcl	Oral Conc	20 MG/ML	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to consume capsules or tablets by mouth. Limited to 300 mL per 30 days.
Zoloft	Sertraline Hcl	Tablet	100 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.

Zoloft	Sertraline Hcl	Tablet	25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Zoloft	Sertraline Hcl	Tablet	50 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Viibryd	Vilazodone Hydrochloride	Tablet	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of two different dose optimized formulary antidepressants for 2 months each
Viibryd	Vilazodone Hydrochloride	Tablet	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of two different dose optimized formulary antidepressants for 2 months each
Viibryd	Vilazodone Hydrochloride	Tablet	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of two different dose optimized formulary antidepressants for 2 months each

Brintellix	Vortioxetine Hydrobromide	Tablet	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of two different dose optimized formulary antidepressants for 2 months each
Brintellix	Vortioxetine Hydrobromide	Tablet	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of two different dose optimized formulary antidepressants for 2 months each
Brintellix	Vortioxetine Hydrobromide	Tablet	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of two different dose optimized formulary antidepressants for 2 months each

DRUG CLASS:	Serotonin-2 Antagonist/Reuptake Inhibitors (Sari				**CATEGORY**	CNS, Mental Health							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Nefazodone Hcl	Nefazodone Hcl	Tablet	100 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 90 tablets per 30 days.
Nefazodone Hcl	Nefazodone Hcl	Tablet	150 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 90 tablets per 30 days.

Nefazodone Hcl	Nefazodone Hcl	Tablet	200 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 90 tablets per 30 days.
Nefazodone Hcl	Nefazodone Hcl	Tablet	250 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 90 tablets per 30 days.
Nefazodone Hcl	Nefazodone Hcl	Tablet	50 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 90 tablets per 30 days.
Trazodone Hcl	Trazodone Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Trazodone Hcl	Trazodone Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Trazodone Hcl	Trazodone Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Serotonin-Norepinephrine Reuptake-Inhib (Snris)				**CATEGORY**	CNS, Mental Health							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pristiq Er	Desvenlafaxine Succinate	Tab Er 24H	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients, with major depressive disorder, who are treatment failure of dose-optimized Venlafaxine and Duloxetine for 2 months each.

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Pristiq Er	Desvenlafaxine Succinate	Tab Er 24H	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients, with major depressive disorder, who are treatment failure of dose-optimized Venlafaxine and Duloxetine for 2 months each.
Cymbalta	Duloxetine Hcl	Capsule Dr	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 capsules per 30 days.
Cymbalta	Duloxetine Hcl	Capsule Dr	30 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 capsules per 30 days.
Cymbalta	Duloxetine Hcl	Capsule Dr	60 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 30 capsules per 30 days.
Fetzima	Levomilnacipran Hydrochloride	Cap Sa 24H	120 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of dose-optimized venlafaxine and duloxetine for 2 months each
Fetzima	Levomilnacipran Hydrochloride	Cap Sa 24H	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of dose-optimized venlafaxine and duloxetine for 2 months each

Fetzima	Levomilnacipran Hydrochloride	Cap Sa 24H	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of dose-optimized venlafaxine and duloxetine for 2 months each
Fetzima	Levomilnacipran Hydrochloride	Cap Sa 24H	80 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of dose-optimized venlafaxine and duloxetine for 2 months each
Effexor Xr	Venlafaxine Hcl	Cap Er 24H	150 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 per day
Effexor Xr	Venlafaxine Hcl	Cap Er 24H	37.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 per day
Effexor Xr	Venlafaxine Hcl	Cap Er 24H	75 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 per day
Effexor	Venlafaxine Hcl	Tablet	100 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 per day
Effexor	Venlafaxine Hcl	Tablet	25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 per day
Effexor	Venlafaxine Hcl	Tablet	37.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 per day
Effexor	Venlafaxine Hcl	Tablet	50 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 per day
Effexor	Venlafaxine Hcl	Tablet	75 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 per day
DRUG CLASS: Tricyclic Antidepressants & Rel. Non-Sel. Ru-Inhib					**CATEGORY** CNS, Mental Health								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Amitriptyline Hcl	Amitriptyline Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Amitriptyline Hcl	Amitriptyline Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Amitriptyline Hcl	Amitriptyline Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Amitriptyline Hcl	Amitriptyline Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Amitriptyline Hcl	Amitriptyline Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Amitriptyline Hcl	Amitriptyline Hcl	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Norpramin	Desipramine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Norpramin	Desipramine Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Norpramin	Desipramine Hcl	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Norpramin	Desipramine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Norpramin	Desipramine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Norpramin	Desipramine Hcl	Tablet	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Doxepin Hcl	Doxepin Hcl	Capsule	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Doxepin Hcl	Doxepin Hcl	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Doxepin Hcl	Doxepin Hcl	Capsule	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Doxepin Hcl	Doxepin Hcl	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Doxepin Hcl	Doxepin Hcl	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Doxepin Hcl	Doxepin Hcl	Capsule	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Doxepin Hcl	Doxepin Hcl	Oral Conc	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tofranil	Imipramine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tofranil	Imipramine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tofranil	Imipramine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nortriptyline Hcl	Nortriptyline Hcl	Capsule	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nortriptyline Hcl	Nortriptyline Hcl	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nortriptyline Hcl	Nortriptyline Hcl	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nortriptyline Hcl	Nortriptyline Hcl	Capsule	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nortriptyline Hcl	Nortriptyline Hcl	Solution	10 MG/5 ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for documented inability to consume capsules or tablets by mouth.

THERAPEUTIC CATEGORY
CNS, Migraine

DRUG CLASS: Antimigraine Preparations **CATEGORY** CNS, Migraine

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Axert	Almotriptan Malate	Tablet	12.5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Almotriptan is step therapy to treatment failure to [1] Sumatriptan or Rizatriptan AND [2] Naratriptan or Zolmitriptan in the last 365 days. For frequent headaches >2 per month, prophylaxis with Topamax, Depakote, or beta blockers may be considered. Limit

Axert	Almotriptan Malate	Tablet	6.25 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Almotriptan is step therapy to treatment failure to [1] Sumatriptan or Rizatriptan AND [2] Naratriptan or Zolmitriptan in the last 365 days. For frequent headaches >2 per month, prophylaxis with Topamax, Depakote, or beta blockers may be considered. Limit
Relpax	Eletriptan Hbr	Tablet	20 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Eletriptan is step therapy to treatment failure to [1] Sumatriptan or Rizatriptan AND [2] Naratriptan or Zolmitriptan in the last 365 days. For frequent headaches >2 per month, prophylaxis with Topamax, Depakote, or beta blockers may be considered. Limite

Relpax	Eletriptan Hbr	Tablet	40 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Eletriptan is step therapy to treatment failure to [1] Sumatriptan or Rizatriptan AND [2] Naratriptan or Zolmitriptan in the last 365 days. For frequent headaches >2 per month, prophylaxis with Topamax, Depakote, or beta blockers may be considered. Limite
Ergomar	Ergotamine Tartrate	Tab Subl	2 MG	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 1 fill per 30 days. For frequent headaches >2 attacks per month, prophylaxis with Topamax, Depakote or a beta blocker may be considered.
Migergot	Ergotamine Tartrate/Caffeine	Supp.Rect	2-100MG	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 1 fill per 30 days. For frequent headaches >2 attacks per month, prophylaxis with Topamax, Depakote or a beta blocker may be considered.

Ergotamine-Caffeine	Ergotamine Tartrate/Caffeine	Tablet	1 MG-100MG	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 1 fill per 30 days. For frequent headaches >2 attacks per month, prophylaxis with Topamax, Depakote or a beta blocker may be considered.
Midrin	Isomethept/Dichlphn/Acetaminop	Capsule	65-100-325	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 1 fill per 30 days. For frequent headaches >2 attacks per month, prophylaxis with Topamax, Depakote or a beta blocker may be considered
Naratriptan Hcl	Naratriptan Hcl	Tablet	1 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Naratriptan is step therapy to treatment failure of Imitrex OR Maxalt. For frequent headaches >2 attacks per month, prophylaxis should be considered. Limited to 9 tablets per 30 days.

Naratriptan Hcl	Naratriptan Hcl	Tablet	2.5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Naratriptan is step therapy to treatment failure of Imitrex OR Maxalt. For frequent headaches >2 attacks per month, prophylaxis should be considered. Limited to 9 tablets per 30 days.
Rizatriptan	Rizatriptan Benzoate	Tab Rapdis	10 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 9 tablets per month.
Rizatriptan	Rizatriptan Benzoate	Tab Rapdis	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 9 tablets per month.
Maxalt	Rizatriptan Benzoate	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 9 tablets per 30 days. For frequent headache > 2 attacks per month, prophylaxis should be considered
Maxalt	Rizatriptan Benzoate	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 9 tablets per 30 days. For frequent headache > 2 attacks per month, prophylaxis should be considered

Imitrex	Sumatriptan	Spray	20 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients ≥12 years of age and unable to take oral meds (including ODT). Limited to 6 actuations per 30 days.
Imitrex	Sumatriptan	Spray	5 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients ≥12 years of age and unable to take oral meds (including ODT). Limited to 6 actuations per 30 days.
Sumatriptan Succinate	Sumatriptan Succinate	Tablet	100 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 9 tablets per 30 days. For frequent headache > 2 attacks per month, prophylaxis should be considered
Sumatriptan Succinate	Sumatriptan Succinate	Tablet	25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 9 tablets per 30 days. For frequent headache > 2 attacks per month, prophylaxis should be considered

Sumatriptan Succinate	Sumatriptan Succinate	Tablet	50 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 9 tablets per 30 days. For frequent headache > 2 attacks per month, prophylaxis should be considered
Zolmitriptan Odt	Zolmitriptan	Tab Rapdis	2.5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Zolmitriptan is step therapy to treatment failure of Imitrex OR Maxalt. For frequent headaches >2 attacks per month, prophylaxis should be considered. Limited to 9 tablets per 30 days.
Zolmitriptan Odt	Zolmitriptan	Tab Rapdis	5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Zolmitriptan is step therapy to treatment failure of Imitrex OR Maxalt. For frequent headaches >2 attacks per month, prophylaxis should be considered. Limited to 9 tablets per 30 days.

Zolmitriptan	Zolmitriptan	Tablet	2.5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Zolmitriptan is step therapy to treatment failure of Imitrex OR Maxalt. For frequent headaches >2 attacks per month, prophylaxis should be considered. Limited to 9 tablets per 30 days.
Zolmitriptan	Zolmitriptan	Tablet	5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Zolmitriptan is step therapy to treatment failure of Imitrex OR Maxalt. For frequent headaches >2 attacks per month, prophylaxis should be considered. Limited to 9 tablets per 30 days.

THERAPEUTIC CATEGORY
CNS, Muscle Relaxants

DRUG CLASS: Skeletal Muscle Relaxants **CATEGORY** CNS, Muscle Relaxants

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Baclofen	Baclofen	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Baclofen	Baclofen	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyclobenzaprine Hcl	Cyclobenzaprine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyclobenzaprine Hcl	Cyclobenzaprine Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robaxin	Methocarbamol	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robaxin-750	Methocarbamol	Tablet	750 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tizanidine Hcl	Tizanidine Hcl	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tizanidine Hcl	Tizanidine Hcl	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Cns, Other

DRUG CLASS: Agents To Treat Multiple Sclerosis					CATEGORY Cns, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Lemtrada	Alemtuzumab	Vial	12Mg/1.2Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Restricted to neurologists. Reserved for patients with diagnosis of relapsing remitting multiple sclerosis, history of treatment failure to [1] Betaseron, Avonex, Rebif, or Copaxone AND [2] Gilenya, Aubagio, or Tecfidera; also no malignancy history, negat

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Zinbryta	Daclizumab	Syringe	150 Mg/Ml	1	☐	☑	☐	☐	☐	☐	☐	☑	Restricted to neurologists. Reserved for patients with diagnosis of relapsing remitting multiple sclerosis, history of treatment failure to [1] Betaseron, Avonex, Rebif, or Copaxone AND [2] Gilenya, Aubagio, or Tecfidera; also no malignancy history, negat
Tecfidera	Dimethyl Fumarate	Capsule Dr	120 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Reserved for treatment failure to Avonex, Betaseron, Rebif or Copaxone.
Tecfidera	Dimethyl Fumarate	Capsule Dr	120-240 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Reserved for treatment failure to Avonex, Betaseron, Rebif or Copaxone.
Tecfidera	Dimethyl Fumarate	Capsule Dr	240 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Reserved for treatment failure to Avonex, Betaseron, Rebif or Copaxone.

Gilenya	Fingolimod Hcl	Capsule	0.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for treatment failure of Avonex/Rebif/Copaxone. Must be prescribed by a neurologist, for verified diagnosis of MS.
Glatopa	Glatiramer Acetate	Syringe	20 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Restricted to neurologists. Reserved for patients with diagnosis of multiple sclerosis.
Copaxone	Glatiramer Acetate	Syringe	20 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Restricted to neurologists. Reserved for patients with diagnosis of multiple sclerosis.
Copaxone	Glatiramer Acetate	Syringe	40 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Restricted to neurologists. Reserved for patients with diagnosis of multiple sclerosis.
Avonex Pen	Interferon Beta-1A	Pen Ij Kit	30MCG/ .5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for multiple sclerosis prescribed by neurologist

Avonex Pen	Interferon Beta-1A	Pen Injctr	30MCG/ .5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for multiple sclerosis prescribed by neurologist
Avonex	Interferon Beta-1A	Syringe	30MCG/ .5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	First line therapy for MS. Must be prescribed by a neurologist, for verified diagnosis of MS. Restricted to Specialty Pharmacy at 877-319-6337
Avonex	Interferon Beta-1A	Syringekit	30MCG/ .5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	First line therapy for MS. Must be prescribed by a neurologist, for verified diagnosis of MS. Restricted to Specialty Pharmacy at 877-319-6337
Avonex Administration Pack	Interferon Beta-1A/Albumin	Kit	30 MCG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for multiple sclerosis prescribed by neurologist

Rebif	Interferon Beta-1A/Albumin	Syringe	22MCG/.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	First line therapy for MS. Must be prescribed by a neurologist, for verified diagnosis of MS. Restricted to Specialty Pharmacy at 877-319-6337
Rebif	Interferon Beta-1A/Albumin	Syringe	44MCG/.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	First line therapy for MS. Must be prescribed by a neurologist, for verified diagnosis of MS. Restricted to Specialty Pharmacy at 877-319-6337
Rebif	Interferon Beta-1A/Albumin	Syringe	8.8-22(6)	1	☑	☐	☐	☐	☐	☐	☐	☑	First line therapy for MS. Must be prescribed by a neurologist, for verified diagnosis of MS. Restricted to Specialty Pharmacy at 877-319-6337
Extavia	Interferon Beta-1B	Kit	0.3 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for multiple sclerosis prescribed by neurologist

Extavia	Interferon Beta-1B	Vial	0.3 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	First line therapy for MS. Must be prescribed by a neurologist, for verified diagnosis of MS. Restricted to Specialty Pharmacy at 877-319-6337
Aubagio	Teriflunomide	Tablet	14 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for treatment failure of Avonex/Rebif/Copaxone. Must be prescribed by a neurologist, for verified diagnosis of MS.
Aubagio	Teriflunomide	Tablet	7 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for treatment failure of Avonex/Rebif/Copaxone. Must be prescribed by a neurologist, for verified diagnosis of MS.

DRUG CLASS:	Agts treatment Neuromusc Transmission Dis,Pot-				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

RESTRICTION KEY

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | FL = Fill Limit | AL = Age Limit
PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Ampyra	Dalfampridine	Tab Er 12H	10 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Reserved for patients on disease modifying therapy who are ambulatory with a timed 25-foot walk test between 8-45 seconds.
DRUG CLASS:	Alzheimer'S Therapy, Nmda Receptor Antagonists				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Namenda	Memantine Hcl	Solution	10 MG/5 ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with moderate-to-severe dementia of Alzheimer's type, based on MMSE score of 3-14.
Namenda	Memantine Hcl	Tab Ds Pk	5 MG-10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with moderate-to-severe dementia of Alzheimer's type, based on MMSE score of 3-14.
Namenda	Memantine Hcl	Tablet	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with moderate-to-severe dementia of Alzheimer's type, based on MMSE score of 3-14.

Namenda	Memantine Hcl	Tablet	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with moderate-to-severe dementia of Alzheimer's type, based on MMSE score of 3-14.

DRUG CLASS:	Anti-Alcoholic Preparations				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Disulfiram	Disulfiram	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Disulfiram	Disulfiram	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Anti-Anxiety Drugs				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Xanax	Alprazolam	Tablet	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Xanax	Alprazolam	Tablet	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Xanax	Alprazolam	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Xanax	Alprazolam	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Buspar	Buspirone Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Buspar	Buspirone Hcl	Tablet	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Buspar	Buspirone Hcl	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Buspar	Buspirone Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Buspirone Hcl	Buspirone Hcl	Tablet	7.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Librium	Chlordiazepoxide Hc	Capsule	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Librium	Chlordiazepoxide Hc	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Librium	Chlordiazepoxide Hc	Capsule	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lorazepam Intensol	Lorazepam	Oral Conc	2 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lorazepam	Lorazepam	Tablet	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lorazepam	Lorazepam	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lorazepam	Lorazepam	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Anticonvulsants				**CATEGORY** CNS, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Carbamazepine	Carbamazepine	Cpmp 12Hr	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Carbamazepine	Carbamazepine	Cpmp 12Hr	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Carbamazepine	Carbamazepine	Cpmp 12Hr	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Tegretol	Carbamazepine	Oral Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tegretol	Carbamazepine	Tab Chew	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tegretol Xr	Carbamazepine	Tab Er 12H	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tegretol Xr	Carbamazepine	Tab Er 12H	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tegretol Xr	Carbamazepine	Tab Er 12H	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tegretol	Carbamazepine	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tegretol	Carbamazepine	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Onfi	Clobazam	Tablet	10 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Onfi	Clobazam	Tablet	20 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Klonopin	Clonazepam	Tab Rapdis	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klonopin	Clonazepam	Tab Rapdis	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klonopin	Clonazepam	Tab Rapdis	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klonopin	Clonazepam	Tab Rapdis	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klonopin	Clonazepam	Tab Rapdis	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Klonopin	Clonazepam	Tablet	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klonopin	Clonazepam	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Klonopin	Clonazepam	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depakote Sprinkle	Divalproex Sodium	Cap Sprink	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depakote Er	Divalproex Sodium	Tab Er 24H	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depakote Er	Divalproex Sodium	Tab Er 24H	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depakote	Divalproex Sodium	Tablet Dr	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depakote	Divalproex Sodium	Tablet Dr	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depakote	Divalproex Sodium	Tablet Dr	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zarontin	Ethosuximide	Capsule	250 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Zarontin	Ethosuximide	Solution	250 MG/5M	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Felbatol	Felbamate	Tablet	400 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Felbatol	Felbamate	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Neurontin	Gabapentin	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neurontin	Gabapentin	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neurontin	Gabapentin	Capsule	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neurontin	Gabapentin	Solution	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neurontin	Gabapentin	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neurontin	Gabapentin	Tablet	800 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vimpat	Lacosamide	Solution	10 MG/ML	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Vimpat	Lacosamide	Tablet	100 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Vimpat	Lacosamide	Tablet	150 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Vimpat	Lacosamide	Tablet	200 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Vimpat	Lacosamide	Tablet	50 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists

Vimpat	Lacosamide	Vial	200MG/ 20ML	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Lamotrigine	Lamotrigine	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamotrigine	Lamotrigine	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamotrigine	Lamotrigine	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamotrigine	Lamotrigine	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamotrigine	Lamotrigine	Tb Chw Dsp	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamotrigine	Lamotrigine	Tb Chw Dsp	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levetiracetam	Levetiracetam	Solution	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levetiracetam	Levetiracetam	Solution	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levetiracetam Er	Levetiracetam	Tab Er 24H	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levetiracetam Er	Levetiracetam	Tab Er 24H	750 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levetiracetam	Levetiracetam	Tablet	1000 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levetiracetam	Levetiracetam	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levetiracetam	Levetiracetam	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Levetiracetam	Levetiracetam	Tablet	750 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Levetiracetam	Levetiracetam	Vial	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Celontin	Methsuximide	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Oxcarbazepine	Oxcarbazepine	Oral Susp	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Oxcarbazepine	Oxcarbazepine	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Oxcarbazepine	Oxcarbazepine	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Oxcarbazepine	Oxcarbazepine	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dilantin-125	Phenytoin	Oral Susp	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dilantin	Phenytoin	Tab Chew	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dilantin	Phenytoin Sodium E	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Phenytek	Phenytoin Sodium E	Capsule	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dilantin	Phenytoin Sodium E	Capsule	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Phenytek	Phenytoin Sodium E	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Lyrica	Pregabalin	Capsule	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of a tricyclic antidepressant and gabapentin at dose larger than 1800mg/day for at least 8 weeks.
Lyrica	Pregabalin	Capsule	150 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of a tricyclic antidepressant and gabapentin at dose larger than 1800mg/day for at least 8 weeks.
Lyrica	Pregabalin	Capsule	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of a tricyclic antidepressant and gabapentin at dose larger than 1800mg/day for at least 8 weeks.

Lyrica	Pregabalin	Capsule	225 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of a tricyclic antidepressant and gabapentin at dose larger than 1800mg/day for at least 8 weeks.
Lyrica	Pregabalin	Capsule	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of a tricyclic antidepressant and gabapentin at dose larger than 1800mg/day for at least 8 weeks.
Lyrica	Pregabalin	Capsule	300 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of a tricyclic antidepressant and gabapentin at dose larger than 1800mg/day for at least 8 weeks.

Lyrica	Pregabalin	Capsule	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of a tricyclic antidepressant and gabapentin at dose larger than 1800mg/day for at least 8 weeks.
Lyrica	Pregabalin	Capsule	75 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of a tricyclic antidepressant and gabapentin at dose larger than 1800mg/day for at least 8 weeks.
Primidone	Primidone	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Primidone	Primidone	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gabitril	Tiagabine Hcl	Tablet	12 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Gabitril	Tiagabine Hcl	Tablet	16 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Gabitril	Tiagabine Hcl	Tablet	2 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists

Gabitril	Tiagabine Hcl	Tablet	4 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	
Topamax	Topiramate	Cap Sprink	15 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Reserved for patients <13 years of age or with a documented inability to swallow tablets.
Topamax	Topiramate	Cap Sprink	25 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Reserved for patients <13 years of age or with a documented inability to swallow tablets.
Topamax	Topiramate	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Topamax	Topiramate	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Topamax	Topiramate	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Topamax	Topiramate	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Topamax	Topiramate	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Topamax	Topiramate	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Topamax	Topiramate	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Topamax	Topiramate	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Depakene	Valproic Acid	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depakene	Valproic Acid (As So	Solution	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Valproic Acid	Valproic Acid (As So	Solution	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zonisamide	Zonisamide	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zonisamide	Zonisamide	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zonisamide	Zonisamide	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Anti-Narcolepsy & Anti-Cataplexy,Sedative-Type A				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Xyrem	Sodium Oxybate	Solution	500 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Sodium oxybate is reserved for use in narcolepsy with cataplexy treated by a sleep specialist or pulmonologist.
DRUG CLASS:	Antiparkinsonism Drugs,Other				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Parlodel	Bromocriptine Mesyl	Capsule	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Parlodel	Bromocriptine Mesyl	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Parcopa	Carbidopa/Levodop	Tab Rapdis	10MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Parcopa	Carbidopa/Levodop	Tab Rapdis	25MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Parcopa	Carbidopa/Levodop	Tab Rapdis	25MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sinemet 10-100	Carbidopa/Levodop	Tablet	10MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sinemet 25-100	Carbidopa/Levodop	Tablet	25MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sinemet 25-250	Carbidopa/Levodop	Tablet	25MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sinemet Cr	Carbidopa/Levodop	Tablet Er	25MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sinemet Cr	Carbidopa/Levodop	Tablet Er	50MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pramipexole Dihydrochloride	Pramipexole Di-Hcl	Tablet	0.125 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Pramipexole Dihydrochloride	Pramipexole Di-Hcl	Tablet	0.25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Pramipexole Dihydrochloride	Pramipexole Di-Hcl	Tablet	0.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Pramipexole Dihydrochloride	Pramipexole Di-Hcl	Tablet	0.75 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.

Pramipexole Dihydrochloride	Pramipexole Di-Hcl	Tablet	1 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Pramipexole Dihydrochloride	Pramipexole Di-Hcl	Tablet	1.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Azilect	Rasagiline Mesylate	Tablet	0.5 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Azilect	Rasagiline Mesylate	Tablet	1 MG	1	☐	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Neurologists
Requip	Ropinirole Hcl	Tablet	0.25 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Requip	Ropinirole Hcl	Tablet	0.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Requip	Ropinirole Hcl	Tablet	1 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Requip	Ropinirole Hcl	Tablet	2 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Requip	Ropinirole Hcl	Tablet	3 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.

Requip	Ropinirole Hcl	Tablet	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Requip	Ropinirole Hcl	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Eldepryl	Selegiline Hcl	Capsule	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Selegiline Hcl	Selegiline Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Barbiturates				**CATEGORY** CNS, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Phenobarbital	Phenobarbital	Elixir	20 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenobarbital	Phenobarbital	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenobarbital	Phenobarbital	Tablet	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenobarbital	Phenobarbital	Tablet	16.2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenobarbital	Phenobarbital	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenobarbital	Phenobarbital	Tablet	32.4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenobarbital	Phenobarbital	Tablet	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenobarbital	Phenobarbital	Tablet	64.8 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Phenobarbital	Phenobarbital	Tablet	97.2MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Cholinesterase Inhibitors				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Donepezil Hcl	Donepezil Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Donepezil Hcl	Donepezil Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Regonol	Pyridostigmine Bro	Ampul	5 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mestinon	Pyridostigmine Bro	Syrup	60 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pyridostigmine Bro	Pyridostigmine Bro	Tablet	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mestinon	Pyridostigmine Bro	Tablet Er	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Exelon	Rivastigmine Tartrate	Capsule	1.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with mild-moderate dementia of the Alzheimer's type with a MMSE score between 10 and 26.
Exelon	Rivastigmine Tartrate	Capsule	3 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with mild-moderate dementia of the Alzheimer's type with a MMSE score between 10 and 26.

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Exelon	Rivastigmine Tartrate	Capsule	4.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with mild-moderate dementia of the Alzheimer's type with a MMSE score between 10 and 26.
Exelon	Rivastigmine Tartrate	Capsule	6 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with mild-moderate dementia of the Alzheimer's type with a MMSE score between 10 and 26.
DRUG CLASS:	Fibromyalgia Agents,Serotonin-Norepineph Ru In				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Savella	Milnacipran Hcl	Tablet	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or documented intolerance to optimally dosed Venlafaxine IR/XR and Duloxetine for two months each.

Savella	Milnacipran Hcl	Tablet	12.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or documented intolerance to optimally dosed Venlafaxine IR/XR and Duloxetine for two months each.
Savella	Milnacipran Hcl	Tablet	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or documented intolerance to optimally dosed Venlafaxine IR/XR and Duloxetine for two months each.
Savella	Milnacipran Hcl	Tablet	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or documented intolerance to optimally dosed Venlafaxine IR/XR and Duloxetine for two months each.
DRUG CLASS:	Sedative-Hypnotics,Non-Barbiturate				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Wal-Som	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Som	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Som	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Som	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Som	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Som	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Som	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Som	Diphenhydramine H	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sleep Aid	Diphenhydramine H	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sominex Max Streng	Diphenhydramine H	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Temazepam	Temazepam	Capsule	15 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tabs/caps per 75 days to encourage as needed use . please counsel on sleep hygiene. Submit PA for patients in care facility or psychiatric conditions.

Temazepam	Temazepam	Capsule	30 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tabs/caps per 75 days to encourage as needed use . please counsel on sleep hygiene. Submit PA for patients in care facility or psychiatric conditions.
Zaleplon	Zaleplon	Capsule	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tabs/caps per 75 days to encourage as needed use . please counsel on sleep hygiene. Submit PA for patients in care facility or psychiatric conditions.
Zaleplon	Zaleplon	Capsule	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tabs/caps per 75 days to encourage as needed use . please counsel on sleep hygiene. Submit PA for patients in care facility or psychiatric conditions.

Ambien	Zolpidem Tartrate	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tabs/caps per 75 days to encourage as needed use . please counsel on sleep hygiene. Submit PA for patients in care facility or psychiatric conditions.
Ambien	Zolpidem Tartrate	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tabs/caps per 75 days to encourage as needed use . please counsel on sleep hygiene. Submit PA for patients in care facility or psychiatric conditions.
DRUG CLASS:	treatment For Attention Deficit-Hyperact.(Adhd),				**CATEGORY**	CNS, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Strattera	Atomoxetine Hcl	Capsule	10 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of stimulants (eg, Concerta, Ritalin SR/ER or Adderall XR).

Strattera	Atomoxetine Hcl	Capsule	100 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of stimulants (eg, Concerta, Ritalin SR/ER or Adderall XR).
Strattera	Atomoxetine Hcl	Capsule	18 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of stimulants (eg, Concerta, Ritalin SR/ER or Adderall XR).
Strattera	Atomoxetine Hcl	Capsule	25 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of stimulants (eg, Concerta, Ritalin SR/ER or Adderall XR).
Strattera	Atomoxetine Hcl	Capsule	40 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of stimulants (eg, Concerta, Ritalin SR/ER or Adderall XR).

Strattera	Atomoxetine Hcl	Capsule	60 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of stimulants (eg, Concerta, Ritalin SR/ER or Adderall XR).
Strattera	Atomoxetine Hcl	Capsule	80 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of stimulants (eg, Concerta, Ritalin SR/ER or Adderall XR).
DRUG CLASS:	Wakefulness-Promoting Agents				**CATEGORY**	Cns, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Modafinil	Modafinil	Tablet	100 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Modafinil Is Reserved For Treatment Of Narcolepsy Or Obstructive Sleep Apnea Treated By A Sleep Specialist Or Pulmonologist. For Apnea, Modafinil Is Reserved For Inadequate Response To Compliant Use Of Properly-Fitting Cpap For At Least 90 Days.

Modafinil	Modafinil	Tablet	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Modafinil is reserved for treatment of narcolepsy or obstructive sleep apnea treated by a sleep specialist or pulmonologist. For apnea, modafinil is reserved for inadequate response to compliant use of properly-fitting CPAP for at least 90 days.

THERAPEUTIC CATEGORY
Contraceptives,Non-Systemic

DRUG CLASS:	Condoms				**CATEGORY**	Contraceptives,Non-Systemic						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Fc2 Female Condom	Condoms, Female	Each		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 6 condoms per 30 days.

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THERAPEUTIC CATEGORY
Cough&Cold

DRUG CLASS: / Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
	1St Gen Antihistamine-Decongestant-Analgesic Co				CATEGORY Cough&Cold								
Non-Aspirin Child'S	P-Ephed Hcl/Acetam	Tab Chew	7.5-80-0	1	☐	☐	☐	☐	☐	☐	☐	☐	
	1St Gen Antihist-Decon-Nsaid,Cox Nonspec				CATEGORY Cough&Cold								
Advil	Chlorphen/Pseudoe	Tablet	2-30-20	1	☐	☐	☐	☐	☐	☐	☐	☐	
	Decongest-Analgesic,Non-Salicylate Comb.				CATEGORY Cough&Cold								
Daytime Sinus Relief	Pseudoephedrine/Ac	Capsule	30MG-3	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist	Pseudoephedrine/Ac	Tablet	30MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist	Pseudoephedrine/Ac	Tablet	30MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist	Pseudoephedrine/Ac	Tablet	30MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist	Pseudoephedrine/Ac	Tablet	30MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist	Pseudoephedrine/Ac	Tablet	30MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tavist	Pseudoephedrine/Ac	Tablet	30MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Tavist	Pseudoephedrine/Ac	Tablet	30MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Decongestant				**CATEGORY** Cough&Cold								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Sudafed Pe	Phenylephrine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed Pe	Phenylephrine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed Pe	Phenylephrine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed Pe	Phenylephrine Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nasal Decongestant	Phenylephrine Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pediacare	Pseudoephedrine Hc	Drops	9.4MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pediacare	Pseudoephedrine Hc	Drops	9.4MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Children'S Sudafed	Pseudoephedrine Hc	Liquid	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Children'S Sudafed	Pseudoephedrine Hc	Liquid	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Children'S Sudafed	Pseudoephedrine Hc	Liquid	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Children'S Sudafed	Pseudoephedrine Hc	Liquid	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pseudoephedrine H	Pseudoephedrine Hc	Liquid	30 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Pseudoephedrine H	Pseudoephedrine Hc	Liquid	30 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pseudoephedrine H	Pseudoephedrine Hc	Tablet	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sudafed 12 Hour	Pseudoephedrine Hc	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
12 Hour Cold Relief	Pseudoephedrine Sul	Tablet Er	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Decongestant-Expectorant Combinations				**CATEGORY** Cough&Cold								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Suphedrin Non-Dryi	Guaifenesin/Pseudo	Capsule	200MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Suphedrin Non-Dryi	Guaifenesin/Pseudo	Capsule	200MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Q-Tussin Pe	Guaifenesin/Pseudo	Syrup	100-30	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triaminic	Guaifenesin/Pseudo	Syrup	50-15M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucinex D	Guaifenesin/Pseudo	Tab Er 12H	1200-12	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Mucinex D	Guaifenesin/Pseudo	Tab Er 12H	600MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Congestac	Guaifenesin/Pseudo	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Congestac	Guaifenesin/Pseudo	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Congestac	Guaifenesin/Pseudo	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Decongestant-Nsaid, Cox Non-Spec Comb.				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ibuprofen Cold	Ibuprofen/Pseudoep	Oral Susp	100-15	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Expectorants				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

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Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin	Guaifenesin	Liquid	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetic Tussin Muc	Guaifenesin	Liquid	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Organidin Nr	Guaifenesin	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Organidin Nr	Guaifenesin	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Organidin Nr	Guaifenesin	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Organidin Nr	Guaifenesin	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Narcotic Antituss-1St Gen. Antihistamine-Deconge				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Phenylhistine Dh	P-Eph Hcl/Cod/Chlorpheni r	Liquid	30-10-2/5	1	☐	☐	☑	☑	☑	☐	☐	☐	RESTRICTED TO 240 ML PER FILL AND 4 FILLS PER 365 DAYS. Patient must be over the age of 5
Phenergan Vc With Codeine	Promethazine/Phen ylephrine/Codeine	Syrup	6.25-5-10	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.

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DRUG CLASS: Narcotic Antituss-Decongestant-Expectorant Com					**CATEGORY** Cough&Cold								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cheratussin Dac	P-Eph Hcl/Codeine/Guaifen	Syrup	30-10-100	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
Cheratussin Dac	P-Eph Hcl/Codeine/Guaifen	Syrup	30-10-100	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
DRUG CLASS: Narcotic Antitussive-1St Generation Antihistamin					**CATEGORY** Cough&Cold								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Promethazine-Codeine	Promethazine Hcl/Codeine	Syrup	6.25-10/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
DRUG CLASS: Narcotic Antitussive-Anticholinergic Comb.					**CATEGORY** Cough&Cold								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Hydromet	Hydrocodone Bit/Homatrop Me-Br	Syrup	5-1.5 MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
Hydromet	Hydrocodone Bit/Homatrop Me-Br	Syrup	5-1.5 MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.

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DRUG CLASS: Narcotic Antitussive-Expectorant Combination					**CATEGORY** Cough&Cold								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Guaifenesin-Codeine	Guaifenesin/Codeine Phosphate	Liquid	100-10MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
Guaifenesin-Codeine	Guaifenesin/Codeine Phosphate	Liquid	100-10MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
Guaifenesin-Codeine	Guaifenesin/Codeine Phosphate	Liquid	100-10MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
Guaifenesin-Codeine	Guaifenesin/Codeine Phosphate	Liquid	100-10MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
Guaifenesin-Codeine	Guaifenesin/Codeine Phosphate	Liquid	100-10MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.
Guaifenesin-Codeine	Guaifenesin/Codeine Phosphate	Liquid	100-10MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥18 years of age. Limited to 240 mL per fill; 4 fills per year.

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DRUG CLASS:	Non-Narc Antitus-1St Gen Antihist-Decon-Analges				CATEGORY	Cough&Cold								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Alka-Seltzer Plus-D	Dm Hb/Pseudoephe	Capsule	10-30-3	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tylenol Cold	Dm Hb/Pseudoephe	Tablet	15-30-3	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tylenol Cold & Flu S	Dm/P-Ephed/Aceta	Liquid	30-12.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Non-Narc Antituss-1St Gen. Antihistamine-Decong				**CATEGORY**	Cough&Cold								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dimetapp Dm	Brompheniram/Phe	Solution	1-2.5-5/	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Cardec Dm	Dm/Phenyleph/Chlo	Drops	3-3.5-1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Cardec Dm	Dm/Phenyleph/Chlo	Drops	3-3.5-1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Bromaline Dm	D-Methorphan Hb/P	Elixir	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐
Bromaline Dm	D-Methorphan Hb/P	Elixir	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐
Bromaline Dm	D-Methorphan Hb/P	Elixir	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐
Bromaline Dm	D-Methorphan Hb/P	Elixir	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐
Bio-Dtuss Dmx	D-Methorphan Hb/P	Liquid	20-30-1	1	☐	☐	☐	☐	☐	☐	☐	☐
Dimetane-diagnosis	D-Methorphan Hb/P	Syrup	10-30-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Dimetane-diagnosis	D-Methorphan Hb/P	Syrup	10-30-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Anaplex Dm	D-Methorphan Hb/P	Syrup	30-60-4	1	☐	☐	☐	☐	☐	☐	☐	☐
Rescon-Dm	D-Methorphan Hb/P	Liquid	10-30-2	1	☐	☐	☐	☐	☐	☐	☐	☐
Pediacare Cough-Col	D-Methorphan Hb/P	Liquid	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐
Pediacare Cough-Col	D-Methorphan Hb/P	Liquid	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐
Pediacare Cough-Col	D-Methorphan Hb/P	Liquid	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐
Pediacare Cough-Col	D-Methorphan Hb/P	Liquid	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐

Pediacare Cough-Col	D-Methorphan Hb/P	Liquid	5-15-1M	1	☐	☐	☐	☐	☐	☐	☐	☐	
M-End Dm	D-Methorphan Hb/P	Syrup	15-15-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Non-Narc Antitussive-1St Gen Antihistamine Com				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Promethazine-Dm	Dextromethorphan Hbr/Promethazine Hcl	Syrup	15-6.25/5	1	☐	☐	☐	☑	☑	☐	☐	☐	Restricted to patients ≥2 years of age. For ages 2 to 6, limited to 1 fill per 365 days. For ages >6, Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
DRUG CLASS:	Non-Narcotic Antituss-Decongestant-Expectorant				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Tussin Cf	Guaifenesin/Dm/Pse	Syrup	100-10-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin Cough &	Guaifenesin/D-Meth	Liquid	100-10-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin Cough &	Guaifenesin/D-Meth	Liquid	100-10-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin Cough &	Guaifenesin/D-Meth	Liquid	100-10-	1	☐	☐	☐	☐	☐	☐	☐	☐	

Robitussin Cough &	Guaifenesin/D-Meth	Liquid	100-10-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin Cough &	Guaifenesin/D-Meth	Liquid	100-10-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Robitussin Cough &	Guaifenesin/D-Meth	Liquid	100-10-	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Non-Narcotic Antitussive And Expectorant Comb.				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Coricidin Hbp	Guaifenesin/Dextro	Capsule	200MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Coricidin Hbp	Guaifenesin/Dextro	Capsule	200MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adult Robitussin Peak Cold	Guaifenesin/Dextro methorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextro methorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin Peak Cold	Guaifenesin/Dextromethorphan	Liquid	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Child Mucus Relief Cough	Guaifenesin/Dextromethorphan	Liquid	100-5 MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Child Mucus Relief Cough	Guaifenesin/Dextromethorphan	Liquid	100-5 MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Child Mucus Relief Cough	Guaifenesin/Dextromethorphan	Liquid	100-5 MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Child Mucus Relief Cough	Guaifenesin/Dextromethorphan	Liquid	100-5 MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Child Mucus Relief Cough	Guaifenesin/Dextromethorphan	Liquid	100-5 MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Child Mucus Relief Cough	Guaifenesin/Dextromethorphan	Liquid	100-5 MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin Dm Max	Guaifenesin/Dextromethorphan	Liquid	200-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin Dm Max	Guaifenesin/Dextromethorphan	Liquid	200-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin Dm Max	Guaifenesin/Dextromethorphan	Liquid	200-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Robitussin Dm Max	Guaifenesin/Dextromethorphan	Liquid	200-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin Dm Max	Guaifenesin/Dextromethorphan	Liquid	200-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin Dm Max	Guaifenesin/Dextromethorphan	Liquid	200-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin Dm Max	Guaifenesin/Dextromethorphan	Liquid	200-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Robitussin Dm Max	Guaifenesin/Dextromethorphan	Liquid	200-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Scot-Tussin Senior	Guaifenesin/Dextromethorphan	Liquid	200-15MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Neo-Tuss	Guaifenesin/Dextromethorphan	Liquid	200-30MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Biospec Dmx	Guaifenesin/Dextromethorphan	Liquid	25-15MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Double Tussin Dm	Guaifenesin/Dextromethorphan	Liquid	300-20MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Double Tussin Dm	Guaifenesin/Dextromethorphan	Liquid	300-20MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Double Tussin Dm	Guaifenesin/Dextromethorphan	Liquid	300-20MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin-Dm Cough	Guaifenesin/Dextromethorphan	Syrup	100-10MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Tussin Dm	Guaifenesin/Dextromethorphan	Syrup	100-15MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Mucus Dm Max	Guaifenesin/Dextro	Tab Er 12H	1200-60	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucinex Dm	Guaifenesin/Dextro	Tab Er 12H	600MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucus Relief Dm	Guaifenesin/Dextro	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucus Relief Dm	Guaifenesin/Dextro	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucus Relief Dm	Guaifenesin/Dextro	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	

Mucus Relief Dm	Guaifenesin/Dextro	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucus Relief Dm	Guaifenesin/Dextro	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucus Relief Dm	Guaifenesin/Dextro	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucus Relief Dm	Guaifenesin/Dextro	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mucus Relief Dm	Guaifenesin/Dextro	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Non-Narcotic Antitussive-Decongestant Combinati				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pedia Relief	Dextromethorphan/	Drops	2.5-7.5/.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Expectorant Max Strength	Dextromethorphan/ Pseudoephed	Liquid	15-30MG/5	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
DRUG CLASS:	Non-Narcotic Antitussive-Decongestant-Analgesic				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Infant Non-Asa Cold	Dm/Pseudoephed/A	Drops	5-15-16	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Nose Preparations, Vasoconstrictors(Otc)				**CATEGORY**	Cough&Cold							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Opcon-A	Naphazoline Hcl/Phe	Drops	.0268-.3	1	☐	☐	☐	☐	☐	☐	☐	☐
Naphcon-A	Naphazoline Hcl/Phe	Drops	0.025-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Naphcon-A	Naphazoline Hcl/Phe	Drops	0.025-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Naphcon-A	Naphazoline Hcl/Phe	Drops	0.025-0.	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Dental

DRUG CLASS: Brand Name	Fluoride Preparations Generic Name	Formulation	Strength	Tier	CATEGORY Dental PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Prevident 5000 Plus	Sodium Fluoride	Cream (G)	0.011	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prevident 5000 Plus	Sodium Fluoride	Cream (G)	0.011	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluoritab	Sodium Fluoride	Drops	0.125/D ROP	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride drops may be filled up to 100 days at a time. Reserved for 16 years old and less.
Fluorabon	Sodium Fluoride	Drops	0.25MG /0.6	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride drops may be filled up to 100 days at a time. Reserved for 16 years old and less.
Fluoritab	Sodium Fluoride	Drops	0.25MG /DRP	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride drops may be filled up to 100 days at a time. Reserved for 16 years old and less.

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Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Luride	Sodium Fluoride	Drops	0.5 MG/ML	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride drops may be filled up to 100 days at a time. Reserved for 16 years old and less.
Fluor-A-Day	Sodium Fluoride	Drops	2.5 MG/ML	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride drops may be filled up to 100 days at a time. Reserved for 16 years old and less.
Prevident	Sodium Fluoride	Gel (Gram)	0.011	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prevident	Sodium Fluoride	Gel (Gram)	0.011	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prevident	Sodium Fluoride	Gel (Gram)	0.011	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prevident 5000	Sodium Fluoride	Gel (Ml)	0.011	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prevident	Sodium Fluoride	Paste (Ml)	0.011	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phos-Flur	Sodium Fluoride	Solution	0.0002	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prevident	Sodium Fluoride	Solution	0.002	1	☐	☐	☐	☐	☐	☐	☐	☐	
Luride	Sodium Fluoride	Tab Chew	0.25(0.55)	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride tabs may be filled up to 100 days at a time. Reserved for 16 years old and less.

Luride	Sodium Fluoride	Tab Chew	0.25(0.55)	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride tabs may be filled up to 100 days at a time. Reserved for 16 years old and less.
Luride	Sodium Fluoride	Tab Chew	0.5(1.1) MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride tabs may be filled up to 100 days at a time. Reserved for 16 years old and less.
Luride	Sodium Fluoride	Tab Chew	0.5(1.1) MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride tabs may be filled up to 100 days at a time. Reserved for 16 years old and less.
Luride	Sodium Fluoride	Tab Chew	1MG(2.2 MG)	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride tabs may be filled up to 100 days at a time. Reserved for 16 years old and less.
Luride	Sodium Fluoride	Tab Chew	1MG(2.2 MG)	1	☐	☐	☑	☐	☑	☐	☐	☐	Oral Fluoride tabs may be filled up to 100 days at a time. Reserved for 16 years old and less.
Fluor-A-Day	Sodium Fluoride/Xyl	Tab Chew	0.25(0.5	1	☐	☐	☐	☐	☐	☐	☐	☐	

Fluor-A-Day	Sodium Fluoride/Xyl	Tab Chew	0.5(1.1)	1	☐	☐	☐	☐	☐	☐	☐	☐
Fluor-A-Day	Sodium Fluoride/Xyl	Tab Chew	1MG(2.2	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Dermatologicals,All Other

DRUG CLASS: -					CATEGORY Dermatologicals,All Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Eucrisa	Crisaborole	Oint. (G)	2 %	1	☐	☑	☐	☐	☐	☐	☐	☐	Step Therapy for patients with atopic dermatitis who have failed treatment, shown intolerance, or has contraindication to a medium to super-high potency topical corticosteroid AND either Pimecrolimus (Elidel) or Tacrolimus (Protopic) within the past 30 da

DRUG CLASS: Antipsoriatic Agents,Systemic					CATEGORY Dermatologicals,All Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Siliq	Brodalumab	Syringe	210 Mg/1.5	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment of Psoriasis, treatment failure/documented intolerance to Adalimumab, Etanercept, or Infliximab. Must be prescribed by dermatologist. Restricted to Diplomat Specialty Pharmacy.
Tremfya	Guselkumab	Syringe	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment of Psoriasis, treatment failure/documented intolerance to Adalimumab, Etanercept, or Infliximab. Must be prescribed by dermatologist. Restricted to Diplomat Specialty Pharmacy.

Taltz Autoinjector (3 Pack)	Ixekizumab	Auto Injct	80 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment of Psoriatic Arthritis, treatment failure/documented intolerance to two 1st line agents (Adalimumab, Etanercept, or Infliximab) OR one 1st line agent (Adalimumab, Etanercept, Infliximab) and one 2nd line agent (Abatacep
Taltz Autoinjector (2 Pack)	Ixekizumab	Auto Injct	80 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment of Psoriatic Arthritis, treatment failure/documented intolerance to two 1st line agents (Adalimumab, Etanercept, or Infliximab) OR one 1st line agent (Adalimumab, Etanercept, Infliximab) and one 2nd line agent (Abatacep

Taltz Autoinjector	Ixekizumab	Auto Injct	80 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment of Psoriatic Arthritis, treatment failure/documented intolerance to two 1st line agents (Adalimumab, Etanercept, or Infliximab) OR one 1st line agent (Adalimumab, Etanercept, Infliximab) and one 2nd line agent (Abatacep
Taltz Syringe	Ixekizumab	Syringe	80 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment of Psoriatic Arthritis, treatment failure/documented intolerance to two 1st line agents (Adalimumab, Etanercept, or Infliximab) OR one 1st line agent (Adalimumab, Etanercept, Infliximab) and one 2nd line agent (Abatacep

Taltz Syringe (3 Pack)	Ixekizumab	Syringe	80 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment of Psoriatic Arthritis, treatment failure/documented intolerance to two 1st line agents (Adalimumab, Etanercept, or Infliximab) OR one 1st line agent (Adalimumab, Etanercept, Infliximab) and one 2nd line agent (Abatacep
Taltz Syringe (2 Pack)	Ixekizumab	Syringe	80 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment of Psoriatic Arthritis, treatment failure/documented intolerance to two 1st line agents (Adalimumab, Etanercept, or Infliximab) OR one 1st line agent (Adalimumab, Etanercept, Infliximab) and one 2nd line agent (Abatacep
DRUG CLASS:	Keratolytics				**CATEGORY**	Dermatologicals,All Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Acne Medication	Benzoyl Peroxide	Gel (Gram)	10 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Acne Medication	Benzoyl Peroxide	Gel (Gram)	5 %	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Dermatology

DRUG CLASS: Acne Agents,Systemic					**CATEGORY** Dermatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Accutane	Isotretinoin	Capsule	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
Accutane	Isotretinoin	Capsule	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
Accutane	Isotretinoin	Capsule	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.

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Accutane	Isotretinoin	Capsule	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
Accutane	Isotretinoin	Capsule	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
Accutane	Isotretinoin	Capsule	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.

Accutane	Isotretinoin	Capsule	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
Accutane	Isotretinoin	Capsule	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
Claravis	Isotretinoin	Capsule	30 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.

Accutane	Isotretinoin	Capsule	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
Accutane	Isotretinoin	Capsule	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
Accutane	Isotretinoin	Capsule	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.

Accutane	Isotretinoin	Capsule	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to failing 2 formulary alternatives: Benzoyl Peroxide, topical retinoids, topical antibiotics or oral antibiotics.
DRUG CLASS:	Acne Agents,Topical				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Aczone	Dapsone	Gel (Gram)	0.05	1	☐	☑	☑	☐	☐	☐	☐	☐	Reserved for treatment failure to Tretinoin/Adapalene and Clindamycin/erythromycin concurrently with Benzoyl Peroxide
DRUG CLASS:	Antiperspirants				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Drysol	Aluminum Chloride	Solution	0.2	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 1 fill per month.
DRUG CLASS:	Antipsoriatic Agents,Systemic				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Acitretin	Acitretin	Capsule	10 MG	1	☑	☐	☐	☐	☐	☑	☐	☑	Acitretin is reserved for prescription by Dermatologists only

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Acitretin	Acitretin	Capsule	25 MG	1	☑	☐	☐	☐	☐	☑	☐	☑	Acitretin is reserved for prescription by Dermatologists only
Cosentyx Pen	Secukinumab	Pen Injctr	150 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. SECOND-LINE AGENT FOR PSORIASIS + PSORIATIC ARTHRITIS, THIRD-LINE TREATMENT FOR ANKLYOSING SPONDYLITIS: RESERVED FOR PATIENTS WHO FAIL FIRST-LINE BIOLOGIC(S) (e.g. HUMIRA, ENBREL, RENFLEXIS, INFLECTRA). RESTRICTED TO SPECIALTY PHARMACY.

Cosentyx Syringe	Secukinumab	Syringe	150 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. SECOND-LINE AGENT FOR PSORIASIS + PSORIATIC ARTHRITIS, THIRD-LINE TREATMENT FOR ANKLYOSING SPONDYLITIS: RESERVED FOR PATIENTS WHO FAIL FIRST-LINE BIOLOGIC(S) (e.g. HUMIRA, ENBREL, RENFLEXIS, INFLECTRA). RESTRICTED TO SPECIALTY PHARMACY.
DRUG CLASS:	Antipsoriatics Agents				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Drithocreme Hp	Anthralin	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dovonex	Calcipotriene	Cream (G)	5e-005	1	☐	☑	☐	☐	☐	☑	☐	☐	Step therapy to 1 fill of medium/high-potency topical corticosteroids within the last 30 days. Must be prescribed by Dermatologist.

Calcipotriene	Calcipotriene	Oint. (G)	5e-005	1	☐	☑	☐	☐	☐	☑	☐	☐	Step therapy to 1 fill of medium/high-potency topical corticosteroids within the last 30 days. Must be prescribed by Dermatologist.
Calcipotriene	Calcipotriene	Solution	5e-005	1	☐	☑	☐	☐	☐	☑	☐	☐	Step therapy to 1 fill of medium/high-potency topical corticosteroids within the last 30 days. Must be prescribed by Dermatologist.
Tazorac	Tazarotene	Cream (G)	0.0005	1	☐	☐	☑	☐	☐	☑	☐	☐	Psoriasis: ST to medium/high-potency corticosteroids within the last 30 days ||| Acne: Failure of Tretinoin or Adapalene + BPO; must be prescribed by Dermatologist; limit 30g per month

Tazorac	Tazarotene	Cream (G)	0.001	1	☐	☐	☑	☐	☐	☑	☐	☐	Psoriasis: ST to medium/high-potency corticosteroids within the last 30 days ||| Acne: Failure of Tretinoin or Adapalene + BPO; must be prescribed by Dermatologist; limit 30g per month
Tazorac	Tazarotene	Gel (Gram)	0.0005	1	☐	☐	☑	☐	☐	☑	☐	☐	Psoriasis: ST to medium/high-potency corticosteroids within the last 30 days ||| Acne: Failure of Tretinoin or Adapalene + BPO; must be prescribed by Dermatologist; limit 30g per month

Tazorac	Tazarotene	Gel (Gram)	0.001	1	☐	☐	☑	☐	☐	☑	☐	☐	Psoriasis: ST to medium/high-potency corticosteroids within the last 30 days ||| Acne: Failure of Tretinoin or Adapalene + BPO; must be prescribed by Dermatologist; limit 30g per month

DRUG CLASS:	Antiseborrheic Agents				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Selseb	Selenium Sulfide	Shampoo	0.0225	1	☐	☐	☐	☐	☐	☐	☐	☐	
Selenium Sulfide	Selenium Sulfide	Suspension	0.025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dandruff Shampoo	Selenium Sulfide/Alo	Shampoo	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Emollients				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Lac-Hydrin	Ammonium Lactate	Cream (G)	0.12	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amlactin	Ammonium Lactate	Kit	12%-12	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lac-Hydrin 5	Ammonium Lactate	Lotion	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Lac-Hydrin	Ammonium Lactate	Lotion	0.12	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hand Cream	Glycerin	Cream (G)		1	☐	☐	☐	☐	☐	☐	☐	☐	
Hand Cream	Glycerin	Cream (G)		1	☐	☐	☐	☐	☐	☐	☐	☐	
Glycerin	Glycerin	Liquid		1	☐	☐	☐	☐	☐	☐	☐	☐	
Wibi	Glycerin	Lotion		1	☐	☐	☐	☐	☐	☐	☐	☐	
Glycerin	Glycerin	Solution	0.995	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lactinol-E	Lactic Acid	Cream (G)	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lactinol	Lactic Acid	Lotion	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Irritants/Counter-Irritants				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Capsaicin	Capsaicin	Cream (G)	0.00025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Capsaicin	Capsaicin	Cream (G)	0.00025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Muscle Relief	Capsaicin	Cream (G)	0.00075	1	☐	☐	☐	☐	☐	☐	☐	☐	
Muscle Relief	Capsaicin	Cream (G)	0.00075	1	☐	☐	☐	☐	☐	☐	☐	☐	
Muscle Relief	Capsaicin	Cream (G)	0.00075	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Muscle Relief	Capsaicin	Cream (G)	0.00075	1	☐	☐	☐	☐	☐	☐	☐	☐	
Muscle Relief	Capsaicin	Cream (G)	0.00075	1	☐	☐	☐	☐	☐	☐	☐	☐	
High Potency Capsai	Capsaicin	Cream (G)	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Keratolytics				**CATEGORY** Dermatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Panoxyl	Benzoyl Peroxide	Bar	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Benzoyl Peroxide	Benzoyl Peroxide	Cleanser	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	
Panoxyl	Benzoyl Peroxide	Cleanser	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acne Treatment	Benzoyl Peroxide	Cream (G)	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Benzoyl Peroxide	Benzoyl Peroxide	Gel (Gram)	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desquam-X	Benzoyl Peroxide	Gel (Gram)	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Benzoyl Peroxide	Benzoyl Peroxide	Lotion	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	
Benzoyl Peroxide	Benzoyl Peroxide	Lotion	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Condylox	Podofilox	Gel (Gram)	0.005	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for use in perianal warts only. Limited to 3.5g per 30 days.

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Podofilox	Podofilox	Solution	0.005	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 3.5g per 30 days
X-Seb T Pearl	Salicylic Acid/Coal T	Shampoo		1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Mineralocorticoids				**CATEGORY**		Dermatology						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Fludrocortisone Ace	Fludrocortisone Acet	Tablet	0.1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Neuromuscular Blocking Agents				**CATEGORY**		Dermatology						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Botox	Onabotulinumtoxina	Vial	100 UNIT	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Refer to Migraine Policy for coverage criteria. Restricted to Specialty Pharmacy.
Botox	Onabotulinumtoxina	Vial	100 UNIT	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Refer to Migraine Policy for coverage criteria. Restricted to Specialty Pharmacy.
DRUG CLASS:	Protectives				**CATEGORY**		Dermatology						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Calamine	Calamine	Lotion		1	☐	☐	☐	☐	☐	☐	☐	☐	

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Calamine	Calamine/Zinc Oxide	Lotion		1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Topical Antifungal/Antiinflammatory,Steriod Age				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Lotrisone	Clotrimazole/Betamethasone Dip	Cream (G)	1 %-0.05 %	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 45g per 30 days
DRUG CLASS:	Topical Anti-Inflammatory Steroidal				**CATEGORY**	Dermatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Beta-Val	Betamethasone Vale	Cream (G)	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Beta-Val	Betamethasone Vale	Lotion	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Betamethasone Valerate	Betamethasone Valerate	Oint. (G)	0.001	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary High Potency (Class 2) topical steroid.
Clobetasol Propionate	Clobetasol Propionate	Cream (G)	0.0005	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Super High Potency (Class 1) topical steroid. Limited to 60 grams per 90 days.

Clobetasol Propionate	Clobetasol Propionate	Oint. (G)	0.0005	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Super High Potency (Class 1) topical steroid. Limited to 60 grams per 90 days.
Cormax	Clobetasol Propionate	Solution	0.0005	1	☐	☐	☑	☐	☐	☐	☐	☐	Quantity limit of 60g per 90 days per P&T Dermatologist recommendation due to rate of absorption and side effects
Desonide	Desonide	Cream (G)	0.0005	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Low Potency (Class 6) topical steroid.
Desonide	Desonide	Lotion	0.0005	1	☐	☐	☐	☐	☐	☐	☐	☐	

Desonide	Desonide	Oint. (G)	0.0005	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Low-Medium Potency (Class 5) topical steroid.
Fluocinolone Acetonide	Fluocinolone Acetonide	Cream (G)	0.0001	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Low Potency (Class 6) topical steroid.
Fluocinolone Aceton	Fluocinolone Acetoni	Cream (G)	0.00025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluocinolone Aceton	Fluocinolone Acetoni	Oil	0.0001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluocinolone Acetonide	Fluocinolone Acetonide	Oint. (G)	0.00025	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Medium Potency (Class 4) topical steroid.
Fluocinolone Aceton	Fluocinolone Acetoni	Solution	0.0001	1	☐	☐	☐	☐	☐	☐	☐	☐	

Fluocinonide	Fluocinonide	Cream (G)	0.0005	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Medium-High Potency (Class 3) topical steroid.
Fluocinonide	Fluocinonide	Gel (Gram)	0.0005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluocinonide	Fluocinonide	Oint. (G)	0.0005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluocinonide	Fluocinonide	Solution	0.0005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dermolate Anti-Itch	Hydrocortisone	Cream (G)	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cortaid	Hydrocortisone	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cortaid	Hydrocortisone	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cortaid	Hydrocortisone	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cortaid	Hydrocortisone	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cortaid	Hydrocortisone	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cortaid	Hydrocortisone	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hytone	Hydrocortisone	Cream (G)	0.025	1	☐	☐	☐	☐	☐	☐	☐	☐	

Aquanil Hc	Hydrocortisone	Lotion	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Aquanil Hc	Hydrocortisone	Lotion	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone	Hydrocortisone	Lotion	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone	Hydrocortisone	Lotion	0.025	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone	Hydrocortisone	Oint. (G)	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone	Hydrocortisone	Oint. (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone	Hydrocortisone	Oint. (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone	Hydrocortisone	Oint. (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone	Hydrocortisone	Oint. (G)	0.025	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone Acet	Hydrocortisone Acet	Cream (G)	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone Acet	Hydrocortisone Acet	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Cortaid	Hydrocortisone Acet	Oint. (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone-Alo	Hydrocortisone/Alo	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Hydrocortisone-Alo	Hydrocortisone/Alo	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐

Elecon	Mometasone Furoate	Cream (G)	0.001	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Medium Potency (Class 4) topical steroid.
Elocon	Mometasone Furoate	Oint. (G)	0.001	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure, contraindication, or intolerance to a formulary Medium Potency (Class 4) topical steroid.
Triamcinolone Acet	Triamcinolone Aceto	Cream (G)	0.00025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamcinolone Acet	Triamcinolone Aceto	Cream (G)	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamcinolone Acet	Triamcinolone Aceto	Cream (G)	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamcinolone Acet	Triamcinolone Aceto	Lotion	0.00025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamcinolone Acet	Triamcinolone Aceto	Lotion	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamcinolone Acet	Triamcinolone Aceto	Oint. (G)	0.00025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamcinolone Acet	Triamcinolone Aceto	Oint. (G)	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Triamcinolone Acet	Triamcinolone Aceto	Oint. (G)	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Topical Anti-Inflammatory, Nsaids					**CATEGORY** Dermatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pennsaid	Diclofenac Sodium	Drops	0.015	1	☐	☐	☐	☐	☑	☐	☐	☐	Step therapy to failure of 3 different nsaids (including meloxicam or etodolac) unless over 65 or at high risk for GI events.
Pennsaid	Diclofenac Sodium	Drops	0.015	1	☐	☐	☐	☐	☑	☐	☐	☐	Step therapy to failure of 3 different nsaids (including meloxicam or etodolac) unless over 65 or at high risk for GI events.
Voltaren	Diclofenac Sodium	Gel (Gram)	0.01	1	☐	☑	☐	☐	☑	☐	☐	☐	RESERVED FOR TX FAILURE OF 3 FORMULARY NSAIDS (INCLUDING MELOXICAM OR ETODOLAC) UNLESS HIGH RISK OF GI BLEED, OVER 65, OR HAS DOCUMENTED INABILITY TO SWALLOW TABLETS OR CAPSULES.

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DRUG CLASS: Topical Immunosuppressive Agents					**CATEGORY** Dermatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Elidel	Pimecrolimus	Cream (G)	0.01	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to formulary medium/high potency corticosteroid. Limited to 30gm per 30 days.
Protopic	Tacrolimus	Oint. (G)	0.0003	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to formulary medium/high potency corticosteroid. Limited to 30gm per 30 days.
Protopic	Tacrolimus	Oint. (G)	0.001	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to formulary medium/high potency corticosteroid. Limited to 30gm per 30 days.

DRUG CLASS: Topical Sulfonamides					**CATEGORY** Dermatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Rosanil Cleanser	Sulfacetamide Sodiu	Cleanser	10-5%(	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to 1 fill per 23 days

DRUG CLASS: Topical/Mucous Membr./Subcut. Enzymes					**CATEGORY** Dermatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Vasolex	Trypsin/Balsam Peru/Castor Oil	Oint. (G)	90 U-87/G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.
Xenaderm	Trypsin/Balsam Peru/Castor Oil	Oint. (G)	90 U-87/G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.
DRUG CLASS:	Vitamin A Derivatives				**CATEGORY** Dermatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Differin	Adapalene	Cream (G)	0.001	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.

Differin OTC	Adapalene	Gel (Gram)	0.001	1	☐	☐	☐	☐	☑	☐	☐	☐	Differin 0.1% Gel OTC version is formulary. Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.
Differin	Adapalene	Gel (Gram)	0.003	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.

Differin	Adapalene	Lotion	0.001	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.
Retin-A	Tretinoin	Cream (G)	0.00025	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.
Retin-A	Tretinoin	Cream (G)	0.0005	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.

Retin-A	Tretinoin	Cream (G)	0.001	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.
Retin-A	Tretinoin	Gel (Gram)	0.0001	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.
Retin-A	Tretinoin	Gel (Gram)	0.00025	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted to use by patients under 35 years old. For patients over 35, approval will require clinic notes, prior use of topical antibiotics and Benzoyl Peroxide or prescribed by Dermatologist.

THERAPEUTIC CATEGORY
Diabetes

DRUG CLASS: Brand Name	Antihypergly, (Dpp-4) Inhibitor & Biguanide Com Generic Name	Formulation	Strength	Tier	CATEGORY Diabetes PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Jentadueto Xr	Linagliptin/Metform	Tab Bp 24H	2.5-100	1	☐	☑	☑	☐	☐	☐	☐	☐	Limited to 2 tablets per day.
Jentadueto Xr	Linagliptin/Metform	Tab Bp 24H	5Mg-10	1	☐	☑	☑	☐	☐	☐	☐	☐	Limited to 1 tablet per day.
Jentadueto	Linagliptin/Metform in Hcl	Tablet	2.5-1000MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to maximum of 2 tablets per day.
Jentadueto	Linagliptin/Metform in Hcl	Tablet	2.5-500 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to maximum of 2 tablets per day.
Jentadueto	Linagliptin/Metform in Hcl	Tablet	2.5-850 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to maximum of 2 tablets per day.
Kombiglyze Xr	Saxagliptin Hcl/Metformin Hcl	Tbmp 24Hr	2.5-1000MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients who have tried and failed sitagliptin and linagliptin. Limited to 2 tablets per day.

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Kombiglyze Xr	Saxagliptin Hcl/Metformin Hcl	Tbmp 24Hr	5 MG-500MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients who have tried and failed sitagliptin and linagliptin. Limited to 1 tablet per day.
Kombiglyze Xr	Saxagliptin Hcl/Metformin Hcl	Tbmp 24Hr	5MG-1000MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients who have tried and failed sitagliptin and linagliptin. Limited to 1 tablet per day.
Janumet	Sitagliptin Phos/Metformin Hcl	Tablet	50-1000	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Janumet	Sitagliptin Phos/Metformin Hcl	Tablet	50MG-500MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Janumet Xr	Sitagliptin Phos/Metformin Hcl	Tbmp 24Hr	100-1000MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Janumet Xr	Sitagliptin Phos/Metformin Hcl	Tbmp 24Hr	50-1000	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Janumet Xr	Sitagliptin Phos/Metformin Hcl	Tbmp 24Hr	50MG-500MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.

DRUG CLASS: Antihypergly, (SGLT-2) Inhibitor & Biguanide Com **CATEGORY** Diabetes														
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Xigduo Xr	Dapagliflozin/Metformin Hcl	Tab Bp 24H	10-1000 Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 30 tablets per 30 days.
Xigduo Xr	Dapagliflozin/Metformin Hcl	Tab Bp 24H	10Mg-500Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 30 tablets per 30 days.
Xigduo Xr	Dapagliflozin/Metformin Hcl	Tab Bp 24H	5 Mg-500Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.

Xigduo Xr	Dapagliflozin/Metformin Hcl	Tab Bp 24H	5Mg-1000Mg	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. Limited to 60 tablets per 30 days.

DRUG CLASS:	Antihypergly,Incretin Mimetic(Glp-1 Recep.Agonis				**CATEGORY**	Diabetes							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Byetta	Exenatide	Pen Injctr	10MCG/0.04	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for an inadequate response to an adequate trial of Metformin (unless intolerant or contraindicated) for patients with HbA1c < 9% AND who have failed Victoza. A trial of Metformin ER is required if intolerance is GI-related.

Byetta	Exenatide	Pen Injctr	5MCG/0.02	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for an inadequate response to an adequate trial of Metformin (unless intolerant or contraindicated) for patients with HbA1c < 9% AND who have failed Victoza. A trial of Metformin ER is required if intolerance is GI-related.
Bydureon	Exenatide Microspheres	Vial	2 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for an inadequate response to an adequate trial of Metformin (unless intolerant or contraindicated) for patients with HbA1c < 9% AND who have failed Victoza. A trial of Metformin ER is required if intolerance is GI-related.

Victoza 2-Pak	Liraglutide	Pen Injctr	0.6MG/ 0.1	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for an inadequate response to an adequate trial of Metformin (unless intolerant or contraindicated) for patients with HbA1c < 9%. A trial of Metformin ER is required if intolerance is GI-related.
Victoza 2-Pak	Liraglutide	Pen Injctr	0.6MG/ 0.1	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for an inadequate response to an adequate trial of Metformin (unless intolerant or contraindicated) for patients with HbA1c < 9%. A trial of Metformin ER is required if intolerance is GI-related.

DRUG CLASS: Antihyperglycemic, Amylin Analog-Type					**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Symlinpen 60	Pramlintide Acetate	Pen Injctr	1500/1.5ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients concurrently on Metformin with HbA1c <9%
DRUG CLASS:	Antihyperglycemic, Dpp-4 Inhibitors				**CATEGORY**	Diabetes							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Tradjenta	Linagliptin	Tablet	5 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related.
Onglyza	Saxagliptin Hcl	Tablet	2.5 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Standard dosing is 5 mg daily, unless there is documentation of renal failure. Reserved for an inadequate response to an adequate and concurrent trial of metformin IR/ER, unless intolerant or contraindicated, AND for patients who have tried

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Onglyza	Saxagliptin Hcl	Tablet	5 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for an inadequate response to an adequate and concurrent trial of metformin IR/ER, unless intolerant or contraindicated, AND for patients who have tried and failed sitagliptin AND linagliptin.
Januvia	Sitagliptin Phosphate	Tablet	100 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. a trial of Metformin ER is required if intolerance is GI-related.
Januvia	Sitagliptin Phosphate	Tablet	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. Standard dose is 100mg daily unless kidney disease. For 50mg/day and lower, please submit recent renal function tests showing impairment.

Januvia	Sitagliptin Phosphate	Tablet	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. Standard dose is 100mg daily unless kidney disease. For 50mg/day and lower, please submit recent renal function tests showing impairment.
DRUG CLASS: Blood Sugar Diagnostics					**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Fora Test Strip	Blood Sugar Diagnostic	Strip		1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 100 per 30 days ; ONLY NDC 16042-0010-40 COVERED
DRUG CLASS: Hyperglycemics					**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Glucagon Emergenc	Glucagon,Human Rec	Kit	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Hypogly, Insulin-Rel Stim. & Biguanide (N-S) Com					**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Glucovance	Glyburide/Metformi	Tablet	1.25-25	1	☐	☐	☐	☐	☐	☐	☐	☐	
Glucovance	Glyburide/Metformi	Tablet	2.5-500	1	☐	☐	☐	☐	☐	☐	☐	☐	
Glucovance	Glyburide/Metformi	Tablet	5 MG-50	1	☐	☐	☐	☐	☐	☐	☐	☐	

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DRUG CLASS: Hypogly, Insul-Resp. Enhancer & Biguanide Comb.					**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pioglitazone-Metformin	Pioglitazone Hcl/Metformin Hcl	Tablet	15MG-500MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Pioglitazone-Metformin	Pioglitazone Hcl/Metformin Hcl	Tablet	15MG-850MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 90 tablets per 30 days.
Actoplus Met Xr	Pioglitazone Hcl/Metformin Hcl	Tbmp 24Hr	15-1000	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
Actoplus Met Xr	Pioglitazone Hcl/Metformin Hcl	Tbmp 24Hr	30-1000	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 30 tablets per 30 days.
DRUG CLASS: Hypoglycemics, Alpha-Glucosidase Inhib Type (N-					**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Precose	Acarbose	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Precose	Acarbose	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Precose	Acarbose	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Hypoglycemics, Biguanide Type (Non-Sulfonylure					**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Glucophage Xr	Metformin Hcl	Tab Er 24H	500 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 5 tablets per day
Glucophage Xr	Metformin Hcl	Tab Er 24H	750 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 tablets per day
Glucophage	Metformin Hcl	Tablet	1000 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 75 per 30 days (max 2500mg per day)
Glucophage	Metformin Hcl	Tablet	500 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 5 tablets per day
Glucophage	Metformin Hcl	Tablet	850 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 tablets per day

DRUG CLASS:	Hypoglycemics, Insulin-Release Stimulant Type				**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Chlorpropamide	Chlorpropamide	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Chlorpropamide	Chlorpropamide	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amaryl	Glimepiride	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amaryl	Glimepiride	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amaryl	Glimepiride	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Glucotrol Xl	Glipizide	Tab Er 24	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Glucotrol Xl	Glipizide	Tab Er 24	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Glucotrol Xl	Glipizide	Tab Er 24	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Glucotrol	Glipizide	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Glucotrol	Glipizide	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diabeta	Glyburide	Tablet	1.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Micronase	Glyburide	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Micronase	Glyburide	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Hypoglycemics, Insulin-Response Enhancer (N-S)				**CATEGORY**	Diabetes							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pioglitazone Hcl	Pioglitazone Hcl	Tablet	15 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related.

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Pioglitazone Hcl	Pioglitazone Hcl	Tablet	30 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related.
Pioglitazone Hcl	Pioglitazone Hcl	Tablet	45 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related.

DRUG CLASS: Insulins **CATEGORY** Diabetes													
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Humulin 70-30	Hum Insulin Nph/Re	Vial	70-30/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Humulin 70-30	Hum Insulin Nph/Re	Vial	70-30/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Novolog Flexpen	Insulin Aspart	Insuln Pen	100/Ml	1	☐	☐	☑	☐	☐	☐	☐	☐	Patients requiring >1 box per 60 days, submit PA. Limited to 15 mL per 60 days.

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Novolog	Insulin Aspart	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Toujeo Solostar	Insulin Glargine,Hum.Rec.Analog	Insuln Pen	300/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients requiring more than 80 units of insulin glargine per injection.
Apidra	Insulin Glulisine	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Humulin 70/30 Kwikpen	Insulin Nph Hum/Reg Insulin	Insuln Pen	70-30/Ml	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 15mL per 60 days.
Humulin N Kwikpen	Insulin Nph Human Isophane	Insuln Pen	100/Ml (3)	1	☐	☐	☑	☐	☐	☐	☐	☐	Patients requiring >1 box per 60 days, submit PA. Limited to 15 mL per 60 days.
Humalog Mix 75-25 Kwikpen	Insulin Npl/Insulin Lispro	Insuln Pen	75-25/Ml	1	☐	☐	☑	☐	☐	☐	☐	☐	Patients requiring >1 box per 60 days, submit PA. Limited to 15 mL per 60 days.
Humalog Mix 75-25	Insulin Npl/Insulin L	Vial	75-25/	1	☐	☐	☐	☐	☐	☐	☐	☐	

Afrezza	Insulin Regular, Human	Cart W/Dev	4 UNIT	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failures of two dose-optimized rapid-acting injectable insulin (3 months each), given patient tested normal FEV1 at baseline. to be use d concurrently with basal insulin.
Afrezza	Insulin Regular, Human	Cart W/Dev	4 UNIT(30)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failures of two dose-optimized rapid-acting injectable insulin (3 months each), given patient tested normal FEV1 at baseline. to be use d concurrently with basal insulin.

Afrezza	Insulin Regular, Human	Cart W/Dev	4 UNIT(60)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failures of two dose-optimized rapid-acting injectable insulin (3 months each), given patient tested normal FEV1 at baseline. to be use d concurrently with basal insulin.
Humulin R	Insulin Regular, Hum	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Humulin R	Insulin Regular, Hum	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Novolog Mix 70-30 Flexpen	Insuln Asp Prt/Insulin Aspart	Insuln Pen	70-30/Ml	1	☐	☐	☑	☐	☐	☐	☐	☐	Patients requiring >1 box per 60 days, submit PA. Limited to 15 mL per 60 days.
Novolog Mix 70-30	Insuln Asp Prt/Insuli	Vial	70-30/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Humulin N	Nph, Human Insulin I	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Humulin N	Nph, Human Insulin I	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Sodium-Gluc Cotransport 2 (Sglt2) Inhib				**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Invokana	Canagliflozin	Tablet	100 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of [1] Metformin AND [2] Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related. Limited to 30 tablets per 30 days.
Invokana	Canagliflozin	Tablet	300 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of [1] Metformin AND [2] Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related. Limited to 30 tablets per 30 days.

Farxiga	Dapagliflozin Propanediol	Tablet	10 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of [1] Metformin AND [2] Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related. Limited to 30 tablets per 30 days.
Farxiga	Dapagliflozin Propanediol	Tablet	5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of [1] Metformin AND [2] Empagliflozin or Ertugliflozin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related. Limited to 30 tablets per 30 days.

Jardiance	Empagliflozin	Tablet	10 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related. Limited to 30 tablets per 30 days.
Jardiance	Empagliflozin	Tablet	25 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related. Limited to 30 tablets per 30 days.
DRUG CLASS:	Urine Acetone Test Aids				**CATEGORY**	Diabetes							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ketone	Urine Acetone Test,Strips	Strip		1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 100 per 30 days.
Ketone	Urine Acetone Test,Strips	Strip		1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 100 per 30 days.

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Ketone	Urine Acetone Test,Strips	Strip		1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 100 per 30 days.
Ketone	Urine Acetone Test,Strips	Strip		1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 100 per 30 days.
Ketone	Urine Acetone Test,Strips	Strip		1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 100 per 30 days.
DRUG CLASS:	Urine Glucose Test Aids				**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Diastix Reagent	Urine Glucose Test,St	Strip		1	☐	☐	☐	☐	☐	☐	☐	☐	
Diastix Reagent	Urine Glucose Test,St	Strip		1	☐	☐	☐	☐	☐	☐	☐	☐	
Clinitest Reagent	Urine Glucose Test,T	Tablet		1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Urine Glucose/Acetone Test Aids,Strips				**CATEGORY** Diabetes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip		1	☐	☐	☐	☐	☐	☐	☐	☐	
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip		1	☐	☐	☐	☐	☐	☐	☐	☐	
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip		1	☐	☐	☐	☐	☐	☐	☐	☐	
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip		1	☐	☐	☐	☐	☐	☐	☐	☐	

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Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip	1	☐	☐	☐	☐	☐	☐	☐	☐
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip	1	☐	☐	☐	☐	☐	☐	☐	☐
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip	1	☐	☐	☐	☐	☐	☐	☐	☐
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip	1	☐	☐	☐	☐	☐	☐	☐	☐
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip	1	☐	☐	☐	☐	☐	☐	☐	☐
Keto-Diastix Reagen	Urine Gluc-Acet Com	Strip	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Diabetic Therapy

DRUG CLASS: Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Diabetic Therapy PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Synjardy Xr	Empagliflozin/Metformin Hcl	Tab Bp 24H	10-1000 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 30 tablets per 30 days.
Synjardy Xr	Empagliflozin/Metformin Hcl	Tab Bp 24H	12.5-1000	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
Synjardy Xr	Empagliflozin/Metformin Hcl	Tab Bp 24H	25-1000 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 30 tablets per 30 days.
Synjardy Xr	Empagliflozin/Metformin Hcl	Tab Bp 24H	5Mg-1000Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
Synjardy	Empagliflozin/Metformin Hcl	Tablet	12.5-1000	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
Synjardy	Empagliflozin/Metformin Hcl	Tablet	12.5-500Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
Synjardy	Empagliflozin/Metformin Hcl	Tablet	5 Mg-500Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.

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Synjardy	Empagliflozin/Metformin Hcl	Tablet	5Mg-1000Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
Steglatro	Ertugliflozin Pidolate	Tablet	15 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related. Limited to 30 tablets per 30 days.
Steglatro	Ertugliflozin Pidolate	Tablet	5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial of Metformin, unless intolerant/contraindicated. A trial of Metformin ER is required if intolerance is GI-related. Limited to 30 tablets per 30 days.
Segluromet	Ertugliflozin/Metformin	Tablet	2.5-1000MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
Segluromet	Ertugliflozin/Metformin	Tablet	2.5-500 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.

Segluromet	Ertugliflozin/Metformin	Tablet	7.5-1000MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
Segluromet	Ertugliflozin/Metformin	Tablet	7.5-500 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 30 days.
DRUG CLASS:	Antihypergly,Incretin Mimetic(Glp-1 Recep.Agonis				**CATEGORY**	Diabetic Therapy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Bydureon Pen	Exenatide Microspheres	Pen Injctr	2Mg/0.65Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for an inadequate response to an adequate trial of Metformin (unless intolerant or contraindicated) for patients with HbA1c < 9% AND who have failed Victoza. A trial of Metformin ER is required if intolerance is GI-related.	
DRUG CLASS:	Insulins				**CATEGORY**	Diabetic Therapy								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Basaglar Kwikpen U-100	Insulin Glargine,Hum.Rec.An	Insuln Pen	100/Ml (3)	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 15 mL per 30 days.	

Admelog Solostar	Insulin Lispro	Insuln Pen	100/ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 box (15mL) per 30 days.
Admelog	Insulin Lispro	Vial	100/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	
Humulin R U-500 Kwikpen	Insulin Regular, Human	Insuln Pen	500/Ml (3)	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients requiring more than 200 units of insulin per day.

THERAPEUTIC CATEGORY
Durable Med. Equip

DRUG CLASS: Durable Medical Equipment,Miscellaneous **CATEGORY** Durable Med. Equip

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Sootheneb Nbl100 Child Mask	Nebulizer Accessories	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
All Flow 5000	Nebulizer Accessories	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Sootheneb Nbl100 Med Cup	Nebulizer Accessories	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Bubbles The Fish Ii	Nebulizer Accessories	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
All Flow 5000	Nebulizer Accessories	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.

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All Flow 4000	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
All Flow 6000	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Filters Replacement	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Mini Elite Filter Replacement	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Filter, Valve Set For Ll & Lc	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Smartmask Kids	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
All Flow 3000 Pft	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.

Sami The Seal Filter	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Filter Pad	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Mask Vortex	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Micro Elite Replacement Filter	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Wing Tip Tubing	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Sidestream Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Proneb Ultra	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.

Pillow Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Sootheneb Nbl100 Adult Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Baby Conversion Pack 2	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Sidestream Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Air Filter	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Sidestream Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
All Flow 3000 Kit	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.

Innospire Replacement Filter	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Inspiration Elite Filter	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Air Tube With Air Plugs	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Mask Vortex	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Silicone Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Mouthpiece	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Sami The Seal Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.

Adult Aerosol Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
All Flow 1000	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Mask Set With Y-Piece	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
All Flow 1000	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Baby Conversion Pack 1	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Airs Adult Aerosol Mask	Nebulizer Accessories	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Baby Conversion Kit	Nebulizer Accessories	Kit	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.

Reusable Nebulizer Kit	Nebulizer Accessories	Kit	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Pari Lc Plus Nebulizer	Nebulizer Accessories	Kit	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.

THERAPEUTIC CATEGORY
Ear

DRUG CLASS: / Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
DRUG CLASS: Ear Preparations, Misc. Anti-Infectives					**CATEGORY** Ear								
Vosol	Acetic Acid	Solution	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Borofair	Acetic Acid/Aluminu	Drops	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vosol Hc	Acetic Acid/Hydroco	Drops	2 %-1 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Ear Preparations,Antibiotics					**CATEGORY** Ear								
Neomycin-Polymyxi	Neomycin/Polymyxi	Drops Susp	3.5-10K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neomycin-Polymyxi	Neomycin/Polymyxi	Solution	3.5-10K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ofloxacin	Ofloxacin	Drops	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Otic Preparations,Anti-Inflammatory-Antibiotics					**CATEGORY** Ear								
Ciprodex	Ciprofloxacin Hcl/Dexameth	Drops Susp	0.3 %-0.1%	1	☐	☑	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure to Ofloxacin and Neomycin/Polymyxin/HC.

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PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

THERAPEUTIC CATEGORY
Electrolytes&Misc Nutrien

DRUG CLASS: Bicarbonate Producing/Containing Agents **CATEGORY** Electrolytes&Misc Nutrien

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Sodium Acetate	Sodium Acetate	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Acetate	Sodium Acetate	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

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Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Sodium Acetate	Sodium Acetate	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Acetate	Sodium Acetate	Vial	4 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Bicarbonate	Sodium Bicarbonate	Syringe	0.5Meq/ Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Bicarbonate	Sodium Bicarbonate	Syringe	0.9Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Bicarbonate	Sodium Bicarbonate	Syringe	1 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Bicarbonate	Sodium Bicarbonate	Syringe	1 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Bicarbonate-Water	Sodium Bicarbonate	Syringe	1 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Bicarbonate	Sodium Bicarbonate	Syringe	10Meq/ 10Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Neut	Sodium Bicarbonate	Vial	0.48Meq /Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Bicarbonate	Sodium Bicarbonate	Vial	0.5Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Bicarbonate	Sodium Bicarbonate	Vial	0.5Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Bicarbonate-Water	Sodium Bicarbonate	Vial	1 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Bicarbonate	Sodium Bicarbonate	Vial	1 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Bicarbonate	Sodium Bicarbonate	Vial	1 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Bicarbonate-D5W	Sodium Bicarbonate In D5W	Plast. Bag	150/1000Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Bicarbonate-D5W	Sodium Bicarbonate In D5W	Plast. Bag	150/11 50Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Lactate	Sodium Lactate	Vial	5 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS:	Calcium Replacement				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

RESTRICTION KEY

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PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

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Calcium Chloride	Calcium Chloride	Syringe	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Chloride	Calcium Chloride	Syringe	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Chloride	Calcium Chloride	Syringe	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Calcium Chloride	Calcium Chloride	Vial	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate	Calcium Gluconate	Vial	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate	Calcium Gluconate	Vial	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Calcium Gluconate	Calcium Gluconate	Vial	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate	Calcium Gluconate	Vial	100 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	1 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	1 G/110 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	1 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	1 G/60 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	2 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	2 G/120 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	2 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	2 G/70 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Plast. Bag	3 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Syringe	1 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Calcium Gluconate-0.9% Nacl	Calcium Gluconate In 0.9% Nacl	Syringe	2 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-D5W	Calcium Gluconate/D5W	Plast. Bag	1 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-D5W	Calcium Gluconate/D5W	Plast. Bag	1 G/110 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Calcium Gluconate-D5W	Calcium Gluconate/D5W	Plast. Bag	1 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-D5W	Calcium Gluconate/D5W	Plast. Bag	1 G/60 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Calcium Gluconate-D5W	Calcium Gluconate/D5W	Plast. Bag	2 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Calcium Gluconate-D5W	Calcium Gluconate/D5W	Plast. Bag	4 G/250 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
DRUG CLASS:	Dietary Supplement, Miscellaneous				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Benecalorie	Caloric Supplement	Liquid	7.5Kcal/ Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Duocal	Caloric Supplement	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Creatine 5000	Creatine Monohydrate	Powd Pack	5000 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Ensure High Protein	Lactose-Reduced Food	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ensure Original	Lactose-Reduced Food	Liquid	0.04G-1.05	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Boost	Lactose-Reduced Food	Liquid	0.04G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Isosource Hn	Lactose-Reduced Food	Liquid	0.05 G-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ensure Plus	Lactose-Reduced Food	Liquid	0.05 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Boost Plus	Lactose-Reduced Food	Liquid	0.06 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Boost High Protein	Lactose-Reduced Food	Liquid	0.06G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Boost High Protein	Lactose-Reduced Food	Liquid	0.06G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ensure Enlive	Lactose-Reduced Food	Liquid	0.08 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ensure Powder	Lactose-Reduced Food	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Jevity 1 Cal	Lactose-Reduced Food/Fiber	Liquid	0.04G-1.06	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Jevity 1.2 Cal	Lactose-Reduced Food/Fiber	Liquid	0.06 G-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Jevity 1.5 Cal	Lactose-Reduced Food/Fiber	Liquid	0.06 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Isosource 1.5 Cal Tube Feed	Lactose-Reduced Food/Fiber	Liquid	0.07 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Isosource 1.5 Cal	Lactose-Reduced Food/Fiber	Liquid	0.07 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Boost Vhc	Nut Tx, Lact-Reduced, Iron	Liquid	0.09G-2.25	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Twocal Hn	Nut.Sup,Spec,Lac-Free,Iron/Fos	Liquid	0.08G-2/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Peptamen Junior Fiber	Nutrit Supp/Inulin/Fos/Fiber	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutren Junior Fiber	Nutrit Supp/Inulin/Fos/Fiber	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutren Fiber 1 Cal	Nutrit Supp/Inulin/Fos/Fiber	Liquid	0.04G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Fibersource Hn	Nutrit Supp/Inulin/Fos/Fiber	Liquid	0.05 G-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Fibersource Hn	Nutrit Supp/Inulin/Fos/Fiber	Liquid	0.05 G-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Compleat	Nutrit Supp/Inulin/Fos/Fiber	Liquid	0.05G-1.06	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Replete With Fiber	Nutrit Supp/Inulin/Fos/Fiber	Liquid	0.06G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Peptamen Af	Nutrition Supp No.1/Fos/Inulin	Oral Susp	0.0756-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Peptamen Junior With Prebio1	Nutritional Supp/Inulin/Fos	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Peptamen Junior Hp	Nutritional Supp/Inulin/Fos	Liquid	0.05 G-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Eo28 Splash	Nutritional Supplement	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Resource 2.0	Nutritional Supplement	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutren Junior	Nutritional Supplement	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Peptamen Junior	Nutritional Supplement	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pediasure Peptide 1.0 Cal	Nutritional Supplement	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pediasure Peptide 1.5 Cal	Nutritional Supplement	Liquid	0.045G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Osmolite 1 Cal	Nutritional Supplement	Liquid	0.04G-1.06	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutren 1.0	Nutritional Supplement	Liquid	0.04G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Osmolite 1.2 Cal	Nutritional Supplement	Liquid	0.06 G-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Osmolite 1.5 Cal	Nutritional Supplement	Liquid	0.06 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Replete	Nutritional Supplement	Liquid	0.06G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Promote	Nutritional Supplement	Liquid	0.06G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutren 1.5	Nutritional Supplement	Liquid	0.07 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Nutren 2.0	Nutritional Supplement	Liquid	0.08G-2/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Core Essentials Peptide	Nutritional Supplement/Fiber	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Core Essentials Ped Peptid Pls	Nutritional Supplement/Fiber	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Core Essentials	Nutritional Supplement/Fiber	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Core Essentials Ped Standard	Nutritional Supplement/Fiber	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Promote With Fiber	Nutritional Supplement/Fiber	Liquid	0.06G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Monogen	Nutritional Supplement/Mct	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pediasure Sidekicks	Pedi Nutrit,Iron,Lac-Free,Fibr	Liquid	0.03 G-0.6	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Compleat Pediatric Reduced Cal	Pedi Nutrit,Iron,Lac-Free,Fibr	Liquid	0.03 G-0.6	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pediasure With Fiber	Pedi Nutrit,Iron,Lac-Free,Fibr	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Pediasure Enteral With Fiber	Pedi Nutrit,Iron,Lac-Free,Fibr	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Compleat Pediatric	Pedi Nutrit,Iron,Lac-Free,Fibr	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Boost Kid Essentials-Fiber	Pedi Nutrit,Iron,Lac-Free,Fibr	Liquid	0.04G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pediasure 1.5 With Fiber	Pedi Nutrit,Iron,Lac-Free,Fibr	Liquid	0.06 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pediasure	Pedi Nutrition,Iron,Lact-Free	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Pediasure Grow-Gain	Pedi Nutrition,Iron,Lact-Free	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pediasure Enteral	Pedi Nutrition,Iron,Lact-Free	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Boost Kid Essentials	Pedi Nutrition,Iron,Lact-Free	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Boost Kid Essentials	Pedi Nutrition,Iron,Lact-Free	Liquid	0.04G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pediasure 1.5	Pedi Nutrition,Iron,Lact-Free	Liquid	0.06 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Promod	Protein Supplement	Liquid	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Procel	Protein Supplement	Packet	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Procel	Protein Supplement	Powder	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Procel 100	Protein Supplement	Powder	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

DRUG CLASS:	Electrolyte Maintenance				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

RESTRICTION KEY

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | FL = Fill Limit | AL = Age Limit
PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Plasma-Lyte 148	Electrolyte-148 Solution	Iv Soln		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-Electrolyte #48	Electrolyte-48 Solution/D5W	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Plasma-Lyte A Ph 7.4	Electrolyte-A Solution	Iv Soln		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Ionosol B With Dextrose 5%	Electrolyte-B Solution/D5W	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Normosol-M And Dextrose	Electrolyte-M Solution/D5W	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Ionosol Mb-Dextrose 5%	Electrolyte-Mb Solution/D5W	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Isolyte P With Dextrose	Electrolyte-P Solution/D5W	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Normosol-R Ph 7.4	Electrolyte-R (Ph 7.4)	Iv Soln		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Normosol-R	Electrolyte-R Solution	Iv Soln		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Normosol-R And Dextrose	Electrolyte-R Solution/D5W	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Isolyte S	Electrolyte-S (Ph 7.4)	Iv Soln		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Isolyte S	Electrolyte-S Solution	Iv Soln		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Ringers Injection	Ringer'S Solution	Iv Soln		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Lactated Ringers	Ringer'S Solution,Lactated	Iv Soln		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Nutrilyte	Sod/Pot/Mag/Cal/Cl /Acet/Glucon	Vial	25-40.6Meq	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Tpn Electrolytes Ii	Sodium/Pot/Mag/Calc/Chlor/Acet	Vial	18-18-5Meq	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Hyperlyte Cr	Sodium/Pot/Mag/Calc/Chlor/Acet	Vial	25-20-5/20	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Tpn Electrolytes	Sodium/Pot/Mag/Calc/Chlor/Acet	Vial	35-20-5Meq	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS: Iv Solutions: Dextrose And Lactated Ringers					**CATEGORY** Electrolytes&Misc Nutrien								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Dextrose In Lactated Ringers	Dextrose 5%-Lactated Ringers	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS: Iv Solutions: Dextrose And Ringers					**CATEGORY** Electrolytes&Misc Nutrien								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Dextrose In Ringers Injection	Dextrose 5 % In Ringer'S	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS: Iv Solutions: Dextrose-Saline					**CATEGORY** Electrolytes&Misc Nutrien								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

RESTRICTION KEY

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PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Dextrose 10%-0.2% Nacl	Dextrose 10 % And 0.2 % Nacl	Dehp Fr Bg	10 %-0.2 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 10%-0.45% Nacl	Dextrose 10 % And 0.45 % Nacl	Iv Soln	10%-0.45%	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 2.5%-0.45% Nacl	Dextrose 2.5 % And 0.45 % Nacl	Iv Soln	2.5%-0.45%	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose 5%-0.3% Nacl	Dextrose 5 % And 0.3 % Nacl	Iv Soln	5 %-0.3 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.33% Nacl	Dextrose 5 % And 0.3 % Nacl	Iv Soln	5 %-0.3 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.9% Nacl	Dextrose 5 % And 0.9 % Nacl	Iv Soln	5 %-0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose 5%-0.225% Nacl	Dextrose 5 %-0.2 % Sod Chlorid	Iv Soln	5 %-0.2 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.2% Nacl	Dextrose 5 %-0.2 % Sod Chlorid	Iv Soln	5 %-0.2 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.45% Nacl	Dextrose 5 %-0.45 % Sod Chlord	Iv Soln	5 %-0.45 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS: Iv Solutions: Dextrose-Water					**CATEGORY** Electrolytes&Misc Nutrien								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Dextrose In Water	Dextrose 10 % In Water	Dehp Fr Bg	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 10 % In Water	Iv Soln	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose In Water	Dextrose 20 % In Water	Iv Soln	20 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 25 % In Water	Syringe	25 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 30 % In Water	Iv Soln	30 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose In Water	Dextrose 40 % In Water	Iv Soln	40 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Glucose In Water	Dextrose 5 % In Water	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Glucose In Water	Dextrose 5 % In Water	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose In Water	Dextrose 5 % In Water	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 5 % In Water	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 5 % In Water	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose In Water	Dextrose 5 % In Water	Pggybk Prt	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 5 % In Water	Pgy Vl Prt	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 5 % In Water	Pgy Vl Prt	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose In Water	Dextrose 5 % In Water	Pgy Vl Prt		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 5 % In Water	Vial	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 50 % In Water	Iv Soln	50 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose In Water	Dextrose 50 % In Water	Syringe	50 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 50 % In Water	Syringe	50 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 50 % In Water	Vial	50 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose In Water	Dextrose 70 % In Water	Iv Soln	70 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose In Water	Dextrose 70 % In Water	Iv Soln	70 %	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to a 7 day supply fill at at time.
DRUG CLASS:	Magnesium Salts Replacement				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Magnesium-Lactated Ringers	Magnesium Sulf/Ringers Lactate	Plast. Bag	10 G/250Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium-Lactated Ringers	Magnesium Sulf/Ringers Lactate	Plast. Bag	20 G/500Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium-Lactated Ringers	Magnesium Sulf/Ringers Lactate	Plast. Bag	20G/250Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium-Lactated Ringers	Magnesium Sulf/Ringers Lactate	Plast. Bag	25G/250Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium-Lactated Ringers	Magnesium Sulf/Ringers Lactate	Plast. Bag	40 G/500Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium-Lactated Ringers	Magnesium Sulf/Ringers Lactate	Plast. Bag	40G/1000Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium-Lactated Ringers	Magnesium Sulf/Ringers Lactate	Plast. Bag	50G/500Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate	Magnesium Sulfate	Vial	4 Meq/Ml	1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to a 7 day supply fill at at time.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	1 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	2 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	2 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	3 G/150 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	3 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	4 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	4 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	6 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	6 G/150 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Piggyback	6 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Plast. Bag	10 G/250Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Plast. Bag	20G/250Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Plast. Bag	40 G/500Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-0.9% Nacl	Magnesium Sulfate In 0.9% Nacl	Plast. Bag	40G/1000Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate	Magnesium Sulfate In Water	Iv Soln	20 G/500Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate	Magnesium Sulfate In Water	Iv Soln	40G/1000Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate	Magnesium Sulfate In Water	Piggyback	2 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate	Magnesium Sulfate In Water	Piggyback	4 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate	Magnesium Sulfate In Water	Piggyback	4 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	1 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	1 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	2 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	2 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	3 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	4 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	4 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	5 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	6 G/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Piggyback	6 G/50 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Plast. Bag	10 G/100Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Plast. Bag	20 G/500Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Plast. Bag	20G/1000Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Plast. Bag	20G/250Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Plast. Bag	40 G/500Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Plast. Bag	40G/1000Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Magnesium Sulfate-D5W	Magnesium Sulfate/D5W	Plast. Bag	50G/500Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
DRUG CLASS:	Mineral Replacement,Miscellaneous				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Chromium	Chromic Chloride	Vial	4 Mcg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Copper Chloride	Cupric Chloride	Vial	0.4 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Manganese	Manganese Chloride	Vial	0.1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Manganese Sulfate	Manganese Sulfate	Vial	0.1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Addamel N	Trace Elements Comb No.1	Ampul	5.33-.34/1	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Multitrace-5	Zinc/Copper/Manga n/Chrom/Selen	Vial	20-1000	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Multitrace-5	Zinc/Copper/Manga n/Chrom/Selen	Vial	5-1-500/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Trace Elements-4	Zinc/Copper/Manganese/Chromic Chl	Vial	0.5-0.1-30	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Multitrace-4	Zinc/Copper/Manganese/Chromic Chl	Vial	1.5-0.1-25	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Multitrace-4	Zinc/Copper/Manganese/Chromic Chl	Vial	1-0.1-25-1	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Multitrace-4	Zinc/Copper/Manganese/Chromic Chl	Vial	1-0.4-0.1	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Multitrace-4	Zinc/Copper/Manganese/Chromic Chl	Vial	5-1-0.5-10	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Peditrace	Zn/Cu/Mang/Selen/Fluor/Pot Iod	Vial	521-53.7/1	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS:	Nutritional Therapy, Med Cond Special Formulatio				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Isovactin Aa Plus 20 Pe	Nut Tx For Isovaleric Acidemia	Liquid	8 G-74/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Lmd	Nut Tx For Isovaleric Acidemia	Powder	16.2G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
I-Valex-2	Nut Tx For Isovaleric Acidemia	Powder	30G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Xleu Maxamum	Nut Tx For Isovaleric Acidemia	Powder	40G-305	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tylactin Rtd 15 Pe	Nut Tx For Tyrosinemia W-Iron	Liquid	6 G-80/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

RESTRICTION KEY

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | FL = Fill Limit | AL = Age Limit
PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Tyr Lophlex	Nut Tx For Tyrosinemia W-Iron	Liquid Pkt	20-120/125	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyr Gel	Nut Tx For Tyrosinemia W-Iron	Powd Pack	41.7 G-338	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyr Express20	Nut Tx For Tyrosinemia W-Iron	Powd Pack	60 G-297	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyr Express	Nut Tx For Tyrosinemia W-Iron	Powd Pack	60 G-297	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyros 2	Nut Tx For Tyrosinemia W-Iron	Powder	22G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Xphe, Xtyr Maxamaid	Nut Tx For Tyrosinemia W-Iron	Powder	25G-324	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyr Anamix Next	Nut Tx For Tyrosinemia W-Iron	Powder	28 G-385	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyrex-2	Nut Tx For Tyrosinemia W-Iron	Powder	30G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glutarade Ga-1	Nut Tx, Ga 1/Flaxseed/Fiber	Powder	25 G-385	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Essential Amino Acid Mix	Nut Tx,Urea Cycle Dis W-O Iron	Powder	79G-316	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Mma-Pa Cooler15	Nut. Tx For Propionic Acidemia	Liquid	11.5 G-79	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Promactin Aa Plus 20 Pe	Nut. Tx For Propionic Acidemia	Liquid	8 G-73/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Mma/Pa Gel	Nut. Tx For Propionic Acidemia	Powd Pack	41.7 G-338	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Mma-Pa	Nut. Tx For Propionic Acidemia	Powd Pack	60 G-302	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Oa2	Nut. Tx For Propionic Acidemia	Powder	21 G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Xmtvi Maxamaid	Nut. Tx For Propionic Acidemia	Powder	25G-324	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Propimex-2	Nut. Tx For Propionic Acidemia	Powder	30G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Xmtvi Maxamum	Nut. Tx For Propionic Acidemia	Powder	40G-305	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Peptamen Intense Vhp	Nut.Soy,Lac-Red/Dha/Epa/Fos/In	Liquid	0.09G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ga Gel	Nut.Therap.Glutaric Aciduria 1	Powd Pack	41.7 G-338	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Ga Express 15	Nut.Therap.Glutaric Aciduria 1	Powd Pack	60 G-297	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glutarade Junior Ga-1	Nut.Therap.Glutaric Aciduria 1	Powder	10 G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ga	Nut.Therap.Glutaric Aciduria 1	Powder	15.1G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Xlys, Xtrp Maxamaid	Nut.Therap.Glutaric Aciduria 1	Powder	25G-324	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glutarex-2	Nut.Therap.Glutaric Aciduria 1	Powder	30G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Glutarade Ga-1	Nut.Therap.Glutaric Aciduria 1	Powder	81 G-324	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ucd Anamix Junior	Nut.Therapy,Urea Cycle Disordr	Powder	12 G-385	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ucd Trio	Nut.Therapy,Urea Cycle Disordr	Powder	15 G-393	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Cyclinex-2	Nut.Therapy,Urea Cycle Disordr	Powder	15G-440	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Wnd 2	Nut.Therapy,Urea Cycle Disordr	Powder	8.2G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Ketocal 4:1	Nut.Tx Ketogenic,Milk Base/Soy	Liquid	3.09 G-150	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ketocal 4:1	Nut.Tx Ketogenic,Milk Base/Soy	Liquid	3.09 G-150	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ketocal 4:1	Nut.Tx Ketogenic,Milk Base/Soy	Powder	14.4 G-701	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Complex Junior Msd	Nut.Tx Msud, Iron/Flaxseed Oil	Powder	13 G-496	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Renalcal	Nut.Tx,Impaired Renal Fxn,Whey	Liquid	0.03G-2/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Rena Start	Nut.Tx,Impaired Renal Fxn,Whey	Powder	7.5 G-494	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Homactin Aa Plus 20 Pe	Nut.Tx,Metabolic Dis,Methio-Fr	Liquid	8 G-74/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hcu Lophlex	Nut.Tx,Metabolic Dis,Methio-Fr	Liquid Pkt	20-120/125	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hcu Cooler	Nut.Tx,Metabolic Dis,Methio-Fr	Oral Susp	0.115G-.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hcu Gel	Nut.Tx,Metabolic Dis,Methio-Fr	Powd Pack	41.7 G-338	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Hcu Express20	Nut.Tx,Metabolic Dis,Methio-Fr	Powd Pack	60 G-297	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hcu Express Powder	Nut.Tx,Metabolic Dis,Methio-Fr	Powd Pack	60 G-302	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hcy 2	Nut.Tx,Metabolic Dis,Methio-Fr	Powder	22G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Xmet Maxamaid	Nut.Tx,Metabolic Dis,Methio-Fr	Powder	25G-324	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hcu Anamix Next	Nut.Tx,Metabolic Dis,Methio-Fr	Powder	28 G-385	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Hominex-2	Nut.Tx,Metabolic Dis,Methio-Fr	Powder	30G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Xmet Maxamum	Nut.Tx,Metabolic Dis,Methio-Fr	Powder	40G-305	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyr Cooler	Nut.Tx. Metabolic Disorder,Reg	Oral Susp	0.115G-.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hcu Cooler	Nut.Tx. Metabolic Disorder,Reg	Oral Susp	0.115G-.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Polycal	Nut.Tx. Metabolic Disorder,Reg	Powder	96 G-384	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Perative	Nut.Tx. Metabolic Disorder,Soy	Liquid	0.067G-1.3	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pfd 2	Nut.Tx. Metabolic Disorder,Soy	Powder	400/100 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Impact 1 Cal	Nut.Tx.Comp. Immune Systm,Reg	Liquid	0.06G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pivot 1.5 Cal	Nut.Tx.Comp. Immune Systm,Reg	Liquid	0.09 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Impact Peptide 1.5 Cal	Nut.Tx.Comp. Immune Systm,Reg	Liquid	0.09 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Boost Glucose Control	Nut.Tx.Gluc Intol,Lf,Soy/Fiber	Liquid	0.06 G-1.1	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Diabetisource Ac	Nut.Tx.Gluc Intol,Lf,Soy/Fiber	Liquid	0.06 G-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glucerna 1 Cal	Nut.Tx.Gluc.Intoler,Lac-Fr,Soy	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glucerna 1.2 Cal	Nut.Tx.Gluc.Intoler,Lac-Fr,Soy	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glucerna 1.5 Cal	Nut.Tx.Gluc.Intoler,Lac-Fr,Soy	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Glucerna	Nut.Tx.Gluc.Intoler,Lac-Fr,Soy	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glucerna Therapeutic Nutrition	Nut.Tx.Gluc.Intoler,Lac-Fr,Soy	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glytrol	Nut.Tx.Gluc.Intoler,Lac-Fr,Soy	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Suplena Carb Steady	Nut.Tx.Imp.Renal Fxn,Lac-Reduc	Liquid	0.04 G-1.8	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nepro Carb Steady	Nut.Tx.Imp.Renal Fxn,Lac-Reduc	Liquid	0.08 G-1.8	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Peptamen-Prebio1	Nut.Tx.Impair Diges/Inulin/Fos	Liquid	0.04G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Peptamen 1.5 Cal With Prebio1	Nut.Tx.Impair Diges/Inulin/Fos	Liquid	0.068G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Eo28 Splash	Nut.Tx.Impaired Digest Fxn	Liquid	0.025-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Neocate Splash	Nut.Tx.Impaired Digest Fxn	Liquid	0.03G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Peptamen Junior 1.5	Nut.Tx.Impaired Digest Fxn	Liquid	0.046G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Peptamen	Nut.Tx.Impaired Digest Fxn	Liquid	0.04G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Peptamen 1.5	Nut.Tx.Impaired Digest Fxn	Liquid	0.068G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Vital High Protein	Nut.Tx.Impaired Digest Fxn	Liquid	0.09G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Mct Pro-Cal	Nut.Tx.Impaired Digest Fxn	Packet		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Vivonex T.E.N	Nut.Tx.Impaired Digest Fxn	Powd Pack	11.5 G-300	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Vivonex Plus	Nut.Tx.Impaired Digest Fxn	Powd Pack	13.5 G-300	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tolerex	Nut.Tx.Impaired Digest Fxn	Powd Pack	6.2-300/80	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Vivonex	Nut.Tx.Impaired Digest Fxn	Powd Pack	6-200/48.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Lipistart	Nut.Tx.Impaired Digest Fxn	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Puramino Toddler	Nut.Tx.Impaired Digest Fxn	Powder	13.9 G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Elecare Jr	Nut.Tx.Impaired Digest Fxn	Powder	14.3 G-469	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Alfamino Junior	Nut.Tx.Impaired Digest Fxn	Powder	15 G-460	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Neocate Junior	Nut.Tx.Impaired Digest Fxn	Powder	16G-451	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Neocate Junior	Nut.Tx.Impaired Digest Fxn	Powder	16G-478	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Vivonex Rtf	Nut.Tx.Impaired Digest Fxn,Soy	Liquid	0.05G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Pepdite Junior	Nut.Tx.Impaired Digest Fxn,Soy	Powd Pack	7.4 G-240	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Monogen	Nut.Tx.Impaired Digest Fxn/Mct	Powder	12.9 G-444	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Portagen	Nut.Tx.Impaired Digest Fxn/Mct	Powder	16.5 G-470	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Vital 1.0 Cal	Nut.Tx.Impaired Digest/Fiber	Liquid	0.04G-1/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Vital Peptide 1.5 Cal	Nut.Tx.Impaired Digest/Fiber	Liquid	0.07 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Vital 1.5 Cal	Nut.Tx.Impaired Digest/Fiber	Liquid	0.07 G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Vital Af 1.2 Cal	Nut.Tx.Impaired Digest/Fiber	Liquid	0.08 G-1.2	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Neocate Junior With Prebiotics	Nut.Tx.Impaired Digest/Fiber	Powder	16 G-459	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Neocate Junior With Prebiotics	Nut.Tx.Impaired Digest/Fiber	Powder	16 G-469	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Neocate Junior With Prebiotics	Nut.Tx.Impaired Digest/Fiber	Powder	16G-478	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Nutrihep	Nut.Tx.Impaired Hepatic Fxn	Liquid	0.04G-1.5	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Novasource Renal 2 Cal	Nut.Tx.Impaired Renal Fxn,Soy	Liquid	0.09G-2/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutren Pulmonary	Nut.Tx.Pulm.Disord. Reg,Lac-Fr	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pulmocare	Nut.Tx.Pulm.Disord.Soy,Lacfree	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Complex Msd	Nutrit. Tx, Msud Without Iron	Powder	10G-42/13G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Vilactin Aa Plus 20 Pe	Nutrit.Therapy, Msud With Iron	Liquid	8 G-74/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Camino Pro 15 Pe Msud	Nutrit.Therapy, Msud With Iron	Liquid Pkt	15-140/140	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Msud Lophlex	Nutrit.Therapy, Msud With Iron	Liquid Pkt	20-120/125	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Msud Express Cooler	Nutrit.Therapy, Msud With Iron	Oral Susp	0.115G-.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Msud Cooler	Nutrit.Therapy, Msud With Iron	Oral Susp	0.115G-.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Msud Gel	Nutrit.Therapy, Msud With Iron	Powd Pack	41.7 G-338	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Msud Express20	Nutrit.Therapy, Msud With Iron	Powd Pack	60 G-297	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Msud Express15	Nutrit.Therapy, Msud With Iron	Powd Pack	60 G-297	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Bcad 2	Nutrit.Therapy, Msud With Iron	Powder	24G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Complex Msd Essential	Nutrit.Therapy, Msud With Iron	Powder	25 G-380	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Msud Maxamaid	Nutrit.Therapy, Msud With Iron	Powder	25G-324	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ketonex-2	Nutrit.Therapy, Msud With Iron	Powder	30G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Msud Maxamum	Nutrit.Therapy, Msud With Iron	Powder	40G-305	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glycosade	Nutritional Therapy For Gsd	Powd Pack	0.3 G-214	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ketocal 3:1	Nutritional Tx, Ketogenic,Milk	Powder	15.3G-699	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Ketovie Peptide 4:1	Nutritional Tx, Ketogenic,Whey	Liquid	3.3 G-171	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ketovie 4:1	Nutritional Tx, Ketogenic,Whey	Liquid	3.4 G-144	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ketovie 4:1	Nutritional Tx, Ketogenic,Whey	Liquid	3.4 G-156	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

DRUG CLASS:	Nutritional Tx, Phenylketonuria (Pku) Formulatio				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pku Trio	Nut. Tx For Pku With Iron #48	Powder	30 G-404	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Xphe Maxamaid	Nut. Tx For Pku With Iron No.5	Powder	25G-324	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

RESTRICTION KEY

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | FL = Fill Limit | AL = Age Limit
PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Xphe Maxamum	Nut. Tx For Pku With Iron No.6	Powd Pack	40G-305	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Xphe Maxamum	Nut. Tx For Pku With Iron No.6	Powder	40G-305	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Lophlex	Nut. Tx For Pku With Iron No.7	Powd Pack	10 Gram-41	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenex-2	Nut.Therapy For Pku, Iron No.1	Powder	30G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenyl-Free 1	Nut.Therapy For Pku,Iron No.10	Powder	16.2G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Eaa	Nut.Tx For Pku With Iron No.13	Powd Pack	5G-36Kcal	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Periflex Lq Pku	Nut.Tx For Pku With Iron No.2	Liquid	0.06G-0.64	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Periflex Advance	Nut.Tx For Pku With Iron No.20	Powder	35 G-369	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Periflex Advance	Nut.Tx For Pku With Iron No.20	Powder	35 G-385	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Lanaflex	Nut.Tx For Pku With Iron No.25	Powd Pack	33Gram-253	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Phenylade60	Nut.Tx For Pku With Iron No.27	Powd Pack	10G-49	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade40	Nut.Tx For Pku With Iron No.27	Powd Pack	10G-84/25G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade60	Nut.Tx For Pku With Iron No.27	Powder	60G-295	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade60	Nut.Tx For Pku With Iron No.27	Powder	60G-327	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade Essential	Nut.Tx For Pku With Iron No.35	Powd Pack	10G-156/40	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Phenylade Essential	Nut.Tx For Pku With Iron No.35	Powder	25G-390	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Cooler 10	Nut.Tx For Pku With Iron No.4	Oral Susp	0.12G-0.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Cooler 15	Nut.Tx For Pku With Iron No.4	Oral Susp	0.12G-0.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Cooler 20	Nut.Tx For Pku With Iron No.4	Oral Susp	0.12G-0.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Lophlex	Nut.Tx For Pku With Iron No.40	Liquid Pkt	20-116/125	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Glytactin Rtd 10 Pe	Nut.Tx For Pku With Iron No.41	Liquid	4 G-61/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glytactin Rtd 15 Pe	Nut.Tx For Pku With Iron No.41	Liquid	6 G-80/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Camino Pro 15 Pe Pku	Nut.Tx For Pku With Iron No.41	Liquid Pkt	15-140/140	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glytactin 20Pe Bettermilk Lite	Nut.Tx For Pku With Iron No.41	Powd Pack	39 G-294	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenyl-Free 2	Nut.Tx For Pku With Iron No.45	Powder	22G-410	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Phenyl-Free 2Hp	Nut.Tx For Pku With Iron No.45	Powder	40G-390	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Gel	Nut.Tx For Pku With Iron No.47	Powd Pack	41.7 G-317	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Gel	Nut.Tx For Pku With Iron No.47	Powd Pack	41.7 G-338	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Express20	Nut.Tx For Pku With Iron No.52	Powd Pack	60 G-279	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Express15	Nut.Tx For Pku With Iron No.52	Powd Pack	60 G-279	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Pku Express20	Nut.Tx For Pku With Iron No.52	Powd Pack	60 G-297	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Express15	Nut.Tx For Pku With Iron No.52	Powd Pack	60 G-297	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Periflex Junior Plus	Nut.Tx For Pku With Iron No.55	Powder	28 G-377	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Periflex Junior Plus	Nut.Tx For Pku With Iron No.55	Powder	28 G-385	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade Gmp	Nut.Tx For Pku With Iron No.57	Powd Pack	30 G-396	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Phenylade Gmp	Nut.Tx For Pku With Iron No.57	Powder	30 G-396	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenactin Aa Plus 20 Pe	Nut.Tx For Pku With Iron No.59	Liquid	8 G-74/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade	Nutritional Tx For Pku No.31	Powd Pack	10G-42/13G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade Mte	Nutritional Tx For Pku No.31	Powd Pack	10G-42/13G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade	Nutritional Tx For Pku No.31	Powder	10G-42/13G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Phenylade Mte	Nutritional Tx For Pku No.31	Powder	10G-42/13G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade Phebloc	Nutritional Tx For Pku No.33	Tablet	750 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glytactin Rtd Lite 15	Nutritional Tx For Pku No.64	Liquid	6 G-48/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pku Sphere20	Nutritional Tx For Pku No.67	Powd Pack	56 G-337	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glytactin 15 Pe Bettermilk	Nutritional Tx For Pku No.68	Powd Pack	29 G-385	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Glytactin 15 Pe Bettermilk	Nutritional Tx For Pku No.68	Powd Pack	31 G-327	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phlexy-10	Nutritional Tx For Pku No.8	Powd Pack	8.33 G-69	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylade Phebloc	Nutritional Tx For Pku, No.43	Powd Pack	2.2G-10/3G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phlexy-10	Nutritional Tx Pku With No.54	Tablet	8.33G-35	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

DRUG CLASS: Oral Lipid Supplements					**CATEGORY** Electrolytes&Misc Nutrien								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Microlipid	Long Chain Triglycerides	Emulsion	7.5 G/15Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

RESTRICTION KEY

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | FL = Fill Limit | AL = Age Limit
PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Betaquik	Medium Chain Triglycerides	Emulsion	21-189/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Liquigen	Medium Chain Triglycerides	Emulsion	50-450/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Mct Oil	Medium Chain Triglycerides	Oil	7.7Kcal/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
DRUG CLASS:	Parenteral Amino Acid Solutions And Combination				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Aa 2%-D10W-Calcium-Heparin	Aa 2 % No1 Ped/D10/Calcium/Hep	Iv Soln	2 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

RESTRICTION KEY

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | FL = Fill Limit | AL = Age Limit
PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Aa 2%-D10W-Low Calcium-Heparin	Aa 2 % No1 Ped/D10/Calcium/Hep	Iv Soln	2 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Perikabiven	Aa 2.36%/D6.8W/Fat/E-Lytes No9	Emulsion	2.36%-6.8%	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Clinimix N9G15E	Aa 2.75%/D7.5%W/Electrolytes12	Iv Soln	2.75%-7.5%	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Aa 3%-D10W-Low Calcium-Heparin	Aa 3% No.2 Ped/D10/Calcium/Hep	Iv Soln	3%-10-2.33	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aa 3%-D10W-Calcium-Heparin	Aa 3% No.2 Ped/D10/Calcium/Hep	Iv Soln	3%-10-3.75	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Kabiven	Aa 3.31 %/D9.8W/Fat/E-Lytes 10	Emulsion	3.31%-9.8%	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Amino Acid 3.5%-D10W-Heparin	Aa 3.5 % No.2 Ped/D10W/Heparin	Iv Soln	3.5 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aa 4%-D10W-Calcium-Heparin	Aa 4% No2 Ped/D10W/Calcium /Hep	Iv Soln	4 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Clinimix N14G30E	Aa 4.25%/D15W/Electrolytes 25	Iv Soln	4.25 %-15%	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Clinimix E	Aa 5%/D15W/Electrolytes	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aa 6%-D10W-Calcium-Heparin	Aa 6% No.1 Ped/D10/Calcium/Hep	Iv Soln	6%-10-3.75	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aa 2.5%-D10W-Calcium-Heparin	Aa2.5%No.2 Ped/D10/Calcium/Hep	Iv Soln	2.5 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Aa 3.5%-D10W-Lo Calcium-Heparn	Aa3.5% No2 Ped/D10/Calcium/Hep	Iv Soln	3.5 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aa 3.5%-D10W-Calcium-Heparin	Aa3.5% No2 Ped/D10/Calcium/Hep	Iv Soln	3.5 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aa 3%-D5W-Low Calcium-Heparin	Aas3%No.2Ped/D5W/Calc Gluc/Hep	Iv Soln	3%-5%-2.33	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Aa 3%-D5W-Calcium-Heparin	Aas3%No.2Ped/D5W/Calc Gluc/Hep	Iv Soln	3%-5%-3.75	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Amino Acid 3%-D10W	Amino Acid 3 % No.2(Ped)/D10W	Iv Soln	3 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Amino Acid 3.5%-D10W	Amino Acid 3.5% No.2(Ped)/D10W	Iv Soln	3.5 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Amino Acid 4%-D10W	Amino Acid 4 % No.2(Ped)/D10W	Iv Soln	4 %-10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aminosyn-Rf	Parent Amino Ac 5.2 % (Renal)	Iv Soln	5.2 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aminosyn	Parent. Amino Acid 8.5 % No.2	Iv Soln	8.5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Aminosyn Ii	Parent. Amino Acid 8.5 % No.3	Iv Soln	8.5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aminosyn-Pf	Parent.Amino Acid 10% No5(Ped)	Iv Soln	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aminosyn-Pf	Parent.Amino Acid 7 % No1(Ped)	Iv Soln	7 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Aminosyn Ii	Parenteral Amino Acid 10% No.1	Iv Soln	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aminosyn	Parenteral Amino Acid 10% No.2	Iv Soln	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Freamine Iii	Parenteral Amino Acid 10% No.4	Iv Soln	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Travasol	Parenteral Amino Acid 10% No.6	Iv Soln	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Synthamin 17 Without Eltye	Parenteral Amino Acid 10% No.6	Iv Soln	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Premasol	Parenteral Amino Acid 10% No.7	Iv Soln	10 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Plenamine	Parenteral Amino Acid 15% No.1	Iv Soln	15 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Clinisol	Parenteral Amino Acid 15% No.1	Iv Soln	15 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aminosyn Ii	Parenteral Amino Acid 15% No.2	Iv Soln	15 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Prosol	Parenteral Amino Acid 20% No.1	Iv Soln	20 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Premasol	Parenteral Amino Acid 6 % No.1	Iv Soln	6 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Aminosyn Ii	Parenteral Amino Acid 7 % No.2	Iv Soln	7 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS: Phosphate Replacement					**CATEGORY** Electrolytes&Misc Nutrien								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Potassium Phosphate-0.9% Nacl	Potassium Phos In 0.9 % Nacl	Piggyback	15Mmol /100	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Phosphate-0.9% Nacl	Potassium Phos In 0.9 % Nacl	Plast. Bag	10Mmol /250	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Phosphate-0.9% Nacl	Potassium Phos In 0.9 % Nacl	Plast. Bag	15Mmol /250	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Phosphate-0.9% Nacl	Potassium Phos In 0.9 % Nacl	Plast. Bag	30Mmol /250	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Phosphate-0.9% Nacl	Potassium Phos In 0.9 % Nacl	Plast. Bag	30Mmol /500	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Phosphate	Potassium Phos,M-Basic-D-Basic	Vial	3Mmol/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Phosphate	Potassium Phos,M-Basic-D-Basic	Vial	3Mmol/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Phosphate	Potassium Phos,M-Basic-D-Basic	Vial	3Mmol/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Phosphate	Sod Phosphate,Monobasic-Dibas	Vial	3Mmol/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Phosphate	Sod Phosphate,Monobasic-Dibas	Vial	3Mmol/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Glycophos	Sodium Glycerophosphate	Vial	1 Mmol/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Phosphate-0.9% Nacl	Sodium Phosphate In 0.9 % Nacl	Plast. Bag	15Mmol /250	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Phosphate-0.9% Nacl	Sodium Phosphate In 0.9 % Nacl	Plast. Bag	30Mmol /250	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Phosphate-0.9% Nacl	Sodium Phosphate In 0.9 % Nacl	Plast. Bag	40Mmol /250	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Phosphate-0.9% Nacl	Sodium Phosphate In 0.9 % Nacl	Plast. Bag	7.5/100 Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Phosphate-D5W	Sodium Phosphate In D5W	Plast. Bag	15Mmol /250	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
DRUG CLASS:	Potassium Replacement				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Potassium Acetate	Potassium Acetate	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Acetate	Potassium Acetate	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride	Potassium Chloride	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Chloride	Potassium Chloride	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride	Potassium Chloride	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride	Potassium Chloride	Vial	2 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Chloride-0.9% Nacl	Potassium Chloride In 0.9%Nacl	Iv Soln	10 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride-0.9% Nacl	Potassium Chloride In 0.9%Nacl	Iv Soln	20 Meq/250	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chl-Normal Saline	Potassium Chloride In 0.9%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Chl-Normal Saline	Potassium Chloride In 0.9%Nacl	Iv Soln	40 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride-0.9% Nacl	Potassium Chloride In 0.9%Nacl	Piggyback	10Meq/ 0.1L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-Potassium Chloride	Potassium Chloride In D5W	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose 5%-Potassium Chloride	Potassium Chloride In D5W	Iv Soln	30 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-Potassium Chloride	Potassium Chloride In D5W	Iv Soln	40 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride In D5Lr	Potassium Chloride In Lr-D5	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Chloride In D5Lr	Potassium Chloride In Lr-D5	Iv Soln	40 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride	Potassium Chloride In Water	Piggyback	10Meq/ 0.1L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride	Potassium Chloride In Water	Piggyback	10Meq/ 50Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Chloride	Potassium Chloride In Water	Piggyback	20Meq/ 0.1L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride	Potassium Chloride In Water	Piggyback	20Meq/ 50Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Chloride	Potassium Chloride In Water	Piggyback	30Meq/ 0.1L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Chloride	Potassium Chloride In Water	Piggyback	40Meq/ 0.1L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-1/4Ns-Kcl	Potassium Chloride/D5-0.2%Nacl	Iv Soln	10 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.2% Nacl-Kcl	Potassium Chloride/D5-0.2%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose 5%-0.225% Nacl-Kcl	Potassium Chloride/D5-0.2%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.225% Nacl-Kcl	Potassium Chloride/D5-0.2%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.2% Nacl-Kcl	Potassium Chloride/D5-0.2%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose 5%-1/4Ns-Kcl	Potassium Chloride/D5-0.2%Nacl	Iv Soln	30 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-1/4Ns-Kcl	Potassium Chloride/D5-0.2%Nacl	Iv Soln	40 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.3% Nacl-Kcl	Potassium Chloride/D5-0.3%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose 5%-0.33% Nacl-Kcl	Potassium Chloride/D5-0.3%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.3% Nacl-Kcl	Potassium Chloride/D5-0.3%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-1/2Ns-Kcl	Potassium Chloride/D5-0.45Nacl	Iv Soln	10 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose 5%-0.45% Nacl-Kcl	Potassium Chloride/D5-0.45Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-0.45% Nacl-Kcl	Potassium Chloride/D5-0.45Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-1/2Ns-Kcl	Potassium Chloride/D5-0.45Nacl	Iv Soln	30 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Dextrose 5%-1/2Ns-Kcl	Potassium Chloride/D5-0.45Nacl	Iv Soln	40 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-Ns-Kcl	Potassium Chloride/D5-0.9%Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Dextrose 5%-Ns-Kcl	Potassium Chloride/D5-0.9%Nacl	Iv Soln	40 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Potassium Chloride-Nacl	Potassium Chloride-0.45% Nacl	Iv Soln	20 Meq/L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Potassium Cl-Lidocaine-Ns	Potassium Cl/Lido/0.9 % Nacl	Piggyback	10Meq/ 0.1L	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS:	Sodium/Saline Preparations				**CATEGORY**	Electrolytes&Misc Nutrien							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Sodium Chloride	0.9 % Sodium Chloride	Iv Soln	0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	0.9 % Sodium Chloride	Iv Soln	0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	0.9 % Sodium Chloride	Iv Soln	0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Chloride	0.9 % Sodium Chloride	Iv Soln	0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	0.9 % Sodium Chloride	Iv Soln	0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	0.9 % Sodium Chloride	Iv Soln	0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Chloride	0.9 % Sodium Chloride	Iv Soln	0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride-Water	0.9 % Sodium Chloride	Iv Soln	0.9 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	0.9 % Sodium Chloride	Pggybk Prt		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Chloride	0.9 % Sodium Chloride	Pgy Vl Prt	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	0.9 % Sodium Chloride	Pgy Vl Prt	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	0.9 % Sodium Chloride	Pgy Vl Prt	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Chloride	Sodium Chloride	Vial	2.5 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	Sodium Chloride	Vial	2.5 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	Sodium Chloride	Vial	4 Meq/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Chloride	Sodium Chloride 0.45 %	Iv Soln	0.45 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	Sodium Chloride 0.45 %	Iv Soln	0.45 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	Sodium Chloride 0.45 %	Iv Soln	0.45 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Sodium Chloride	Sodium Chloride 0.45 %	Pggybk Prt		1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	Sodium Chloride 3 %	Iv Soln	3 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Sodium Chloride	Sodium Chloride 5 %	Iv Soln	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS: Zinc Replacement					**CATEGORY** Electrolytes&Misc Nutrien								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zinc Chloride	Zinc Chloride	Vial	1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Zinc Sulfate	Zinc Sulfate	Vial	1 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Zinc Sulfate	Zinc Sulfate	Vial	5 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

THERAPEUTIC CATEGORY
Endocrinology

DRUG CLASS: Adrenocorticotrophic Hormones					**CATEGORY** Endocrinology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cortrosyn	Cosyntropin	Vial	0.25 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

DRUG CLASS: Androgenic Agents					**CATEGORY** Endocrinology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Vogelxo	Testosterone	Gel (Gram)	50 MG (1%)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who meet BOTH of the following criteria:a. Treatment failure to or inability to administer intramuscular testosterone injections patients ANDb. Undergoing Gender Transition OR having documentation of hypogonadism as evidenced by te
Vogelxo	Testosterone	Gel (Gram)	50 MG (1%)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who meet BOTH of the following criteria:a. Treatment failure to or inability to administer intramuscular testosterone injections patients ANDb. Undergoing Gender Transition OR having documentation of hypogonadism as evidenced by te

Androgel	Testosterone	Gel Md Pmp	1.25G (1%)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who meet BOTH of the following criteria:a. Treatment failure to or inability to administer intramuscular testosterone injections patients ANDb. Undergoing Gender Transition OR having documentation of hypogonadism as evidenced by te
Androgel	Testosterone	Gel Md Pmp	1.25G (1%)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who meet BOTH of the following criteria:a. Treatment failure to or inability to administer intramuscular testosterone injections patients ANDb. Undergoing Gender Transition OR having documentation of hypogonadism as evidenced by te

Androgel	Testosterone	Gel Packet	25MG(1 %)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who meet BOTH of the following criteria:a. Treatment failure to or inability to administer intramuscular testosterone injections patients ANDb. Undergoing Gender Transition OR having documentation of hypogonadism as evidenced by te
Androgel	Testosterone	Gel Packet	50 MG (1%)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who meet BOTH of the following criteria:a. Treatment failure to or inability to administer intramuscular testosterone injections patients ANDb. Undergoing Gender Transition OR having documentation of hypogonadism as evidenced by te

Androgel	Testosterone	Gel Packet	50 MG (1%)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who meet BOTH of the following criteria:a. Treatment failure to or inability to administer intramuscular testosterone injections patients ANDb. Undergoing Gender Transition OR having documentation of hypogonadism as evidenced by te
Depo-Testosterone	Testosterone Cypionate	Vial	100 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Testosterone therapy is reserved for patients undergoing Gender Transition, orwith documentation of hypogonadism as evidenced by testosterone levels below 300ng/dL confirmed on two separate occasions with levels drawn before 10:00am.

Depo-Testosterone	Testosterone Cypionate	Vial	200 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Testosterone therapy is reserved for patients undergoing Gender Transition, orwith documentation of hypogonadism as evidenced by testosterone levels below 300ng/dL confirmed on two separate occasions with levels drawn before 10:00am.

DRUG CLASS:	Antithyroid Preparations				**CATEGORY**	Endocrinology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Methimazole	Methimazole	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methimazole	Methimazole	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Propylthiouracil	Propylthiouracil	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Bone Resorption Inhibitors				**CATEGORY**	Endocrinology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Prolia	Denosumab	Syringe	60 MG/ML	1	☐	☑	☐	☐	☐	☐	☐	☑	Reserved for diagnosis of osteoporosis and failure of 2 bisphosphonates or fracture on bisphosphonate therapy. 1
Reclast	Zoledronic Acid	Infus. Btl	5 MG/100 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients unable to swallow tablets. 1 fill per 365 days
DRUG CLASS:	Growth Hormones				**CATEGORY** Endocrinology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Nutropin Aq	Somatropin	Cartridge	10 MG/2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Nutropin Aq	Somatropin	Cartridge	10 MG/2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Omnitrope	Somatropin	Cartridge	10MG/1.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Humatrope	Somatropin	Cartridge	12 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Genotropin	Somatropin	Cartridge	12 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Nutropin Aq	Somatropin	Cartridge	20 MG/2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Nutropin Aq	Somatropin	Cartridge	20 MG/2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Humatrope	Somatropin	Cartridge	24 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Norditropin	Somatropin	Cartridge	5 MG/1.5 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Nutropin Aq Nuspin	Somatropin	Cartridge	5 MG/2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Genotropin	Somatropin	Cartridge	5 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Humatrope	Somatropin	Cartridge	6 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Norditropin Nordiflex	Somatropin	Pen Injctr	10MG/1.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Norditropin Nordiflex	Somatropin	Pen Injctr	15MG/1.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Norditropin Nordiflex	Somatropin	Pen Injctr	30 MG/3 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Norditropin Nordiflex	Somatropin	Pen Injctr	5 MG/1.5 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Genotropin	Somatropin	Syringe	0.2MG/ 0.25	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Genotropin	Somatropin	Syringe	0.4MG/ 0.25	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Genotropin	Somatropin	Syringe	0.6MG/ 0.25	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Genotropin	Somatropin	Syringe	0.8MG/ 0.25	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Genotropin	Somatropin	Syringe	1.2MG/ 0.25	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Genotropin	Somatropin	Syringe	1.4MG/ 0.25	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Genotropin	Somatropin	Syringe	1.6MG/ 0.25	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Genotropin	Somatropin	Syringe	1.8MG/ 0.25	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Genotropin	Somatropin	Syringe	1MG/0. 25ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Genotropin	Somatropin	Syringe	2MG/0.25ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Serostim	Somatropin	Vial	4 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Serostim	Somatropin	Vial	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Serostim	Somatropin	Vial	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Humatrope	Somatropin	Vial	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
Omnitrope	Somatropin	Vial	5.8 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy

Serostim	Somatropin	Vial	6 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for children with documented growth hormone deficiency, Turner Syndrome, Prader-Willi Syndrome, or small for gestational age restricted to Specialty Pharmacy
DRUG CLASS:	Lhrh(Gnrh)Agnst Pit.Sup-Central Precocious Pube				**CATEGORY**	Endocrinology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Lupron Depot-Ped	Leuprolide Acetate	Kit	11.25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Lupron Depot-Ped	Leuprolide Acetate	Kit	15 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Changes are made on a quarterly basis. Please contact HPSJ if there are any questions. Current as of 4/29/2019

Lupron Depot-Ped	Leuprolide Acetate	Kit	7.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Lupron Depot-Ped	Leuprolide Acetate	Syringekit	11.25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Pineal Hormone Agents				**CATEGORY**	Endocrinology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Melatonin	Melatonin	Tablet	3 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Thyroid Function Diagnostic Agents				**CATEGORY**	Endocrinology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Thyrogen	Thyrotropin Alfa	Vial	1.1 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

DRUG CLASS:	Thyroid Hormones				**CATEGORY** Endocrinology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Synthroid	Levothyroxine Sodiu	Tablet	100 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Synthroid	Levothyroxine Sodiu	Tablet	112 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Synthroid	Levothyroxine Sodiu	Tablet	125 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Synthroid	Levothyroxine Sodiu	Tablet	137 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Synthroid	Levothyroxine Sodiu	Tablet	150 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Synthroid	Levothyroxine Sodiu	Tablet	175MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Synthroid	Levothyroxine Sodiu	Tablet	200 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Synthroid	Levothyroxine Sodiu	Tablet	25 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Synthroid	Levothyroxine Sodiu	Tablet	300 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	

Synthroid	Levothyroxine Sodiu	Tablet	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Synthroid	Levothyroxine Sodiu	Tablet	75 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Synthroid	Levothyroxine Sodiu	Tablet	88 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Liothyronine Sodiu	Liothyronine Sodium	Tablet	25 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Liothyronine Sodiu	Liothyronine Sodium	Tablet	5 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Liothyronine Sodiu	Liothyronine Sodium	Tablet	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	240 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Armour Thyroid	Thyroid,Pork	Tablet	90 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Armour Thyroid	Thyroid,Pork	Tablet	90 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Enzyme

DRUG CLASS: Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
DRUG CLASS: Metabolic diagnosis Enzyme Replace, Mucopolysa					CATEGORY Enzyme								
Aldurazyme	Laronidase	Vial	2.9 MG/5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS: Metabolic Disease Enzyme Replacement, Fabry'S d					CATEGORY Enzyme								
Fabrazyme	Agalsidase Beta	Vial	35 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Fabrazyme	Agalsidase Beta	Vial	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

THERAPEUTIC CATEGORY
Enzymes

DRUG CLASS: Pancreatic Enzymes					**CATEGORY** Enzymes								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zenpep	Lipase/Protease/Am	Capsule Dr	40-126-	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Eye

DRUG CLASS: Brand Name	Artificial Tears Generic Name	Formulation	Strength	Tier	CATEGORY Eye PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Refresh Liquigel	Carboxymethylcellul	Drp Lq Gel	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tears Naturale-Ii	Dextran 70/Hyprom	Drops		1	☐	☐	☐	☐	☐	☐	☐	☐	
Tears Naturale-Ii	Dextran 70/Hyprom	Drops		1	☐	☐	☐	☐	☐	☐	☐	☐	
Artificial Tears	Dextran 70/Hyprom	Drops	0.1%-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Advanced Eye Relief	Glycerin/Propylene	Drops	0.3%-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Advanced Eye Relief	Glycerin/Propylene	Drops	0.3%-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Refresh P.M.	Petrolat,Wht/Min Oil	Oint. (G)		1	☐	☐	☐	☐	☐	☐	☐	☐	
Refresh P.M.	Petrolat,Wht/Min Oil	Oint. (G)		1	☐	☐	☐	☐	☐	☐	☐	☐	
Teargen	Polyvinyl Alcohol	Drops	0.014	1	☐	☐	☐	☐	☐	☐	☐	☐	
Teargen	Polyvinyl Alcohol	Drops	0.014	1	☐	☐	☐	☐	☐	☐	☐	☐	
Teargen	Polyvinyl Alcohol	Drops	0.014	1	☐	☐	☐	☐	☐	☐	☐	☐	
Teargen	Polyvinyl Alcohol	Drops	0.014	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Systane	Propylene Glycol/Pe	Drops	0.3 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Systane	Propylene Glycol/Pe	Drops	0.3 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Carbonic Anhydrase Inhibitors				**CATEGORY**	Eye							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Acetazolamide	Acetazolamide	Capsule Er	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acetazolamide	Acetazolamide	Tablet	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acetazolamide	Acetazolamide	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methazolamide	Methazolamide	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methazolamide	Methazolamide	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Eye Antibiotic-Corticoid Combinations				**CATEGORY**	Eye							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pred-G	Gentamicin/Prednis	Drops Susp	0.3%-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pred-G	Gentamicin/Prednis	Oint. (G)	0.3-0.6	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maxitrol	Neo/Polymyx B Sulf/	Drops Susp	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maxitrol	Neo/Polymyx B Sulf/	Oint. (G)	3.5-10K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neomycin-Bacitraci	Neomy Sulf/Bacitrac	Oint. (G)	3.5-10K-	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Cortisporin	Neomycin/Polymyxi	Drops Susp	3.5-10K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tobradex	Tobramycin/Dexam	Drops Susp	0.3 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tobradex	Tobramycin/Dexam	Oint. (G)	0.3 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Eye Antihistamines				**CATEGORY** Eye								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Azelastine Hcl	Azelastine Hcl	Drops	0.0005	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to Ketotifen.
Refresh	Ketotifen Fumarate	Drops	0.00025	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 10 ml per 30 days.
Refresh	Ketotifen Fumarate	Drops	0.00025	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 10 ml per 30 days.
Refresh	Ketotifen Fumarate	Drops	0.00025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Refresh	Ketotifen Fumarate	Drops	0.00025	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 10 ml per 30 days.
Refresh	Ketotifen Fumarate	Drops	0.00025	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 10 ml per 30 days.
Refresh	Ketotifen Fumarate	Drops	0.00025	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 10 ml per 30 days.

Refresh	Ketotifen Fumarate	Drops	0.00025	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 10 ml per 30 days.
Refresh	Ketotifen Fumarate	Drops	0.00025	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 10 ml per 30 days.
Patanol	Olopatadine Hcl	Drops	0.001	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for treatment failure to Azelastine AND either Alaway, Zaditor, or Visine-A. Limited to 5mL per 30 days.
DRUG CLASS:	Eye Antiinflammatory Agents				**CATEGORY**	Eye							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Dexamethasone Sod	Dexamethasone Sod	Drops	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Voltaren	Diclofenac Sodium	Drops	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fml	Fluorometholone	Drops Susp	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fml Forte	Fluorometholone	Drops Susp	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fml S.O.P.	Fluorometholone	Oint. (G)	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ocufen	Flurbiprofen Sodium	Drops	0.0003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acular Ls	Ketorolac Trometha	Drops	0.004	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Acular	Ketorolac Trometha	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lotemax	Loteprednol Etabonate	Drops Gel	0.005	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients with glaucoma or for use in children ≤10 years. Must be prescribed by an ophthalmologist.
Alrex	Loteprednol Etabonate	Drops Susp	0.002	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients with glaucoma or for use in children ≤10 years. Must be prescribed by an ophthalmologist.
Lotemax	Loteprednol Etabonate	Drops Susp	0.005	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients with glaucoma or for use in children ≤10 years. Must be prescribed by an ophthalmologist.
Lotemax	Loteprednol Etabonate	Oint. (G)	0.005	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients with glaucoma or for use in children ≤10 years. Must be prescribed by an ophthalmologist.
Pred Mild	Prednisolone Acetat	Drops Susp	0.0012	1	☐	☐	☐	☐	☐	☐	☐	☐	

Omnipred	Prednisolone Acetat	Drops Susp	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐		
Prednisolone Sodiu	Prednisolone Sod Ph	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐		
DRUG CLASS:	Eye Antivirals			**CATEGORY**	Eye									
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Viroptic	Trifluridine	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐		
DRUG CLASS:	Eye Local Anesthetics			**CATEGORY**	Eye									
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Alcaine	Proparacaine Hcl	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐		
DRUG CLASS:	Eye Sulfonamides			**CATEGORY**	Eye									
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Sulfamide	Sulfacetamide Sodiu	Drops	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐		
Sulfacetamide Sodiu	Sulfacetamide Sodiu	Oint. (G)	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐		
Sulfacetamide-Pred	Sulfacetamide/Pred	Drops	10 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐		
Blephamide	Sulfacetm Na/Predni	Drops Susp	10 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐		
Blephamide S.O.P.	Sulfacetm Na/Predni	Oint. (G)	10 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐		
DRUG CLASS:	Eye Vasoconstrictors (Rx Only)			**CATEGORY**	Eye									
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	

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Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Albalon	Naphazoline Hcl	Drops	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mydfrin	Phenylephrine Hcl	Drops	0.025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenylephrine Hcl	Phenylephrine Hcl	Drops	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Miotics/Other Intraoc. Pressure Reducers				**CATEGORY** Eye								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Iopidine	Apraclonidine Hcl	Droperette	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Iopidine	Apraclonidine Hcl	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Betaxolol Hcl	Betaxolol Hcl	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Betoptic S	Betaxolol Hcl	Drops Susp	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lumigan	Bimatoprost	Drops	0.0001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Alphagan P	Brimonidine Tartrat	Drops	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Alphagan P	Brimonidine Tartrat	Drops	0.0015	1	☐	☐	☐	☐	☐	☐	☐	☐	
Brimonidine Tartrat	Brimonidine Tartrat	Drops	0.002	1	☐	☐	☐	☐	☐	☐	☐	☐	
Combigan	Brimonidine Tartrat	Drops	0.2%-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Azopt	Brinzolamide	Drops Susp	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Miostat	Carbachol	Vial	0.0001	1	☐	☐	☐	☐	☐	☐	☐	☐
Carteolol Hcl	Carteolol Hcl	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Trusopt	Dorzolamide Hcl	Drops	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Cosopt	Dorzolamide Hcl/Ti	Drops	22.3-6.8	1	☐	☐	☐	☐	☐	☐	☐	☐
Phospholine Iodide	Echothiophate Iodid	Drops	0.00125	1	☐	☐	☐	☐	☐	☐	☐	☐
Xalatan	Latanoprost	Drops	5e-005	1	☐	☐	☐	☐	☐	☐	☐	☐
Betagan	Levobunolol Hcl	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐
Optipranolol	Metipranolol	Drops	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐
Pilocarpine Hcl	Pilocarpine Hcl	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Pilocarpine Hcl	Pilocarpine Hcl	Drops	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Pilocarpine Hcl	Pilocarpine Hcl	Drops	0.04	1	☐	☐	☐	☐	☐	☐	☐	☐
Betimol	Timolol	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐
Timoptic	Timolol Maleate	Drops	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐
Timoptic	Timolol Maleate	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐
Timoptic-Xe	Timolol Maleate	Sol-Gel	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐

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Timoptic-Xe	Timolol Maleate	Sol-Gel	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Timoptic Ocudose	Timolol Maleate/Pf	Droperette	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Timoptic Ocudose	Timolol Maleate/Pf	Droperette	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Mydriatics				**CATEGORY** Eye								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Atropine Sulfate	Atropine Sulfate	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Atropine Sulfate	Atropine Sulfate	Oint. (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyclogyl	Cyclopentolate Hcl	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyclogyl	Cyclopentolate Hcl	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyclogyl	Cyclopentolate Hcl	Drops	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isopto Homatropine	Homatropine Hbr	Drops	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isopto Homatropine	Homatropine Hbr	Drops	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isopto Hyoscine	Scopolamine Hydrob	Drops	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tropicamide	Tropicamide	Drops	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mydriacyl	Tropicamide	Drops	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Ophthalmic Antibiotics					**CATEGORY** Eye								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Bacitracin	Bacitracin	Oint. (G)	500 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bacitracin-Polymyxi	Bacitracin/Polymyxi	Oint. (G)	500-10K	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ciloxan	Ciprofloxacin Hcl	Drops	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Erythromycin	Erythromycin Base	Oint. (G)	5 MG/G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Garamycin	Gentamicin Sulfate	Drops	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Garamycin	Gentamicin Sulfate	Drops	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Garamycin	Gentamicin Sulfate	Drops	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gentamicin Sulfate	Gentamicin Sulfate	Oint. (G)	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gentamicin Sulfate	Gentamicin Sulfate	Oint. (G)	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gentamicin Sulfate	Gentamicin Sulfate	Oint. (G)	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vigamox	Moxifloxacin Hcl	Drops	0.005	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of ofloxacin or ciprofloxacin opthalmic suspension in the last 90 days.

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Moxeza	Moxifloxacin Hcl	Drops Visc	0.005	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of ofloxacin or ciprofloxacin opthalmic suspension in the last 90 days.
Neomycin-Bacitraci	Neomy Sulf/Bacitra/	Oint. (G)	3.5MG-4	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neomycin-Polymyxi	Neomycin/Polymyxn	Drops	1.75MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ocuflox	Ofloxacin	Drops	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Polytrim	Polymyxin B Sulf/Tri	Drops	10000-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tobrex	Tobramycin	Drops	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tobrex	Tobramycin	Oint. (G)	0.003	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Ophthalmic Anti-Inflammatory Immunomodulato				**CATEGORY**	Eye							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Restasis	Cyclosporine	Droperette	0.0005	1	☐	☑	☐	☐	☐	☐	☐	☐	Reserved for patients who have failed ophthalmic lubricants in the last 6 months.
DRUG CLASS:	Ophthalmic Mast Cell Stabilizers				**CATEGORY**	Eye							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Cromolyn Sodium	Cromolyn Sodium	Drops	0.04	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Topical Antifungals				**CATEGORY** Eye								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Natacyn	Natamycin	Drops Susp	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
GI, GERD

DRUG CLASS: Antacids					CATEGORY GI, GERD								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Calcium Carbonate	Calcium Carbonate	Tablet	260MG(	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Mag Hydrox/Al Hydr	Oral Susp	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐
Alamag Plus	Mag Hydrox/Al Hydr	Oral Susp	200-225	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐

Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox Maximum St	Mag Hydrox/Al Hydr	Oral Susp	400-400	1	☐	☐	☐	☐	☐	☐	☐	☐

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Gelusil	Mag Hydrox/Al Hydr	Tab Chew	200-200	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Proton-Pump Inhibitors				**CATEGORY**	GI, GERD							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Kapidex	Dexlansoprazole	Cap Dr Bp	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	Step Therapy to 2 (two) first line PPI (omeprazole/pantoprazole /lansoprazole), Nexium OTC, AND Aciphex (rabeprazole)
Dexilant	Dexlansoprazole	Cap Dr Bp	60 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	Step Therapy to 2 (two) first line PPI (omeprazole/pantoprazole /lansoprazole), Nexium OTC, AND Aciphex (rabeprazole)

Nexium 24h OTC	Esomeprazole Magnesium	Capsule Dr	20 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Nexium otc is reserved for documentation of treatment failure of 2 (two) dose-optimized first line agents (omeprazole 40mg or higher, pantoprazole 40mg or higher, lansoprazole 60mg or higher).
Prevacid 24Hr	Lansoprazole	Capsule Dr	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lansoprazole	Lansoprazole	Capsule Dr	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prevacid	Lansoprazole	Tab Rap Dr	15 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	For treatment failure to ranitidine syrup in <10 yrs old or documented inability to swallow.
Prevacid	Lansoprazole	Tab Rap Dr	30 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	For treatment failure to ranitidine syrup in <10 yrs old or documented inability to swallow.
Omeprazole	Omeprazole	Capsule Dr	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Omeprazole	Omeprazole	Capsule Dr	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Pantoprazole Sodiu	Pantoprazole Sodiu	Tablet Dr	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pantoprazole Sodiu	Pantoprazole Sodiu	Tablet Dr	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rabeprazole Sodium	Rabeprazole Sodium	Tablet Dr	20 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step Therapy to 2 (two) first line PPI (omeprazole/pantoprazole /lansoprazole), and Nexium OTC capsules.

THERAPEUTIC CATEGORY
GI, Other

DRUG CLASS: / Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
DRUG CLASS: Ammonia Inhibitors				**CATEGORY** GI, Other									
Lactulose	Lactulose	Solution	10 G/15	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lactulose	Lactulose	Solution	10 G/15	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Amyotrophic Lateral Sclerosis Agents				**CATEGORY** GI, Other									
Rilutek	Riluzole	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Anticholinergics/Antispasmodics				**CATEGORY** GI, Other									
Dicyclomine Hcl	Dicyclomine Hcl	Capsule	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dicyclomine Hcl	Dicyclomine Hcl	Solution	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dicyclomine Hcl	Dicyclomine Hcl	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Antidiarrheals				**CATEGORY** GI, Other									
Kaopectate	Bismuth Subsalicylat	Oral Susp	262MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Maalox	Bismuth Subsalicylat	Oral Susp	525MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Bismuth Subsalicylat	Oral Susp	525MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Bismuth Subsalicylat	Oral Susp	525MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Bismuth Subsalicylat	Oral Susp	525MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Bismuth Subsalicylat	Oral Susp	525MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Maalox	Bismuth Subsalicylat	Oral Susp	525MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Relief	Bismuth Subsalicylat	Tab Chew	262 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Soothe	Bismuth Subsalicylat	Tablet	262 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Lomotil	Diphenoxylate Hcl/A	Liquid	2.5-.025	1	☐	☐	☐	☐	☐	☐	☐	☐
Lomotil	Diphenoxylate Hcl/A	Tablet	2.5-.025	1	☐	☐	☐	☐	☐	☐	☐	☐
Loperamide	Loperamide Hcl	Capsule	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Loperamide	Loperamide Hcl	Capsule	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Imodium A-D	Loperamide Hcl	Liquid	1 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐
Imodium A-D	Loperamide Hcl	Liquid	1 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐
Loperamide	Loperamide Hcl	Liquid	1MG/7.	1	☐	☐	☐	☐	☐	☐	☐	☐

Imodium A-D	Loperamide Hcl	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Imodium A-D	Loperamide Hcl	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Imodium A-D	Loperamide Hcl	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Imodium A-D	Loperamide Hcl	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Imodium A-D	Loperamide Hcl	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Paregoric	Paregoric	Liquid	2 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Antiflatulents				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Simethicone	Simethicone	Drops Susp	40MG/0	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Anti-Ulcer Preparations				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cytotec	Misoprostol	Tablet	100 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cytotec	Misoprostol	Tablet	200 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sucralfate	Sucralfate	Oral Susp	1 G/10	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sucralfate	Sucralfate	Oral Susp	1 G/10	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sucralfate	Sucralfate	Tablet	1 G	1	☐	☐	☐	☐	☐	☐	☐	☐	

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DRUG CLASS: Belladonna Alkaloids **CATEGORY** GI, Other													
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Levsin	Hyoscyamine Sulfate	Drops	0.125M G/ML	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted for use in children and infants <2 years old only.
Levsin	Hyoscyamine Sulfate	Drops	0.125M G/ML	1	☐	☐	☐	☐	☑	☐	☐	☐	Restricted for use in children and infants <2 years old only.
Levsin	Hyoscyamine Sulfate	Elixir	125MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levsin	Hyoscyamine Sulfate	Elixir	125MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyoscyamine Sulfat	Hyoscyamine Sulfate	Tab Er 12H	0.375 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyoscyamine Sulfat	Hyoscyamine Sulfate	Tab Er 12H	0.375 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyomax-Dt	Hyoscyamine Sulfate	Tab Mphase	0.125-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Anaspaz	Hyoscyamine Sulfate	Tab Rapdis	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Anaspaz	Hyoscyamine Sulfate	Tab Rapdis	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Anaspaz	Hyoscyamine Sulfate	Tab Rapdis	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyoscyamine Sulfat	Hyoscyamine Sulfate	Tab Subl	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Hyoscyamine Sulfat	Hyoscyamine Sulfate	Tab Subl	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyoscyamine Sulfat	Hyoscyamine Sulfate	Tab Subl	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyoscyamine Sulfat	Hyoscyamine Sulfate	Tablet	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hyoscyamine Sulfat	Hyoscyamine Sulfate	Tablet	0.125 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Belladonna-Phenob	Phenobarb/Hyoscy/	Elixir	16.2MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Belladonna-Phenob	Phenobarb/Hyoscy/	Tablet	16.2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Bile Salts				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ursodiol	Ursodiol	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ursodiol	Ursodiol	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ursodiol	Ursodiol	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Chronic Inflam. Colon diagnosis, 5-A-Salicylat,Rect				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Mesalamine	Mesalamine	Enema	4 G/60	1	☐	☐	☐	☐	☐	☐	☐	☐	
Canasa	Mesalamine	Supp.Rect	1000 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients unable to administer Mesalamine enema.

DRUG CLASS:	Drug treatment-Chronic Inflam. Colon diagnosis,5-				**CATEGORY**	GI, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Colazal	Balsalazide Disodiu	Capsule	750 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pentasa	Mesalamine	Capsule Er	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for induction of remission and maintenance therapy in ileal disease.
Pentasa	Mesalamine	Capsule Er	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for induction of remission and maintenance therapy in ileal disease.

DRUG CLASS:	Drugs To treatment Chronic Inflamm. Disease Of C				**CATEGORY**	GI, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cimzia	Certolizumab Pegol	Kit	400 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA, PsA, AS, and CD: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy.

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Cimzia	Certolizumab Pegol	Syringekit	400MG/ 2ML	1	☐	☑	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA, PsA, AS, and CD: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy.
Cimzia	Certolizumab Pegol	Syringekit	400MG/ 2ML	1	☐	☑	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA, PsA, AS, and CD: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy.
DRUG CLASS:	Glucocorticoids				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Entocort EC	Budesonide	Capdr - Er	3 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Reserved for induction of remission in those intolerant to conventional steroids for up to 90 days of therapy.

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DRUG CLASS:	Hemorrhoidal Prep,Anti-Infam Steriods/Local Ane				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Analpram Hc	Hydrocortisone/Pra	Cream/Appl	1 %-1 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Analpram Hc	Hydrocortisone/Pra	Cream/Appl	1 %-1 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Analpram Hc	Hydrocortisone/Pra	Cream/Appl	2.5 %-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Proctofoam-Hc	Hydrocortisone/Pra	Foam	1 %-1 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Hemorrhoidal Preparations				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Hemorrhoidal	Phenylephrine Hcl	Supp.Rect	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hemorrhoidal	Phenylephrine Hcl	Supp.Rect	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Proctofoam	Pramoxine Hcl	Foam	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Intestinal Motility Stimulants				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Metoclopramide Hcl	Metoclopramide Hcl	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Reglan	Metoclopramide Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Reglan	Metoclopramide Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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DRUG CLASS: Laxatives And Cathartics					**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ex-Lax	Bisacodyl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Doxidan	Bisacodyl	Tablet Dr	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Stool Softener	Docusate Sodium	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Stool Softener	Docusate Sodium	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Stool Softener	Docusate Sodium	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Stool Softener	Docusate Sodium	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Stool Softener	Docusate Sodium	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Stool Softener	Docusate Sodium	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Stool Softener	Docusate Sodium	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Stool Softener	Docusate Sodium	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Docusate Sodium	Docusate Sodium	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Docusate Sodium	Docusate Sodium	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Docusate Sodium	Docusate Sodium	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Docusate Sodium	Docusate Sodium	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Col-Rite	Docusate Sodium	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Col-Rite	Docusate Sodium	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Docusate Sodium	Docusate Sodium	Liquid	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Docusate Sodium	Docusate Sodium	Liquid	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Docusate Sodium	Docusate Sodium	Liquid	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Docusate Sodium	Docusate Sodium	Liquid	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pedia-Lax Stool Soft	Docusate Sodium	Syrup	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Docusate Sodium	Docusate Sodium	Syrup	60 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Docusate Sodium	Docusate Sodium	Syrup	60 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Docusate Sodium	Docusate Sodium	Syrup	60 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Docusate Sodium	Docusate Sodium	Syrup	60 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Dok	Docusate Sodium	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dok	Docusate Sodium	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dok	Docusate Sodium	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Lactulose	Lactulose	Solution	10 G/15	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lactulose	Lactulose	Solution	10 G/15	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lactulose	Lactulose	Solution	10 G/15	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lactulose	Lactulose	Solution	20 G/30	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amitiza	Lubiprostone	Capsule	24MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Amitiza is reserved for members who have failed treatment with linaclotide (Linzess) or naloxegol (Movantik). Patient must have also failedregularly scheduled, dose optimized polyethylene glycol (Miralax), AND two of the following: bisacodyl

Amitiza	Lubiprostone	Capsule	8 MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Amitiza is reserved for members who have failed treatment with linaclotide (Linzess) or naloxegol (Movantik). Patient must have also failedregularly scheduled, dose optimized polyethylene glycol (Miralax), AND two of the following: bisacodyl
Magnesium Citrate	Magnesium Citrate	Solution		1	☐	☐	☐	☐	☐	☐	☐	☐	
Magnesium Citrate	Magnesium Citrate	Solution		1	☐	☐	☐	☐	☐	☐	☐	☐	
Ex-Lax Milk Of Magn	Magnesium Hydroxi	Oral Susp	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Peg-3350 And Electr	Peg 3350/Na Sulf,Bic	Soln Recon	236-22.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Peg-3350 And Electr	Peg 3350/Na Sulf,Bic	Soln Recon	236-22.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Colyte With Flavor P	Peg 3350/Na Sulf,Bic	Soln Recon	240-22.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Colyte With Flavor P	Peg 3350/Na Sulf,Bic	Soln Recon	240-22.	1	☐	☐	☐	☐	☐	☐	☐	☐	

Clearlax	Polyethylene Glycol 3350	Powder	17G/DOSE	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1054g per 30 days.
Clearlax	Polyethylene Glycol 3350	Powder	17G/DOSE	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1054g per 30 days.
Clearlax	Polyethylene Glycol 3350	Powder	17G/DOSE	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1054g per 30 days.
Clearlax	Polyethylene Glycol 3350	Powder	17G/DOSE	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1054g per 30 days.
Clearlax	Polyethylene Glycol 3350	Powder	17G/DOSE	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1054g per 30 days.
Clearlax	Polyethylene Glycol 3350	Powder	17G/DOSE	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1054g per 30 days.
Clearlax	Polyethylene Glycol 3350	Powder	17G/DOSE	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1054g per 30 days.
Clearlax	Polyethylene Glycol 3350	Powder	17G/DOSE	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1054g per 30 days.
Clearlax	Polyethylene Glycol	Powder	17G/DO	1	☐	☐	☐	☐	☐	☐	☐	☐	
Wal-Mucil	Psyllium Husk (With	Powder	3.4 G/7	1	☐	☐	☐	☐	☐	☐	☐	☐	

Wal-Mucil	Psyllium Husk (With	Powder	3.4 G/7	1	☐	☐	☐	☐	☐	☐	☐	☐
Wal-Mucil	Psyllium Husk/Aspa	Powder	3.4G/5.8	1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Konsyl	Psyllium Seed	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐

Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Genfiber	Psyllium Seed (With	Powder		1	☐	☐	☐	☐	☐	☐	☐	☐
Metamucil	Psyllium Seed (With	Wafer		1	☐	☐	☐	☐	☐	☐	☐	☐
Senna	Sennosides	Capsule	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Senexon	Sennosides	Syrup	8.8MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Senexon	Sennosides	Syrup	8.8MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Ex-Lax	Sennosides	Tab Chew	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Ex-Lax	Sennosides	Tab Chew	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Ex-Lax	Sennosides	Tablet	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Laxative	Sennosides	Tablet	17.2MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Laxative	Sennosides	Tablet	17.2MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Ex-Lax Maximum Re	Sennosides	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Natural Senna Laxat	Sennosides	Tablet	8.6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Senna S	Sennosides/Docusat	Tablet	8.6MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐
Senna S	Sennosides/Docusat	Tablet	8.6MG-5	1	☐	☐	☐	☐	☐	☐	☐	☐
Trilyte With Flavor	Sodium Chloride/Na	Soln Recon	420G	1	☐	☐	☐	☐	☐	☐	☐	☐
Trilyte With Flavor	Sodium Chloride/Na	Soln Recon	420G	1	☐	☐	☐	☐	☐	☐	☐	☐
Trilyte With Flavor	Sodium Chloride/Na	Soln Recon	420G	1	☐	☐	☐	☐	☐	☐	☐	☐

DRUG CLASS: Laxatives, Local/Rectal					**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Bisacodyl	Bisacodyl	Enema	10MG/3	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bisacodyl	Bisacodyl	Supp.Rect	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adult Glycerin	Glycerin	Supp.Rect	ADULT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adult Glycerin	Glycerin	Supp.Rect	ADULT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adult Glycerin	Glycerin	Supp.Rect	ADULT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pedia-Lax	Glycerin	Supp.Rect	PEDIAT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pedia-Lax	Glycerin	Supp.Rect	PEDIAT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pedia-Lax	Glycerin	Supp.Rect	PEDIAT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pedia-Lax	Glycerin	Supp.Rect	PEDIAT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pedia-Lax	Glycerin	Supp.Rect	PEDIAT	1	☐	☐	☐	☐	☐	☐	☐	☐	
Enema	Sod Phos,M-B/Na Ph	Enema	19G-7G/	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Pancreatic Enzymes					**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zenpep	Lipase/Protease/Am	Capsule Dr	10-34-5	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Creon	Lipase/Protease/Am	Capsule Dr	12K-38	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zenpep	Lipase/Protease/Am	Capsule Dr	15-51-8	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zenpep	Lipase/Protease/Am	Capsule Dr	20-68-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Creon	Lipase/Protease/Am	Capsule Dr	24-76-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zenpep	Lipase/Protease/Am	Capsule Dr	25-85-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Creon	Lipase/Protease/Am	Capsule Dr	36-114-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Creon	Lipase/Protease/Am	Capsule Dr	3-9.5-15	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zenpep	Lipase/Protease/Am	Capsule Dr	3K-10K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pancrelipase 5,000	Lipase/Protease/Am	Capsule Dr	5K-17K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pancrelipase 5,000	Lipase/Protease/Am	Capsule Dr	5K-17K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Creon	Lipase/Protease/Am	Capsule Dr	6K-19K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Parasympathetic Agents				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Bethanechol Chlorid	Bethanechol Chlorid	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bethanechol Chlorid	Bethanechol Chlorid	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Bethanechol Chlorid	Bethanechol Chlorid	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bethanechol Chlorid	Bethanechol Chlorid	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Rectal Preparations				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Procto-Kit	Hydrocortisone	Cream/Appl	0.025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Procto-Kit	Hydrocortisone	Cream/Appl	0.025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydrocortisone Acet	Hydrocortisone Acet	Supp.Rect	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydrocortisone Acet	Hydrocortisone Acet	Supp.Rect	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydrocortisone Acet	Hydrocortisone Acet	Supp.Rect	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hemril	Hydrocortisone Acet	Supp.Rect	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hemril	Hydrocortisone Acet	Supp.Rect	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Rectal/Lower Bowel Prep.,Glucocort. (Non-Hemor				**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Hydrocortisone	Hydrocortisone	Enema	100MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydrocortisone	Hydrocortisone	Enema	100MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cortifoam	Hydrocortisone Acet	Foam/Appl	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	

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DRUG CLASS: Topical Local Anesthetics					**CATEGORY** GI, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Linzess	Linaclotide	Capsule	145 MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Linzess is reserved for patients with treatment failure of properly titrated and regularly scheduled dosing of polyethylene glycol for 2 months (as evidenced by prescription history fills) AND two of the following: bisacodyl, Senna, psyllium,
Linzess	Linaclotide	Capsule	290 MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Linzess is reserved for patients with treatment failure of properly titrated and regularly scheduled dosing of polyethylene glycol for 2 months (as evidenced by prescription history fills) AND two of the following: bisacodyl, Senna, psyllium,

THERAPEUTIC CATEGORY
Glucocorticoids

DRUG CLASS: -					CATEGORY Glucocorticoids								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Qvar Redihaler	Beclomethasone Dipropionate	Hfa Aeroba	40 Mcg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 package per 30 days.
DRUG CLASS:	Glucocorticoids, Orally Inhaled				CATEGORY Glucocorticoids								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Qvar Redihaler	Beclomethasone Dipropionate	Hfa Aeroba	80 Mcg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 package per 30 days.
DRUG CLASS:	Topical Anti-Inflammatory Steroidal				CATEGORY Glucocorticoids								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Betamethasone Dipropionate	Betamethasone Dipropionate	Lotion	0.05 %	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 grams per 90 days.
Clobetasol Propionate	Clobetasol Propionate	Gel (Gram)	0.05 %	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 grams per 90 days.
Clobex	Clobetasol Propionate	Shampoo	0.05 %	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 118 mL per 90 days.
Fluocinonide Emolli	Fluocinonide/Emolli	Cream (G)	0.05 %	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Ultravate	Halobetasol Propionate	Cream (G)	0.05 %	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 grams per 90 days.
Ultravate	Halobetasol Propionate	Oint. (G)	0.05 %	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 grams per 90 days.

THERAPEUTIC CATEGORY
Hematinics & Blood Cell Stimulators

DRUG CLASS: Hematinics,Other					**CATEGORY** Hematinics & Blood Cell Stimulators								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Retacrit	Epoetin Alfa-Epbx	Vial	10000/ ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation.
Retacrit	Epoetin Alfa-Epbx	Vial	2000/M L	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation.
Retacrit	Epoetin Alfa-Epbx	Vial	3000/M L	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation.

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Retacrit	Epoetin Alfa-Epbx	Vial	4000/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation.
Retacrit	Epoetin Alfa-Epbx	Vial	40000/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation.

DRUG CLASS: Leukocyte (Wbc) Stimulants					**CATEGORY** Hematinics & Blood Cell Stimulators								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zarxio	Filgrastim-Sndz	Syringe	300Mcg/0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Zarxio	Filgrastim-Sndz	Syringe	480Mcg /0.8	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Granix	Tbo-Filgrastim	Syringe	300Mcg /0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta).
Granix	Tbo-Filgrastim	Syringe	300Mcg /0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta).

Granix	Tbo-Filgrastim	Syringe	480Mcg /0.8	1	☑	☐	☐	☐	☐	☐	☐	☑	filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta).
Granix	Tbo-Filgrastim	Syringe	480Mcg /0.8	1	☑	☐	☐	☐	☐	☐	☐	☑	filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta).

THERAPEUTIC CATEGORY
Hemorrhoidal Preparations

DRUG CLASS: Hemorrhoidals, Local Rectal Anesthetics					CATEGORY Hemorrhoidal Preparations								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Recticare	Lidocaine	Cream (G)	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for relief of pain or itching due to anorectal disorder.
Anecream5	Lidocaine	Cream (G)	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for relief of pain or itching due to anorectal disorder.
Lc-5	Lidocaine	Cream (G)	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for relief of pain or itching due to anorectal disorder.
Lidocaine	Lidocaine	Cream (G)	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for relief of pain or itching due to anorectal disorder.
Rectasmoothe	Lidocaine	Cream (G)	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for relief of pain or itching due to anorectal disorder.

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Lmx 5	Lidocaine	Cream (G)	5 %	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for relief of pain or itching due to anorectal disorder.

THERAPEUTIC CATEGORY
Infant Formulas

DRUG CLASS: Brand Name	Infant Formulas Generic Name	Formulation	Strength	Tier	CATEGORY Infant Formulas PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Ga-1 Anamix Early Years	Inf For, Glutar Acid I/Dha/Ara	Powder	13.5 G-473	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyr Anamix Early Years	Inf Form For Tyrosinemia, Iron	Powder	13.5 G-473	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyrex-1	Inf Form For Tyrosinemia, Iron	Powder	15G-480	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyros 1	Inf Form For Tyrosinemia, Iron	Powder	16.7G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

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Glutarex-1	Inf Form, Glutaric Aciduria I	Powder	15G-480	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Iva Anamix Early Years	Inf Form, Isoval Iron/Dha/Ara	Powder	13.5 G-473	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Mma-Pa Anamix Early Years	Inf Form, Propionic Ac/Dha/Ara	Powder	13.5 G-473	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Alfamino Infant	Inf Form,Iron,Lf/Amino /Dha/Ara	Powder	2.8 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutramigen Enflora-Lgg	Inf Form,Iron,Spc.Met,Lac-Free	Powder	2.8 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Gerber Extensive Ha	Inf Form,Sp.Met,Lf,Iron/ B.Anim	Powder	2.6 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Sod Anamix Early Years	Inf Form,Sul Ox Def,Iron/Dha/A	Powder	13.5 G-473	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Puramino Dha-Ara	Inf Form/Iron/Amino Ac/Dha/Ara	Powder	2.8 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
I-Valex-1	Inf. Form, Isovaleric Acidemia	Powder	15G-480	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Iva Anamix Next	Inf. Form, Isovaleric Acidemia	Powder	28 G-377	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Hcu Anamix Early Years	Inf.Form,Metab,Iron Methion-Fr	Powder	13.5 G-473	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hominex-1	Inf.Form,Metab,Iron Methion-Fr	Powder	15G-480	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Hcy 1	Inf.Form,Metab,Iron Methion-Fr	Powder	16.2G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutramigen Dha-Ara	Inf.Formula,Iron,Sp. Met.Lac-Fr	Liquid	2.8 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Nutramigen Dha-Ara	Inf.Formula,Iron,Sp. Met.Lac-Fr	Oral Conc	2.8 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Wnd 1	Inf.Formula,Urea Cycle Disordr	Powder	6.5G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Cyclinex-1	Inf.Formula,Urea Cycle Disordr	Powder	7.5G-510	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Product 3232A	Infant Form,Iron,Lac-Fr,Hypoal	Powder	22-33-14.8	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Oa 1	Infant Form,Propionic Acidemia	Powder	15.7G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Propimex-1	Infant Form,Propionic Acidemia	Powder	15G-480	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Mma-Pa Anamix Next	Infant Form,Propionic Acidemia	Powder	28 G-377	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Similac Expert Care Alimentum	Infant Form.Iron Lac-F/Dha/Ara	Oral Susp	2.75G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Similac Expert Care Alimentum	Infant Form.Iron Lac-F/Dha/Ara	Powder	2.75G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Similac Alimentum	Infant Form.Iron Lac-F/Dha/Ara	Powder	2.75G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Elecare	Infant Form.Iron Lac-F/Dha/Ara	Powder	3.1 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Similac Human Milk Fortifier	Infant Form.Iron,Human Milk Ft	Powd Pack	0.25G/0.9G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Enfamil Human Milk Fortifier	Infant Form.Iron,Human Milk Ft	Powd Pack	0.275/0.71	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Rcf Soy Formula	Infant Form.Soy-Iron,Lact-Free	Oral Conc		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Similac Expert Care Neosure	Infant Formula With Iron	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pregestimil	Infant Formula With Iron	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Calcilo Xd	Infant Formula With Iron	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Msud Anamix Early Years	Infant Formula With Iron, Msud	Powder	13.5 G-473	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Ketonex-1	Infant Formula With Iron, Msud	Powder	15G-480	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Bcad 1	Infant Formula With Iron, Msud	Powder	16.2G-500	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Enfamil Enfacare	Infant Formula, Iron/Dha/Ara	Liquid	2.8 G-5.3G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Enfamil Premature	Infant Formula, Iron/Dha/Ara	Liquid	3.3 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Enfamil Premature	Infant Formula, Iron/Dha/Ara	Liquid	3.3 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Enfamil Premature	Infant Formula, Iron/Dha/Ara	Liquid	3.3 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Enfamil Premature	Infant Formula, Iron/Dha/Ara	Liquid	3.6 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Similac Special Care 24	Infant Formula, Iron/Dha/Ara	Liquid	3G/100 Kcal	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Similac Special Care 30	Infant Formula, Iron/Dha/Ara	Oral Susp	3G/100 Kcal	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Similac Expert Care Neosure	Infant Formula, Iron/Dha/Ara	Powder	2.8 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Neocate Infant Dha-Ara	Infant Formula, Iron/Dha/Ara	Powder	2.8 G-5.1G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Enfamil Enfacare	Infant Formula, Iron/Dha/Ara	Powder	2.8 G-5.3G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Enfaport	Infant Formula, Metabolic,Iron	Liquid	3.5G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Pro-Phree	Infant Formula, Metabolic,Iron	Powder	5.5 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pfd Toddler	Infant Formula, Metabolic,Iron	Powder	530/100G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Similac Pm 60-40	Infant Formula,Regular	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Neocate Syneo Infant	Infnt Formula,Iron/Fos/B. Breve	Powder	2.8 G/100	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
DRUG CLASS:	Nutritional Tx, Phenylketonuria (Pku) Formulatio				**CATEGORY**	Infant Formulas							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Pku Periflex Early Years	Infant Form.For Pku,Iron No.4	Powder	13.5 G-473	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

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Phenex-1	Infant Formula Pku,Iron No.2	Powder	15G-480	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

THERAPEUTIC CATEGORY
Infection, Hepatitis

DRUG CLASS: Brand Name	Hepatitis B Treatment Agents Generic Name	Formulation	Strength	Tier	CATEGORY Infection, Hepatitis PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Adefovir Dipivoxil	Adefovir Dipivoxil	Tablet	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Baraclude	Entecavir	Tablet	0.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Baraclude	Entecavir	Tablet	1 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Tyzeka	Telbivudine	Tablet	600 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Hepatitis C Treatment Agents				**CATEGORY**	Infection, Hepatitis							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Daklinza	Daclatasvir Dihydrochloride	Tablet	30 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Daklinza	Daclatasvir Dihydrochloride	Tablet	60 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.

Harvoni	Ledipasvir/Sofosbuvir	Tablet	90Mg-400Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Technivie	Ombitasvir/Paritaprevir/Ritonavir	Tablet	12.5-75 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Pegasys Proclick	Peginterferon Alfa-2A	Pen Injctr	180MCG/0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.

Pegasys	Peginterferon Alfa-2A	Syringe	180MCG /0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Pegasys	Peginterferon Alfa-2A	Vial	180MCG /ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Pegintron Redipen	Peginterferon Alfa-2B	Pen Ij Kit	120MCG /0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.

Pegintron Redipen	Peginterferon Alfa-2B	Pen Ij Kit	150MCG /0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Pegintron Redipen	Peginterferon Alfa-2B	Pen Ij Kit	50 MCG/0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Pegintron Redipen	Peginterferon Alfa-2B	Pen Ij Kit	80MCG/0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.

Rebetol	Ribavirin	Capsule	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Rebetol	Ribavirin	Capsule	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Copegus	Ribavirin	Tablet	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.

Copegus	Ribavirin	Tablet	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Olysio	Simeprevir Sodium	Capsule	150 MG	1	☑	☐	☑	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.
Sovaldi	Sofosbuvir	Tablet	400 MG	1	☑	☐	☑	☐	☐	☐	☐	☑	Reserved for members with a diagnosis of Hepatitis C who meet the California Department of Health Care Services (DHCS) requirements for use.

THERAPEUTIC CATEGORY
Infection, HIV

DRUG CLASS: Antivirals, Hiv-Specific, Nucleoside Analog, Rti **CATEGORY** Infection, HIV

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Videx Ec	Didanosine	Capsule Dr	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Videx Ec	Didanosine	Capsule Dr	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Videx Ec	Didanosine	Capsule Dr	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Videx Ec	Didanosine	Capsule Dr	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Videx	Didanosine	Soln Recon	FNL10M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Videx	Didanosine	Soln Recon	FNL10M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Retrovir	Zidovudine	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Retrovir	Zidovudine	Syrup	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zidovudine	Zidovudine	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Retrovir	Zidovudine	Vial	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Infection, Other

DRUG CLASS: / Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
DRUG CLASS: 2Nd Gen. Anaerobic Antiprotozoal-Antibacterial					**CATEGORY** Infection, Other								
Tinidazole	Tinidazole	Tablet	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to metronidazole within last 30 days.
Tinidazole	Tinidazole	Tablet	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to metronidazole within last 30 days.
DRUG CLASS: Absorbable Sulfonamides					**CATEGORY** Infection, Other								
Sulfamethoxazole-T	Sulfamethoxazole/Tr	Oral Susp	200-40	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sulfamethoxazole-T	Sulfamethoxazole/Tr	Tablet	400MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sulfamethoxazole-T	Sulfamethoxazole/Tr	Tablet	800-160	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Aminoglycosides					**CATEGORY** Infection, Other								

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Gentamicin Sulfate	Gentamicin Sulfate	Vial	40 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neomycin Sulfate	Neomycin Sulfate	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tobi	Tobramycin In 0.225% Nacl	Ampul-Neb	300 MG/5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

DRUG CLASS:	Anaerobic Antiprotozoal-Antibacterial Agents				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Flagyl	Metronidazole	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Flagyl	Metronidazole	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Anthelmintics				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Albenza	Albendazole	Tablet	200 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per 180 days. For larger quantity, please submit PA
Household Lice Cont	Piperonyl Butoxide/	Spray		1	☐	☐	☐	☐	☐	☐	☐	☐	
Licide	Piperonyl Butoxide/	Spray	1 %-0.2	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Reese Pinworm	Pyrantel Pamoate	Oral Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Reese Pinworm	Pyrantel Pamoate	Oral Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Antifungal Agents				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Clotrimazole	Clotrimazole	Troche	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diflucan	Fluconazole	Susp Recon	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diflucan	Fluconazole	Susp Recon	40 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diflucan	Fluconazole	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diflucan	Fluconazole	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diflucan	Fluconazole	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diflucan	Fluconazole	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ancobon	Flucytosine	Capsule	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Ancobon	Flucytosine	Capsule	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Sporanox	Itraconazole	Capsule	100 MG	1	☑	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Infectious Disease or Transplant specialists.
Ketoconazole	Ketoconazole	Tablet	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to other systemic antifungal medications.
Noxafil	Posaconazole	Oral Susp	200 MG/5ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Restricted to physician specialty: Infectious Disease or Transplant specialists.
Noxafil	Posaconazole	Tablet Dr	100 MG	1	☑	☐	☐	☐	☐	☑	☐	☐	Restricted to physician specialty: Infectious Disease or Transplant specialists.

Terbinafine Hcl	Terbinafine Hcl	Tablet	250 MG	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 1 tablet per day and 3 fills per year.
Vfend	Voriconazole	Tablet	200 MG	1	☑	☐	☐	☐	☐	☑	☐	☑	Restricted to use for treatment failure of Fluconazole for Aspergillosis or Candidiasis
Vfend	Voriconazole	Tablet	50 MG	1	☑	☐	☐	☐	☐	☑	☐	☑	Restricted to use for treatment failure of Fluconazole for Aspergillosis or Candidiasis
DRUG CLASS:	Antifungal Antibiotics				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cancidas	Caspofungin Acetate	Vial	50 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Cancidas	Caspofungin Acetate	Vial	70 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gris-Peg	Griseofulvin Ultrami	Tablet	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gris-Peg	Griseofulvin Ultrami	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Grifulvin V	Griseofulvin, Microsi	Oral Susp	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Grifulvin V	Griseofulvin, Microsi	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nystatin	Nystatin	Oral Susp	100000	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nystatin	Nystatin	Powder(Ea)	150MM	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nystatin	Nystatin	Powder(Ea)	500MM	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nystatin	Nystatin	Powder(Ea)	50MM U	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mycostatin	Nystatin	Tablet	500K U	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Antileprotics				**CATEGORY** Infection, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Dapsone	Dapsone	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dapsone	Dapsone	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Thalomid	Thalidomide	Capsule	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Thalomid	Thalidomide	Capsule	150 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Thalomid	Thalidomide	Capsule	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Thalomid	Thalidomide	Capsule	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antimalarial Drugs				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Malarone	Atovaquone/Proguanil Hcl	Tablet	250-100 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.
Malarone	Atovaquone/Proguanil Hcl	Tablet	62.5-25 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.
Chloroquine Phosph	Chloroquine Phosph	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aralen Phosphate	Chloroquine Phosph	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Plaquenil	Hydroxychloroquine	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Lariam	Mefloquine Hcl	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Primaquine	Primaquine Phospha	Tablet	26.3 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Daraprim	Pyrimethamine	Tablet	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Restricted to patients unable to take sulfamethoxazole.
DRUG CLASS:	Anti-Mycobacterium Agents				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Myambutol	Ethambutol Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Myambutol	Ethambutol Hcl	Tablet	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Trecator	Ethionamide	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isoniazid	Isoniazid	Solution	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isoniazid	Isoniazid	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isoniazid	Isoniazid	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pyrazinamide	Pyrazinamide	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Antiprotozoal Drugs,Miscellaneous				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Mepron	Atovaquone	Oral Susp	750 MG/5ML	1	☐	☑	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.

DRUG CLASS:	Antitubercular Antibiotics				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Seromycin	Cycloserine	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rifadin	Rifampin	Capsule	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rifadin	Rifampin	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rifamate	Rifampin/Isoniazid	Capsule	300-150	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Antiviral Monoclonal Antibodies				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Synagis	Palivizumab	Vial	100 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for high risk pediatric patients based on current guidelines.
Synagis	Palivizumab	Vial	50MG/0.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for high risk pediatric patients based on current guidelines.

DRUG CLASS: Antivirals, General **CATEGORY** Infection, Other													
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Acyclovir	Acyclovir	Capsule	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zovirax	Acyclovir	Oral Susp	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acyclovir	Acyclovir	Tablet	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acyclovir	Acyclovir	Tablet	800 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tamiflu	Oseltamivir Phosphate	Capsule	30 MG	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 2 fills in 6 months. Maximum of 120ml (liquid), 20 caps (30mg) or 10 caps (75mg) per fill.
Tamiflu	Oseltamivir Phosphate	Capsule	45 MG	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 2 fills in 6 months. Maximum of 120ml (liquid), 20 caps (30mg) or 10 caps (75mg) per fill.

Tamiflu	Oseltamivir Phosphate	Capsule	75 MG	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 2 fills in 6 months. Maximum of 120ml (liquid), 20 caps (30mg) or 10 caps (75mg) per fill.
Tamiflu	Oseltamivir Phosphate	Susp Recon	6 MG/ML	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 2 fills in 6 months. Maximum of 120ml (liquid), 20 caps (30mg) or 10 caps (75mg) per fill.
Virazole	Ribavirin	Vial-Neb	6G	1	☐	☐	☐	☐	☐	☐	☐	☑	Restricted to Specialty Pharmacy at 877-319-6337
Valcyte	Valganciclovir Hcl	Tablet	450 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Relenza	Zanamivir	Blst W/Dev	5 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills in 6 months.

DRUG CLASS:	Cephalosporins - 1St Generation				**CATEGORY** Infection, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Cephalexin	Cephalexin	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cephalexin	Cephalexin	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cephalexin	Cephalexin	Susp Recon	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cephalexin	Cephalexin	Susp Recon	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Cephalosporins - 2Nd Generation				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cefaclor	Cefaclor	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cefaclor	Cefaclor	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cefaclor	Cefaclor	Susp Recon	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cefaclor	Cefaclor	Susp Recon	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cefaclor	Cefaclor	Susp Recon	375 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ceftin	Cefuroxime Axetil	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ceftin	Cefuroxime Axetil	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Cephalosporins - 3Rd Generation				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Omnicef	Cefdinir	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	Step therapy to 1 course of generic first line antibiotics within the last 90 days.
Omnicef	Cefdinir	Susp Recon	125 MG/5ML	1	☐	☐	☐	☐	☐	☐	☐	☐	Step therapy to 1 course of generic first line antibiotics within the last 90 days.
Omnicef	Cefdinir	Susp Recon	250 MG/5ML	1	☐	☐	☐	☐	☐	☐	☐	☐	Step therapy to 1 course of generic first line antibiotics within the last 90 days.
DRUG CLASS:	Chemotherapeutics, Antibacterial, Misc.				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Hiprex	Methenamine Hippu	Tablet	1 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mandelamine	Methenamine Mande	Tablet	1 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mandelamine	Methenamine Mande	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Primsol	Trimethoprim	Solution	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Trimethoprim	Trimethoprim	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Drug treatment-Chronic Inflam. Colon diagnosis,5-				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Azulfidine	Sulfasalazine	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Azulfidine	Sulfasalazine	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Azulfidine	Sulfasalazine	Tablet Dr	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Azulfidine	Sulfasalazine	Tablet Dr	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Immunomodulators				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Proleukin	Aldesleukin	Vial	22MM UNIT	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Imiquimod	Imiquimod	Cream Pack	0.05	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 12 packets per dispensing and treatment for a maximum of 16 weeks.

Intron A	Interferon Alfa-2B,Recomb.	Vial	10MM UNIT	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Intron A	Interferon Alfa-2B,Recomb.	Vial	10MM/ ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Intron A	Interferon Alfa-2B,Recomb.	Vial	18MM UNIT	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Intron A	Interferon Alfa-2B,Recomb.	Vial	50MM UNIT	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Intron A	Interferon Alfa-2B,Recomb.	Vial	6MMUN IT/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Alferon N	Interferon Alfa-N3	Vial	5MMUN IT/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.
Actimmune	Interferon Gamma-1B,Recomb.	Vial	100MCG /0.5	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.

DRUG CLASS: Immunosuppressives **CATEGORY** Infection, Other													
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Azathioprine	Azathioprine	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gengraf	Cyclosporine, Modifi	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gengraf	Cyclosporine, Modifi	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyclosporine Modifi	Cyclosporine, Modifi	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gengraf	Cyclosporine, Modifi	Solution	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zortress	Everolimus	Tablet	0.25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. If medication is not being used for post-renal or post-liver transplant, approval is determined by medical necessity criteria.
Zortress	Everolimus	Tablet	0.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. If medication is not being used for post-renal or post-liver transplant, approval is determined by medical necessity criteria.

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Zortress	Everolimus	Tablet	0.75 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. If medication is not being used for post-renal or post-liver transplant, approval is determined by medical necessity criteria.
Cellcept	Mycophenolate Mofe	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cellcept	Mycophenolate Mofe	Susp Recon	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cellcept	Mycophenolate Mofe	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Myfortic	Mycophenolate Sodi	Tablet Dr	180 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Myfortic	Mycophenolate Sodi	Tablet Dr	360 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rapamune	Sirolimus	Solution	1 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. If medication is not being used for post-renal or post-liver transplant, approval is determined by medical necessity criteria.

Rapamune	Sirolimus	Tablet	0.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. If medication is not being used for post-renal or post-liver transplant, approval is determined by medical necessity criteria.
Rapamune	Sirolimus	Tablet	1 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. If medication is not being used for post-renal or post-liver transplant, approval is determined by medical necessity criteria.
Rapamune	Sirolimus	Tablet	2 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. If medication is not being used for post-renal or post-liver transplant, approval is determined by medical necessity criteria.
Prograf	Tacrolimus	Ampul	5 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hecoria	Tacrolimus	Capsule	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hecoria	Tacrolimus	Capsule	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Hecoria	Tacrolimus	Capsule	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Lincosamides					**CATEGORY** Infection, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cleocin Hcl	Clindamycin Hcl	Capsule	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cleocin Hcl	Clindamycin Hcl	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cleocin Hcl	Clindamycin Hcl	Capsule	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cleocin Palmitate	Clindamycin Palmita	Soln Recon	75 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cleocin Palmitate	Clindamycin Palmita	Soln Recon	75 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Macrolides					**CATEGORY** Infection, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zithromax	Azithromycin	Packet	1 G	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zmax Pediatric	Azithromycin	Sus Er Rec	2 G/60	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zithromax	Azithromycin	Susp Recon	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zithromax	Azithromycin	Susp Recon	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zithromax	Azithromycin	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zithromax	Azithromycin	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Zithromax	Azithromycin	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Biaxin	Clarithromycin	Susp Recon	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Clarithromycin	Clarithromycin	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Clarithromycin	Clarithromycin	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Erythromycin	Erythromycin Base	Capsule Dr	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pce	Erythromycin Base	Tab Part	333 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pce	Erythromycin Base	Tab Part	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Erythromycin	Erythromycin Base	Tablet	250 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required for subsequent fills.
Erythromycin	Erythromycin Base	Tablet	500 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required for subsequent fills.
Ery-Tab	Erythromycin Base	Tablet Dr	250 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required for subsequent fills.
Ery-Tab	Erythromycin Base	Tablet Dr	333 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ery-Tab	Erythromycin Base	Tablet Dr	500 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required for subsequent fills.

Eryped 200	Erythromycin Ethyls	Susp Recon	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Eryped 200	Erythromycin Ethyls	Susp Recon	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Erythromycin Ethylsuccinate	Erythromycin Ethylsuccinate	Tablet	400 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required for subsequent fills.
Erythromycin Ethylsuccinate	Erythromycin Ethylsuccinate	Tablet	400 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required for subsequent fills.
Erythrocin Stearate	Erythromycin Stearate	Tablet	250 MG	1	☐	☐	☐	☑	☐	☐	☐	☐	PA required for subsequent fills.
DRUG CLASS:	Monoclonal Antibody-Human Interleukin 12/23 I				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Stelara	Ustekinumab	Syringe	45MG/0.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. SECOND-LINE TREATMENT FOR PSO, THIRD-LINE TREATMENT FOR PSA: RESERVED FOR PATIENTS WHO FAIL FIRST-LINE BIOLOGIC(S). RESTRICTED TO SPECIALTY PHARMACY.

Stelara	Ustekinumab	Syringe	90 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. SECOND-LINE TREATMENT FOR PSO, THIRD-LINE TREATMENT FOR PSA: RESERVED FOR PATIENTS WHO FAIL FIRST-LINE BIOLOGIC(S). RESTRICTED TO SPECIALTY PHARMACY.
DRUG CLASS:	Nitrofuran Derivatives				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Nitrofurantoin	Nitrofurantoin	Oral Susp	25 MG/5 ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for infections resistant to ALL first line antibiotics as proven by urine culture and sensitivity. Submit culture/sensitivity to HPSJ for review.
Nitrofurantoin	Nitrofurantoin Macr	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nitrofurantoin	Nitrofurantoin Macr	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Macrobid	Nitrofurantoin Mono	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Oxazolidinones					**CATEGORY** Infection, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zyvox	Linezolid	Tablet	600 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.

DRUG CLASS: Penicillins					**CATEGORY** Infection, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Amoxicillin	Amoxicillin	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amoxil	Amoxicillin	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amoxicillin	Amoxicillin	Susp Recon	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amoxicillin	Amoxicillin	Susp Recon	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amoxil	Amoxicillin	Susp Recon	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amoxil	Amoxicillin	Susp Recon	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amoxicillin	Amoxicillin	Tab Chew	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Amoxicillin	Amoxicillin	Tab Chew	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Amoxicillin	Amoxicillin	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Amoxicillin	Amoxicillin	Tablet	875 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Amox Tr-Potassium	Amoxicillin/Potassiu	Susp Recon	200-28.	1	☐	☐	☐	☐	☐	☐	☐	☐
Augmentin	Amoxicillin/Potassiu	Susp Recon	400-57	1	☐	☐	☐	☐	☐	☐	☐	☐
Augmentin Es-600	Amoxicillin/Potassiu	Susp Recon	600-42.	1	☐	☐	☐	☐	☐	☐	☐	☐
Augmentin	Amoxicillin/Potassiu	Tablet	250-125	1	☐	☐	☐	☐	☐	☐	☐	☐
Augmentin	Amoxicillin/Potassiu	Tablet	500-125	1	☐	☐	☐	☐	☐	☐	☐	☐
Augmentin	Amoxicillin/Potassiu	Tablet	875-125	1	☐	☐	☐	☐	☐	☐	☐	☐
Ampicillin Trihydrat	Ampicillin Trihydrat	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Ampicillin Trihydrat	Ampicillin Trihydrat	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Ampicillin Trihydrat	Ampicillin Trihydrat	Susp Recon	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Ampicillin Trihydrat	Ampicillin Trihydrat	Susp Recon	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dicloxacillin Sodium	Dicloxacillin Sodium	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dicloxacillin Sodium	Dicloxacillin Sodium	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Penicillin V Potassiu	Penicillin V Potassiu	Soln Recon	125 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Penicillin V Potassiu	Penicillin V Potassiu	Soln Recon	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Penicillin V Potassiu	Penicillin V Potassiu	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Penicillin V Potassiu	Penicillin V Potassiu	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Quinolones				**CATEGORY** Infection, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cipro	Ciprofloxacin	Sus Mc Rec	250 MG/5ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 300 ml per month (for 250mg/5ml suspension) or 150 ml per month (500mg/5ml suspension).
Cipro	Ciprofloxacin	Sus Mc Rec	250 MG/5ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 300 ml per month (for 250mg/5ml suspension) or 150 ml per month (500mg/5ml suspension).
Cipro	Ciprofloxacin	Sus Mc Rec	500 MG/5ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 300 ml per month (for 250mg/5ml suspension) or 150 ml per month (500mg/5ml suspension).

Cipro	Ciprofloxacin	Sus Mc Rec	500 MG/5ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 300 ml per month (for 250mg/5ml suspension) or 150 ml per month (500mg/5ml suspension).
Ciprofloxacin Hcl	Ciprofloxacin Hcl	Tablet	100 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 28 tablets per month
Cipro	Ciprofloxacin Hcl	Tablet	250 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 28 tablets per month
Cipro	Ciprofloxacin Hcl	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cipro	Ciprofloxacin Hcl	Tablet	750 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levaquin	Levofloxacin	Solution	250MG/10ML	1	☐	☐	☑	☐	☑	☐	☐	☐	Restricted to patients 18 and older, maximum of 14 tablets or 280 ml per month.
Levofloxacin	Levofloxacin	Solution	250MG/10ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to patients 18 and older, maximum of 14 tablets or 280 ml per month.

Levaquin	Levofloxacin	Tablet	250 MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Restricted to patients 18 and older, maximum of 14 tablets or 280 ml per month.
Levaquin	Levofloxacin	Tablet	500 MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Restricted to patients 18 and older, maximum of 14 tablets or 280 ml per month.
Levaquin	Levofloxacin	Tablet	750 MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Restricted to patients 18 and older, maximum of 14 tablets or 280 ml per month.

DRUG CLASS:	Rifamycins And Related Derivative Antibiotics				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Xifaxan	Rifaximin	Tablet	550 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	For use in Hepatic encephalopathy, Xifaxan is reserved for treatment failure of compliant use of lactulose evidenced by consistent lactulose fills.For use in IBS-D, Xifaxan is reserved for patients who have failed treatment with at least one antispasmodi

DRUG CLASS:	Rosacea Agents, Topical				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Metronidazole	Metronidazole	Cream (G)	0.0075	1	☐	☐	☐	☐	☐	☐	☐	☐	
Metronidazole	Metronidazole	Gel (Gram)	0.0075	1	☐	☐	☐	☐	☐	☐	☐	☐	
Metrogel	Metronidazole	Gel (Gram)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Metronidazole	Metronidazole	Lotion	0.0075	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Tetracyclines				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Doxycycline Monohy	Doxycycline Monohy	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Doxycycline Monohy	Doxycycline Monohy	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Minocycline Hcl	Minocycline Hcl	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Minocycline Hcl	Minocycline Hcl	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Minocycline Hcl	Minocycline Hcl	Capsule	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Topical Antibiotics				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Bacitracin	Bacitracin	Oint. (G)	500 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bacitracin	Bacitracin	Packet	500 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bacitracin Zinc	Bacitracin Zinc	Oint. (G)	500 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bacitracin Zinc	Bacitracin Zinc	Packet	500 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐	
Polysporin	Bacitracin/Polymyxi	Oint. (G)	500-10K	1	☐	☐	☐	☐	☐	☐	☐	☐	
Polysporin	Bacitracin/Polymyxi	Packet		1	☐	☐	☐	☐	☐	☐	☐	☐	
Cleocin T	Clindamycin Phosph	Gel (Gram)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cleocin T	Clindamycin Phosph	Lotion	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cleocin T	Clindamycin Phosph	Med. Swab	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

Cleocin T	Clindamycin Phosph	Solution	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Erythromycin	Erythromycin Base/	Gel (Gram)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ery	Erythromycin Base/	Med. Swab	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ery	Erythromycin Base/	Med. Swab	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Erythromycin	Erythromycin Base/	Solution	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gentamicin Sulfate	Gentamicin Sulfate	Cream (G)	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gentamicin Sulfate	Gentamicin Sulfate	Oint. (G)	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bactroban	Mupirocin	Oint. (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neosporin	Neomy Sulf/Bacitrac	Oint. (G)	3.5-400-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neosporin	Neomy Sulf/Bacitrac	Oint. (G)	3.5-400-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neosporin Plus	Neomy Sulf/Polymyx	Cream (G)	3.5-10K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neosporin Plus	Neomycn/Baci Zn/P	Oint. (G)	3.5-10K-	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Topical Antibiotics/Antiinflammatory,Steroidal				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cortisporin	Neomycin/Bacitra/P	Oint. (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Cortisporin	Neomycin/Polymyxi	Cream (G)	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Topical Antifungals				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Desenex	Clotrimazole	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desenex	Clotrimazole	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desenex	Clotrimazole	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desenex	Clotrimazole	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desenex	Clotrimazole	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desenex	Clotrimazole	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desenex	Clotrimazole	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desenex	Clotrimazole	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Clotrimazole	Clotrimazole	Solution	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Econazole Nitrate	Econazole Nitrate	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ketoconazole	Ketoconazole	Cream (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nizoral A-D	Ketoconazole	Shampoo	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

Ketoconazole	Ketoconazole	Shampoo	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Micatin	Miconazole Nitrate	Aero Powd	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Micatin	Miconazole Nitrate	Aero Powd	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Micatin	Miconazole Nitrate	Cream (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Micatin	Miconazole Nitrate	Cream (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Micatin	Miconazole Nitrate	Cream (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Micatin	Miconazole Nitrate	Cream (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Fungoid Tincture	Miconazole Nitrate	Kit	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Aloe Vesta	Miconazole Nitrate	Oint. (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Aloe Vesta	Miconazole Nitrate	Oint. (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Aloe Vesta	Miconazole Nitrate	Oint. (G)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Desenex	Miconazole Nitrate	Spray	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Fungoid Tincture	Miconazole Nitrate	Tincture	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Fungoid Tincture	Miconazole Nitrate	Tincture	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Nystatin	Nystatin	Cream (G)	100000	1	☐	☐	☐	☐	☐	☐	☐	☐

Nystatin	Nystatin	Oint. (G)	100000	1	☐	☐	☐	☐	☐	☐	☐	☐
Nystop	Nystatin	Powder	100000	1	☐	☐	☐	☐	☐	☐	☐	☐
Nystop	Nystatin	Powder	100000	1	☐	☐	☐	☐	☐	☐	☐	☐
Nystop	Nystatin	Powder	100000	1	☐	☐	☐	☐	☐	☐	☐	☐
Nystatin-Triamcinol	Nystatin/Triamcin	Cream (G)	100000-	1	☐	☐	☐	☐	☐	☐	☐	☐
Nystatin-Triamcinol	Nystatin/Triamcin	Oint. (G)	100000-	1	☐	☐	☐	☐	☐	☐	☐	☐
Desenex	Terbinafine Hcl	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Desenex	Terbinafine Hcl	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Desenex	Terbinafine Hcl	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Desenex	Terbinafine Hcl	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Desenex	Terbinafine Hcl	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Jock Itch	Tolnaftate	Aero Powd	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Jock Itch	Tolnaftate	Aero Powd	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Jock Itch	Tolnaftate	Aero Powd	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐
Jock Itch	Tolnaftate	Aero Powd	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐

Jock Itch	Tolnaftate	Aero Powd	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Jock Itch	Tolnaftate	Aero Powd	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Jock Itch	Tolnaftate	Aero Powd	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamisil Af Defense	Tolnaftate	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamisil Af Defense	Tolnaftate	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamisil Af Defense	Tolnaftate	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Medi-First Anti-Fun	Tolnaftate	Packet	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamisil Af	Tolnaftate	Powder	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lamisil Af	Tolnaftate	Powder	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tolnaftate	Tolnaftate	Solution	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Topical Antiparasitics				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ulesfia	Benzyl Alcohol	Lotion	0.05	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure of Spinosad (Natroba) AND Malathion (Ovide) in the last 30 days.

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Eurax	Crotamiton	Cream (G)	0.1	1	☐	☑	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of 2 treatments of Permethrin 5% cream within the past 30 days as evidenced by prescription fill history.
Eurax	Crotamiton	Lotion	0.1	1	☐	☑	☐	☐	☐	☐	☐	☐	Reserved for patients with treatment failure of 2 treatments of Permethrin 5% cream within the past 30 days as evidenced by prescription fill history.
Malathion	Malathion	Lotion	0.005	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of at least 2 (two) documented treatment courses of permethrin in the last 30 days. Limited to 118mL per 30 days.
Elimite	Permethrin	Cream (G)	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Treatment	Permethrin	Liquid	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Treatment	Permethrin	Liquid	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

Lice Treatment	Permethrin	Liquid	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Treatment	Permethrin	Liquid	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Treatment	Permethrin	Liquid	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rid	Piperonyl Butoxide/	Kit		1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Treatment	Piperonyl Butoxide/	Liquid		1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Treatment	Piperonyl Butoxide/	Liquid	4%-0.33	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Killing	Piperonyl Butoxide/	Shampoo	4%-0.33	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Killing	Piperonyl Butoxide/	Shampoo	4%-0.33	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lice Killing	Piperonyl Butoxide/	Shampoo	4%-0.33	1	☐	☐	☐	☐	☐	☐	☐	☐	
Spinosad	Spinosad	Suspension	0.009	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of at least 2 (two) documented treatment courses of permethrin 1% lotion in the last 30 days.

DRUG CLASS: Topical Sulfonamides					**CATEGORY** Infection, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Silver Sulfadiazine	Silver Sulfadiazine	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Silver Sulfadiazine	Silver Sulfadiazine	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Vaginal Antibiotics				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cleocin	Clindamycin Phosph	Cream/Appl	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cleocin	Clindamycin Phosph	Supp.Vag	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vandazole	Metronidazole	Gel W/Appl	0.0075	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Vaginal Antifungals				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Gyne-Lotrimin	Clotrimazole	Cream/Appl	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gyne-Lotrimin	Clotrimazole	Cream/Appl	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gyne-Lotrimin	Clotrimazole	Cream/Appl	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gyne-Lotrimin	Clotrimazole	Cream/Appl	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gyne-Lotrimin	Clotrimazole	Cream/Appl	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Miconazole 3	Miconazole Nitrate	Cmb Pf Crm	200 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Monistat 7	Miconazole Nitrate	Cream/Appl	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Monistat 7	Miconazole Nitrate	Cream/Appl	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Monistat 3	Miconazole Nitrate	Cream/Appl	0.04	1	☐	☐	☐	☐	☐	☐	☐	☐	
Monistat 3	Miconazole Nitrate	Crm/Pf App	0.04	1	☐	☐	☐	☐	☐	☐	☐	☐	
Miconazole 1	Miconazole Nitrate	Kit	1200MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Monistat 3	Miconazole Nitrate	Kit	200 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Monistat 3	Miconazole Nitrate	Kit	200 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Monistat 7	Miconazole Nitrate	Supp.Vag	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Monistat 7	Miconazole Nitrate	Supp.Vag	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Terazol 7	Terconazole	Cream/Appl	0.004	1	☐	☐	☐	☐	☐	☐	☐	☐	
Terazol 3	Terconazole	Cream/Appl	0.008	1	☐	☐	☐	☐	☐	☐	☐	☐	
Terazol 3	Terconazole	Supp.Vag	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vagistat-1	Tioconazole	Oin/Pf App	0.065	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vagistat-1	Tioconazole	Oin/Pf App	0.065	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Vancomycin And Derivatives				**CATEGORY**	Infection, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Vancomycin Hcl	Vancomycin Hcl	Capsule	125 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for recurrent C. difficile infections in a pulse tapered regimen.

THERAPEUTIC CATEGORY
Lipotropics

DRUG CLASS: - CATEGORY Lipotropics Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Praluent Pen	Alirocumab	Pen Injctr	150 Mg/Ml	1	☑	☐	☑	☐	☐	☐	☐	☑	PA required. Reserved for patients who meet all of the following criteria:[1] Clinical ASCVD with LDL ≥70 mg/dL or non-HDL-C ≥ 100 mg/dL OR Heterozygous Familial Hypercholesterolemia (HeFH) with LDL > 100 mg/dL or non-HDL-C > 130 mg/dL.[2] Treatment fai

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Praluent Pen	Alirocumab	Pen Injctr	75 Mg/Ml	1	☑	☐	☑	☐	☐	☐	☐	☑	PA required. Reserved for patients who meet all of the following criteria:[1] Clinical ASCVD with LDL ≥70 mg/dL or non-HDL-C ≥ 100 mg/dL OR Heterozygous Familial Hypercholesterolemia (HeFH) with LDL > 100 mg/dL or non-HDL-C > 130 mg/dL.[2] Treatment fai
Praluent Syringe	Alirocumab	Syringe	150 Mg/Ml	1	☑	☐	☑	☐	☐	☐	☐	☑	PA required. Reserved for patients who meet all of the following criteria:[1] Clinical ASCVD with LDL ≥70 mg/dL or non-HDL-C ≥ 100 mg/dL OR Heterozygous Familial Hypercholesterolemia (HeFH) with LDL > 100 mg/dL or non-HDL-C > 130 mg/dL.[2] Treatment fai

Praluent Syringe	Alirocumab	Syringe	75 Mg/Ml	1	☑	☐	☑	☐	☐	☐	☐	☑	PA required. Reserved for patients who meet all of the following criteria:[1] Clinical ASCVD with LDL ≥70 mg/dL or non-HDL-C ≥ 100 mg/dL OR Heterozygous Familial Hypercholesterolemia (HeFH) with LDL > 100 mg/dL or non-HDL-C > 130 mg/dL.[2] Treatment fai
Repatha Sureclick	Evolocumab	Pen Injctr	140 Mg/Ml	1	☑	☐	☑	☐	☐	☐	☐	☑	PA required. Reserved for patients who meet all of the following criteria:[1] Clinical ASCVD with LDL ≥70 mg/dL or non-HDL-C ≥ 100 mg/dL OR Heterozygous Familial Hypercholesterolemia (HeFH) with LDL > 100 mg/dL or non-HDL-C > 130 mg/dL OR Homozygous Fami

Repatha Syringe	Evolocumab	Syringe	140 Mg/Ml	1	☑	☐	☑	☐	☐	☐	☐	☑	PA required. Reserved for patients who meet all of the following criteria:[1] Clinical ASCVD with LDL ≥70 mg/dL or non-HDL-C ≥ 100 mg/dL OR Heterozygous Familial Hypercholesterolemia (HeFH) with LDL > 100 mg/dL or non-HDL-C > 130 mg/dL OR Homozygous Fami
Repatha Pushtronex	Evolocumab	Wear Injct	420 Mg/3.5	1	☑	☐	☑	☐	☐	☐	☐	☑	PA required. Reserved for patients who meet all of the following criteria:[1] Clinical ASCVD with LDL ≥70 mg/dL or non-HDL-C ≥ 100 mg/dL OR Heterozygous Familial Hypercholesterolemia (HeFH) with LDL > 100 mg/dL or non-HDL-C > 130 mg/dL OR Homozygous Fami

THERAPEUTIC CATEGORY
Medical Supplies, Devices

DRUG CLASS: Respiratory Aids,Devices,Equipment **CATEGORY** Medical Supplies, Devices

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Vortex Vhc Ladybug	Inhaler, Assist Devic	Spacer		1	☐	☐	☐	☐	☐	☐	☐	☐	
Innospire Essence	Nebulizer And Compressor	EACH		1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 1 nebulizer per lifetime.

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THERAPEUTIC CATEGORY
Medical Supplies, Diabetes

DRUG CLASS: Needles/Needleless Devices **CATEGORY** Medical Supplies, Diabetes

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Pen Needle	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Easy Touch Pen Nee	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ultra-Thin Ii	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Unifine Pentips	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Unifine Pentips Plus	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lite Touch	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
1St Tier Unifine Pen	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ulticare	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Insupen	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Carefine Pen Needle	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pen Needles	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Bd Ultra-Fine Pen N	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Sure Comfort	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Advocate Pen Needl	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Incontrol Pen Needl	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Insulin Pen Needle	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Sure-Fine Pen Needl	Pen Needle, Diabetic	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Ultilet Pen Needle	Pen Needle, Diabetic	Dis Needle	29 Gaug	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips	Pen Needle, Diabetic	Dis Needle	29 Gaug	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips	Pen Needle, Diabetic	Dis Needle	29Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Novotwist	Pen Needle, Diabetic	Dis Needle	30 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Novofine	Pen Needle, Diabetic	Dis Needle	30 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Carefine Pen Needle	Pen Needle, Diabetic	Dis Needle	30Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Sure Comfort	Pen Needle, Diabetic	Dis Needle	30Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips	Pen Needle, Diabetic	Dis Needle	30Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pen Needle	Pen Needle, Diabetic	Dis Needle	30Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Insupen	Pen Needle, Diabetic	Dis Needle	30Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐

Insulin Pen Needle	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Pen Needle	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
1St Tier Unifine Pen	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Needles	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Pen Needles	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Lite Touch	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Topcare Clickfine	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Incontrol Pen Needl	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Insupen	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Healthy Accents Unif	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Insulin Pen Needle	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Ulticare	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips Plus	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Clickfine	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐

Easy Touch Pen Nee	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Carefine Pen Needle	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Insulin Pen Needle	Pen Needle, Diabetic	Dis Needle	31 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips Plus	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Sure-Fine Pen Needl	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pen Needles	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Lite Touch	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Easy Touch Pen Nee	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Mini Ultra-Thin Ii	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pen Needle	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Incontrol Pen Needl	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Healthy Accents Unif	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
1St Tier Unifine Pen	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pentips	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐

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Advocate Pen Needl	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Sure Comfort	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Bd Ultra-Fine Pen N	Pen Needle, Diabetic	Dis Needle	31 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips Plus	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Healthy Accents Unif	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Easy Touch Pen Nee	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Incontrol Pen Needl	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Insupen	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Advocate Pen Needl	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pen Needle	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pen Needles	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pentips	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Sure Comfort	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Lite Touch	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐

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Sure-Fine Pen Needl	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Bd Ultra-Fine Pen N	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
1St Tier Unifine Pen	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
1St Tier Unifine Pen	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Topcare Clickfine	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Ultra-Thin Ii	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Clickfine	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Ulticare	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Carefine Pen Needle	Pen Needle, Diabetic	Dis Needle	31 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Sure Comfort	Pen Needle, Diabetic	Dis Needle	32 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Novofine 32	Pen Needle, Diabetic	Dis Needle	32 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Insupen	Pen Needle, Diabetic	Dis Needle	32 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Carefine Pen Needle	Pen Needle, Diabetic	Dis Needle	32 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Easy Touch Pen Nee	Pen Needle, Diabetic	Dis Needle	32 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Novotwist	Pen Needle, Diabetic	Dis Needle	32 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐

Novofine Plus	Pen Needle, Diabetic	Dis Needle	32 Gx 1/	1	☐	☐	☐	☐	☐	☐	☐	☐
Easy Touch Pen Nee	Pen Needle, Diabetic	Dis Needle	32 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Carefine Pen Needle	Pen Needle, Diabetic	Dis Needle	32 Gx3/	1	☐	☐	☐	☐	☐	☐	☐	☐
Insupen	Pen Needle, Diabetic	Dis Needle	32 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Pentips	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Relion Pen Needles	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Carefine Pen Needle	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Ultilet Pen Needle	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Bd Ultra-Fine Pen N	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Sure Comfort	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Clickfine	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
1St Tier Unifine Pen	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Insupen	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Ulticare	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐

Pen Needles	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Easy Touch Pen Nee	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Unifine Pentips Plus	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Incontrol Pen Needl	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Healthy Accents Unif	Pen Needle, Diabetic	Dis Needle	32Gx 5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Insupen	Pen Needle, Diabetic	Dis Needle	33 Gx5/	1	☐	☐	☐	☐	☐	☐	☐	☐
Healthy Accents Unif	Pen Needle, Diabetic,	Dis Needle	29 G X1	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Miscellaneous

DRUG CLASS: C1 Esterase Inhibitors					CATEGORY Miscellaneous								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cinryze	C1 Esterase Inhibitor	Vial	500 (5 ML)	1	☐	☑	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.

DRUG CLASS: Dental Aids And Preparations					CATEGORY Miscellaneous								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Chlorhexidine Gluco	Chlorhexidine Gluco	Mouthwash	0.0012	1	☐	☐	☐	☐	☐	☐	☐	☐	
Oralone	Triamcinolone Aceto	Paste (G)	0.001	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Irrigants					CATEGORY Miscellaneous								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Acetic Acid	Acetic Acid	Irrig Soln	0.0025	1	☐	☐	☐	☐	☐	☐	☐	☐	
Neomycin-Polymyxi	Neomy Sulf/Polymyx	Ampul	40-200K	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	Sodium Chloride Irri	Irrig Soln	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Water	Water For Irrigation,	Irrig Soln		1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Multivitamins

DRUG CLASS:	Multivitamin Preparations				**CATEGORY** Multivitamins								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Tyr Cooler	Amino Acids/Mv,Tx,Iron,Mineral	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

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THERAPEUTIC CATEGORY
Non-Narcotic Analgesics

DRUG CLASS: Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
	Drug Tx-Chronic Inflam. Colon Dx,5-Aminosalicyla				CATEGORY	Non-Narcotic Analgesics							
Apriso	Mesalamine	Cap Er 24H	0.375G	1	☑	☐	☑	☑	☐	☐	☐	☐	Reserved for treatment failure of balsalazide, sulfasalazine, or mesalamine enema for 3 months for induction or maintenance. Restricted to 120 capsules per 30 days, 6 fills per 180 days.
Lialda	Mesalamine	Tablet Dr	1.2 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of balsalazide, sulfasalazine, or mesalamine enema for 3 months for induction or maintenance.

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Asacol Hd	Mesalamine	Tablet Dr	800 Mg	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for treatment failure of balsalazide, sulfasalazine, or mesalamine enema for 3 months for induction or maintenance. Restricted to 252 tablets per 180 days.
DRUG CLASS:	Tx For Attention Deficit-Hyperact(Adhd)/Narcole				**CATEGORY**	Non-Narcotic Analgesics							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Quillichew Er	Methylphenidate Hcl	Tab Cbp24H	30 Mg	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documented inability to take methylphenidate ER capsules by mouth with or without applesauce. Limited to persons ≥ 4 years of age.
Quillichew Er	Methylphenidate Hcl	Tab Cbp24H	40 Mg	1	☑	☐	☐	☐	☑	☐	☐	☐	PA required. Reserved for documented inability to take methylphenidate ER capsules by mouth with or without applesauce. Limited to persons ≥ 4 years of age.

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THERAPEUTIC CATEGORY
Non-Opioid Analgesics

DRUG CLASS: Antimigraine Preparations					**CATEGORY** Non-Opioid Analgesics								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Aimovig Autoinjector (2 Pack)	Erenumab-Aooe	Auto Injct	70 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure to Botox therapy for 12 months.
Aimovig Autoinjector	Erenumab-Aooe	Auto Injct	70 Mg/Ml	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure to Botox therapy for 12 months.

THERAPEUTIC CATEGORY
Nutrition

DRUG CLASS: Anorexic Agents / Brand Name / Generic Name	Formulation	Strength	Tier	CATEGORY Nutrition PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Phentermine Hcl / Phentermine Hcl	Tablet	37.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for individuals who have received exercise and dietary counseling at least twice by a registered dietitian AND one of the following: [1] BMI of ≥ 27 with 2 or more comorbidities OR [2] BMI > 30.

DRUG CLASS: Calcium Replacement / Brand Name / Generic Name	Formulation	Strength	Tier	CATEGORY Nutrition PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Parva-Cal 500 / Calcium Carb &Gluco	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calci-Mix / Calcium Carbonate	Capsule	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calcium Carbonate / Calcium Carbonate	Oral Susp	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calci-Chew / Calcium Carbonate	Tab Chew	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Calci-Chew	Calcium Carbonate	Tab Chew	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐
Calci-Chew	Calcium Carbonate	Tab Chew	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium Carbonate	Calcium Carbonate	Tablet	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium Carbonate	Calcium Carbonate	Tablet	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium Carbonate	Calcium Carbonate	Tablet	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium Carbonate	Calcium Carbonate	Tablet	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium Carbonate	Calcium Carbonate	Tablet	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium Carbonate	Calcium Carbonate	Tablet	500(125	1	☐	☐	☐	☐	☐	☐	☐	☐
Caltrate 600	Calcium Carbonate	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Caltrate 600	Calcium Carbonate	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Caltrate 600	Calcium Carbonate	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Caltrate 600	Calcium Carbonate	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Oyster Shell Calcium	Calcium Carbonate/	Tablet	250 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Oyst-Cal-D	Calcium Carbonate/	Tablet	250 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Oyst-Cal-D	Calcium Carbonate/	Tablet	250 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐

Calcium 500 + Vitam	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 500 + Vitam	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Os-Cal 500+D3	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Os-Cal 500+D3	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Os-Cal 500+D3	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Os-Cal 500+D3	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 500 + Vit D	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 500 + Vit D	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 500 + Vit D	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 500 + Vit D	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 500 + Vit D	Calcium Carbonate/	Tablet	500 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 600 + Vit D	Calcium Carbonate/	Tablet	600 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 600 + Vit D	Calcium Carbonate/	Tablet	600 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 600 + Vit D	Calcium Carbonate/	Tablet	600 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Calcium 600 + Vit D	Calcium Carbonate/	Tablet	600 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐

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Caltrate 600 + D	Calcium Carbonate/	Tablet	600 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Dietary Supplement, Miscellaneous				**CATEGORY**	Nutrition							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Jevity 1.2 Cal	Lactose-Reduced Food/Fiber	Liquid		1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for ESRD patients diagnosed with malnutrition that cannot meet nutritional needs through a standard diet and able to meet the criteria of use for medical necessity.

DRUG CLASS:	Metabolic Deficiency Agents				**CATEGORY**	Nutrition							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Carnitor Sf	Levocarnitine	Solution	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levocarnitine	Levocarnitine	Tablet	330 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levocarnitine	Levocarnitine (With	Solution	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Multivitamin Preparations				**CATEGORY**	Nutrition							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Surbex W-C	B Complex With Vita	Tablet		1	☐	☐	☐	☐	☐	☐	☐	☐	

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Chewable-Vite	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Pediatric Vitamin Preparations				**CATEGORY**	Nutrition							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Tri-Vit With Fluorid	Fluoride/Iron/Vit A,	Drops	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	
Fruity Chews	Multivitamin	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐	

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Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Fruity Chews	Multivitamin	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Cerovite Jr	Multivitamin W/Iron	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Cerovite Jr	Multivitamin W/Iron	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Cerovite Jr	Multivitamin W/Iron	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Cerovite Jr	Multivitamin W/Iron	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Cerovite Jr	Multivitamin W/Iron	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐
Cerovite Jr	Multivitamin W/Iron	Tab Chew	1	☐	☐	☐	☐	☐	☐	☐	☐

Cerovite Jr	Multivitamin W/Iron	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Centrum Kids	Multivitamins With I	Tab Chew		1	☐	☐	☐	☐	☐	☐	☐	☐
Polyvitamin With Ir	Ped Multivit #46/Iro	Drops	1500-10	1	☐	☐	☐	☐	☐	☐	☐	☐
Tri-Vitamin With Fl	Ped Mv A,C,D3 #21	Drops	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tri-Vitamin With Fl	Ped Mv A,C,D3 #21	Drops	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tri-Vitamin With Fl	Ped Mv A,C,D3 #21	Drops	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Tri-Vitamin With Fl	Ped Mv A,C,D3 #21	Drops	0.5 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi M.Vit No.17 Wit	Tab Chew	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi M.Vit No.17 Wit	Tab Chew	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi M.Vit No.17 Wit	Tab Chew	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi M.Vit No.17 Wit	Tab Chew	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi M.Vit No.17 Wit	Tab Chew	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi M.Vit No.17 Wit	Tab Chew	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tri-Vitamin	Pedi Multivits A,C,&D	Drops	1500-35	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins W-Flu	Pedi Mv #75/Fluorid	Drops	0.25-10	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi Mvi No.12/Sodi	Tab Chew	0.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi Mvi No.12/Sodi	Tab Chew	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi Mvi No.12/Sodi	Tab Chew	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Multivitamins With	Pedi Mvi No.16 With	Tab Chew	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Poly-Vitamin	Pediatric Multivit Co	Drops	1500-40	1	☐	☐	☐	☐	☐	☐	☐	☐
Poly-Vitamin	Pediatric Multivit Co	Drops	1500-40	1	☐	☐	☐	☐	☐	☐	☐	☐

Tri-Vi-Sol	Vit A Palmitate/Vit C	Drops	750-35/	1	☑	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Prenatal Vitamin Preparations				**CATEGORY**	Nutrition							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Se-Natal 19	Pnv No.118/Iron Fu	Tab Chew	29 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vol-Plus	Pnv With Ca,No.71/I	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vol-Plus	Pnv With Ca,No.71/I	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prenatal Plus	Pnv With Ca,No.72/I	Tablet	29 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prenatal Plus	Pnv With Ca,No.72/I	Tablet	29 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prenatal Plus	Pnv With Ca,No.72/I	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prenatal Plus	Pnv With Ca,No.72/I	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prenatal Low Iron	Pnv With Ca,No.74/I	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Se-Natal 90	Pnv/Ferrous Fumara	Tablet Er	90-50-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Materna	Pnv/Ferrous Fumara	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Materna	Pnv/Ferrous Fumara	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mynatal	Pnv/Iron,Carbonyl/	Tablet	90-50-1	1	☐	☐	☐	☐	☐	☐	☐	☐	

Prenatal Multivitam	Pnv95/Ferrous Fum	Tablet	28MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Prenatal Multivitam	Pnv95/Ferrous Fum	Tablet	28MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Tricare	Prenatal #103/Iron	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐
Vol-Tab Rx	Prenatal Vit #76/Iro	Tablet	29 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐
Vol-Tab Rx	Prenatal Vit #76/Iro	Tablet	29 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐
Triadvance	Prenatal Vit 15/Iron	Tablet	90-1-50	1	☐	☐	☐	☐	☐	☐	☐	☐
Co-Natal Fa	Prenatal Vit No.78/Ir	Tablet	29 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐
Co-Natal Fa	Prenatal Vit No.78/Ir	Tablet	29 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐
Prenatal	Prenatal Vit#96/Fer	Tablet	27MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Prenatal S	Prenatal Vit/Iron Fu	Tablet	27MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Prenatal S	Prenatal Vit/Iron Fu	Tablet	27MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Classic Prenatal	Prenatal Vit/Iron Fu	Tablet	28MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Classic Prenatal	Prenatal Vit/Iron Fu	Tablet	28MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Classic Prenatal	Prenatal Vit/Iron Fu	Tablet	28MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐
Classic Prenatal	Prenatal Vit/Iron Fu	Tablet	28MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐

Classic Prenatal	Prenatal Vit/Iron Fu	Tablet	28MG-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prenatal 1-1	Prenatal Vit/Iron Fu	Tablet	65 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prenatal 1-1	Prenatal Vit/Iron Fu	Tablet	65 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prenatal 1-1	Prenatal Vit/Iron Fu	Tablet	65 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
O-Cal Fa	Prenatal Vit/Iron Fu	Tablet	66-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Natalvit	Prenatal Vit/Iron Fu	Tablet	75-1MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Trinatal Rx 1	Prenatal Vit27&Calci	Tablet	60 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Trinatal Rx 1	Prenatal Vit27&Calci	Tablet	60 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
P-D Natal Plus	Prenatal Vits W-Ca,F	Tablet		1	☐	☐	☐	☐	☐	☐	☐	☐	
P-D Natal Plus	Prenatal Vits W-Ca,F	Tablet		1	☐	☐	☐	☐	☐	☐	☐	☐	
P-D Natal Plus	Prenatal Vits W-Ca,F	Tablet		1	☐	☐	☐	☐	☐	☐	☐	☐	
Obstetrix Ec	Pv W-O Cal/Fe,Carbo	Tablet Dr	29-50-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
M-Vit	Pv W-O Cal/Ferrous	Tablet	27 MG-1	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Protein Replacement				**CATEGORY**	Nutrition							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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L-Carnitine	Levocarnitine	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Vitamin B Preparations				**CATEGORY**	Nutrition							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Dialyvite 3000	Fa/Vit Bcomp&C/Se	Tablet	3MG-15	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dialyvite 800-Ultra	Fa/Vit Bcomp&C/Zin	Tablet	0.8MG-2	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nephro-Vite	Folic Acid/Vitamin B	Tablet	0.8 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Nephro-Vite	Folic Acid/Vitamin B	Tablet	0.8 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Supervite	Lysine Hcl/Vit B Co	Liquid	1000-1-	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Vitamin B1 Preparations				**CATEGORY**	Nutrition							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Vitamin B-1	Thiamine Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin B-1	Thiamine Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin B-1	Thiamine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin B-1	Thiamine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin B-1	Thiamine Mononitra	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Vitamin B12 Preparations					**CATEGORY** Nutrition								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Vitamin B-12	Cyanocobalamin (Vit	Tablet	1000 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin B-12	Cyanocobalamin (Vit	Tablet	1000 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydroxocobalamin	Hydroxocobalamin	Vial	1000MC	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Vitamin B6 Preparations					**CATEGORY** Nutrition								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Vitamin B-6	Pyridoxine Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin B-6	Pyridoxine Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pyridoxine Hcl	Pyridoxine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Pyridoxine Hcl	Pyridoxine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin B-6	Pyridoxine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin B-6	Pyridoxine Hcl	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Oncology

DRUG CLASS: Brand Name	Alkylating Agents Generic Name	Formulation	Strength	Tier	CATEGORY Oncology PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Hexalen	Altretamine	Capsule	50 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Myleran	Busulfan	Tablet	2 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Busulfex	Busulfan	Vial	60 MG/10 ML	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Bicnu	Carmustine	Vial	100 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Leukeran	Chlorambucil	Tablet	2 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Cytoxan	Cyclophosphamide	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cytoxan	Cyclophosphamide	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hydrea	Hydroxyurea	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ceenu	Lomustine	Capsule	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Ceenu	Lomustine	Capsule	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Ceenu	Lomustine	Capsule	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Alkeran	Melphalan	Tablet	2 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Eloxatin	Oxaliplatin	Vial	100MG/ 20ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Eloxatin	Oxaliplatin	Vial	50 MG/10 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Temodar	Temozolomide	Capsule	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Temodar	Temozolomide	Capsule	140 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Temodar	Temozolomide	Capsule	180 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Temodar	Temozolomide	Capsule	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Temodar	Temozolomide	Capsule	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Temodar	Temozolomide	Capsule	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Temodar	Temozolomide	Vial	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antiandrogenic Agents				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Bicalutamide	Bicalutamide	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☑	Restricted to Specialty Pharmacy at 877-319-6337

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Flutamide	Flutamide	Capsule	125 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Nilandron	Nilutamide	Tablet	150 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Anti-Arthritic And Chelating Agents				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cuprimine	Penicillamine	Capsule	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depen	Penicillamine	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Anti-Cd20 (B Lymphocyte) Monoclonal Antibody				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Rituxan	Rituximab	Vial	10 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy.
DRUG CLASS:	Antiemetic/Antivertigo Agents				**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Emend	Aprepitant	Cap Ds Pk	125MG-80MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Reserved for patients who are receiving highly emetogenic chemotherapy or for post-operative nausea and vomiting that is treatment failure of ondansetron.
Emend	Aprepitant	Capsule	125 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Reserved for patients who are receiving highly emetogenic chemotherapy or for post-operative nausea and vomiting that is treatment failure of ondansetron.

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Emend	Aprepitant	Capsule	40 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Reserved for patients who are receiving highly emetogenic chemotherapy or for post-operative nausea and vomiting that is treatment failure of ondansetron.
Emend	Aprepitant	Capsule	80 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Reserved for patients who are receiving highly emetogenic chemotherapy or for post-operative nausea and vomiting that is treatment failure of ondansetron.
Anzemet	Dolasetron Mesylate	Tablet	100 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure of Ondansetron andGranisetron Tablets. Restricted to Specialty Pharmacy.

Anzemet	Dolasetron Mesylate	Tablet	50 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure of Ondansetron andGranisetron Tablets. Restricted to Specialty Pharmacy.
Marinol	Dronabinol	Capsule	10 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Restricted to patients with anorexia/weight loss due to AIDS or chemotherapy who have failed ondansetron, Emend and/or dexamethasone
Marinol	Dronabinol	Capsule	2.5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Restricted to patients with anorexia/weight loss due to AIDS or chemotherapy who have failed ondansetron, Emend and/or dexamethasone

Marinol	Dronabinol	Capsule	5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Restricted to patients with anorexia/weight loss due to AIDS or chemotherapy who have failed ondansetron, Emend and/or dexamethasone
Sancuso	Granisetron	Patch Tdwk	3.1MG/ 24HR	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for members with documented inability totake medications by mouth, including ODT formulations. Restricted to Specialty Pharmacy.
Granisetron Hcl	Granisetron Hcl	Tablet	1 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with documented treatment failure of dose optimized Ondansetron therapy.
Meclizine Hcl	Meclizine Hcl	Tab Chew	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Meclizine Hcl	Meclizine Hcl	Tab Chew	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Antivert	Meclizine Hcl	Tablet	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dramamine Ii	Meclizine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Dramamine Ii	Meclizine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dramamine Ii	Meclizine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dramamine Ii	Meclizine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dramamine Ii	Meclizine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dramamine Ii	Meclizine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dramamine Ii	Meclizine Hcl	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ondansetron Odt	Ondansetron	Tab Rapdis	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tablets per 30 days.
Ondansetron Odt	Ondansetron	Tab Rapdis	8 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tablets per 30 days.
Ondansetron Hcl	Ondansetron Hcl	Tablet	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tablets per 30 days.
Ondansetron Hcl	Ondansetron Hcl	Tablet	8 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 60 tablets per 30 days.

Aloxi	Palonosetron Hcl	Vial	0.25MG /5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for use in patients receiving highly-emetogenicchemotherapy, with treatment failure of ondansetron, or documented inability to swallow.
Prochlorperazine M	Prochlorperazine Ma	Supp.Rect	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prochlorperazine M	Prochlorperazine Ma	Supp.Rect	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prochlorperazine M	Prochlorperazine Ma	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Prochlorperazine M	Prochlorperazine Ma	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Promethazine Hcl	Promethazine Hcl	Supp.Rect	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Promethazine Hcl	Promethazine Hcl	Supp.Rect	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Promethazine Hcl	Promethazine Hcl	Supp.Rect	12.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Promethazine Hcl	Promethazine Hcl	Supp.Rect	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Promethazine Hcl	Promethazine Hcl	Supp.Rect	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Promethazine Hcl	Promethazine Hcl	Supp.Rect	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Promethazine Hcl	Promethazine Hcl	Supp.Rect	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Trimethobenzamide	Trimethobenzamide	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Antimetabolites				**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Xeloda	Capecitabine	Tablet	150 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Xeloda	Capecitabine	Tablet	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Mercaptopurine	Mercaptopurine	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methotrexate	Methotrexate Sodiu	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methotrexate Sodiu	Methotrexate Sodiu	Vial	25 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Alimta	Pemetrexed Disodium	Vial	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Alimta	Pemetrexed Disodium	Vial	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Tabloid	Thioguanine	Tablet	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antineoplast Egf Receptor Blocker Rcmb Mc Antib				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Erbitux	Cetuximab	Vial	200MG/ 0.1L	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

DRUG CLASS:	Antineoplastic - Aromatase Inhibitors				**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Anastrozole	Anastrozole	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aromasin	Exemestane	Tablet	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Letrozole	Letrozole	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Antineoplastic - Mtor Kinase Inhibitors				**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Afinitor	Everolimus	Tablet	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Afinitor	Everolimus	Tablet	2.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Afinitor	Everolimus	Tablet	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Afinitor	Everolimus	Tablet	7.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antineoplastic - Topoisomerase I Inhibitors				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Hycamtin	Topotecan Hcl	Capsule	0.25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Hycamtin	Topotecan Hcl	Capsule	1 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antineoplastic Immunomodulator Agents				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Revlimid	Lenalidomide	Capsule	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Revlimid	Lenalidomide	Capsule	15 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Revlimid	Lenalidomide	Capsule	2.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Revlimid	Lenalidomide	Capsule	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Revlimid	Lenalidomide	Capsule	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Revlimid	Lenalidomide	Capsule	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antineoplastic Lhrh(Gnrh) Agonist,Pituitary Supp				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Zoladex	Goserelin Acetate	Implant	10.8MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Zoladex	Goserelin Acetate	Implant	3.6 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Supprelin La	Histrelin Ac	Kit	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Supprelin La	Histrelin Ac	Kit	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Leuprolide Acetate	Leuprolide Acetate	Kit	1 MG/0.2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Eligard	Leuprolide Acetate	Syringe	22.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Eligard	Leuprolide Acetate	Syringe	30 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Eligard	Leuprolide Acetate	Syringe	45 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Eligard	Leuprolide Acetate	Syringe	7.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Lupron Depot	Leuprolide Acetate	Syringekit	22.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Lupron Depot	Leuprolide Acetate	Syringekit	30 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Lupron Depot	Leuprolide Acetate	Syringekit	7.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Trelstar	Triptorelin Pamoate	Syringe	11.25/2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Trelstar	Triptorelin Pamoate	Syringe	3.75MG /2ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antineoplastic Systemic Enzyme Inhibitors				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Velcade	Bortezomib	Vial	3.5 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Sprycel	Dasatinib	Tablet	100 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Sprycel	Dasatinib	Tablet	140 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Sprycel	Dasatinib	Tablet	20 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Sprycel	Dasatinib	Tablet	50 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Sprycel	Dasatinib	Tablet	70 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Sprycel	Dasatinib	Tablet	80 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Tarceva	Erlotinib Hcl	Tablet	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Tarceva	Erlotinib Hcl	Tablet	150 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Tarceva	Erlotinib Hcl	Tablet	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Gleevec	Imatinib Mesylate	Tablet	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gleevec	Imatinib Mesylate	Tablet	400 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Tykerb	Lapatinib Ditosylate	Tablet	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Tasigna	Nilotinib Hcl	Capsule	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Nexavar	Sorafenib Tosylate	Tablet	200 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Sutent	Sunitinib Malate	Capsule	12.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Sutent	Sunitinib Malate	Capsule	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Sutent	Sunitinib Malate	Capsule	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antineoplastics,Histone Deacetylase Inhibitors,Hd				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zolinza	Vorinostat	Capsule	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Antineoplastics,Miscellaneous				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Docefrez	Docetaxel	Vial	20 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Docefrez	Docetaxel	Vial	80 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Etoposide	Etoposide	Capsule	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Etopophos	Etoposide Phosphate	Vial	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Lysodren	Mitotane	Tablet	500 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Mitoxantrone Hcl	Mitoxantrone Hcl	Vial	2 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Abraxane	Paclitaxel Protein-Bound	Vial	100 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Matulane	Procarbazine Hcl	Capsule	50 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Vesanoid	Tretinoin	Capsule	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

DRUG CLASS: Appetite Stim. For Anorexia,Cachexia,Wasting Syn					**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Megace	Megestrol Acetate	Oral Susp	400MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Megestrol Acetate	Megestrol Acetate	Oral Susp	400MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	

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DRUG CLASS:	Chemotherapy Rescue/Antidote Agents				**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Leucovorin Calcium	Leucovorin Calcium	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Leucovorin Calcium	Leucovorin Calcium	Tablet	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Leucovorin Calcium	Leucovorin Calcium	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Leucovorin Calcium	Leucovorin Calcium	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Hematinics,Other				**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Epogen	Epoetin Alfa	Vial	10000/ Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation AND have treatment failure or intolerance to Retacrit.

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Epogen	Epoetin Alfa	Vial	2000/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation AND have treatment failure or intolerance to Retacrit.
Epogen	Epoetin Alfa	Vial	20000/2Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation AND have treatment failure or intolerance to Retacrit.
Epogen	Epoetin Alfa	Vial	20000/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation AND have treatment failure or intolerance to Retacrit.

Epogen	Epoetin Alfa	Vial	3000/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation AND have treatment failure or intolerance to Retacrit.
Epogen	Epoetin Alfa	Vial	4000/Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for patients who have Hemoglobin (Hgb) < 9 g/dl with TSAT > 20% and serum ferritin > 100 ng/ml at initiation AND have treatment failure or intolerance to Retacrit.
DRUG CLASS:	Hyperuricemia treatment - Urate-Oxidase Enzyme				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Elitek	Rasburicase	Vial	1.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☑	Restricted to Specialty Pharmacy at 877-319-6337
Elitek	Rasburicase	Vial	7.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☑	Restricted to Specialty Pharmacy at 877-319-6337

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DRUG CLASS: Leukocyte (Wbc) Stimulants					**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Neupogen	Filgrastim	Syringe	300MCG /0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta)).
Neupogen	Filgrastim	Syringe	480MCG /0.8	1	☑	☐	☐	☐	☐	☐	☐	☑	filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta)).

Neupogen	Filgrastim	Vial	300 MCG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta)).
Neupogen	Filgrastim	Vial	480MCG/1.6	1	☑	☐	☐	☐	☐	☐	☐	☑	filgrastim (Neupogen), tbo-filgrastim (Granix) are reserved for documentation of treatment failure of a 1st line agent (filgrastim-sndz (Zarxio), peg-filgrastim (Neulasta)).
Neulasta	Pegfilgrastim	Syringe	6MG/0.6ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

DRUG CLASS:	Lhrh(Gnrh) Agonist Analog Pituitary Suppressants				**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Lupron Depot	Leuprolide Acetate	Syringekit	11.25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Lupron Depot	Leuprolide Acetate	Syringekit	3.75 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Synarel	Nafarelin Acetate	Spray	2 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

DRUG CLASS:	Lhrh(Gnrh) Antagonist,Pituitary Suppressant Age				**CATEGORY** Oncology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Cetrotide	Cetrorelix Acetate	Kit	0.25 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Ganirelix Acetate	Ganirelix Acetate	Syringe	250MCG /0.5	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Metallic Poison,Agents To Treat				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Exjade	Deferasirox	Tab Disper	125 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Exjade	Deferasirox	Tab Disper	250 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Exjade	Deferasirox	Tab Disper	500 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Platelet Proliferation Stimulants				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Neumega	Oprelvekin	Vial	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Steroid Antineoplastics				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Emcyt	Estramustine Phosphate Sodium	Capsule	140 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Megestrol Acetate	Megestrol Acetate	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Megestrol Acetate	Megestrol Acetate	Tablet	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Topical Antineoplastic & Premalignant Lesion Agn				**CATEGORY**	Oncology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Carac	Fluorouracil	Cream (G)	0.005	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluoroplex	Fluorouracil	Cream (G)	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Efudex	Fluorouracil	Cream (G)	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	
Efudex	Fluorouracil	Solution	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Efudex	Fluorouracil	Solution	0.05	1	☐	☐	☐	☐	☐	☐	☐	☐	

THERAPEUTIC CATEGORY
Ophthalmic Preparations

DRUG CLASS: Brand Name	Artificial Tears Generic Name	Formulation	Strength	Tier	CATEGORY Ophthalmic Preparations PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Lubricant Eye	Carboxymethylcell/	Droperette	0.5%-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricant Eye	Carboxymethylcellul	Drops	0.5%-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricating Eye Dro	Carboxymethylcellul	Drops	0.5%-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricating Eye Dro	Carboxymethylcellul	Drops	0.5%-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricating Eye Dro	Carboxymethylcellul	Drops	0.5%-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Refresh Optive	Carboxymethylcellul	Drops Gel	1 %-0.9	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricating Plus	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Refresh Plus	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricating Plus	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricant Plus	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricant Eye Drops	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Retaine Cmc	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Lubricating Plus	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Lubricating Plus	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Lubricant Eye Drops	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Revive Plus	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Lubricant Eye Drops	Carboxymethylcellul	Droperette	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Ultra Fresh	Carboxymethylcellul	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Restore Tears	Carboxymethylcellul	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Refresh Tears	Carboxymethylcellul	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Lubricant Eye Drops	Carboxymethylcellul	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Lubricant Eye Drops	Carboxymethylcellul	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Lubricant Eye	Carboxymethylcellul	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Moisturizing Lubric	Carboxymethylcellul	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Lubricant Eye	Carboxymethylcellul	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Genteal Mild	Hypromellose	Drops	0.2 %	1	☐	☐	☐	☐	☐	☐	☐	☐
Pure & Gentle Eye D	Hypromellose	Drops	0.3 %	1	☐	☐	☐	☐	☐	☐	☐	☐

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Eq Gentle	Hypromellose	Drops	0.3 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Isopto Tears	Hypromellose	Drops	0.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Systane Gel	Hypromellose	Gel (Gram)	0.3 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Genteal Severe	Hypromellose	Gel (Gram)	0.3 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Retaine Hpmc	Hypromellose/Pf	Drops	0.3 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Visine	Peg 400/Hypromello	Drops	1 %-0.3	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dry Eye Relief	Peg 400/Hypromello	Drops	1-0.2-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Eye Drop Tears	Peg 400/Hypromello	Drops	1-0.2-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Artificial Tears	Peg 400/Hypromello	Drops	1-0.2-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricant Eye	Propylene Glycol/Pe	Droperette	0.3 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lubricant Eye	Propylene Glycol/Pe	Droperette	0.3 %-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Miotics/Other Intraoc. Pressure Reducers				**CATEGORY**	Ophthalmic Preparations							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Simbrinza	Brinzolamide/Brimo	Drops Susp	1 %-0.2	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Ophthalmic Anti-Inflammatory Immunomodulato				**CATEGORY**	Ophthalmic Preparations							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Restasis Multidose	Cyclosporine	Drops	0.05 %	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who have failed ophthalmic lubricants in the last 6 months.

DRUG CLASS:	Ophthalmic Preparations, Miscellaneous				**CATEGORY**	Ophthalmic Preparations							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Gonak	Hypromellose	Drops	2.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Goniotaire	Hypromellose	Drops	2.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	
Goniovisc	Hypromellose	Drops	2.5 %	1	☐	☐	☐	☐	☐	☐	☐	☐	

THERAPEUTIC CATEGORY
Osteoporosis

DRUG CLASS: Bone Formation Stim. Agents - Parathyroid Hormo					CATEGORY Osteoporosis								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Forteo	Teriparatide	Pen Injctr	20MCG/ DOSE	1	☑	☐	☑	☑	☐	☐	☐	☑	Reserved for treatment of osteoporosis as evidenced by documented t-score <- 2.5 in patients OR with treatment failure to 1 year of Prolia with calcium supplementation AND treatment failure or intolerance to Abaloparatide.

DRUG CLASS: Bone Resorption Inhibitors					CATEGORY Osteoporosis								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Fosamax	Alendronate Sodium	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 4 tablets per month (35mg and 70mg) or 30 tablets per month (5mg, 10mg and 40mg)

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Fosamax	Alendronate Sodium	Tablet	35 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 4 tablets per month (35mg and 70mg) or 30 tablets per month (5mg, 10mg and 40mg)
Fosamax	Alendronate Sodium	Tablet	40 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 4 tablets per month (35mg and 70mg) or 30 tablets per month (5mg, 10mg and 40mg)
Fosamax	Alendronate Sodium	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 4 tablets per month (35mg and 70mg) or 30 tablets per month (5mg, 10mg and 40mg)
Fosamax	Alendronate Sodium	Tablet	70 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 4 tablets per month (35mg and 70mg) or 30 tablets per month (5mg, 10mg and 40mg)
Miacalcin	Calcitonin,Salmon,Synthetic	Spray/Pump	200/SPRAY	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved as last-line therapy for treatment failure/intolerance to all other formulary agents.

Boniva	Ibandronate Sodium	Tablet	150 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to an adequate trial or intolerance to Alendronate. Restricted to 1 tablet per month
Actonel	Risedronate Sodium	Tablet	150 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to [1] Alendronate (Fosamax), and [2] Ibandronate (Boniva) unless patient has documented high risk factors for hip or non-vertebral fractures; restricted to 1 tablet per 30 days.

Actonel	Risedronate Sodium	Tablet	30 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to [1] Alendronate (Fosamax), and [2] Ibandronate (Boniva) unless patient has documented high risk factors for hip or non-vertebral fractures; Restricted to 4 tablets per 28 days.
Actonel	Risedronate Sodium	Tablet	35 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to [1] Alendronate (Fosamax), and [2] Ibandronate (Boniva) unless patient has documented high risk factors for hip or non-vertebral fractures; Restricted to 4 tablets per 28 days.

Actonel	Risedronate Sodium	Tablet	5 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for treatment failure or intolerance to [1] Alendronate (Fosamax), and [2] Ibandronate (Boniva) unless patient has documented high risk factors for hip or non-vertebral fractures; Restricted to 30 tablets per 30 days.
DRUG CLASS:	Hyperparathyroid treatment Agents - Vitamin D A				**CATEGORY**	Osteoporosis							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Zemplar	Paricalcitol	Capsule	1 MCG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who have failed calcitriol
Zemplar	Paricalcitol	Capsule	2 MCG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who have failed calcitriol
Zemplar	Paricalcitol	Capsule	4MCG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who have failed calcitriol
DRUG CLASS:	Selective Estrogen Receptor Modulators (Serm)				**CATEGORY**	Osteoporosis							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Tamoxifen Citrate	Tamoxifen Citrate	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Tamoxifen Citrate	Tamoxifen Citrate	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fareston	Toremifene Citrate	Tablet	60 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

DRUG CLASS: Vitamin D Preparations					**CATEGORY** Osteoporosis								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Calcijex	Calcitriol	Ampul	1 MCG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Calcitriol	Calcitriol	Capsule	0.25 MC	1	☐	☐	☐	☐	☐	☐	☐	☐	
Rocaltrol	Calcitriol	Solution	1 MCG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for use in chronic kidney disease with documented inability to swallow calcitriol capsules.
Vitamin D3	Cholecalciferol (Vita	Capsule	400 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin D3	Cholecalciferol (Vita	Capsule	400 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐	
D-Vi-Sol	Cholecalciferol (Vita	Drops	400/ML	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Vitamin D	Cholecalciferol (Vita	Tablet	1000 U	1	☐	☐	☐	☐	☐	☐	☐	☐
Vitamin D3	Cholecalciferol (Vita	Tablet	400 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐
Drisdol	Ergocalciferol (Vita	Capsule	50000 U	1	☐	☐	☐	☐	☐	☐	☐	☐
Drisdol	Ergocalciferol (Vita	Capsule	50000 U	1	☐	☐	☐	☐	☐	☐	☐	☐
Drisdol	Ergocalciferol (Vita	Drops	8000/M	1	☐	☐	☐	☐	☐	☐	☐	☐
Drisdol	Ergocalciferol (Vita	Drops	8000/M	1	☐	☐	☐	☐	☐	☐	☐	☐
Vitamin D	Ergocalciferol (Vita	Tablet	400 UNI	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Other Antibiotics

DRUG CLASS: Anti-Mycobacterium Agents					**CATEGORY** Other Antibiotics								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Rifabutin	Rifabutin	Capsule	150 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved as alternate to standard therapy for MAC prophylaxis in HIV or TB.
Mycobutin	Rifabutin	Capsule	150 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved as alternate to standard therapy for MAC prophylaxis in HIV or TB.

DRUG CLASS: Macrolides					**CATEGORY** Other Antibiotics								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Dificid	Fidaxomicin	Tablet	200 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure to recurrent episodes of C. difficile that has been treated with one standard 10 day course of oral Vancomycin AND a tapered/pulsed dose course of oral Vancomycin for at least 6 weeks. Positive (detected) C. dif

THERAPEUTIC CATEGORY
Other Hormones

DRUG CLASS: - / Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Other Hormones PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Tymlos	Abaloparatide	Pen Injctr	80MCG/ DOSE	1	☑	☐	☑	☑	☐	☐	☐	☑	Reserved for treatment of osteoporosis as evidenced by documented t-score <- 2.5 in patients with treatment failure to 1 year of Prolia with calcium supplementation.

DRUG CLASS: Pineal Hormone Agents / Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Other Hormones PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Melatonin	Melatonin	Tablet	5 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Pituitary Suppressive Agents / Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Other Hormones PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Cabergoline	Cabergoline	Tablet	0.5 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 8 tablets per 30 days.

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THERAPEUTIC CATEGORY
Other Hypotensives

DRUG CLASS: Angiotensin Receptr Antg./Thiazide & Related Co **CATEGORY** Other Hypotensives

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Avalide	Irbesartan/Hydrochlorothiazide	Tablet	150-12.5MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days.
Avalide	Irbesartan/Hydrochlorothiazide	Tablet	300-12.5MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days.
Benicar Hct	Olmesartan/Hydrochlorothiazide	Tablet	20-12.5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 30 tablets per 30 days.
Benicar Hct	Olmesartan/Hydrochlorothiazide	Tablet	40 MG-25MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 30 tablets per 30 days.

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Benicar Hct	Olmesartan/Hydrochlorothiazide	Tablet	40-12.5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 30 tablets per 30 days.

DRUG CLASS:	Hypotensives,Angiotensin Receptor Antagonist				**CATEGORY**	Other Hypotensives							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Benicar	Olmesartan Medoxomil	Tablet	20 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 30 tablets per 30 days.
Benicar	Olmesartan Medoxomil	Tablet	40 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 30 tablets per 30 days.
Benicar	Olmesartan Medoxomil	Tablet	5 MG	1	☐	☑	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of Losartan 100mg/day in the past 90 days. Limited to 60 tablets per 30 days.

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PL = Provider Limit | GL = Gender Limit | SP = Specialty Pharmacy

THERAPEUTIC CATEGORY
Oxytocics

DRUG CLASS: Oxytocics					**CATEGORY** Oxytocics								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Methergine	Methylergonovine Maleate	Tablet	0.2 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 28 tablets per 365 days.

THERAPEUTIC CATEGORY
Pain Management, Chronic

DRUG CLASS:	Analgesic/Antipyretics, Salicylates				CATEGORY Pain Management, Chronic								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Aspirin	Aspirin	Supp.Rect	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Supp.Rect	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tab Chew	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tab Chew	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tab Chew	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tab Chew	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tab Chew	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin	Aspirin	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Aspirin Ec	Aspirin	Tablet Dr	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Aspirin Ec	Aspirin	Tablet Dr	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Ecotrin	Aspirin	Tablet Dr	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin Ec	Aspirin	Tablet Dr	81 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Choline Mag Trisalic	Choline Sal/Mag Sali	Liquid	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Salflex	Salsalate	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Salflex	Salsalate	Tablet	750 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

DRUG CLASS: Analgesics,Narcotics					**CATEGORY** Pain Management, Chronic								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Codeine Sulfate	Codeine Sulfate	Tablet	15 MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Must be >/= 12 years of age. Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Codeine Sulfate	Codeine Sulfate	Tablet	30 MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Must be >/= 12 years of age. Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Codeine Sulfate	Codeine Sulfate	Tablet	60 MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Must be >/= 12 years of age. Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Fentanyl	Fentanyl	Patch Td72	100 MCG/HR	1	☑	☐	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of adequate dose of or intolerance to MS Contin or unable to take medications by mouth.
Fentanyl	Fentanyl	Patch Td72	12 MCG/HR	1	☑	☐	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of adequate dose of or intolerance to MS Contin or unable to take medications by mouth.

Fentanyl	Fentanyl	Patch Td72	25MCG/ HR	1	☑	☐	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of adequate dose of or intolerance to MS Contin or unable to take medications by mouth.
Fentanyl	Fentanyl	Patch Td72	50MCG/ HR	1	☑	☐	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of adequate dose of or intolerance to MS Contin or unable to take medications by mouth.
Fentanyl	Fentanyl	Patch Td72	75MCG/ HR	1	☑	☐	☑	☐	☐	☐	☐	☐	Step therapy to treatment failure of adequate dose of or intolerance to MS Contin or unable to take medications by mouth.
Hydrocodone-Acetaminophen	Hydrocodone/Acetaminophen	Solution	2.5-167/5	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 946ml per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, methadone) may be considered.

Hydrocodone-Acetaminophen	Hydrocodone/Acetaminophen	Solution	7.5-325/15	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 946ml per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, methadone) may be considered.
Hydrocodone-Acetaminophen	Hydrocodone/Acetaminophen	Tablet	10MG-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Hydrocodone-Acetaminophen	Hydrocodone/Acetaminophen	Tablet	5 MG-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Hydrocodone-Acetaminophen	Hydrocodone/Acetaminophen	Tablet	7.5-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Hydromorphone Hcl	Hydromorphone Hcl	Tablet	2 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Hydromorphone Hcl	Hydromorphone Hcl	Tablet	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Hydromorphone Hcl	Hydromorphone Hcl	Tablet	8 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Levorphanol Tartrat	Levorphanol Tartrat	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Meperidine Hcl	Meperidine Hcl	Solution	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	

Demerol	Meperidine Hcl	Tablet	100 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Demerol	Meperidine Hcl	Tablet	100 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Demerol	Meperidine Hcl	Tablet	50 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Methadone Hcl	Methadone Hcl	Oral Conc	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methadone Hcl	Methadone Hcl	Oral Conc	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methadone Hcl	Methadone Hcl	Solution	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Methadone Hcl	Methadone Hcl	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dolophine Hcl	Methadone Hcl	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dolophine Hcl	Methadone Hcl	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diskets	Methadone Hcl	Tablet Sol	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diskets	Methadone Hcl	Tablet Sol	40 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Morphine Sulfate	Morphine Sulfate	Solution	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	

Morphine Sulfate	Morphine Sulfate	Solution	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Morphine Sulfate	Morphine Sulfate	Solution	20 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Morphine Sulfate	Morphine Sulfate	Supp.Rect	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Morphine Sulfate	Morphine Sulfate	Supp.Rect	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Morphine Sulfate	Morphine Sulfate	Supp.Rect	30 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Morphine Sulfate	Morphine Sulfate	Supp.Rect	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Morphine Sulfate	Morphine Sulfate	Tablet	15 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Morphine Sulfate	Morphine Sulfate	Tablet	30 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Morphine Sulfate Er	Morphine Sulfate	Tablet Er	100 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 tabs per day, consolidate dose or submit PA if not possible

Morphine Sulfate Er	Morphine Sulfate	Tablet Er	15 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 tabs per day, consolidate dose or submit PA if not possible
Morphine Sulfate Er	Morphine Sulfate	Tablet Er	200 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 tabs per day, consolidate dose or submit PA if not possible
Morphine Sulfate Er	Morphine Sulfate	Tablet Er	30 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 tabs per day, consolidate dose or submit PA if not possible
Morphine Sulfate Er	Morphine Sulfate	Tablet Er	60 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 3 tabs per day, consolidate dose or submit PA if not possible
Oxycodone Hcl	Oxycodone Hcl	Capsule	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Oxycodone IR: Restricted to 120 tabs per 30 days, for chronic pain req. >120, use long-acting opioids (e.g., MS Contin, Methadone)
Oxycodone Hcl	Oxycodone Hcl	Oral Conc	20 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Oxycodone Hcl	Oxycodone Hcl	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	

Oxycontin	Oxycodone Hcl	Tab Er 12H	10 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Oxycontin is step to failure of MS Contin and fentanyl patch, restricted to 2 tabs per day.
Oxycontin	Oxycodone Hcl	Tab Er 12H	15 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Oxycontin is step to failure of MS Contin and fentanyl patch, restricted to 2 tabs per day.
Oxycontin	Oxycodone Hcl	Tab Er 12H	20 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Oxycontin is step to failure of MS Contin and fentanyl patch, restricted to 2 tabs per day.
Oxycontin	Oxycodone Hcl	Tab Er 12H	30 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Oxycontin is step to failure of MS Contin and fentanyl patch, restricted to 2 tabs per day.
Oxycontin	Oxycodone Hcl	Tab Er 12H	40 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Oxycontin is step to failure of MS Contin and fentanyl patch, restricted to 2 tabs per day.

Oxycontin	Oxycodone Hcl	Tab Er 12H	60 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Oxycontin is step to failure of MS Contin and fentanyl patch, restricted to 2 tabs per day.
Oxycontin	Oxycodone Hcl	Tab Er 12H	80 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Oxycontin is step to failure of MS Contin and fentanyl patch, restricted to 2 tabs per day.
Oxycodone Hcl	Oxycodone Hcl	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Oxycodone IR: Restricted to 120 tabs per 30 days, for chronic pain req. >120, use long-acting opioids (e.g., MS Contin, Methadone)
Oxycodone Hcl	Oxycodone Hcl	Tablet	15 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Oxycodone IR: Restricted to 120 tabs per 30 days, for chronic pain req. >120, use long-acting opioids (e.g., MS Contin, Methadone)

Oxycodone Hcl	Oxycodone Hcl	Tablet	20 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Oxycodone IR: Restricted to 120 tabs per 30 days, for chronic pain req. >120, use long-acting opioids (e.g., MS Contin, Methadone)
Oxycodone Hcl	Oxycodone Hcl	Tablet	30 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Oxycodone IR: Restricted to 120 tabs per 30 days, for chronic pain req. >120, use long-acting opioids (e.g., MS Contin, Methadone)
Oxycodone Hcl	Oxycodone Hcl	Tablet	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Oxycodone IR: Restricted to 120 tabs per 30 days, for chronic pain req. >120, use long-acting opioids (e.g., MS Contin, Methadone)

Oxycodone Hcl-Acetaminophen	Oxycodone Hcl/Acetaminophen	Tablet	10MG-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Oxycodone Hcl-Acetaminophen	Oxycodone Hcl/Acetaminophen	Tablet	10MG-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Oxycodone-Acetaminophen	Oxycodone Hcl/Acetaminophen	Tablet	5 MG-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Oxycodone-Acetaminophen	Oxycodone Hcl/Acetaminophen	Tablet	5 MG-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Oxycodone-Acetami	Oxycodone Hcl/Acet	Tablet	5 MG-32	1	☐	☐	☐	☐	☐	☐	☐	☐	

Oxycodone-Acetaminophen	Oxycodone Hcl/Acetaminophen	Tablet	7.5-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Oxycodone-Acetaminophen	Oxycodone Hcl/Acetaminophen	Tablet	7.5-325MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Ultram	Tramadol Hcl	Tablet	50 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
DRUG CLASS:	Nsaids, Cyclooxygenase 2 Inhibitor - Type				**CATEGORY**	Pain Management, Chronic							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Celebrex	Celecoxib	Capsule	100 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Step therapy to failure of 3 different nsaids (including meloxicam or etodolac) unless over 65 or at high risk for GI events.
Celebrex	Celecoxib	Capsule	200 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Step therapy to failure of 3 different nsaids (including meloxicam or etodolac) unless over 65 or at high risk for GI events.

Celebrex	Celecoxib	Capsule	400 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Step therapy to failure of 3 different nsaids (including meloxicam or etodolac) unless over 65 or at high risk for GI events.
Celebrex	Celecoxib	Capsule	50 MG	1	☐	☐	☐	☐	☑	☐	☐	☐	Step therapy to failure of 3 different nsaids (including meloxicam or etodolac) unless over 65 or at high risk for GI events.
DRUG CLASS:	Nsaids, Cyclooxygenase Inhibitor - Type				**CATEGORY**	Pain Management, Chronic							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cataflam	Diclofenac Potassiu	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Voltaren-Xr	Diclofenac Sodium	Tab Er 24H	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Diclofenac Sodium	Diclofenac Sodium	Tablet Dr	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Voltaren	Diclofenac Sodium	Tablet Dr	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lodine	Etodolac	Capsule	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Etodolac	Etodolac	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Etodolac	Etodolac	Tablet	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Etodolac	Etodolac	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Indomethacin	Indomethacin	Capsule	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Indomethacin	Indomethacin	Capsule	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Indomethacin	Indomethacin	Capsule Er	75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Indomethacin	Indomethacin	Supp.Rect	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nabumetone	Nabumetone	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Nabumetone	Nabumetone	Tablet	750 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Pain Management, General

DRUG CLASS: Analgesic/Antipyretics,Non-Salicylate **CATEGORY** Pain Management, General

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Mapap	Acetaminophen	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mapap	Acetaminophen	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mapap	Acetaminophen	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mapap	Acetaminophen	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Mapap	Acetaminophen	Capsule	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acetaminophen	Acetaminophen	Drops	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acetaminophen	Acetaminophen	Drops	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acetaminophen	Acetaminophen	Drops	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acetaminophen	Acetaminophen	Drops	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acetaminophen	Acetaminophen	Drops	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Q-Pap	Acetaminophen	Drops	80MG/0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Q-Pap	Acetaminophen	Drops	80MG/0	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Infant'S Pain Relief	Acetaminophen	Drops Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Infant'S Pain Relief	Acetaminophen	Drops Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Infant'S Pain Relief	Acetaminophen	Drops Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol	Acetaminophen	Drops Susp	80MG/0	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Elixir	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Elixir	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Elixir	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Elixir	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Elixir	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Elixir	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Child Triaminic Fev	Acetaminophen	Liquid	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Child Triaminic Fev	Acetaminophen	Liquid	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Child Triaminic Fev	Acetaminophen	Liquid	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Child Triaminic Fev	Acetaminophen	Liquid	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Child Triaminic Fev	Acetaminophen	Liquid	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Child Triaminic Fev	Acetaminophen	Liquid	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Child Triaminic Fev	Acetaminophen	Liquid	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Liquid	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Liquid	500MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Liquid	500MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Liquid	500MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

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Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Oral Susp	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Solution	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Acetaminophen	Acetaminophen	Supp.Rect	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	120 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen	Acetaminophen	Supp.Rect	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Feverall	Acetaminophen	Supp.Rect	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen Juni	Acetaminophen	Tab Chew	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen Juni	Acetaminophen	Tab Chew	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Acetaminophen Juni	Acetaminophen	Tab Chew	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Pain Reli	Acetaminophen	Tab Chew	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Pain Reli	Acetaminophen	Tab Chew	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Pain Reli	Acetaminophen	Tab Chew	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Pain Reli	Acetaminophen	Tab Chew	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Children'S Pain Reli	Acetaminophen	Tab Chew	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Pain Reli	Acetaminophen	Tab Chew	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Pain Reli	Acetaminophen	Tab Chew	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Pain Reli	Acetaminophen	Tab Chew	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Jr. Tylenol Meltaway	Acetaminophen	Tab Rapdis	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Jr. Tylenol Meltaway	Acetaminophen	Tab Rapdis	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Jr. Tylenol Meltaway	Acetaminophen	Tab Rapdis	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Jr. Tylenol Meltaway	Acetaminophen	Tab Rapdis	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Jr. Tylenol Meltaway	Acetaminophen	Tab Rapdis	160 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Tab Rapdis	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Tab Rapdis	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Tab Rapdis	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Tylenol	Acetaminophen	Tab Rapdis	80 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Pain Relief	Acetaminophen	Tablet	325 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Extra Streng	Acetaminophen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Arthritis	Acetaminophen	Tablet Er	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

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Tylenol Arthritis	Acetaminophen	Tablet Er	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Arthritis	Acetaminophen	Tablet Er	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Arthritis	Acetaminophen	Tablet Er	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Arthritis	Acetaminophen	Tablet Er	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Arthritis	Acetaminophen	Tablet Er	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Arthritis	Acetaminophen	Tablet Er	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Tylenol Arthritis	Acetaminophen	Tablet Er	650 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

DRUG CLASS:	Nsaids, Cyclooxygenase Inhibitor - Type				**CATEGORY**	Pain Management, General							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Infant'S Ibuprofen	Ibuprofen	Drops Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Infant'S Ibuprofen	Ibuprofen	Drops Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Infant'S Ibuprofen	Ibuprofen	Drops Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Infant'S Ibuprofen	Ibuprofen	Drops Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Infant'S Ibuprofen	Ibuprofen	Drops Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Infant'S Ibuprofen	Ibuprofen	Drops Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Infant'S Ibuprofen	Ibuprofen	Drops Susp	50 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Motrin	Ibuprofen	Oral Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Motrin	Ibuprofen	Oral Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Motrin	Ibuprofen	Oral Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Motrin	Ibuprofen	Oral Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Motrin	Ibuprofen	Oral Susp	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Motrin	Ibuprofen	Tab Chew	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Motrin	Ibuprofen	Tab Chew	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Motrin	Ibuprofen	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Motrin Ib	Ibuprofen	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Motrin Ib	Ibuprofen	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Motrin Ib	Ibuprofen	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Motrin Ib	Ibuprofen	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Motrin Ib	Ibuprofen	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Ibuprofen	Ibuprofen	Tablet	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

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Ibuprofen	Ibuprofen	Tablet	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ibuprofen	Ibuprofen	Tablet	800 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Meloxicam	Meloxicam	Tablet	15 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day.
Meloxicam	Meloxicam	Tablet	7.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 tablets per day.
Naprosyn	Naproxen	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Naprosyn	Naproxen	Tablet	375 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Naprosyn	Naproxen	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ec-Naprosyn	Naproxen	Tablet Dr	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sulindac	Sulindac	Tablet	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Clinoril	Sulindac	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

THERAPEUTIC CATEGORY
Pain Management, Other

DRUG CLASS: Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
	Analgesic, Salicylate, Barbiturate,&Xanthine Cmb				CATEGORY Pain Management, Other								
Butalbital-Aspirin-Caffeine	Butalbital/Aspirin/Caffeine	Capsule	50-325-40	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 30 tabs/caps per 30 days. For frequent headache > 2 attacks per month, prophylaxis should be considered
	Analgesic,Non-Salicylate,Barbiturate,&Xanthine C				CATEGORY Pain Management, Other								
Butalbital-Acetaminophen-Caffe	Butalb/Acetaminophen/Caffeine	Tablet	50-325-40	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 30 tabs/caps per 30 days. For frequent headache > 2 attacks per month, prophylaxis should be considered
Butalbital-Acetaminophen-Caffe	Butalb/Acetaminophen/Caffeine	Tablet	50-325-40	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 30 tabs/caps per 30 days. For frequent headache > 2 attacks per month, prophylaxis should be considered

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DRUG CLASS:	Antinflammatory, Sel.Costim.Mod.,T-Cell Inhibitor				**CATEGORY**	Pain Management, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Orencia	Abatacept	Syringe	125 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. SECOND-LINE TREATMENT FOR RHEUMATOID ARTHRITIS + PSORIATIC ARTHRITIS: RESERVED FOR PATIENTS WHO QUALIFY FOR BIOLOGIC WITH TREATMENT FAILURE TO AT LEAST 1 OF THE FOLLOWING: HUMIRA, ENBREL, RENFLEXIS, INFLECTRA. RESTRICTED TO SPECIALTY PHARMACY

Orencia	Abatacept/Maltose	Vial	250 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. SECOND-LINE TREATMENT FOR RHEUMATOID ARTHRITIS + PSORIATIC ARTHRITIS: RESERVED FOR PATIENTS WHO QUALIFY FOR BIOLOGIC WITH TREATMENT FAILURE TO AT LEAST 1 OF THE FOLLOWING: HUMIRA, ENBREL, RENFLEXIS, INFLECTRA. RESTRICTED TO SPECIALTY PHARMACY
DRUG CLASS:	Antiseptics,General				**CATEGORY**		Pain Management, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Alcohol Prep Pads	Alcohol Antiseptic Pads	Med. Pad		1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 100 per 30 days.	
DRUG CLASS:	Colchicine				**CATEGORY**		Pain Management, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	

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Colchicine	Colchicine	Tablet	0.6 MG	1	☐	☑	☑	☑	☐	☐	☐	☐	Step therapy to allopurinol filled within the last 30 days. Limited to 61 tablets per 30 days and 6 fills per 365 days.
Probenecid-Colchici	Colchicine/Probenec	Tablet	0.5-500	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Hyperuricemia treatment - Purine Inhibitors				**CATEGORY**	Pain Management, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Allopurinol	Allopurinol	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Allopurinol	Allopurinol	Tablet	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Uloric	Febuxostat	Tablet	40 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who are allergic to allopurinol
Uloric	Febuxostat	Tablet	80 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients who are allergic to allopurinol
DRUG CLASS:	Local Anesthetics				**CATEGORY**	Pain Management, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Anbesol	Benzocaine	Gel (Gram)	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
Hurricaine	Benzocaine	Gel (Gram)	0.2	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Orasep	Benzocaine/Menth/	Spray	2-0.5-0.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lidocaine Hcl	Lidocaine Hcl	Jel (Ml)	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lidocaine Hcl	Lidocaine Hcl	Jel/Pf App	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lidocaine Hcl Viscou	Lidocaine Hcl	Solution	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lidocaine Hcl Viscou	Lidocaine Hcl	Solution	0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lidocaine Hcl	Lidocaine Hcl	Solution	40 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Narc.&Non-Sal.Analgesic,Barbiturate &Xanthine C				**CATEGORY**	Pain Management, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Butalb-Caff-Acetaminoph-Codein	Butalbit/Acetamin/Caff/Codeine	Capsule	50-325-30	1	☐	☐	☑	☐	☑	☐	☐	☐	Restricted to patients ≥12 years of age. Limited to 30 capsules per 30 days.
DRUG CLASS:	Narcotic Analgesic & Non-Salicylate Analgesic Co				**CATEGORY**	Pain Management, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Acetaminophen-Codeine	Acetaminophen With Codeine	Solution	120-12MG/5	1	☐	☐	☑	☑	☑	☐	☐	☐	Restricted to patients ≥12 years of age. Limited to 240 mL per fill; 4 fills per year.

Acetaminophen-Codeine	Acetaminophen With Codeine	Tablet	300MG-15MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Must be ≥12 years of age. Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
Tylenol-Codeine No.3	Acetaminophen With Codeine	Tablet	300MG-30MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Must be ≥12 years of age. Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.

Tylenol-Codeine No.4	Acetaminophen With Codeine	Tablet	300MG-60MG	1	☐	☐	☑	☐	☑	☐	☐	☐	Must be ≥12 years of age. Short-acting opioids limited to a total of 120 tabs/caps combined per 30 days. For chronic pain requiring > 120/month, long-acting opioids, (MS Contin, Methadone, Fentanyl) may be considered.
DRUG CLASS:	Topical Local Anesthetics				**CATEGORY**	Pain Management, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Lidocaine	Lidocaine	Adh. Patch	5%(700 MG)	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with peripheral neuropathy and treatment failure of 2 conventional treatments (e.g. Amitriptyline, Venlafaxine, Gabapentin).
Lidocaine-Prilocaine	Lidocaine/Prilocaine	Cream (G)	2.5 %-2.5%	1	☐	☐	☑	☑	☐	☐	☐	☐	Restricted to 30g per fill and 1 fill per 30 days
Sarna Sensitive	Pramoxine Hcl	Lotion	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sarna Sensitive	Pramoxine Hcl	Lotion	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	

Summer'S Eve	Pramoxine Hcl	Towelette	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
Summer'S Eve	Pramoxine Hcl	Towelette	0.01	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Uricosuric Agents				**CATEGORY**	Pain Management, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Probenecid	Probenecid	Tablet	500 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Pain Mgmt, Chronic

DRUG CLASS: Mu-Opioid Receptor Antagonists,Peripherally-Acti **CATEGORY** Pain Mgmt, Chronic

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Relistor	Methylnaltrexone Bromide	Syringe	12Mg/0.6Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for [1] documented diagnosis of opioid-induced constipation with chronic non-cancer pain, [2] treatment failure of naloxegol (Movantik) and lubiprostone (Amitiza), and [3] patient must have also failed regularly scheduled, dose optimized polyethy

Relistor	Methylnaltrexone Bromide	Syringe	8 Mg/0.4 Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for [1] documented diagnosis of opioid-induced constipation with chronic non-cancer pain, [2] treatment failure of naloxegol (Movantik) and lubiprostone (Amitiza), and [3] patient must have also failed regularly scheduled, dose optimized polyethy
Relistor	Methylnaltrexone Bromide	Tablet	150 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for [1] documented diagnosis of opioid-induced constipation with chronic non-cancer pain, [2] treatment failure of naloxegol (Movantik) and lubiprostone (Amitiza), and [3] patient must have also failed regularly scheduled, dose optimized polyethy

Relistor	Methylnaltrexone Bromide	Vial	12Mg/0.6Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for [1] documented diagnosis of opioid-induced constipation with chronic non-cancer pain, [2] treatment failure of naloxegol (Movantik) and lubiprostone (Amitiza), and [3] patient must have also failed regularly scheduled, dose optimized polyethy
Movantik	Naloxegol Oxalate	Tablet	12.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for documented diagnosis of opioid-induced constipation with chronic non-cancer pain; AND Treatment failure of dose-optimized, regularly scheduled polyethylene glycol for 2 months (as evidenced by prescription history fills) AND two of the follow

Movantik	Naloxegol Oxalate	Tablet	25 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for documented diagnosis of opioid-induced constipation with chronic non-cancer pain; AND Treatment failure of dose-optimized, regularly scheduled polyethylene glycol for 2 months (as evidenced by prescription history fills) AND two of the follow

THERAPEUTIC CATEGORY
Pain Mgmt, Rheumato

DRUG CLASS: Anti-Inflammatory Tumor Necrosis Factor Inhibit **CATEGORY** Pain Mgmt, Rheumato

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Humira Pen Crohn'S-Uc-Hs	Adalimumab	Pen Ij Kit	40Mg/0.8Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Pa Required. Reserved For Treatment Failure To Adequate Trial Of Dmard Therapy. Restricted To Specialty Pharmacy.
Humira Pen Psoriasis	Adalimumab	Pen Ij Kit	40Mg/0.8Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Pa Required. Reserved For Treatment Failure To Adequate Trial Of Dmard Therapy. Restricted To Specialty Pharmacy.
Humira	Adalimumab	Syringekit	10Mg/0.2Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Pa Required. Reserved For Treatment Failure To Adequate Trial Of Dmard Therapy. Restricted To Specialty Pharmacy.

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Humira Pediatric Crohn'S	Adalimumab	Syringekit	40Mg/0.8Ml	1	☑	☐	☐	☐	☐	☐	☐	☑	Pa Required. Reserved For Treatment Failure To Adequate Trial Of Dmard Therapy. Restricted To Specialty Pharmacy.

THERAPEUTIC CATEGORY
Protein Lysates

DRUG CLASS: Brand Name	Protein Replacement Generic Name	Formulation	Strength	Tier	CATEGORY Protein Lysates PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Complete Amino Acid Mix	Amino Acids	Powder	82 G-328	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Arginine	Arginine	Powd Pack	2000 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Arginine	Arginine	Powd Pack	500 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Arginine	Arginine	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

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Citrulline 1000	Citrulline	Powd Pack	1 G/4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Citrulline 200	Citrulline	Powd Pack	200 Mg/4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Cystine	Cystine	Packet	0.5G-15/4G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glycine	Glycine	Powd Pack	500 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Glycine	Glycine	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Isoleucine	Isoleucine	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Isoleucine 1000	Isoleucine Supp In Carbohydrat	Powd Pack	1 G/4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Isoleucine	Isoleucine Supp In Carbohydrat	Powd Pack	50 Mg/4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Leucine	Leucine	Powd Pack	0.1G-15/4G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
L-Leucine	Leucine	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

Lysine 4000	Lysine Acetate	Powd Pack	4000 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Methionine	Methionine Supp In Carbohydrat	Powd Pack	100 Mg/4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Phenylalanine	Phenylalanine	Powd Pack	50 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyrosine	Tyrosine	Packet	1 G-15/4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Tyrosine	Tyrosine	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

L-Valine	Valine	Powder		1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Valine	Valine Suppl In Carbohydrate	Packet	50 Mg/4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Valine 1000	Valine Suppl In Carbohydrate	Powd Pack	1 G/4 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Beneprotein	Whey Protein Isolate	Powder	6 G-25/7 G	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

THERAPEUTIC CATEGORY
Psychostimulants-Antidepressants

DRUG CLASS: Serotonin-Norepinephrine Reuptake-Inhib (Snris)	**CATEGORY** Psychostimulants-Antidepressants												
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Fetzima	Levomilnacipran Hcl	Cap24Hdspk	20-40Mg	1	☑	☐	☐	☑	☐	☐	☐	☐	PA required. Reserved for treatment failure or documented intolerance to optimally dosed Venlafaxine IR/XR and Duloxetine for two months each. Limited to 1 titration pack per 180 days.

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THERAPEUTIC CATEGORY
Pulmonary, Asthma/Co

DRUG CLASS: Respiratory Aids,Devices,Equipment **CATEGORY** Pulmonary, Asthma/Co

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Devilbiss Pulmo-Aide	Compressor, For Nebulizer	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Devilbiss Pulmo-Aide	Compressor, For Nebulizer	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Devilbiss Pulmomate	Compressor, For Nebulizer	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Pulmo-Aide	Compressor, For Nebulizer	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Pulmo-Aide	Compressor, For Nebulizer	Each		1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

Sunrise Compressor-Nebulizer	Compressor, For Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Devilbiss Compact	Compressor, For Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Sidestream	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Vixone Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Vixone Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Vixone Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Truneb Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

Sinustar	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Sidestream	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Sidestream Plus	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Sidestream Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Inspiration	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Aeroeclipse Ii	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Aeroeclipse	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

Airs Disposable Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Devilbiss Disposable Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Sidestream	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Lc Plus	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Micro Plus	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Mini Plus Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Nasoneb Nasal Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

Prodigy Mini-Mist	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Lc D Nebulizer Set	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Lc Plus	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Lc Plus	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Lc Sprint Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Tubing Sets are limited to 1 fill per 180 days.
Pari Lc Sprint Sinus	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Lc Star	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

Baby Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Compact Compressor Nebulizer	Nebulizer	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Pulmoneb Lt Compressor Nebul	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Proneb Ultra Ii	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Comp-Air Nebulizer Compressor	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Devilbiss Pulmoneb Lt Comp-Neb	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Pediatric Dinosaur Nebulizer	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

Trek S Compact Compressor	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Comp-Air Nebulizer Compressor	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Comp-Air Elite Compressor Syst	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Clever Choice Nebulizer	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Pediatric Frog Nebulizer	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
My Mdi Portable Nebuliser	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Sami The Seal	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

Comp-Air Elite Compressor Syst	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Sootheneb Compressor Nebulizer	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Sinustar	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Innospire Elegance	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Innospire Essence	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Inspiration Elite	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Innospire Essence	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

Innospire Deluxe	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Vios Aerosol Delivery System	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Pediatric Dog Nebulizer	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.
Devilbiss Traveler	Nebulizer And Compressor	Each	1	☐	☐	☐	☑	☐	☐	☐	☐	Nebulizer Delivery Systems are limited to 1 fill per lifetime.

THERAPEUTIC CATEGORY
Pulmonary, Asthma/COPD

DRUG CLASS: / Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
	-			CATEGORY	Pulmonary, Asthma/COPD								
Trelegy Ellipta	Fluticasone/Umeclidin/Vilanter	BLST W/DEV	100-62.5	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients with COPD GOLD grade 3 or 4, Group D with compliant use of ICS+LABA or LABA+LAMA in the prior 12 weeks. Limited to 1 Inhaler per 30 days.
	-ADRENERGIC AND GLUCOCORTICOID COMBO, IN			CATEGORY	Pulmonary, Asthma/COPD								
Breo Ellipta	Fluticasone/Vilanterol	BLST W/DEV	100-25MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 inhaler per 30 days.
Breo Ellipta	Fluticasone/Vilanterol	BLST W/DEV	200-25 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 inhaler per 30 days.
	Anaphylaxis Therapy Agents			CATEGORY	Pulmonary, Asthma/COPD								
Epinephrine (Generic)	Epinephrine	Auto Injct	0.15MG/0.3	1	☐	☐	☐	☐	☐	☐	☐	☐	NDC: 54505-0101-02, 54505-0101-01

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Epinephrine (Generic)	Epinephrine	Auto Injct	0.3MG/ 0.3	1	☐	☐	☐	☐	☐	☐	☐	☐	NDC: 54569-6425-00, 54505-0102-02, 54505-0102-01
DRUG CLASS:	Beta-Adrenergic Agents				**CATEGORY**	Pulmonary, Asthma/COPD							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ventolin Hfa	Albuterol Sulfate	Hfa Aer Ad	90 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Generic preferred - Ventolin HFA: Max 2 inhalers/month and 7/6 months; for uncontrolled asthma, standard of care is inhaled steroids (QVAR, Flovent) or combo inhaler (Advair, Symbicort)
Albuterol Sulfate	Albuterol Sulfate	Solution	5 MG/ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 40 ml in 30 days
Albuterol Sulfate	Albuterol Sulfate	Vial-Neb	0.63MG /3ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 375 ml per month. For uncontrolled asthma, standard of care is ICS +/- LABA (Flovent, QVAR, Breo, Dulera)

Albuterol Sulfate	Albuterol Sulfate	Vial-Neb	1.25MG /3ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 375 ml per month. For uncontrolled asthma, standard of care is ICS +/- LABA (Flovent, QVAR, Breo, Dulera)
Albuterol Sulfate	Albuterol Sulfate	Vial-Neb	2.5 MG/0.5	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 375ml per 30 days
Albuterol Sulfate	Albuterol Sulfate	Vial-Neb	2.5 MG/3ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 375 ml per month. For uncontrolled asthma, standard of care is ICS +/- LABA (Flovent, QVAR, Breo, Dulera)
Foradil	Formoterol Fumarate	Cap W/Dev	12 MCG	1	☐	☑	☑	☐	☐	☐	☐	☐	Concurrent use of inhaled corticosteroids is required. Restricted to 1 inhaler per month.
Levalbuterol Hcl	Levalbuterol Hcl	Vial-Neb	0.31MG /3ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to intolerance to albuterol; formulary rescue inhaler is Ventolin HFA with dose counter

Levalbuterol Hcl	Levalbuterol Hcl	Vial-Neb	0.63MG /3ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to intolerance to albuterol. Formulary rescue inhaler is Ventolin HFA with dose counter
Levalbuterol Concentrate	Levalbuterol Hcl	Vial-Neb	1.25MG /0.5	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to intolerance to albuterol. Formulary rescue inhaler is Ventolin HFA with dose counter
Levalbuterol Hcl	Levalbuterol Hcl	Vial-Neb	1.25MG /3ML	1	☑	☐	☐	☐	☐	☐	☐	☐	Step therapy to intolerance to albuterol. Formulary rescue inhaler is Ventolin HFA with dose counter
Xopenex Hfa	Levalbuterol Tartrate	Hfa Aer Ad	45 MCG	1	☑	☐	☑	☑	☐	☐	☐	☐	PA required. Reserved for intolerance to albuterol. Limited to 7 inhalers per 180 days, 2 inhalers per 30 days.
DRUG CLASS:	Beta-Adrenergic And Anticholinergic Combination				**CATEGORY**	Pulmonary, Asthma/COPD							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ipratropium-Albuterol	Ipratropium/Albuterol Sulfate	Ampul-Neb	0.5-3MG/3	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 375 ml per 30 days

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Combivent Respimat	Ipratropium/Albuterol Sulfate	Mist Inhal	20-100 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Stiolto Respimat	Tiotropium Br/Olodaterol Hcl	Mist Inhal	2.5-2.5Mcg	1	☑	☐	☑	☐	☐	☐	☐	☐	Reserved for patients with at least Stage II COPD confirmed by PFTs. Limited to 1 device per month.
DRUG CLASS:	Beta-Adrenergics And Glucocorticoids Combinatio				**CATEGORY**		Pulmonary, Asthma/COPD						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Symbicort	Budesonide/Formoterol Fumarate	Hfa Aer Ad	160-4.5MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Symbicort	Budesonide/Formoterol Fumarate	Hfa Aer Ad	80-4.5 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Dulera	Mometasone/Formoterol	Hfa Aer Ad	100-5 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Dulera	Mometasone/Formoterol	Hfa Aer Ad	200-5 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
DRUG CLASS:	Corticosteroids (Respiratory Tract)				**CATEGORY**		Pulmonary, Asthma/COPD						
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Qvar	Beclomethasone Dipropionate	Aer W/Adap	40 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	QVAR: Restricted to 1 inhaler per 30 days.
Qvar	Beclomethasone Dipropionate	Aer W/Adap	80 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	QVAR: Restricted to 1 inhaler per 30 days.
Pulmicort Flexhaler	Budesonide	Aer Pow Ba	180 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Budesonide	Budesonide	Ampul-Neb	0.25MG /2ML	1	☐	☐	☑	☐	☑	☐	☐	☐	Pulmicort: Restricted to patients <=4 years old. Max 120 ml/month. For patients over 4, use Flovent or QVAR with spacer and mask.
Budesonide	Budesonide	Ampul-Neb	0.5 MG/2ML	1	☐	☐	☑	☐	☑	☐	☐	☐	Pulmicort: Restricted to patients <=4 years old. Max 120 ml/month. For patients over 4, use Flovent or QVAR with spacer and mask.

Pulmicort	Budesonide	Ampul-Neb	1 MG/2 ML	1	☐	☐	☑	☐	☑	☐	☐	☐	Pulmicort: Restricted to patients <=4 years old. Max 120 ml/month. For patients over 4, use Flovent or QVAR with spacer and mask.
Arnuity Ellipta	Fluticasone Furoate	Blst W/Dev	100 MCG	1	☐	☐	☑	☐	☑	☐	☐	☐	Reserved for patients 12 years and older. Limited to 1 device per month.
Arnuity Ellipta	Fluticasone Furoate	Blst W/Dev	200 MCG	1	☐	☐	☑	☐	☑	☐	☐	☐	Reserved for patients 12 years and older. Limited to 1 device per month.
Flovent Hfa	Fluticasone Propionate	Aer W/Adap	110 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Flovent Hfa	Fluticasone Propionate	Aer W/Adap	220 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Flovent Hfa	Fluticasone Propionate	Aer W/Adap	44 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Flovent Diskus	Fluticasone Propionate	Blst W/Dev	100 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.

Flovent Diskus	Fluticasone Propionate	Blst W/Dev	250 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Flovent Diskus	Fluticasone Propionate	Blst W/Dev	50 MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 inhaler per 30 days.
Asmanex	Mometasone Furoate	Aer Pow Ba	110MCG (30)	1	☐	☐	☑	☐	☑	☐	☐	☐	Restricted to patients under 12 yrs old
Asmanex	Mometasone Furoate	Aer Pow Ba	220MCG 120	1	☐	☐	☑	☐	☐	☐	☐	☐	Asmanex: Restricted to 1 inhaler per 30 days.
Asmanex	Mometasone Furoate	Aer Pow Ba	220MCG (60)	1	☐	☐	☑	☐	☐	☐	☐	☐	Asmanex: Restricted to 1 inhaler per 30 days.
DRUG CLASS:	General Bronchodilator Agents				**CATEGORY**	Pulmonary, Asthma/COPD							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Tudorza Pressair	Aclidinium Bromide	Aer Pow Ba	400 MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients with COPD confirmed by PFTs and are GOLD Group B or higher. Limited to 1 package per 30 days.
Atrovent Hfa	Ipratropium Bromide	Hfa Aer Ad	17MCG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 2 inhalers per 30 days.

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Ipratropium Bromid	Ipratropium Bromid	Solution	0.2 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Spiriva	Tiotropium Bromide	Cap W/Dev	18 MCG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients with COPD confirmed by PFTs and are GOLD Group B or higher. Limited to 1 package per 30 days.
Spiriva Respimat	Tiotropium Bromide	Mist Inhal	2.5 MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients with COPD confirmed by PFTs and are GOLD Group B or higher. Limited to 1 package per 30 days.

DRUG CLASS: Glucocorticoids					**CATEGORY** Pulmonary, Asthma/COPD								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cortisone Acetate	Cortisone Acetate	Tablet	25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dexamethasone Inte	Dexamethasone	Drops	1 MG/M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dexamethasone	Dexamethasone	Elixir	0.5 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dexamethasone	Dexamethasone	Solution	0.5 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Dexpak	Dexamethasone	Tab Ds Pk	1.5MG (	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Dexamethasone	Dexamethasone	Tablet	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dexamethasone	Dexamethasone	Tablet	0.75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dexamethasone	Dexamethasone	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dexamethasone	Dexamethasone	Tablet	1.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dexamethasone	Dexamethasone	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dexamethasone	Dexamethasone	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dexamethasone	Dexamethasone	Tablet	6 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Dexamethasone Sod	Dexamethasone Sod	Vial	10 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Cortef	Hydrocortisone	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Cortef	Hydrocortisone	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Cortef	Hydrocortisone	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Medrol	Methylprednisolone	Tab Ds Pk	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Medrol	Methylprednisolone	Tablet	16 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Medrol	Methylprednisolone	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Medrol	Methylprednisolone	Tablet	32 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Medrol	Methylprednisolone	Tablet	4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Medrol	Methylprednisolone	Tablet	8 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisolone	Prednisolone	Solution	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisolone	Prednisolone	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisolone Sodiu	Prednisolone Sod Ph	Solution	15 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisolone Sodiu	Prednisolone Sod Ph	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisone	Prednisone	Solution	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐
Sterapred	Prednisone	Tab Ds Pk	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisone	Prednisone	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisone	Prednisone	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisone	Prednisone	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisone	Prednisone	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisone	Prednisone	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Prednisone	Prednisone	Tablet	50 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Aristospan	Triamcinolone Hexacetonide	Vial	20 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Leukocyte Adhesion Inhib,Alpha4-Mediat Igg4K M				**CATEGORY**	Pulmonary, Asthma/COPD								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Tysabri	Natalizumab	Vial	300MG/ 15ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Treatment for CD: Reserved for patients with contraindication to TNF biologic and a negative anti-JCV antibody detection test result.	
DRUG CLASS:	Leukotriene Receptor Antagonists				**CATEGORY**	Pulmonary, Asthma/COPD								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**	
Singulair	Montelukast Sodium	Tab Chew	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day	
Singulair	Montelukast Sodium	Tab Chew	5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day	

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Singulair	Montelukast Sodium	Tablet	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 tablet per day

DRUG CLASS:	Monoclonal Antibodies To Immunoglobulin E(Ige)				**CATEGORY**	Pulmonary, Asthma/COPD							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Xolair	Omalizumab	Vial	150 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for inadequate asthma control or uncontrolled chronic idiopathic urticaria.

DRUG CLASS:	Phosphodiesterase-4 (Pde4) Inhibitors				**CATEGORY**	Pulmonary, Asthma/COPD							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Daliresp	Roflumilast	Tablet	500 MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients with GOLD Grade 4, Group D who have failed treatment or are intolerant to high dose ICS+LABA+LAMA in the past 12 weeks. Limited to 30 tablets per 30 days.

DRUG CLASS:	Xanthines				**CATEGORY**	Pulmonary, Asthma/COPD							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Cafcit	Caffeine Citrated	Solution	60 MG/3 ML	1	☐	☑	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Theo-24	Theophylline Anhydr	Cap Er 24H	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theo-24	Theophylline Anhydr	Cap Er 24H	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theo-24	Theophylline Anhydr	Cap Er 24H	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Elixophyllin	Theophylline Anhydr	Elixir	80 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theophylline	Theophylline Anhydr	Elixir	80 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theophylline	Theophylline Anhydr	Solution	80 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theophylline Anhyd	Theophylline Anhydr	Tab Er 12H	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theophylline Anhyd	Theophylline Anhydr	Tab Er 12H	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theophylline Anhyd	Theophylline Anhydr	Tab Er 12H	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theochron	Theophylline Anhydr	Tab Er 12H	450 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Theophylline	Theophylline Anhydr	Tablet Er	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

Theophylline	Theophylline Anhydr	Tablet Er	600 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Pulmonary, Other

DRUG CLASS: Anticholinergics,Quaternary Ammonium					CATEGORY Pulmonary, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Glycopyrrolate	Glycopyrrolate	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Glycopyrrolate	Glycopyrrolate	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Glycopyrrolate	Glycopyrrolate	Vial	0.2 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Propantheline Brom	Propantheline Bromi	Tablet	15 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Brand Name	Antitussives,Non-Narcotic **Generic Name**	**Formulation**	**Strength**	**Tier**	CATEGORY Pulmonary, Other **PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Tessalon Perle	Benzonatate	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Benzonatate	Benzonatate	Capsule	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Adult Robitussin	Dextromethorphan Hbr	Syrup	15 MG/5 ML	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

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Adult Robitussin	Dextromethorphan Hbr	Syrup	15 MG/5 ML	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Adult Robitussin	Dextromethorphan Hbr	Syrup	15 MG/5 ML	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin Pediatric Cough	Dextromethorphan Hbr	Syrup	7.5 MG/5ML	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.
Robitussin Pediatric Cough	Dextromethorphan Hbr	Syrup	7.5 MG/5ML	1	☐	☐	☑	☑	☐	☐	☐	☐	Limited to 240 mL per fill; 7 fills per year for all dextromethorphan containing syrups/liquids/solutions.

DRUG CLASS: General Inhalation Agents					**CATEGORY** Pulmonary, Other								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Sodium Chloride	Sodium Chloride For	Vial-Neb	0.009	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	Sodium Chloride For	Vial-Neb	0.03	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	Sodium Chloride For	Vial-Neb	0.07	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Chloride	Sodium Chloride For	Vial-Neb	0.1	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Mast Cell Stabilizers				**CATEGORY**	Pulmonary, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cromolyn Sodium	Cromolyn Sodium	Ampul-Neb	20 MG/	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cromolyn Sodium	Cromolyn Sodium	Solution	20 MG/ML	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Mucolytics				**CATEGORY**	Pulmonary, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Acetylcysteine	Acetylcysteine	Vial	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Acetylcysteine	Acetylcysteine	Vial	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Pulmozyme	Dornase Alfa	Solution	1 MG/ML	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.
DRUG CLASS:	Pulm.Anti-Htn,Sel.C-Gmp Phosphodiesterase T5 In				**CATEGORY**	Pulmonary, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Revatio	Sildenafil Citrate	Tablet	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with IPAH with a (-) vasoreactivity test or (+)vasoreactivity test and use of/contraindication to Calcium Channel Blocker use. Members must have WHO Functional Class II-IV disease.
Adcirca	Tadalafil	Tablet	20 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to dose optimized sildenafil for at least 3 months.
DRUG CLASS:	Pulmonary Anti-Htn, Endothelin Receptor Antago				**CATEGORY**	Pulmonary, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Letairis	Ambrisentan	Tablet	10 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Reserved for patients with IPAH class II with failure of Sildenafil/Tadalafil or IPAH class III
Letairis	Ambrisentan	Tablet	5 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Reserved for patients with IPAH class II with failure of Sildenafil/Tadalafil or IPAH class III
Tracleer	Bosentan	Tablet	125 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who meet all of the following criteria: [1] Treatment failure to Sildenafil, [2] Treatment failure to Ambrisentan or Macitentan, [3] Prescribed by a Cardiologist, Pulmonologist, or Critical care, [4] Diagnosis of PAH, WH

Tracleer	Bosentan	Tablet	62.5 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	PA required. Reserved for patients who meet all of the following criteria: [1] Treatment failure to Sildenafil, [2] Treatment failure to Ambrisentan or Macitentan, [3] Prescribed by a Cardiologist, Pulmonologist, or Critical care, [4] Diagnosis of PAH, WH
Opsumit	Macitentan	Tablet	10 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for patients with IPAH Class II with failure of PDE-5-I or IPAH class III-IV.

DRUG CLASS:	Pulmonary Antihypertensives				**CATEGORY**	Pulmonary, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Adempas	Riociguat	Tablet	0.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Prescribed by cardiologist or pulmonologist. Reserved for patients with WHO Functional Class II or higher, WHO Group IV, with inoperable or recurrent disease. For WHO Group I PAH, step therapy to treatment failure of Sildenafil and Tadalafil.
Adempas	Riociguat	Tablet	1 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Prescribed by cardiologist or pulmonologist. Reserved for patients with WHO Functional Class II or higher, WHO Group IV, with inoperable or recurrent disease. For WHO Group I PAH, step therapy to treatment failure of Sildenafil and Tadalafil.

Adempas	Riociguat	Tablet	1.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Prescribed by cardiologist or pulmonologist. Reserved for patients with WHO Functional Class II or higher, WHO Group IV, with inoperable or recurrent disease. For WHO Group I PAH, step therapy to treatment failure of Sildenafil and Tadalafil.
Adempas	Riociguat	Tablet	2 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Prescribed by cardiologist or pulmonologist. Reserved for patients with WHO Functional Class II or higher, WHO Group IV, with inoperable or recurrent disease. For WHO Group I PAH, step therapy to treatment failure of Sildenafil and Tadalafil.

Adempas	Riociguat	Tablet	2.5 Mg	1	☑	☐	☐	☐	☐	☐	☐	☐	Prescribed by cardiologist or pulmonologist. Reserved for patients with WHO Functional Class II or higher, WHO Group IV, with inoperable or recurrent disease. For WHO Group I PAH, step therapy to treatment failure of Sildenafil and Tadalafil.
DRUG CLASS:	Pulmonary Antihypertensives, Prostacyclin-Type				**CATEGORY**	Pulmonary, Other							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Veletri	Epoprostenol Sodium (Arginine)	Vial	0.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of Revatio AND Adcirca/Tracleer/Letairis.
Veletri	Epoprostenol Sodium (Arginine)	Vial	1.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of Revatio AND Adcirca/Tracleer/Letairis.
Flolan	Epoprostenol Sodium (Glycine)	Vial	0.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of Revatio AND Adcirca/Tracleer/Letairis.

Flolan	Epoprostenol Sodium (Glycine)	Vial	1.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	Reserved for treatment failure of Revatio AND Adcirca/Tracleer/Letairis.
Ventavis	Iloprost Tromethamine	Ampul-Neb	10 MCG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	3rd-line for tx failure after revatio and adcirca/tracleer/letairis.
Ventavis	Iloprost Tromethamine	Ampul-Neb	20 MCG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	3rd-line for tx failure after revatio and adcirca/tracleer/letairis.
Uptravi	Selexipag	Tab Ds Pk	200-800Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an

Uptravi	Selexipag	Tablet	1000 Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an
Uptravi	Selexipag	Tablet	1200 Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an

Uptravi	Selexipag	Tablet	1400 Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an
Uptravi	Selexipag	Tablet	1600 Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an

Uptravi	Selexipag	Tablet	200 Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an
Uptravi	Selexipag	Tablet	400 Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an

Uptravi	Selexipag	Tablet	600 Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an
Uptravi	Selexipag	Tablet	800 Mcg	1	☑	☐	☐	☐	☐	☐	☐	☑	Reserved for patients with all of the following: [1] WHO Group I and PAH Functional Class III; [2] (-) vasoreactivity test OR (+) vasoreactivity test and use of CCB (if appropriate); AND [3] Inadequate response to dose optimized use of PDE-5 inhibitors an

Tyvaso	Treprostinil	Ampul-Neb	1.74MG /2.9	1	☑	☐	☐	☐	☐	☐	☐	☐	PAH Functional Class III or higher. Step therapy to use of PDE-5 inhibitors and/or ERA, with a (-) vasoreactivity test or (+) vasoreactivity test and use of/contraindication to Calcium Channel Blocker use.
Remodulin	Treprostinil Sodium	Vial	1 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PAH Functional Class IV with a (-) vasoreactivity test or (+) vasoreactivity test and use of/contraindication to Calcium Channel Blocker use.
Remodulin	Treprostinil Sodium	Vial	10 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PAH Functional Class IV with a (-) vasoreactivity test or (+) vasoreactivity test and use of/contraindication to Calcium Channel Blocker use.

Remodulin	Treprostinil Sodium	Vial	2.5 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PAH Functional Class IV with a (-) vasoreactivity test or (+) vasoreactivity test and use of/contraindication to Calcium Channel Blocker use.
Remodulin	Treprostinil Sodium	Vial	5 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PAH Functional Class IV with a (-) vasoreactivity test or (+) vasoreactivity test and use of/contraindication to Calcium Channel Blocker use.
Tyvaso	Treprostinil/Neb Accessories	Ampul-Neb	1.74MG /2.9	1	☑	☐	☐	☐	☐	☐	☐	☐	PAH Functional Class III or higher. Step therapy to use of PDE-5 inhibitors and/or ERA, with a (-) vasoreactivity test or (+) vasoreactivity test and use of/contraindication to Calcium Channel Blocker use.

Tyvaso	Treprostinil/Nebulizer/Accesor	Ampul-Neb	1.74MG/2.9	1	☑	☐	☐	☐	☐	☐	☐	☐	PAH Functional Class III or higher. Step therapy to use of PDE-5 inhibitors and/or ERA, with a (-) vasoreactivity test or (+) vasoreactivity test and use of/contraindication to Calcium Channel Blocker use.

THERAPEUTIC CATEGORY
Renal

DRUG CLASS: Calcimimetic,Parathyroid Calcium Enhancer **CATEGORY** Renal

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Sensipar	Cinacalcet Hcl	Tablet	30 MG	1	☐	☑	☑	☐	☐	☐	☐	☑	PA Required. Indicated for patients with secondary hyperparathyroidismwith BiPTH > 200 pg/ml despite compliant use of phosphate binders OR patients with CKD-5D. Limited to 2 tablets per day.
Sensipar	Cinacalcet Hcl	Tablet	60 MG	1	☐	☑	☑	☐	☐	☐	☐	☑	PA Required. Indicated for patients with secondary hyperparathyroidismwith BiPTH > 200 pg/ml despite compliant use of phosphate binders OR patients with CKD-5D. Limited to 2 tablets per day.

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Sensipar	Cinacalcet Hcl	Tablet	90 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	PA Required. Indicated for patients with secondary hyperparathyroidismwith BiPTH > 200 pg/ml despite compliant use of phosphate binders OR patients with CKD-5D.

DRUG CLASS: Urinary Ph Modifiers					**CATEGORY** Renal								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Sodium Citrate & Cit	Citric Acid/Sodium C	Solution	334-500	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sodium Citrate & Cit	Citric Acid/Sodium C	Solution	334-500	1	☐	☐	☐	☐	☐	☐	☐	☐	
K-Phos Neutral	Phosphorus #1	Tablet	250 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Urocit-K	Potassium Citrate	Tablet Er	10 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Urocit-K	Potassium Citrate	Tablet Er	10 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	
Urocit-K	Potassium Citrate	Tablet Er	15 Meq	1	☐	☐	☐	☐	☐	☐	☐	☐	
Urocit-K	Potassium Citrate	Tablet Er	5 MEQ	1	☐	☐	☐	☐	☐	☐	☐	☐	

THERAPEUTIC CATEGORY
Rheumatology

DRUG CLASS: / Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
	Alkylating Agents			CATEGORY	Rheumatology								
Droxia	Hydroxyurea	Capsule	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Droxia	Hydroxyurea	Capsule	300 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Droxia	Hydroxyurea	Capsule	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
	Anti-Arthritic, Folate Antagonist Agents			CATEGORY	Rheumatology								
Methotrexate	Methotrexate Sodiu	Tab Ds Pk	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
	Anti-Inflammatory Tumor Necrosis Factor Inhibit			CATEGORY	Rheumatology								
Humira	Adalimumab	Pen Ij Kit	40MG/0 .8ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure to adequate trial of DMARD therapy. Restricted to specialty pharmacy.

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Humira	Adalimumab	Syringekit	20MG/0.4ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure to adequate trial of DMARD therapy. Restricted to specialty pharmacy.
Humira	Adalimumab	Syringekit	40MG/0.8ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure to adequate trial of DMARD therapy. Restricted to specialty pharmacy.
Enbrel	Etanercept	Pen Injctr	50 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure to adequate trial of DMARD therapy. Restricted to specialty pharmacy.
Enbrel	Etanercept	Syringe	25MG/0.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure to adequate trial of DMARD therapy. Restricted to specialty pharmacy.

Enbrel	Etanercept	Syringe	50 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure to adequate trial of DMARD therapy. Restricted to specialty pharmacy.
Enbrel	Etanercept	Vial	25 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Reserved for treatment failure to adequate trial of DMARD therapy. Restricted to specialty pharmacy.
Simponi	Golimumab	Pen Injctr	100 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA, PsA, AS, and UC: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy

Simponi	Golimumab	Pen Injctr	50MG/0.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA, PsA, AS, and UC: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy
Simponi	Golimumab	Syringe	100 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA, PsA, AS, and UC: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy
Simponi	Golimumab	Syringe	50MG/0.5ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA, PsA, AS, and UC: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy

DRUG CLASS:	Anti-Inflammatory, Pyrimidine Synthesis Inhibitor				**CATEGORY** Rheumatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Arava	Leflunomide	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Arava	Leflunomide	Tablet	20 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Anti-Inflammatory/Antiarthritics Agents, Misc.				**CATEGORY** Rheumatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Hyalgan	Hyaluronate Sodium	Syringe	10 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Hyalgan	Hyaluronate Sodium	Syringe	10 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Hyalgan	Hyaluronate Sodium	Syringe	10 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Orthovisc	Hyaluronate Sodium	Syringe	30 MG/2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Hyalgan	Hyaluronate Sodium	Vial	10 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Synvisc	Hylan G-F 20	Syringe	16MG/2 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Synvisc-One	Hylan G-F 20	Syringe	48 MG/6 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
DRUG CLASS:	Disease-Modifying Antirheumatic Agents				**CATEGORY** Rheumatology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Otezla	Apremilast	Tab Ds Pk	10-20-30Mg	1	☐	☑	☐	☐	☐	☐	☐	☑	Pa Required. Reserved For Patients With Pso Or Psa Who Have Tried An Adequate Trial Of Oral Dmard But Cannot Use Biologics (E.G. History Of Severe Infection, Etc). Restricted To Specialty Pharmacy.

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Otezla	Apremilast	Tab Ds Pk	10-20-30Mg	1	☐	☑	☐	☐	☐	☐	☐	☑	Pa Required. Reserved For Patients With Pso Or Psa Who Have Tried An Adequate Trial Of Oral Dmard But Cannot Use Biologics (E.G. History Of Severe Infection, Etc). Restricted To Specialty Pharmacy.
Otezla	Apremilast	Tablet	30 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	PA required. Reserved for patients with PsO or PsA who have tried an adequate trial of oral DMARD but cannot use biologics (e.g. history of severe infection, etc). Restricted to specialty pharmacy.

Xeljanz	Tofacitinib Citrate	Tablet	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Third-line treatment for RA: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent AND 1 second-line agent. Restricted to specialty pharmacy.

DRUG CLASS:	Gold Salts				**CATEGORY**	Rheumatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ridaura	Auranofin	Capsule	3 MG	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704.

DRUG CLASS:	Interleukin-6 (Il-6) Receptor Inhibitors				**CATEGORY**	Rheumatology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

Actemra	Tocilizumab	Syringe	162 MG/0.9	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy.
Actemra	Tocilizumab	Vial	200MG/ 10ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy.
Actemra	Tocilizumab	Vial	400MG/ 20ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy.

Actemra	Tocilizumab	Vial	80 MG/4 ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Second-line treatment for RA: Reserved for patients who qualify for biologic with treatment failure to at least 1 first-line agent. Restricted to specialty pharmacy.

THERAPEUTIC CATEGORY
Sedative, Non-Barbiturate

DRUG CLASS: Sedative-Hypnotics,Non-Barbiturate **CATEGORY** Sedative, Non-Barbiturate

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Lunesta	Eszopiclone	Tablet	1 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 75 days.
Lunesta	Eszopiclone	Tablet	2 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 75 days.
Lunesta	Eszopiclone	Tablet	3 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 60 tablets per 75 days.

THERAPEUTIC CATEGORY
Streptomycins

DRUG CLASS: Vancomycin And Derivatives					CATEGORY Streptomycins								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Firvanq	Vancomycin Hcl	Soln Recon	25 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	300mL bottle only - PA required. Reserved for Clostridium difficile infections as evidenced by C. difficile toxin assay or C. difficile DNA PCR.
Firvanq	Vancomycin Hcl	Soln Recon	50 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for Clostridium difficile infections as evidenced by C. difficile toxin assay or C. difficile DNA PCR.

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THERAPEUTIC CATEGORY
Systemic Contraceptives

DRUG CLASS: Brand Name	Contraceptives,Oral Generic Name	Formulation	Strength	Tier	CATEGORY Systemic Contraceptives PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Juleber	Desogestrel-Ethinyl	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyred	Desogestrel-Ethinyl	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fallback Solo	Levonorgestrel	Tablet	1.5 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	
Opcicon One-Step	Levonorgestrel	Tablet	1.5 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	
Delyla	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Larissia	Levonorgestrel-Ethi	TABLET	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lillow	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	6-5-10	1	☐	☐	☐	☐	☐	☐	☐	☐	
Sharobel	Norethindrone	Tablet	0.35 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	
Lyza	Norethindrone	Tablet	0.35 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norlyroc	Norethindrone	Tablet	0.35 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Deblitane	Norethindrone	Tablet	0.35 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	
Larin	Norethindrone Ac-Et	Tablet	1.5-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐	
Larin	Norethindrone Ac-Et	Tablet	1Mg-20	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norethindron-Ethin	Norethindrone Ac-Et	Tablet	1Mg-20	1	☐	☐	☐	☐	☐	☐	☐	☐	
Blisovi Fe	Norethindrone-E.Est	Tablet	1.5-30(2	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norethin-Eth Estra F	Norethindrone-E.Est	Tablet	1Mg-20(	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tarina Fe	Norethindrone-E.Est	Tablet	1Mg-20(	1	☐	☐	☐	☐	☐	☐	☐	☐	
Blisovi Fe	Norethindrone-E.Est	Tablet	1Mg-20(	1	☐	☐	☐	☐	☐	☐	☐	☐	
Femynor	Norgestimate-Ethinyl Estradiol	Tablet	0.25-0.035	1	☐	☐	☐	☐	☐	☐	☐	☐	Quantity limit of 13 cycles per year.
Tri-Lo-Sprintec	Norgestimate-Ethiny	Tablet	7Daysx3	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tri-Lo-Marzia	Norgestimate-Ethiny	Tablet	7Daysx3	1	☐	☐	☐	☐	☐	☐	☐	☐	
Tri-Lo-Estarylla	Norgestimate-Ethiny	Tablet	7Daysx3	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norgestimate-Ethin	Norgestimate-Ethiny	Tablet	7Daysx3	1	☐	☐	☐	☐	☐	☐	☐	☐	

THERAPEUTIC CATEGORY
Tb Preparations

DRUG CLASS: Antitubercular Antibiotics					CATEGORY Tb Preparations								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Sirturo	Bedaquiline Fumarate	Tablet	100 Mg	1	☐	☑	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity.
Priftin	Rifapentine	Tablet	150 Mg	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 128 tablets per 180 days.

THERAPEUTIC CATEGORY
Tetracyclines

DRUG CLASS: Tetracyclines					CATEGORY Tetracyclines								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Adoxa	Doxycycline Monohy	Tablet	100 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Topical Nasal And Otic Prepartions

DRUG CLASS: Nasal Anti-Inflammatory Steroids **CATEGORY** Topical Nasal And Otic Prepartions

Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Qnasl	Beclomethasone Dipropionate	Hfa Aer Ad	80 MCG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to an adequate trial (7-14 days) of any 2 (two) first-line agents (fluticasone, budesonide, triamcinolone) AND flunisolide.
Allergy Relief	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Allergy Relief	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
24 Hour Allergy	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluticasone Propion	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Clarispray	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluticasone Propion	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Allergy Relief	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Fluticasone Propion	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Flonase Allergy Reli	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Fluticasone Propion	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children 24 Hr Aller	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Children'S Flonase A	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
24 Hour Allergy Reli	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Aller-Flo	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Allergy Relief	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐
Fluticasone Propion	Fluticasone Propiona	Spray Susp	50 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐

THERAPEUTIC CATEGORY
Unclassified Drug Product

DRUG CLASS: - / Brand Name	Generic Name	Formulation	Strength	Tier	CATEGORY Unclassified Drug Product PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Dupixent	Dupilumab	Syringe	300 MG/2ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Must be prescribed by an allergist or pulmonologist for either atopic dermatitis, eosinophilic asthma, or oral corticosteroid dependent asthma. See Asthma & COPD coverage policy for further details.
Linzess	Linaclotide	CAPSULE	72 MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Linzess is reserved for patients with treatment failure of properly titrated and regularly scheduled dosing of polyethylene glycol for 2 months (as evidenced by prescription history fills) AND two of the following: bisacodyl, Senna, psyllium,

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DRUG CLASS: AGENTS TO TREAT MULTIPLE SCLEROSIS					**CATEGORY** Unclassified Drug Product								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ocrevus	Ocrelizumab	VIAL	300MG/ 10ML	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Patient must have chart notes showing a diagnosis of Multiple Sclerosis and prescription must be written by a neurologist. For patients with Primary Progressive Multiple Sclerosis (PPMS), this will be considered a first line agent. For diagn

DRUG CLASS: Dietary Supplement, Miscellaneous					**CATEGORY** Unclassified Drug Product								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Liquacel	Amino Ac/Protein Hydr/Whey Pro	Liq Md Pmp	16 G-90/30	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Liquacel	Amino Ac/Protein Hydr/Whey Pro	Liquid	16 G-90/30	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.

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Liquacel	Amino Ac/Protein Hydr/Whey Pro	Liquid Pkt	16 G-90/30	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Procel Whey Protein	Amino Ac/Whey Prot Conc, Isol	Powder	15G-110/25	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pro-Stat Renal Care	Amino Acids/Protein Hydr/Fiber	Liquid	15G-100/30	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
Pro-Stat Sugar Free	Amino Acids/Protein Hydrolys	Liquid	15G-100/30	1	☑	☐	☐	☐	☐	☐	☐	☐	PA Required. See criteria listed in PH19 - Nutritional Supps. For Medical Conditions.
DRUG CLASS:	Drugs To Tx Chronic Inflamm. Disease Of Colon				**CATEGORY**	Unclassified Drug Product							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Renflexis	Infliximab-Abda	Vial	100 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Rheumatoid Arthritis, Psoriasis, Psoriatic Arthritis, Chronic Bowel Disease: Reserved for treatment failure to 12 weeks of dose-optimized, oral DMARD therapy. If patient is unable to tolerate one oral DMARD, a second oral DMARD must be tried.
Inflectra	Infliximab-Dyyb	Vial	100 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA required. Rheumatoid Arthritis, Psoriasis, Psoriatic Arthritis, Chronic Bowel Disease: Reserved for treatment failure to 12 weeks of dose-optimized, oral DMARD therapy. If patient is unable to tolerate one oral DMARD, a second oral DMARD must be tried.
DRUG CLASS:	Fibromyalgia Agents,Serotonin-Norepineph Ru In				**CATEGORY**	Unclassified Drug Product							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Savella	Milnacipran Hcl	Tab Ds Pk	12.5-25-50	1	☑	☐	☐	☑	☐	☐	☐	☐	PA required. Reserved for treatment failure or documented intolerance to optimally dosed Venlafaxine IR/XR and Duloxetine for two months each. Limited to 1 titration pack per 180 days.

DRUG CLASS:	Interleukin-6 (Il-6) Receptor Inhibitors				**CATEGORY**	Unclassified Drug Product							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Kevzara	Sarilumab	Syringe	150Mg/1.14	1	☑	☐	☐	☐	☐	☐	☐	☑	PA Required. Reserved for treatment of Rheumatoid Arthritis, ttreatment failure to 12 weeks of dose-optimized, oral DMARD therapy (Methotrexate 15-25mg/week, Leflunomide, Hydroxychloroquine, Sulfasalazine, Azathioprine). If patient is unable to tolerate o

Kevzara	Sarilumab	Syringe	200Mg/ 1.14	1	☑	☐	☐	☐	☐	☐	☐	☑	PA Required. Reserved for treatment of Rheumatoid Arthritis, ttreatment failure to 12 weeks of dose-optimized, oral DMARD therapy (Methotrexate 15-25mg/week, Leflunomide, Hydroxychloroquine, Sulfasalazine, Azathioprine). If patient is unable to tolerate o
DRUG CLASS:	Iv Fat Emulsions				**CATEGORY**	Unclassified Drug Product							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Nutrilipid	Fat Emulsions	Emulsion	20 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

Intralipid	Fat Emulsions	Emulsion	20 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.
Intralipid	Fat Emulsions	Emulsion	30 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval Is Determined By Medical Necessity Criteria. Fax Pa Form And Supporting Info To Hpsj At 209-762-4704. This Medication May Be Restricted To Specialty Pharmacy.

DRUG CLASS:	Phodiesterase-4 (Pde4) Inhibitors				**CATEGORY**	Unclassified Drug Product							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Daliresp	Roflumilast	Tablet	250 MCG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA required. Reserved for patients with GOLD Grade 4, Group D who have failed treatment or are intolerant to high dose ICS+LABA+LAMA in the past 12 weeks. Limited to 30 tablets per 365 days.

DRUG CLASS:	Platelet Reducing Agents				**CATEGORY**	Unclassified Drug Product							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Anagrelide Hcl	Anagrelide Hcl	Capsule	0.5 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	
Agrylin	Anagrelide Hcl	Capsule	0.5 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	
Anagrelide Hcl	Anagrelide Hcl	Capsule	1 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS:	Water				**CATEGORY**	Unclassified Drug Product							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Water	Water For Injection,Sterile	Iv Soln		1	☐	☐	☐	☐	☐	☐	☐	☐	Limited to a 7 day supply fill at at time.

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THERAPEUTIC CATEGORY
Urology

DRUG CLASS: Antidiuretic And Vasopressor Hormones					CATEGORY Urology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ddavp	Desmopressin Acetate	Tablet	0.1 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to failing a 3-month trial of behavioral therapy with bed-wetting alarm. the nasal spray is no longer recommended due to hyponatremia risk.
Ddavp	Desmopressin Acetate	Tablet	0.2 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to failing a 3-month trial of behavioral therapy with bed-wetting alarm. the nasal spray is no longer recommended due to hyponatremia risk.
DRUG CLASS: Benign Prostatic Hypertrophy/Micturition Agents					**CATEGORY** Urology								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Uroxatral	Alfuzosin Hcl	Tab Er 24H	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Proscar	Finasteride	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Tamsulosin Hcl	Tamsulosin Hcl	Cap Er 24H	0.4 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Beta-3-Adrenergic Agonists				**CATEGORY**	Urology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Myrbetriq	Mirabegron	Tab Er 24H	25 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Step to intolerance or treatment failure of: 1) Oxybutynin immediate-release (except those over 65); 2) Oxybutynin extended-release, and; 3) Sanctura XR
Myrbetriq	Mirabegron	Tab Er 24H	50 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	Step to intolerance or treatment failure of: 1) Oxybutynin immediate-release (except those over 65); 2) Oxybutynin extended-release, and; 3) Sanctura XR
DRUG CLASS:	Urinary Tract Analgesic Agents				**CATEGORY**	Urology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Elmiron	Pentosan Polysulfate	Capsule	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Urinary Tract Anesthetic/Analgesic Agnt (Azo-Dye				**CATEGORY**	Urology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Phenazopyridine Hc	Phenazopyridine Hcl	Tablet	100 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Phenazopyridine Hc	Phenazopyridine Hcl	Tablet	200 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Urinary Tract Antispasmodic, M(3) Selective Anta				**CATEGORY**	Urology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Enablex	Darifenacin Hydrobromide	Tab Er 24H	15 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER, and Trospium IR (unless over 65) or XR in the past 365 days.
Enablex	Darifenacin Hydrobromide	Tab Er 24H	7.5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER, and Trospium IR (unless over 65) or XR in the past 365 days.

Vesicare	Solifenacin Succinate	Tablet	10 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER, Trospium IR (unless over 65) or XR, Detrol LA and Enablex.
Vesicare	Solifenacin Succinate	Tablet	5 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER, Trospium IR (unless over 65) or XR, Detrol LA and Enablex.
DRUG CLASS:	Urinary Tract Antispasmodic/Antiincontinence Ag				**CATEGORY**	Urology							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Toviaz	Fesoterodine Fumarate	Tab Er 24H	4 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER, Trospium IR (unless over 65) or XR, Detrol LA and Enablex.

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Toviaz	Fesoterodine Fumarate	Tab Er 24H	8 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER, Trospium IR (unless over 65) or XR, Detrol LA and Enablex.
Gelnique	Oxybutynin	Gel Md Pmp	28MG/0 .92G	1	☑	☐	☑	☐	☐	☐	☐	☐	Restricted to 1 pump unit per 30 days
Gelnique	Oxybutynin Chloride	Gel Packet	0.1	1	☑	☐	☑	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of Oxybutynin immediate-release (within last 180 days) or patients over 65 years of age.
Oxybutynin Chlorid	Oxybutynin Chloride	Syrup	5 MG/5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Oxybutynin Chloride Er	Oxybutynin Chloride	Tab Er 24	10 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of Oxybutynin immediate-release (within last 180 days) or patients over 65 years of age.

Oxybutynin Chloride Er	Oxybutynin Chloride	Tab Er 24	15 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of Oxybutynin immediate-release (within last 180 days) or patients over 65 years of age.
Oxybutynin Chloride Er	Oxybutynin Chloride	Tab Er 24	5 MG	1	☐	☑	☐	☐	☐	☐	☐	☐	Step therapy to intolerance or treatment failure of Oxybutynin immediate-release (within last 180 days) or patients over 65 years of age.
Oxybutynin Chlorid	Oxybutynin Chloride	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Detrol La	Tolterodine Tartrate	Cap Er 24H	2 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER, and Trospium IR (unless over 65) or XR in the past 365 days.

Detrol La	Tolterodine Tartrate	Cap Er 24H	4 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER, and Trospium IR (unless over 65) or XR in the past 365 days.
Sanctura Xr	Trospium Chloride	Cap Er 24H	60 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for treatment failure or intolerance to Oxybutynin IR (unless over 65), Oxybutynin ER and Trospium IR (unless over 65) in the past 365 days.

THERAPEUTIC CATEGORY
Vaccines

DRUG CLASS: Brand Name	Antisera Generic Name	Formulation	Strength	Tier	CATEGORY Vaccines PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
Cytogam	Cytomegalovirus Immune Glob	Vial	50 MG/ML	1	☐	☑	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Hepagam B	Hepatitis B Immun Glob/Maltose	Vial	>312/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Hepagam B	Hepatitis B Immun Glob/Maltose	Vial	>312/ML(5)	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

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Hyperhep B S-D	Hepatitis B Immune Globulin	Syringe	220 UNIT/1	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Hyperhep B S-D	Hepatitis B Immune Globulin	Vial	220/ML (5)	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Flebogamma	Immune Globulin,Gamma(Igg)	Vial	0.05	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Flebogamma	Immune Globulin,Gamma(Igg)	Vial	0.05	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gammagard Liquid	Immune Globulin,Gamma(Igg)	Vial	0.1	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gammagard Liquid	Immune Globulin,Gamma(Igg)	Vial	0.1	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Gammagard Liquid	Immune Globulin,Gamma(Igg)	Vial	0.1	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gammagard Liquid	Immune Globulin,Gamma(Igg)	Vial	0.1	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gammagard S-D	Immune Globulin,Gamma(Igg)	Vial	10 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Gammagard S-D	Immune Globulin,Gamma(Igg)	Vial	10 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Carimune Nf Nanofiltered	Immune Globulin,Gamma(Igg)	Vial	12G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gamastan S-D	Immune Globulin,Gamma(Igg)	Vial	15 %-18 %	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Gammagard S-D	Immune Globulin,Gamma(Igg)	Vial	2.5 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gammagard S-D	Immune Globulin,Gamma(Igg)	Vial	5 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Gammagard S-D	Immune Globulin,Gamma(Igg)	Vial	5 G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Carimune Nf Nanofiltered	Immune Globulin,Gamma(Igg)	Vial	6G	1	☑	☐	☐	☐	☐	☐	☐	☐	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Atgam	Lymphocyte Immune Globulin	Ampul	50 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Hyperrab S-D	Rabies Immune Globulin/Pf	Vial	150 UNIT/1	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy

Hyperrab S-D	Rabies Immune Globulin/Pf	Vial	150 UNIT/1	1	☑	☐	☐	☐	☐	☐	☐	☑	Approval is determined by medical necessity criteria. Fax PA form and supporting info to HPSJ at 209-762-4704. Restricted to Specialty Pharmacy
Rhogam Ultra-Filtered Plus	Rho(D) Immune Globulin	Syringe	1500 UNIT	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.
Rhogam Ultra-Filtered Plus	Rho(D) Immune Globulin	Syringe	1500 UNIT	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.
Rhophylac	Rho(D) Immune Globulin	Syringe	1500/2 ML	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.
Micrhogam Ultra-Filtered Plus	Rho(D) Immune Globulin	Syringe	250 UNIT	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.
Micrhogam Ultra-Filtered Plus	Rho(D) Immune Globulin	Syringe	250 UNIT	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.
Winrho Sdf	Rho(D) Immune Globulin/Maltose	Vial	1500/1.3ML	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.
Winrho Sdf	Rho(D) Immune Globulin/Maltose	Vial	15000/13ML	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.

Winrho Sdf	Rho(D) Immune Globulin/Maltose	Vial	2500/2.2ML	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.
Winrho Sdf	Rho(D) Immune Globulin/Maltose	Vial	5000/4.4ML	1	☐	☐	☐	☑	☐	☐	☐	☐	Limited to 2 fills per 365 days.

THERAPEUTIC CATEGORY
Vasodilators Coronary

DRUG CLASS: - **CATEGORY** Vasodilators Coronary													
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Xeljanz Xr	Tofacitinib Citrate	Tab Er 24H	11 Mg	1	☑	☐	☐	☐	☐	☐	☐	☑	PA REQUIRED. THIRD-LINE AGENT FOR RA: RESERVED FOR TREATMENT FAILURE TO 1 FIRST-LINE BIOLOGIC AND 1 SECOND-LINE BIOLOGIC. RESTRICTED TO SPECIALTY PHARMACY.

DRUG CLASS: Gold Salts **CATEGORY** Vasodilators Coronary													
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ridaura	Auranofin	Capsule	3 Mg	1	☐	☐	☐	☐	☐	☐	☐	☐	

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THERAPEUTIC CATEGORY
Vitamins, Fat Soluble

DRUG CLASS:	Vitamin D Preparations				**CATEGORY** Vitamins, Fat Soluble								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Thera-D	Cholecalciferol (Vita	Tablet	2000 U	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vitamin D3	Cholecalciferol (Vita	Tablet	5000 U	1	☐	☐	☐	☐	☐	☐	☐	☐	

THERAPEUTIC CATEGORY
Water Soluble Vitamins

DRUG CLASS:	Vitamin B12 Preparations				**CATEGORY** Water Soluble Vitamins								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Cyanocobalamin Injection	Cyanocobalamin (Vitamin B-12)	Vial	1000Mcg/Ml	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to 1 vial per 28 days.

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THERAPEUTIC CATEGORY
Wellness

DRUG CLASS: Fat Absorption Decreasing Agents					CATEGORY Wellness								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Xenical	Orlistat	Capsule	120 MG	1	☑	☐	☐	☐	☐	☐	☐	☐	PA required. Reserved for individuals who have received exercise and dietary counseling at least twice by a registered dietitian AND one of the following: [1] BMI of ≥ 27 with 2 or more comorbidities OR [2] BMI > 30.

DRUG CLASS: Prenatal Vitamin Preparations					CATEGORY Wellness								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Trimesis Rx	Pnv W-O Iron/Fa/Ca	Tbmp 24Hr	1-200-7	1	☐	☐	☐	☐	☐	☐	☐	☐	
Trimesis Rx	Pnv W-O Iron/Fa/Ca	Tbmp 24Hr	1-200-7	1	☐	☐	☐	☐	☐	☐	☐	☐	

DRUG CLASS: Smoking Deterrent Agents (Ganglionic Stim,Other					CATEGORY Wellness								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Nicotrol	Nicotine	Cartridge	10 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Patch	Nicotine	Patch Dysq	21-14-7MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Patch	Nicotine	Patch Td24	11MG/24HR	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Patch	Nicotine	Patch Td24	14MG/24HR	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Patch	Nicotine	Patch Td24	21 MG/24HR	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.

Nicotine Patch	Nicotine	Patch Td24	21 MG/24HR	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Patch	Nicotine	Patch Td24	22 MG/24HR	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Patch	Nicotine	Patch Td24	7MG/24 HR	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotrol Ns	Nicotine	Spray	10 MG/ML	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Thrive Nicotine	Nicotine Polacrilex	Gum	2 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.

Thrive Nicotine	Nicotine Polacrilex	Gum	2 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Thrive Nicotine	Nicotine Polacrilex	Gum	2 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Thrive Nicotine	Nicotine Polacrilex	Gum	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Thrive Nicotine	Nicotine Polacrilex	Gum	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Thrive Nicotine	Nicotine Polacrilex	Gum	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.

Nicotine Lozenge	Nicotine Polacrilex	Lozenge	2 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Lozenge	Nicotine Polacrilex	Lozenge	2 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Lozenge	Nicotine Polacrilex	Lozenge	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Nicotine Lozenge	Nicotine Polacrilex	Lozenge	4 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.

DRUG CLASS:	Smoking Deterrent-Nocotinic Recept.Partial Agoni				**CATEGORY**	Wellness							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Chantix	Varenicline Tartrate	Tab Ds Pk	0.5(11)-1	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.

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Chantix	Varenicline Tartrate	Tablet	0.5 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Chantix	Varenicline Tartrate	Tablet	1 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.
Chantix	Varenicline Tartrate	Tablet	1 MG	1	☐	☐	☑	☐	☐	☐	☐	☐	Limited to two 3-month courses of any smoking cessation agent per 365 days.

THERAPEUTIC CATEGORY
Women's Health

DRUG CLASS: / Brand Name	Generic Name	Formulation	Strength	Tier	PA	ST	QL	FL	AL	PL	GL	SP	Restrictions (if applicable)
DRUG CLASS: Contraceptives, Intravaginal, Systemic					CATEGORY Women's Health								
Nuvaring	Etonogestrel/Ethinyl	Vag Ring	.12-.015	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Contraceptives,Injectable					CATEGORY Women's Health								
Depo-Provera	Medroxyprogesteron	Syringe	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depo-Provera	Medroxyprogesteron	Vial	150 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Contraceptives,Intravaginal					CATEGORY Women's Health								
Vcf	Nonoxynol 9	Film	0.28	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vcf	Nonoxynol 9	Film	0.28	1	☐	☐	☐	☐	☐	☐	☐	☐	
Delfen Contraceptiv	Nonoxynol 9	Foam/Appl	0.125	1	☐	☐	☐	☐	☐	☐	☐	☐	
Conceptrol	Nonoxynol 9	Gel/Pf App	0.04	1	☐	☐	☐	☐	☐	☐	☐	☐	
Gynol Ii Extra Streng	Nonoxynol 9	Jelly/Appl	0.03	1	☐	☐	☐	☐	☐	☐	☐	☐	

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DRUG CLASS: Contraceptives,Oral					**CATEGORY** Women's Health								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Desogen	Desogestrel-Ethinyl	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desogen	Desogestrel-Ethinyl	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desogen	Desogestrel-Ethinyl	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desogen	Desogestrel-Ethinyl	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Desogen	Desogestrel-Ethinyl	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyclessa	Desogestrel-Ethinyl	Tablet	7 DAYS	1	☐	☐	☐	☐	☐	☐	☐	☐	
Cyclessa	Desogestrel-Ethinyl	Tablet	7 DAYS	1	☐	☐	☐	☐	☐	☐	☐	☐	
Kelnor 1-35	Ethynodiol D-Ethinyl	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐	
Kelnor 1-35	Ethynodiol D-Ethinyl	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐	
Zovia 1-50E	Ethynodiol D-Ethinyl	Tablet	1 MG-50	1	☐	☐	☐	☐	☐	☐	☐	☐	
Plan B One-Step	Levonorgestrel	Tablet	1.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Plan B One-Step	Levonorgestrel	Tablet	1.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Plan B One-Step	Levonorgestrel	Tablet	1.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.1-0.02	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Levonorgestrel-Eth	Levonorgestrel-Ethi	Tablet	0.15-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐

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Enpresse	Levonorgestrel-Ethi	Tablet	40334	1	☐	☐	☐	☐	☐	☐	☐	☐
Enpresse	Levonorgestrel-Ethi	Tablet	40334	1	☐	☐	☐	☐	☐	☐	☐	☐
Enpresse	Levonorgestrel-Ethi	Tablet	40334	1	☐	☐	☐	☐	☐	☐	☐	☐
Enpresse	Levonorgestrel-Ethi	Tablet	40334	1	☐	☐	☐	☐	☐	☐	☐	☐
Micronor	Norethindrone	Tablet	0.35 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Micronor	Norethindrone	Tablet	0.35 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Micronor	Norethindrone	Tablet	0.35 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Micronor	Norethindrone	Tablet	0.35 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Micronor	Norethindrone	Tablet	0.35 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Micronor	Norethindrone	Tablet	0.35 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Micronor	Norethindrone	Tablet	0.35 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Micronor	Norethindrone	Tablet	0.35 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Junel	Norethindrone Ac-Et	Tablet	1.5-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Junel	Norethindrone Ac-Et	Tablet	1.5-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Junel	Norethindrone Ac-Et	Tablet	1.5-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐

Junel	Norethindrone Ac-Et	Tablet	1.5-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethindron-Ethin	Norethindrone Ac-Et	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethindron-Ethin	Norethindrone Ac-Et	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethindron-Ethin	Norethindrone Ac-Et	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethindron-Ethin	Norethindrone Ac-Et	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐
Junel Fe	Norethindrone-E.Est	Tablet	1.5-30(2	1	☐	☐	☐	☐	☐	☐	☐	☐
Junel Fe	Norethindrone-E.Est	Tablet	1.5-30(2	1	☐	☐	☐	☐	☐	☐	☐	☐
Junel Fe	Norethindrone-E.Est	Tablet	1.5-30(2	1	☐	☐	☐	☐	☐	☐	☐	☐
Junel Fe	Norethindrone-E.Est	Tablet	1.5-30(2	1	☐	☐	☐	☐	☐	☐	☐	☐
Junel Fe	Norethindrone-E.Est	Tablet	1.5-30(2	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethin-Eth Estra F	Norethindrone-E.Est	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethin-Eth Estra F	Norethindrone-E.Est	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethin-Eth Estra F	Norethindrone-E.Est	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethin-Eth Estra F	Norethindrone-E.Est	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐
Norethin-Eth Estra F	Norethindrone-E.Est	Tablet	1MG-20	1	☐	☐	☐	☐	☐	☐	☐	☐

Ovcon-35	Norethindrone-Ethin	Tablet	0.4-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Ovcon-35	Norethindrone-Ethin	Tablet	0.4-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Ovcon-35	Norethindrone-Ethin	Tablet	0.4-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Ovcon-35	Norethindrone-Ethin	Tablet	0.4-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Ovcon-35	Norethindrone-Ethin	Tablet	0.4-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Ovcon-35	Norethindrone-Ethin	Tablet	0.4-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Modicon	Norethindrone-Ethin	Tablet	0.5-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Modicon	Norethindrone-Ethin	Tablet	0.5-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Modicon	Norethindrone-Ethin	Tablet	0.5-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐

Ortho-Novum	Norethindrone-Ethin	Tablet	1 MG-35	1	☐	☐	☐	☐	☐	☐	☐	☐
Aranelle	Norethindrone-Ethin	Tablet	38542	1	☐	☐	☐	☐	☐	☐	☐	☐
Aranelle	Norethindrone-Ethin	Tablet	38542	1	☐	☐	☐	☐	☐	☐	☐	☐
Necon	Norethindrone-Ethin	Tablet	42288	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	7 DAYS	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	7 DAYS	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	7 DAYS	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	7 DAYS	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	7 DAYS	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Ethin	Tablet	7 DAYS	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Mest	Tablet	1 MG-50	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Novum	Norethindrone-Mest	Tablet	1 MG-50	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Cyclen	Norgestimate-Ethiny	Tablet	0.25-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Cyclen	Norgestimate-Ethiny	Tablet	0.25-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Cyclen	Norgestimate-Ethiny	Tablet	0.25-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐

Ortho-Cyclen	Norgestimate-Ethiny	Tablet	0.25-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Cyclen	Norgestimate-Ethiny	Tablet	0.25-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho-Cyclen	Norgestimate-Ethiny	Tablet	0.25-0.0	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho Tri-Cyclen	Norgestimate-Ethiny	Tablet	7DAYSX	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho Tri-Cyclen	Norgestimate-Ethiny	Tablet	7DAYSX	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho Tri-Cyclen	Norgestimate-Ethiny	Tablet	7DAYSX	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho Tri-Cyclen	Norgestimate-Ethiny	Tablet	7DAYSX	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho Tri-Cyclen	Norgestimate-Ethiny	Tablet	7DAYSX	1	☐	☐	☐	☐	☐	☐	☐	☐
Ortho Tri-Cyclen	Norgestimate-Ethiny	Tablet	7DAYSX	1	☐	☐	☐	☐	☐	☐	☐	☐
Lo-Ovral-28	Norgestrel-Ethinyl E	Tablet	0.3-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Lo-Ovral-28	Norgestrel-Ethinyl E	Tablet	0.3-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Lo-Ovral-28	Norgestrel-Ethinyl E	Tablet	0.3-0.03	1	☐	☐	☐	☐	☐	☐	☐	☐
Ogestrel	Norgestrel-Ethinyl E	Tablet	0.5 MG-	1	☐	☐	☐	☐	☐	☐	☐	☐
Ella	Ulipristal Acetate	Tablet	30 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

DRUG CLASS: Contraceptives,Transdermal					CATEGORY Women's Health								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Ortho Evra	Norelgestromin/Ethi	Patch Tdwk	150-35/	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Estrogen/Androgen Combinations					**CATEGORY** Women's Health								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Estratest H.S.	Estrogen,Ester/Me-T	Tablet	0.625-1.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Estratest H.S.	Estrogen,Ester/Me-T	Tablet	0.625-1.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Estratest H.S.	Estrogen,Ester/Me-T	Tablet	0.625-1.	1	☐	☐	☐	☐	☐	☐	☐	☐	
Estratest	Estrogen,Ester/Me-T	Tablet	1.25-2.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Estratest	Estrogen,Ester/Me-T	Tablet	1.25-2.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
Estratest	Estrogen,Ester/Me-T	Tablet	1.25-2.5	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS: Estrogenic Agents					**CATEGORY** Women's Health								
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Vivelle-Dot	Estradiol	Patch Tdsw	.025MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vivelle-Dot	Estradiol	Patch Tdsw	.025MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vivelle-Dot	Estradiol	Patch Tdsw	.0375M	1	☐	☐	☐	☐	☐	☐	☐	☐	

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Vivelle-Dot	Estradiol	Patch Tdsw	.0375M	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	.075MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	.075MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	.075MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	0.05MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	0.05MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	0.05MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	0.1MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	0.1MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Vivelle-Dot	Estradiol	Patch Tdsw	0.1MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Estradiol	Estradiol	Patch Tdwk	.025MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Estradiol	Estradiol	Patch Tdwk	.0375M	1	☐	☐	☐	☐	☐	☐	☐	☐
Estradiol	Estradiol	Patch Tdwk	.075MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Estradiol	Estradiol	Patch Tdwk	0.05MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Estradiol	Estradiol	Patch Tdwk	0.06MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Estradiol	Estradiol	Patch Tdwk	0.1MG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Menostar	Estradiol	Patch Tdwk	14MCG/	1	☐	☐	☐	☐	☐	☐	☐	☐
Estradiol	Estradiol	Tablet	0.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Estradiol	Estradiol	Tablet	1 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Estradiol	Estradiol	Tablet	2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Climara Pro	Estradiol/Levonorge	Patch Tdwk	45-15/2	1	☐	☐	☐	☐	☐	☐	☐	☐
Prempro	Estrogen,Con/M-Pro	Tablet	0.3-1.5	1	☐	☐	☐	☐	☐	☐	☐	☐
Prempro	Estrogen,Con/M-Pro	Tablet	0.45-1.5	1	☐	☐	☐	☐	☐	☐	☐	☐
Premphase	Estrogen,Con/M-Pro	Tablet	0.625 (1	1	☐	☐	☐	☐	☐	☐	☐	☐
Prempro	Estrogen,Con/M-Pro	Tablet	0.625-2.	1	☐	☐	☐	☐	☐	☐	☐	☐
Prempro	Estrogen,Con/M-Pro	Tablet	0.625-5	1	☐	☐	☐	☐	☐	☐	☐	☐
Premarin	Estrogens, Conjugate	Tablet	0.3 MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Premarin	Estrogens, Conjugate	Tablet	0.45MG	1	☐	☐	☐	☐	☐	☐	☐	☐
Premarin	Estrogens, Conjugate	Tablet	0.625 M	1	☐	☐	☐	☐	☐	☐	☐	☐
Premarin	Estrogens, Conjugate	Tablet	0.9 MG	1	☐	☐	☐	☐	☐	☐	☐	☐

Premarin	Estrogens, Conjugate	Tablet	1.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Menest	Estrogens,Esterified	Tablet	0.3 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Menest	Estrogens,Esterified	Tablet	0.625 M	1	☐	☐	☐	☐	☐	☐	☐	☐	
Menest	Estrogens,Esterified	Tablet	1.25 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Menest	Estrogens,Esterified	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ogen	Estropipate	Tablet	0.75 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ogen	Estropipate	Tablet	1.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Ogen	Estropipate	Tablet	3 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Jinteli	Norethindrone Ac-Et	Tablet	1MG-5M	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Oxytocics				**CATEGORY**	Women's Health							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Methergine	Methylergonovine M	Tablet	0.2 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
DRUG CLASS:	Progestational Agents				**CATEGORY**	Women's Health							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**

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Makena	Hydroxyprogesterone Caproate	Vial	250 MG/ML	1	☑	☐	☑	☐	☐	☐	☐	☑	Reserved for women with history of singleton pregnancy with history of preterm birth (less than 37 weeks). Therapy must be initiated between 16 weeks, 0 days and 23 weeks, 6 days. Limited to 5 mL per 35 days.
Provera	Medroxyprogesteron	Tablet	10 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Provera	Medroxyprogesteron	Tablet	2.5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Provera	Medroxyprogesteron	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Depo-Provera	Medroxyprogesteron	Vial	400 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Norethindrone Acet	Norethindrone Aceta	Tablet	5 MG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Progesterone	Progesterone	Vial	50 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA REQUIRED. RESERVED FOR WOMEN WITH HISTORY OF 2 MISCARRIAGES.

Progesterone	Progesterone	Vial	50 MG/ML	1	☑	☐	☐	☐	☐	☐	☐	☐	PA REQUIRED. RESERVED FOR WOMEN WITH HISTORY OF 2 MISCARRIAGES.
Prometrium	Progesterone,Micronized	Capsule	100 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA REQUIRED. RESERVED FOR PREGNANCY WITH HISTORY OF PRE-TERM BIRTH, SHORT CERVIX (< 25mm), OR HISTORY OF 2 MISCARRIAGES.
Prometrium	Progesterone,Micronized	Capsule	200 MG	1	☑	☐	☑	☐	☐	☐	☐	☐	PA REQUIRED. RESERVED FOR PREGNANCY WITH HISTORY OF PRE-TERM BIRTH, SHORT CERVIX (< 25mm), OR HISTORY OF 2 MISCARRIAGES.
DRUG CLASS:	Vaginal Estrogen Preparations				**CATEGORY**	Women's Health							
Brand Name	**Generic Name**	**Formulation**	**Strength**	**Tier**	**PA**	**ST**	**QL**	**FL**	**AL**	**PL**	**GL**	**SP**	**Restrictions (if applicable)**
Estrace	Estradiol	Cream/Appl	0.0001	1	☐	☐	☐	☐	☐	☐	☐	☐	
Vagifem	Estradiol	Tablet	10 MCG	1	☐	☐	☐	☐	☐	☐	☐	☐	
Premarin	Estrogens, Conjugate	Cream/Appl	0.625 M	1	☐	☐	☐	☐	☐	☐	☐	☐	

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