



CareSource Healthy Indiana Plan (HIP) Basic

07/01/2019

INTRODUCTION

* Por favor, consulte las páginas 5-8, para ver la versión en español.

We are pleased to offer the 2019 **CareSource Medicaid Formulary** as a guide to help you. This list can help medical providers in picking clinically-appropriate and lower priced products for their patients. All Indiana Medicaid drugs are covered by CareSource. But this is a list of preferred drugs.

The drugs listed have been reviewed by a National Pharmacy and Therapeutics (P&T) Committee. The list is then approved by a local Pharmacy and Therapeutics (P&T) Committee for inclusion. The list reflects up-to-date medical practice at the time of review.

The data in this list and its appendices is supplied to assist medical providers. We do not warrant or assure accuracy of the data. It is also not meant to be complete in nature. This list is not meant to be a substitute for the knowledge, expertise, skill and judgment of the medical provider in his or her choice of prescription drugs. All the data in the list is provided as a guide for drug therapy choice. Specific drug choice for a unique patient rests fully with the prescriber.

The list is subject to state-specific laws and rules. This can include, but is not limited to, those about generic substitution, controlled substance schedules, preference for brands and mandatory generics when it applies.

We take no responsibility for the actions or gaps of any medical provider based on trust, in whole or in part, on the data contained in this list. The medical provider should review the drug maker's product information or standard references for details.

National standards can be found on the National Guideline Clearinghouse site at <http://www.guideline.gov>, on the websites listed under each therapeutic class and on the sites listed in the WEBSITES section of this list.

PREFACE

The list is set up in sections. Each section is split up by therapeutic drug class primarily defined by mechanism of action. Products are listed by generic name if available with brand name listed for information only. Unless the cited drug can be taken as an injection or a special case is noted, usually, all dosage forms and strengths of the drug cited are part of the list.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

The services of an independent National Pharmacy and Therapeutics (P&T) Committee are used to approve safe and clinically effective drug therapies. The P&T Committee is an outside panel of experts from across the United States. The P&T Committee's voters include physicians, pharmacists, a pharmacoeconomist and a medical ethicist, all of whom have a broad background

and knowledge of prescription drugs. Voting members of the P&T Committee must make known any financial relationship or conflicts of interest with any pharmaceutical manufacturers.

In addition to the National P&T Committee review, the CareSource Pharmacy and Therapeutics (P&T) Committee makes formulary recommendations based on the needs of members in your area. The CareSource P&T Committee is made up of the Plan's Medical Directors, Pharmacy staff and those in the medical community.

DRUG LIST PRODUCT DESCRIPTIONS

To help you know which exact strengths and dosage forms on the list are covered, examples are below. The basic ideas shown in the examples can often count for other entries in the list. Any exceptions are noted.

Listed products generally include all strengths and dosage forms of the cited brand-name product.

Pregabalin Lyrica

Oral capsules, oral solution and all strengths of Lyrica would be part of this listing.

When a strength, dosage or different formulation is noted, only that specific strength, dosage or formulation may be covered. Other strengths/dosage/formulations, which includes injectable dosage forms of the listed product, are not covered.

Colestipol tabs Colestid

The generic-name oral tablet formulation is on the list. From this entry, the oral packets and granules cannot be assumed to be on the list unless there is a unique entry.

Extended-release and delayed-release products have a separate entry.

Metformin Glucophage

The immediate-release product listing of Glucophage alone would not include the extended-release product Glucophage XR.

Metformin ext-rel Glucophage XR

A separate entry for Glucophage XR confirms that the extended-release product is on the list.

Dosage forms on the list will be consistent with the category and use where listed.

Neomycin/polymyxin B/hydrocortisone Cortisporin

Since Cortisporin is listed only in the OTIC section, it is limited to the otic solution and suspension. From this entry you cannot assume the topical cream is on the list unless there is an entry for this product in the DERMATOLOGY section of the list.

GENERIC SUBSTITUTION

Generic substitution is a pharmacy action in which a generic version is dispensed rather than a prescribed brand-name product. **Boldface type** means a generic is available. But, not all strengths or dosage forms of the generic name in boldface type may be generically on hand. In most cases, a brand-name drug for which a generic product becomes available will become non-formulary. The generic product will be covered in the brand-name drug's place, when it is

released into the market. But, the list is subject to state-specific regulations and rules about generic substitution and mandatory generic rules apply where needed.

Generic drugs are often priced lower than their brand-name equivalents and should be prescribed first, as long as the standards are followed. Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are made under the same strict standards as brand-name drugs.
- Tested in humans to make sure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may differ from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drug.
- Made in the same strength and dosage form as the brand-name drugs.

When a generic drug is substituted for a brand-name drug, you can expect the generic to have the same clinical effect and safety profile as the brand-name drug (therapeutic equivalence).

PLAN DESIGN

The list shows a closed formulary plan design. The medications listed are covered by the plan as represented. Certain medications on the list are covered if utilization management standards are met (i.e. Step Therapy, Prior Authorization, Quantity Limits, etc.). Requests for use of such medications outside of their listed standards will be reviewed for medical need. If a medication is not listed, a formulary exception may be requested for coverage. Medical need or formulary exception requests will be reviewed based on drug-specific prior authorization measures or standard non-formulary prescription request criteria.

HIP BASIC

HIP Basic is the plan for HIP members who do not make their monthly POWER Account Contributions for more than 60 days. HIP Basic members must have incomes that are \$990 or less per month for an individual or \$2,025 or less per month for a family of four. With HIP Basic, you will have out of pocket expenses called copays. HIP Basic members have copays for most health services including visiting the doctor, filling a prescription and staying in the hospital. These copays may range from \$4 to \$8 per doctor visit or prescription filled and may be as high as \$75 per hospital stay.

HIP Basic provides basic benefits that meet the State of Indiana minimum coverage requirements. The plan does not include coverage for vision or dental services, bariatric surgery, Temporomandibular Joint Disorders (TMJ) or transportation. HIP Basic benefits also allow for fewer visits to physical, speech and occupational therapists.

LEGEND

AL Age Limit

OTC Over the counter

PA Prior Authorization; Prior Authorization includes but is not limited to therapeutic interchange

QL Quantity Limit

SP Specialty Drug

ST Step Therapy

boldface	Indicates generic availability; boldface may not apply to every strength or dosage form under the listed generic name
delayed-rel	Delayed-release (also known as enteric-coated), refer to the reference brand listed for clarification
ext-rel	Extended-release (also known as sustained-release), refer to the reference brand listed for clarification

NOTICE

The data contained in this list is proprietary. The information may not be copied in whole or in part without written permission. ©2018. All rights reserved.

This list refers to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers.

CareSource does not operate the websites/organizations listed here, nor is it responsible for the availability or reliability of the websites' content. These listings do not imply or constitute an endorsement, sponsorship or recommendation by CareSource.

Please be advised that this document is updated periodically and changes may appear prior to their effective date to allow for client notification.

INTRODUCCIÓN

Nos complace ofrecerle el **formulario de Medicaid 2019 de CareSource** como una guía para ayudarlo. Esta lista puede ayudar a los proveedores de servicios médicos en la selección de productos clínicamente adecuados y de menor precio para sus pacientes. Todos los medicamentos de Medicaid de Indiana están cubiertos por CareSource. No obstante, esta es una lista de medicamentos preferidos.

Los medicamentos que se representan fueron revisados por un Comité nacional de farmacia y terapéutica (Pharmacy and Therapeutics, P&T). Posteriormente, un Comité local de farmacia, terapéutica y tecnología (Pharmacy, Therapeutics and Technology, PT&T) aprueba la lista para su inclusión. La lista refleja la práctica médica actualizada al momento de la revisión.

La información en esta lista y sus anexos se suministra para ayudar a los proveedores de servicios médicos. No garantizamos ni aseguramos la exactitud de la información. Tampoco pretende ser de naturaleza exhaustiva. Esta lista no pretende ser un sustituto para los conocimientos, la experiencia, la habilidad y el criterio del proveedor médico en su elección de medicamentos de venta con receta. Todos los datos de la lista se proporcionan como una guía para la elección de terapia de medicamentos. La elección de un medicamento específico para un paciente es decisión exclusiva de la persona que receta.

La lista está sujeta a las leyes y normas específicas en cada estado. Esto puede incluir, pero no se limita a, las referidas a sustitución por medicamento genérico, programas de sustancias controladas, preferencias de marcas y medicamentos genéricos obligatorios cuando corresponde.

No nos hacemos responsables por las acciones o la omisión de ningún proveedor médico basadas en la confianza, en su totalidad o en parte, en la información contenida en esta lista. El proveedor médico debe revisar la información sobre los productos del fabricante de medicamentos o referencias estándar para conocer más detalles.

Los estándares nacionales se pueden encontrar en el sitio de la Cámara Nacional de Compensación de Pautas (National Guideline Clearinghouse) en <http://www.guideline.gov>, en los sitios web que figuran bajo cada clase terapéutica y en los sitios que figuran en la sección SITIOS WEB de la lista.

PREFACIO

La lista está ordenada por secciones. Cada sección se divide de acuerdo con la clase terapéutica que se define principalmente por el mecanismo de acción. Los productos se enumeran por nombre que no es de marca con el nombre de la marca solo con fines informativos. A menos que el citado medicamento pueda administrarse como una inyección o se especifique un caso especial, por lo general, todas las formas de dosificación y las concentraciones correspondientes del medicamento mencionado forman parte de la lista.

COMITÉ DE FARMACIA y TERAPÉUTICA (P&T)

Los servicios de un Comité nacional de farmacia y terapéutica (P&T) independiente se usan para aprobar las terapias con medicamentos seguros y clínicamente efectivos. El Comité de P&T es un panel de expertos externos de todos los Estados Unidos. Los votantes de la Comisión de P&T incluyen médicos, farmacéuticos, un farmacoeconomista y un especialista en ética médica, los cuales tienen antecedentes y conocimientos amplios de los medicamentos de venta con receta. Se invita a los empleados con experiencia clínica significativa a reunirse con el Comité de P&T, pero ningún empleado puede votar sobre los temas antes que el Comité de P&T. Los miembros

del Comité de P&T que votan deben dar a conocer cualquier relación financiera o conflicto de intereses con los fabricantes farmacéuticos.

Además de la revisión del Comité nacional de P&T, el Comité de farmacia, terapéutica y tecnología (PT&T) de CareSource hace recomendaciones de formulario de acuerdo con las necesidades de los afiliados en su área. El Comité de PT&T de CareSource está integrado por los directores del plan médico, personal de farmacia y quienes pertenecen a la comunidad médica.

DESCRIPCIONES DE PRODUCTOS DE LA LISTA DE MEDICAMENTOS

A continuación encontrará ejemplos para ayudarlo a saber qué concentraciones exactas y formas de dosificación de la lista están cubiertas. Las ideas básicas que se muestran en los ejemplos con frecuencia pueden servir para otros puntos de la lista. Se informa sobre cualquier excepción.

Por lo general, los productos que figuran en la lista incluyen todas las concentraciones y las formas de dosificación del producto de marca citado.

Pregabalina Lyrica

Las cápsulas orales, la solución oral y todas las concentraciones de Lyrica formarían parte de esta lista.

Cuando se especifica una concentración, dosis o formulación diferente, puede estar cubierta únicamente esa concentración, dosis o formulación específica. Otras concentraciones/dosis/formulaciones, lo que incluye las formas de dosificación inyectables del producto de la lista, no están cubiertas.

Colestipol en comprimidos Colestid

La formulación de comprimidos orales de nombre genérico se encuentra en la lista. A partir de esta entrada, no se puede dar por sentado que los paquetes orales y gránulos están en la lista a menos que exista una entrada específica.

Los productos de liberación prolongada y liberación retardada necesitan su propia entrada.

Metformina Glucophage

El hecho de que el producto de liberación inmediata de Glucophage figure en la lista por sí solo no incluirá los productos de liberación prolongada Glucophage XR.

Metformina ext-rel Glucophage XR

Una entrada aparte para Glucophage XR confirma que el producto de liberación prolongada está en la lista.

Las formas de dosificación de la lista son consistentes con la categoría y el uso cuando se indican.

Noemicita/polimixina B, hidrocortisona Cortisporin

Dado que Cortisporin figura solo en la sección ÓTICA, se limita a la solución ótica y a la suspensión. A partir de esta entrada no se puede dar por sentado que la crema tópica está en la

lista a menos que exista una entrada de este producto en la sección de DERMATOLOGÍA de la lista.

SUSTITUCIÓN POR GENÉRICO

La sustitución por medicamento genérico es una acción de la farmacia en la que se dispensa una versión genérica en lugar de un producto de marca recetado. Lo que figura en negrita se refiere a la disponibilidad de genéricos. Sin embargo, no todas las concentraciones o las formas de dosificación del nombre genérico en **negritas** pueden encontrarse como medicamentos genéricos. En la mayoría de los casos, un medicamento de marca para el cual hay disponible un producto genérico no pertenecerá al formulario. Se cubrirán los productos genéricos en lugar del medicamento de marca cuando se lancen al mercado. Sin embargo, la lista está sujeta a los reglamentos estatales específicos y se aplican reglas sobre la sustitución por medicamentos genéricos y medicamentos genéricos obligatorios cuando es necesario.

Los medicamentos genéricos a menudo tienen un precio más bajo que sus equivalentes de marca y deben ser recetados en primer lugar, siempre y cuando se cumplan los estándares. Los medicamentos genéricos de venta con receta están:

- Aprobados por la Administración de Alimentos y Medicamentos de los EE. UU. en cuanto a la seguridad y efectividad, y se fabrican bajo las mismas normas estrictas que los medicamentos de marca.
- Probados en humanos, para asegurar que el medicamento genérico se absorbe en el torrente sanguíneo en una tasa y un grado similar en comparación con el medicamento de marca (bioequivalencia). Los medicamentos genéricos pueden diferir de los medicamentos de marca en el tamaño, el color y los ingredientes inactivos, pero esto no altera la efectividad ni la capacidad de que se absorban igual que el medicamento de marca.
- Fabricados con la misma concentración y la misma forma de dosificación que los medicamentos de marca.

Cuando un medicamento genérico sustituye a un medicamento de marca, puede esperar que el genérico tenga el mismo perfil de seguridad y efecto clínico que el medicamento de marca (equivalencia terapéutica).

DISEÑO DEL PLAN

La lista muestra un diseño de plan de formulario cerrado. Los medicamentos de la lista están cubiertos por el plan tal y como aparecen. Determinados medicamentos en la lista están cubiertos si se cumplen los estándares de gestión de uso (por ej., terapia escalonada, autorización previa, límites de cantidad, etc.). Se revisarán las solicitudes para el uso de estos medicamentos fuera de los estándares de la lista en caso de necesidad médica. Si un medicamento no está en la lista, puede solicitar una excepción al formulario para la cobertura. Las solicitudes de excepción al formulario o por necesidad médica se revisarán de acuerdo con las medidas de la autorización previa de medicamentos específicos o criterios estándar de solicitud de prescripción que no pertenezcan al formulario.

HIP BASIC

HIP Basic es el plan para afiliados al plan HIP que no hacen su contribución mensual a la cuenta POWER durante más de 60 días. Los miembros de HIP Basic deben tener ingresos mensuales de \$990 o menos para un individuo o de \$2,025 mensuales o menos para una familia de cuatro personas. Con el HIP Basic, tendrá gastos de bolsillo llamados copagos. Los miembros de HIP

Basic tienen copagos para la mayoría de los servicios de salud, lo que incluye las visitas al médico, el surtido de recetas y la estadía en el hospital. Los copagos pueden variar de \$4 a \$8 por visita al médico o por receta que se realiza y se puede alcanzar los \$75 por la estadía en el hospital.

HIP Basic ofrece beneficios básicos que cumplen con los requisitos mínimos de cobertura de estado de Indiana. El plan no incluye cobertura para la visión ni servicios odontológicos, ni cirugía bariátrica, ni para trastornos de la articulación temporomandibular (TMJ) ni servicios de transporte. Los beneficios del plan HIP Basic también permiten un número menor de visitas a los servicios de terapia ocupacional, física y del habla.

LEYENDA

AL Límite de edad

OTC De venta libre

PA Autorización previa; Autorización previa incluye, pero no se limita, al intercambio terapéutico

QL Límite de cantidad

SP Medicamentos de especialidad

ST Terapia escalonada

negrita Indica la disponibilidad de genéricos; es posible que la negrita no se aplique a cada concentración o forma de dosificación bajo el nombre genérico de la lista

delayed-rel liberación retardada (también conocido como tableta con recubrimiento entérico), consulte la marca de referencia que figura como aclaración

ext-rel liberación prolongada (también conocida como liberación sostenida), consulte la marca de referencia que figura como aclaración

AVISO

La información incluida en esta lista es de propiedad. La información no puede copiarse en su totalidad o en parte sin permiso por escrito. ©2018. Todos los derechos reservados.

Esta lista hace referencia a medicamentos con receta de marca que son marcas registradas de fabricantes farmacéuticos.

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Se le advierte que este documento se actualiza periódicamente y pueden aparecer cambios antes de su fecha de entrada en vigencia para permitir que se notifique al cliente.



CareSource HIP Basic

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OVER-THE-COUNTER DRUG LIST

The **Over-The-Counter Drug List** is a guide to non-prescription medications that are covered by your plan. This list can help your doctor choose the medicines that are right for you. If an over-the-counter medicine that you use is not on this list, it may still be covered if your doctor asks for you to get it. Over-the-counter drug coverage requires a valid prescription.

This list is not an all-inclusive list and does not guarantee coverage. Please visit www.caresource.com for a complete list.

PRODUCT NAME	BRAND NAME EXAMPLES	REQUIREMENTS/LIMITS
acetaminophen caps, tabs	TYLENOL	
acetaminophen chew tabs, orally disintegrating tabs 80 mg	TYLENOL	
acetaminophen supp	ACEPHEN	
acetaminophen susp 80 mg/0.8 mL	TYLENOL	
acetaminophen susp 160 mg/5 mL	TYLENOL	
aluminum & magnesium hydroxide/simethicone chew tabs	GELUSIL	
aluminum & magnesium hydroxide/ simethicone susp 200-200-20 mg/5 mL	MYLANTA	
aluminum & magnesium hydroxide/ simethicone susp 400-400-40 mg/5 mL	MYLANTA DS	
aluminum hydroxide gel		
aluminum hydroxide/magnesium carbonate	GAVISCON	
artificial tears oint, soln	ARTIFICIAL TEARS	
aspirin buffered	BUFFERIN	
aspirin chew tabs 81 mg, tabs 325 mg		
aspirin delayed-rel 81 mg, 325 mg	ECOTRIN	
bacitracin oint	BACIGUENT	
bacitracin/polymyxin B oint	POLYSPORIN	
benzoyl peroxide crm 10%		
benzoyl peroxide gel 5%, 10%		
benzoyl peroxide liq 2.5%	PANOXYL	
benzoyl peroxide liq 4%, 5%, 10%	DESQUAM-X, PANOXYL	
bisacodyl delayed-rel	DULCOLAX	
bisacodyl supp	DULCOLAX	
bismuth subsalicylate chew tabs, tabs	PEPTO-BISMOL	
bismuth subsalicylate susp 262 mg/15 mL	PEPTO-BISMOL	
blood glucose test strips QL	ACCU-CHEK AVIVA TEST STRIPS	Max 200 strips per month
blood glucose test strips QL	ACCU-CHEK SMARTVIEW TEST STRIPS	Max 200 strips per month
blood glucose test strips QL	FREESTYLE FREEDOM LITE TEST STRIPS	Max 200 strips per month
blood glucose test strips QL	FREESTYLE INSULINX TEST STRIPS	Max 200 strips per month
blood glucose test strips QL	FREESTYLE LITE TEST STRIPS	Max 200 strips per month
blood glucose test strips QL	TRUE METRIX TEST STRIPS	Max 200 strips per month
budesonide nasal spray	RHINOCORT ALLERGY	
calcium carbonate chew tabs, tabs 500 mg		
calcium carbonate susp 500 mg/5 mL		

PRODUCT NAME	BRAND NAME EXAMPLES	REQUIREMENTS/LIMITS
calcium carbonate/magnesium carbonate	MAGNEBIND 300	
capsaicin crm 0.025%, 0.075%	ZOSTRIX	
carbamide peroxide 6.5%	DEBROX	
cetirizine soln	ZYRTEC	
cetirizine tabs 5 mg	ZYRTEC	
cetirizine tabs 10 mg	ZYRTEC	
chlorpheniramine syrup	CHLOR-TRIMETON	
chlorpheniramine tabs	CHLOR-TRIMETON	
cimetidine	TAGAMET HB	
clotrimazole crm 1%	LOTRIMIN AF	
clotrimazole vaginal crm	GYNE-LOTRIMIN	
cromolyn sodium nasal spray	NASALCROM	
dextromethorphan polistirex ext-rel susp	DELSYM	
dextromethorphan/guaifenesin liq 5-100 mg/5 mL, 10-100 mg/5 mL, 20-300 mg/5 mL, 30-200 mg/5 mL		
dextromethorphan/guaifenesin syrup 10-100 mg/5 mL	ROBITUSSIN DM	
dextromethorphan/guaifenesin tabs		
dibucaine rectal oint	NUPERCAINAL	
dimethicone crm 1%, 2%, 5%		
dimethicone lotion 1%, 1.3%, 1.5%, 3%	AVEENO	
diphenhydramine	UNISOM SLEEP	
diphenhydramine caps, tabs	BENADRYL	
diphenhydramine liq	BENADRYL	
docosanol	ABREVA	
docusate calcium		
docusate sodium caps 50 mg	COLACE	
docusate sodium caps, tabs 100 mg	COLACE	
docusate sodium liq 150 mg/15 mL		
docusate sodium syrup 60 mg/15 mL		
famotidine tabs 10 mg	PEPCID AC	
fexofenadine susp	ALLEGRA ALLERGY	
fexofenadine tabs	ALLEGRA ALLERGY	
glycerin supp	COLACE	
glycerin/hypromellose/peg 400 ophth soln 0.2-0.2-1%	VISINE TEARS	
guaifenesin liq, syp 100 mg/5 mL	BUCKLEY'S CHEST CONGESTION	
hydrocortisone crm, oint	CORTIZONE	
hypertonic nasal wash	NEILMED SINUS RINSE	
hypromellose soln 0.4%	ARTIFICIAL TEARS	
ibuprofen	ADVIL, MOTRIN	
ketotifen ophth soln	ZADITOR	
lactic acid (ammonium lactate) lotion 12%	LAC-HYDRIN	
lidocaine patch 4%		Max 30 patches per month

PRODUCT NAME	BRAND NAME EXAMPLES	REQUIREMENTS/LIMITS
loperamide caps, liq	IMODIUM A-D	
loratadine orally disintegrating tabs 10 mg	CLARITIN RDT	
loratadine syrup	CLARITIN	
loratadine tabs	CLARITIN	
loratadine/pseudoephedrine ext-rel	CLARITIN-D	
magnesium citrate soln		
magnesium hydroxide susp	MILK OF MAGNESIA	
meclizine 25 mg		
miconazole crm 2%	MICATIN	
miconazole vaginal crm 2%, supp 100 mg	MONISTAT-7	
miconazole vaginal supp 200 mg & crm 2%	MONISTAT-3 KIT	
miconazole vaginal supp 1200 mg & crm 2%	MONISTAT-1 KIT	
naphazoline/pheniramine ophth soln 0.25-0.3%	NAPHCON-A	
naproxen sodium tabs	ALEVE	
neomycin/bacitracin/polymyxin B oint	NEOSPORIN	
nicotine polacrilex gum	NICORETTE	
nicotine transdermal	NICODERM CQ	
permethrin creme rinse, lotion 1%	NIX	
phenylephrine/mineral oil/petrolatum oint	PREPARATION H	
phenylephrine/shark liver oil/cocoa butter supp		
phenylephrine/shark liver oil/mineral oil/petrolatum oint		
polyethylene glycol 3350	MIRALAX	
polyvinyl alcohol soln 1.4%	ARTIFICIAL TEARS	
polyvinyl alcohol/povidone soln 0.5-0.6%	CLEAR EYES, MURINE TEARS	
povidone-iodine soln 10%	BETADINE	
propylene glycol/glycerin soln 1-0.3%	MOISTURE EYE DROPS	
pseudoephedrine	SUDAFED	
pseudoephedrine ext-rel	SUDAFED 12 HOUR	
psyllium powder	METAMUCIL	
pyrethrins/piperonyl butoxide liq, shampoo	RID	
pyridoxine 50 mg	VITAMIN B6	
ranitidine 75 mg	ZANTAC	
rectal protectant/emollient supp	CALMOL-4	
selenium sulfide shampoo 1%	SELSUN BLUE	
sennosides syrup		
sennosides tabs	EX-LAX, SENOKOT	
simethicone susp	PHAZYME	
skin protectant oint	A+D FIRST AID	
sodium bicarbonate 325 mg, 650 mg		
sodium phosphate/sodium bisphosphate enema	FLEET ENEMA-PEDIATRIC	
sodium phosphates enema	FLEET ENEMA	
starch powder	CORN STARCH	

PRODUCT NAME	BRAND NAME EXAMPLES	REQUIREMENTS/LIMITS
tioconazole	VAGISTAT-1	
vitamin A & D crm, oint		
white petrolatum/mineral oil ophth oint	TEARS NATURALE	

ANALGESICS

Practice guidelines of pain management are available at:
<https://www.asahq.org>

NSAIDs

	diclofenac potassium	
	diclofenac sodium delayed-rel	
	diclofenac sodium ext-rel	
	diflunisal	
	etodolac	
	etodolac ext-rel	
	flurbiprofen	
	ibuprofen	
	indomethacin	
	indomethacin ext-rel	
	indomethacin supp	INDOCIN
	indomethacin susp	INDOCIN
	ketoprofen	
QL	ketorolac	
PA	ketorolac nasal spray	SPRIX
	meclofenamate	
	meloxicam	MOBIC
	nabumetone	
	naproxen	NAPROSYN
	naproxen sodium	
	oxaprozin	DAYPRO
	piroxicam	FELDENE
	sulindac	

QL ketorolac = Max 20 tabs per month

NSAIDs, COMBINATIONS

	diclofenac sodium delayed-rel/misoprostol	ARTHROTEC
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NSAIDs, TOPICAL

QL	diclofenac sodium gel 1%	VOLTAREN
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QL diclofenac sodium gel 1% = Max 100 grams per month

COX-2 INHIBITORS

ST	celecoxib	CELEBREX
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GOUT

	allopurinol	ZYLOPRIM
QL	colchicine tabs	COLCRYS
ST	febuxostat	ULORIC
	probenecid	

QL colchicine tabs = Max 30 tabs per month

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 ext-rel: extended-release (also known as sustained-release)

OPIOID ANALGESICS

Practice Guidelines for Cancer Pain Management (includes WHO analgesic ladder) are available at:

<https://www.asahq.org>

<https://www.nccn.org>

Opioid guidelines in the management of chronic non-malignant pain are available at:

<https://www.asipp.org/ASIPP-Guidelines.html>

QL	butalbital/acetaminophen/caffeine/codeine	FIORICET w/CODEINE
QL	butalbital/aspirin/caffeine/codeine	FIORINAL w/CODEINE
QL	butorphanol nasal spray	
QL	codeine sulfate 30 mg	
QL	codeine sulfate 60 mg	CODEINE SULFATE 60 mg
QL	codeine/acetaminophen	TYLENOL w/CODEINE
PA, QL	fentanyl citrate buccal	FENTORA
PA, QL	fentanyl lozenge	ACTIQ
PA, QL	fentanyl sublingual	ABSTRAL
PA, QL	fentanyl transdermal	DURAGESIC
QL	hydrocodone/acetaminophen	NORCO
QL	hydrocodone/acetaminophen - Vicodin	
QL	hydrocodone/acetaminophen soln	
QL	hydrocodone/ibuprofen	
QL	hydromorphone	DILAUDID
QL	meperidine	DEMEROL
PA, QL	methadone soln	
PA, QL	methadone tabs 5 mg, 10 mg	DOLOPHINE
QL	morphine	
PA, QL	morphine ext-rel	MS CONTIN
PA, QL	morphine ext-rel 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg, 100 mg	KADIAN
PA, QL	morphine ext-rel 200 mg	KADIAN
QL	morphine supp	
QL	oxycodone	
QL	oxycodone	ROXICODONE
PA, QL	oxycodone ext-rel	OXYCONTIN
QL	oxycodone/acetaminophen	PERCOCET
QL	oxycodone/aspirin	PERCODAN
PA, QL	oxymorphone ext-rel	
QL	pentazocine/naloxone	
QL	tramadol	ULTRAM
QL	tramadol/acetaminophen	ULTRACET

QL all opioid analgesics = Max quantity limit of 7 days supply per fill; Max quantity limit of 14 days supply per 45 days; Greater than 60 mg morphine equivalent dose requires prior authorization

NON-OPIOID ANALGESICS

QL	butalbital/acetaminophen	
QL	butalbital/acetaminophen/caffeine	FIORICET
QL	butalbital/aspirin/caffeine	FIORINAL

QL butalbital/acetaminophen = Max 48 tabs per month
 QL butalbital/acetaminophen/caffeine = Max 48 tabs per month
 QL butalbital/aspirin/caffeine = Max 48 tabs per month

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VISCOSUPPLEMENTS - Medical Benefit Only

PA, SP	sodium hyaluronate	DUROLANE
PA, SP	sodium hyaluronate	GELSYN-3
PA, SP	sodium hyaluronate	SUPARTZ FX

ANTI-INFECTIVES

Practice guidelines and statements developed and endorsed by the Infectious Diseases Society of America are available at:
<https://www.idsociety.org>

Hepatitis: CDC recommendations on the treatment of hepatitis are available at:
<https://www.cdc.gov/hepatitis/Resources/>

Guidelines for the management of chronic hepatitis by the American Association for the Study of Liver Disease are available at:
<https://www.aasld.org>

HIV/AIDS: Guidelines for the treatment of HIV patients by the U.S. Department of Health and Human Services are available at:
<https://www.aidsinfo.nih.gov>

Infective Endocarditis: American Heart Association recommendations for the prevention of bacterial endocarditis are available at:
<https://professional.heart.org>

Influenza: Recommendations of the Advisory Committee on Immunization Practices are available at:
<https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html>

International Travel: CDC recommendations for international travel are available at:
<https://wwwnc.cdc.gov/travel>

Respiratory Tract Infection/Antibiotic Use/Community Acquired Pneumonia/Other: Principles of appropriate antibiotic use for treatment of nonspecific upper respiratory tract infection in adults are available at:
<https://www.cdc.gov/pneumonia/management-prevention-guidelines.html>

Sexually Transmitted Diseases: CDC Sexually Transmitted Diseases Guidelines are available at:
<https://www.cdc.gov/std/treatment/default.htm>

ANTIBACTERIALS**Aminoglycosides**

neomycin	
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Cephalosporins*First Generation*

cefadroxil	
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cephalexin	KEFLEX
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Second Generation

cefaclor	
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cefprozil	
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cefuroxime axetil	
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Third Generation

cefdinir	
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Erythromycins/Macrolides

azithromycin	ZITHROMAX
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clarithromycin	
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clarithromycin ext-rel	
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erythromycin base	
erythromycin delayed-rel	
erythromycin ethylsuccinate	E.E.S.
erythromycin ethylsuccinate susp 200 mg/5 mL	ERYPED
erythromycin ethylsuccinate susp 400 mg/5 mL	ERYPED
erythromycin stearate	

Fluoroquinolones

ciprofloxacin	CIPRO
ciprofloxacin ext-rel	
levofloxacin	LEVAQUIN
QL ofloxacin	

QL ofloxacin 400 mg = Max 2 tabs per day

Penicillins

amoxicillin	
amoxicillin/clavulanate	AUGMENTIN
amoxicillin/clavulanate ext-rel	
ampicillin	
dicloxacillin	
penicillin VK	

Sulfonamides

sulfadiazine	SULFADIAZINE
sulfamethoxazole/trimethoprim	
sulfamethoxazole/trimethoprim DS	BACTRIM DS

Tetracyclines

doxycycline hyclate caps 50 mg, 100 mg	VIBRAMYCIN
doxycycline hyclate tabs 20 mg, 100 mg	
doxycycline monohydrate caps 50 mg, 75 mg, 100 mg	
doxycycline monohydrate susp	VIBRAMYCIN
doxycycline monohydrate tabs 75 mg	
minocycline	MINOCIN
tetracycline	

ANTIFUNGALS

clotrimazole troches	
fluconazole	DIFLUCAN
griseofulvin microsize	
griseofulvin ultramicrosize	
QL itraconazole caps	SPORANOX
ketoconazole	
nystatin	
QL terbinafine tabs	

QL itraconazole caps = Max 4 caps per day

QL terbinafine tabs = Max 30 tabs per month

ANTIMALARIALS

QL artemether/lumefantrine	COARTEM
QL atovaquone/proguanil	MALARONE
QL chloroquine	
QL mefloquine	

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QL	primaquine		PRIMAQUINE
QL	atovaquone/proguanil	=	Max 12 tabs per 180 days
QL	chloroquine	=	Max 10 tabs per 180 days
QL	mefloquine	=	Max 6 tabs per 180 days
QL	primaquine	=	Max 1 tab per day
QL	COARTEM	=	Max 24 tabs per 180 days

ANTIRETROVIRAL AGENTS**Antiretroviral Adjuvants**

	cobicistat		TYBOST
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Antiretroviral Combinations

PA	abacavir/dolutegravir/lamivudine		TRIUMEQ
	abacavir/lamivudine		EPZICOM
	abacavir/lamivudine/zidovudine		TRIZIVIR
	atazanavir/cobicistat		EVOTAZ
	bictegravir/emtricitabine/tenofovir alafenamide		BIKTARVY
	darunavir/cobicistat		PREZCOBIX
	darunavir/cobicistat/emtricitabine/tenofovir alafenamide		SYM TUZA
	dolutegravir/rilpivirine		JULUCA
QL	doravirine/lamivudine/tenofovir disoproxil fumarate		DELSTRIGO
	efavirenz/emtricitabine/tenofovir disoproxil fumarate		ATRIPLA
	elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide		GENVOYA
	elvitegravir/cobicistat/emtricitabine/ tenofovir disoproxil fumarate		STRIBILD
	emtricitabine/rilpivirine/tenofovir alafenamide		ODEFSEY
	emtricitabine/rilpivirine/tenofovir disoproxil fumarate		COMPLERA
	emtricitabine/tenofovir alafenamide		DESCOVY
	emtricitabine/tenofovir disoproxil fumarate		TRUVADA
	lamivudine/zidovudine		COMBIVIR

QL DELSTRIGO = Max 30 tabs per month

Chemokine Receptor Antagonists

PA	maraviroc		SELZENTRY
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Fusion Inhibitors

SP	enfuvirtide		FUZEON
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Integrase Inhibitors

	dolutegravir		TIVICAY
	raltegravir		ISENTRESS
	raltegravir		ISENTRESS HD

Non-nucleoside Reverse Transcriptase Inhibitors

	delavirdine		RESCRIPTOR
QL	doravirine		PIFELTRO
	efavirenz		SUSTIVA
	etravirine		INTELENCE
	nevirapine		VIRAMUNE
	nevirapine ext-rel		VIRAMUNE XR
	rilpivirine		EDURANT

QL PIFELTRO = Max 30 tabs per month

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Nucleoside Reverse Transcriptase Inhibitors

abacavir	ZIAGEN
didanosine delayed-rel 125 mg	VIDEX EC
didanosine delayed-rel 200 mg, 250 mg, 400 mg	VIDEX EC
didanosine soln	VIDEX
emtricitabine	EMTRIVA
lamivudine	EPIVIR
stavudine caps	
zidovudine	RETROVIR

Nucleotide Reverse Transcriptase Inhibitors

tenofovir disoproxil fumarate 150 mg, 200 mg, 250 mg	VIREAD
tenofovir disoproxil fumarate 300 mg	VIREAD
tenofovir disoproxil fumarate powder	VIREAD

Protease Inhibitors

atazanavir caps	REYATAZ
atazanavir powder	REYATAZ
QL darunavir susp	PREZISTA
darunavir tabs	PREZISTA
fosamprenavir susp	LEXIVA
fosamprenavir tabs	LEXIVA
indinavir	CRIXIVAN
lopinavir/ritonavir soln	KALETRA
lopinavir/ritonavir tabs	KALETRA
nelfinavir	VIRACEPT
ritonavir caps, soln	NORVIR
ritonavir tabs	NORVIR
saquinavir mesylate	INVIRASE
tipranavir	APTIVUS

QL PREZISTA susp = Max 30 mL per month

ANTITUBERCULAR AGENTS

PA bedaquiline	SIRTURO
ethambutol	MYAMBUTOL
PA ethionamide	TRECTOR
isoniazid	
pyrazinamide	
rifabutin	MYCOBUTIN
rifampin	RIFADIN
PA rifapentine	PRIFTIN

ANTIVIRALS**Cytomegalovirus Agents**

valganciclovir	VALCYTE
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Hepatitis Agents*Hepatitis B*

PA adefovir dipivoxil	HEPSERA
PA entecavir soln	BARACLUDE
PA entecavir tabs	BARACLUDE
PA lamivudine soln	EPIVIR-HBV
PA lamivudine tabs	EPIVIR-HBV

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Herpes Agents

	acyclovir	ZOVIRAX
	famciclovir	
	valacyclovir	VALTREX

Influenza Agents

QL	oseltamivir	TAMIFLU
	rimantadine	FLUMADINE
QL	zanamivir	RELENZA

QL	oseltamivir 30 mg	=	Max 20 caps per 6 months
QL	oseltamivir 45 mg, 75 mg	=	Max 10 caps per 6 months
QL	oseltamivir susp 6 mg/mL	=	Max 180 mL per 6 months
QL	RELENZA	=	Max 1 inhaler per 6 months

MISCELLANEOUS

OTC	pyrantel - Reeses Pinworm Medicine	
	atovaquone	MEPRON
	clindamycin	CLEOCIN
	dapsone	
	daptomycin	CUBICIN
	ivermectin	STROMEKTOL
	mebendazole chew tabs	EMVERM
	methenamine hippurate	HIPREX
	metronidazole	FLAGYL
PA, QL	nitazoxanide	ALINIA
	nitrofurantoin ext-rel	MACROBID
	nitrofurantoin macrocrystals	MACRODANTIN
	nitrofurantoin susp	FURADANTIN
PA	pentamidine	NEBUPENT
PA	pentamidine	PENTAM
	praziquantel	BILTRICIDE
PA	rifaximin	XIFAXAN
	trimethoprim	
PA	vancomycin oral soln	FIRVANQ

QL	ALINIA tabs	=	Max 20 tabs per month
QL	ALINIA susp	=	Max 540 mL per month

ANTINEOPLASTIC AGENTS

Clinical practice guidelines in oncology are available at:

<https://www.asco.org>

<https://www.nccn.org>

ALKYLATING AGENTS

	busulfan	MYLERAN
	chlorambucil	LEUKERAN
	estramustine	EMCYT
PA, QL	mechlorethamine gel	VALCHLOR
	melphalan	ALKERAN
PA, SP	temozolomide	TEMODAR

QL	VALCHLOR	=	Max 60 grams per month
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ANTIMETABOLITES

PA, SP	brentuximab vedotin	ADCETRIS
PA, SP	capecitabine	XELODA
	mercaptopurine	
	methotrexate	TREXALL
PA	thioguanine	TABLOID

HORMONAL ANTINEOPLASTIC AGENTS**Antiandrogens**

PA, SP	abiraterone	ZYTIGA
	bicalutamide	CASODEX
PA, SP	enzalutamide	XTANDI
	flutamide	

Antiestrogens

	tamoxifen	
	toremifene	FARESTON

Aromatase Inhibitors

	anastrozole	ARIMIDEX
	exemestane	AROMASIN
PA	letrozole	FEMARA

Luteinizing Hormone-Releasing Hormone (LHRH) Agonists

PA, SP	goserelin acetate	ZOLADEX
PA, SP	leuprolide acetate	
PA, SP	triptorelin pamoate	TRELSTAR

Gonadotropin Releasing Hormone (GnRH) Antagonists

PA, SP	degarelix acetate	FIRMAGON
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Progestins

	megestrol acetate susp 40 mg/mL, tabs	
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IMMUNOMODULATORS

PA, SP	lenalidomide	REVLIMID
PA, SP	pomalidomide	POMALYST
PA, SP	thalidomide	THALOMID

KINASE INHIBITORS

PA, SP	afatinib	GILOTRIF
PA, SP	axitinib	INLYTA
PA, SP	cabozantinib	COMETRIQ
PA, SP	ceritinib	ZYKADIA
PA, SP	crizotinib	XALKORI
PA, SP	dabrafenib	TAFINLAR
PA, SP	erlotinib	TARCEVA
PA, SP	everolimus	AFINITOR
PA, SP	everolimus soluble tabs	AFINITOR DISPERZ
PA, SP	ibrutinib	IMBRUVICA
PA, SP	lapatinib	TYKERB
PA, SP	lenvatinib	LENVIMA
PA, SP	palbociclib	IBRANCE
PA, SP	pazopanib	VOTRIENT
PA, SP	ruxolitinib	JAKAFI

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PA, SP	sorafenib	NEXAVAR
PA, SP	sunitinib	SUTENT
PA, SP	trametinib	MEKINIST
PA, SP	vemurafenib	ZELBORAF

KINASE INHIBITORS FOR CML

PA, SP	dasatinib	SPRYCEL
PA, SP	imatinib mesylate	GLEEVEC
PA, SP	nilotinib	TASIGNA
PA, SP	ponatinib	ICLUSIG

TOPOISOMERASE INHIBITORS

PA, SP	topotecan caps	HYCANTIN
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MISCELLANEOUS

PA, SP	bexarotene caps	TARGRETIN
PA, SP	bexarotene gel	TARGRETIN
	etoposide	
	hydroxyurea	DROXIA
	hydroxyurea	HYDREA
	leucovorin	
	mesna	MESNEX
	mitotane	LYSODREN
PA, SP	olaparib	LYNPARZA
PA, SP	panobinostat	FARYDAK
	procarbazine	MATULANE
PA	rituximab	RITUXAN
PA, SP	romidepsin	ISTODAX
	tretinoin caps	
PA, SP	vismodegib	ERIVEDGE
PA, SP	vorinostat	ZOLINZA

CARDIOVASCULAR

The Eighth Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure is available at:

<https://jamanetwork.com/journals/jama/fullarticle/1791497>

Guidelines for the evaluation and management of cardiovascular diseases in adults are available at:

<https://www.acc.org>

<https://professional.heart.org>

ACE INHIBITORS

Guidelines for the use of ACE inhibitors are available at:

<https://jamanetwork.com/journals/jama/fullarticle/1791497>

<https://professional.diabetes.org>

<https://www.acc.org>

<https://professional.heart.org>

	benazepril	LOTENSIN
	captopril	
	enalapril	VASOTEC
PA	enalapril oral soln	EPANED
	fosinopril	
	lisinopril	ZESTRIL

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moexipril	
perindopril	
quinapril	ACCUPRIL
ramipril	ALTACE
trandolapril	

ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATIONS

amlodipine/benazepril	LOTREL
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ACE INHIBITOR/DIURETIC COMBINATIONS

benazepril/hydrochlorothiazide	LOTENSIN HCT
captopril/hydrochlorothiazide	
enalapril/hydrochlorothiazide	VASERETIC
fosinopril/hydrochlorothiazide	
lisinopril/hydrochlorothiazide	ZESTORETIC
quinapril/hydrochlorothiazide	ACCURETIC

ADRENOLYTICS, CENTRAL

QL clonidine	CATAPRES
clonidine transdermal	CATAPRES-TTS
guanfacine	

QL clonidine 0.1 mg, 0.2 mg = Max 300 tabs per month

QL clonidine 0.3 mg = Max 240 tabs per month

ALDOSTERONE RECEPTOR ANTAGONISTS

eplerenone	INSPIRA
spironolactone	ALDACTONE

ALPHA BLOCKERS

Guidelines for the use of alpha blockers in various patient populations are available at:

<https://jamanetwork.com/journals/jama/fullarticle/1791497>

doxazosin	CARDURA
prazosin	MINIPRESS
terazosin	

ANGIOTENSIN II RECEPTOR ANTAGONISTS/DIURETIC COMBINATIONS

Guidelines for the use of angiotensin II receptor antagonists in various patient populations are available at:

<https://jamanetwork.com/journals/jama/fullarticle/1791497>

<https://professional.diabetes.org>

candesartan	ATACAND
candesartan/hydrochlorothiazide	ATACAND HCT
irbesartan	AVAPRO
irbesartan/hydrochlorothiazide	AVALIDE
losartan	COZAAR
losartan/hydrochlorothiazide	HYZAAR
olmesartan	BENICAR
olmesartan/hydrochlorothiazide	BENICAR HCT
telmisartan	MICARDIS
telmisartan/hydrochlorothiazide	MICARDIS HCT
valsartan	DIOVAN
valsartan/hydrochlorothiazide	DIOVAN HCT

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ext-rel: extended-release (also known as sustained-release)

ANGIOTENSIN II RECEPTOR ANTAGONIST/CALCIUM CHANNEL BLOCKER COMBINATIONS

amlodipine/olmesartan	AZOR
amlodipine/telmisartan	TWYNSTA
amlodipine/valsartan	EXFORGE

ANGIOTENSIN II RECEPTOR ANTAGONIST/CALCIUM CHANNEL BLOCKER/DIURETIC COMBINATIONS

amlodipine/olmesartan/hydrochlorothiazide	TRIBENZOR
amlodipine/valsartan/hydrochlorothiazide	EXFORGE HCT

ANTIARRHYTHMICS

Guidelines for the use of antiarrhythmics and cardiac glycosides in various patient populations are available at:
<https://www.acc.org>

	amiodarone 200 mg	
	disopyramide	NORPACE
	disopyramide ext-rel	NORPACE CR
SP	dofetilide	TIKOSYN
	flecainide	
	propafenone	
	propafenone ext-rel	RYTHMOL SR
	sotalol	BETAPACE
	sotalol	BETAPACE AF

ANTILIPEMICS

The 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults is available at:

<https://www.ahajournals.org/doi/full/10.1161/01.cir.0000437738.63853.7a>

Bile Acid Resins

	cholestyramine	QUESTRAN/QUESTRAN LIGHT
	colestipol tabs	COLESTID

Cholesterol Absorption Inhibitors

QL	ezetimibe	ZETIA
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QL ezetimibe = Max 30 tabs per month

Fibrates

	fenofibrate	LOFIBRA
	fenofibrate	TRICOR
	gemfibrozil	LOPID

HMG-CoA Reductase Inhibitors

	atorvastatin	LIPITOR
	lovastatin	
	pravastatin	PRAVACHOL
ST	rosuvastatin	CRESTOR
	simvastatin	ZOCOR

Microsomal Triglyceride Transfer Protein Inhibitors

PA, SP	lomitapide	JUXTAPID
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Omega-3 Fatty Acids

	omega-3 acid ethyl esters	LOVAZA
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ext-rel: extended-release (also known as sustained-release)

Miscellaneous

PA, SP	mipomersen	KYNAMRO
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BETA-BLOCKERS

Guidelines for the use of beta-blockers and beta-blocker combinations in various patient populations are available at:

<https://jamanetwork.com/journals/jama/fullarticle/1791497>

<https://www.acc.org>

acebutolol	
atenolol	TENORMIN
betaxolol	
bisoprolol	
carvedilol	COREG
labetalol	TRANDATE
metoprolol succinate ext-rel	TOPROL-XL
metoprolol tartrate 25 mg, 50 mg, 100 mg	LOPRESSOR
nadolol	CORGARD
pindolol	
propranolol	
propranolol ext-rel	INDERAL LA
propranolol ext-rel	INDERAL XL
propranolol ext-rel	INNOPRAN XL
propranolol inj	
timolol	

BETA-BLOCKER/DIURETIC COMBINATIONS

Guidelines for the use of beta-blockers and beta-blocker combinations in various patient populations are available at:

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<https://www.acc.org>

atenolol/chlorthalidone	TENORETIC
bisoprolol/hydrochlorothiazide	ZIAC
metoprolol/hydrochlorothiazide	LOPRESSOR HCT
nadolol/bendroflumethiazide	
propranolol/hydrochlorothiazide	

CALCIUM CHANNEL BLOCKERS**Dihydropyridines**

amlodipine	NORVASC
felodipine ext-rel	
nifedipine ext-rel	ADALAT CC
nifedipine ext-rel	PROCARDIA XL
PA nimodipine oral soln	NYMALIZE

Nondihydropyridines

diltiazem	CARDIZEM
diltiazem ext-rel	
diltiazem ext-rel	CARDIZEM CD
diltiazem ext-rel	CARDIZEM LA
diltiazem ext-rel	TIAZAC
verapamil ext-rel	CALAN SR
verapamil ext-rel	VERELAN

DIGITALIS GLYCOSIDES

digoxin 0.125 mg, 0.25 mg	LANOXIN
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digoxin ped elixir		
DIURETICS		
Carbonic Anhydrase Inhibitors		
	acetazolamide	
	acetazolamide ext-rel	
	methazolamide	
Loop Diuretics		
	bumetanide	
	furosemide	LASIX
	torseamide	DEMADEX
Potassium-sparing Diuretics		
	amiloride	
Thiazides and Thiazide-like Diuretics		
	chlorothiazide susp	DIURIL
	chlorthalidone	
	hydrochlorothiazide	
	indapamide	
	methyclothiazide	
	metolazone	
Diuretic Combinations		
	amiloride/hydrochlorothiazide	
	spironolactone/hydrochlorothiazide	ALDACTAZIDE
	triamterene/hydrochlorothiazide	DYAZIDE
	triamterene/hydrochlorothiazide	MAXZIDE
HEART FAILURE		
PA	sacubitril/valsartan	ENTRESTO
NITRATES		
Oral		
	isosorbide dinitrate ext-rel tabs	
	isosorbide dinitrate oral	ISORDIL
	isosorbide mononitrate	
	isosorbide mononitrate ext-rel	
	nitroglycerin ext-rel	
Sublingual		
	nitroglycerin sublingual	NITROSTAT
Transdermal		
	nitroglycerin transdermal	
	nitroglycerin transdermal 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	NITRO-DUR
PULMONARY ARTERIAL HYPERTENSION		
Endothelin Receptor Antagonists		
PA, SP	ambrisentan	LETAIRIS
PA, SP	bosentan	TRACLEER
PA, SP	macitentan	OPSUMIT

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Phosphodiesterase Inhibitors

PA, SP	sildenafil inj	REVATIO
PA, SP, QL	sildenafil tabs	REVATIO

QL sildenafil tabs = Max 90 tabs per month

Prostaglandin Vasodilators

PA, SP	epoprostenol sodium	FLOLAN
PA, SP	iloprost	VENTAVIS
PA, SP	treprostinil	REMODULIN
PA, SP	treprostinil	TYVASO

Soluble Guanylate Cyclase Stimulators

PA, SP	riociguat	ADEMPAS
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MISCELLANEOUS

	hydralazine	
	methyldopa	
	methyldopa/hydrochlorothiazide	
PA	metyrosine	DEMSER
	midodrine	
	minoxidil	
	ranolazine ext-rel	RANEXA

CENTRAL NERVOUS SYSTEM

Practice guidelines for psychiatric disorders are available at:
<https://www.psychiatry.org>

ANTIANSXIETY**Benzodiazepines**

QL	alprazolam	XANAX
QL	alprazolam ext-rel	XANAX XR
QL	alprazolam oral concentrate	ALPRAZOLAM INTENSOL
QL	alprazolam orally disintegrating tabs	NIRAVAM
QL	chlordiazepoxide	
QL	clonazepam	KLONOPIN
QL	clorazepate	TRANXENE T-TAB
	diazepam inj	
QL	diazepam oral concentrate 5 mg/mL	
	diazepam soln 1 mg/mL	
QL	diazepam tabs	VALIUM
	lorazepam inj	ATIVAN
	lorazepam oral concentrate	
QL	lorazepam tabs	ATIVAN
QL	oxazepam	

QL alprazolam ext-rel = Max 30 tabs per month
QL alprazolam orally disintegrating tabs = Max 120 tabs per month
QL alprazolam tabs = Max 120 tabs per month
QL chlordiazepoxide = Max 120 caps per month
QL clorazepate = Max 120 tabs per month
QL clonazepam = Max 90 tabs per month
QL diazepam oral concentrate 5 mg/mL = Max 240 mL per month
QL diazepam tabs = Max 120 tabs per month

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ext-rel: extended-release (also known as sustained-release)

QL	lorazepam tabs	=	Max 120 tabs per month
QL	oxazepam	=	Max 120 caps per month
QL	ALPRAZOLAM INTENSOL	=	Max 120 mL per month

Miscellaneous

QL	bupirone	
QL	clomipramine	ANAFRANIL
QL	fluvoxamine	
QL	fluvoxamine ext-rel	
QL	hydroxyzine HCl	
	hydroxyzine HCl inj	
QL	hydroxyzine pamoate	VISTARIL
QL	meprobamate	

QL	bupirone 5 mg, 7.5 mg, 10 mg, 15 mg	=	Max 90 tabs per month
QL	bupirone 30 mg	=	Max 60 tabs per month
QL	clomipramine 25 mg	=	Max 60 caps per month
QL	clomipramine 50 mg	=	Max 150 caps per month
QL	clomipramine 75 mg	=	Max 90 caps per month
QL	fluvoxamine 25 mg, 50 mg	=	Max 30 tabs per month
QL	fluvoxamine 100 mg	=	Max 90 tabs per month
QL	fluvoxamine ext-rel	=	Max 60 caps per month
QL	hydroxyzine HCl 10 mg, 25 mg	=	Max 120 tabs per month
QL	hydroxyzine HCl 50 mg	=	Max 240 tabs per month
QL	hydroxyzine HCl soln	=	Max 3000 mL per month
QL	hydroxyzine pamoate	=	Max 120 caps per month
QL	meprobamate	=	Max 120 tabs per month

ANTICONVULSANTS

Practice guidelines for the treatment of epilepsy are available at:

<https://www.aan.com>

	carbamazepine	TEGRETOL
	carbamazepine ext-rel	CARBATROL
	carbamazepine ext-rel	TEGRETOL-XR
ST	clobazam	ONFI
	diazepam rectal gel	DIASTAT
	divalproex sodium delayed-rel	DEPAKOTE
	divalproex sodium ext-rel	DEPAKOTE ER
	ethosuximide	ZARONTIN
	ethotoin	PEGANONE
	felbamate	FELBATOL
QL	gabapentin caps, tabs	NEURONTIN
	gabapentin oral soln	NEURONTIN
ST	lacosamide	VIMPAT
	lamotrigine	LAMICTAL
	lamotrigine ext-rel	LAMICTAL XR
QL	levetiracetam ext-rel	KEPPRA XR
	levetiracetam inj	KEPPRA
	levetiracetam oral soln	KEPPRA
QL	levetiracetam tabs	KEPPRA
	methsuximide	CELONTIN
	oxcarbazepine	TRILEPTAL
	oxcarbazepine ext-rel	OXTELLAR XR
ST	perampanel	FYCOMPA

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	phenobarbital	
	phenobarbital inj	
	phenytoin	DILANTIN INFATABS
	phenytoin sodium extended	DILANTIN
	phenytoin sodium extended	PHENYTEK
	primidone	MYSOLINE
ST	rufinamide	BANZEL
	tiagabine	GABITRIL
QL	topiramate ext-rel	QUDEXY XR
QL	topiramate ext-rel	TROKENDI XR
	topiramate sprinkle caps, tabs	TOPAMAX
	valproate sodium inj	DEPACON
	valproic acid	DEPAKENE
	valproic acid delayed-rel	STAVZOR
QL	zonisamide 25 mg, 50 mg	ZONEGRAN
	zonisamide 100 mg	ZONEGRAN

QL	gabapentin 100 mg, 400 mg	=	Max 180 caps per month
QL	gabapentin 300 mg	=	Max 270 caps per month
QL	gabapentin 600 mg	=	Max 180 tabs per month
QL	gabapentin 800 mg	=	Max 120 tabs per month
QL	levetiracetam 250 mg	=	Max 60 tabs per month
QL	levetiracetam 500 mg	=	Max 180 tabs per month
QL	levetiracetam 750 mg	=	Max 120 tabs per month
QL	levetiracetam 1000 mg	=	Max 90 tabs per month
QL	levetiracetam ext-rel 500 mg	=	Max 60 tabs per month
QL	levetiracetam ext-rel 750 mg	=	Max 120 tabs per month
QL	topiramate ext-rel	=	Max 60 caps per month
QL	zonisamide 25 mg, 50 mg	=	Max 30 caps per month
QL	TROKENDI XR	=	Max 60 caps per month

ANTIDEMENTIA

Practice guidelines for the management of dementia are available at:

<https://www.aan.com>

QL	donepezil	ARICEPT
QL	galantamine	RAZADYNE
QL	galantamine ext-rel	RAZADYNE ER
QL	memantine	NAMENDA
QL	memantine ext-rel	NAMENDA XR
QL	memantine/donepezil	NAMZARIC
QL	rivastigmine	
QL	rivastigmine transdermal	EXELON

QL	donepezil	=	Max 30 tabs per month
QL	galantamine ext-rel	=	Max 30 caps per month
QL	galantamine soln	=	Max 180 mL per month
QL	galantamine tabs	=	Max 60 tabs per month
QL	memantine ext-rel	=	Max 30 tabs per month
QL	memantine tabs	=	Max 60 tabs per month
QL	memantine soln	=	Max 300 mL per month
QL	rivastigmine	=	Max 60 caps per month
QL	rivastigmine transdermal	=	Max 30 patches per month
QL	NAMENDA XR titration pack	=	Max 1 pack per 28 days
QL	NAMZARIC	=	Max 60 caps per month

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ANTIDEPRESSANTS

Although these agents are primarily indicated for depression, some of these are also approved for other indications, including bipolar disorder, obsessive-compulsive disorder, panic disorder and premenstrual dysphoric disorder.

Guidelines for the evaluation and management of bipolar and depressive disorders are available at:

<https://www.psychiatry.org>

Monoamine Oxidase Inhibitors (MAOIs)

QL	isocarboxazid	MARPLAN
QL	phenelzine	NARDIL
QL	selegiline transdermal	EMSAM
QL	tranylcypromine	PARNATE

QL	phenelzine	=	Max 180 tabs per month
QL	tranylcypromine	=	Max 180 tabs per month
QL	EMSAM	=	Max 30 patches per month
QL	MARPLAN	=	Max 90 tabs per month

Selective Serotonin Reuptake Inhibitors (SSRIs)

QL	citalopram	CELEXA
QL	escitalopram	LEXAPRO
QL	fluoxetine	PROZAC
QL	fluoxetine	SARAFEM
QL	fluoxetine 60 mg	FLUOXETINE 60 mg
QL	fluoxetine delayed-rel	
AL, QL	paroxetine HCl ext-rel	PAXIL CR
AL, QL	paroxetine HCl susp	PAXIL
AL, QL	paroxetine HCl tabs	PAXIL
AL, QL	paroxetine mesylate	PEXEVA
QL	sertraline	ZOLOFT
QL	vilazodone	VIIBRYD
QL	vortioxetine	TRINTELLIX

QL	citalopram soln	=	Max 600 mL per month
QL	citalopram tabs	=	Max 30 tabs per month
QL	escitalopram 5 mg, 10 mg	=	Max 30 tabs per month
QL	escitalopram 20 mg	=	Max 45 tabs per month
QL	escitalopram soln	=	Max 600 mL per month
QL	fluoxetine caps 10 mg	=	Max 30 caps per month
QL	fluoxetine caps 20 mg	=	Max 120 caps per month
QL	fluoxetine caps 40 mg	=	Max 60 caps per month
QL	fluoxetine delayed-rel	=	Max 4 tabs per 28 days
QL	fluoxetine soln	=	Max 600 mL per month
QL	fluoxetine tabs 10 mg	=	Max 45 tabs per month
QL	fluoxetine tabs 20 mg	=	Max 120 tabs per month
QL	fluoxetine tabs 60 mg	=	Max 30 tabs per month
QL	paroxetine HCl 10 mg, 20 mg	=	Max 30 tabs per month
QL	paroxetine HCl 30 mg, 40 mg	=	Max 60 tabs per month
QL	paroxetine HCl ext-rel	=	Max 30 tabs per month
QL	sertraline 25 mg, 50 mg	=	Max 60 tabs per month
QL	sertraline 100 mg	=	Max 90 tabs per month
QL	sertraline concentrate	=	Max 300 mL per month
QL	PAXIL susp	=	Max 1200 mL per month
QL	PEXEVA	=	Max 30 tabs per month
QL	TRINTELLIX	=	Max 30 tabs per month

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 ext-rel: extended-release (also known as sustained-release)

QL	VIIBRYD tabs	=	Max 30 tabs per month
QL	VIIBRYD kit	=	Max 1 kit per month

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)

QL	desvenlafaxine ext-rel	KHEDEZLA
QL	desvenlafaxine fumarate ext-rel	DESVENLAFAXINE ER
QL	desvenlafaxine succinate ext-rel	PRISTIQ
QL	duloxetine delayed-rel	CYMBALTA
QL	levomilnacipran ext-rel	FETZIMA
QL	venlafaxine	
QL	venlafaxine ext-rel caps	EFFEXOR XR
QL	venlafaxine ext-rel tabs	VENLAFAXINE ER

QL	desvenlafaxine ext-rel 50 mg	=	Max 30 tabs per month
QL	desvenlafaxine ext-rel 100 mg	=	Max 60 tabs per month
QL	desvenlafaxine succinate ext-rel 25 mg, 50 mg	=	Max 30 tabs per month
QL	desvenlafaxine succinate ext-rel 100 mg	=	Max 60 tabs per month
QL	duloxetine delayed-rel	=	Max 60 caps per month
QL	venlafaxine	=	Max 90 tabs per month
QL	venlafaxine ext-rel 37.5 mg	=	Max 30 caps, tabs per month
QL	venlafaxine ext-rel 75 mg	=	Max 90 caps, tabs per month
QL	venlafaxine ext-rel 150 mg	=	Max 60 caps, tabs per month
QL	DESVENLAFAXINE ER 50 mg	=	Max 30 tabs per month
QL	DESVENLAFAXINE ER 100 mg	=	Max 60 tabs per month
QL	FETZIMA	=	Max 30 caps per month
QL	VENLAFAXINE ER 225 mg	=	Max 30 tabs per month

Tricyclic Antidepressants (TCAs)

QL	amitriptyline	
QL	amoxapine	
QL	desipramine	NORPRAMIN
QL	doxepin	
QL	imipramine HCl	TOFRANIL
QL	imipramine pamoate	TOFRANIL-PM
QL	nortriptyline	PAMELOR
QL	protriptyline	VIVACTIL
QL	trimipramine	SURMONTIL

QL	amitriptyline	=	Max 90 tabs per month
QL	amoxapine 25 mg, 150 mg	=	Max 60 tabs per month
QL	amoxapine 50 mg, 100 mg	=	Max 120 tabs per month
QL	desipramine 10 mg	=	Max 120 tabs per month
QL	desipramine 25 mg, 50 mg, 75 mg, 150 mg	=	Max 60 tabs per month
QL	desipramine 100 mg	=	Max 90 tabs per month
QL	doxepin 10 mg	=	Max 120 caps per month
QL	doxepin 25 mg, 50 mg, 75 mg, 100 mg, 150 mg	=	Max 60 caps per month
QL	doxepin 10 mg/mL	=	Max 900 mL per month
QL	imipramine HCl 10 mg	=	Max 60 tabs per month
QL	imipramine HCl 25 mg	=	Max 30 tabs per month
QL	imipramine HCl 50 mg	=	Max 180 tabs per month
QL	imipramine pamoate 75 mg	=	Max 30 caps per month
QL	imipramine pamoate 100 mg	=	Max 90 caps per month
QL	imipramine pamoate 125 mg, 150 mg	=	Max 60 caps per month
QL	nortriptyline 10 mg, 25 mg	=	Max 120 caps per month
QL	nortriptyline 50 mg	=	Max 90 caps per month

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 ext-rel: extended-release (also known as sustained-release)

QL	nortriptyline 75 mg	=	Max 60 caps per month
QL	nortriptyline 10 mg/5 mL	=	Max 600 mL per month
QL	protriptyline	=	Max 120 tabs per month
QL	trimipramine 25 mg, 50 mg	=	Max 30 caps per month
QL	trimipramine 100 mg	=	Max 90 caps per month

Tricyclic Antidepressants/Benzodiazepine Combination

chlordiazepoxide/amitriptyline

Miscellaneous Agents

QL	bupropion	
QL	bupropion ext-rel	APLENZIN
QL	bupropion ext-rel	FORFIVO XL
QL	bupropion ext-rel	WELLBUTRIN SR
QL	bupropion ext-rel	WELLBUTRIN XL
QL	maprotiline	
QL	mirtazapine	REMERON
QL	nefazodone	
QL	trazodone	

QL	bupropion	=	Max 120 tabs per month
QL	bupropion ext-rel (generic for FORFIVO XL)	=	Max 30 tabs per month
QL	bupropion ext-rel (generic for WELLBUTRIN SR)	=	Max 60 tabs per month
QL	bupropion ext-rel (generic for WELLBUTRIN XL)	=	Max 30 tabs per month
QL	maprotiline	=	Max 90 tabs per month
QL	mirtazapine	=	Max 30 tabs per month
QL	nefazodone	=	Max 60 tabs per month
QL	trazodone 50 mg, 300 mg	=	Max 60 tabs per month
QL	trazodone 100 mg, 150 mg	=	Max 90 tabs per month
QL	APLENZIN	=	Max 30 tabs per month

ANTIPARKINSONIAN AGENTS

Practice guidelines for the diagnosis and treatment of Parkinson's disease are available at:

<https://www.aan.com>

	amantadine	
	benztropine	
	bromocriptine	PARLODEL
	carbidopa/levodopa	SINEMET
	carbidopa/levodopa ext-rel	SINEMET CR
	carbidopa/levodopa/entacapone	STALEVO
	entacapone	COMTAN
	pramipexole	MIRAPEX
	ropinirole	REQUIP
	selegiline	
	trihexyphenidyl	

ANTIPSYCHOTICS

Atypicals

QL	aripiprazole	ABILIFY
AL, QL	aripiprazole ext-rel inj	ABILIFY MAINTENA
AL, QL	aripiprazole lauroxil ext-rel inj	ARISTADA
QL	asenapine	SAPHRIS
AL, QL	brexipiprazole	REXULTI
AL, QL	cariprazine	VRAYLAR

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AL, QL	clozapine	CLOZARIL
AL, QL	clozapine orally disintegrating tabs	FAZACLO
AL, QL	clozapine susp	VERSACLOZ
AL, QL	iloperidone	FANAPT
AL, QL	lurasidone	LATUDA
QL	olanzapine	ZYPREXA
	olanzapine inj	ZYPREXA
QL	olanzapine orally disintegrating tabs	ZYPREXA ZYDIS
AL, QL	olanzapine pamoate ext-rel inj	ZYPREXA RELPREVV
AL, QL	olanzapine/fluoxetine	SYMBYAX
QL	paliperidone ext-rel	INVEGA
AL, QL	paliperidone palmitate ext-rel inj	INVEGA SUSTENNA
AL, QL	paliperidone palmitate ext-rel inj	INVEGA TRINZA
QL	quetiapine	SEROQUEL
QL	quetiapine ext-rel	SEROQUEL XR
QL	risperidone	RISPERDAL
AL, QL	risperidone long-acting inj	RISPERDAL CONSTA
QL	risperidone orally disintegrating tabs	
AL, QL	ziprasidone	GEODON
AL	ziprasidone inj	GEODON

QL	aripiprazole orally disintegrating tabs	=	Max 60 tabs per month
QL	aripiprazole soln	=	Max 900 mL per month
QL	aripiprazole tabs 2 mg, 10 mg, 15 mg, 30 mg	=	Max 30 tabs per month
QL	aripiprazole tabs 5 mg	=	Max 45 tabs per month
QL	aripiprazole tabs 20 mg	=	Max 60 tabs per month
QL	clozapine orally disintegrating tabs 12.5 mg, 25 mg, 150 mg, 200 mg	=	Max 90 tabs per month
QL	clozapine orally disintegrating tabs 100 mg	=	Max 180 tabs per month
QL	clozapine tabs 25 mg, 50 mg, 200 mg	=	Max 90 tabs per month
QL	clozapine tabs 100 mg	=	Max 180 tabs per month
QL	olanzapine orally disintegrating tabs 5 mg	=	Max 30 tabs per month
QL	olanzapine orally disintegrating tabs 10 mg, 15 mg	=	Max 60 tabs per month
QL	olanzapine orally disintegrating tabs 20 mg	=	Max 90 tabs per month
QL	olanzapine tabs 2.5 mg, 5 mg, 7.5 mg	=	Max 30 tabs per month
QL	olanzapine tabs 10 mg, 15 mg	=	Max 60 tabs per month
QL	olanzapine tabs 20 mg	=	Max 90 tabs per month
QL	olanzapine/fluoxetine	=	Max 30 caps per month
QL	paliperidone ext-rel 1.5 mg, 3 mg, 9 mg	=	Max 30 tabs per month
QL	paliperidone ext-rel 6 mg	=	Max 60 tabs per month
QL	risperidone orally disintegrating tabs	=	Max 60 tabs per month
QL	risperidone soln	=	Max 240 mL per month
QL	risperidone tabs	=	Max 60 tabs per month
QL	quetiapine 25 mg, 50 mg, 100 mg, 200 mg	=	Max 90 tabs per month
QL	quetiapine 300 mg, 400 mg	=	Max 120 tabs per month
QL	quetiapine ext-rel 50 mg	=	Max 60 tabs per month
QL	quetiapine ext-rel 150 mg, 200 mg	=	Max 30 tabs per month
QL	quetiapine ext-rel 300 mg	=	Max 90 tabs per month
QL	quetiapine ext-rel 400 mg	=	Max 120 tabs per month
QL	ziprasidone 20 mg, 40 mg	=	Max 60 caps per month
QL	ziprasidone 60 mg, 80 mg	=	Max 90 caps per month
QL	ABILIFY MAINTENA	=	Max 1 inj per 28 days
QL	ARISTADA	=	Max 1 inj per 28 days
QL	FANAPT	=	Max 60 tabs per month
QL	INVEGA SUSTENNA	=	Max 1 inj per 28 days

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 ext-rel: extended-release (also known as sustained-release)

QL	INVEGA TRINZA	=	Max 1 inj per 84 days
QL	LATUDA 20 mg, 40 mg, 60 mg, 120 mg	=	Max 30 tabs per month
QL	LATUDA 80 mg	=	Max 60 tabs per month
QL	REXULTI	=	Max 30 tabs per month
QL	RISPERDAL CONSTA	=	Max 2 inj per 28 days
QL	SAPHRIS	=	Max 60 tabs per month
QL	VERSACLOZ	=	Max 360 mL per month
QL	VRAYLAR 1.5 mg	=	Max 60 caps per month
QL	VRAYLAR 3 mg, 4.5 mg, 6 mg	=	Max 30 caps per month
QL	VRAYLAR THERAPY PACK	=	Max 1 pack per 28 days
QL	ZYPREXA RELPREVV 210 mg, 300 mg	=	Max 2 inj per 28 days
QL	ZYPREXA RELPREVV 405 mg	=	Max 1 inj per 28 days

Miscellaneous

QL	chlorpromazine	
	chlorpromazine inj	
AL	fluphenazine decanoate inj	
AL	fluphenazine HCl concentrate, elixir	
AL	fluphenazine HCl inj	
AL, QL	fluphenazine HCl tabs	
AL	haloperidol decanoate inj	HALDOL DECANOATE
	haloperidol lactate inj	HALDOL
	haloperidol oral concentrate	
QL	haloperidol tabs	
AL, QL	loxapine	
QL	molindone	
AL, QL	perphenazine	
	perphenazine/amitriptyline	
QL	pimozide	
	prochlorperazine	
	prochlorperazine inj	
QL	thioridazine	
QL	thiothixene	
QL	trifluoperazine	

QL	chlorpromazine	=	Max 120 tabs per month
QL	fluphenazine HCl tabs	=	Max 120 tabs per month
QL	haloperidol tabs	=	Max 90 tabs per month
QL	loxapine	=	Max 120 caps per month
QL	molindone 5 mg, 10 mg	=	Max 120 caps per month
QL	molindone 25 mg	=	Max 270 tabs per month
QL	perphenazine	=	Max 120 tabs per month
QL	pimozide 1 mg	=	Max 300 tabs per month
QL	pimozide 2 mg	=	Max 150 tabs per month
QL	thioridazine	=	Max 120 tabs per month
QL	thiothixene	=	Max 90 tabs per month
QL	trifluoperazine 1 mg, 2 mg, 5 mg	=	Max 60 tabs per month
QL	trifluoperazine 10 mg	=	Max 120 tabs per month

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Guidelines for the evaluation and management of attention deficit disorder are available at:

<https://www.aacap.org>

<https://www.aap.org>

QL	amphetamine ext-rel orally disintegrating tabs	ADZENYS XR-ODT
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QL	amphetamine ext-rel susp	DYANAVEL XR
QL	amphetamine sulfate	EVEKEO
QL	amphetamine/dextroamphetamine mixed salts	ADDERALL
QL	amphetamine/dextroamphetamine mixed salts ext-rel	ADDERALL XR
QL	atomoxetine	STRATTERA
QL	clonidine ext-rel	KAPVAY
QL	dexmethylphenidate	FOCALIN
QL	dexmethylphenidate ext-rel	FOCALIN XR
QL	dextroamphetamine ext-rel	DEXEDRINE SPANSULE
QL	dextroamphetamine soln	PROCENTRA
QL	dextroamphetamine tabs	
QL	guanfacine ext-rel	INTUNIV
QL	lisdexamfetamine caps, chew tabs	VYVANSE
	methamphetamine	DESOXYN
QL	methylphenidate	RITALIN
QL	methylphenidate chew tabs, soln, tabs	METHYLIN
QL	methylphenidate ext-rel caps	APTENSIO XR
QL	methylphenidate ext-rel caps	METADATE CD
QL	methylphenidate ext-rel caps	RITALIN LA
QL	methylphenidate ext-rel chew tabs	QUILLICHEW ER
QL	methylphenidate ext-rel susp	QUILLIVANT XR
QL	methylphenidate ext-rel tabs	
QL	methylphenidate transdermal	DAYTRANA

QL	amphetamine 5 mg	=	Max 30 tabs per month
QL	amphetamine 10 mg	=	Max 180 tabs per month
QL	amphetamine/dextroamphetamine mixed salts	=	Max 90 tabs per month
QL	amphetamine/dextroamphetamine mixed salts ext-rel 5 mg, 10 mg, 15 mg	=	Max 30 caps per month
QL	amphetamine/dextroamphetamine mixed salts ext-rel 20 mg, 25 mg, 30 mg	=	Max 60 caps per month
QL	atomoxetine 10 mg, 18 mg, 25 mg, 40 mg	=	Max 60 caps per month
QL	atomoxetine 60 mg, 80 mg, 100 mg	=	Max 30 caps per month
QL	clonidine ext-rel	=	Max 120 tabs per month
QL	dexmethylphenidate 2.5 mg, 5 mg	=	Max 60 tabs per month
QL	dexmethylphenidate 10 mg	=	Max 120 tabs per month
QL	dexmethylphenidate ext-rel	=	Max 30 caps per month
QL	dextroamphetamine ext-rel	=	Max 60 caps per month
QL	dextroamphetamine 2.5 mg, 5 mg, 15 mg	=	Max 30 tabs per month
QL	dextroamphetamine 7.5 mg, 20 mg, 30 mg	=	Max 60 tabs per month
QL	dextroamphetamine 10 mg	=	Max 120 tabs per month
QL	dextroamphetamine soln	=	Max 1200 mL per month
QL	guanfacine ext-rel	=	Max 30 tabs per month
QL	methylphenidate	=	Max 90 tabs per month
QL	methylphenidate chew tabs (generic for METHYLIN)	=	Max 90 tabs per month
QL	methylphenidate soln 5 mg/5 mL	=	Max 1800 mL per month
QL	methylphenidate soln 10 mg/5 mL	=	Max 900 mL per month
QL	methylphenidate ext-rel caps (generic for METADATE CD)	=	Max 30 caps per month
QL	methylphenidate ext-rel caps 10 mg, 20 mg, 40 mg, 60 mg (generic for RITALIN LA)	=	Max 30 caps per month
QL	methylphenidate ext-rel caps 30 mg (generic for RITALIN LA)	=	Max 60 caps per month
QL	methylphenidate ext-rel tabs 10 mg, 20 mg	=	Max 90 tabs per month
QL	methylphenidate ext-rel tabs 18 mg, 27 mg, 72 mg	=	Max 30 tabs per month
QL	methylphenidate ext-rel tabs 36 mg, 54 mg	=	Max 60 tabs per month

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QL	ADZENYS XR-ODT	=	Max 30 tabs per month
QL	APTENSIO XR	=	Max 30 caps per month
QL	DAYTRANA	=	Max 30 patches per month
QL	DYANAVEL XR	=	Max 240 mL per month
QL	QUILLICHEW ER 20 mg, 40 mg	=	Max 30 tabs per month
QL	QUILLICHEW ER 30 mg	=	Max 60 tabs per month
QL	QUILLIVANT XR	=	Max 360 mL per month
QL	VYVANSE	=	Max 30 caps per month

FIBROMYALGIA

milnacipran	SAVELLA
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HYPNOTICS

Practice parameters for the treatment of sleep disorders and clinical guidelines for the evaluation and management of chronic insomnia are available at:

<https://aasm.org>

Benzodiazepines

QL	estazolam	PROSOM
QL	flurazepam	
	midazolam	
	midazolam inj	
QL	quazepam	DORAL
QL	temazepam	RESTORIL
QL	triazolam	HALCION

QL	estazolam	=	Max 30 tabs per month
QL	flurazepam	=	Max 30 caps per month
QL	quazepam	=	Max 30 tabs per month
QL	temazepam	=	Max 30 caps per month
QL	triazolam	=	Max 30 tabs per month

Nonbenzodiazepines

OTC	diphenhydramine	UNISOM SLEEP
OTC	doxylamine	UNISOM
	amobarbital inj	AMYTAL SODIUM
QL	butabarbital	BUTISOL SODIUM
	chloral hydrate	
	dexmedetomidine inj	
QL	eszopiclone	LUNESTA
	pentobarbital inj	NEMBUTAL
QL	ramelteon	ROZEREM
	secobarbital	SECONAL
QL	suvorexant	BELSOMRA
SP, QL	tasimelteon	HETLIOZ
QL	zaleplon	
QL	zolpidem	AMBIEN
QL	zolpidem ext-rel	AMBIEN CR
QL	zolpidem spray	ZOLPIMIST
QL	zolpidem sublingual	EDLUAR
QL	zolpidem sublingual	INTERMEZZO

QL	eszopiclone	=	Max 30 tabs per month
QL	zaleplon	=	Max 60 caps per month
QL	zolpidem	=	Max 30 tabs per month

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QL	zolpidem ext-rel	=	Max 30 tabs per month
QL	zolpidem orally disintegrating tabs	=	Max 30 tabs per month
QL	BELSOMRA	=	Max 30 tabs per month
QL	BUTISOL SODIUM	=	Max 90 tabs per month
QL	EDLUAR	=	Max 30 tabs per month
QL	HETLIOZ	=	Max 30 caps per month
QL	ROZEREM	=	Max 30 tabs per month
QL	ZOLPIMIST	=	Max 1 bottle per month

Tricyclics

QL	doxepin		SILENOR
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QL	SILENOR	=	Max 30 tabs per month
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MIGRAINE

Guidelines for prevention and management of migraine headaches are available at:

<https://www.aan.com>

Ergotamine Derivatives

	dihydroergotamine inj		D.H.E. 45
	ergotamine/caffeine		CAFERGOT

Selective Serotonin Agonists

QL	almotriptan		
QL	naratriptan		AMERGE
QL	rizatriptan		MAXALT
QL	rizatriptan orally disintegrating tabs		MAXALT-MLT
QL	sumatriptan		IMITREX
QL	sumatriptan inj		IMITREX
QL	sumatriptan nasal spray		IMITREX

QL	almotriptan	=	Max 12 tabs per month
QL	naratriptan	=	Max 9 tabs per month
QL	rizatriptan	=	Max 12 tabs per month
QL	rizatriptan orally disintegrating tabs	=	Max 12 tabs per month
QL	sumatriptan	=	Max 12 tabs per month
QL	sumatriptan inj	=	Max 10 inj per month
QL	sumatriptan nasal spray	=	Max 12 doses (2 boxes) per month

MOOD STABILIZERS

QL	carbamazepine ext-rel		EQUETRO
	lithium carbonate		
	lithium carbonate ext-rel tabs 300 mg		LITHOBID
	lithium carbonate ext-rel tabs 450 mg		

QL	EQUETRO 100 mg	=	Max 120 caps per month
QL	EQUETRO 200 mg	=	Max 240 caps per month
QL	EQUETRO 300 mg	=	Max 150 caps per month

MOVEMENT DISORDERS

PA, SP	tetrabenazine		XENAZINE
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 ext-rel: extended-release (also known as sustained-release)

MULTIPLE SCLEROSIS AGENTS

Practice guidelines for multiple sclerosis are available at:
<https://www.aan.com>

PA, SP	dalfampridine ext-rel	AMPYRA
PA, SP	dimethyl fumarate delayed-rel	TECFIDERA
PA, SP	fingolimod	GILENYA
SP	glatiramer	
PA, SP	interferon beta-1a	AVONEX
PA, SP	interferon beta-1a	REBIF
PA, SP	interferon beta-1b	EXTAVIA
PA, SP	teriflunomide	AUBAGIO

MUSCULOSKELETAL THERAPY AGENTS

	baclofen	
QL	carisoprodol 350 mg	SOMA
ST, QL	carisoprodol/aspirin	
	chlorzoxazone	
	cyclobenzaprine 5 mg, 10 mg	
	dantrolene	DANTRIUM
	methocarbamol	ROBAXIN
	orphenadrine ext-rel	
	tizanidine tabs	ZANAFLEX tabs

QL carisoprodol 350 mg = Max 120 tabs per month

QL carisoprodol/aspirin = Max 240 tabs per month

MYASTHENIA GRAVIS

	pyridostigmine	MESTINON
	pyridostigmine ext-rel	MESTINON TIMESPAN

NARCOLEPSY/CATAPLEXY

QL	armodafinil	NUVIGIL
QL	modafinil	PROVIGIL
QL	sodium oxybate	XYREM

QL armodafinil 50 mg = Max 60 tabs per month

QL armodafinil 150 mg, 200 mg, 250 mg = Max 30 tabs per month

QL modafinil 100 mg = Max 30 tabs per month

QL modafinil 200 mg = Max 60 tabs per month

QL XYREM = Max 540 mL per month

PSYCHOTHERAPEUTIC-MISCELLANEOUS**Alcohol Deterrents**

	acamprosate calcium	
	disulfiram	ANTABUSE

Opioid Antagonists

QL	naloxone inj	
	naloxone nasal spray	NARCAN
	naltrexone	
SP	naltrexone microspheres	VIVITROL

QL naloxone inj = Max 2 mL per month

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 ext-rel: extended-release (also known as sustained-release)

Partial Opioid Agonists

PA	buprenorphine sublingual	
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Partial Opioid Agonist/Opioid Antagonist Combinations

PA	buprenorphine/naloxone sublingual tabs	
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Pseudobulbar Affect

PA	dextromethorphan/quinidine	NUEDEXTA
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Smoking Deterrents

Treating Tobacco Use and Dependence: 2008 Update-Clinical Practice Guideline is available at:

<https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html>

QL	bupropion ext-rel	ZYBAN
QL	varenicline	CHANTIX

QL bupropion ext-rel = Max 180 days supply per year

QL CHANTIX = Max 180 days supply per year

MISCELLANEOUS

	doxapram	DOPRAM
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QL	ergoloid mesylates	
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PA	riluzole	RILUTEK
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QL ergoloid mesylates = Max 90 tabs per month

ENDOCRINE AND METABOLIC**ACROMEGALY**

PA, SP	octreotide acetate	SANDOSTATIN
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PA, SP	pegvisomant	SOMAVERT
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ANDROGENS

Clinical practice guidelines for the treatment of hypogonadism are available at:

<https://www.aace.com>

PA	oxandrolone	
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PA	oxymetholone	ANADROL-50
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PA	testosterone cypionate	DEPO-TESTOSTERONE
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PA	testosterone enanthate	DELATESTRYL
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PA, QL	testosterone gel	ANDROGEL
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PA, QL	testosterone gel	FORTESTA
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QL testosterone gel 1% (50 mg/5 g) = Max 150 grams per month

QL testosterone gel 1.62% (20.25 mg/1.25 g) = Max 30 packets per month

QL testosterone gel 1.62% (40.5 mg/2.5 g) = Max 60 packets per month

QL testosterone gel 2% (generic for FORTESTA) = Max 60 grams per month

ANTIDIABETICS

Guidelines of treatment and management of diabetes are available at:

<https://professional.diabetes.org>

Alpha-glucosidase Inhibitors

	acarbose	PRECOSE
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ST	miglitol	GLYSET
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ext-rel: extended-release (also known as sustained-release)

Amylin Analogs

ST	pramlintide	SYMLINPEN
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Biguanides

	metformin	GLUCOPHAGE
	metformin ext-rel	GLUCOPHAGE XR

Biguanide/Sulfonylurea Combinations

	glipizide/metformin	
QL	glyburide/metformin	

QL glyburide/metformin = Max 300 tabs per month

Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

	alogliptin	NESINA
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Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/Biguanide Combinations

	alogliptin/metformin	KAZANO
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Dipeptidyl Peptidase-4 (DPP-4) Inhibitor/Insulin Sensitizer Combinations

	alogliptin/pioglitazone	OSENI
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Incretin Mimetic Agents

ST, QL	dulaglutide	TRULICITY
ST, QL	liraglutide	VICTOZA
ST, QL	semaglutide	OZEMPIC

QL OZEMPIC = Max 4 pens per month

QL TRULICITY = Max 4 pens per month

QL VICTOZA = Max 3 pens per month

Incretin Mimetic Agent/Insulin Combinations

ST, QL	lixisenatide/insulin glargine	SOLIQUA
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QL SOLIQUA = Max 6 pens per month

Insulins

OTC, QL	insulin human	HUMULIN R
OTC, QL	insulin human	NOVOLIN R
OTC, QL	insulin isophane human	HUMULIN N
OTC, QL	insulin isophane human	NOVOLIN N
OTC, QL	insulin isophane human 70%/regular 30%	HUMULIN 70/30
OTC, QL	insulin isophane human 70%/regular 30%	NOVOLIN 70/30
QL	insulin aspart protamine 70%/insulin aspart 30%	NOVOLOG MIX 70/30
QL	insulin degludec	TRESIBA
QL	insulin degludec	TRESIBA FLEXTOUCH
QL	insulin glargine	BASAGLAR KWIKPEN
QL	insulin human	HUMULIN R U-500
QL	insulin lispro	ADMELOG
QL	insulin lispro	ADMELOG SOLOSTAR
QL	insulin lispro protamine/insulin lispro	HUMALOG MIX

QL ADMELOG = Max 4 vials per month

QL ADMELOG SOLOSTAR = Max 10 pens (30 mL) per month

QL BASAGLAR KWIKPEN = Max 10 pens (30 mL) per month

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 ext-rel: extended-release (also known as sustained-release)

QL	HUMALOG MIX	=	Max 4 vials per month
QL	HUMALOG MIX KWIKPEN	=	Max 10 pens (30 mL) per month
QL	HUMULIN, NOVOLIN pens	=	Max 10 pens (30 mL) per month
QL	HUMULIN, NOVOLIN vials	=	Max 4 vials per month
QL	HUMULIN R U-500 vials	=	Max 2 vials per month
QL	NOVOLOG MIX 70/30	=	Max 4 vials per month
QL	NOVOLOG MIX 70/30 FLEXPEN	=	Max 10 pens (30 mL) per month
QL	TRESIBA vials	=	Max 4 vials per month
QL	TRESIBA FLEXTOUCH U-100	=	Max 10 pens (30 mL) per month
QL	TRESIBA FLEXTOUCH U-200	=	Max 9 pens (27 mL) per month

Insulin Sensitizers

	pioglitazone	ACTOS
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Insulin Sensitizer/Biguanide Combinations

	pioglitazone/metformin	ACTOPLUS MET
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Insulin Sensitizer/Sulfonylurea Combinations

ST	pioglitazone/glimepiride	DUETACT
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Meglitinides

	nateglinide	STARLIX
	repaglinide	PRANDIN

Meglitinide/Biguanide Combinations

	repaglinide/metformin	
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Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors

ST	ertugliflozin	STEGLATRO
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Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitor/Biguanide Combinations

ST	ertugliflozin/metformin	SEGLUROMET
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Sulfonylureas

	glimepiride	AMARYL
	glipizide	GLUCOTROL
	glipizide ext-rel	GLUCOTROL XL
QL	glyburide	
QL	glyburide micronized	GLYNASE
	tolazamide	

QL	glyburide 1.25 mg	=	Max 480 tabs per month
QL	glyburide 2.5 mg	=	Max 240 tabs per month
QL	glyburide 5 mg	=	Max 120 tabs per month
QL	glyburide micronized 1.5 mg	=	Max 240 tabs per month
QL	glyburide micronized 3 mg	=	Max 120 tabs per month
QL	glyburide micronized 6 mg	=	Max 60 tabs per month

Supplies

OTC, QL	alcohol swabs	
OTC, QL	blood glucose test strips	ACCU-CHEK AVIVA TEST STRIPS
OTC, QL	blood glucose test strips	ACCU-CHEK SMARTVIEW TEST STRIPS

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ext-rel: extended-release (also known as sustained-release)

OTC, QL	blood glucose test strips	FREESTYLE FREEDOM LITE TEST STRIPS
OTC, QL	blood glucose test strips	FREESTYLE INSULINX TEST STRIPS
OTC, QL	blood glucose test strips	FREESTYLE LITE TEST STRIPS
OTC, QL	blood glucose test strips	TRUE METRIX TEST STRIPS
OTC	glucose	
OTC, QL	insulin syringes, needles	
OTC, QL	lancets	
OTC	urine glucose test strips	

QL	alcohol swabs	=	Max 200 per month
QL	blood glucose test strips	=	Max 200 strips per month
QL	insulin syringes, needles	=	Max 200 per month
QL	lancets	=	Max 204 per month

CALCIUM RECEPTOR ANTAGONISTS

SP	cinacalcet	SENSIPAR
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CALCIUM REGULATORS

Guidelines of treatment and management of osteoporosis are available at:

<https://www.aace.com>

<https://www.nof.org>

Bisphosphonates

	alendronate tabs	FOSAMAX
	etidronate	
	ibandronate tabs	BONIVA

Calcitonins

	calcitonin-salmon inj	MIACALCIN
	calcitonin-salmon spray	MIACALCIN

CONTRACEPTIVES

EE = ethinyl estradiol

Monophasic*20 mcg Estrogen*

	drospirenone/EE 3/20	YAZ
PA	drospirenone/EE/levomefolate 3/20 and levomefolate	BEYAZ
	levonorgestrel/EE 0.1/20	
	norethindrone acetate/EE 1/20	LOESTRIN 1/20
	norethindrone acetate/EE 1/20 and iron	LOESTRIN FE 1/20
	norethindrone acetate/EE 1/20 and iron - Junel 24 Fe	

30 mcg Estrogen

	desogestrel/EE 0.15/30 - Apri	
	drospirenone/EE 3/30	YASMIN
	levonorgestrel/EE 0.15/30	
	norethindrone acetate/EE 1.5/30	LOESTRIN 1.5/30
	norethindrone acetate/EE 1.5/30 and iron	LOESTRIN FE 1.5/30
	norgestrel/EE 0.3/30	

35 mcg Estrogen

	ethynodiol diacetate/EE 1/35	
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ext-rel: extended-release (also known as sustained-release)

	norethindrone/EE 0.4/35	
	norethindrone/EE 0.5/35	
	norethindrone/EE 1/35	ORTHO-NOVUM 1/35
	norgestimate/EE 0.25/35	ORTHO-CYCLEN

50 mcg Estrogen

	ethynodiol diacetate/EE 1/50	
QL	norgestrel/EE 0.5/50 - Ogestrel	

QL norgestrel/EE 0.5/50 - Ogestrel = Max 28 tabs per 28 days

Biphasic

	desogestrel/EE	MIRCETTE
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Triphasic

	desogestrel/EE	
	levonorgestrel/EE	
	norethindrone acetate/EE and iron	ESTROSTEP FE
	norethindrone/EE	ORTHO-NOVUM 7/7/7
	norethindrone/EE	TRI-NORINYL
	norgestimate/EE	ORTHO TRI-CYCLEN

Progestin Only

	norethindrone	ORTHO MICRONOR
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Emergency Contraception

OTC, QL	levonorgestrel	PLAN B ONE-STEP
QL	ulipristal	ELLA

QL levonorgestrel = Max 6 tabs per year

QL ELLA = Max 6 tabs per year

Extended Cycle

	levonorgestrel/EE 0.1/20 and EE 10	LOSEASONIQUE
	levonorgestrel/EE 0.15/30	
	levonorgestrel/EE 0.15/30 and EE 10	SEASONIQUE

Implant

SP	etonogestrel implant	NEXPLANON
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Injectable

QL	medroxyprogesterone acetate 150 mg/mL	DEPO-PROVERA
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QL medroxyprogesterone acetate 150 mg/mL = Max 1 inj per 3 months

Intrauterine Devices

	copper IUD	PARAGARD T380A
SP	levonorgestrel-releasing IUD	KYLEENA
SP	levonorgestrel-releasing IUD	LILETTA
SP	levonorgestrel-releasing IUD	MIRENA
SP	levonorgestrel-releasing IUD	SKYLA

Transdermal

ST	norelgestromin/EE - Xulane	
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ext-rel: extended-release (also known as sustained-release)

Vaginal

	etonogestrel/EE ring	NUVARING
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Miscellaneous

OTC, QL	condoms, male	
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QL condoms, male = Max 24 condoms per month

ENDOMETRIOSIS

	danazol	
PA	elagolix	ORILISSA
PA	nafarelin	SYNAREL

ESTROGENS

Guidelines of treatment and management of hormone therapy and menopause are available at:

<https://www.menopause.org>

<https://www.aace.com/files/menopause.pdf>

Oral

	estradiol	ESTRACE
	estrogens, conjugated	PREMARIN
	estrogens, esterified	MENEST
	estrogens, esterified/methyltestosterone	
	estrogens, esterified/ methyltestosterone - Covaryx, Covaryx HS	

Transdermal

QL	estradiol	ALORA
	estradiol	CLIMARA

QL ALORA = Max 8 patches per month

Vaginal

	estradiol vaginal crm	ESTRACE CREAM
	estradiol vaginal tabs	VAGIFEM
	estrogens, conjugated crm	PREMARIN CREAM

ESTROGEN/PROGESTINS**Oral**

	EE/norethindrone acetate	FEMHRT
	EE/norethindrone acetate - Jinteli	
	estradiol/norethindrone acetate	ACTIVELLA
	estradiol/norgestimate	PREFEST
	estrogens, conjugated/medroxyprogesterone	PREMPHASE
	estrogens, conjugated/medroxyprogesterone	PREMPRO

Transdermal

ST	estradiol/levonorgestrel	CLIMARA PRO
	estradiol/norethindrone acetate	COMBIPATCH

ESTROGEN/SELECTIVE ESTROGEN RECEPTOR MODULATOR COMBINATIONS

ST	conjugated estrogens/bazedoxifene	DUAVEE
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GAUCHER DISEASE

PA	miglustat	ZAVESCA
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GLUCOCORTICOIDS

	cortisone acetate	
	dexamethasone	
PA	dexamethasone	DEXPAK
	fludrocortisone	
	hydrocortisone	CORTEF
	hydrocortisone succinate	SOLU-CORTEF
	methylprednisolone	MEDROL
	prednisolone sodium phosphate soln 5 mg/5 mL, 15 mg/5 mL	
	prednisolone syrup	
	prednisone	

GLUCOSE ELEVATING AGENTS

QL	glucagon, human recombinant	GLUCAGEN HYPOKIT
QL	glucagon, human recombinant	GLUCAGON EMERGENCY KIT

QL	GLUCAGEN HYPOKIT	=	Max 2 inj per month
QL	GLUCAGON EMERGENCY KIT	=	Max 2 inj per month

HUMAN GROWTH HORMONES

Guidelines for use of growth hormone are available at:

<https://www.aace.com/publications/guidelines>

PA, SP	somatropin vials 5.8 mg	OMNITROPE
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HYPERPARATHYROID TREATMENT, VITAMIN D ANALOGS

	calcitriol (1,25-D3)	ROCALTROL
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INSULIN-LIKE GROWTH FACTOR

PA, SP	mecasermin	INCRELEX
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PHENYLKETONURIA TREATMENT AGENTS

PA, SP	sapropterin	KUVAN
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PHOSPHATE BINDER AGENTS

	calcium acetate	
	lanthanum chew tabs	FOSRENOL

POTASSIUM-REMOVING AGENTS

	sodium polystyrene sulfonate	
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PROGESTINS

Oral

	medroxyprogesterone acetate	PROVERA
	norethindrone acetate	AYGESTIN
	progesterone, micronized	PROMETRIUM

Vaginal

	progesterone gel	CRINONE
	progesterone supp	FIRST-PROGESTERONE VGS
	progesterone vaginal inserts	ENDOMETRIN

SELECTIVE ESTROGEN RECEPTOR MODULATORS

	raloxifene	EVISTA
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THYROID AGENTS**Antithyroid Agents**

	methimazole	TAPAZOLE
	potassium iodide	SSKI
	propylthiouracil	

Thyroid Supplements

	levothyroxine	
	levothyroxine	SYNTHROID
	levothyroxine - Levoxyl	
	liothyronine	CYTOMEL
QL	liotrix	THYROLAR
	thyroid	ARMOUR THYROID

QL THYROLAR = Max 30 tabs per month

UREA CYCLE DISORDERS

PA, SP	sodium phenylbutyrate	BUPHENYL
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VASOPRESSIN RECEPTOR ANTAGONISTS

PA, SP	tolvaptan	SAMSCA
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VASOPRESSINS

SP	desmopressin spray	STIMATE
	desmopressin spray, tabs	DDAVP

MISCELLANEOUS

	cabergoline	
	methylergonovine - Methergine	
PA, SP	nitisinone	ORFADIN
SP	tesamorelin	EGRIFTA

GASTROINTESTINAL

Guidelines for the treatment and management of various gastrointestinal diseases/conditions are available at:

<https://gi.org>

<https://www.gastro.org>

ANTIDIARRHEALS

PA	crofelemer delayed-rel	MYTESI
	diphenoxylate/atropine	LOMOTIL
	loperamide	

ANTIEMETICS

PA	aprepitant 40 mg, 80 mg	EMEND
PA, QL	aprepitant 125 mg & 80 mg pack	EMEND TRIPACK
PA	dronabinol	MARINOL
	droperidol inj	
QL	granisetron tabs	
	metoclopramide	REGLAN
PA	netupitant/palonosetron	AKYNZEO
	ondansetron	ZOFRAN
	prochlorperazine supp	
	promethazine	

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trimethobenzamide		TIGAN
QL	aprepitant 80 mg & 125 mg pack	= Max 1 pack per 15 days
QL	granisetron tabs	= Max 15 tabs per month
ANTISPASMODICS		
	chlordiazepoxide	
	chlordiazepoxide/clidinium	
	dicyclomine	BENTYL
	glycopyrrolate tabs 1 mg, 2 mg	
	hyoscyamine sublingual	LEVSIN/SL
	hyoscyamine sulfate	LEVSIN
	hyoscyamine sulfate ext-rel	LEVBID
	hyoscyamine sulfate orally disintegrating tabs	ANASPAZ
	methscopolamine tabs 2.5 mg	
CHOLELITHOLYTICS		
	ursodiol	ACTIGALL
	ursodiol	URSO
H₂ RECEPTOR ANTAGONISTS		
	cimetidine	
	famotidine	PEPCID
	nizatidine	
	ranitidine	ZANTAC
INFLAMMATORY BOWEL DISEASE		
Oral Agents		
	balsalazide	
	budesonide delayed-rel caps	ENTOCORT EC
	mesalamine delayed-rel caps	DELZICOL
	mesalamine delayed-rel tabs	ASACOL HD
ST	mesalamine delayed-rel tabs	LIALDA
	mesalamine ext-rel caps	APRISO
ST	mesalamine ext-rel caps	PENTASA
ST	olsalazine	DIPENTUM
	sulfasalazine	AZULFIDINE
	sulfasalazine delayed-rel	AZULFIDINE EN-TABS
Rectal Agents		
	hydrocortisone acetate foam	CORTIFOAM
	hydrocortisone enema	
	mesalamine rectal susp	ROWASA
	mesalamine supp	CANASA
IRRITABLE BOWEL SYNDROME		
Irritable Bowel Syndrome with Constipation/Chronic Idiopathic Constipation		
PA, QL	plecanatide	TRULANCE
QL	TRULANCE	= Max 30 tabs per month
Irritable Bowel Syndrome with Diarrhea		
PA	alosetron	LOTRONEX

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LAXATIVES/STOOL SOFTENERS

OTC	bisacodyl	DULCOLAX
OTC	docusate calcium	
OTC	docusate sodium	COLACE
OTC	polyethylene glycol 3350	MIRALAX
OTC	senna	
OTC	sennosides	SENOKOT
OTC	sennosides/docusate sodium	SENNAPLUS
OTC	sodium phosphate/sodium bisphosphate enema soln	FLEET ENEMA-PEDIATRIC
	lactulose soln	
	peg 3350/electrolytes	COLYTE
	peg 3350/electrolytes	GOLYTELY
	peg 3350/electrolytes	NULYTELY

PANCREATIC ENZYMES

	pancrelipase	VIOKACE
	pancrelipase delayed-rel	CREON
	pancrelipase delayed-rel	ZENPEP

PROSTAGLANDINS

	misoprostol	CYTOTEC
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PROTON PUMP INHIBITORS

OTC, QL	esomeprazole magnesium delayed-rel	NEXIUM 24HR
OTC, QL	lansoprazole delayed-rel	PREVACID 24HR
OTC, QL	omeprazole magnesium delayed-rel	PRILOSEC OTC
OTC, QL	omeprazole magnesium delayed-rel caps	
OTC, QL	omeprazole/sodium bicarbonate	ZEGERID OTC
QL	lansoprazole powder for suspension	FIRST-LANSOPRAZOLE
QL	omeprazole delayed-rel	
QL	omeprazole powder for suspension	FIRST-OMEPRAZOLE
QL	omeprazole powder for suspension	PRILOSEC
QL	pantoprazole delayed-rel tabs	PROTONIX

QL	lansoprazole delayed-rel	=	Max 60 caps per month and max 180 days supply per year
QL	omeprazole delayed-rel	=	Max 60 caps per month and max 180 days supply per year
QL	omeprazole magnesium delayed-rel caps	=	Max 60 caps per month and max 180 days supply per year
QL	omeprazole/sodium bicarbonate	=	Max 60 caps per month and max 180 days supply per year
QL	pantoprazole	=	Max 60 tabs per month and max 180 days supply per year
QL	FIRST-LANSOPRAZOLE	=	Max 1 bottle per month and max 180 days supply per year
QL	FIRST-OMEPRAZOLE	=	Max 1 bottle per month and max 180 days supply per year
QL	NEXIUM 24HR	=	Max 120 caps per month and max 180 days supply per year
QL	PRILOSEC OTC	=	Max 60 tabs per month and max 180 days supply per year
QL	PRILOSEC POWDER	=	Max 30 packets per month and max 180 days supply per year

SALIVA STIMULANTS

	pilocarpine tabs	SALAGEN
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STEROIDS, RECTAL

	hydrocortisone crm	ANUSOL-HC 2.5%
	hydrocortisone crm	PROCTOCORT 1%

MISCELLANEOUS

PA	carglumic acid	CARBAGLU
PA, SP	cholic acid	CHOLBAM

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PA	cromolyn sodium oral concentrate	GASTROCROM
PA	glycopyrrolate	CUVPOSA
PA	sacrosidase	SUCRAID
	sucrafate susp	CARAFATE
	sucrafate tabs	CARAFATE

GENITOURINARY

BENIGN PROSTATIC HYPERPLASIA

Guidelines for the management of BPH are available at:

<https://www.auanet.org/guidelines>

	alfuzosin ext-rel	UROXATRAL
	doxazosin	CARDURA
	finasteride	PROSCAR
	tamsulosin	FLOMAX
	terazosin	

URINARY ANTISPASMODICS

OTC	oxybutynin transdermal	OXYTROL FOR WOMEN
	flavoxate	
	oxybutynin	
	oxybutynin ext-rel	DITROPAN XL

VAGINAL ANTI-INFECTIVES

	clindamycin crm	CLEOCIN
	clindamycin supp	CLEOCIN vaginal supp
	clotrimazole	
	metronidazole	METROGEL-VAGINAL
	terconazole	

MISCELLANEOUS

PA	acetohydroxamic acid	LITHOSTAT
	bethanechol	URECHOLINE
	hyoscyamine/methenamine/methylene blue/ phenyl salicylate/sodium phosphate	UROGESIC-BLUE
	hyoscyamine/methenamine/methylene blue/ phenyl salicylate/sodium phosphate - Urelle	
	pentosan polysulfate sodium	ELMIRON
	phenazopyridine	PYRIDIUM
	potassium citrate ext-rel	UROCIT-K
	potassium citrate/citric acid	CYTRA-K
	potassium citrate/sodium citrate/citric acid	CYTRA-3
	sodium citrate/citric acid	CYTRA-2

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HEMATOLOGIC

Guidelines of treatment and management of hemophilia are available at:

<https://www.hemophilia.org>

ANTICOAGULANTS

CHEST guidelines are available at:

<https://www.chestnet.org/Guidelines-and-Resources/CHEST-Guideline-Topic-Areas/Pulmonary-Vascular>

Injectable

PA	dalteparin	FRAGMIN
	enoxaparin	LOVENOX
	heparin	

Oral

	apixaban	ELIQUIS
	rivaroxaban	XARELTO
	warfarin	COUMADIN

Synthetic Heparinoid-like Agents

QL	fondaparinux	ARIXTRA
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QL fondaparinux = Max 30 syringes per 6 months, unless PA is initiated

HEMOPHILIA, VON WILLEBRAND DISEASE AND RELATED BLEEDING DISORDERS

PA, SP	antihemophilic factor (human)	HEMOFIL M
PA, SP	antihemophilic factor (human)	KOATE-DVI
PA, SP	antihemophilic factor (human)	MONOCLATE-P
PA, SP	antihemophilic factor (recombinant)	ADVATE
PA, SP	antihemophilic factor (recombinant)	AFSTYLA
PA, SP	antihemophilic factor (recombinant)	ELOCTATE
PA, SP	antihemophilic factor (recombinant)	HELIXATE FS
PA, SP	antihemophilic factor (recombinant)	KOGENATE FS
PA, SP	antihemophilic factor (recombinant)	KOVALTRY
PA, SP	antihemophilic factor (recombinant)	NOVOEIGHT
PA, SP	antihemophilic factor (recombinant)	NUWIQ
PA, SP	antihemophilic factor (recombinant)	RECOMBIMATE
PA, SP	antihemophilic factor (recombinant)	XYNTHA
PA, SP	antihemophilic factor (recombinant)	XYNTHA SOLOFUSE
PA, SP	antihemophilic factor/von Willebrand factor complex (human)	HUMATE-P
PA, SP	anti-inhibitor coagulant complex	FEIBA NF
PA, SP	coagulation factor IX	ALPHANINE SD
PA, SP	coagulation factor IX (recombinant)	BENEFIX
PA, SP	coagulation factor IX (recombinant)	IDELVION
PA, SP	coagulation factor IX (recombinant)	IXINITY
PA, SP	coagulation factor IX (recombinant)	RIXUBIS
PA, SP	coagulation factor VIIa (recombinant)	NOVOSEVEN RT
PA, SP	coagulation factor XIII A-subunit (recombinant)	TRETTEN
PA, SP	factor IX concentrate	MONONINE
PA, SP	factor IX recombinant, Fc fusion protein	ALPROLIX
PA, SP	factor XIII concentrate (human)	CORIFACT KIT
PA, SP	fibrinogen	RIASTAP

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HEMATOPOIETIC GROWTH FACTORS

Guidelines for the management of neutropenia are available at:

<https://www.asco.org>

Guidelines for the management of anemia associated with chronic kidney disease are available at:

<https://www.kidney.org/professionals/guidelines#guidelines>

PA, SP	darbepoetin alfa	ARANESP
PA, SP	epoetin alfa	EPOGEN
PA, SP	epoetin alfa	PROCRIT
PA, SP	filgrastim-sndz	ZARXIO

HEREDITARY ANGIOEDEMA AGENTS

PA, SP	C1 esterase inhibitor	BERINERT
PA, SP	C1 esterase inhibitor	CINRYZE
PA, SP	C1 esterase inhibitor	HAEGARDA

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) AGENTS

PA, SP	eculizumab	SOLIRIS
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PLATELET AGGREGATION INHIBITORS

	clopidogrel	PLAVIX
	dipyridamole	
	prasugrel	EFFIENT
PA	ticagrelor	BRILINTA

PLATELET SYNTHESIS INHIBITORS

	anagrelide	AGRYLIN
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THROMBOCYTOPENIA AGENTS

PA, SP	eltrombopag	PROMACTA
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MISCELLANEOUS

	aminocaproic acid soln	AMICAR
	aminocaproic acid tabs	AMICAR
	cilostazol	
PA, SP	deferasirox	EXJADE
	pentoxifylline ext-rel	
	succimer	CHEMET
ST	tranexamic acid	LYSTEDA

IMMUNOLOGIC AGENTS

Guidelines for the management of rheumatic diseases are available at:

<https://www.rheumatology.org>**ALLERGENIC EXTRACTS**

PA	grass mixed pollen allergen extract	ORALAIR
PA	ragweed pollen allergen extract	RAGWITEK
PA	timothy grass pollen allergen extract	GRASTEK

AUTOIMMUNE AGENTS**Ankylosing Spondylitis**

PA, SP	certolizumab	CIMZIA
PA, SP	etanercept	ENBREL

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PA, SP	secukinumab	COSENTYX
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Crohn's Disease

PA, SP	adalimumab	HUMIRA
PA, SP	certolizumab	CIMZIA

Juvenile Idiopathic Arthritis (JIA)

PA, SP	etanercept	ENBREL
PA, SP	tocilizumab	ACTEMRA

Psoriasis

PA, SP	apremilast	OTEZLA
PA, SP	brodalumab	SILIQ
PA, SP	certolizumab	CIMZIA
PA, SP	etanercept	ENBREL
PA, SP	secukinumab	COSENTYX

Psoriatic Arthritis

PA, SP	apremilast	OTEZLA
PA, SP	certolizumab	CIMZIA
PA, SP	etanercept	ENBREL
PA, SP	secukinumab	COSENTYX
PA, SP	tofacitinib	XELJANZ
PA, SP	tofacitinib ext-rel	XELJANZ XR

Rheumatoid Arthritis

PA, SP	baricitinib	OLUMIANT
PA, SP	certolizumab	CIMZIA
PA, SP	etanercept	ENBREL
PA, SP	sarilumab	KEVZARA
PA, SP	tocilizumab	ACTEMRA
PA, SP	tofacitinib	XELJANZ
PA, SP	tofacitinib ext-rel	XELJANZ XR

Ulcerative Colitis

PA, SP	adalimumab	HUMIRA
PA, SP	tofacitinib	XELJANZ

DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDs)

	hydroxychloroquine	PLAQUENIL
	leflunomide	ARAVA
	methotrexate	

IMMUNE GLOBULINS - Medical Benefit Only**IMMUNOMODULATORS**

CDC recommendations on the treatment of hepatitis are available at:
<https://www.cdc.gov/hepatitis/Resources/>

Guidelines for the management of hepatitis are available at:
<https://www.aasld.org>

Interferons

PA, SP	interferon alfa-2b	INTRON A
PA, SP	interferon gamma-1b	ACTIMMUNE

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PA, SP	peginterferon alfa-2a	PEGASYS
PA, SP	peginterferon alfa-2b	SYLATRON

Miscellaneous

PA, SP	canakinumab	ILARIS
PA, SP	rilonacept	ARCALYST

IMMUNOSUPPRESSANTS**Antimetabolites**

	azathioprine	AZASAN
	azathioprine	IMURAN
	mycophenolate mofetil	CELLCEPT
	mycophenolate sodium delayed-rel	MYFORTIC

Calcineurin Inhibitors

	cyclosporine caps	SANDIMMUNE
	cyclosporine soln	SANDIMMUNE
	cyclosporine, modified	NEORAL
	tacrolimus	PROGRAF

Rapamycin Derivatives

	everolimus	ZORTRESS
	sirolimus	RAPAMUNE

NUTRITIONAL/SUPPLEMENTS**ELECTROLYTES****Potassium**

	potassium chloride ext-rel	
	potassium chloride ext-rel	K-TAB
	potassium chloride liquid	

VITAMINS AND MINERALS**Prenatal Vitamins**

OTC	prenatal vitamins/ferrous fumarate/ folic acid 27 mg/0.8 mg	PRENATAL TAB
	prenatal vitamins without A/ferrous asparto glycinate/ l-methylfolate/folic acid/DHA	PRENATE DHA
	prenatal vitamins without A/ferrous asparto glycinate/ l-methylfolate/folic acid/DHA	PRENATE ESSENTIAL
	prenatal vitamins without A/ferrous asparto glycinate/ iron carbonyl/methylfolate/folic acid/DHA	PRENATE MINI
	prenatal vitamins without A/ferrous asparto glycinate/ l-methylfolate/folic acid/DHA	PRENATE PIXIE
	prenatal vitamins without A/ferrous fumarate/ l-methylfolate/folic acid/DHA	PRENATE ENHANCE
	prenatal vitamins without A/ferrous fumarate/ l-methylfolate/folic acid/DHA	PRENATE RESTORE
	prenatal vitamins/calcium/vitamin B6/vitamin B12/ folic acid/ginger	PRENATE AM
	prenatal vitamins/ferrous asparto glycinate/l-methylfolate/ folic acid	PRENATE ELITE
	prenatal vitamins/minerals/l-methylfolate/folic acid	PRENATE CHEWABLE

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Miscellaneous

OTC	acetyl l-carnitine	
OTC	ferrous sulfate	FEOSOL
OTC	ferrous sulfate 160 mg - Slow Release Iron	
	cyanocobalamin inj	
	ergocalciferol (D2)	
	ferrous fumarate/folic acid - Hemocyte-F	
	ferrous fumarate/vitamin B12/vitamin C/ folic acid/intrinsic factor - Ferrocon	
	ferrous fumarate/vitamin B12/vitamin C/ intrinsic factor - Hematogen	
	fluoride drops, tabs	
	multiple vitamins/minerals	
	multivitamins/fluoride drops, tabs	
	multivitamins/fluoride/iron drops, tabs	
QL	phytonadione	MEPHYTON
	vitamin ADC/fluoride drops	
PA	zinc acetate	GALZIN

QL phytonadione = Max 15 tabs per month

RESPIRATORY

Guidelines to the management, prevention, or treatment of COPD and asthma are available at:

<https://www.aaaai.org>

<https://www.ginasthma.org>

<https://www.goldcopd.org>

<https://www.nhlbi.nih.gov>

The Allergy Report and guidelines for allergy-related conditions are available at:

<https://www.aaaai.org>

ANAPHYLAXIS TREATMENT AGENTS

QL	epinephrine auto-injector	
QL	epinephrine auto-injector	EPIPEN
QL	epinephrine auto-injector	EPIPEN JR.

QL epinephrine auto-injector = Max 4 pens per year

QL EPIPEN = Max 4 pens per year

QL EPIPEN JR. = Max 4 pens per year

ANTICHOLINERGICS

QL	ipratropium soln	
QL	ipratropium, CFC-free aerosol	ATROVENT HFA
QL	tiotropium	SPIRIVA RESPIMAT

QL ipratropium soln = Max 120 units per month

QL ATROVENT HFA = Max 5 inhalers per month

QL SPIRIVA RESPIMAT = Max 1 inhaler per month

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS**Short Acting**

QL	ipratropium/albuterol inhalation spray	COMBIVENT RESPIMAT
QL	ipratropium/albuterol soln	

QL ipratropium/albuterol soln = Max 180 units per month

AL: Age Limit; **OTC:** Over the counter; **PA:** Prior Authorization; **QL:** Quantity Limit; **SP:** Specialty Drug; **ST:** Step Therapy
boldface: indicates generic availability; delayed-rel: delayed-release (also known as enteric-coated);
 ext-rel: extended-release (also known as sustained-release)

QL COMBIVENT RESPIMAT = Max 1 inhaler per month

Long Acting

QL	tiotropium/olodaterol	STIOLTO RESPIMAT
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QL STIOLTO RESPIMAT = Max 1 inhaler per month

ANTI-HISTAMINES, LOW SEDATING

levocetirizine

ANTI-HISTAMINES, SEDATING

carbinoxamine soln

clemastine

cyproheptadine

diphenhydramine

ANTITUSSIVES

Clinical practice guidelines are available at:

[https://journal.chestnet.org/article/S0012-3692\(15\)52856-0/pdf](https://journal.chestnet.org/article/S0012-3692(15)52856-0/pdf)

benzonatate	TESSALON
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ANTITUSSIVE COMBINATIONS**Opioid**

hydrocodone/homatropine

Non-opioid

dextromethorphan/promethazine

BETA AGONISTS**Inhalants****Short Acting**

QL	albuterol inhalation soln	
QL	albuterol sulfate, CFC-free aerosol	VENTOLIN HFA
QL	levalbuterol tartrate, CFC-free aerosol	XOPENEX HFA

QL albuterol sulfate, CFC-free aerosol (generic for VENTOLIN HFA) = Max 4 inhalers per 90 days

QL albuterol inhalation soln 0.5% = Max 50 mL per month

QL albuterol inhalation soln 0.83%, 0.63 mg/3 mL, 1.25 mg/3 mL = Max 375 mL per month

QL levalbuterol tartrate, CFC-free aerosol = Max 2 inhalers per month

Long Acting**Hand-held Active Inhalation**

QL	indacaterol	ARCAPTA NEOHALER
QL	olodaterol, CFC-free aerosol	STRIVERDI RESPIMAT
QL	salmeterol xinafoate	SEREVENT

QL ARCAPTA NEOHALER = Max 1 inhaler per month

QL SEREVENT = Max 1 inhaler per month

QL STRIVERDI RESPIMAT = Max 1 inhaler per month

Oral Agents

albuterol

AL: Age Limit; **OTC:** Over the counter; **PA:** Prior Authorization; **QL:** Quantity Limit; **SP:** Specialty Drug; **ST:** Step Therapy
boldface: indicates generic availability; **delayed-rel:** delayed-release (also known as enteric-coated);
ext-rel: extended-release (also known as sustained-release)

	albuterol ext-rel	
	metaproterenol	
	terbutaline	

CYSTIC FIBROSIS

PA, SP	aztreonam lysine inhalation soln	CAYSTON
PA, SP	dornase alfa	PULMOZYME
PA, SP	ivacaftor	KALYDECO
PA, SP	lumacaftor/ivacaftor	ORKAMBI
SP	tobramycin inhalation soln	KITABIS PAK
SP	tobramycin inhalation soln	TOBI

LEUKOTRIENE RECEPTOR MODULATORS

	montelukast	SINGULAIR
	zafirlukast	ACCOLATE

MAST CELL STABILIZERS

QL	cromolyn soln for inhalation	
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QL cromolyn soln for inhalation = Max 120 vials per month

MEDICAL SUPPLIES

OTC, QL	spacer	AEROCHAMBER
	sodium chloride for inhalation	

QL spacer = Max 2 per year

NASAL ANTIHISTAMINES

	azelastine spray	
	azelastine spray	ASTEPRO

NASAL STEROIDS

OTC, QL	fluticasone spray	FLONASE ALLERGY RELIEF
OTC, QL	triamcinolone acetone spray	NASACORT ALLERGY 24HR
QL	flunisolide spray	
QL	fluticasone spray	

QL flunisolide spray = Max 2 bottles per month

QL fluticasone spray = Max 1 bottle per month

QL triamcinolone acetone spray = Max 1 bottle per month

PHOSPHODIESTERASE-4 INHIBITORS

ST	roflumilast	DALIRESP
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PULMONARY FIBROSIS AGENTS

PA, SP	nintedanib	OFEV
PA, SP	pirfenidone	ESBRIET

RESPIRATORY SYNCYTIAL VIRUS

PA, SP	palivizumab	SYNAGIS
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SEVERE ASTHMA AGENTS

PA, SP	omalizumab	XOLAIR
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boldface: indicates generic availability; **delayed-rel:** delayed-release (also known as enteric-coated);
ext-rel: extended-release (also known as sustained-release)

STEROID/BETA AGONIST COMBINATIONS

QL	fluticasone/salmeterol	AIRDUO RESPICLICK
QL	fluticasone/salmeterol 100/50	ADVAIR 100/50
QL	fluticasone/vilanterol	BREO ELLIPTA
QL	mometasone/formoterol	DULERA

QL	fluticasone/salmeterol	=	Max 1 inhaler per month
QL	BREO ELLIPTA	=	Max 1 inhaler per month
QL	DULERA	=	Max 1 inhaler per month

STEROID INHALANTS

QL	budesonide inhalation susp	PULMICORT RESPULES
QL	fluticasone furoate	ARNUIITY ELLIPTA
QL	fluticasone propionate	FLOVENT DISKUS
QL	fluticasone propionate, CFC-free aerosol	FLOVENT HFA

QL	budesonide inhalation susp	=	Max 60 units per month
QL	ARNUIITY ELLIPTA	=	Max 2 inhalers per month
QL	FLOVENT DISKUS	=	Max 2 inhalers per month
QL	FLOVENT HFA	=	Max 2 inhalers per month

XANTHINES

	theophylline ext-rel caps	THEO-24
	theophylline ext-rel tabs	
	theophylline liquid	
	theophylline liquid	ELIXOPHYLLIN

MISCELLANEOUS

	ipratropium nasal spray	
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TOPICAL**DERMATOLOGY****Acne**

Guidelines for the care and treatment of acne vulgaris are available at:

<https://www.aad.org/practicecenter/quality/clinical-guidelines>

Oral

PA	isotretinoin	
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Topical

OTC, QL	adapalene gel 0.1%	DIFFERIN OTC
	clindamycin gel, lotion	CLEOCIN T
QL	clindamycin soln	CLEOCIN T
	erythromycin gel 2%	
	erythromycin pads	
	erythromycin soln	
	sulfacetamide lotion 10%	KLARON
	sulfacetamide/sulfur crm, gel, lotion, pads	
ST	sulfacetamide/sulfur pad, wash	SUMAXIN
ST	sulfacetamide/sulfur susp	
AL, QL	tretinoin	RETIN-A

QL	DIFFERIN OTC	=	Max 1 tube per month
QL	clindamycin soln	=	Max 60 mL per month

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boldface: indicates generic availability; **delayed-rel:** delayed-release (also known as enteric-coated);
ext-rel: extended-release (also known as sustained-release)

QL tretinoin = Max 45 grams per month

Actinic Keratosis

	fluorouracil crm 5%	EFUDEX
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Antibiotics

OTC	bacitracin	
OTC	bacitracin/polymyxin B	POLYSPORIN
OTC	neomycin/polymyxin B/bacitracin	NEOSPORIN
OTC	neomycin/polymyxin B/bacitracin/pramoxine	
	gentamicin	
	mupirocin	
	silver sulfadiazine	SILVADENE

Antifungals

	ciclopirox	LOPROX
	clotrimazole	
QL	clotrimazole/betamethasone crm	LOTRISONE
	ketoconazole crm, shampoo 2%	
	nystatin	

QL clotrimazole/betamethasone crm = Max 45 grams per month

Antipsoriatics

Guidelines of care for the management and treatment of psoriasis with topical therapies are available at:

<https://www.aad.org>

Topical

QL	calcipotriene	
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QL calcipotriene soln = Max 60 mL per month

QL calcipotriene crm, oint = Max 120 grams per month

Antiseborrheics

	ketoconazole shampoo 2%	NIZORAL
	selenium sulfide shampoo 2.5%	

Atopic Dermatitis

Guidelines for the treatment of atopic dermatitis are available at:

<https://www.aad.org/practicecenter/quality/clinical-guidelines>

Topical

ST, QL	pimecrolimus	ELIDEL
	tacrolimus	PROTOPIC

QL pimecrolimus = Max 100 grams per month

Corticosteroids

Low Potency

	alclometasone crm, oint 0.05%	
	desonide crm, oint 0.05%	DESOWEN
	fluocinolone acetonide oil 0.01%	DERMA-SMOOTHIE/FS
	fluocinolone acetonide soln 0.01%	
	hydrocortisone crm, lotion, oint 2.5%	

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boldface: indicates generic availability; delayed-rel: delayed-release (also known as enteric-coated);
 ext-rel: extended-release (also known as sustained-release)

Medium Potency

	betamethasone valerate crm, lotion, oint 0.1%	
	fluocinolone acetonide crm, oint 0.025%	
	fluticasone propionate crm, lotion 0.05%, oint 0.005%	CUTIVATE
	hydrocortisone butyrate crm, oint, soln 0.1%	LOCOID
	hydrocortisone valerate crm 0.2%	
	mometasone crm, lotion, oint 0.1%	ELOCON
	prednicarbate crm, oint 0.1%	
	triamcinolone acetonide crm, lotion, oint 0.025%	
	triamcinolone acetonide crm, lotion, oint 0.1%	

High Potency

	betamethasone dipropionate augmented crm 0.05%	DIPROLENE AF
	betamethasone dipropionate augmented lotion 0.05%	DIPROLENE
	betamethasone dipropionate crm, lotion, oint 0.05%	
QL	desoximetasone crm 0.25%	TOPICORT
ST, QL	diflorasone diacetate crm 0.05%	
ST	fluocinonide crm, gel, oint 0.05%	
	fluocinonide soln 0.05%	
	triamcinolone acetonide crm, oint 0.5%	

QL desoximetasone crm 0.25% = Max 1 tube per month
 QL diflorasone diacetate crm 0.05% = Max 1 tube per month

Very High Potency

ST	betamethasone dipropionate augmented oint 0.05%	DIPROLENE
ST	clobetasol propionate crm, gel, oint, soln 0.05%	TEMOVATE
ST, QL	diflorasone diacetate oint 0.05%	

QL diflorasone diacetate oint 0.05% = Max 1 tube per month

Local Analgesics

OTC, QL	lidocaine patch 4%	
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QL lidocaine patch 4% = Max 30 patches per month

Local Anesthetics

	lidocaine crm 3%	
	lidocaine/prilocaine crm	

Rosacea

	metronidazole crm 0.75%	METROCREAM
	metronidazole gel 0.75%	
	metronidazole lotion 0.75%	METROLOTION
	sulfacetamide/sulfur	

Scabicides and Pediculicides

ST, QL	benzyl alcohol	ULESFIA
	malathion	OVIDE
	permethrin	
PA	spinosad	NATROBA

QL ULESFIA = Max 277 grams per month

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boldface: indicates generic availability; delayed-rel: delayed-release (also known as enteric-coated);
 ext-rel: extended-release (also known as sustained-release)

Miscellaneous Skin and Mucous Membrane

ST, QL	acyclovir crm, oint	ZOVIRAX
PA	alitretinoin	PANRETIN
PA	becaplermin	REGRANEX
QL	collagenase	SANTYL
ST, QL	penciclovir	DENAVIR
QL	podofilox soln	CONDYLOX
PA	sinecatechins	VEREGEN
	trichloroacetic acid	TRI-CHLOR

QL	acyclovir crm	=	Max 5 grams per month
QL	acyclovir oint	=	Max 15 grams per month
QL	podofilox soln	=	Max 1 bottle per month
QL	DENAVIR	=	Max 1 tube per dispense
QL	SANTYL	=	Max 60 grams per 3 months

MOUTH/THROAT/DENTAL AGENTS**Anesthetics - Topical Oral**

	lidocaine viscous	
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Steroids - Mouth/Throat

	triamcinolone paste	
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Miscellaneous

	chlorhexidine	PERIDEX
	sodium fluoride	PREVIDENT

OPHTHALMIC

Preferred Practice Pattern Guidelines for the treatment of various ophthalmic conditions are available at:

<https://one.aao.org>

Antiallergics

OTC	ketotifen	ZADITOR
	azelastine	
	cromolyn sodium	

Antifungals

QL	natamycin	NATACYN
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QL	NATACYN	=	Max 15 mL per month
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Anti-infectives

	bacitracin	
	ciprofloxacin soln	CILOXAN
	erythromycin	
	gentamicin	
ST	moxifloxacin	VIGAMOX
	neomycin/polymyxin B/gramicidin	
QL	ofloxacin	OCUFLOX
	polymyxin B/bacitracin	
	polymyxin B/trimethoprim	POLYTRIM
	sulfacetamide soln 10%	BLEPH-10
	tobramycin soln	TOBREX

QL	ofloxacin	=	Max 10 mL per month
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boldface: indicates generic availability; **delayed-rel:** delayed-release (also known as enteric-coated);
ext-rel: extended-release (also known as sustained-release)

Anti-infective/Anti-inflammatory Combinations

	gentamicin/prednisolone acetate	PRED-G
	gentamicin/prednisolone acetate	PRED-G SOP
	neomycin/polymyxin B/bacitracin/hydrocortisone oint	
	neomycin/polymyxin B/dexamethasone	MAXITROL
	neomycin/polymyxin B/hydrocortisone susp	
	sulfacetamide/prednisolone acetate oint 10%/0.2%	BLEPHAMIDE SOP
	sulfacetamide/prednisolone phosphate 10%/0.25%	
	tobramycin/dexamethasone oint 0.3%/0.1%	TOBRADEX
	tobramycin/dexamethasone susp 0.3%/0.05%	TOBRADEX ST
	tobramycin/dexamethasone susp 0.3%/0.1%	TOBRADEX

Anti-inflammatories*Nonsteroidal*

	diclofenac sodium	
QL	ketorolac 0.4%	ACULAR LS
	ketorolac 0.5%	ACULAR

QL ketorolac 0.4% = Max 5 mL per month

Steroidal

	dexamethasone sodium phosphate	
QL	fluorometholone 0.1% oint	FML
	fluorometholone 0.1% susp	FML LIQUIFILM
	prednisolone acetate 0.12%	PRED MILD
	prednisolone acetate 1%	PRED FORTE
	prednisolone phosphate 1%	

QL FML oint = Max 3.5 grams per month

Antivirals

PA	ganciclovir	ZIRGAN
	trifluridine	VIROPTIC

Beta-blockers*Nonselective*

	carteolol	
	levobunolol	
	timolol maleate	TIMOPTIC
	timolol maleate gel	TIMOPTIC-XE

Selective

	betaxolol 0.5%	
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Carbonic Anhydrase Inhibitors*Topical*

	dorzolamide	TRUSOPT
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Carbonic Anhydrase Inhibitor/Beta-blocker Combinations

	dorzolamide/timolol maleate	COSOPT
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Dry Eye Disease

PA, QL	lifitegrast	XIIDRA
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QL XIIDRA = Max 60 single use containers per month

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boldface: indicates generic availability; **delayed-rel:** delayed-release (also known as enteric-coated);
ext-rel: extended-release (also known as sustained-release)

Mydriatics

atropine sulfate oint	
atropine sulfate soln	
cyclopentolate	CYCLOGYL
homatropine	ISOPTO HOMATROPINE
tropicamide	MYDRIACYL

Parasympathomimetic

pilocarpine	ISOPTO CARPINE
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Prostaglandins

latanoprost	XALATAN
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Sympathomimetics

brimonidine 0.2%	
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Sympathomimetic/Beta-blocker Combinations

brimonidine/timolol	COMBIGAN
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Miscellaneous

echothiophate iodide	PHOSPHOLINE IODIDE
naphazoline 0.1%	
PA, SP, QL ociplasmin	JETREA

QL JETREA = Max 1 inj per lifetime

OTIC

Clinical practice guidelines for the treatment of otitis media are available at:
<https://www.aap.org>

Anti-infectives

acetic acid	
ciprofloxacin otic	CETRAXAL
ofloxacin otic	

Anti-infective/Anti-inflammatory Combinations

QL acetic acid/hydrocortisone	
ciprofloxacin/dexamethasone	CIPRODEX
neomycin/polymyxin B/hydrocortisone	CORTISPORIN OTIC

QL acetic acid/hydrocortisone = Max 10 mL per month

AL: Age Limit; **OTC:** Over the counter; **PA:** Prior Authorization; **QL:** Quantity Limit; **SP:** Specialty Drug; **ST:** Step Therapy
boldface: indicates generic availability; **delayed-rel:** delayed-release (also known as enteric-coated);
ext-rel: extended-release (also known as sustained-release)

WEBSITES

Agency for Healthcare Research and Quality
<https://www.ahrq.gov>

Alzheimer's Association
<https://www.alz.org>

American Academy of Allergy, Asthma and Immunology
<https://www.aaaai.org>

American Academy of Child & Adolescent Psychiatry
<https://www.aacap.org>

American Academy of Dermatology
<https://www.aad.org>

American Academy of Neurology
<https://www.aan.com>

American Academy of Ophthalmology
<https://www.aao.org>

American Academy of Pediatrics
<https://www.aap.org>

American Association for the Study of Liver Disease
<https://www.aasld.org>

American Association of Clinical Endocrinologists
<https://www.aace.com>

American Association of Diabetes Educators
<https://www.diabeteseducator.org>

American Cancer Society
<https://www.cancer.org>

American College of Allergy, Asthma and Immunology
<https://www.acaai.org>

American College of Cardiology
<https://www.acc.org>

American College of Chest Physicians
<https://www.chestnet.org>

American College of Gastroenterology
<https://gi.org>

American College of Physicians
<https://www.acponline.org>

American College of Rheumatology
<https://www.rheumatology.org>

American Congress of Obstetricians and Gynecologists
<https://www.acog.org>

American Diabetes Association
<http://www.diabetes.org>

American Gastroenterological Association
<https://www.gastro.org>

American Headache Society Committee for Headache Education
<https://americanheadachesociety.org>

American Heart Association
<https://professional.heart.org>

American Lung Association
<https://www.lung.org>

American Medical Association
<https://www.ama-assn.org>

American Psychiatric Association
<https://www.psychiatry.org>

American Society of Anesthesiologists
<https://www.asahq.org>

American Society of Clinical Oncology
<https://www.asco.org>

American Society of Interventional Pain Physicians
<https://www.asipp.org>

American Urological Association
<https://www.auanet.org>

Centers for Disease Control and Prevention
<https://www.cdc.gov>

Centers for Disease Control and Prevention
Guideline topics: AIDS
<https://www.cdc.gov/hiv/default.html>

Centers for Disease Control and Prevention
Guideline topics: Sexually Transmitted Diseases
<https://www.cdc.gov/std/treatment/default.htm>

CVS Caremark®
<https://www.caremark.com>

The Food and Drug Administration
<https://www.fda.gov>

Global Initiative for Asthma
<https://www.ginasthma.org>

Infectious Diseases Society of America
<https://www.idsociety.org>

Institute for Safe Medication Practices
<https://www.ismp.org>

Johns Hopkins AIDS Service
<https://www.thebody.com/content/art12096.html>

Juvenile Diabetes Research Foundation International
<https://www.jdrf.org>

MedWatch
<https://www.fda.gov/Safety/MedWatch/default.htm>

National Agricultural Library
<https://www.nal.usda.gov>

National Cancer Institute
<https://www.cancer.gov/about-cancer>

National Comprehensive Cancer Network
<https://www.nccn.org>

National Foundation for Infectious Diseases
<http://www.nfid.org>

National Guideline Clearinghouse
<https://www.ahrq.gov>

National Heart, Lung and Blood Institute
<https://www.nhlbi.nih.gov>

National Institutes of Health
<https://www.nih.gov>

National Kidney Foundation
<https://www.kidney.org>

National Osteoporosis Foundation
<https://www.nof.org>

North American Menopause Society
<https://www.menopause.org>

United States Department of Health and Human Services
<https://www.hhs.gov>

World Health Organization
<https://www.who.int>

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CareSource cumple con las leyes de derechos civiles estatales y federales y no discrimina basándose en la edad, el sexo, la identidad de género, el color, la raza, una discapacidad, el origen nacional, el estado civil, la preferencia sexual, la filiación religiosa, el estado de salud o el estado de asistencia pública.

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

如果您或者您在帮助的人对 CareSource 存有疑问，您有权 免费获得以您的语言提供的帮助和信息。如果您需要与一位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码。

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OMPP Approved 12/30/2016

If you, or someone you're helping, have questions about CareSource, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-607-2829 TTY:711.

ARABIC

إذا كان لديك، أو لدى أي شخص تساعد، أية استفسارات بخصوص CareSource، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، اتصل على 1-844-607-2829 (TTY: 1-800-743-3333 or 711)

AMHARIC

እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ CareSource ጥያቄ ክላቸው፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸው። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-844-607-2829 (TTY: 1-800-743-3333 or 711) ይደውሉ።

BURMESE

CareSource အကြောင်း သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်စုံတစ်ယောက်က မေးမြန်းလာပါက သင်ပြောဆိုသော ဘာသာစကားဖြင့် အကူအညီနှင့် အချက်အလက်များအား အခမဲ့ ရယူနိုင်ရန် အခွင့်အရေးရှိပါသည်။ ဘာသာပြန်တစ်ဦးအား စကားပြောဆိုရန် 1-844-607-2829 (TTY: 1-800-743-3333 or 711) ဤတွင် နံပါတ်ဖြည့်သွင်းပါ] သို့ ခေါ်ဆိုပါ။

CHINESE

如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。如果您需要与一位翻译交谈，请致电 1-844-607-2829 (TTY: 1-800-743-3333 or 711)。

CUSHITE – OROMO

Isin yookan namni biraa isin deeggartan CareSource irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-607-2829 (TTY: 1-800-743-3333 or 711) tiin bilbilaa.

DUTCH

Als u, of iemand die u helpt, vragen heeft over CareSource, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk, bel dan naar 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

FRENCH (CANADA)

Des questions au sujet de CareSource? Vous ou la personne que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète, veuillez téléphoner au 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

GERMAN

Wenn Sie, oder jemand dem Sie helfen, eine Frage zu CareSource haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 1-844-607-2829 (TTY: 1-800-743-3333 or 711) an.

GUJARATI

જો તમે અથવા તમે કોઈને મદદ કરી રહ્યાં તમે iથી કોઈને CareSource વિશે પ્રશ્નો હોય તો તમને મદદ અને મેહુતી મેળિાનો અવિકર છ. તે અર્થે વિન તમ રી ભ ષ મ i પ્ર પ્ત કરી શક ર છ. દ ભ વપરો તિ કરિ મ ટે, આ 1-844-607-2829 (TTY: 1-800-743-3333 or 711) પર કોલ કરો.

HINDI

यदि आपके, या आप जिसकी मदद कर रहे हैं उसके CareSource के बारे में कोई सवाल है तो आपके पास बगैर किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिए से बात करने के लिए कॉल करें, 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

ITALIAN

Se Lei, o qualcuno che Lei sta aiutando, ha domande su CareSource, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete, chiami il 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

JAPANESE

ご本人様、または身の回りの方で、CareSourceに関するご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます(無償)。通訳をご利用の場合は、1-844-607-2829 (TTY: 1-800-743-3333 or 711) にご連絡ください。

KOREAN

귀하 본인이나 귀하께서 돕고 계신 분이 CareSource에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받을 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 주십시오: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

PENNSYLVANIA DUTCH

Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut CareSource, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-607-2829 (TTY: 1-800-743-3333 or 711) uffrufe.

RUSSIAN

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно CareSource, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком, позвоните по номеру 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

SPANISH

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

UKRAINIAN

Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо CareSource, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, зателефонуйте за номером 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

VIETNAMESE

Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về CareSource, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số 1-844-607-2829 (TTY: 1-800-743-3333 or 711).



Notice of Non-Discrimination



CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-844-607-2829 (TTY: 1-800-743-3333 or 711)

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.