12/1/17 Edition

Status	Definition
PA required	Prior Authorization is required. Please submit a Pharmacy Prior Authorization Request Form.
Non-Preferred	Use another agent similar to requested agent. Specific indication might be required also.
Step Therapy	An adequate trial of another preferred agent(s) is required before approval.
Specialty	Requires Prior Authorization. Refer to Specialty Pharmacy Medication Policies on CareSource.com
Note: A drug is available generically if its listing includes both a generic and a brand name.	

Drug	Status	Special Instructions
8-Mop 10 mg Capsule	PA required	Required Diagnosis= Cutaneous T-Cell Lymphoma (CTCL) OR Psoriasis With A 30 Day Trial Of Calcipotriene
Abelcet 5 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
ABSORICA 10 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
ABSORICA 20 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
ABSORICA 30 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin

Drug	Status	Special Instructions
ABSORICA 40 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
ABSTRAL 100 mcg TABLET SUBLINGAL	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
ABSTRAL 200 mcg TABLET SUBLINGAL	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
ABSTRAL 300 mcg TABLET SUBLINGAL	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
ABSTRAL 400 mcg TABLET SUBLINGAL	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
ABSTRAL 600 mcg TABLET SUBLINGAL	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
ABSTRAL 800 mcg TABLET SUBLINGAL	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
ACANYA GEL PUMP 2.5%-1.2%	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% GEL AND CLINDAMYCIN, CLINDAMAX (CLEOCIN-T) 1% GEL separately used together
Acebutolol 200 mg Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Beta-Blockers (Atenolol, Bisoprolol, Carvedilol, Labetalol, Metoprolol Succinate Or Tartrate, Nadolol, Propranolol)
Acebutolol 400 mg Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Beta-Blockers (Atenolol, Bisoprolol, Carvedilol, Labetalol, Metoprolol Succinate Or Tartrate, Nadolol, Propranolol)
ACETAMINOPHEN-ISOMETHEPTENE-CAFFEINE (PRODRIN) TAB 325-65-20 MG	Non-Preferred	Formulary Agents: Butalbital-Acetaminophen 50-325MG tablet (Phrenilin, Marten tabs), Butalbital-Acetaminophen-Caffeine (Esgic-Plus) 50-500-40MG tablet, Butalbital-Aceteminophen-Caffeine (Fioricet) 50-325-40MG tablet
ACETAMINOPHEN-ISOMETHEPTENE-CAFFEINE (PRODRIN) TAB 500-130-20 MG	Non-Preferred	Formulary Agents: Butalbital-Acetaminophen 50-325MG tablet (Phrenilin, Marten tabs), Butalbital-Acetaminophen-Caffeine (Esgic-Plus) 50-500-40MG tablet, Butalbital-Aceteminophen-Caffeine (Fioricet) 50-325-40MG tablet
ACCU-CHEK TEST STRIPS/METER	Non-Preferred	Formulary Agents: FreeStyle or Precision products
ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE (PANLOR/PANLOR SS) 712.8-60-32 mg TABLET	Non-Preferred	Formulary Agent: Butalbital-Aceteminophen-Caffeine-Codeine (FIORICET-COD) 30-50-325-40 capsule
ACETYLCYSTEINE 10% Solution	Non-Preferred	Required Diagnosis: acetaminophen overdose OR *as mucolytic for diagnoses such as: chronic emphysema, chronic asthmatic bronchitis, emphyseam with bronchits, pneumonia, bronchitis, pulmonary complications of cystic fibrosis

Drug	Status	Special Instructions
ACETYLCYSTEINE 20% Solution	Non-Preferred	Required Diagnosis: acetaminophen overdose OR *as mucolytic for diagnoses such as: chronic emphysema, chronic asthmatic bronchitis, emphyseam with bronchits, pneumonia, bronchitis, pulmonary complications of cystic fibrosis
ACID JELLY	Non-Preferred	Formulary Agents: ALIGN, FLORAJEN, FLORA-Q, RESTORA, RISAQUAD, REZYST, or DIFF-STAT (oral probiotics)
ACIPHEX 10 mg SPRINKLE CAPS	Non-Preferred	Formulary Agent: RABEPRAZOLE (ACIPHEX EC) 20 MG TABLET
ACIPHEX 5 mg SPRINKLE CAPS	Non-Preferred	Formulary Agent: RABEPRAZOLE (ACIPHEX EC) 20 MG TABLET
ACITRETIN (SORIATANE) 10 mg CAPSULE	Non-Preferred	Formulary Agent: calcipotriene (Dovonex) or previous approval of Enbrel, Humira, or Stelara
ACITRETIN (SORIATANE) 17.5 mg CAPSULE	Non-Preferred	Formulary Agent: calcipotriene (Dovonex) or previous approval of Enbrel, Humira, or Stelara
ACITRETIN (SORIATANE) 25 mg CAPSULE	Non-Preferred	Formulary Agent: calcipotriene (Dovonex) or previous approval of Enbrel, Humira, or Stelara
ACLARO, ACLARO PD 4% EMULSION	Excluded benefit	
ACTEMRA 200/10 mL	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Actemra by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ACTEMRA 400/20 mL	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Actemra by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ACTEMRA 162 mg/0.9 mL	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Actemra by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ACTEMRA 80 mg/4 mL	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Actemra by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ACTHAR HP	Specialty	Specialty; follow policy on CareSource.com.
Acticlate 75 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Acticlate 150 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
ACTIMMUNE 2 MILLION UNIT VIAL	PA required	Required diagnosis = chronic granulomatous disease or malignant osteoporosis
Active OB	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
ACTONEL 150 mg TABLET	Non-Preferred	Formulary Agent: alendronate
ACTONEL 30 mg TABLET	Non-Preferred	Formulary Agent: alendronate
ACTONEL 35 mg TABLET	Non-Preferred	Formulary Agent: alendronate
ACTONEL 5 mg TABLET	Non-Preferred	Formulary Agent: alendronate

Drug	Status	Special Instructions
ACTONEL WITH CALCIUM TABLET 35 mg/500 mg	Non-Preferred	Formulary Agent: alendronate then Actonel and OTC calcium 500 mg tablet
ACTOPLUS MET XR 15-1,000MG TABLET	Step Therapy	Formulary agents: Metformin IR or ER (Glucophage or Glucophage ER)
ACTOPLUS MET XR 30-1,000MG TABLET	Step Therapy	Formulary agents: Metformin IR or ER (Glucophage or Glucophage ER)
ACUVAIL 0.45% OPHTH SOLUTION	Non-Preferred	Formulary Agent: ketorolac (ACULAR) 0.5% EYE DROPS
ACYCLOVIR (ZOVIRAX) 5% OINTMENT	Step Therapy	Required Diagnosis= Acute Outbreak Of Genital Herpes Simplex OR Cold Sores/Oral Herpes Simplex With A Trial Of Abreva
Aczone 5% Gel	Non-Preferred	Formulary Agent(s): Adapalene 0.1% Gel Or Cream, Benzoyl Peroxide 5% Or 10%, Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Clindamycin Topical (Cleocin T), Erythromycin Topical, Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Or Tretinoin Cream Or Gel
Aczone 7.5% Gel With Pump	Non-Preferred	Formulary Agent(s): Adapalene 0.1% Gel Or Cream, Benzoyl Peroxide 5% Or 10%, Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Clindamycin Topical (Cleocin T), Erythromycin Topical, Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Or Tretinoin Cream Or Gel
ADAPALENE (DIFFERIN) 0.1% LOTION	Non-Preferred	Formulary agent: Adapalene (Differin) 0.1% cream or gel
ADAPALENE (DIFFERIN) 0.3% GEL	Non-Preferred	Formulary Agent: Adapalene (Differin) 0.1% cream or gel
ADAPALENE (DIFFERIN) 0.3% GEL PUMP	Non-Preferred	Formulary Agent: Adapalene (Differin) 0.1% cream or gel
ADAPALENE-BENZOYL PEROXIDE (EPIDUO) GEL	Non-Preferred	Formulary Agents: Benzoyl peroxide gel 2.5% and Adapalene gel 0.1%
ADASUVE 10MG INHALATION	Non-Preferred	Formulary Agents: aripiprazole (Abilify) tablets
Adcetris 50 mg Vial	Specialty	Request Must Go Through Clinical Review
ADCIRCA 20 mg TABLET	Specialty	Specialty; Follow Policy On CareSource.com
Addyi Tablet	Excluded Benefit	
ADEMPAS 0.5 mg TABLET	PA required	Required diagnosis = Pulmonary Arterial Hypertension, rx prescribed by pulmonologist and/or cardiologist, and WHO Group 1 with NYHA Functional class II or III or IV symptoms AND PAP pressures not adequately controlled using an oral vasodilator at maximal doses OR The member was not vasodilator sensitive as determined by a epoprostenol, adenosine, or inhaled nitric oxide challenge

Drug	Status	Special Instructions
ADEMPAS 1 mg TABLET	PA required	Required diagnosis = Pulmonary Arterial Hypertension, rx prescribed by pulmonologist and/or cardiologist, and WHO Group 1 with NYHA Functional class II or III or IV symptoms AND PAP pressures not adequately controlled using an oral vasodilator at maximal doses OR The member was not vasodilator sensitive as determined by a epoprostenol, adenosine, or inhaled nitric oxide challenge
ADEMPAS 1.5 mg TABLET	PA required	Required diagnosis = Pulmonary Arterial Hypertension, rx prescribed by pulmonologist and/or cardiologist, and WHO Group 1 with NYHA Functional class II or III or IV symptoms AND PAP pressures not adequately controlled using an oral vasodilator at maximal doses OR The member was not vasodilator sensitive as determined by a epoprostenol, adenosine, or inhaled nitric oxide challenge
ADEMPAS 2 mg TABLET	PA required	Required diagnosis = Pulmonary Arterial Hypertension, rx prescribed by pulmonologist and/or cardiologist, and WHO Group 1 with NYHA Functional class II or III or IV symptoms AND PAP pressures not adequately controlled using an oral vasodilator at maximal doses OR The member was not vasodilator sensitive as determined by a epoprostenol, adenosine, or inhaled nitric oxide challenge
ADEMPAS 2.5 mg TABLET	PA required	Required diagnosis = Pulmonary Arterial Hypertension, rx prescribed by pulmonologist and/or cardiologist, and WHO Group 1 with NYHA Functional class II or III or IV symptoms AND PAP pressures not adequately controlled using an oral vasodilator at maximal doses OR The member was not vasodilator sensitive as determined by a epoprostenol, adenosine, or inhaled nitric oxide challenge
Adoxa Pak 1-100 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Adoxa Pak 1-150 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Adoxa Pak 2-100 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet

Drug	Status	Special Instructions
ADRENALIN 1:1,000 NASAL SOLUTION	Non-Preferred	Required Diagnosis= Nasal Congestion Required Trial Of: OTC Nasal Decongestants (i.e.; 12 HR Nasal, Anefrin, Nasal NoDrip (Afrin, Dristan, Neo-Synephrine,), Nrs Nasal or Neo-Synephrine)
ADASUVE 10MG INHALATION	Non-Preferred	Formulary Agent: aripiprazole (Abilify) tablets
Adlyxin 10 mcg/0.2mL & 20 mcg/0.2mL Pen Injector	Non-Preferred	Formulary Agent(s): Victoza Or Trulicity (Which Require A 30 Day Trial Of Metformin Or Metformin ER)
ADVAIR DISKUS 250-50MCG	Non-Preferred	Requires A Diagnosis Of Asthma or COPD (Emphysema, Chronic Bronchitis) AND A *30 Day Trial Of: Dulera (Ages 12 to 17) Or *30 Day Trial Of: Breo Ellipta or Dulera (Ages 18 and older)
ADVAIR DISKUS 500-50MCG	Non-Preferred	Requires A Diagnosis Of Asthma or COPD (Emphysema, Chronic Bronchitis) AND A *30 Day Trial Of: Dulera (Ages 12 to 17) Or *30 Day Trial Of: Breo Ellipta or Dulera (Ages 18 and older)
ADVAIR HFA 45-21MCG	Non-Preferred	Requires A Diagnosis Of Asthma or COPD (Emphysema, Chronic Bronchitis) AND A *30 Day Trial Of: Dulera (Ages 12 to 17) Or *30 Day Trial Of: Breo Ellipta or Dulera (Ages 18 and older)
ADVAIR HFA 115-21MCG	Non-Preferred	Requires A Diagnosis Of Asthma or COPD (Emphysema, Chronic Bronchitis) AND A *30 Day Trial Of: Dulera (Ages 12 to 17) Or *30 Day Trial Of: Breo Ellipta or Dulera (Ages 18 and older)
ADVAIR HFA 230-21MCG	Non-Preferred	Requires A Diagnosis Of Asthma or COPD (Emphysema, Chronic Bronchitis) AND A *30 Day Trial Of: Dulera (Ages 12 to 17) Or *30 Day Trial Of: Breo Ellipta or Dulera (Ages 18 and older)
ADVATE VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
ADVICOR 1,000 mg-20 mg TABLET	Non-Preferred	Formulary Agents : lovastatin (Mevacor) with OTC niacin separately AND simvastatin (Zocor) or atorvastatin (Lipitor) with OTC niacin separately
ADVICOR 1,000 mg-40 mg TABLET	Non-Preferred	Formulary Agents : lovastatin (Mevacor) with OTC niacin separately AND simvastatin (Zocor) or atorvastatin (Lipitor) with OTC niacin separately
ADVICOR 500 mg-20 mg TABLET	Non-Preferred	Formulary Agents : lovastatin (Mevacor) with OTC niacin separately AND simvastatin (Zocor) or atorvastatin (Lipitor) with OTC niacin separately
ADVICOR 750 mg-20 mg TABLET	Non-Preferred	Formulary Agents : lovastatin (Mevacor) with OTC niacin separately AND simvastatin (Zocor) or atorvastatin (Lipitor) with OTC niacin separately
ADVIL 200 mg LIQUI-GEL CAPSULE	Non-Preferred	Formulary Agent: IBUPROFEN 200 mg OTC tablet
ADYNOVATE VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
Adzenys-XR 3.1 mg ODT Tablet	Non-Preferred	Age 6 Or Older AND A Trial Of Dextroamphetamine-Amphetamine (Adderall) Or Adderall XR
Adzenys-XR 6.3 mg ODT Tablet	Non-Preferred	Age 6 Or Older AND A Trial Of Dextroamphetamine-Amphetamine (Adderall) Or Adderall XR
Adzenys-XR 9.4 mg ODT Tablet	Non-Preferred	Age 6 Or Older AND A Trial Of Dextroamphetamine-Amphetamine (Adderall) Or Adderall XR

Drug	Status	Special Instructions
Adzenys-XR 12.5 mg ODT Tablet	Non-Preferred	Age 6 Or Older AND A Trial Of Dextroamphetamine-Amphetamine (Adderall) Or Adderall XR
Adzenys-XR 15.7 mg ODT Tablet	Non-Preferred	Age 6 Or Older AND A Trial Of Dextroamphetamine-Amphetamine (Adderall) Or Adderall XR
Adzenys-XR 18.8 mg ODT Tablet	Non-Preferred	Age 6 Or Older AND A Trial Of Dextroamphetamine-Amphetamine (Adderall) Or Adderall XR
AFINITOR 10 mg TABLET	PA required	Required diagnosis = advanced hormone receptor–positive, human epidermal growth receptor 2 (HER2)–negative breast cancer, advanced neuroendocrine tumors of pancreatic origin, advanced renal cell carcinoma, or renal angiomyolipoma and tuberous sclerosis complex, adult and pediatric patients 3 years and older with subependymal giant cell astrocytoma
AFINITOR 2.5 mg TABLET	PA required	Required diagnosis = advanced hormone receptor–positive, human epidermal growth receptor 2 (HER2)–negative breast cancer, advanced neuroendocrine tumors of pancreatic origin, advanced renal cell carcinoma, or renal angiomyolipoma and tuberous sclerosis complex, adult and pediatric patients 3 years and older with subependymal giant cell astrocytoma
AFINITOR 5 mg TABLET	PA required	Required diagnosis = advanced hormone receptor–positive, human epidermal growth receptor 2 (HER2)–negative breast cancer, advanced neuroendocrine tumors of pancreatic origin, advanced renal cell carcinoma, or renal angiomyolipoma and tuberous sclerosis complex, adult and pediatric patients 3 years and older with subependymal giant cell astrocytoma
AFINITOR 7.5 mg TABLET	PA required	Required diagnosis = advanced hormone receptor–positive, human epidermal growth receptor 2 (HER2)–negative breast cancer, advanced neuroendocrine tumors of pancreatic origin, advanced renal cell carcinoma, or renal angiomyolipoma and tuberous sclerosis complex, adult and pediatric patients 3 years and older with subependymal giant cell astrocytoma
AFINITOR DISPERZ 2 mg TABLET	PA required	Required diagnosis = advanced hormone receptor–positive, human epidermal growth receptor 2 (HER2)–negative breast cancer, advanced neuroendocrine tumors of pancreatic origin, advanced renal cell carcinoma, or renal angiomyolipoma and tuberous sclerosis complex, adult and pediatric patients 3 years and older with subependymal giant cell astrocytoma
AFINITOR DISPERZ 3 mg TABLET	PA required	Required diagnosis = advanced hormone receptor–positive, human epidermal growth receptor 2 (HER2)–negative breast cancer, advanced neuroendocrine tumors of pancreatic origin, advanced renal cell carcinoma, or renal angiomyolipoma and tuberous sclerosis complex, adult and pediatric patients 3 years and older with subependymal giant cell astrocytoma
AFINITOR DISPERZ 5 mg TABLET	PA required	Required diagnosis = advanced hormone receptor–positive, human epidermal growth receptor 2 (HER2)–negative breast cancer, advanced neuroendocrine tumors of pancreatic origin, advanced renal cell carcinoma, or renal angiomyolipoma and tuberous sclerosis complex, adult and pediatric patients 3 years and older with subependymal giant cell astrocytoma
AFREZZA 4 UNIT/CARTRIDGE INHALABLE INSULIN	Non-Preferred	Formulary Agents: Humulin R or Novolin R

Drug	Status	Special Instructions
AFSTYLA VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
AGAMATRIX AMP BLOOD GLUCOSE METER	Non-Preferred	*90 Day Trial: Formulary Agent(s): FreeStyle Or Precision Products
AGAMATRIX AMP BLOOD GLUCOSE STRIPS	Non-Preferred	*90 Day Trial: Formulary Agent(s): FreeStyle Or Precision Products
A-Hydrocortisone (Solu-Cortef) 100 mg Vial	Medical Benefit	Bill Through Medical Benefit
AKNE-MYCIN 2% OINTMENT	Non-Preferred	Formulary Agents: ERYTHROMYCIN 2% GEL, ERYTHROMYCIN 2% PLEDGETS, or ERYTHROMYCIN 2% SOLUTION
AKYNZEO 300-0.5MG CAPSULE	PA required	Required Dx= Treat nausea and vomiting in patients undergoing cancer chemotherapy
ALAMAST 0.1% DROPS	Non-Preferred	Formulary Agents: OTC agents with ketotifen AND azelastine (Optivar)
ALA-QUIN 3/1% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
Alcortin A 1-2-1% Gel	Excluded Benefit	
ALCORTIN A GEL (Contains: IODOQUINOL-HYDROCORTISONE-ALOE POLYSACCHARIDE GEL 1-2-1%	Non-Preferred	Formulary Agents: OTC hydrocortisone-aloe vera with topical anti-fungal (clotrimazole, terbinafine)
ALDURAZYME	Specialty	Specialty; follow policy on CareSource.com.
Alecensa 150mg Capsule	Non-Preferred	Request Must Go Through Clinical Review
ALEVICYN GEL	Non-Preferred	*Requires A 7 Day Trial Of Woun'Dres Wound Dressing
ALINIA 100 mg/5 mL SUSPENSION	PA required	Required diagnosis = diarrhea caused by Giarda lamblia or Cryptosporidium parvum
ALINIA 500 mg TABLET	PA required	Required diagnosis = diarrhea caused by Giarda lamblia or Cryptosporidium parvum
ALLEGRA 30 mg/5 mL SUSPENSION	Non-Preferred	No longer available; use ALLEGRA ALLERGY 30 mg/5 mL SUSPENSION
ALLEGRA ODT 30 mg TABLET	Non-Preferred	Formulary Agents: ALLEGRA ALLERGY (OTC) 30 mg tablet OR ALLEGRA ALLERGY 30 mg/5 mL SUSPENSION
ALLFEN CD TABLET	Non-Preferred	Formulary Agent: OTC guaifenesin tablet
ALOCRIL 2% EYE DROPS	Non-Preferred	Formulary Agents: OTC agents with ketotifen AND azelastine (Optivar)
ALOMIDE 0.1% EYE DROPS	Non-Preferred	Requires a 30 day trial of each of the following: cromolyn ophthalmic drops, ketotifen ophthalmic drops
ALOSETRON (LOTRONEX) 0.5 mg TABLET	PA required	Required diagnosis = severe diarrhea, IBS with a trial of atropine-diphenoxylate (Lomotil) or dicyclomine (Bentyl)
ALOSETRON (LOTRONEX) 1 mg TABLET	PA required	Required diagnosis = severe diarrhea, IBS with a trial of atropine-diphenoxylate (Lomotil) or dicyclomine (Bentyl)

Drug	Status	Special Instructions
ALOXI 0.25 mg/ML	PA required	Required diagnosis=Chemotherapy-induced nausea and vomiting or Postoperative nausea and vomiting
ALPHAGAN P 0.1% DROPS	Non-Preferred	Formulary Agent: brimonidine ophthalmic 0.2%
ALPHANATE VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
ALPRAZOLAM (XANAX) 1 mg/ML ORAL CONCENTRATE	Non-Preferred	Requires an inability to swallow pills or a Trial of alprazolam tablet
ALPRAZOLAM ODT (NIRAVAM) 0.25 mg ORALLY DISINTEGRATING TABLET	Non-Preferred	Requires an inability to swallow pills or a Trial of alprazolam tablet
ALPRAZOLAM ODT (NIRAVAM) 0.5 mg ORALLY DISINTEGRATING TABLET	Non-Preferred	Requires an inability to swallow pills or a Trial of alprazolam tablet
ALPRAZOLAM ODT (NIRAVAM) 1 mg ORALLY DISINTEGRATING TABLET	Non-Preferred	Requires an inability to swallow pills or a Trial of alprazolam tablet
ALPRAZOLAM ODT (NIRAVAM) 2 mg ORALLY DISINTEGRATING TABLET	Non-Preferred	Requires an inability to swallow pills or a Trial of alprazolam tablet
ALPROLIX VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
ALREX 0.2% EYE DROPS	Non-Preferred	Formulary Agents: OTC agents with ketotifen AND azelastine (Optivar)
ALTABAX 1% OINTMENT	Non-Preferred	Formulary Agent: mupirocin ointment
ALTOPREV 20 mg TABLET	Non-Preferred	Formulary Agents: lovastatin (Mevacor) AND simvastatin (Zocor) OR atorvastatin (Lipitor)
ALTOPREV 40 mg TABLET	Non-Preferred	Formulary Agents: lovastatin (Mevacor) AND simvastatin (Zocor) OR atorvastatin (Lipitor)
ALTOPREV 60 mg TABLET	Non-Preferred	Formulary Agents: lovastatin (Mevacor) AND simvastatin (Zocor) OR atorvastatin (Lipitor)
Alunbrig 30 mg TABLET	Lower Cost	Required Diagnosis=Anaplastic lymphoma kinase-positive non-smell lung cancer
ALVESCO 160 mcg INHALER	Non-Preferred	Formulary Agent(s): Aerospan or Asmanex
ALVESCO 80 mcg INHALER	Non-Preferred	Formulary Agent(s): Aerospan or Asmanex
AMCINONIDE 0.1% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
AMCINONIDE 0.1% LOTION	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
AMCINONIDE 0.1% OINTMENT	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
Ameluz 10% Gel	Non-Preferred	Medical Benefit ONLY
AMETHYST 90-20 mcg TABLET	Non-Preferred	Formulary Agents: a formulary birth control option (most similar agent=Sronyx)
AMEVIVE	PA required	Specialty; follow policy on CareSource.com.
Aminosyn 10% IV Solution	Medical Benefit	Bill Through Medical Benefit

Drug	Status	Special Instructions
Aminosyn II 10% IV Solution	Medical Benefit	Bill Through Medical Benefit
Aminosyn-PF 10% IV Solution	Medical Benefit	Bill Through Medical Benefit
Amitiza 24 mcg Capsule	Step Therapy	Formulary Agent(s): A 7 Day Trial Of: Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, Or PureLax (MiraLax) Powder In The Last 30 Days
Amitiza 8 mcg Capsule	Step Therapy	Formulary Agent(s): A 7 Day Trial Of: Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, Or PureLax (MiraLax) Powder In The Last 30 Days
AMLODIPINE-ATORVASTATIN (CADUET) 10 mg-10 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 10 mg-20 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 10 mg-40 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 10 mg-80 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 2.5 mg-10 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 2.5 mg-20 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 2.5 mg-40 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 5 mg-10 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 5 mg-20 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 5 mg-40 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMLODIPINE-ATORVASTATIN (CADUET) 5 mg-80 mg TABLET	Non-Preferred	Formulary Agent: amlodipine and atorvastatin separately taken together
AMNESTEEM 10 mg TABLET	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin

Drug	Status	Special Instructions
AMNESTEEM 20 mg TABLET	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
AMNESTEEM 40 mg TABLET	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
AMOXICILLIN-CLARITHROMYCIN-LANSOPRAZOLE (PREVPAC) PATIENT PACK	Non-Preferred	Formulary Agents: amoxicillin, clarithromycin, and lansoprazole separately
Ampicillin 125 mg Vial	Medical Benefit	Bill Through Medical Benefit
Ampicillin 250 mg Vial	Medical Benefit	Bill Through Medical Benefit
Ampicillin 500 mg Vial	Medical Benefit	Bill Through Medical Benefit
Ampicillin 1 G Vial	Medical Benefit	Bill Through Medical Benefit
Ampicillin 2 G Vial	Medical Benefit	Bill Through Medical Benefit
Ampicillin 10 G Vial	Medical Benefit	Bill Through Medical Benefit
AMPYRA ER 10 mg TABLET	PA required	Specialty; Request Must Go Through Clinical Review
AMRIX 15 mg CAPSULE	Non-Preferred	Formulary Agent: NON-ER cyclobenzaprine tablet
AMRIX 30 mg CAPSULE	Non-Preferred	Formulary Agent: NON-ER cyclobenzaprine tablet
AMTURNIDE 150-5-12.5 mg TABLET	Non-Preferred	Formulary Agent: losartan/hctz (Hyzaar), Irbesartan/Hctz (Avalide), valsartan/hctz (Diovan HCT), or candesartan/Hctz (Atacand HCT) (must try 2 of the 4)
AMTURNIDE 300-10-12.5 mg TABLET	Non-Preferred	Formulary Agent: losartan/hctz (Hyzaar), Irbesartan/Hctz (Avalide), valsartan/hctz (Diovan HCT), or candesartan/Hctz (Atacand HCT) (must try 2 of the 4)
AMTURNIDE 300-10-25 mg TABLET	Non-Preferred	Formulary Agent: losartan/hctz (Hyzaar), Irbesartan/Hctz (Avalide), valsartan/hctz (Diovan HCT), or candesartan/Hctz (Atacand HCT) (must try 2 of the 4)
AMTURNIDE 300-5-12.5 mg TABLET	Non-Preferred	Formulary Agent: losartan/hctz (Hyzaar), Irbesartan/Hctz (Avalide), valsartan/hctz (Diovan HCT), or candesartan/Hctz (Atacand HCT) (must try 2 of the 4)
AMTURNIDE 300-5-25 mg TABLET	Non-Preferred	Formulary Agent: losartan/hctz (Hyzaar), Irbesartan/Hctz (Avalide), valsartan/hctz (Diovan HCT), or candesartan/Hctz (Atacand HCT) (must try 2 of the 4)
ANABAR CAPLET	Non-Preferred	No longer available on the market
ANADROL-50 TABLET	PA required	Required diagnosis = anemia
ANALPRAM KIT ADVANCED	Non-Preferred	Requires a 30-Day Trial Of HYDROCORTISONE Acetate 1%/Pramoxine Hydrochloride 1% (ANALPRAM-HC) CREAM

Drug	Status	Special Instructions
ANDRODERM 2 mg/24HR PATCH	Non-Preferred	Formulary agents = Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a prior authorization) with a diagnosis of hypogonadism and total testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
ANDRODERM 4 mg/24HR PATCH	Non-Preferred	Formulary agents = Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a prior authorization) with a diagnosis of hypogonadism and total testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
ANDROGEL 1% GEL PUMP	Non-Preferred	Formulary agents = Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a prior authorization) with a diagnosis of hypogonadism and total testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
ANDROGEL 1.62% (20.25 MG/ACT) GEL PUMP	Non-Preferred	Formulary agents = Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a prior authorization) with a diagnosis of hypogonadism and total testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
ANDROGEL 1.62% (20.25 mg/1.25 gM) GEL PACKET	Non-Preferred	Formulary agents = Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a prior authorization) with a diagnosis of hypogonadism and total testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
ANDROGEL 1.62% (40.5 mg/2.5 gM) GEL PACKET	Non-Preferred	Formulary agents = Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a prior authorization) with a diagnosis of hypogonadism and total testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
ANDROXY 10 mg TABLET	PA required	Required diagnosis = metastatic mammary cancer or hypogonadism Formulary agents = Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a prior authorization)
ANECREAM, LIDOCREAM (LMX 4 PLUS) KIT 4%	Non-Preferred	Formulary Agent(s): AneCream, Lidocream, LC-4 Lidocaine (LMX 4) AND Transparent Dressing Separately Used Together At The Same Time
ANECREAM5, LC-5, LIDOCAINE (RECTICARE, LMX 5) CREAM	Non-Preferred	A 7 Day Trial Of: Lidocaine 2% Gel, Lidocaine 3% Cream, Or Lidocaine 4% Cream
ANGELIQ 0.25-0.5 mg TABLET	Non-Preferred	Formulary Agents: Femhrt or Prempro
ANGELIQ 0.5 mg-1 mg TABLET	Non-Preferred	Formulary Agents: Femhrt or Prempro
ANIMI-3 500-1,000-1MG CAPSULE	Non-Preferred	Formulary Agent(s): Omega 3 with EPA/DHA, Vitamin B6, Vitamin B12, and Folate taken separately used together at the same time
ANORO ELLIPTA 62.2-25 MCG/INH	Non-Preferred	Required Dx= COPD; Required 30 day trial of: Stiolto Respimat Mist Inhaler

Drug	Status	Special Instructions
ANTARA 43 mg CAPSULE	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
ANTARA 90 mg CAPSULE	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
ANTIVERT 50 mg TABLET	Non-Preferred	Formulary Agent: MECLIZINE 12.5 mg OR 25 mg
ANZEMET 100 mg TABLET	Non-Preferred	Formulary Agents: ondansetron, meclizine, promethazine, prochlorperazine, granisetron
ANZEMET 50 mg TABLET	Non-Preferred	Formulary Agents: ondansetron, meclizine, promethazine, prochlorperazine, granisetron
APEXICON E 0.05% CREAM	Non-Preferred	Formulary Agent: DIFLORASONE 0.05% CREAM
ARZERRA 100MG/5ML FOR IV INFUSION	Non-Preferred	Required diagnosis= Chronic lymphocytic leukemia (CLL) *In combination with chlorambucil, for the treatment of previously untreated patients with CLLfor whom fludarabine-based therapy is considered inappropriate *For the treatment of patients with CLL refractory to fludarabine and alemtuzumab *In combination with fludarabine and cyclophosphamide for the treatment of patients with relapsed CLL *For extended treatment of patients who are in complete or partial response after at least two lines of therapy for recurrent or progressive CLL
ARZERRA 1,000MG/50ML FOR IV INFUSION		Required diagnosis= Chronic lymphocytic leukemia (CLL) *In combination with chlorambucil, for the treatment of previously untreated patients with CLLfor whom fludarabine-based therapy is considered inappropriate *For the treatment of patients with CLL refractory to fludarabine and alemtuzumab *In combination with fludarabine and cyclophosphamide for the treatment of patients with relapsed CLL *For extended treatment of patients who are in complete or partial response after at least two lines of therapy for recurrent or progressive CLL
APHTHASOL PST 5%	PA required	Required diagnosis = aphthous ulcers in patients with normal immune systems who have failed TRIAMCINOLONE 0.1% PASTE administered 4 times daily; doxycycline capsule of 100 mg in 10 mL of water administered as a mouth rinse for 3 minutes; chlorhexidine gluconate mouth rinses; vitamin B12 used orally
APLENZIN ER 174 mg TABLET	Non-Preferred	Formulary Agent: buproprion XL
APLENZIN ER 348 mg TABLET	Non-Preferred	Formulary Agent: buproprion XL
APLENZIN ER 522 mg TABLET	Non-Preferred	Formulary Agent: buproprion XL
Aplisol 5 Units/0.1 mL Vial	Medical Benefit	Bill Through Medical Benefit
APOKYN 30 mg/3 mL CARTRIDGE	Non-Preferred	Formulary Agents: bromocriptine, amantadine, carbidopa/levodopa, pramipexole, ropinirole, selegiline
APRACLONIDINE (IOPIDINE) 0.5% EYE DROPS	Non-Preferred	Formulary Agent: brimonidine ophthalmic 0.2%
APREPITANT (EMEND) 40 mg CAPSULE	PA required	Required diagnosis= nausea/vomiting due to chemo or surgery Required trial of: formulary agents ondansetron, promethazine, etc
APREPITANT (EMEND) 80 mg CAPSULE	PA required	Required diagnosis= nausea/vomiting due to chemo or surgery Required trial of: formulary agents ondansetron, promethazine, etc
APREPITANT (EMEND) 125 mg CAPSULE	PA required	Required diagnosis= nausea/vomiting due to chemo or surgery Required trial of: formulary agents ondansetron, promethazine, etc
APREPITANT (EMEND) TRIFOLD PACK (80 mg and 125 mg)	PA required	Required diagnosis= nausea/vomiting due to chemo or surgery Required trial of: formulary agents ondansetron, promethazine, etc

Drug	Status	Special Instructions
APTENSIO XR 10MG CAPSULE	Non-Preferred	Required diagnoses: ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome Trials per Ages below Age under 6 - off label (need clinicals to support use) And Trial (90 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) OR Age 6 and Over And A 90-Day Trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA)
APTENSIO XR 15MG CAPSULE	Non-Preferred	Required diagnoses: ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome Trials per Ages below Age under 6 - off label (need clinicals to support use) and Trial (90 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) OR A 90-Day trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA)
APTENSIO XR 20MG CAPSULE	Non-Preferred	Required diagnoses: ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome Trials per Ages below Age under 6 - off label (need clinicals to support use) and Trial (90 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) OR A 90 day trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA)

Drug	Status	Special Instructions
APTENSIO XR 30MG CAPSULE	Non-Preferred	Required diagnoses: ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome Trials per Ages below Age under 6 - off label (need clinicals to support use) and Trial (90 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) OR Age 6 and Over And A 90-Day Trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA)
APTENSIO XR 40MG CAPSULE	Non-Preferred	Required diagnoses: ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome Trials per Ages below Age under 6 - off label (need clinicals to support use) and Trial (90 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) OR A 90-day trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA)
APTENSIO XR 50MG CAPSULE	Non-Preferred	Required diagnoses: ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome Trials per Ages below Age under 6 - off label (need clinicals to support use) and Trial (90 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) OR Age 6 and Over And A 90-Day Trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA)

Drug	Status	Special Instructions
APTENSIO XR 60MG CAPSULE	Non-Preferred	Required diagnoses: ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome Trials per Ages below Age under 6 - off label (need clinicals to support use) and Trial (90 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) OR Age 6 and Over And A 90-Day Trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA)
APTIOM 200MG TABLET	Non-Preferred	Required Diagnosis = Seizure or Epilespsy Formulary agents:gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
APTIOM 400MG TABLET	Non-Preferred	Required Diagnosis = Seizure or Epilespsy Formulary agents:gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
APTIOM 600MG TABLET	Non-Preferred	Required Diagnosis = Seizure or Epilespsy Formulary agents:gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
APTIOM 800MG TABLET	Non-Preferred	Required Diagnosis = Seizure or Epilespsy Formulary agents:gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
ARALAST NP 1000 mg SOLUTION Alpha 1-proteinase inhibitor INJECTION	Specialty	Specialty; follow policy on CareSource.com.
ARALAST NP 400 mg SOLUTION Alpha 1-proteinase inhibitor INJECTION	Specialty	Specialty; follow policy on CareSource.com.
ARALAST NP 500 mg SOLUTION Alpha 1-proteinase inhibitor INJECTION	Specialty	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
ARALAST NP 800 mg SOLUTION Alpha 1-proteinase inhibitor INJECTION	Specialty	Specialty; follow policy on CareSource.com.
ARANESP 10MCG/0.4ML SYRINGE	PA required	Specialty; follow policy on CareSource.com.
ARANESP 100 mcg/0.5 mL SYRINGE	PA required	Specialty; follow policy on CareSource.com.
ARANESP 100 mcg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
ARANESP 150 mcg/0.3 mL SYRINGE	PA required	Specialty; follow policy on CareSource.com.
ARANESP 150 mcg/0.75 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
ARANESP 200 mcg/0.4 mL SYRINGE	PA required	Specialty; follow policy on CareSource.com.
ARANESP 200 mcg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
ARANESP 25 mcg/0.42 mL SYRINGE	PA required	Specialty; follow policy on CareSource.com.
ARANESP 25 mcg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
ARANESP 300 mcg/0.6 mL SYRINGE	PA required	Specialty; follow policy on CareSource.com.
ARANESP 300 mcg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
ARANESP 40 mcg/0.4 mL SYRINGE	PA required	Specialty; follow policy on CareSource.com.
ARANESP 40 mcg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
ARANESP 500 mcg/1 mL SYRINGE	PA required	Specialty; follow policy on CareSource.com.
ARANESP 60 mcg/0.3 mL SYRINGE	PA required	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
ARANESP 60 mcg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
ARCALYST 220 mg INJECTION	PA required	Request Must Go Through Clinical Review
ARESTIN 1 mg SUBGINGIVAL	Medical Benefit	Bill through Medical Benefit
Armodafinil (Nuvigil) 50 mg Tablet	PA required	Requires a diagnosis of: Narcolepsy/Cataplexy/Sleep Apnea/OSA/ Shift Work Disorder
Armodafinil (Nuvigil) 150 mg Tablet	PA required	Requires a diagnosis of: Narcolepsy/Cataplexy/Sleep Apnea/OSA/ Shift Work Disorder
Armodafinil (Nuvigil) 200 mg Tablet	PA required	Requires a diagnosis of: Narcolepsy/Cataplexy/Sleep Apnea/OSA/ Shift Work Disorder
Armodafinil (Nuvigil) 250 mg Tablet	PA required	Requires a diagnosis of: Narcolepsy/Cataplexy/Sleep Apnea/OSA/ Shift Work Disorder
ARNUITY ELLIPTA 100MCG INHALER	Non-Preferred	For Ages 6 And Under: Formulary Agent(s): Asmanex Or For Ages 7 And Older: Formulary Agent(s): Asmanex Or Aerospan
ARNUITY ELLIPTA 200MCG INHALER	Non-Preferred	For Ages 6 and under: Required 30 day trial of: Asmanex OR For Ages 7 and older: Required 30 day trial of either: Aerospan or Asmanex
ARZERRA 100MG/5ML FOR IV INFUSION	Non-Preferred	Request Must Go Through Clinical Review
ASCENSIA Contour TEST STRIPS/METER	Non-Preferred	Formulary Agents: FreeStyle or Precision products
Ascorbic Acid Vial	Non-Preferred	Required Diagnosis Of Ascorbic Acid Deficiency, Burns, Wound Healing, Or Scurvy AND Formulary Agent(s): Ascorbic Acid Tablet
Aspirin-Dipyridamole ER (Aggrenox) 25-200 mg Capsule	Non-Preferred	Required Diagnosis= Transient Ischemia Of The Brain Or Complete Ischemic Stroke Due To Thrombosis AND A 30 Day Trial Of Dipyridamole With OTC Aspirin Separately Taken Together At The Same Time
ASTAGRAF XL 0.5 mg CAPSULE	Non-Preferred	Formulary Agent: Tacrolimus (PROGRAF) 0.5 mg CAPSULE
ASTAGRAF XL 1 mg CAPSULE	Non-Preferred	Formulary Agent: Tacrolimus (PROGRAF) 0.5 mg CAPSULE
ASTAGRAF XL 5 mg CAPSULE	Non-Preferred	Formulary Agent: Tacrolimus (PROGRAF) 0.5 mg CAPSULE
ATGAM 50 mg/ML AMPULE	PA required	Required diagnosis = Diagnosis of management of allograft rejin renal transplant patients or Aplactic anemia
ATOPICLAIR CREAM	Non-Preferred	Formulary Agents: Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin)
AUBAGIO 14 mg TABLET	Specialty	Specialty; Request Must Go Through Clinical Review
AUBAGIO 7 mg TABLET	Specialty	Specialty; Request Must Go Through Clinical Review
AURAX (AURALGAN) 5.5-1.4% OTIC SOLUTION	Non-Preferred	Formulary Agent: antipyrine-Benzocaine (AURODEX) OTIC SOLUTION

Drug	Status	Special Instructions
AURODEX OTIC SOLUTION DAW	Non-Preferred	Formulary Agent: Antipyrine-Benzocaine (AURODEX) OTIC SOLUTION
AURYXIA 1G (210MG FERRIC IRON) TABLET	Non-Preferred	Required Diagnosis: For the control of serum phosphorus levels in patients with chronic kidney disease (CKD) receiving dialysis AND Formulary Agent(s): calcium acetate (PhosLo)
Austedo 6 mg Tablet	Non-Preferred	Specialty; Request Must Go Through Clinical Review
Austedo 9 mg Tablet	Non-Preferred	Specialty; Request Must Go Through Clinical Review
Austedo 12 mg Tablet	Non-Preferred	Specialty; Request Must Go Through Clinical Review
Avalide 150-12.5 mg TABLET DAW	Non-Preferred	Formulary Agents: 2 different manufacturers of generic IRBESARTAN/HCTZ (Avalide) 150-12.5 mg tablet
Avalide 300-12.5 mg TABLET DAW	Non-Preferred	Formulary Agents: 2 different manufacturers of generic IRBESARTAN/HCTZ (Avalide) 150-12.5 mg tablet
Avalide 300-25 mg TABLET DAW	Non-Preferred	Formulary Agents: 2 different manufacturers of generic IRBESARTAN/HCTZ (Avalide) 150-12.5 mg tablet
AVANDAMET 2 mg-1,000 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND Pioglitazone/Metformin (ActosPlusMet)
AVANDAMET 2 mg-500 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND Pioglitazone/Metformin (ActosPlusMet)
AVANDAMET 4 mg-1,000 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND Pioglitazone/Metformin (ActosPlusMet)
AVANDAMET 4 mg-500 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND Pioglitazone/Metformin (ActosPlusMet)
AVANDARYL 4 mg-1 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND AND pioglitazone/glimepiride (Duetact)
AVANDARYL 4 mg-2 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND AND pioglitazone/glimepiride (Duetact))
AVANDARYL 4 mg-4 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND AND pioglitazone/glimepiride (Duetact))
AVANDARYL 8 mg-2 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND AND pioglitazone/glimepiride (Duetact)
AVANDARYL 8 mg-4 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND AND pioglitazone/glimepiride (Duetact))
AVANDIA 2 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND PIOGLITAZONE (ACTOS)

Drug	Status	Special Instructions
AVANDIA 4 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND PIOGLITAZONE (ACTOS)
AVANDIA 8 mg TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage or Glucophage ER) AND PIOGLITAZONE (ACTOS)
AVAPRO 150 mg TABLET	Non-Preferred	Formulary Agents: 2 different manufacturers of generic irbesartan tablet
AVAPRO 75 mg TABLET	Non-Preferred	Formulary Agents: 2 different manufacturers of generic irbesartan tablet
AVAPRO 300 mg TABLET	Non-Preferred	Formulary Agents: 2 different manufacturers of generic irbesartan tablet
AVAR 9.5-5% Cleansing Pads	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
AVAR 9.5-5% FOAM	Non-Preferred	Formulary Agent(s): Sulfacetamide Sodium W/ Sulfur (Avar-E LS) 10-2% Cream
Avar LS 10-2% Cleansing Pads	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
AVAR LS 10-2% FOAM	Non-Preferred	Formulary Agent(s): Sulfacetamide Sodium W/ Sulfur (Avar-E LS) 10-2% Cream
AVASTIN 100 mg/4 mL	Specialty	Specialty; follow policy on CareSource.com.
AVASTIN 400 mg/16 mL	Specialty	Specialty; follow policy on CareSource.com.
AVC 15% VAGINAL CREAM	Non-Preferred	Formulary Agent: fluconazole oral tablet or miconazole vaginal suppositories
Avo Cream Emulsion	Non-Preferred	Formulary Agent(s): Woun'Dres Wound Dressing
AVONEX ADMIN PACK 30 mcg VIAL	PA required	Specialty; Request Must Go Through Clinical Review
AVONEX PREFILLED SYRINGE 30 mcg	PA required	Specialty; Request Must Go Through Clinical Review
AVYCAZ 2.5 GM (2-0.5 GM) IV SOLUTION	Medical Benefit	Bill through Medical Benefit
AXID AR 75 mg CAPSULE	Non-Preferred	Formulary Agent: NIZATIDINE (AXID) 150 mg CAPSULE, NIZATIDINE (AXID) 300 mg CAPSULE OR NIZATIDINE (AXID) 15 mg/ML SOLUTION
AXIRON 30 mg/ACTUATION SOLUTION	Non-Preferred	Formulary Agents= Testosterone TD (Androgel, Testim, Vogelxo) 1% (50GM) Gel Packet or Fortesta (Both Still Require A Prior Authorization) With A Diagnosis Of Hypogonadism And Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
AXSAIN 4%-0.25% CREAM	Non-Preferred	Formulary Agent(s): Arthritis Pain Relief, Capsaicin, Muscle Relief, Theragen-HP, Trixaicin HP (Zostrix HP) 0.075% Cream
AZACITIDINE (VIDAZA) 100 mg Suspension for INJECTION	Non-Preferred	Request Must Go Through Clinical Review
AZASITE 1% EYE DROPS	Non-Preferred	Formulary Agents: ciprofloxacin or ofloxacin ophthalmic

Drug	Status	Special Instructions
AZELEX 20% CREAM	Non-Preferred	Formulary Agents: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl); erythromycin/benzoyl (Benzamycin); sulfacetamide (Klaron); clindamycin topical (Cleocin T); erythromycin topical; tretinoin cream or gel; adapalene 0.1% gel or cream
Azithromycin 500 mg Vial	Medical Benefit	Bill Through Medical Benefit
AZOPT 1% EYE DROPS	Non-Preferred	Formulary Agent: DORZOLAMIDE (TRUSOPT) 2% EYE DROPS
BACK & BODY (BAYER BACK & BODY) 500-32.5MG TABLET	Non-Preferred	Formulary Agent(s): aspirin 325mg or 500mg
BANZEL 200 mg TABLET	Step Therapy	Requires trial of: topiramate (Topamax), gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), phenytoin (Dilantin), VALPROIC ACID (Depakene) or zonisamide or previous approval of Lyrica, Vimpat, Onfi, Stavzor, or Potiga
BANZEL 400 mg TABLET	Step Therapy	Requires trial of: topiramate (Topamax), gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), phenytoin (Dilantin), VALPROIC ACID (Depakene) or zonisamide or previous approval of Lyrica, Vimpat, Onfi, Stavzor, or Potiga
BANZEL 40 mg/ML SUSPENSION	Non-Preferred	Requires trial of: topiramate (Topamax), gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), phenytoin (Dilantin), VALPROIC ACID (Depakene) or zonisamide or previous approval of Lyrica, Vimpat, Onfi, Stavzor, or Potiga AND Banzel tablets (Which also require a PA)
BAYER CONTOR TEST STRIPS	Non-Preferred	*90 Day Trial of Formulary Agents: FreeStyle or Precision products
B-Donna, Phenohytro (Donnatal) 16.2 mg Tablet	Non-Preferred	Formulary Agent(s): Phenobarbital 16.2 mg And Hyoscyamine 0.125 mg Or 0.375 mg Tablet Separately Taken Together At The Same Time
BECONASE AQ 0.042% SPRAY	Non-Preferred	Formulary Agent(s): Ages 2-3: Nasacort OTC Allergy 24HR Spray OR Ages 4-5: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 And Older: 2 Of The Following 4 Drugs: Fluticasone (Flonase), Flunisolide, Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray
BELBUCA 75MCG BUCCAL FILM	Non-Preferred	Formulary Agent(s): Morphine Sulfate ER, Oxymorphone ER, Or Fentanyl
BELBUCA 150MCG BUCCAL FILM	Non-Preferred	Formulary Agent(s): Morphine Sulfate ER, Oxymorphone ER, Or Fentanyl
BELBUCA 300MCG BUCCAL FILM	Non-Preferred	Formulary Agent(s): Morphine Sulfate ER, Oxymorphone ER, Or Fentanyl

Drug	Status	Special Instructions
BELBUCA 450MCG BUCCAL FILM	Non-Preferred	Formulary Agent(s): Morphine Sulfate ER, Oxymorphone ER, Or Fentanyl
BELBUCA 600MCG BUCCAL FILM	Non-Preferred	Formulary Agent(s): Morphine Sulfate ER, Oxymorphone ER, Or Fentanyl
BELBUCA 750MCG BUCCAL FILM	Non-Preferred	Formulary Agent(s): Morphine Sulfate ER, Oxymorphone ER, Or Fentanyl
BELBUCA 900MCG BUCCAL FILM	Non-Preferred	Formulary Agent(s): Morphine Sulfate ER, Oxymorphone ER, Or Fentanyl
Belladona-Opium Suppository	Non-Preferred	Required Diagnosis Of Ureteral Spasms Not Responsive To Non-Opioid Analgesics AND Formulary Agent(s): Any 2 Formulary Urinary Antispasmodics: Oxybutynin, Flavocate, Tolterodine (ER Requires Step), Trospium
BELSOMRA 5MG TABLET	Non-Preferred	Formulary Agents: zaleplon or zolpidem
BELSOMRA 10MG TABLET	Non-Preferred	Formulary Agents: zaleplon or zolpidem
BELSOMRA 15MG TABLET	Non-Preferred	Formulary Agents: zaleplon or zolpidem
BELSOMRA 20MG TABLET	Non-Preferred	Formulary Agents: zaleplon or zolpidem
BELVIQ 10 mg TABLET	Excluded benefit	
BELVIQ XR 20 mg TABLET	Excluded Benefit	
BENEFIX VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
BENLYSTA	Specialty	Specialty; follow policy on CareSource.com.
Bensal HP 6-3% Ointment	Non-Preferred	Formulary Agent(s): OTC Salicylic Acid 6% Cream, Gel, Or Lotion OR OTC Salicylic Acid 17.6%
BENZACLIN 1-5% GEL PUMP and GEL	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 5% GEL (Panoxyl) WITH CLINDAMYCIN, CLINDAMAX (CLEOCIN T) 1% LOTION, CLINDAMYCIN SWAB (CLEOCIN T) 1% PLEDGETS, CLINDAMYCIN PHOSPHATE 1% SOLUTION separately used together
BENZAMYCIN PAK GEL	Non-Preferred	Formulary Agent: BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
BENZEPRO SC, BENZOYL PEROXIDE (BENZEFOAM ULTRA) 9.8% FOAM	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, OR BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
BENZEPRO, BENZOYL PEROXIDE (BENZEFOAM) 5.3% EMOLLIENT FOAM	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, OR BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL

Drug	Status	Special Instructions
BENZIQ 5.25% GEL	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, OR BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
BENZIQ 5.25% WASH	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, OR BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
BENZONATATE (ZONATUSS) 150 mg CAPSULE	Non-Preferred	Formulary agent: benzonatate capsule
BENZOYL PEROXIDE 7% WASH	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, OR BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
BENZOYL PEROXIDE KIT AC (BPO CREAMY KIT) 8%-5%	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 8% CLEANSER (Panoxyl-8) with Benzoyl Peroxide 5% Lotion or BENZOYL PEROXIDE 5% GEL (Panoxyl)
BENZOYL PEROXIDE KIT AC, BPO CREAMY KIT 4%-5%	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 4% CLEANSER (Panoxyl-4) with Benzoyl Peroxide 5% Lotion or BENZOYL PEROXIDE 5% GEL (Panoxyl)
BENZPHETAMINE (DIDREX) 50 mg TABLET	Excluded benefit	
BEPREVE 1.5% EYE DROPS	Non-Preferred	Formulary Agents: OTC agents with ketotifen AND azelastine (Optivar)
BERINERT C1 Esterase Inhibitor (Human) 500 UNIT KIT	Specialty	Specialty; Request Must Go Through Clinical Review
BESIVANCE 0.6% SUSPENSION	Non-Preferred	Required diagnosis = cataract surgery or corneal ulcer/keratitis or conjunctivitis Formulary Agents: ciprofloxacin or ofloxacin ophthalmic
BETAMETHASONE DP AUG 0.05% GEL	Non-Preferred	Formulary Agents: BETAMETHASONE DP 0.05% CREAM, LOTION OR OINTMENT
BETAMETHASONE VALERATE (LUXIQ) 0.12% FOAM	Non-Preferred	Formulary Agents: BETAMETHASONE VALERATE 0.1% CREAM, LOTION, or OINTMENT
BETASERON 0.3 mg KIT	Specialty	Specialty; Request Must Go Through Clinical Review
Betaxolol 10 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Beta-Blockers (Atenolol, Bisoprolol, Carvedilol, Labetalol, Metoprolol Succinate Or Tartrate, Nadolol, Propranolol)
Betaxolol 20 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Beta-Blockers (Atenolol, Bisoprolol, Carvedilol, Labetalol, Metoprolol Succinate Or Tartrate, Nadolol, Propranolol)

Drug	Status	Special Instructions
BETHKIS 300/4 mL NEBULIZING SOLUTION	Non-Preferred	Required diagnosis = Cystic Fibrosis Formulary agent: Cayston
BETIMOL 0.25% EYE DROPS	Non-Preferred	Formulary Agents: TIMOLOL (TIMOPTIC) 0.25% EYE DROPS or TIMOLOL (TIMOPTIC) 0.5% EYE DROPS
BETIMOL 0.5% EYE DROPS	Non-Preferred	Formulary Agents: TIMOLOL (TIMOPTIC) 0.25% EYE DROPS or TIMOLOL (TIMOPTIC) 0.5% EYE DROPS
BETOPTIC-S 0.25% EYE DROPS	Non-Preferred	Formulary Agent: BETAXOLOL 0.5% EYE DROP
BEVESPI AEROSOL 4.8 mcg - 9 mcg	Non-Preferred	Requires trial of 30 days and failure (in the last 90 days), contraindication, or adverse reaction to at least ONE agent from each of the below: Long acting anticholinergic: Tudorza Pressair Inhaler, Spiriva, or Incruse (which requires PA) AND Long acting beta-2 agonist: Arcapta, Serevent, Brovana (which requires PA), Perforomist (which requires PA), Striverdi Respimat
BEXAROTENE (TARGRETIN) 75MG CAPSULE	PA required	Required diagnosis = Cutaneous T-cell lymphoma
BEYAZ 28 TABLET	PA required	Requires a trial of: Gianvi, Loryna, or Vestura with folic acid separately
Biafine Emulsion	Non-Preferred	Formulary Agent(s): Woun'Dres Wound Dressing
BIDIL TABLET	Non-Preferred	Formulary Agent: isosorbide and hydralazine separately
BIMATOPROST (LUMIGAN) 0.03% EYE DROPS	Non-Preferred	Formulary Agent: Latanoprost 0.005% EYE DROPS
BINOSTO 70 mg EFFERVESCENT TABLET	Non-Preferred	Formulary Agent: alendronate
BIONECT 0.2% CREAM	Non-Preferred	Required Diagnosis= Dermal Ulcers/Wounds/Skin Irritations/Burns With A Trial Of: Santyl, And/Or TBC (Granulex) Spray
BIONECT 0.2% FOAM	Non-Preferred	Required Diagnosis= Dermal Ulcers/Wounds/Skin Irritations/Burns With A Trial Of: Santyl, And/Or TBC (Granulex) Spray
BIONECT 0.2% GEL	Non-Preferred	Required Diagnosis= Dermal Ulcers/Wounds/Skin Irritations/Burns With A Trial Of: Santyl, And/Or TBC (Granulex) Spray
BIOTIN FORTE 3MG TABLET	Non-Preferred	Formulary agents: DIALYVITE, RENAL TAB, FULL SPECT, RENA-VITE (NEPHRO-VITE) 0.8MG TABLET
BIOTIN FORTE 5MG TABLET	Non-Preferred	Formulary agents: DIALYVITE, RENAL TAB, FULL SPECT, RENA-VITE (NEPHRO-VITE) 0.8MG TABLET
BIVIGAM INJECTION 10%	Specialty	Specialty; follow policy on CareSource.com.
BLINCYTO 35MCG FOR IV INFUSION	Non-Preferred	Required diagnosis = Philadelphia chromosome-negative relapsed or refractory B-cell precursor acute lymphoblastic leukemia
B-NEXA, PRENAISSANCE NEXT, VP-GGR-B6	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
BONIVA IV	PA required	Specialty

Drug	Status	Special Instructions
BOSULIF 100 mg TABLET	Non-Preferred	Required diagnosis = chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with resistance or intolerance to prior therapy
BOSULIF 500 mg TABLET	Non-Preferred	Required diagnosis = chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with resistance or intolerance to prior therapy
BOTOX	Specialty	Specialty; follow policy on CareSource.com.
BP CLEANSING (BENZOYL PEROXIDE) LOTION 4%	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, OR BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
BP CLEANSING (SULFACETAMIDE SODIUM-SULFUR IN UREA) WASH 10-4%	Non-Preferred	Requires diagnosis: Acne rosacea, acne vulgaris, seborrheic dermatitis (ages 12 and up) And a 30 day Trial of one of the following agents: Avar-E Ls 10-2% Cream, Sulfacetamide Sodium W/ Sulfur Suspension 10-5%, Sulfacetamide Sodium W/ Sulfur Lotion 10-5%, Or Sulfacetamide Sodium W/ Sulfur Emulsion, Avar Cleanser , Rosanil, Prascion 10-5%
B-PLEX PLUS TABLET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
BRAVELLE INJECTION 75UNIT	Excluded Benefit	
Breast Pumps	Medical Benefit	Bill through Medical Benefit
BREVOXYL-4 COMPLETE PACK	Non-Preferred	No longer available on the market
BREVOXYL-8 COMPLETE PACK	Non-Preferred	No longer available on the market
BRILINTA 60MG TABLET	PA required	Formulary Agent(s): Clopidogrel (Plavix)
BRILINTA 90MG TABLET	PA required	Formulary Agent(s): Clopidogrel (Plavix)
BRIMONIDINE (ALPHAGAN P) 0.15% EYE DROPS	Non-Preferred	Formulary Agent: BRIMONIDINE 0.2% EYE DROP
BRINEURA	Lower Cost	Specialty; follow policy on CareSource.com.
Briviact 10 mg/mL Solution	Non-Preferred	Required Diagnosis= Seizure Or Epilepsy AND A 30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Briviact 10 mg Tablet	Non-Preferred	Required Diagnosis= Seizure Or Epilepsy AND A 30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide

Drug	Status	Special Instructions
Briviact 25 mg Tablet	Non-Preferred	Required Diagnosis= Seizure Or Epilepsy AND A 30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Briviact 50 mg Tablet	Non-Preferred	Required Diagnosis= Seizure Or Epilepsy AND A 30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Briviact 75 mg Tablet	Non-Preferred	Required Diagnosis= Seizure Or Epilepsy AND A 30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Briviact 100 mg Tablet	Non-Preferred	Required Diagnosis= Seizure Or Epilepsy AND A 30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
Briviact 10 mg/mL Vial	Non-Preferred	Required Diagnosis= Seizure Or Epilepsy AND A 30 Day Trial Of 1 Of The Following: Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide
BROMDAY 0.09% EYE DROPS	Non-Preferred	Formulary Agent: DICLOFENAC (VOLTAREN) 0.1% EYE DROPS
BROMFENAC 0.09% EYE DROPS	Non-Preferred	Formulary Agent: DICLOFENAC (VOLTAREN) 0.1% EYE DROPS
BROMSITE 0.075% EYE DROPS	Non-Preferred	Requires a *Diagnosis of= post-operative ocular inflammation/pain following cataract surgery AND a *7 day trial (each) of at least 2 of the following: Prolensa, Ilevro, or Bromfenac
Brovana 15mcg/2mL Solution	Non-Preferred	Formulary Agent(s): Arcapta Neohaler Or Serevent
BUNAVAIL 2.1-0.3MG	Non-Preferred	Request Must Go Through Clinical Review
BUNAVAIL 4.2-0.7MG	Non-Preferred	Request Must Go Through Clinical Review
BUNAVAIL 6.3-1MG	Non-Preferred	Request Must Go Through Clinical Review
BUPAP (PROMACET) 50-650 mg TABLET	Non-Preferred	No longer available on the market
BUPAP 50-300 mg TABLET	Non-Preferred	Formulary Agent: BUTALBITAL-ACETAMINOPHEN (Phrenilin, Marten tabs) 50-325 mg tablet
BUPHENYL 500 mg TABLET	PA required	Required diagnosis=urea cycle disorders
BUPHENYL POWDER	PA required	Required diagnosis=urea cycle disorders
BUPRENORPHINE (SUBUTEX) 2 mg SUBLINGUAL TABLET	PA required	Request must go through clinical review

Drug	Status	Special Instructions
BUPRENORPHINE (SUBUTEX) 8 mg SUBLINGUAL TABLET	PA required	Request must go through clinical review
BUPRENORPHINE-NALOXONE (SUBOXONE) 2 mg-0.5 mg SUBLINGUAL TABLET	PA required	Request must go through clinical review
BUPRENORPHINE-NALOXONE (SUBOXONE) 8 mg-2 mg SUBLINGUAL TABLET	PA required	Request must go through clinical review
BUTALBITAL-ACETAMINOPHEN-CAFFEINE-CODEINE (FIORICET-COD) 30-50-300-40 CAPSULE	Non-Preferred	Formulary Agent: BUTALBITAL-ACETAMINOPHEN-CAFFEINE-CODEINE (FIORICET-COD) 30-50-325-40 CAPSULE
BUTISOL SODIUM 30 mg TABLET	Non-Preferred	Formulary Agent: phenobarbital
BUTISOL SODIUM 30 mg/5 mL ELIXIR	Non-Preferred	Formulary Agent: phenobarbital
BUTISOL SODIUM 50 mg TABLET	Non-Preferred	Formulary Agent: phenobarbital
Bupivacaine 0.25% Vial	Medical Benefit	Bill Through Medical Benefit
Buprenorphine (Butrans) 5 mcg/HR Patch	Non-Preferred	Formulary Agents: Oxycodone IR, Hydrocodone/Acetaminophen, Oxycodone/Acetaminophen, Hydrocodone/Ibuprofen, Morphine Sulfate IR Or Tramadol
Buprenorphine (Butrans) 10 mcg/HR Patch	Non-Preferred	Formulary Agents: Oxycodone IR, Hydrocodone/Acetaminophen, Oxycodone/Acetaminophen, Hydrocodone/Ibuprofen, Morphine Sulfate IR Or Tramadol
Buprenorphine (Butrans) 15 mcg/HR Patch	Non-Preferred	Formulary Agents: Oxycodone IR, Hydrocodone/Acetaminophen, Oxycodone/Acetaminophen, Hydrocodone/Ibuprofen, Morphine Sulfate IR Or Tramadol
Buprenorphine (Butrans) 20 mcg/HR Patch	Non-Preferred	Formulary Agents: Oxycodone IR, Hydrocodone/Acetaminophen, Oxycodone/Acetaminophen, Hydrocodone/Ibuprofen, Morphine Sulfate IR Or Tramadol
Buprenorphine (Butrans) 7.5 mcg/HR Patch	Non-Preferred	Formulary Agents: Oxycodone IR, Hydrocodone/Acetaminophen, Oxycodone/Acetaminophen, Hydrocodone/Ibuprofen, Morphine Sulfate IR Or Tramadol
Butalbital-Acetaminophen (Phrenilin, Marten) Tablet	Non-Preferred	Required Diagnosis Of Tension Or Muscle Contraction Headache AND Formulary Agent(s): Butalbital/Acetaminophen/Caffeine Or Butalbital/Aspirin/Caffeine
BYDUREON 2 mg WEEKLY INJECTION	Non-Preferred	Requires a 60 day trial of: Victoza or Trulicity (which require a 30 day trial of metformin or metformin ER)
BYDUREON 2 mg Vial	Non-Preferred	Requires a 60 day trial of: Victoza or Trulicity (which require a 30 day trial of metformin or metformin ER)
BYETTA 10 mcg DOSE PEN	Step Therapy	Requires a 60 day trial of: Victoza or Trulicity (which require a 30 day trial of metformin or metformin ER)
BYETTA 5 mcg DOSE PEN	Step Therapy	Requires a 60 day trial of: Victoza or Trulicity (which require a 30 day trial of metformin or metformin ER)
BYSTOLIC 10 mg TABLET	Non-Preferred	Formulary Agents: carvedilol, labetalol, metoprolol, atenolol, nadolol, propranolol, sotalol, or bisoprolol
BYSTOLIC 2.5 mg TABLET	Non-Preferred	Formulary Agents: carvedilol, labetalol, metoprolol, atenolol, nadolol, propranolol, sotalol, or bisoprolol

Drug	Status	Special Instructions
BYSTOLIC 20 mg TABLET	Non-Preferred	Formulary Agents: carvedilol, labetalol, metoprolol, atenolol, nadolol, propranolol, sotalol, or bisoprolol
BYSTOLIC 5 mg TABLET	Non-Preferred	Formulary Agents: carvedilol, labetalol, metoprolol, atenolol, nadolol, propranolol, sotalol, or bisoprolol
Byvalson 5-80 mg Tablet	Non-Preferred	Required Diagnosis= Hypertension AND 30 Day Trial Of One Of Each (Group) Separately Taken Together At The Same Time: Valsartan, Irbesartan, Losartan, Or Candesartan AND Carvedilol, Nadolol, Atenolol, Metoprolol, Propranolol, Sotalol Or Bisoprolol
C1 INHIBITOR (HUMAN) FOR IV INJECTION 500 UNIT	PA required	Required diagnosis = prophylaxis against angioedema attacks in patients with hereditary angioedema (HAE)
Cabometyx 20 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Cabometyx 40 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Cabometyx 60 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Cafergot 1-100 mg Tablet	Non-Preferred	Required Diagnosis= Prevention Of Vascular Headaches (Migraines) AND A Trial Of At Least 2 Of The Following Drugs: Sumatriptan Tablets, Injection, Or Nasal Spray, Naratriptan, Rizatriptan, Almotriptan OR Dihydroergotamine Injection Or Nasal Spray OR Ergomar (Which Also Requires A PA)
Caffeine Citrate 60 mg/3 mL Vial	Medical Benefit	Required Diagnosis=Apnea of Prematurity
CALCITRIOL (VECTICAL) 3 mcg/GM OINTMENT	Non-Preferred	Formulary Agent: calcipotriene (Dovonex)
Calcium Gluconate 100 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
CAMBIA 50 mg POWDER PACKET	Non-Preferred	Formulary Agents: diclofenac potassium (Cataflam) tablet and diclofenac sodium (Voltaren) tablet
CAMPTOSAR 300 mg/15 mL VIAL	Non-Preferred	Required diagnosis = metastatic carcinoma of the colon or rectum
Cancidas 50 mg Vial	Medical Benefit	Bill Through Medical Benefit
Cancidas 70 mg Vial	Medical Benefit	Bill Through Medical Benefit
CANTIL 25 mg TABLET	Non-Preferred	Formulary Agent: glycopyrrolate tablet
Capecitabine (Xeloda) 150mg Tablet	PA required	Required Diagnosis= Colorectal, Colon Or Breast Cancer OR Adjuvant For Colon Cancer
Capecitabine (Xeloda) 500mg Tablet	PA required	Required Diagnosis= Colorectal, Colon Or Breast Cancer OR Adjuvant For Colon Cancer

Drug	Status	Special Instructions
CAPEX SHAMPOO	Non-Preferred	Formulary Agent: ketoconazole shampoo (Nizoral) Required with a diagnosis of seborrhea on scalp OR Formulary Agent: coal tar topical shampoo, calcipotriene solution, OR Age 2-11: BETAMETHASONE DP 0.05% LOTION, BETAMETHASONE VALERATE 0.1% LOTION Age 12-17: BETAMETHASONE DP 0.05% LOTION, BETAMETHASONE VALERATE 0.1% LOTION, Mometasone (ELOCON) 0.1% LOTION Age 18 and older: FLUOCINOLONE 0.01% Topical SOLUTION , TRIAMCINOLONE 0.025% LOTION, BETAMETHASONE DP 0.05% LOTION, BETAMETHASONE VALERATE 0.1% LOTION, or Mometasone (ELOCON) 0.1% LOTION for a diagnosis of scalp psoriasis
CAPITAL WITH CODEINE SUSPENSION	Non-Preferred	Formulary Agent: ACETAMINOPHEN-CODEINE 120 mg/5 mL ELIXIR
CAPTRACIN 0.0375-5% PATCH	Non-Preferred	Formulary agent: lidocaine (Lidoderm) 5% patch
CARBAGLU 200 mg DISPER TABLET	PA required	Required diagnosis = hyperammonemia
CARBIDOPA & LEVODOPA (PARCOPA) 10 mg-100 mg ODT	Non-Preferred	Formulary Agent: carbidopa/levodopa non-ODT OR and inability to swallow
CARBIDOPA & LEVODOPA (PARCOPA) 25 mg-100 mg ODT	Non-Preferred	Formulary Agent: carbidopa/levodopa non-ODT OR and inability to swallow
CARBINOXAMINE, Arbinoxa (PALGIC) 4MG/5ML LIQUID	Non-Preferred	Formulary Agents: chlorpheniramine OR diphenhydramine
CARBINOXAMINE, Arbinoxa (PALGIC) 4 mg TABLET	Non-Preferred	Formulary Agents: chlorpheniramine OR diphenhydramine
CARBINOXAMINE MALEATE (KARBINAL ER) SUSPENSION 4 mg/ 5 mL	Non-Preferred	One of the DX below: - Seasonal and perennial allergic rhinitis - Vasomotor rhinitis - Allergic conjunctivitis due to inhalant allergens and foods - Mild, uncomplicated allergic skin manifestations of urticaria and angioedema - Dematographism (dermatographic urticarial) - Anaphylaxis, adjunct after acute manifestation controlled - Hypersensitivity reaction to blood or plasma AND Plus, 2-week trial and failure within the last 120 days or intolerance to ALL of the following (supported by claims history as all are covered by CareSource): - Loratadine, desloratadine, cetirizine, fexofenadine, diphenhydramine, chlorpheniramine
CARDENE SR 30 mg CAPSULE	Non-Preferred	Formulary Agent: non-SR nicardipine
CARDENE SR 45 mg CAPSULE	Non-Preferred	Formulary Agent: non-SR nicardipine
CARDENE SR 60 mg CAPSULE	Non-Preferred	Formulary Agent: non-SR nicardipine
CARDURA XL 4 mg TABLET	Non-Preferred	Formulary Agent: non-XL doxazosin

Drug	Status	Special Instructions
CARDURA XL 8 mg TABLET	Non-Preferred	Formulary Agent: non-XL doxazosin
CARIMUNE NF 12 gM VIAL	PA required	Specialty; follow policy on CareSource.com.ets:
CARIMUNE NF 3 gM VIAL	PA required	Specialty; follow policy on CareSource.com.
CARIMUNE NF 6 gM VIAL	PA required	Specialty; follow policy on CareSource.com.
CARISOPRODOL (SOMA) 250 mg TABLET	Non-Preferred	Formulary Agent: carisoprodol 350 mg tablet (1/2 tab)
CARISOPRODOL-ASPIRIN 200-325 mg COMPOUND TABLET	PA required	Required diagnosis=acute musculoskeletal conditions with a trial of carisoprodol 350 mg tablet
CARISOPRODOL-ASPIRIN-CODEINE 200-325-16 mg TABLET	Non-Preferred	Formulary Agent: carisoprodol 350 mg tablet
CARNITOR SF 100 mg/ML ORAL	Non-Preferred	Formulary Agent: levocarnitine (Carnitor) 1000 mg/10 mL (1 gm/10 mL) solution
CARTICEL IMPLANT	Medical Benefit	Bill through Medical Benefit
CAVAN-EC VITAMIN 30-1-440 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CAVAN-FOLATE DHA COMBO PACK 65-1-250 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CAVAN-HEME OB TABLET 22-6-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CAVERJECT FOR INJECTION	Excluded Benefit	
CAYSTON 75 mg INHAL SOLUTION	PA required	Required diagnosis = cystic fibrosis
CEDAX 90 mg/5 mL SUSPENSION	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin
CEFACLOR 125/5 mL SUSPENSION	Non-Preferred	Required trial of: Cefaclor 250MG and 500MG capsule or cephalexin 125MG/5mL suspension
CEFACLOR 250/5 mL SUSPENSION	Non-Preferred	Required trial of: Cefaclor 250MG and 500MG capsule or cephalexin 250MG/5mL suspension
CEFACLOR 375/5 mL SUSPENSION	Non-Preferred	Required trial of: Cefaclor 250MG and 500MG capsule or cephalexin 250MG/5mL suspension
Cefazolin 500 mg Vial	Medical Benefit	Bill Through Medical Benefit
Cefazolin 1G Vial	Medical Benefit	Bill Through Medical Benefit
Cefazolin 10G Vial	Medical Benefit	Bill Through Medical Benefit
Cefepime 1G Vial	Medical Benefit	Bill Through Medical Benefit
Cefepime 2G Vial	Medical Benefit	Bill Through Medical Benefit
Cefotetan 1G Vial	Medical Benefit	Bill Through Medical Benefit
Cefoxitin 2G Vial	Medical Benefit	Bill Through Medical Benefit
CEFPODOXIME 100 mg TABLET	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin

Drug	Status	Special Instructions
CEFPODOXIME 100 mg/5 mL SUSPENSION	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin
CEFPODOXIME 200 mg TABLET	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin
CEFPODOXIME 50 mg/5 mL SUSPENSION	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin
CEFTIBUTEN (CEDAX) 180 mg/5 mL SUSPENSION	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin
CEFTIBUTEN (CEDAX) 400 mg CAPSULE	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin
Ceftriaxone (Rocephin) 250 mg Vial	Medical Benefit	Bill Through Medical Benefit
Ceftriaxone (Rocephin) 500 mg Vial	Medical Benefit	Bill Through Medical Benefit
Ceftriaxone (Rocephin) 1G Vial	Medical Benefit	Bill Through Medical Benefit
Ceftriaxone (Rocephin) 2G Vial	Medical Benefit	Bill Through Medical Benefit
CELESTONE 0.6 mg/5 mL SOLUTION	Non-Preferred	Formulary Agent: prednisone tablet
CENESTIN 0.3 mg TABLET	Non-Preferred	Formulary Agent: Premarin
CENESTIN 0.45 mg TABLET	Non-Preferred	Formulary Agent: Premarin
CENESTIN 0.625 mg TABLET	Non-Preferred	Formulary Agent: Premarin
CENESTIN 0.9 mg TABLET	Non-Preferred	Formulary Agent: Premarin
CENESTIN 1.25 mg TABLET	Non-Preferred	Formulary Agent: Premarin
CEPHALEXIN (KEFLEX) 750 mg CAPSULE	Non-Preferred	Formulary Agent: cephalexin 500 MG capsule
CEPHALEXIN 500 mg TABLET	Non-Preferred	Formulary Agent: cephalexin 500 MG capsule
CEPROTIN 500 UNIT VIAL	Non-Preferred	Required diagnosis: Prevention of Severe Congenital Protein C Deficiency, Treatment of Venous Thrombosis, or Purpura Fulminans
CEPROTIN 1000 UNIT VIAL	Non-Preferred	Required diagnosis: Prevention of Severe Congenital Protein C Deficiency, Treatment of Venous Thrombosis, or Purpura Fulminans
CERDELGA 84MG CAPSULE	Specialty	Specialty; follow policy on CareSource.com.
CEREDASE INJECTION 80UNT/ML	PA required	Specialty
CEREFOLIN NAC CAPELET 600-2-6 mg	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
CEREFOLIN TABLET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
CEREZYME	Specialty	Specialty; follow policy on CareSource.com.
CERISA WASH 10-1%, BP 10-1% Emulsion	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%

Drug	Status	Special Instructions
CEROVEL, X-VIATE, UREA 40% GEL	Non-Preferred	Formulary Agent: Rea Lo 40% cream
CESAMET 1 mg CAPSULE	Non-Preferred	Formulary Agents: ondansetron, meclizine, promethazine, prochlorperazine, or granisetron
CETACAINE 2-2-14% SPRAY	Medical Benefit	Bill through Medical Benefit
CETROTIDE KIT 0.25 mg	Excluded Benefit	
CEVIMELINE (EVOXAC) 30 mg CAPSULE	Non-Preferred	Formulary Agents: PILOCARPINE TABLET OR OTC saliva substitute (examples: SALIVASURE, SALESE (NUMOISYN) lozenges, AQUORAL AEROSOL SOLUTION, or CAPHOSOL, NUMOISYN, BIOTENE, MOUTHKOTE, MOI-STIR SOLUTION)
CHENODAL 250 mg TABLET	Non-Preferred	Formulary Agent: ursodiol
CHILD DELSYM COUGH-COLD NIGHT	Non-Preferred	Formulary Agent: ROBITUSSIN PEDIATRIC COUGH 7.5MG/5ML
CHILDREN'S MUCINEX 5 mg-10 mg-325 mg-200 mg/10 mL	Non-Preferred	Formulary Agent: CHILD'S MUCINEX 100 mg/5 mL LIQUID
CHILDREN'S ZYRTEC ALLERGY 10MG RAPDIS TAB	Non-Preferred	Formulary agent: cetirizine (Zyrtec) 10MG chewable tablet
Chloroquine 250 mg Tablet	Non-Preferred	Required Diagnosis Of Malaria Chemoprophylaxis Or Malaria Treatment In Adults And Children OR Extraintestinal Amebiasis In Adults Age 18 And Older
Chloroquine 500 mg Tablet	Non-Preferred	Required Diagnosis Of Malaria Chemoprophylaxis Or Malaria Treatment In Adults And Children OR Extraintestinal Amebiasis In Adults Age 18 And Older
Chlorothiazide 250 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Thiazide Or Thiazide-Like Diuretic (Chlorthalidone, Hydrochlorthiazide, Indapamide, Metolazone)
Chlorothiazide 500 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Thiazide Or Thiazide-Like Diuretic (Chlorthalidone, Hydrochlorthiazide, Indapamide, Metolazone)
CHLORPROPAMIDE 100 mg TABLET	Non-Preferred	Requires a 30 day trial of each of the following: glimepiride, glipizide, and glyburide
CHLORPROPAMIDE 250 mg TABLET	Non-Preferred	Requires a 30 day trial of each of the following: glimepiride, glipizide, and glyburide
CHOLBAM 50MG CAPSULE	PA required	Request Must Go Through Clinical Review
CHOLBAM 250MG CAPSULE		
CHOLINE MAGNESIUM TRISALICYLATE 500 mg/5 mL Liquid	Non-Preferred	Required Diagnosis: acute painful shoulder, osteoarthritis, rheumatoid arthritis, analgesia Or pyrexia AND a 14 day trial of aspirin or a non-steroidal anti-inflammatory agent (ibuprofen, meloxicam, indomethacin, etodolac, naproxen, etc.)
CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL 10,000 UNIT INJECTION	Excluded benefit	
CIALIS 10 mg TABLET	Excluded benefit	
CIALIS 2.5 mg TABLET	Excluded benefit Non-Preferred	Excluded benefit except for diagnosis of Benign Prostatic Hypertrophy (BPH) with a trial of doxazosin, terazosin, tamsulosin, or prazosin
CIALIS 20 mg TABLET	Excluded benefit	

Drug	Status	Special Instructions
CIALIS 5 mg TABLET	Excluded benefit Non-Preferred	Excluded benefit except for diagnosis of Benign Prostatic Hypertrophy (BPH) with a trial of doxazosin, terazosin, tamsulosin, or prazosin
CICLOPIROX KIT 8%	Non-Preferred	Formulary Agents: CICLOPIROX (Penlac, Ciclodan) 8% SOLUTION AND vitamin E separatelyFormulary Agents: CICLOPIROX (Penlac, Ciclodan) 8% SOLUTION AND vitamin E separately
CILOXAN 0.3% OINTMENT	Non-Preferred	Formulary Agent: ciprofloxacin solution
CIMZIA 200 mg/ML SYRINGE KIT	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Cimzia by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
CIMZIA 400 mg/ML SYRINGE KIT	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Cimzia by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
CINRYZE C1 Esterase Inhibitor (Human) 500 UNIT SOLUTION	PA required	Specialty; Request Must Go Through Clinical Review
Cinqair 10 mg/mL Vial	Non-Preferred	Specialty; Request Must Go Through Clinical Review
CIPRO HC OTIC SUSPENSION	Non-Preferred	Required 7 day trial of: ciprofloxacin (Cetraxal) 0.2% OTIC Solution or Neomycin-Polymyxin-HC (Cortisporin) 1% Otic Solution THEN 7 day trial of: Ciprodex
Ciprofloxacin (Cipro) In D5W 200 mg/100 mL Vial	Medical Benefit	Bill Through Medical Benefit
Ciprofloxacin (Cipro) In D5W 400 mg/200 mL Vial	Medical Benefit	Bill Through Medical Benefit
Ciprofloxacin (Cipro) 200 mg/20 mL Vial	Medical Benefit	Bill Through Medical Benefit
Ciprofloxacin (Cipro) 400 mg/40 mL Vial	Medical Benefit	Bill Through Medical Benefit
CITRACAL MAXIMUM	Non-Preferred	Formulary Agent: CALCIUM + D TAB 315 mg-200 UNIT
CITRANATAL 90 DHA PACK 90-1-300 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CITRANATAL ASSURE COMBO PACK 35-1-50 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CITRANATAL B-CALM PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CITRANATAL DHA PACK 27-1-50 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CitraNatal Harmony 27-1-50 mg Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CitraNatal Harmony 29-1-50 mg Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CITRANATAL RX TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin

Drug	Status	Special Instructions
CLARAVIS or ACCUTANE 30 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
CLARAVIS, ZENATANE or ACCUTANE 10 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
CLARAVIS, ZENATANE or ACCUTANE 20 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
CLARAVIS, ZENATANE or ACCUTANE 40 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
CLARINEX 0.5 mg/ML (2.5 mg/5 mL)	Non-Preferred	Formulary Agents: desloratadine (Clarinex)
CLARINEX-D 12 HOUR TABLET	Non-Preferred	Formulary Agents: desloratadine (Clarinex) and pseudoephedrine separately taken together
CLARINEX-D 24 HOUR TABLET	Non-Preferred	Formulary Agents: desloratadine reditabs or tablets and pseudoephedrine separately taken together
CLARIS CLARIFYING WASH	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%

Drug	Status	Special Instructions
CLARITIN 5MG CHEWABLE TABLET	Excluded	Excluded per CMS
CLARITIN 10 mg LIQUI-GEL CAPSULE	Non-Preferred	Formulary Agent: OTC loratadine
CLARITIN 5 mg REDI-TABLET	Non-Preferred	Formulary Agent: CHILD'S CLARITIN 5 mg CHEWABLE tablet
CLENIA EMOLLIENT CREAM	Non-Preferred	Formulary Agent: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
CLIMARA PRO PATCH	Step Therapy	Requires trial of: COMBIPATCH, Prempro, Premarin, or FemHRT
CLINDACIN ETZ 1% KIT	Non-Preferred	Formulary agent: clindamycin swab (Cleocin T) 1% pledgets
CLINDACIN PAC 1% KIT	Non-Preferred	Formulary agent: clindamycin swab (Cleocin T) 1% pledgets
CLINDAMYCIN (EVOCLIN) 1% FOAM	Non-Preferred	Formulary Agent: clindamycin gel or solution
CLINDAMYCIN, CLINDAMAX (CLEOCIN T, CLINDAGEL) 1% GEL	Non-Preferred	Formulary Agent: CLINDAMYCIN, CLINDAMAX (CLEOCIN T) 1% LOTION, CLINDAMYCIN SWAB (CLEOCIN T) 1% PLEDGETS, CLINDAMYCIN PHOSPHATE 1% SOLUTION
CLINDAMYCIN/BENZOYL PEROXIDE (BENZACLIN) GEL 50 gram jar	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 5% GEL (Panoxyl) WITH CLINDAMYCIN, CLINDAMAX (CLEOCIN T) 1% LOTION, CLINDAMYCIN SWAB (CLEOCIN T) 1% PLEDGETS, CLINDAMYCIN PHOSPHATE 1% SOLUTION separately used together
CLINDAMYCIN -BENZOYL PEROXIDE (DUAC) 1-5% GEL	Non-Preferred	Formulary Agent: BENZOYL PEROXIDE 5% GEL (Panoxyl) WITH CLINDAMYCIN, CLINDAMAX (CLEOCIN T) 1% LOTION, CLINDAMYCIN SWAB (CLEOCIN T) 1% PLEDGETS, CLINDAMYCIN PHOSPHATE 1% SOLUTION separately used together
Clindamycin-Tretinoin (Veltin, Ziana) 1.2-0.025% Gel	Non-Preferred	A 30 Day Trial Of: Clindamycin Pledgets Or Clindamycin Topical Solution AND Tretinoin Gel Or Cream
CLINDESSE 2% VAGINAL CREAM	Non-Preferred	No longer available on the market
ClinPro 5000 (Prevident 5000 Booster Plus) 1.1% Paste	Non-Preferred	Formulary Agent(s): ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, Or SF 5000 Plus 1.1% Cream
CLOBETASOL (CLOBEX) 0.05% SHAMPOO	Non-Preferred	Formulary Agent: CLOBETASOL, CORMAX SCALP (TEMOVATE) 0.05% SOLUTION
CLOBETASOL (CLOBEX) 0.05% TOPICAL LOTION	Non-Preferred	Lower Cost option: CLOBETASOL (OLUX) 0.05% FOAM
CLOBETASOL AERO (OLUX AERO) 0.05% FOAM	Non-Preferred	Formulary Agents: CLOBETASOL (TEMOVATE) 0.05% CREAM, CLOBETASOL (TEMOVATE) 0.05% GEL, CLOBETASOL (TEMOVATE) 0.05% OINTMENT or CLOBETASOL, CORMAX SCALP (TEMOVATE) 0.05% SOLUTION
CLOBETASOL EMULSION (OLUX-E) 0.05% FOAM	Non-Preferred	Lower Cost option: CLOBETASOL (TEMOVATE) 0.05% CREAM, CLOBETASOL (TEMOVATE) 0.05% GEL, CLOBETASOL (TEMOVATE) 0.05% OINTMENT or CLOBETASOL, CORMAX SCALP (TEMOVATE) 0.05% SOLUTION
CLOBETASOL (CLOBEX) 0.05% SPRAY	Non-Preferred	Formulary Agents: clobetasol topical cream, gel, ointment, or solution
CLOCORTOLONE (CLODERM) 0.1% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.

Drug	Status	Special Instructions
CLODAN 0.05% KIT	Non-Preferred	Required trial of: clobetasol, cormax scalp (Temovate) 0.05% solution
Clomiphene (Clomid)	Excluded benefit	
CLONAZEPAM (KLONOPIN) 0.125 mg DISINTEGRATING TABLET	Non-Preferred	Formulary Agent: CLONAZEPAM tablet unless for use during seizures OR inability to swallow
CLONAZEPAM (KLONOPIN) 0.25 mg DISINTEGRATING TABLET	Non-Preferred	Formulary Agent: CLONAZEPAM tablet unless for use during seizures OR inability to swallow
CLONAZEPAM (KLONOPIN) 0.5 mg DISINTEGRATING TABLET	Non-Preferred	Formulary Agent: CLONAZEPAM tablet unless for use during seizures OR inability to swallow
CLONAZEPAM (KLONOPIN) 1 mg DISINTEGRATING TABLET	Non-Preferred	Formulary Agent: CLONAZEPAM tablet unless for use during seizures OR inability to swallow
CLONAZEPAM (KLONOPIN) 2 mg DISINTEGRATING TABLET	Non-Preferred	Formulary Agent: CLONAZEPAM tablet unless for use during seizures OR inability to swallow
Clonidine 100 mcg/mL Vial	Medical Benefit	Bill Through Medical Benefit
CLORPRES 0.2-15 TABLET	Non-Preferred	Formulary Agent: clonidine and chlorthalidone separately
CLORPRES 0.3-15 TABLET	Non-Preferred	Formulary Agent: clonidine and chlorthalidone separately
CLOZAPINE ODT (FAZACLO ODT) 100 mg	Non-Preferred	Formulary Agent: clozapine
CLOZAPINE ODT (FAZACLO ODT) 12.5 mg	Non-Preferred	Formulary Agent: clozapine
CLOZAPINE ODT (FAZACLO ODT) 150 mg	Non-Preferred	Formulary Agent: clozapine
CLOZAPINE ODT (FAZACLO ODT) 200 mg	Non-Preferred	Formulary Agent: clozapine
CLOZAPINE ODT (FAZACLO ODT) 25 mg	Non-Preferred	Formulary Agent: clozapine
CNL8 NAIL 8 % KIT	Non-Preferred	Formulary Agent: CICLOPIROX (Penlac, Ciclodan) 8% SOLUTION AND vitamin E separately
COCET 650-30 mg TABLET	Non-Preferred	No longer available on the market: use ACETAMINOPHEN-CODEINE #3 tablet
Coenzyme Q10 200 mg SoftGel	Non-Preferred	A 30 Day Trial Of: Coenzyme Q10 SoftGel (10 mg, 30 mg, 50 mg, 60 mg, Or 100 mg)
Coenzyme Q10 400 mg SoftGel	Non-Preferred	A 30 Day Trial Of: Coenzyme Q10 SoftGel (10 mg, 30 mg, 50 mg, 60 mg, Or 100 mg)
COLCHICINE (MITIGARE) 0.6MG CAPSULE	Non-Preferred	*Formulary Agent(s): Colchicine (Colcrys) 0.6mg Tablet
COLESTIPOL (COLESTID) FLAVORED GRANULES	Non-Preferred	Formulary Agent: COLESTIPOL tablet
COLESTIPOL (COLESTID) GRANULES	Non-Preferred	Formulary Agent: COLESTIPOL tablet
COLESTIPOL (COLESTID) GRANULES PACKET	Non-Preferred	Formulary Agent: COLESTIPOL tablet

Drug	Status	Special Instructions
Colistimethate Sodium 150 mg Vial	Medical Benefit	Bill Through Medical Benefit
COLY-MYCIN EAR DROPS	Non-Preferred	Formulary Agent: neomycin/hydrocortisone/polymyxin otic
COLYTE/FLAVR SOLUTION 227.1 gM 3785 mL	Non-Preferred	Formulary Agent: Colyte with Flavor Packs 4000 mL
COMETRIQ 100 MG DAILY-DOSE	PA required	Required diagnosis = progressive, metastatic medullary thyroid cancer
COMETRIQ 140 MG DAILY-DOSE	PA required	Required diagnosis = progressive, metastatic medullary thyroid cancer
COMETRIQ 60 MG DAILY-DOSE	PA required	Required diagnosis = progressive, metastatic medullary thyroid cancer
COMPLETE-RF PRENATAL	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
COMPLETE NATAL DHA 29-1-250 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CONCEPT DHA CAPSULE 35-1-200 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
CONCERTA 18MG ER TABLET	Non-Preferred	Formulary Agent: methylphenidate ER tablet by Actavis
CONCERTA 27MG ER TABLET	Non-Preferred	Formulary Agent: methylphenidate ER tablet by Actavis
CONCERTA 36MG ER TABLET	Non-Preferred	Formulary Agent: methylphenidate ER tablet by Actavis
CONCERTA 54MG ER TABLET	Non-Preferred	Formulary Agent: methylphenidate ER tablet by Actavis
CONDYLOX 0.5% GEL	Non-Preferred	Formulary Agent: podofilox (solution)
COPAXONE 40 mg INJECTION	PA required	Specialty; Request Must Go Through Clinical Review
COPEGUS TABLET 200 mg	PA required	Specialty
CORDRAN 4 mcg/SQ CM TAPE	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
COREG CR 10 mg CAPSULE	Non-Preferred	Formulary Agent: non-cr carvedilol
COREG CR 20 mg CAPSULE	Non-Preferred	Formulary Agent: non-cr carvedilol
COREG CR 40 mg CAPSULE	Non-Preferred	Formulary Agent: non-cr carvedilol
COREG CR 80 mg CAPSULE	Non-Preferred	Formulary Agent: non-cr carvedilol
CORLANOR 5MG TABLET	Non-Preferred	Required diagnosis = Worsening heart failure with left ventricular ejection fraction of 35% or less *Sinus rhythm with resting heart rate at least 70 beats per minute *Currently taking or are unable to take a beta-blocker (i.e. carvedilol, labetalol, metoprolol, atenolol, nadolol, propranololm sotalol, or bisoprolol)
CORLANOR 7.5MG TABLET	Non-Preferred	Required diagnosis = Worsening heart failure with left ventricular ejection fraction of 35% or less *Sinus rhythm with resting heart rate at least 70 beats per minute *Currently taking or are unable to take a beta-blocker (i.e. carvedilol, labetalol, metoprolol, atenolol, nadolol, propranololm sotalol, or bisoprolol)
CORTISPORIN 0.5% CREAM	Non-Preferred	Formulary Agent: OTC topical cream
CORTISPORIN 1% OINTMENT	Non-Preferred	Formulary Agent: OTC triple antibiotic ointment and hydrocortisone separately
CORTISPORIN-TC EAR SUSPENSION, COLY-MYCIN S	Non-Preferred	Formulary Agent: neomycin/hydrocortisone/polymyxin otic

Drug	Status	Special Instructions
COSENTYX 150MG/ML PEN INJECTOR	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Cosentyx by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
COSENTYX 150MG/ML SYRINGE	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Cosentyx by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
COSOPT PF SOLUTION	Non-Preferred	Formulary Agent: dorzolamide HCl/timolol Maleate (COSOPT)
Cosyntropin 0.25 mg Vial	Medical Benefit	Bill Through Medical Benefit
COTAB AX 4-20 MG TABLET	Non-Preferred	Formulary Agent: CHLORPHENIRAMINE-ACETAMINOPHEN
COTELLIC 20MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
COTEMPLA XR ODT 8.6 mg Tablet	Lower Cost	Required Diagnosis=ADHD documented in the chart notes
COTEMPLA XR ODT 17.3 mg Tablet	Lower Cost	Required Diagnosis=ADHD documented in the chart notes
COTEMPLA XR ODT 25.9 mg Tablet	Lower Cost	Required Diagnosis=ADHD documented in the chart notes
COVERA-HS ER 180 mg TABLET	Non-Preferred	No longer available on the market
COVERA-HS ER 240 mg TABLET	Non-Preferred	No longer available on the market
CRESEMBA 186MG CAPSULE	Non-Preferred	Formulary Agent(s): itraconazole
CROMOLYN SODIUM (GASTROCROM) 20MG/ML CONCENTRATE	PA required	Required diagnosis = diagnosis of mastocytosis Formulary Agent: diphenhydramine (Benadryl)
CROMOLYN SODIUM (GASTROCROM) 100 mg/5 mL CONCENTRATE	PA required	Required diagnosis = diagnosis of mastocytosis Formulary Agent: diphenhydramine (Benadryl)
CUVITRU 1 gm/5 mL SUBCUTANEOUS SOLUTION	Medical Benefit	Bill Through Medical Benefit
CUVITRU 2 gm/10 mL SUBCUTANEOUS SOLUTION	Medical Benefit	Bill Through Medical Benefit
CUVITRU 4 gm/20 mL SUBCUTANEOUS SOLUTION	Medical Benefit	Bill Through Medical Benefit
CUVITRU 8 gm/40 mL SUBCUTANEOUS SOLUTION	Medical Benefit	Bill Through Medical Benefit
CUVPOSA 1 mg/5 mL SOLUTION	PA required	Required Diagnosis= Drooling With Neurological Conditions Associated With Problem Drooling (Cerebral Palsy) Or Frey Syndrome. Must Be Between 3-16 Years Of Age AND Inability To Swallow Glycopyrrolate Tablet
CYCLIVERT TABLET 25 mg	Non-Preferred	Formulary Agents: meclizine or dimenhydrinate
CYCLOBENZAPRINE (FEXMID) 7.5 mg TABLET	Non-Preferred	Formulary Agents: cyclobenzaprine tablet 5 mg and 10 mg
CYCLOGYL 0.5% EYE DROPS	Non-Preferred	Formulary Agent: 1% ATROPINE EYE DROPS
CYCLOMYDRIL EYE DROPS	Non-Preferred	Formulary Agent: 1% ATROPINE EYE DROPS/2.5% PHENYLEPHRINE EYE DROPS separately taken together
Cycloserine (SEROMYCIN) 250 mg CAPSULE	Non-Preferred	Formulary Agent: rifampin

Drug	Status	Special Instructions
Cycloset 0.8 mg TABLET	Non-Preferred	Required diagnosis = Type 2 Diabetes (Trials of at least 2 agents Including orals and/or injectables)
CYRAMZA 100MG/10ML VIAL	Non-Preferred	Required diagnosis= Advanced Gastric Cancer or Gastoesphogeal Junction Adenocarcinoma OR metastatic non–small cell lung cancer (NSCLC) in patients with disease progression on or after platinum-based chemotherapy *Prescribed by an oncologist
CYRAMZA 500MG/10ML VIAL	Non-Preferred	Required diagnosis= Advanced Gastric Cancer or Gastoesphogeal Junction Adenocarcinoma OR metastatic non–small cell lung cancer (NSCLC) in patients with disease progression on or after platinum-based chemotherapy *Prescribed by an oncologist
CYSTADANE POWDER	Non-Preferred	Required diagnosis= Homocystinuria
CYSTAGON 150 mg CAPSULE	Non-Preferred	Formulary Agent=cuprimine with a diagnosis of Nephropathic cystinosis
CYSTAGON 50 mg CAPSULE	Non-Preferred	Formulary Agent=cuprimine with a diagnosis of Nephropathic cystinosis
CYSTARAN 0.44% SOLUTION	Non-Preferred	Required diagnosis= corneal cystine crystal accumulation in patients with cystinosis
CYTOGAM 2.5 gM/50 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
DAKLINZA 30MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
DAKLINZA 60MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
Daliresp 500mcg	Step Therapy	Required Diagnosis = Severe COPD *Currently On Albuterol (i.e., Albuterol Inhalation, Ventolin, ProAir, Proventil, Or Combivent) WITH *30 Day Trial From Two Of The Following Four Groups: Breo/Dulera/Advair OR Asmanex/Aerospan/Qvar/Flovent/Pulmicort OR Spiriva Respimat OR Montelukast (Singulair)/Theophylline With Continued Exacerbations
Dallergy 12.5-5 mg Chewables	Non-Preferred	Formulary Agents: OTC phenylephrine, chlorpheniramine, or methoscopolamine
DAILY PRENATAL COMBO PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
DALLERGY 25-10 mg TABLET	Non-Preferred	Formulary Agents: NOHIST OR ACTIFIED
DALVANCE 500MG VIAL	Non-Preferred	*Required 7 day trial of: Vancomycin IV or IV/Oral Zyvox
DAPSONE GEL 5%	Lower Cost	*30 day trial of 2 different agents: Adapalene 0.1% Gel Or Cream, Benzoyl Peroxide 5% Or 10%, Benzoyl Peroxide 4% Or 8% Liquid (Panoxyl), Clindamycin Topical (Cleocin T), Erythromycin Topical, Erythromycin/Benzoyl (Benzamycin), Sulfacetamide (Klaron), Or Tretinoin Cream Or Gel
Daptomycin (Cubicin) 500 mg Vial	Medical Benefit	Bill Through Medical Benefit
DARAPRIM 25 mg TABLET	Non-Preferred	Requires diagnosis of chemoprophylaxis of malaria due to it not being suitable as a prophylactic agent for travelers, toxoplasmosis (with a trial of a sulfonamide within the past 30 days), or acute malaria (with a trial of a sulfonamide)
DARIFENACIN ER (ENABLEX) 15 MG TABLET	Non-Preferred	Formulary Agents: OXYBUTYNIN, OXYBUTYNIN ER, TOLTERODINE, TROSPIUM, or TROSPIUM SR

Drug	Status	Special Instructions
DARIFENACIN ER (ENABLEX) 7.5 MG TABLET	Non-Preferred	Formulary Agents: OXYBUTYNIN, OXYBUTYNIN ER, TOLTERODINE, TROSPIUM, or TROSPIUM SR
DARZALEX 100MG/5ML VIAL	Medical Benefit	Bill Through Medical Benefit
DARZALEX 400MG/20ML VIAL	Medical Benefit	Bill Through Medical Benefit
DAYTRANA 10 mg/9 HR PATCH	Non-Preferred	Requires diagnosis of ADD/ADHD; autism; Asperger's; hyperkinetic syndrome with trials if age under 6 of of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) and if age 6 or older, any combo of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), or Methylphenidate SR capsule (Ritalin LA)
DAYTRANA 15 mg/9 HR PATCH	Non-Preferred	Requires diagnosis of ADD/ADHD; autism; Asperger's; hyperkinetic syndrome with trials if age under 6 of of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) and if age 6 or older, any combo of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), or Methylphenidate SR capsule (Ritalin LA)
DAYTRANA 20 mg/9 HOUR PATCH	Non-Preferred	Requires diagnosis of ADD/ADHD; autism; Asperger's; hyperkinetic syndrome with trials if age under 6 of of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) and if age 6 or older, any combo of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), or Methylphenidate SR capsule (Ritalin LA)
DAYTRANA 30 mg/9 HOUR PATCH	Non-Preferred	Requires diagnosis of ADD/ADHD; autism; Asperger's; hyperkinetic syndrome with trials if age under 6 of of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) and if age 6 or older, any combo of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), or Methylphenidate SR capsule (Ritalin LA)
Deferoxamine (Desferal) Vial	Medical Benefit	Bill Through Medical Benefit
DEMECLOCYCLINE (DECLOMYCIN) 150 mg TABLET	Non-Preferred	Formulary Agents: minocycline or doxycycline
DEMECLOCYCLINE (DECLOMYCIN) 300 mg TABLET	Non-Preferred	Formulary Agents: minocycline or doxycycline
DEMSER 250 mg CAPSULE	PA required	Required diagnosis = Pheochromocytoma
DENAVIR 1% CREAM	Step Therapy	Required diagnosis = cold sores Required trial of: OTC Abreva
DentaGel, Fluoridex Daily Defense, Fluoridex Defense Whitening, Phos-Flur, SF (Prevident, Prevident 5000, Prevident 5000 Dry Mouth) 1.1% Gel	Non-Preferred	Formulary Agent(s): ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, Or SF 5000 Plus 1.1% Cream

Drug	Status	Special Instructions
DEPEN 250 mg TITRATAB	Non-Preferred	Formulary Agent=cuprimine with a diagnosis of Wilson's Disease, RA, or cystinuria
DEPLIN, L-METHYLFOLATE 15 mg CAPSULE	Non-Preferred	Requires a 30 Day trial of L-methylfolate 15 mg tablet AND Required diagnosis = Anemia secondary to MTFHR deficiency OR Required diagnosis = Depression AND Currently on an anti-depressant OR diagnosis= Schizophrenia who have or are at risk for hyperhomocysteinemia and have schizophrenia (per chart notes)
DEPLIN, L-METHYLFOLATE 15 mg TABLET	Non-Preferred	Required diagnosis = Anemia secondary to MTFHR deficiency OR Required diagnosis = Depression AND Currently on an anti-depressant OR diagnosis= Schizophrenia who have or are at risk for hyperhomocysteinemia and have schizophrenia (per chart notes)
DEPLIN, L-METHYLFOLATE 7.5 mg CAPSULE	Non-Preferred	Requires a 30 Day trial of L-methylfolate 7.5 mg tablet AND Required diagnosis = Anemia secondary to MTFHR deficiency OR Required diagnosis = Depression AND Currently on an anti-depressant OR diagnosis= Schizophrenia who have or are at risk for hyperhomocysteinemia and have schizophrenia (per chart notes)
DEPLIN, L-METHYLFOLATE 7.5 mg TABLET	Non-Preferred	Required diagnosis = Anemia secondary to MTFHR deficiency OR Required diagnosis = Depression AND Currently on an anti-depressant OR diagnosis= Schizophrenia who have or are at risk for hyperhomocysteinemia and have schizophrenia (per chart notes)
Depo-Estradiol 5 mg/mL Injection	Non-Preferred	Formulary Agent(s): Estradiol Tablets, Estradiol Patches (Climara) Or Alora
DEPO-SQ PROVERA 104 INJECTION	Non-Preferred	Formulary Agent(s): Medroxyprogesterone Acetate (Depo-Provera) IM 150mg/mL Suspension
DERMASORB XM 39% CREAM KIT	Non-Preferred	Formulary Agents: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION

Drug	Status	Special Instructions
DERMAZENE, HYDROCORTISONE-IODOQUINOL 1-1% CREAM	Non-Preferred	*30 day trial of: OTC Hydrocortisone with OTC anti-fungal (clotrimazole, tolnaftate, miconazole) used separately at the same time
DESLORATADINE (CLARINEX) 2.5 mg REDITABLETS	Non-Preferred	Formulary Agents: loratadine, cetirizine or fexofenadine
DESLORATADINE (CLARINEX) 5 mg REDITABLETS	Non-Preferred	Formulary Agents: loratadine, cetirizine or fexofenadine
DESLORATADINE (CLARINEX) 5 mg TABLET	Non-Preferred	Formulary Agents: loratadine, cetirizine or fexofenadine
Desmopressin (DDAVP) 4 mcg/mL Ampule	Non-Preferred	Required Diagnosis Of Diabetes Inspidius AND Formulary Agent(s): Desmopressin Tablet
Desmopressin (DDAVP) 4 mcg/mL Vial	Non-Preferred	Required Diagnosis Of Diabetes Inspidius AND Formulary Agent(s): Desmopressin Tablet
DESONATE 0.05% GEL	Non-Preferred	Formulary Agents: DESONIDE (DESOWEN) 0.05% CREAM OR OINTMENT
DESONIDE (DESOWEN) 0.05% LOTION	Non-Preferred	Formulary Agents: DESONIDE (DESOWEN) 0.05% CREAM OR OINTMENT
DESOWEN 0.05% LOTION KIT	Non-Preferred	Formulary Agent: desonide cream or ointment with generic OTC Cetaphil Lotion
DESOXIMETASONE (TOPICORT LP) 0.05% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
DESOXIMETASONE (TOPICORT) 0.05% GEL	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
DESOXIMETASONE (TOPICORT) 0.05% OINTMENT	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
DESOXIMETASONE (TOPICORT) 0.25% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
DESOXIMETASONE (TOPICORT) 0.25% OINTMENT	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
DESVENLAFAXINE ER 100 mg TABLET	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
DESVENLAFAXINE ER 50 mg TABLET	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
DESVENLAFAXINE ER (KHEDEZLA) 100 mg TABLET	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
DESVENLAFAXINE ER (KHEDEZLA) 50 mg TABLET	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)

Drug	Status	Special Instructions
TOLTERODINE ER (DETROL LA) 2 MG CAPSULE	Step Therapy	Formulary Agent: tolterodine IR
TOLTERODINE ER (DETROL LA) 4 MG CAPSULE	Step Therapy	Formulary Agent: tolterodine IR
Dexamethasone Phosphate 4 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Dexamethasone Phosphate 10 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
DEXCHLORPHENIRAMINE 2 mg/5 mL SYRUP	Non-Preferred	Formulary Agent(s): Chlorpheniramine OR Diphenhydramine
DEXILANT DR 30 mg CAPSULE	Non-Preferred	*May Approve If Member Is Pregnant OR Requires A 30 Day Trial Each Within ALL Pharmacy Claims Of 2 Of The Following 4 Formulary Options: Esomeprazole (Nexium Or Nexium 20 mg OTC), Pantoprazole 40 mg, Lansoprazole 30 mg, Omeprazole 40 mg (Or 20mg BID)
DEXILANT DR 60 mg CAPSULE	Non-Preferred	*May Approve If Member Is Pregnant OR Requires A 30 Day Trial Each Within ALL Pharmacy Claims Of 2 Of The Following 4 Formulary Options: Esomeprazole (Nexium Or Nexium 20 mg OTC), Pantoprazole 40 mg, Lansoprazole 30 mg, Omeprazole 40 mg (Or 20mg BID)
DEXPAK 13 DAY 1.5 mg TABLET	Non-Preferred	Age 12-15:
DEXPAK 6 DAY 1.5 mg TABLET	Non-Preferred	FLUOCINONIDE 0.05%, FLUOCINONIDE-E 0.05%, CLOBETASOL (TEMOVATE) 0.05%, PREDNICARBATE (DERMATOP) 0.1% OINTMENT, HYDROCORTISONE 0.1%, HYDROCORTISONE 2.5%, FLUTICASONE Propionate (CUTIVATE) 0.05% CREAM, PREDNICARBATE (DERMATOP) 0.1% CREAM, BETAMETHASONE DP 0.05%, BETAMETHASONE VALERATE 0.1%, AMCINONIDE 0.1%
DEXTROAMPHETAMINE (PROCENTRA) 5 mg/5 mL SOLUTION	Non-Preferred	
DEXTROMETHORPHAN SYRUP 15 mg/5 mL	Non-Preferred	Age 16-17:
Dextrose 5% Injection	Medical Benefit	Bill Through Medical Benefit
Dextrose 70% Injection	Medical Benefit	Bill Through Medical Benefit
Dextrose 5% Piggyback Injection	Medical Benefit	Bill Through Medical Benefit
DIALYVITE 3,000 TABLET	Non-Preferred	CLOBETASOL-E (TEMOVATE E) 0.05%, FLUOCINONIDE 0.05%, FLUOCINONIDE-E 0.05%, CLOBETASOL (TEMOVATE) 0.05%, PREDNICARBATE (DERMATOP) 0.1% OINTMENT, HYDROCORTISONE 0.1%, HYDROCORTISONE 2.5%, FLUTICASONE Propionate (CUTIVATE) 0.05% CREAM, PREDNICARBATE (DERMATOP) 0.1% CREAM, BETAMETHASONE DP 0.05%, BETAMETHASONE VALERATE 0.1%, AMCINONIDE 0.1%
DIALYVITE 5000 TABLET	Non-Preferred	
DIALYVITE SUPREME D TABLET	Non-Preferred	Age over 18:

Drug	Status	Special Instructions
DIALYVITE W/ZINC, BIOTIN FORTE W/ZINC 0.8 mg TABLET	Non-Preferred	FLUOCINOLONE 0.01%, TRIAMCINOLONE 0.025%, TRIAMCINOLONE 0.1%, TRIAMCINOLONE 0.5%, FLUTICASONE Propionate (CUTIVATE) 0.005% OINTMENT, DIFLORASONE 0.05%, CLOBETASOL-E (TEMOVATE E) 0.05%, FLUOCINONIDE 0.05%, FLUOCINONIDE-E 0.05%, CLOBETASOL (TEMOVATE) 0.05%, PREDNICARBATE (DERMATOP) 0.1% OINTMENT, HYDROCORTISONE 0.1%, HYDROCORTISONE 2.5%, FLUTICASONE Propionate (CUTIVATE) 0.05% CREAM, PREDNICARBATE (DERMATOP) 0.1% CREAM, BETAMETHASONE DP 0.05%, BETAMETHASONE VALERATE 0.1%, AMCINONIDE 0.1% (Accepted trials but not recommended:MOMETASONE AND ALCLOMETASONE)
DIALYVITE W/ZINC, NEPHPLEX TABLET	Non-Preferred	Formulary Agent: DIALYVITE, RENAL TAB, FULL SPECT, RENA-VITE, BIOTIN FORTE (NEPHRO-VITE) 0.8 mg TABLET
DIALYVITE, VOL-CARE, NEPHRONEX, RENA-VITE (NEPHRO-VITE) TABLET	Non-Preferred	Formulary Agent: DIALYVITE, RENAL TAB, FULL SPECT, RENA-VITE, BIOTIN FORTE (NEPHRO-VITE) 0.8 mg TABLET
DIATX ZN TABLET	Non-Preferred	Formulary Agent: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
DICLEGIS 10-10 mg TABLET	Non-Preferred	Formulary Agents: OTC DOXYLAMINE (UNISOM) AND PYRIDOXINE (VITAMIN B6) separately
DICLOFENAC (SOLARAZE) 3% GEL	Non-Preferred	Formulary Agents: FLUOROURACIL (EFUDEX) 5% CREAM with a diagnosis of Actinic keratoses
DIFFERIN 0.1% LOTION	Non-Preferred	Formulary Agents: adapalene (DIFFERIN) 0.1% CREAM OR GEL
DIFFERIN 0.3% GEL	Non-Preferred	Formulary Agents: adapalene (DIFFERIN) 0.1% CREAM OR GEL
DIFFERIN 0.3% GEL PUMP	Non-Preferred	Formulary Agents: adapalene (DIFFERIN) 0.1% CREAM OR GEL
DIFICID 200 mg TABLET	Non-Preferred	Formulary Agents: oral Metronidazole (Flagyl) and oral VANCOMYCIN (Vancocin) for a diagnosis of C.Diff (Clostridium Difficile) Colitis/Diarrhea
DIFIL-G 400 TABLET	Non-Preferred	No longer available on the market
Digoxin 0.25 mg/mL Injection	Medical Benefit	Bill Through Medical Benefit
DIHYDROCODEINE COMPOUND CAP (SYNALGOS-DC) CAPSULE 16-356-30 mg	Non-Preferred	Formulary Agent: ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE (PANLOR/PANLOR SS) 712.8-30-32 mg TABLET
DILATRATE-SR 40 mg CAPSULE	Non-Preferred	Formulary Agent: isosorbide dinitrate
DIPENTUM 250 MG CAPSULE	Step Therapy	Must first try sulfasalazine
Diphenhydramine 50 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
DIVIGEL 0.25 mg GEL PACKET	Non-Preferred	Formulary Agents: estradiol tablet, patches (Climara) or Alora
DIVIGEL 0.5 mg GEL PACKET	Non-Preferred	Formulary Agents: estradiol tablet, patches (Climara) or Alora
DIVIGEL 1 mg GEL PACKET	Non-Preferred	Formulary Agents: estradiol tablet, patches (Climara) or Alora
DONEPEZIL (ARICEPT) 23 mg TABLET	Non-Preferred	Formulary Agent: DONEPEZIL (ARICEPT) 5 mg or 10 mg
DONNATAL 16.2 mg/5 mL ELIXIR	Non-Preferred	Formulary Agent: PHENOBARBITAL 20 mg/5 mL ELIXIR and HYOSCYAMINE, Hyosyne 125 mcg/5 mL Elixir separately taken together
DORYX MPC 120MG TABLET	Non-Preferred	Requires a trial of doxycycline hyclate DR tablet cannot be used (also requires PA)

Drug	Status	Special Instructions
Doxepin HCL (Prudoxin, Zonalon) 5% Cream	Non-Preferred	Formulary Agents(s): OTC Topical Antihistamine (Diphenhydramine HCL Cream 2%, Anti-Itch (Benadryl) 1% Cream, Or Anti-Itch (Benadryl) 2% Cream)
Doxycycline (Oracea) DR 40 mg Capsule	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Hyclate (Doryx) DR 75 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Hyclate (Doryx) DR 100 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Hyclate (Doryx) DR 150 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Hyclate (Doryx) DR 200 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Monohydrate (Adoxa) 50 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Monohydrate (Adoxa) 150 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Monohydrate 75 mg Capsule	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Monohydrate 150 mg Capsule	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Doxycycline Monohydrate, Avidoxy (Adoxa) 100 mg Tablet	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet
Dritho-Crème HP 1% CREAM	Non-Preferred	Formulary Agent: CALCIPOTRIENE (DOVONEX) 0.005% CREAM
DRONABINOL (Marinol) 10 mg CAPSULE	PA required	Required diagnosis = appetite stimulation in AIDS patients or cancer chemotherapy-induced nausea and vomiting
DRONABINOL (Marinol) 2.5 mg CAPSULE	PA required	Required diagnosis = appetite stimulation in AIDS patients or cancer chemotherapy-induced nausea and vomiting
DRONABINOL (Marinol) 5 mg CAPSULE	PA required	Required diagnosis = appetite stimulation in AIDS patients or cancer chemotherapy-induced nausea and vomiting
DROXIA 200 mg CAPSULE	PA required	Required diagnosis = sickle cell anemia
DROXIA 300 mg CAPSULE	PA required	Required diagnosis = sickle cell anemia
DROXIA 400 mg CAPSULE	PA required	Required diagnosis = sickle cell anemia
DUAC CS KIT 1-5%	Non-Preferred	No Longer available on market

Drug	Status	Special Instructions
DUAVEE 0.45-20 MG Tablet	Step Therapy	Formulary Agents: COMBIPATCH, Prempro, PREMARIN, or FemHRT
DUET DHA BALANCED COMBO PACK 27-1-380 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
DUET DHA COMPLETE COMBO PACK 27-1-300 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
DUET DHA COMPLETE COMBO PACK 27-1-430 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
DUEXIS 800/26.6 mg TABLET	Non-Preferred	Formulary Agent: famotidine and ibuprofen separately
DUOPA 4.63-20MG/ML SUSPENSION	Non-Preferred	Lower cost agent: carbidopa-levodopa (Sinemet) tablets
DUPIXENT 300 mg/2 mL INJECTION	Non-Preferred	Request Must Go Through Clinical Review
DURAFLU TABLET 60-20-200-500 mg	Non-Preferred	Formulary Agent: MUCINEX DM ER and Acetaminophen separately
DUREZOL 0.05% EYE DROPS	Non-Preferred	Formulary Agents: DEXAMETHASONE 0.1% OPHTHALMIC SOLUTION, PREDNISOLONE ACETATE (PRED FORTE, OMNIPRED) 1%, or PREDNISOLONE SODIUM PHOSPHATE 1%
DURLAZA 162.5MG ER CAPSULE	Non-Preferred	Formulary Agent(s): Aspirin 81mg
DUTASTERIDE (AVODART) 0.5 mg SOFTGEL	Non-Preferred	Formulary Agent(s): Doxazosin, Terazosin, Tamsulosin, or Prazosin
Dutasteride-Tamsulosin (Jalyn) 05mg-0.4mg Capsule	Non-Preferred	Formulary Agent(s): Tamsulosin AND Dutasteride (Avodart)
DUTOPROL (metoprolol succinate ER/hydrochlorothiazide) 100 mg-12.5 mg	Non-Preferred	Formulary Agent: METOPROLOL and HYDROCHLOROTHIAZIDE separately taken together
DUTOPROL (metoprolol succinate ER/hydrochlorothiazide) 25 mg-12.5 mg	Non-Preferred	Formulary Agent: METOPROLOL and HYDROCHLOROTHIAZIDE separately taken together
DUTOPROL (metoprolol succinate ER/hydrochlorothiazide) 50 mg-12.5 mg	Non-Preferred	Formulary Agent: METOPROLOL and HYDROCHLOROTHIAZIDE separately taken together
Dyanavel XR 2.5 mg/mL Suspension	Non-Preferred	Age 6 Or Older AND A Trial Of Dextroamphetamine-Amphetamine (Adderall) Or Adderall XR
DYLIX 100 mg/15 mL ELIXIR	Non-Preferred	No longer available on the market
DYMISTA 50/137 mcg	Non-Preferred	Formulary Agent(s): Fluticasone (Flonase) Or Flonase OTC Allergy Relief Spray AND Azelastine (Astelin) Separately Taken Together At The Same Time
DYNACIRC CR 10 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
DYNACIRC CR 5 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
DYRENIUM 100 mg CAPSULE	Non-Preferred	Formulary Agents: spironolactone, triamterene-hctz, or amiloride
DYRENIUM 50 mg CAPSULE	Non-Preferred	Formulary Agents: spironolactone, triamterene-hctz, or amiloride

Drug	Status	Special Instructions
DYSPORT	Specialty	Specialty; follow policy on CareSource.com.
Easygel, Gel-Tin, Just For Kids (Gel-Kam) 0.4% Gel	Non-Preferred	Formulary Agents: Denta 5000 Plus, SF 5000 Plus (Prevident 5000 Plus) 1.1% Cream
ECOZA 1% AEROSOL FOAM	Non-Preferred	Requires a Diagnosis of: Interdigital Tinea Pedis caused by Trichophyton rubrum, Trichophyton mentagrophytes, or Epidermophyton floccosum AND a Trial of TWO of the following topical or oral antifungal medications: clotrimazole, econazole, ketoconazole, miconazole, terbinafine or tolnaftate
ED CHLORPED D PEDIATRIC DROPS	Non-Preferred	Formulary Agent: TRIAMINIC COLD-ALLERGY PE LIQUID
ED CYTE F TABLET	Non-Preferred	Formulary Agent: FERROUS FUMARATE 324 mg-FOLIC ACID 1 mg-DOCUSATE SODIUM 50 mg separately
EDARBI 40 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)
EDARBI 80 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)
Edarbyclor 40-12.5 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan/HCTZ (Hyzaar), Candesartan/HCTZ (Atacand HCT), Valsartan/HCTZ (Diovan HCT), Or Irbesartan/HCTZ (Avalide)
Edarbyclor 40-25 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan/HCTZ (Hyzaar), Candesartan/HCTZ (Atacand HCT), Valsartan/HCTZ (Diovan HCT), Or Irbesartan/HCTZ (Avalide)
EDEX	Excluded benefit	
ED-FLEX CAPSULE	Non-Preferred	Formulary Agents: BIPHENOX, BIOGESIC, or DOLOGESIC
EDLUAR 10 mg SL TABLET	Non-Preferred	Formulary Agent: non-CR zolpidem
EDLUAR 5 mg SL TABLET	Non-Preferred	Formulary Agent: non-CR zolpidem
EFFER-K 10 MEQ TABLET EFFERVESCENT	Non-Preferred	Formulary Agent: formulary potassium supplement
EFFER-K 20 MEQ TABLET EFFERVESCENT	Non-Preferred	Formulary Agent: formulary potassium supplement
ELAPRASE	Specialty	Specialty; follow policy on CareSource.com.
ELDERCAP CAPSULE	Non-Preferred	Formulary Agent: multivitamin and fish oil separately
ELELYSO INJ 200 UNIT	Specialty	Specialty; follow policy on CareSource.com.
ELESTRIN 0.06% GEL	Non-Preferred	Formulary Agent(s): Estradiol Tablets, Estradiol Patches (Climara) Or Alora
ELETONE CREAM	Non-Preferred	Formulary Agent(s): Theraplex, Velvachol, Nutraderm, Cetaphil, Or Aveeno
ELETRIPTAN (RELPAX)20 mg TABLET	Non-Preferred	Formulary Agent(s): *Ages 6-17 = Sumatriptan Tablets, Injection, Or Nasal Spray Or Rizatriptan OR *Ages 18 & Older = Must Try 2 Of The Following 4: Sumatriptan Tablets, Injection, Or Nasal Spray, Naratriptan, Rizatriptan Or Almotriptan

Drug	Status	Special Instructions
ELETRIPTAN (RELPAX)40 mg TABLET	Non-Preferred	Formulary Agent(s): *Ages 6-17 = Sumatriptan Tablets, Injection, Or Nasal Spray Or Rizatriptan OR *Ages 18 & Older = Must Try 2 Of The Following 4: Sumatriptan Tablets, Injection, Or Nasal Spray, Naratriptan, Rizatriptan Or Almotriptan
ELIDEL 1% CREAM	Step Therapy	Required Diagnosis= Atopic Dermatitis Or Eczema AND Required 7 Day Trial Of: Tacrolimus (Protopic) 0.1% Or 0.03% Ointment
ELIGARD 22.5 mg SUBQ INJECTION	Non-Preferred	Required Diagnosis= Advanced Prostate Cancer
ELIGARD 30 mg SUBQ INJECTION	Non-Preferred	Required Diagnosis= Advanced Prostate Cancer
ELIGARD 45 mg SUBQ INJECTION	Non-Preferred	Required Diagnosis= Advanced Prostate Cancer
ELIGARD 7.5 mg SUBQ INJECTION	Non-Preferred	Required Diagnosis= Advanced Prostate Cancer
ELITEK 1.5 MG VIAL	Non-Preferred	Request Must Go Through Clinical Review
ELITEK 7.5 MG VIAL	Non-Preferred	Request Must Go Through Clinical Review
ELITE OB DHA SOFTGEL 28-1.25 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
ELITE-OB 400 CAPSULE 35-5-1.2 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
ELOCTATE VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
EMADINE 0.05% EYE DROPS	Non-Preferred	Formulary Agents: OTC agents with ketotifen AND azelastine (Optivar) unless patient is pregnant
EMBEDA 20-0.8MG ER CAPSULE	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
EMBEDA 30-1.2MG ER CAPSULE	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
EMBEDA 50-2MG ER CAPSULE	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
EMBEDA 60-2.4MG ER CAPSULE	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
EMBEDA 80-3.2MG ER CAPSULE	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
EMBEDA 100-4MG ER CAPSULE	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
EMBRACE BLOOD GLUCOSE TEST STRIPS	Non-Preferred	*90 Day Trial of Formulary Agents: FreeStyle or Precision products
EMBRACE METER	Non-Preferred	*90 Day Trial of Formulary Agents: FreeStyle or Precision products
Emcyt 140 mg Capsule	Non-Preferred	Required Diagnosis Of Palliative Treatment Of Progressive Or Metastatic Prostate Cancer
EMFLAZA 22.75 mg/mL	PA Required	Request Must Go Through Clinical Review
EMFLAZA 6 mg	PA required	Request Must Go Through Clinical Review

Drug	Status	Special Instructions
EMFLAZA 18 mg	PA required	Request Must Go Through Clinical Review
EMFLAZA 30 mg	PA required	Request Must Go Through Clinical Review
EMFLAZA 36 mg	PA required	Request Must Go Through Clinical Review
EMPLICITI 300MG SOLUTION FOR INJECTION	Non-Preferred	Request Must Go Through Clinical Review
EMPLICITI 400MG SOLUTION FOR INJECTION	Non-Preferred	Request Must Go Through Clinical Review
EMSAM 12 mg/24 HOURS PATCH	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
EMSAM 6 mg/24 HOURS PATCH	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
EMSAM 9 mg/24 HOURS PATCH	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
Emverm 100 mg Chewable Tablet	Non-Preferred	30 Day Trial Of: Pin-X, Pamix 144 mg/mL (50 mg/mL) OTC Or Pinworm Tab Medicine 180 mg OTC
ENBRACE HR 1.5-8.73MG CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
ENBREL 25 mg KIT	PA required	Please see the state specific Pharmacy Policy Statement titled Enbrel by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ENBREL 25 mg/0.5 mL SYRINGE	PA required	Please see the state specific Pharmacy Policy Statement titled Enbrel by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ENBREL 50 mg/ML SURECLICK	PA required	Please see the state specific Pharmacy Policy Statement titled Enbrel by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ENBREL 50 mg/ML SYRINGE	PA required	Please see the state specific Pharmacy Policy Statement titled Enbrel by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ENJUVIA 0.3 mg TABLET	Non-Preferred	Formulary Agent: Premarin
ENJUVIA 0.45 mg TABLET	Non-Preferred	Formulary Agent: Premarin
ENJUVIA 0.625 mg TABLET	Non-Preferred	Formulary Agent: Premarin
ENJUVIA 0.9 mg TABLET	Non-Preferred	Formulary Agent: Premarin
ENJUVIA 1.25 mg TABLET	Non-Preferred	Formulary Agent: Premarin
ENOVARX-LIDOCAINE HCL 5% CREAM	Non-Preferred	Formulary agent: Formulary Lidocaine Product
ENOVARX-LIDOCAINE HCL 10% CREAM	Non-Preferred	Formulary agent: Formulary Lidocaine Product

Drug	Status	Special Instructions
Enstilar 0.005-0.064% Aerosol Foam	Non-Preferred	Required Diagnosis= Plaque Psoriasis, Age= 18 Years Or Older AND Formulary Agent(s): Calcipotriene
ENTRESTO 24MG-26MG TABLET	PA required	Formulary Agent(s): Formulary Ace Inhibitor or Formulary ARB Agent
ENTRESTO 49MG-51MG TABLET	PA required	Formulary Agent(s): Formulary Ace Inhibitor or Formulary ARB Agent
ENTRESTO 97MG-103MG TABLET	PA required	Formulary Agent(s): Formulary Ace Inhibitor or Formulary ARB Agent
ENTYVIO 300MG VIAL	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Actemra by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ENVARSUS XR 0.75MG TABLET	Non-Preferred	Formulary Agent(s): Tacrolimus (Prograf) 0.5mg Capsule
ENVARSUS XR 1MG TABLET	Non-Preferred	Formulary Agent(s): Tacrolimus (Prograf) 0.5mg Capsule
ENVARSUS XR 4MG TABLET	Non-Preferred	Formulary Agent(s): Tacrolimus (Prograf) 0.5mg Capsule
EPANED 1 mg/ML SOLUTION	PA required	Formulary Agent: ENALAPRIL tablet for those over age 12
Epclusa 400-100 mg Tablet	PA required	Please see the state specific Pharmacy Policy Statement titled Epclusa by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
EPICERAM	Non-Preferred	Required Diagnosis = atopic dermatitis, irritant contact dermatitis, and radiation dermatitis or eczema Required trial of: THERAPLEX, VELVACHOL, NUTRADERM, CETAPHIL, or AVEENO
EPIDUO FORTE 0.3%-2.5% GEL	Non-Preferred	Formulary Agents: benzoyl peroxide gel 2.5% and adapalene gel 0.1%
EPIFOAM 1-1%	Non-Preferred	Formulary Agent: PRAMOXINE AEROSOL (Proctofoam) 1% with Procto-Pak (PROCTOCORT) 1% CREAM separately
EPINASTINE (ELESTAT) 0.05% EYE DROPS	Non-Preferred	Formulary Agents: OTC agents with ketotifen AND azelastine (Optivar)
EPINEPHRINE AUTO-INJECTOR 0.3MG	Lower Cost	Formulary Agent: 90 day trial of: Epi-Pen(brand) or Epinephrine 0.15mg/0.15 ml
EPOGEN 10,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
EPOGEN 2,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
EPOGEN 20,000 UNITS/2 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
EPOGEN 20,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
EPOGEN 3,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
EPOGEN 4,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
ERBITUX 2MG/ML VIAL	Non-Preferred	Request Must Go Through Clinical Review
ERELZI 25 mg/0.5 Ml	PA Required	Specialty; follow policy on CareSource.com.
ERELZI 50 mg/Ml	PA Required	Specialty; follow policy on CareSource.com.
ERGOLOID MESYLATES 1 mg TABLET	Non-Preferred	Formulary Agents: Namenda, generic Aricept, galantamine, generic Exelon

Drug	Status	Special Instructions
ERGOMAR 2 mg SUBLINGUAL TABLET	Non-Preferred	Formulary Agents: propranolol or topiramate for migraine prevention OR sumatriptan or naratriptan for migraine abortion
ERIVEDGE 150 mg CAPSULE	PA required	Required diagnosis = basal cell carcinoma
ERTACZO 2% CREAM	Non-Preferred	Formulary Agents: ketoconazole or clotrimazole for a diagnosis of tinea pedis
ERWINAZE 10,000 Unit Solution	Non-Preferred	Required diagnosis = Acute lymphocytic leukemia
ESBRIET 267MG CAPSULE	PA required	Request Must Go Through Clinical Review
Esomeprazole (Nexium) 20 mg Capsule	Non-Preferred	Formulary Agent(s): Nexium 24 HR OTC Capsule
Esomeprazole (Nexium) 40 mg Capsule	Non-Preferred	Formulary Agent(s): Nexium 24 HR OTC Capsule
Esomeprazole (Nexium) 20 mg Vial	Medical Benefit	Bill Through Medical Benefit
Esomeprazole (Nexium) 40 mg Vial	Medical Benefit	Bill Through Medical Benefit
Esomeprazole 24.65 mg Capsule	Non-Preferred	A 30 Day Trial Of: OTC Nexium 20MG, Or Esomeprazole (Nexium) 20 mg Or 40 mg Capsules At Maximum Dosing
Esomeprazole 49.3 mg Capsule	Non-Preferred	A 30 Day Trial Of: OTC Nexium 20MG, Or Esomeprazole (Nexium) 20 mg Or 40 mg Capsules At Maximum Dosing
ESTRADERM 0.05 mg PATCH	Non-Preferred	No longer available on the market
ESTRADERM 0.1 mg PATCH	Non-Preferred	No longer available on the market
ESTRADIOL (MINIVELLE DIS) 0.1 mg PATCH	Non-Preferred	Formulary agents: Alora or Estradiol (Climara) patches
ESTRADIOL (MINIVELLE DIS) 0.0375 mg PATCH	Non-Preferred	Formulary agents: Alora or Estradiol (Climara) patches
ESTRADIOL (MINIVELLE DIS) 0.05 mg PATCH	Non-Preferred	Formulary agents: Alora or Estradiol (Climara) patches
ESTRADIOL (MINIVELLE DIS) 0.075 mg PATCH	Non-Preferred	Formulary agents: Alora or Estradiol (Climara) patches
Estradiol Valerate (Delestrogen) 20 mg/mL Vial	Non-Preferred	Formulary Agent(s): Estradiol Tablets, Estradiol Patches (Climara) Or Alora
Estradiol Valerate (Delestrogen) 40 mg/mL Vial	Non-Preferred	Formulary Agent(s): Estradiol Tablets, Estradiol Patches (Climara) Or Alora
Estradiol (VAGIFEM) 10 mcg VAGINAL TABLET	Clinical	Required diagnosis = atrophic vaginitis Formulary agents = Estradiol tablets, Alora, or Estradiol (Climara) patches
ESTRASORB PACKET	Non-Preferred	Formulary Agents: estradiol tablets, patches (Climara) or Alora
ESTRING 2 mg VAGINAL RING	Non-Preferred	Formulary Agents: estradiol tablets, patches (Climara) or Alora
ESTROGEL 0.6% GEL	Non-Preferred	Formulary Agents: estradiol tablets, patches (Climara) or Alora
ESZOPICLONE (LUNESTA) 1 mg TABLET	Non-Preferred	Formulary agents: zolpidem or zaleplon
ESZOPICLONE (LUNESTA) 2 mg TABLET	Non-Preferred	Formulary agents: zolpidem or zaleplon

Drug	Status	Special Instructions
ESZOPICLONE (LUNESTA) 3 mg TABLET	Non-Preferred	Formulary agents: zolpidem or zaleplon
Ethacrynic Acid (EDECRIN) 25 mg TABLET	Non-Preferred	Formulary Agents: furosemide or torsemide
ETIDRONATE (Didronel) 400 mg TABLET	Non-Preferred	Formulary Agent: alendronate
ETIDRONATE 200 mg TABLET	Non-Preferred	Formulary Agent: alendronate
EUFLEXXA	Non-Preferred	Specialty; follow policy on CareSource.com. Formulary Agents: Supartz & Gel-One
EURAX 10% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each OR Required Diagnosis= Scabies AND Must Use Permethrin (Elimite) 5% Cream For 7 Days
EURAX 10% LOTION	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each OR Required Diagnosis= Scabies AND Must Use Permethrin (Elimite) 5% Cream For 7 Days
EVAMIST 1.53 mg/SPRAY	Non-Preferred	Formulary Agents: estradiol tablets, patches (Climara) or Alora
Evzio 0.4 mg/0.4 mL Injection	Non-Preferred	Formulary Agent(s): Narcan Nasal Spray
Evzio 2 mg/0.4 mL Injection	Non-Preferred	Formulary Agent(s): Narcan Nasal Spray
EXELDERM 1% CREAM	Non-Preferred	Required diagnosis = tinea pedis (athlete's foot), tinea cruris, and tinea corporis and tinea versicolor Formulary Agents: ketoconazole, clotrimazole, metronidazole
EXELDERM 1% SOLUTION	Non-Preferred	Required diagnosis = tinea pedis (athlete's foot), tinea cruris, and tinea corporis and tinea versicolor Formulary Agents: ketoconazole, clotrimazole, metronidazole
Exjade 125 mg Tablet	PA Required	Request Must Go Through Clinical Review
Exjade 250 mg Tablet	PA Required	Request Must Go Through Clinical Review
Exjade 500 mg Tablet	PA Required	Request Must Go Through Clinical Review
Exondys 51 injection 100 mg/2 mL	Non-Preferred	MEDICAL BENEFIT ONLY
Exondys 51 injection 500 mg/10 mL	Non-Preferred	MEDICAL BENEFIT ONLY
EXTAVIA 0.3 mg KIT	PA required	Specialty; Request Must Go Through Clinical Review
EYLEA INJECTION 2/0.05 mL	Specialty	Specialty; follow policy on CareSource.com.
FABB, TL GARD RX, VIRT-GARD (FOLGARD RX) 1-5.2-25MG TABLET	Non-Preferred	Formulary Agent(s): Folgard OS Or TL G-Fol OS Tablet
FABIOR 0.1% AEROSOL FOAM	Non-Preferred	Required diagnosis = Acne Formulary Agent: Tazorac 0.1% cream or gel
FABIOR 0.1% AEROSOL FOAM	Non-Preferred	Required diagnosis = Acne Formulary Agent: Tazorac 0.1% cream or gel

Drug	Status	Special Instructions
FABRAZYME	Specialty	Specialty; follow policy on CareSource.com.
FACTIVE 320 mg TABLET	Non-Preferred	Formulary Agent: ciprofloxacin or levofloxacin
FaLessa	Non-Preferred	Use a formulary oral contraceptive
FANAPT 10 mg TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
FANAPT 12 mg TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
FANAPT 1 mg TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
FANAPT 2 mg TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
FANAPT 4 mg TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
FANAPT 6 mg TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
FANAPT 8 mg TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
FANAPT TITRATION PACK	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
FARXIGA 10MG TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage) then Invokana
FARXIGA 5MG TABLET	Non-Preferred	Formulary Agents: Metformin IR or ER (Glucophage) then Invokana
FARYDAK 10MG CAPSULE	PA required	Request Must Go Through Clinical Review
FARYDAK 15MG CAPSULE	PA required	Request Must Go Through Clinical Review
FARYDAK 20MG CAPSULE	PA required	Request Must Go Through Clinical Review
Fayosim, Rivelsa (Quartette) Tablet	Non-Preferred	Formulary Agents: any formulary birth control
FEMECAL OB TABLET 22-6-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
FEMCAP 22MM CERVICAL CAP	Excluded Benefit	
FEMCAP 26MM CERVICAL CAP	Excluded Benefit	
FEMCAP 30MM CERVICAL CAP	Excluded Benefit	
FEM PH 0.9-0.025% VAGINAL GEL	Non-Preferred	Required 14 day trial of: povidone-iodine douch (Summer's Eve) 0.3% solution
FEMRING 0.05 mg VAGINAL RING	Non-Preferred	Formulary Agents: Femhrt or Prempro
FEMTRACE 0.45 mg TABLET	Non-Preferred	Formulary Agents: estradiol tablets, patches (Climara) or Alora
FEMTRACE 0.9 mg TABLET	Non-Preferred	Formulary Agents: estradiol tablets, patches (Climara) or Alora
FEMTRACE 1.8 mg TABLET	Non-Preferred	Formulary Agents: estradiol tablets, patches (Climara) or Alora

Drug	Status	Special Instructions
FENOFIBRATE (ANTARA) 130 mg CAPSULE	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
FENOFIBRATE (ANTARA) 30 mg CAPSULE	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
FENOFIBRIC ACID (TRILIPIX DR) 135 mg CAPSULE	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
FENOFIBRIC ACID (TRILIPIX DR) 45 mg CAPSULE	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
FENOPROFEN 600 mg TABLET	Non-Preferred	Required Diagnosis: osteoarthritis, rheumatoid arthritis, Or mild to moderate pain AND a 14 day trial of a non-steroidal anti-inflammatory agent (ibuprofen, meloxicam, indomethacin, etodolac, naproxen, etc.)
Fentanyl Citrate (ACTIQ) 1,200 mcg LOZENGE	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
Fentanyl Citrate (ACTIQ) 400 mcg LOZENGE	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
Fentanyl Citrate (ACTIQ) 600 mcg LOZENGE	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
Fentanyl Citrate (ACTIQ) 800 mcg LOZENGE	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
Fentanyl Citrate (ACTIQ)1,600 mcg LOZENGE	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
Fentanyl Citrate (ACTIQ) 200 mcg LOZENGE	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
Fentanyl Citrate 0.05 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
FENTANYL 12 MCG/HR PATCH	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
FENTANYL 25 MCG/HR PATCH	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
FENTANYL 50 MCG/HR PATCH	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
FENTANYL 75 MCG/HR PATCH	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
FENTANYL 100 MCG/HR PATCH	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
FENTANYL 37.5MCG/HR PATCH	Non-Preferred	Formulary Agent(s): Fentanyl (Duragesic) Patch (12mcg/HR, 25mcg/HR, 50mcg/HR, 75mcg/HR, Or 100mcg/HR)
FENTANYL 62.5MCG/HR PATCH	Non-Preferred	Formulary Agent(s): Fentanyl (Duragesic) Patch (12mcg/HR, 25mcg/HR, 50mcg/HR, 75mcg/HR, Or 100mcg/HR)
FENTANYL 87.5MCG/HR PATCH	Non-Preferred	Formulary Agent(s): Fentanyl (Duragesic) Patch (12mcg/HR, 25mcg/HR, 50mcg/HR, 75mcg/HR, Or 100mcg/HR)
FENTORA 100 mcg BUCCAL TABLET	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
FENTORA 200 mcg BUCCAL TABLET	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
FENTORA 400 mcg BUCCAL TABLET	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
FENTORA 600 mcg BUCCAL TABLET	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
FENTORA 800 mcg BUCCAL TABLET	PA required	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
FERAHEME IRON INJECTION	Medical Benefit	Bill Through Medical Benefit
FERIVA 21-7 75-1-175MG TABLET	Non-Preferred	*Formulary Agent(s): Daily Vite With Iron Tablet
FERIVA 75-1 MG CAPSULE	Non-Preferred	Formulary Agents: FERREX 150 CAP, FERROUS GLUCONATE tablet 240MG, FERROUS FUMARATE tablet 325MG, FERROUS SULFATE tablet 134MG, or SLOW RELEASE IRON 130GM
FERRALET 90 DUAL-IRON 90-1 mg TABLET	Non-Preferred	Formulary Agents: Formulary Iron (Examples: FERREX 150 CAP, FERROUS GLUCONATE tablet 240 mg, FERROUS FUMARATE tablet 325 mg , FERROUS SULFATE tablet 134 mg, etc)
FERRAPLUS 90 TABLET	Non-Preferred	Formulary Agents: Formulary Iron (Examples: FERREX 150 CAP, FERROUS GLUCONATE tablet 240 mg, FERROUS FUMARATE tablet 325 mg , FERROUS SULFATE tablet 134 mg, etc)
FERREX 150 FORTE PLUS CAPSULE	Non-Preferred	Formulary Agent: FERREX 150 PLUS capsule and a B-COMPLEX W/ FOLIC ACID TAB separately

Drug	Status	Special Instructions
FERREX 28 TABLET	Non-Preferred	Formulary Agent: Formulary Iron (Examples: FERREX 150 CAP, FERROUS GLUCONATE tablet 240 mg, FERROUS FUMARATE tablet 325 mg , FERROUS SULFATE tablet 134 mg, etc)
FERRIC GLUCONATE (FERRLECIT) 62.5 mg/5 mL VIAL	Medical Benefit	Bill Through Medical Benefit
Ferriprox 100 mg/mL Oral Solution	Non-Preferred	Required Diagnosis = Chronic Iron Overload
FERRIPROX 500 mg TABLET	Non-Preferred	Required diagnosis = Chronic iron overload
FERROGELS FORTE, TRIGELS-F FORTE, HEMATOGEN FORTE 460 (151 FE)-60-0.01-1 mg SOFTGEL	Non-Preferred	Formulary Agents: Formulary Iron (Examples: FERREX 150 CAP, FERROUS GLUCONATE tablet 240 mg, FERROUS FUMARATE tablet 325 mg , FERROUS SULFATE tablet 134 mg, etc)
FETZIMA 120 mg CAPSULE	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
FETZIMA 20 mg CAPSULE	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
FETZIMA 40 mg CAPSULE	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
FETZIMA 80 mg CAPSULE	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
FETZIMA TITRATION KIT	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
FEXOFENADINE (ALLEGRA) 180 mg TABLET RX	Non-Preferred	Formulary Agent: FEXOFENADINE (Allegra) 30 mg or 30 mg tablet OTC
FEXOFENADINE (ALLEGRA) 30 mg TABLET RX	Non-Preferred	Formulary Agent: FEXOFENADINE (Allegra) 30 mg tablet OTC
FEXOFENADINE (ALLEGRA) 60 mg TABLET RX	Non-Preferred	Formulary Agent: Fexofenadine (Allegra) 30 mg tablet OTC
FENOFIBRATE (FIBRICOR) 105 mg TABLET	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
FENOFIBRATE (FIBRICOR) 35 mg TABLET	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
Finacea 15% Foam	Non-Preferred	A 30 Day Trial Of: Metronidazole Topical

Drug	Status	Special Instructions
Finacea 15% Gel	Non-Preferred	A 30 Day Trial Of: Metronidazole Topical
FINACEA PLUS KIT	Non-Preferred	Formulary Agent: Finacea 15% gel (which also requires a step through metronidazole topical)
FINASTERIDE 1 mg (PROPECIA) TABLET	Excluded benefit	
FIORICET-COD 30-50-325-40 CAPSULE	Non-Preferred	Formulary Agent: FIORICET-COD 30-50-325-40 CAPSULE
FIRAZYR 30 mg/3 mL SYRINGE	Non-Preferred	Specialty; Request Must Go Through Clinical Review
FIRMAGON (DEGARELIX ACETATE) FOR INJECTION 120 mg (BASE EQUIV)	PA required	Specialty
FIRMAGON (DEGARELIX ACETATE) FOR INJECTION 80 mg (BASE EQUIV)	PA required	Specialty
FIRST-HYDROCORTISONE 10% GEL	Non-Preferred	Formulary Agents: formulary topical hydrocortisone
FIRST-TESTOSTERONE 2% CREAM	Non-Preferred	Required diagnosis = hypogonadism with total testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care) Formulary agents: Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet
FIRST-TESTOSTERONE 2% OINTMENT	Non-Preferred	Required diagnosis = hypogonadism with total testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care) Formulary agents: Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet
FIRST-VANCOMYCIN 25 MG/ML SOLUTION	Non-Preferred	Required Diagnosis= C.Diff (Clostridium Difficile) Colitis/Diarrhea AND 5- Day Trial of Oral Metronidazole
FIRST VANCOMYCIN 50 MG/ML SOLUTION	Non-Preferred	Required Diagnosis= C.Diff (Clostridium Difficile) Colitis/Diarrhea AND 5- Day Trial of Oral Metronidazole
FLAGYL ER 750 mg TABLET	Non-Preferred	Formulary Agent: Metronidazole 500 mg
FLAREX 0.1% ophthalmic SUSPENSION	Non-Preferred	Formulary Agent: FLUOROMETHOLONE, FLUOR-OP (FML LIQUIFLM) 0.1% DROPS
FLEBOGAMMA DIF 5% VIAL	PA required	Specialty; follow policy on CareSource.com.
FLEBOGAMMA DIF 10% VIAL	PA required	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
FLECTOR (Diclofenac) 1.3% PATCH	Non-Preferred	Formulary Agents: 30 DAY TRIAL OF NSAIDS (celecoxib (Celebrex), naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, Sulindac or piroxicam); AND topical Voltaren Gel for a diagnosis of pain OR Formulary Agents: 30 DAY TRIAL OF NSAIDS (celecoxib (Celebrex), naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, Sulindac or piroxicam) for a diagnosis of low back pain
FLOLAN, VELETRI (EPOPROSTENOL SODIUM) FOR INJECTION 0.5MG	PA required	Specialty; follow policy on CareSource.com.
FLOLAN, VELETRI (EPOPROSTENOL SODIUM) FOR INJECTION 1.5MG	PA required	Specialty; follow policy on CareSource.com.
FLO-PRED 15 mg/5 mL	Non-Preferred	Formulary Agent: prednisolone suspension
FLOVENT DISKUS 50MCG	Non-Preferred	Required diagnosis: Eosinophilic Esophagitis (EoC) OR *30 day trial of: Aerospan or Asmanex *Members 8 y/o and younger will not require a PA*
FLOVENT DISKUS 100MCG	Non-Preferred	Required diagnosis: Eosinophilic Esophagitis (EoC) OR *30 day trial of: Aerospan or Asmanex *Members 8 y/o and younger will not require a PA*
FLOVENT DISKUS 250MCG	Non-Preferred	Required diagnosis: Eosinophilic Esophagitis (EoC) OR *30 day trial of: Aerospan or Asmanex *Members 8 y/o and younger will not require a PA*
FLOVENT HFA 44MCG	Non-Preferred	Required diagnosis: Eosinophilic Esophagitis (EoC) OR *30 day trial of: Aerospan or Asmanex *Members 8 y/o and younger will not require a PA*
FLOVENT HFA 110MCG	Non-Preferred	Required diagnosis: Eosinophilic Esophagitis (EoC) OR *30 day trial of: Aerospan or Asmanex *Members 8 y/o and younger will not require a PA*
FLOVENT HFA 220MCG	Non-Preferred	Required diagnosis: Eosinophilic Esophagitis (EoC) OR *30 day trial of: Aerospan or Asmanex *Members 8 y/o and younger will not require a PA*
FLOWTUSS 200-2.5MG/5ML SOLUTION	Non-Preferred	Formulary Agent(s): Guaifenesin-Codeine 200-10MG/5mL Liquid

Drug	Status	Special Instructions
Flublok Vial For Injection	Non-Preferred	Formulary Agent(s): Afluria, Afluria Quadrivalent, Fluarix Quadrivalent, Flucelvax Quadrivalent, Flulaval Quadrivalent, Fluvirin, Fluzone HD, Or Fluzone Quadrivalent
FLUCYTOSINE (ANCOBON) 250 mg CAPSULE	Non-Preferred	Required diagnosis= Cryptococcus Meningitis AND Formulary Agent(s): fluconazole OR Required diagnosis= Candida, UTI, Septicemia and Pulmonary AND Formulary Agent(s): fluconazole or ketoconazole
FLUCYTOSINE (ANCOBON) 500 mg CAPSULE	Non-Preferred	Required diagnosis= Cryptococcus Meningitis AND Formulary Agent(s): fluconazole OR Required diagnosis= Candida, UTI, Septicemia and Pulmonary AND Formulary Agent(s): fluconazole or ketoconazole
Flumist Quadrivalent Nasal Spray	Non-Preferred	Formulary Agent(s): Afluria, Afluria Quadrivalent, Fluarix Quadrivalent, Flucelvax Quadrivalent, Flulaval Quadrivalent, Fluvirin, Fluzone HD, Or Fluzone Quadrivalent
FLUOCINOLONE (DERMOTIC) OIL 0.01% EAR DROP	Non-Preferred	Required diagnosis= chronic eczematous external otitis
FLUOCINONIDE (VANOS) 0.1% CREAM	Non-Preferred	Formulary Agent: fluocinolone cream
Fluoridex Sensitivity Relief (Prevident 5000 Enamel Protect, Prevident 5000 Sensitive) 1.1%-5% Paste	Non-Preferred	Formulary Agent(s): ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, Or SF 5000 Plus 1.1% Cream
FLUOROPLEX 1% CREAM	Non-Preferred	Formulary Agent: FLUOROURACIL (EFUDEX) 5% CREAM
FLUOROURACIL (CARAC) 0.5% CREAM	Non-Preferred	Required diagnosis= Actinic Keratosis AND a 14 day trial of imiquimod (Aldara) 5% cream packet
FLUOXETINE 60 mg TABLET	Non-Preferred	Formulary Agent: fluoxetine (10 mg, 20 mg, 40 mg, or 20 mg/5 ml soln)
FLUOXETINE DR (PROZAC) 60 mg CAPSULE	Non-Preferred	Formulary Agent: fluoxetine (10 mg, 20 mg, 40 mg, or 20 mg/5 ml soln)
FLUOXETINE DR (PROZAC) 90 mg CAPSULE	Non-Preferred	Formulary Agent: fluoxetine (10 mg, 20 mg, 40 mg, or 20 mg/5 ml soln)
Fluoxetine (SARAFEM) 10 mg PMDD TABLET	Non-Preferred	Formulary Agent: FLUOXETINE 10 MG TABLET OR CAPSULES
Fluoxetine (SARAFEM) 20 mg PMDD TABLET	Non-Preferred	Formulary Agent: FLUOXETINE 20 MG TABLET OR CAPSULES
Flurandrenolide (Cordran) 0.05% Cream	Non-Preferred	Required Diagnosis= Atopic Dermatitis (Eczema) AND Must Use 2 Different Formulary Corticosteroid Agents For 7 Days Each
Flurandrenolide (Cordran) 0.05% Lotion	Non-Preferred	Required Diagnosis= Atopic Dermatitis (Eczema) AND Must Use 2 Different Formulary Corticosteroid Agents For 7 Days Each

Drug	Status	Special Instructions
Flurandrenolide (Cordran) 0.05% Ointment	Non-Preferred	Required Diagnosis= Atopic Dermatitis (Eczema) AND Must Use 2 Different Formulary Corticosteroid Agents For 7 Days Each
Flurbiprofen Sodium (Ocufen) Eye Drops	Non-Preferred	Formulary Agent(s): Diclofenac Sodium (ophthalmic) AND Ketorolac (0.4% Or 0.5%)
FLUROX, ALTAFLUOR, FLUORESCEIN W/ BENOXINATE 0.25-0.4% OPHTHALMIC SOLUTION	Non-Preferred	Will Approve For Procedures In Which A Topical Ophthalmic Anesthetic Agent In Conjunction With A Disclosing Agent Is Indicated, Such As Corneal Anesthesia Of Short Duration (i.e., Tonometry, Gonioscopy, Removal Of Foreign Bodies) And Short Corneal And Conjunctival Procedures
FLUTICASONE Propionate (CUTIVATE) 0.05% LOTION	Non-Preferred	Formulary Agents: Age 2-11: BETAMETHASONE DP 0.05% LOTION, BETAMETHASONE VALERATE 0.1% LOTION Age 12-17: BETAMETHASONE DP 0.05% LOTION, BETAMETHASONE VALERATE 0.1% LOTION, Mometasone (ELOCON) 0.1% LOTION Age 18 and older: BETAMETHASONE DP 0.05% LOTION, BETAMETHASONE VALERATE 0.1% LOTION, Mometasone (ELOCON) 0.1% LOTION, FLUOCINOLONE 0.01% Topical SOLUTION, CLOBETASOL FOAM
Fluticasone Propionate/Salmeterol (AirDuo Respiclick) 55 mcg/14 mcg Inhaler	Non-Preferred	Required Diagnosis Of Asthma WITH (Ages 12-17) Dulera THEN Advair Diskus OR (Ages 18 And Older) 2 Of The Following: Breo Ellipta, Dulera Or Advair Diskus
Fluticasone Propionate/Salmeterol (AirDuo Respiclick) 113 mcg/14 mcg Inhaler	Non-Preferred	Required Diagnosis Of Asthma WITH (Ages 12-17) Dulera THEN Advair Diskus OR (Ages 18 And Older) 2 Of The Following: Breo Ellipta, Dulera Or Advair Diskus
Fluticasone Propionate/Salmeterol (AirDuo Respiclick) 232 mcg/14 mcg Inhaler	Non-Preferred	Required Diagnosis Of Asthma WITH (Ages 12-17) Dulera THEN Advair Diskus OR (Ages 18 And Older) 2 Of The Following: Breo Ellipta, Dulera Or Advair Diskus
Fluvastatin (LESCOL) 20 mg CAPSULE	Non-Preferred	Formulary Agent(s): Simvastatin (Zocor) Or Atorvastatin (Lipitor)
Fluvastatin (LESCOL) 40 mg CAPSULE	Non-Preferred	Formulary Agent(s): Simvastatin (Zocor) Or Atorvastatin (Lipitor)
Fluvastatin ER (Lescol XL) 80mg Tablet	Non-Preferred	Formulary Agent(s): Simvastatin (Zocor) Or Atorvastatin (Lipitor)
FLUVOXAMINE SR (LUVOX CR) 100 mg CAPSULE	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)

Drug	Status	Special Instructions
FLUVOXAMINE SR (LUVOX CR) 150 mg CAPSULE	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
Fluzone Intradermal Quadrivalent Preservative Free Pre-Filled Syringe	Non-Preferred	Formulary Agent(s): Afluria, Afluria Quadrivalent, Fluarix Quadrivalent, Flucelvax Quadrivalent, Flulaval Quadrivalent, Fluvirin, Fluzone HD, Or Fluzone Quadrivalent
FML FORTE 0.25% EYE DROPS	Non-Preferred	Formulary Agent: FLUOROMETHOLONE, FLUOR-OP (FML LIQUIFLM) 0.1% DROPS
FOCALGIN 90 DHA 90-1-300MG COMBO PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
FOCALGIN CA 35-1-50MG COMBO PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
FOLAST TABLET 2-2.8-25 mg	Non-Preferred	Formulary Agent: folic acid
FOLBEE PLUS TABLET	Non-Preferred	Formulary Agent: folic acid
FOLCAP, FOLPLEX, FA-B6-B12 TABLET	Non-Preferred	Formulary Agent: folic acid
FOLGARD 2000-800 TABLET	Non-Preferred	Formulary Agent(s): Folgard OS Or TL G-Fol OS Tablet
Folic Acid Vial	Non-Preferred	Required Diagnosis Of Megaloblastic And Macrocytic Anemia Due To Folate Deficiency AND Formulary Agent(s): Folic Acid Tablet
FOLIVANE-EC CALCIUM DHA COMBO 27-1-250 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
FOLIVANE-OB CAPSULE 85 mg-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
FOLIVANE-PRX DHA NF CAPSULE 30-1.24-55	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
FOLLISTIM AQ INJECTION 600UNIT	Excluded Benefit	
FOLLISTIM AQ INJECTION 75UNIT	Excluded Benefit	
FOLLISTIM AQ INJECTION 900UNIT	Excluded Benefit	
FORFIVO XL 450 mg TABLET	Non-Preferred	Formulary Agent(s): Bupropion XL 150 mg (3 Tablets) OR Bupropion XL 150 mg AND Bupropion XL 300 mg Tablet
FORMALDEHYDE 10% SOLUTION (Lazerformaldehyde)	Non-Preferred	Formulary Agent: FORMALDEHYDE 37% SOLUTION
FORTEO 600 mcg/2.4 mL PEN	Specialty	Specialty; Follow Policy On CareSource.com
FORTESTA 10 mg GEL PUMP	PA required	Required diagnosis = hypogonadism with Total Testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
FOSAMAX 70 mg ORAL SOLUTION	Non-Preferred	Formulary Agent: alendronate

Drug	Status	Special Instructions
FOSAMAX PLUS D 70 mg-2,800 TABLET	Non-Preferred	Formulary Agent: alendronate AND OTC vitamin D separately
FOSAMAX PLUS D 70 mg-5,600 TABLET	Non-Preferred	Formulary Agent: alendronate AND OTC vitamin D separately
Foscarnet (Foscavir) 24 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
FOSTEUM CAP	Non-Preferred	Formulary Agent: VP-GSTN CAP [which requires a trial of OTC Vitamin D (CHOLECALCIFEROL) with OTC ZINC GLUCONATE TAB separately]
FRAGMIN 10,000 UNITS SYRING	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)
FRAGMIN 12,500 UNITS SYRING	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)
FRAGMIN 15,000 UNITS SYRING	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)
FRAGMIN 18,000 UNITS SYRING	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)
FRAGMIN 2,500 UNITS SYRINGE	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)
FRAGMIN 25,000 UNITS/ML VIAL	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)
FRAGMIN 5,000 UNITS SYRINGE	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)

Drug	Status	Special Instructions
FRAGMIN 7,500 UNITS SYRINGE	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)
FRAGMIN 95,000 UNIT SYRINGE	PA required	Required diagnosis = VTE/ Unstable angina /non-Q wave MI Required trial: oral warfarin or enoxaparin (Lovenox) OR Required diagnosis = DVT Required trial: enoxaparin (Lovenox)
Freamine III 10% IV Solution	Medical Benefit	Bill Through Medical Benefit
Freestyle Libre Pro	Excluded benefit	
FreeStyle Precision Neo Meter	Excluded benefit	
FreeStyle Precision Neo Test Strips	Excluded benefit	
FRESHKOTE EYE DROPS	Non-Preferred	Formulary Agent: OTC artificial tears
FROVA 2.5 mg TABLET	Non-Preferred	Formulary agents: sumatriptan, naratriptan, rizatriptan, or almotriptan (trial of 2 of 4)
FULYZAQ 125 MG DR TABLET	Non-Preferred	Required diagnosis = HIV/AIDs related Diarrhea
FUMATINIC ER CAPSULE	Non-Preferred	No longer available on the market
Furosemide 10 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Fusilev 50 mg Vial	Medical Benefit	Bill Through Medical Benefit
Fusion Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Fycompa 0.5 mg/mL Solution	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
FYCOMPA 2 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
FYCOMPA 4 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
FYCOMPA 6 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
FYCOMPA 8 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide

Drug	Status	Special Instructions
FYCOMPA 10 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
FYCOMPA 12 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
GALZIN 25 mg CAPSULE	PA required	Required diagnosis = Wilson's Disease with a trial of cupriine 250 mg capsule
GALZIN 50 mg CAPSULE	PA required	Required diagnosis = Wilson's Disease with a trial of cupriine 250 mg capsule
GAMASTAN S/D SYRINGE	PA required	Specialty; follow policy on CareSource.com.
GAMASTAN S-D VIAL	PA required	Specialty; follow policy on CareSource.com.
GAMMAGARD LIQUID 10% VIAL	PA required	Specialty; follow policy on CareSource.com.
GAMMAGARD S-D 5 GM VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMMAGARD S-D 10 GM VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMMAKED 1 GM/10 ML VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMMAKED 5 GM/50 ML VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMMAKED 10 GM/100 ML VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMMAKED 20 GM/200 ML VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMMAPLEX 2.5 GM/50 ML VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMMAPLEX 5 GM/100 ML VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMMAPLEX 10 GM/200 ML VIAL	Specialty	Specialty; follow policy on CareSource.com.
GAMUNEX 10% VIAL	PA required	Specialty; follow policy on CareSource.com.
GAMUNEX-C 1 GRAM/10 mL VIAL	PA required	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
GAMUNEX-C 10 GRAM/100 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
GAMUNEX-C 2.5 GRAM/25 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
GAMUNEX-C 20 GRAM/200 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
GAMUNEX-C 5 GRAM/50 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
GANIRELIX AC INJECTION	Excluded Benefit	
GATIFLOXACIN (ZYMAXID) 0.5% EYE DROPS	Non-Preferred	Formulary Agents: ciprofloxacin or ofloxacin ophthalmic with a diagnosis of conjunctivitis OR a diagnosis of cataract surgery or Corneal ulcer/Keratitis
GATTEX 5 mg KIT	Specialty	Specialty; follow policy on CareSource.com.
Gavilyte-H And Bisacodyl Kit	Non-Preferred	*Formulary Agent(s): Peg-3350, Gavilyte-G (Golytely)
GAZYVA 25 mg/ML INJECTION	Non-Preferred	Diagnosis = Previously untreated chronic lymphocytic leukemia (CLL) Provider Specialty = Oncologist
GELCLAIR GEL PACKETS	Non-Preferred	Required Diagnosis= Treating Sores And Ulcers In The Mouth Caused By Various Conditions (i.e., Radiation, Chemotherapy, Canker Sores, Surgery, Poorly Fitting Dentures)
GELNIQUE 10% GEL SACHETS	Non-Preferred	Requires a 90-Day Trial of OXYBUTYNIN, OXYBUTYNIN ER, or OXYBUTYNIN SYRUP
GELNIQUE 3% GEL SACHETS	Non-Preferred	Requires a 90-Day Trial of OXYBUTYNIN, OXYBUTYNIN ER, or OXYBUTYNIN SYRUP
GEL-ONE 10MG/ML	PA required	Specialty; follow policy on CareSource.com
GEL-ONE 30MG/3ML	PA required	Specialty; follow policy on CareSource.com
Gelsyn-3 16.8 mg/2 mL Syringe	Non-Preferred	Specialty; Follow Policy On CareSource.com Formulary Agent(s): Supartz & Gel-One
GENOTROPIN 12 mg CARTRIDGE	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN 5 mg CARTRIDGE	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 0.2 mg	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 0.4 mg	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 0.6 mg	Specialty	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
GENOTROPIN MINIQUICK 0.8 mg	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 1.2 mg	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 1.4 mg	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 1.6 mg	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 1.8 mg	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 1 mg	Specialty	Specialty; follow policy on CareSource.com.
GENOTROPIN MINIQUICK 2 mg	Specialty	Specialty; follow policy on CareSource.com.
Gentamicin 40 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
GENTIAN VIOLET 2% SOLUTION	Non-Preferred	Formulary Agent: Gentian Violet 1% (OTC)
GenVisc 850 10mg/mL Syringe	Non-Preferred	Specialty; Follow Policy On CareSource.com Formulary Agent(s): Supartz & Gel-One
GIAZO 1.1 gM TABLET	Non-Preferred	Formulary Agents: BALSALAZIDE (COLAZAL) 750 mg capsule for exclusively for the treatment of mildly to moderately active ulcerative colitis disease in adult males
GILENYA 0.5 mg CAPSULE	PA required	Specialty; Request Must Go Through Clinical Review
GILOTRIF 20 mg TABLET	PA required	Required diagnosis = Metastatic non-small lung cancer - Test results required
GILOTRIF 30 mg TABLET	PA required	Required diagnosis = Metastatic non-small lung cancer - Test results required
GILOTRIF 40 mg TABLET	PA required	Required diagnosis = Metastatic non-small lung cancer - Test results required
GLASSIA 1000 mg/50 mL IV SOLUTION Alpha 1-proteinase inhibitor INJECTION	Specialty	Specialty; follow policy on CareSource.com.
GLATOPA (COPAXONE) 20MG SYRINGE	PA required	Specialty; Request Must Go Through Clinical Review
GLUCOSE METER BATTERIES	Bill as DME	
GLYCATE 1.5 mg TABLET	Non-Preferred	Requires a 30 day trial of: GLYCOPYRROLATE tablet
GLYCINE 1.5% IRRIGATION	Non-Preferred	Formulary Agent: Normal Saline
Glycopyrrolate (Robinul) 0.2 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit

Drug	Status	Special Instructions
GLYXAMBI 10MG-5MG TABLET	Step Therapy	Requires a 30 day trial of: Invokana AND 30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
GLYXAMBI 25MG-5MG TABLET	Step Therapy	Requires a 30 day trial of: Invokana AND 30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
GONAL-F INJECTION 1050UNIT	Excluded Benefit	
GONAL-F INJECTION 450UNIT	Excluded Benefit	
GONAL-F RFF INJECTION 300UNIT	Excluded Benefit	
GONAL-F RFF INJECTION 450	Excluded Benefit	
GONAL-F RFF INJECTION 75UNIT	Excluded Benefit	
GONAL-F RFF INJECTION 900 UNIT	Excluded Benefit	
GoNitro 400 MCG Packet	Non-Preferred	Requires a 30-day trial of generic nitroglycerin sublingual tablets, translingual solution, or transdermal patches
GRAFCO (ARZOL) 75-25% SILVER NITRATE APPLICATOR STICKS	Non-Preferred	Required use= cauterization of skin or mucous membranes and for removing warts and granulated tissue
GRALISE 300 mg	Non-Preferred	Formulary Agent: gabapentin with a diagnosis of Post Herpetic Neuralgia
GRALISE 600 mg	Non-Preferred	Formulary Agent: gabapentin with a diagnosis of Post Herpetic Neuralgia
GRALISE Starter Kit 300 mg and 600 mg	Non-Preferred	Formulary Agent: gabapentin with a diagnosis of Post Herpetic Neuralgia
Granix 300 mcg/0.5 mL Syringe	PA required	Request Must Go Through Clinical Review
Granix 480 mcg/0.8 mL Syringe	PA required	Request Must Go Through Clinical Review
GRASTEK SUB 2800BAU	PA required	Required diagnosis = grass pollen-induced allergic rhinitis
GUANIDINE 125 mg TABLET	Non-Preferred	Required diagnosis = Myasthenic syndrome of Eaton-Lambert
GYNAZOLE-1 CREAM	Non-Preferred	Formulary Agents: MICONAZOLE NITRATE VAGINAL SUPPOSITORIES, CLOTRIMAZOLE VAGINAL CREAM 1% or 2%, TERCONAZOLE 0.4% or 0.8% CREAM, or TIOCONAZOLE (VAGISTAT-1, MONISTAT-1) 6.5% OINTMENT
HALOBETASOL (ULTRAVATE) 0.05% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
HALOBETASOL (ULTRAVATE) 0.05% OINTMENT	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
HALOG 0.1% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
HALOG 0.1% OINTMENT	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
HARVONI 90-400MG TABLET	PA required	Please see the state specific Pharmacy Policy Statement titled Harvoni by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/

Drug	Status	Special Instructions
HC AC/ ALOE, CORTALO (NUZON) 2% GEL	Non-Preferred	Formulary Agents: HYDROCORTISONE , PROCTOSOL-HC, Proctozone, Proctocream, Proctocare (Anusol-HC) 2.5% CREAM, HYDROCORTISONE 2.5% LOTION, HYDROCORTISONE 2.5% OINTMENT
HEARING AID BATTERIES	Bill as DME	
HELIDAC THERAPY	Non-Preferred	Will currently approve due to backorder of tetracycline
HELIXATE FS VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
HEMATOGEN, IRON COMPLEX SOFTGEL	Non-Preferred	Formulary Agent(s): Ferrous Fumarate 325 mg Tablet
HEMOFIL M VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
HEPAGAM B VIAL	PA required	Specialty
HERCEPTIN 440MG VIAL	Non-Preferred	Request Must Go Through Clinical Review
HETLIOZ 20 MG	PA required	Required diagnosis=Non-24-hour sleep-wake disorder Or Insomnia Related To Blindness
HISTEX PDX DROPS	Lower Cost	Formulary Agents=OTC Ketotifen AND Azelastine
HIZENTRA 1 GRAM/5 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
HIZENTRA 2 GRAM/10 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
HIZENTRA 20% (200 mg/ML) VIAL	PA required	Specialty; follow policy on CareSource.com.
HIZENTRA 4 GRAM/20 mL VIAL	PA required	Specialty; follow policy on CareSource.com.
HORIZANT ER TABLET 300 mg	Non-Preferred	Required Diagnosis= RLS AND Ropinirole Or Pramipexole OR Required Diagnosis= Post-Herpetic Neuralgia AND Gabapentin
HORIZANT ER TABLET 600 mg	Non-Preferred	Formulary Agents for diagnosis of RLS (Restless leg syndrome): gabapentin, ropinirole, or pramipexole
HUMATROPE 12 mg CARTRIDGE	Specialty	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
HUMATROPE 24 mg CARTRIDGE	Specialty	Specialty; follow policy on CareSource.com.
HUMATROPE 5 mg VIAL	Specialty	Specialty; follow policy on CareSource.com.
HUMATROPE 6 mg CARTRIDGE	Specialty	Specialty; follow policy on CareSource.com.
HUMATROPEN 6 mg	Specialty	Please see the state specific Pharmacy Policy Statement titled HumatroPen by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
HUMATROPEN 12 mg	Specialty	Please see the state specific Pharmacy Policy Statement titled HumatroPen by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
HUMATROPEN 24 mg	Specialty	Please see the state specific Pharmacy Policy Statement titled HumatroPen by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
HUMIRA 20 mg/0.4 mL SYRINGE	PA required	Please see the state specific Pharmacy Policy Statement titled Humira by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
HUMIRA 40 mg/0.8 mL PEN	PA required	Please see the state specific Pharmacy Policy Statement titled Humira by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
HUMIRA 40 mg/0.8 mL SYRINGE	PA required	Please see the state specific Pharmacy Policy Statement titled Humira by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
HYALGAN	Non-Preferred	Specialty; follow policy on CareSource.com. Formulary Agents: Supartz & Gel-One
HYCAMTIN 0.25 mg CAPSULE	PA required	Required diagnosis=relapsed small cell lung cancer
HYCAMTIN 1 mg CAPSULE	PA required	Required diagnosis=relapsed small cell lung cancer
HYCOFENIX 30-2.5-200MG/5ML SOLUTION	Non-Preferred	Formulary Agent(s): Guaifenesin-Codeine 200-10MG/5mL Liquid
HYDRO 40 AREOSOL FOAM	Non-Preferred	Formulary Agents: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
HYDROCODONE W/ HOMATROPINE (TUSSIGON) TABLET	Non-Preferred	Formulary Agent: benzonatate capsule
HYDROCODONE-ACETAMINOPHEN (MAXIDONE) 10-750 mg TABLET	Non-Preferred	Formulary Agent: HYDROCODONE-ACETAMINOPHEN (LORTAB) 10-500 TABLET
HYDROCODONE-ACETAMINOPHEN, VICODIN (XODOL) 5-300 mg TABLET	Non-Preferred	Formulary Agent: HYDROCODONE-ACETAMINOPHEN (NORCO) 5-325 MG

Drug	Status	Special Instructions
HYDROCODONE-ACETAMINOPHEN, VICODIN ES (XODOL)7.5-300 mg TABLET	Non-Preferred	Formulary Agent: HYDROCODONE-ACETAMINOPHEN (NORCO) 7.5-325 MG
HYDROCODONE-ACETAMINOPHEN, VICODIN HP (XODOL) 10-300 mg TABLET	Non-Preferred	Formulary Agent: HYDROCODONE-ACETAMINOPHEN (NORCO) 10-325 M
HYDROCODONE-CHLORPHENIRAMINE (TUSSIONEX) PENNKINETIC SUSPENSION	Non-Preferred	Formulary Agents: Age: 2-6 = off label (can use Dextromethorphan) Age: 6-12 = Dextromethorphan Age over 12 = Dextromethorphan or Benzonatate capsules
HYDROCODONE-IBUPROFEN, (REPREXAIN) 2.5-200 mg TABLET	Non-Preferred	Formulary Agent: HYDROCODONE-ACETAMINOPHEN 2.5-500 mg
HYDROCODONE-IBUPROFEN, IBUDONE (REPREXAIN) 5-200 mg TABLET	Non-Preferred	Formulary Agents: HYDROCODONE-ACETAMINOPHEN (VICODIN, Anexsia, Lortab) 5-500 tablet or HYDROCODONE-ACETAMINOPHEN 5-325 MG (Norco)
HYDROCODONE-IBUPROFEN, REPREXAIN, IBUDONE 10-200 mg TABLET	Non-Preferred	Formulary Agent: HYDROCODONE-ACETAMINOPHEN 10-325 MG
HYDROCORTISONE BUTYRATE HYDROPHILIC LIPO BASE (LOCOID LIPOCREAM) 0.1% CREAM	Non-Preferred	Formulary Agent(s): Hydrocortisone Butyrate (Locoid) 0.1% Cream
HYDROCORTISONE VALERATE (WESTCORT) 0.2% OINTMENT	Non-Preferred	Formulary Agent: HYDROCORTISONE VALERATE (WESTCORT) 0.2% CREAM
HYDROGEL GEL	Non-Preferred	Formulary Agent(s): Woun'Dres Wound Dressing
HYDROGESIC, STAGESIC (MARGESIC H) 5-500 mg CAPSULE	Non-Preferred	Formulary Agent: HYDROCODONE-ACETAMINOPHEN (VICODIN, Anexsia, Lortab) 5-500 MG tablet
HYDROMORPHONE ER (EXALGO ER) 8MG TABLET	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
HYDROMORPHONE ER (EXALGO ER) 12MG TABLET	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
HYDROMORPHONE ER (EXALGO ER) 16MG TABLET	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
HYDROMORPHONE ER (EXALGO ER) 32MG TABLET	Non-Preferred	Formulary agents: Fentanyl Patches, Morphine Sulfate ER (MS Contin), or Oxymorphone ER
HYDROQUINONE 4% CREAM TIME RELEASE (EpiQuin Micro, EpiQuin Micro/Pump)	Excluded benefit	

Drug	Status	Special Instructions
HYDROQUINONE 4% CREAM (TL HYDROQUINONE, SKIN BLEACHING, REMERGENT HQ, MELQUIN HP, MELPAQUE HP, LUSTRA-ULTRA, LUSTRA, ELDOPAQUE FORTE, ELDOQUIN FORTE)	Excluded benefit	
HYGEL, HYALURONATE GEL (HYLIRA) 0.2% GEL	Non-Preferred	Request Must Go Through Clinical Review
HYLAN INTRA-ARTICULAR INJECTION 8 mg/ML	PA required	Formulary Agents: Supartz or Gel-One
HYLATOPIC AREOSOL FOAM	Non-Preferred	Formulary Agents: Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin)
HYLATOPIC PLUS CREAM	Non-Preferred	Formulary Agents: Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin)
HYLIRA 0.2% LOTION	Non-Preferred	Request Must Go Through Clinical Review
HYOPHEN (PROSED-DS) TABLET	Non-Preferred	Formulary Agents: URELLE tablet, UROGESIC-BLUE or UTRONA-C
HYPERHEP B INJECTION S/D	Non-Preferred	Request Must Go Through Clinical Review
IBRANCE 75MG CAPSULE	PA required	Specialty
IBRANCE 100MG CAPSULE	PA required	Specialty
IBRANCE 125MG CAPSULE	PA required	Specialty
ICLUSIG 15 mg TABLET	PA required	Required diagnosis= Philadelphia chromosome–positive acute lymphoblastic leukemia (Ph+ALL) OR diagnosis = chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) with T3151 mutation with resistance or intolerance to prior therapy (Gleevec, Sprycel, Tasigna)
ICLUSIG 45 mg TABLET	PA required	Required diagnosis= Philadelphia chromosome–positive acute lymphoblastic leukemia (Ph+ALL) OR diagnosis = chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) with T3151 mutation with resistance or intolerance to prior therapy (Gleevec, Sprycel, Tasigna)
IDELVION VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
ILARIS FOR INJECTION 180 mg	PA required	Please see the state specific Pharmacy Policy Statement titled Ilaris by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ILEVRO 0.3% ophthalmic SUSPENSION	Non-Preferred	Formulary Agent: DICLOFENAC (VOLTAREN) 0.1% EYE DROPS
ILUVIEN 0.19MG INTRAVITREAL IMPLANT	Non-Preferred	Set Up And Send To Rph See state specific policy Biologic Ophthalmologic Agents Policy at https://www.caresource.com/providers/ohio/ohio-providers/pharmacy-policies/

Drug	Status	Special Instructions
Imatinib Mesylate (Gleevec) 100mg Tablet	PA required	Required Diagnosis= Acute Lymphoblastic Leukemia; Aggressive Systemic Mastocytosis; Chronic Myeloid Leukemia; Dermatofibrosarcoma Protuberans; GI Stromal Tumors; Hypereosinophilic Syndrome And/Or Chronic Eosinophilic Leukemia; Or Myelodysplastic/Myeloproliferative Diseases
Imatinib Mesylate (Gleevec) 400mg Tablet	PA required	Required Diagnosis= Acute Lymphoblastic Leukemia; Aggressive Systemic Mastocytosis; Chronic Myeloid Leukemia; Dermatofibrosarcoma Protuberans; GI Stromal Tumors; Hypereosinophilic Syndrome And/Or Chronic Eosinophilic Leukemia; Or Myelodysplastic/Myeloproliferative Diseases
IMBRUVICA 140 mg CAPSULE	PA required	Required diagnosis = MCL (Mantle Cell Lymphoma)
Imipenem-Cilastatin (Primaxin) 500 mg Vial	Medical Benefit	Bill Through Medical Benefit
IMIQUIMOD (ALDARA) 5% CREAM PACKET	PA required	*Dx= Actinic Keratosis OR *Dx= Genital and Perianal Warts (Condyloma Acuminata) OR *Dx= Superficial Basal Cell Carcinoma
IMLYGIC 1M UNITS/ML VIAL	Non-Preferred	Request Must Go Through Clinical Review
IMLYGIC 100M UNITS/ML VIAL	Non-Preferred	Request Must Go Through Clinical Review
IMOVAX INJECTION (RABIES VACCINE)	Medical Benefit	Bill through medical benefit and no PA is required
IMPLANON IMPLANT 68 mg	Medical Benefit	Bill on medical benefit and no PA is required
INCRELEX 40 mg/4 mL VIAL	PA required	Request Must Go Through Clinical Review
Incruse Ellipta 62.5mcg Inhaler	Non-Preferred	Formulary Agent(s): Spiriva Respimat
Inderal XL, Innopran XL 80 mg Capsule	Non-Preferred	Formulary Agent(s): Propranolol SR 80 mg
Inderal XL, Innopran XL 120 mg Capsule	Non-Preferred	Formulary Agent(s): Propranolol SR 120 mg
INFLECTRA	Medical Benefit	Bill Through Medical Benefit
INFERGEN 15 mcg/0.5 mL VIAL	Specialty	Specialty; follow policy on CareSource.com.
INFERGEN 9 mcg/0.3ML VIAL	Specialty	Specialty; follow policy on CareSource.com.
Infuvite Vial	Non-Preferred	Formulary Agent(s): Formulary Multi-Vitamin Tablet
Infuvite Pediatric Vial	Non-Preferred	Formulary Agent(s): Formulary Pediatric Multi-Vitamin Tablet
INGREZZA 40 mg	Specialty	Please see the state specific Pharmacy Policy Statement titled Ingrezza by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
INJECTAFER 750/15 mL INJECTION	Medical Benefit	Bill Through Medical Benefit
INLYTA TABLET 1 mg	PA required	Required diagnosis= Advanced renal cell cancer
INLYTA TABLET 5 mg	PA required	Required diagnosis= Advanced renal cell cancer

Drug	Status	Special Instructions
INOVA 4 and 5% EASY PAD KIT	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, or BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
INOVA 4/1 EASY PAD KIT	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, or BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
INOVA 8 and 5 % EASY PAD KIT	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, or BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
INOVA 8/2 EASY PAD KIT	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, or BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
INTERMEZZO 1.75 mg SUBLINGUAL TABLET	Non-Preferred	Formulary Agent: 7 day trial of IR & ER zolpidem
INTERMEZZO 3.5 mg SUBLINGUAL TABLET	Non-Preferred	Formulary Agent: 7 day trial of IR & ER zolpidem
INTRALIPID	PA required	Typically TPN and Additives (including vitamins and Intralipids) need to all be billed on the same benefit: If Pharmacy must bill TPN Medical and Additives Pharmacy First
INTRAROSA 6.5 mg Insert	Excluded Benefit	Sexual Dysfunction: Excluded Benefit
INTRON A 10 MILLION UNIT PEN	PA required	Specialty
INTRON A 10 MILLION UNIT/ML	PA required	Specialty
INTRON A 10 MILLION UNITS VIAL	PA required	Specialty
INTRON A 18 MILLION UNITS VIAL	PA required	Specialty

Drug	Status	Special Instructions
INTRON A 3 MILLION UNIT/ML	PA required	Specialty
INTRON A 5 MILLION UNIT/ML	PA required	Specialty
INTRON A 50 MILLION UNITS VIAL	PA required	Specialty
INTRON A 6 MILLION UNIT/ML	PA required	Specialty
Invanz 1G Vial	Medical Benefit	Bill Through Medical Benefit
INVOKAMET 50-500MG TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKAMET 50-1000MG TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKAMET 150-500MG TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKAMET 150-1000MG TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKAMET XR 50-500MG TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKAMET XR 50-1,000MG TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKAMET XR 150-500MG TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKAMET XR 150-1,000MG TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKANA 100 mg TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
INVOKANA 300 mg TABLET	Step Therapy	Formulary Agent(s): Metformin IR or ER (Glucophage or Glucophage XR)
IOPIDINE 1% EYE DROPS	Non-Preferred	Formulary Agent: brimonidine ophthalmic 0.2%
IQUIX 1.5% EYE DROPS	Non-Preferred	No longer available on the market
IRESSA 250 mg TABLET	PA required	Required diagnosis=non-small cell lung cancer
IRINOTECAN (CAMPTOSAR) 100 mg/5 mL VIAL	Non-Preferred	Required diagnosis=metastatic carcinoma of the colon or rectum
IRINOTECAN (CAMPTOSAR) 40 mg/2 mL VIAL	Non-Preferred	Required diagnosis=metastatic carcinoma of the colon or rectum
IRINOTECAN 500 mg/25 mL VIAL	Non-Preferred	Required diagnosis=metastatic carcinoma of the colon or rectum
Irospan Iron/Folic Acid/Supplement Tablets and Succinic Acid 65-1 mg Tablets	Non-Preferred	Required Trial Of: Ferraplus 90, Multigen Folic Caplet, Hematogen FA Or Hematogen Forte (All Which Require A PA)
ISOPTO CARBACHOL 1.5% DROPS	Non-Preferred	Formulary Agent: PILOCARPINE 1%, 2%, or 4% EYE DROPS
ISOPTO CARBACHOL 3% DROPS	Non-Preferred	Formulary Agent: PILOCARPINE 1%, 2%, or 4% EYE DROPS
ISOXSUPRINE 10 mg TABLET	Non-Preferred	Required Diagnosis = cerebrovascular insufficiency (stroke or TIA (transient ischemic attack) or peripheral vascular disease (arteriosclerosis obliterans, thromboangitis obliteranse (Buerger disease), or Raynaud disease)
ISRADIPINE 2.5 mg CAPSULE	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine

Drug	Status	Special Instructions
ISRADIPINE 5 mg CAPSULE	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
ISTALOL 0.5% EYE DROPS	Non-Preferred	Formulary Agent: TIMOLOL (TIMOPTIC) 0.5% EYE DROPS or TIMOLOL (TIMOPTIC-XE) 0.5% GEL EYE SOLUTION
ISTODAX INJECTION 10 mg	PA required	Required diagnosis=Cutaneous T-cell lymphoma (CTCL) OR Peripheral T-cell lymphoma (PTCL) * MD Specialty = Oncology
IVACAFTOR	PA required	Required diagnosis = Cystic Fibrosis with the G551D mutation
IXINITY VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
Jadenu 90 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Jadenu 180 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Jadenu 360 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Jakafi 5 mg Tablet	Lower Cost	Required Diagnosis=Intermediate or high-risk myelofibrosis indicated by International Prognostic Scoring System (IPSS) score > 1 *Symptomatic low risk myelofibrosis *Primary post-polycythemia vera myelofibrosis *Post-essential thrombocythemia myelofibrosis. OR *Dx=Polycythemia Vera
Jakafi 10 mg Tablet	Lower Cost	Required Diagnosis=Intermediate or high-risk myelofibrosis indicated by International Prognostic Scoring System (IPSS) score > 1 *Symptomatic low risk myelofibrosis *Primary post-polycythemia vera myelofibrosis *Post-essential thrombocythemia myelofibrosis. OR *Dx=Polycythemia Vera
Jakafi 15 mg Tablet	Lower Cost	Required Diagnosis=Intermediate or high-risk myelofibrosis indicated by International Prognostic Scoring System (IPSS) score > 1 *Symptomatic low risk myelofibrosis *Primary post-polycythemia vera myelofibrosis *Post-essential thrombocythemia myelofibrosis. OR *Dx=Polycythemia Vera
Jakafi 20 mg Tablet	Lower Cost	Required Diagnosis=Intermediate or high-risk myelofibrosis indicated by International Prognostic Scoring System (IPSS) score > 1 *Symptomatic low risk myelofibrosis *Primary post-polycythemia vera myelofibrosis *Post-essential thrombocythemia myelofibrosis. OR *Dx=Polycythemia Vera

Drug	Status	Special Instructions
Jakafi 25 mg Tablet	Lower Cost	Required Diagnosis=Intermediate or high-risk myelofibrosis indicated by International Prognostic Scoring System (IPSS) score > 1 *Symptomatic low risk myelofibrosis *Primary post-polycythemia vera myelofibrosis *Post-essential thrombocythemia myelofibrosis. OR *Dx=Polycythemia Vera
JANUMET 50-1,000 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JANUMET 50-500 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JANUMET XR 100-1,000 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JANUMET XR 50-1,000 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JANUMET XR 50-500 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JANUVIA 100 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JANUVIA 25 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JANUVIA 50 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JARDIANCE 10MG TABLET	Non-Preferred	Formulary agents: metformin IR or ER (Glucophage or Glucophage ER) THEN Invokana
JARDIANCE 25MG TABLET	Non-Preferred	Formulary agents: metformin IR or ER (Glucophage or Glucophage ER) THEN Invokana
JENTADUETO 2.5-500MG TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JENTADUETO 2.5-850MG TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
JENTADUETO 2.5-1000MG TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
Jentadueto XR 2.5 mg - 1,000 mg Tablet	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
Jentadueto XR 5 mg - 1,000 mg Tablet	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)

Drug	Status	Special Instructions
JETREA 2.5 mg/ML INTRAOCULAR INJECTION	PA required	Required diagnosis = symptomatic vitreo-macular adhesion (379.27) *Age ≥ 18 yrs old *vitreous adhesion to the macula within a 6-mm central retinal field surrounded by elevation of the posterior vitreous cortex, as seen on optical coherence tomography (OCT) *best-corrected visual acuity of 20/25 or less in the affected eye *Vitreomacular adhesion has been observed over a period of six or more weeks for spontaneous resolution *None of the following: Proliferative diabetic retinopathy, Neovascular age-related macular degeneration, Retinal vascular occlusion, Aphakia, High myopia (more than −8 diopters), Uncontrolled glaucoma, Macular hole greater than 400 µm in diameter, Vitreous opacification, Lenticular or zonular instability, History of retinal detachment in either eye, Prior vitrectomy, Prior laser photocoagulation of the macula, Prior treatment with ocriplasmin; or Treatment with ocular surgery, intravitreal injection, or retinal laser photocoagulation in the previous 3 months *Max one per lifetime
Jevtana 60 mg/1.5 mL Vial	Medical Benefit	Bill Through Medical Benefit
JUBLIA 10% SOLUTION	Non-Preferred	Formulary Agent(s): Ciclopirox (Penlac, Ciclodan) 8% Solution AND Oral Terbinafine Or Oral Itraconazole
JUXTAPID 5MG CAPSULE	PA required	Specialty; Request Must Go Through Clinical Review
JUXTAPID 10MG CAPSULE	PA required	Specialty; Request Must Go Through Clinical Review
JUXTAPID 20MG CAPSULE	PA required	Specialty; Request Must Go Through Clinical Review
JUXTAPID 30MG CAPSULE	PA required	Specialty; Request Must Go Through Clinical Review
JUXTAPID 40MG CAPSULE	PA required	Specialty; Request Must Go Through Clinical Review
JUXTAPID 60MG CAPSULE	PA required	Specialty; Request Must Go Through Clinical Review
KADCYLA 100 mg INJECTION	Non-Preferred	Required diagnosis = HER2 protein overexpression or gene amplification with a trial of Herceptin
KADCYLA 160 mg INJECTION	Non-Preferred	Required diagnosis = HER2 protein overexpression or gene amplification with a trial of Herceptin
Kadian ER 40 mg Capsule	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
Kadian ER 70 mg Capsule	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
Kadian ER 130 mg Capsule	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
Kadian ER 150 mg Capsule	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
Kadian ER 200 mg Capsule	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
KALBITOR C1 Esterase Inhibitor (Human) 10 mg/ML SOLUTION	Non-Preferred	Specialty; Request Must Go Through Clinical Review
KALYDECO 150MG TABLET	PA required	Request Must Go Through Clinical Review
Kanuma 20 mg/10 mL Vial	Non-Preferred	Request Must Go Through Clinical Review
KAPVAY ER 0.1/0.2 mg TITRATION KIT	Non-Preferred	Formulary Agent: CLONIDINE SR (KAPVAY ER) 0.1 mg TABLET
Kenalog 10 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Kenalog 40 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
KERAFOAM 30% AREOSOL	Non-Preferred	Formulary Agents: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
KERAFOAM 42 AREOSOL 42%	Non-Preferred	Formulary Agents: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
KEROL AD 45% EMULSION	Non-Preferred	Formulary Agent: Rea Lo 40% cream
Kerydin 5% Solution With Applicator	Non-Preferred	Formulary Agent(s): A 90 Day Trial Of: Ciclopirox (Penlac, Ciclodan) 8% Solution AND A 30 Day Trial Of Oral Terbinafine Or Oral Itraconazole
KETEK 300 mg TABLET	Non-Preferred	Formulary Agents: clarithromycin, azithromycin, or erythromycin
KETEK 400 mg TABLET	Non-Preferred	Formulary Agents: clarithromycin, azithromycin, or erythromycin
KETOCONAZOLE POWDER	Non-Preferred	Formulary Agent(s): ketoconazole (Kuric) 2% cream
KETODAN, KETOCONAZOLE (EXTINA) 2% FOAM	Non-Preferred	Formulary Agents: KETOCONAZOLE (NIZORAL) 2% SHAMPOO or KETOCONAZOLE (KURIC) 2% CREAM
KEVEYIS 50MG TABLET	Non-Preferred	Formulary Agent(s): Acetazolamide
KEYTRUDA 50MG VIAL	Non-Preferred	Request Must Go Through Clinical Review
KEYTRUDA 100MG/4ML VIAL	Non-Preferred	Request Must Go Through Clinical Review
KINERET 100 mg/0.67 mL SYRINGE	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Kineret by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
KOATE-DVI INJECTION 1000UNIT	Specialty	Specialty; follow policy on CareSource.com.
KOATE-DVI INJECTION 250UNIT	Specialty	Specialty; follow policy on CareSource.com.
KOATE-DVI INJECTION 500UNIT	Specialty	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
KOGENATE FS VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
KOGENATE FS BIO-SET VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
KOMBIGLYZE XR 2.5-1,000 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
KOMBIGLYZE XR 5-1,000 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
KOMBIGLYZE XR 5-500 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
KORLYM 300MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
KOVALTRY VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
K-PHOS #2 TABLET	Non-Preferred	Formulary Agent: formulary potassium supplement
K-PHOS M.F. TABLET	Non-Preferred	Formulary Agent: formulary potassium supplement
K-PHOS ORIGINAL 500 mg TABLET	Non-Preferred	Formulary Agent: formulary potassium supplement
Kristalose Packet	Non-Preferred	Formulary Agent(s): Lactulose Solution (Constulose, Enulose, Generlac, Or Generic)
KRYSTEXXA INJECTION 8 mg/ML	Non-Preferred	Required diagnosis = Gout with a trial of allopurinol and then Colcrys OR Uloric Prescriber Specialty = Rheumatology
KUVAN 100 mg TABLET	PA required	Required diagnosis = Hyperphenylalaninemia or PKU (phenylketonuria)
KYLEENA 19.5 mg IUD	PA required	Required diagnosis = Prevention of pregnancy
KYMRIAH	Lower Cost	Specialty; follow policy on CareSource.com.
Kynamro 200 mg/mL	PA required	Specialty; Request Must Go Through Clinical Review
KYPROLIS 60 mg POWDER FOR INJECTION	PA required	Required diagnosis = multiple myeloma
LACRISERT 5 mg EYE INSERT	Non-Preferred	Formulary Agents: OTC artificial tears
Lactated Ringers Irrigation Solution	Medical Benefit	Bill Through Medical Benefit
Lactated Ringers Vial	Medical Benefit	Bill Through Medical Benefit
LACTIC ACID 10% LOTION	Non-Preferred	Formulary Agents: Ammonium Lactate, LacLotion, Amlactin, Geri-Hydrolac, AL-12 (Lac-Hydrin,Lac-Hydrin Twelve) 12 % Lotion
LACTOCAL-F	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
LAMICTAL STARTER KIT (BLUE)	Non-Preferred	Formulary Agent: LAMOTRIGINE
LAMICTAL STARTER KIT (GREEN)	Non-Preferred	Formulary Agent: LAMOTRIGINE
LAMICTAL STARTER KIT (ORANGE)	Non-Preferred	Formulary Agent: LAMOTRIGINE
LAMICTAL XR STARTER KIT (BLUE)	Non-Preferred	Formulary Agent: LAMOTRIGINE tablets then LAMOTRIGINE SR (LAMICTAL XR)

Drug	Status	Special Instructions
LAMICTAL XR STARTER KIT (GREEN)	Non-Preferred	Formulary Agent: LAMOTRIGINE tablets then LAMOTRIGINE SR (LAMICTAL XR)
LAMICTAL XR STARTER KIT (ORANGE)	Non-Preferred	Formulary Agent: LAMOTRIGINE tablets then LAMOTRIGINE SR (LAMICTAL XR)
LAMISIL 125 mg GRANULES PACKETS	Non-Preferred	Formulary Agent: GRISEOFULVIN 125 mg/5 mL SUSPENSION
LAMISIL 187.5 mg GRANULES PACKETS	Non-Preferred	Formulary Agent: GRISEOFULVIN 125 mg/5 mL SUSPENSION
LAMOTRIGINE (LAMICTAL) ODT STARTER KIT (BLUE)	Non-Preferred	Requires an Inability To Swallow Pills Or Diagnosis of Seizures Or a Trial of LAMOTRIGINE tablets then LAMICTAL ODT tablets
LAMOTRIGINE (LAMICTAL) ODT STARTER KIT (GREEN)	Non-Preferred	Requires an Inability To Swallow Pills Or Diagnosis of Seizures Or a Trial of LAMOTRIGINE tablets then LAMICTAL ODT tablets
LAMOTRIGINE (LAMICTAL) ODT STARTER KT (ORANGE)	Non-Preferred	Requires an Inability To Swallow Pills Or Diagnosis of Seizures Or a Trial of LAMOTRIGINE tablets then LAMICTAL ODT tablets
LAMOTRIGINE (LAMICTAL) ODT 25MG TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE (LAMICTAL) ODT 50MG TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE (LAMICTAL) ODT 100MG TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE (LAMICTAL) ODT 200MG TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE SR (LAMICTAL XR) 100 mg TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE SR (LAMICTAL XR) 200 mg TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE SR (LAMICTAL XR) 250 mg TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE SR (LAMICTAL XR) 25 mg TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE SR (LAMICTAL XR) 300 mg TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LAMOTRIGINE SR (LAMICTAL XR) 50 mg TABLET	Non-Preferred	Formulary Agent: Lamotrigine Tablets
LANOXIN 62.5 MCG	Non-Preferred	Formulary Agent: Digoxin or Digitek (Lanoxin) 125 mcg or 250 mcg tablets
LANOXIN 187.5 MCG	Non-Preferred	Formulary Agent: Digoxin or Digitek (Lanoxin) 125 mcg or 250 mcg tablets

Drug	Status	Special Instructions
Lansoprazole (Prevacid) 15 mg Capsule	Non-Preferred	Formulary Agent(s): Prevacid OTC 24 HR DR Capsule
Lansoprazole (Prevacid) 30 mg Capsule	Non-Preferred	Formulary Agent(s): Prevacid OTC 24 HR DR Capsule
LANTUS SOLOSTAR PEN 100 U/mL	Non-Preferred	Requires A 30 day trial of Basaglar or Tresiba
LANTUS VIAL 100 U/mL	Non-Preferred	Requires A 30 day trial of Basaglar or Tresiba
LARIN FE 1.5/30 TABLET	Non-Preferred	Must use a formulary birth control agent (Most similar: Balziva)
LARIN FE 1/20 TABLET	Non-Preferred	Must use a formulary birth control agent (Most similar: Balziva)
LARTRUVO	Medical Benefit	Bill Through Medical Benefit
LASTACAFT 0.25% EYE DROPS	Non-Preferred	Formulary Agents: OTC agents with ketotifen AND azelastine (Optivar) unless patient is pregnant or for a child aged 2 to 3 years
Latisse	Excluded benefit	
LATRIX XM 45% EMULSION	Non-Preferred	Formulary Agents: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
LATRIX, UREA 50% TOPICAL SUSPENSION	Non-Preferred	Formulary Agents: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
LATUDA 120 mg TABLET	Step Therapy	Required diagnosis of: Szhiophrenia or Bipolar Depression AND a 30 Day Trial Of at least 2 of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon)
LATUDA 20 mg TABLET	Step Therapy	Required diagnosis of: Szhiophrenia or Bipolar Depression AND a 30 Day Trial Of at least 2 of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon)
LATUDA 40 mg TABLET	Step Therapy	Required diagnosis of: Szhiophrenia or Bipolar Depression AND a 30 Day Trial Of at least 2 of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon)
LATUDA 60 mg TABLET	Step Therapy	Required diagnosis of: Szhiophrenia or Bipolar Depression AND a 30 Day Trial Of at least 2 of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon)
LATUDA 80 mg TABLET	Step Therapy	Required diagnosis of: Szhiophrenia or Bipolar Depression AND a 30 Day Trial Of at least 2 of the following: Aripiprazole (Abilify), Risperidone (Risperdal), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine IR or ER (Seroquel or XR) Or Ziprasidone (Geodon)
LAYOLIS FE, KAITLIB FE, NORETHINDRONE & ETHINYL ESTRADIOL FERROUS FUMARATE (GENERESS FE) CHEWABLE TABLET	Non-Preferred	Formulary Agent(s): Formulary Birth Control Agent
LAZANDA 100MCG SPRAY	Non-Preferred	*Dx = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy AND *30 day trial of: fentanyl (Actiq) lozenge

Drug	Status	Special Instructions
LAZANDA 400MCG SPRAY	Non-Preferred	*Dx = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy AND *30 day trial of: fentanyl (Actiq) lozenge
LEMTRADA 12MG/1.2ML SOLUTION	Non-Preferred	Specialty; Request Must Go Through Clinical Review
LENVIMA 10MG/DAY CAPSULE	PA required	*Dx = Advanced pancreatic neuroendocrine tumors; Advanced renal cell carcinoma; GI stromal tumor
LENVIMA 14MG/DAY CAPSULE	PA required	*Dx = Advanced pancreatic neuroendocrine tumors; Advanced renal cell carcinoma; GI stromal tumor
LENVIMA 20MG/DAY CAPSULE	PA required	*Dx = Advanced pancreatic neuroendocrine tumors; Advanced renal cell carcinoma; GI stromal tumor
LENVIMA 24MG/DAY CAPSULE	PA required	*Dx = Advanced pancreatic neuroendocrine tumors; Advanced renal cell carcinoma; GI stromal tumor
LETAIRIS 10 mg TABLET	PA required	Specialty; follow policy on CareSource.com.
LETAIRIS 5 mg TABLET	PA required	Specialty; follow policy on CareSource.com.
Letrozole (Femara) 2.5 mg Tablet	PA required	Required Diagnosis= Breast Cancer
Leukine 250 mcg/mL Vial	PA required	Specialty; follow policy on CareSource.com.
Leukine 500 mcg/mL Vial	PA required	Specialty; follow policy on CareSource.com.
LEUPROLIDE INJECTION	PA required	
LEVALBUTEROL (XOPENEX) HFA 45 mcg INHALER	Non-Preferred	Formulary Agents: Ventolin
LEVALBUTEROL (XOPENEX) 0.31 mg/3 mL SOLUTION	Non-Preferred	Formulary Agent: albuterol inhalation solution
LEVALBUTEROL (XOPENEX) 0.63 mg/3 mL SOLUTION	Non-Preferred	Formulary Agent: albuterol inhalation solution
LEVALBUTEROL (XOPENEX) 1.25 mg/3 mL SOLUTION	Non-Preferred	Formulary Agent: albuterol inhalation solution
LEVALBUTEROL (XOPENEX) CONCENTRATED 1.25 mg/0.5 mL	Non-Preferred	Formulary Agent: albuterol inhalation solution
LEVAQUIN 25 mg/ML SOLUTION	Non-Preferred	Formulary Agent: 2 different manufacturers of generic levofloxacin solution
LEVATOL 20 mg TABLET	Non-Preferred	Formulary Agents: carvedilol, labetalol, metoprolol, atenolol, nadolol, propranolol, sotalol, or bisoprolol
LEVEMIR 100 UNITS/ML VIAL	Non-Preferred	Requires A 30 day trial of Basaglar or Tresiba
LEVEMIR FLEXPEN 100 UNITS/M	Non-Preferred	Requires A 30 day trial of Basaglar or Tresiba

Drug	Status	Special Instructions
Levetiracetam (Keppra) 100 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Levetiracetam (Keppra) 500 mg/5 mL Vial	Medical Benefit	Bill Through Medical Benefit
LEVITRA	Excluded benefit	
Levocarnitine 100 mg/mL Solution	Non-Preferred	Required Diagnosis Of Primary Systemic Carnitine Deficiency OR Secondary Carnitine Deficiency
Levocarnitine 330 mg Tablet	Non-Preferred	Required Diagnosis Of Primary Systemic Carnitine Deficiency OR Secondary Carnitine Deficiency
Levocarnitine (Carnitor) 200 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
LEVOCETIRIZINE (XYZAL) 2.5 mg/5 mL SOLUTION	Non-Preferred	Formulary Agents for Allergies/Allergic Rhinitis: loratadine, cetirizine or fexofenadine Formulary Agents for urticaria: loratadine, cetirizine, fexofenadine, diphenhydramine, chlorpheniramine, carbinoxamine or hydroxyzine AND 30 day trial of topicals: FLUTICASONE Propionate (CUTIVATE) 0.05% CREAM, PREDNICARBATE (DERMATOP) 0.1% CREAM, BETAMETHASONE DP 0.05%, BETAMETHASONE VALERATE 0.1%, HYDROCORTISONE 0.1%, HYDROCORTISONE 2.5%, PREDNICARBATE (DERMATOP) 0.1% OINTMENT, FLUOCINONIDE 0.05%, FLUOCINONIDE-E 0.05%, CLOBETASOL (TEMOVATE) 0.05%, CLOBETASOL-E (TEMOVATE E) 0.05%, FLUOCINOLONE 0.01%, TRIAMCINOLONE 0.025%, TRIAMCINOLONE 0.1%, TRIAMCINOLONE 0.5%, FLUTICASONE Propionate (CUTIVATE) 0.005% OINTMENT, DIFLORASONE 0.05% (Accepted trials but not recommended:MOMETASONE AND ALCLOMETASONE)
Levofloxacin (Levaquin) 25 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
LEVOFLOXACIN 0.5% EYE DROPS	Non-Preferred	Formulary Agent: ciprofloxacin or ofloxacin ophthalmic
LEVORPHANOL 2 mg TABLET	Non-Preferred	Formulary Agent: morphine sulfate IR
LEXAPRO 10 mg TABLET DAW	Non-Preferred	Required trial of 2 different manufacturers of generic escitalopram
LEXAPRO 20 mg TABLET DAW	Non-Preferred	Required trial of 2 different manufacturers of generic escitalopram
LEXAPRO 5 mg TABLET DAW	Non-Preferred	Required trial of 2 different manufacturers of generic escitalopram
LEXAPRO 5 mg/5 mL SOLUTION DAW	Non-Preferred	Required trial of 2 different manufacturers of generic escitalopram
LIALDA DR 1.2GM TABLET	Non-Preferred	Formulary Agent(s): Mesalamine (Asacol HD), Delzicol Or Apriso ER
Lidocaine 3% Lotion	Non-Preferred	A 30 Day Trial Of: Lidocaine 2% Gel, Lidocaine 3% Cream, Or Lidocaine 4% Cream
Lidocaine 5% Ointment	Non-Preferred	A 30 Day Trial Of: Lidocaine 2% Gel, Lidocaine 3% Cream, Or Lidocaine 4% Cream
Lidocaine 10 mg/mL Syringe	Medical Benefit	Bill Through Medical Benefit
Lidocaine 20 mg/mL Syringe	Medical Benefit	Bill Through Medical Benefit
LIDOCAINE-HYDROCORTISONE RECTAL CREAM KIT 2-2%	Non-Preferred	Formulary agent: LIDOCAINE 2% GEL JELLY or VISCOUS SOLUTION WITH HYDROCORTISONE , PROCTOSOL-HC, Proctozone, Proctocream, Proctocare (AnuSOL-HC) 2.5% CREAM separately used together
LIDOCAINE-HYDROCORTISONE RECTAL CREAM KIT 3-0.5%	Non-Preferred	Formulary agent: LIDOCAINE 3% CREAM WITH HYDROCORTISONE 0.5% CREAM separately used together

Drug	Status	Special Instructions
LIDOCAINE-HYDROCORTISONE RECTAL CREAM KIT 3-1%	Non-Preferred	Formulary agent: LIDOCAINE 3% CREAM WITH HYDROCORTISONE 1% CREAM separately used together
LIDOCAINE-HYDROCORTISONE RECTAL GEL KIT 3-2.5%	Non-Preferred	Formulary agent: LIDOCAINE 3% CREAM WITH HYDROCORTISONE , PROCTOSOL-HC, Proctozone, Proctocream, Proctocare (AnuSOL-HC) 2.5% CREAM separately used together
LIDOCAINE-TETRACAINE (PLIAGLIS) 7-7% CREAM	Non-Preferred	Formulary agent: LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
LIDORX 3% GEL WITH PUMP	Non-Preferred	Formulary Agent(s): Anecream, Lidocream, LC-4 Lidocaine (LMX 4) 4% Cream
LIDOVIR 4-4% OINTMENT	Non-Preferred	Formulary Agents: ZOVIRAX 5% OINTMENT and LIDOCAINE 5% OINTMENT separately
LIMBREL 250 mg CAPSULE	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam
LIMBREL 500 mg CAPSULE	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam
LIMBREL 250-50 mg CAPSULE	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam
LIMBREL 500-50 mg CAPSULE	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam
LIMBREL 525-50 mg CAPSULE	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam
Lincomycin (Lincocin) 300 mg/mL Vial	Non-Preferred	Required diagnosis: Serious Infections Caused By Susceptible Strains Of Streptococci, Pneumococci, And Staphylococci Or In Members Who Are Allergic To Penicillin
LINDANE 1% LOTION	Non-Preferred	Formulary Agent: permethrin cream with a diagnosis of scabies

Drug	Status	Special Instructions
LINDANE 1% SHAMPOO	Non-Preferred	Formulary Agents for head lice per age group below: Age 2 months - 2 years old: permethrin Age 2 years - 3 years: ACTICIN, PERMETHRIN (ELIMITE), permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT) Age 4 years to 5 years old: ACTICIN, PERMETHRIN (ELIMITE), permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT) or spinosad (Natroba) Age 6 years and older: ACTICIN, PERMETHRIN (ELIMITE), permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), spinosad (Natroba) or malathion (Ovide)
Linezolid (Zyvox) 600 mg/300 mL IV Solution	Medical Benefit	Bill Through Medical Benefit
Linezolid (ZYVOX) 100 mg/5 mL SUSPENSION	Non-Preferred	Formulary Agent: Vancomyin IV in-patient or outpatient with a diagnosis of Pneumonia; Skin and Skin structure infections OR a diagnosis of VANCOMYCIN IV -resistant eneterococcus (VRE)
LINEZOLID (ZYVOX) 600 mg TABLET	Non-Preferred	Formulary agent: Vancomyin IV in-patient or outpatient with a diagnosis of Pneumonia; Skin and Skin structure infections OR a diagnosis of VANCOMYCIN IV -resistant eneterococcus (VRE)
Linzess 72 mcg Capsule	Step Therapy	Formulary Agent(s): A 7 Day Trial Of: Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, Or PureLax (MiraLax) Powder In The Last 30 Days
Linzess 145 mcg Capsule	Step Therapy	Formulary Agent(s): A 7 Day Trial Of: Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, Or PureLax (MiraLax) Powder In The Last 30 Days
Linzess 290 mcg Capsule	Step Therapy	Formulary Agent(s): A 7 Day Trial Of: Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, Or PureLax (MiraLax) Powder In The Last 30 Days
LIPOFEN 150 mg CAPSULE	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
LIPOFEN 50 mg CAPSULE	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
LIPTRUZET 10-10 mg TABLET	Non-Preferred	Formulary Agent: atorvastatin and Zetia separately taken together
LIPTRUZET 10-20 mg TABLET	Non-Preferred	Formulary Agent: atorvastatin and Zetia separately taken together
LIPTRUZET 10-40 mg TABLET	Non-Preferred	Formulary Agent: atorvastatin and Zetia separately taken together
LIPTRUZET 10-80 mg TABLET	Non-Preferred	Formulary Agent: atorvastatin and Zetia separately taken together
LITHOSTAT 250 mg TABLET	Non-Preferred	Required diagnosis=Chronic urea-splitting urinary infection
LIVALO 1 mg TABLET	Non-Preferred	Formulary Agent(s): Simvastatin (Zocor), Atorvastatin (Lipitor) Or Rosuvastatin (Crestor)
LIVALO 2 mg TABLET	Non-Preferred	Formulary Agent(s): Simvastatin (Zocor), Atorvastatin (Lipitor) Or Rosuvastatin (Crestor)
LIVALO 4 mg TABLET	Non-Preferred	Formulary Agent(s): Simvastatin (Zocor), Atorvastatin (Lipitor) Or Rosuvastatin (Crestor)

Drug	Status	Special Instructions
L-METHYLFOLATE FORTE 7.5 - 90.314 mg CAPSULE	Non-Preferred	Requires a 30-day trial of L-methylfolate tablets AND Diagnosis of = Anemia secondary to MTFHR deficiency OR Diagnosis of = Depression AND Currently on an anti-depressant; either formulary (escitalopram, citalopram, fluoxetine, paroxetine, fluvoxamine, sertraline, venlafaxine tablet, venlafaxine ER capsule, duloxetine (Cymbalta) or bupropion) or recently approved/paid claims for a non-formulary anti-depressant (Pristiq, Venlafaxine ER tablets, Viibryd, Desvenlafaxine ER, Fluvoxamine ER (Luvox), Khedezla, Fetzima or Trintellix (Formerly Known As Brintellix)) OR Diagnosis of= Schizophrenia ho have or are at risk for hyperhomocysteinemia and have schizophrenia (per chart notes)
L-METHYLFOLATE FORTE 15-90.314 mg CAPSULE	Non-Preferred	Requires a 30-day trial of L-methylfolate tablets AND Diagnosis of = Anemia secondary to MTFHR deficiency OR Diagnosis of = Depression AND Currently on an anti-depressant; either formulary (escitalopram, citalopram, fluoxetine, paroxetine, fluvoxamine, sertraline, venlafaxine tablet, venlafaxine ER capsule, duloxetine (Cymbalta) or bupropion) or recently approved/paid claims for a non-formulary anti-depressant (Pristiq, Venlafaxine ER tablets, Viibryd, Desvenlafaxine ER, Fluvoxamine ER (Luvox), Khedezla, Fetzima or Trintellix (Formerly Known As Brintellix)) OR Diagnosis of= Schizophrenia ho have or are at risk for hyperhomocysteinemia and have schizophrenia (per chart notes)
LO LOESTRIN FE 1-10 TABLET	Non-Preferred	Formulary Agents: a formulary birth control option (most similar agent=Balziva)
LO MINASTRIN PAK FE CHEWABLE	Non-Preferred	Formulary Agents: a formulary birth control option (most similar agent=Balziva)
LOCOID LOTION 0.1%	Non-Preferred	Formulary Agent: HYDROCORTISONE BUTYRATE 0.1% CREAM (LOCOID)
CARBIDOPA (LODOSYN) 25 mg TABLET	Non-Preferred	Formulary Agent: carbidopa/levodopa (Sinemet)
LOMAIRA 8 mg TABLET	Excluded benefit	
Lomustine (Gleostine) 10 mg Capsule	Non-Preferred	Required Diagnosis Of Primary Or Metastatic Brain Tumor AND Member Has Already Received Surgical And/Or Radiotherapeutic Procedures OR A Diagnosis Of Relapsed Or Refractory Hodgkin's Disease
Lomustine (Gleostine) 40 mg Capsule	Non-Preferred	Required Diagnosis Of Primary Or Metastatic Brain Tumor AND Member Has Already Received Surgical And/Or Radiotherapeutic Procedures OR A Diagnosis Of Relapsed Or Refractory Hodgkin's Disease
Lomustine (Gleostine) 100 mg Capsule	Non-Preferred	Required Diagnosis Of Primary Or Metastatic Brain Tumor AND Member Has Already Received Surgical And/Or Radiotherapeutic Procedures OR A Diagnosis Of Relapsed Or Refractory Hodgkin's Disease
LONSURF 15-6.14MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
LONSURF 20-8.19MG TABLET	Non-Preferred	Request Must Go Through Clinical Review

Drug	Status	Special Instructions
LORTAB 10-300MG/15ML ELIXIR	Non-Preferred	Formulary Agent: Hydrocodone-Acetaminophen (Hycet) 7.5MG-325MG/15ML Solution
LORZONE 375 mg TABLET	Non-Preferred	Formulary Agent: chlorzoxazone 250 mg or 500 mg tablet
LORZONE 750 mg TABLET	Non-Preferred	Formulary Agent: chlorzoxazone 250 mg or 500 mg tablet
LOSEASONIQUE TABLET DAW	Non-Preferred	Formulary Agents: 2 different manufacturers of generic Camrese Lo, Amethia Lo
LOTEMAX 0.5% EYE DROPS	Non-Preferred	A One Time Trial Of: Pred Mild 0.12%, Prednisolone Acetate (Pred Forte, Omnipred) 1%, Prednisolone Sodium Phosphate 1%, Dexamethasone 0.1%, Or Fluorometholone, Fluor-Op (FML Liquifilm) 0.1% Ophthalmic Drops
Lotemax 0.5% Ophthalmic Gel	Non-Preferred	A One Time Trial Of: Pred Mild 0.12%, Prednisolone Acetate (Pred Forte, Omnipred) 1%, Prednisolone Sodium Phosphate 1%, Dexamethasone 0.1%, Or Fluorometholone, Fluor-Op (FML Liquifilm) 0.1% Ophthalmic Drops
LOTEMAX 0.5% OPHTHALMIC OINTMENT	Non-Preferred	A One Time Trial Of: Pred Mild 0.12%, Prednisolone Acetate (Pred Forte, Omnipred) 1%, Prednisolone Sodium Phosphate 1%, Dexamethasone 0.1%, Or Fluorometholone, Fluor-Op (FML Liquifilm) 0.1% Ophthalmic Drops
Loutrex, Promiseb, TL Triseb Cream	Excluded benefit	
LUCENTIS SOLUTION 0.3 mg	Specialty	Specialty; follow policy on CareSource.com.
LUCENTIS SOLUTION 0.5 mg	Specialty	Specialty; follow policy on CareSource.com.
LUMIGAN 0.01% EYE DROPS	Non-Preferred	Formulary Agent: Latanoprost 0.005% EYE DROPS
LUMIZYME	Specialty	Specialty; follow policy on CareSource.com.
LUPANETA KIT 3.75-5MG	Non-Preferred	Required Diagnosis= Endometriosis AND Required Trial Of Both Formulary NSAIDs And Contraceptives
LUPRON DEPOT INJECTION KIT 11.25 mg (3 - MONTH)	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT INJECTION KIT 22.5 mg (3 - MONTH)	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT INJECTION KIT 30 mg (4 - MONTH)	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT INJECTION KIT 45 mg (6-MONTH)	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT INJECTION KIT 7.5 mg	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT INJJ KIT 3.75 mg	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT-PED INJECTION KIT 11.25 mg	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT-PED INJECTION KIT 11.25 mg (3 - MONTH)	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT-PED INJECTION KIT 15 mg	Specialty	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
LUPRON DEPOT-PED INJECTION KIT 30 mg (3 - MONTH)	Specialty	Specialty; follow policy on CareSource.com.
LUPRON DEPOT-PED INJECTION KIT 7.5 mg	Specialty	Specialty; follow policy on CareSource.com.
LUVERIS INJECTION 75UNIT	PA required	
LUZU 1% CREAM	Non-Preferred	Formulary Agents: Ketoconazole Clotrimazole, Lamisil gel, or Terbinafine cream
LYBREL 90-20 mcg TABLET	Non-Preferred	No longer available on the market
LYNPARZA 50MG CAPSULE	Non-Preferred	Required Dx= Advanced Ovarian Cancer associated with defective BRCA genes
LYRICA 100 mg CAPSULE	Step Therapy	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
LYRICA 150 mg CAPSULE	Step Therapy	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
LYRICA 200 mg CAPSULE	Step Therapy	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
LYRICA 20 mg/ML SOLUTION	Non-Preferred	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
LYRICA 225 mg CAPSULE	Step Therapy	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide

Drug	Status	Special Instructions
LYRICA 25 mg CAPSULE	Step Therapy	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
LYRICA 300 mg CAPSULE	Step Therapy	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
LYRICA 50 mg CAPSULE	Step Therapy	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
LYRICA 75 mg CAPSULE	Step Therapy	For diagnosis of: fibromyalgia/neuropathy/neuralgia/sciatica, must first try 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule For diagnosis of seizure or epilepsy, must first try gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
MACUGEN INJECTION 0.3 mg/90 MICROLITER	Specialty	Specialty; follow policy on CareSource.com.
MAGNACET 10 mg-400 mg TABLET	Non-Preferred	Formulary Agent: Oxycodone-Acetaminophen (PERCOCET) 10-325 mg tablet
MAGNACET 5 mg-400 mg TABLET	Non-Preferred	Formulary Agent: Oxycodone-Acetaminophen (PERCOCET) 5-325 mg tablet
MAGNACET 7.5 mg-400 mg TABLET	Non-Preferred	Formulary Agent: Oxycodone-Acetaminophen (PERCOCET) 7.5-325 mg tablet
MAGNEBIND 400 RX TABLET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
Magnesium Sulfate 4MEQ/mL Vial	Medical Benefit	Bill Through Medical Benefit
MAKENA 250 mg/ML IMTRAMUSCULAR OIL	PA Required Medical Benefit	Bill through Medical Benefit

Drug	Status	Special Instructions
Maprotiline Tablet	Non-Preferred	Required Diagnosis Of Depression Or Anxiety AND Formulary Agent(s): Any Formulary TCA (Amitriptyline, Amoxapine, Desipramine, Doxepin, Imipramine, Nortriptyline, Trimipramine)
MARNATAL-F CAPSULE 60 mg-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
MARPLAN 10 mg TABLET	Non-Preferred	Formulary Agent: Parnate
MATERNITY VITAMIN 27 mg-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
MAVYRET 100 MG-40 MG	Lower Cost	Request Must Go Through Clinical Review
MAXARON FORTE CAPSULE	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
MAXIDEX 0.1% EYE DROPS	Non-Preferred	Formulary Agent: DEXAMETHASONE 0.1% OPHTHALMIC SOLUTION
MAXIFED-G CD TABLET	Non-Preferred	Formulary Agent: CHERATUSSIN DAC SYRUP
MAXIFLU CD TABLET	Non-Preferred	Formulary Agent: CAPMIST DM tablet and acetaminophen separately
MEBARAL 32 mg TABLET	Non-Preferred	No longer available on the market
MEBARAL 50 mg TABLET	Non-Preferred	No longer available on the market
M-Clear WC Liquid	Non-Preferred	Formulary Agent(s): Guaifenesin-Codeine 100 mg-10 mg/5 mL) Syrup OR Guaifenesin-Codeine 200 mg-10 mg/5 mL, 300 mg-10 mg/5 mL Liquid
Meclofenamate Capsule	Non-Preferred	Formulary Agent(s): Any Two Formulary NSAIDs (Ibuprofen, Naproxen, Diclofenac, Diflunisal, Etodolac, Flurbiprofen, Indomethacin, Ketoprofen, Ketorolac, Meloxicam, Nabumetone, Oxaprozin, Sulindac)
MEDERMA SPF 30 CREAM	Excluded benefit	
MEDROL 2MG TABLET	Non-Preferred	Formulary agent: methylprednisolone 4MG tablet
MEFENAMIC (Ponstel) 250 mg CAPSULE	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam
Megestrol Acetate (Megace ES) 625mg/5mL Suspension	Non-Preferred	Formulary Agent(s): Megestrol Acetate (Megace) 40mg/mL Suspension
MEKINIST 0.5 mg TABLET	PA required	Required diagnosis = advanced melanoma that is unresectable or metastatic (stage III or stage IV) with BRAF V600E or V600K mutations detected by an FDA approved test, used as a single agent OR concurrently with Tafinlar (dabrafenib)
MEKINIST 2 mg TABLET	PA required	Required diagnosis = advanced melanoma that is unresectable or metastatic (stage III or stage IV) with BRAF V600E or V600K mutations detected by an FDA approved test, used as a single agent OR concurrently with Tafinlar (dabrafenib)
Melquin 3% SOLUTION	Excluded benefit	
M-END DM SYRUP	Non-Preferred	Formulary Agent: RESCON-DM SYRUP
M-END PE LIQUID	Non-Preferred	Formulary Agent: DIMAPHEN ELIXIR
M-END WC LIQUID	Non-Preferred	Formulary Agent: BROMFED SYRUP
MENOPUR INJECTION 75UNIT	Excluded Benefit	
MENOSTAR 1 mg PATCH	Non-Preferred	Formulary Agents: Alora or Estradiol (Climara) patches
MENTAX 1% CREAM	Non-Preferred	Formulary Agents: clotrimazole/ketoconazole/miconazole

Drug	Status	Special Instructions
Meperidine (Demerol) 100 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Meprobamate Tablet	Non-Preferred	Required Diagnosis Of Anxiety
Meropenem 500 mg Vial	Medical Benefit	Bill Through Medical Benefit
Meropenem 1G Vial	Medical Benefit	Bill Through Medical Benefit
MESALAMINE (LIALDA DR) 1.2GM TABLET	Lower Cost	Formulary Agent(s): Mesalamine (Asacol HD), Delzicol Or Apriso ER
MESALAMINE (Rowasa) 4 gM/60 mL KIT	Non-Preferred	Formulary Agent: MESALAMINE (Rowasa) 4 GM/60 mL ENEMA
METANX, METHYLFOL/ME, FOLTANX RF CAPSULE	Non-Preferred	Formulary Agents: METHYLFOL/ME, VITACIRC-B, FOLTANX,L-METHYL-B6 TABLET
METAXALONE (Skelaxin) 800 mg TABLET	Non-Preferred	Formulary Agents: cyclobenzaprine, baclofen, methocarbamol, or tizanidine (carisoprodol- accepted trial but not preferred agent)
METFORMIN ER (FORTAMET) 1,000 mg TABLET	Non-Preferred	Formulary agent: Metformin ER (Glucophage ER)
METFORMIN ER (FORTAMET) 500 mg TABLET	Non-Preferred	Formulary agent: Metformin ER (Glucophage ER)
Metformin HCL (Glumetza) ER 500 mg Tablet	Non-Preferred	Formulary Agent(s): Metformin ER (Glucophage ER)
Metformin HCL (Glumetza) ER 1,000 mg Tablet	Non-Preferred	Formulary Agent(s): Metformin ER (Glucophage ER)
Methadone (Dolophine) 5 mg Tablet	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, hospice, or burns OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months

Drug	Status	Special Instructions
Methadone (Dolophine) 10 mg Tablet	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, hospice, or burns OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months
Methadone (Methadose) 10 mg/mL Concentrate	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, hospice, or burns OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months
Methadone 5 mg/5 mL Solution	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, hospice, or burns OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months

Drug	Status	Special Instructions
Methadone 10 mg/5 mL Solution	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, hospice, or burns OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months
MethAMPHETAMINE (DESOXYN) 5 mg TABLET	Non-Preferred	Formulary Agents for diagnosis of ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome: WITH trials per age group below: Age under 6 Trial (30 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR) Age 6 and older Trial (30 days total) of any combo of: dextroamphetamine, dextroamphetamine ER (Dexedrine), dexmethylphenidate (Focalin), amphetamine salt combo (ADDERALL), dextroamphetamine-amphetamine ER (ADDERALL XR), methlphenidate ER (Concerta), methlphenidate CR (Metadate CD), methlphenidate SR (Ritalin LA), methlphenidate (Methylin, Ritalin), Methylin ER, or Vyvanse
METHITEST 10 mg TABLET	Non-Preferred	Formulary Agents: Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a PA also) with a diagnosis of hypogonadism and Total Testosterone lab value = ≤ 300 ng/dL before treatment OR a Total Testosterone lab value within the normal range during treatment (for continuation of care)
Methyclothiazide 5 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Thiazide Or Thiazide-Like Diuretic (Chlorthalidone, Hydrochlorthiazide, Indapamide, Metolazone)
Methyldopa-HCTZ 250-15 mg Tablet	Non-Preferred	Formulary Agent(s): Methyldopa And Hydrochlorothiazide Separately Taken Together At The Same Time
Methyldopa-HCTZ 250-25 mg Tablet	Non-Preferred	Formulary Agent(s): Methyldopa And Hydrochlorothiazide Separately Taken Together At The Same Time
Methyltestosterone (Android, Testred) 10mg Capsule	Non-Preferred	Required Diagnosis= Hypogonadism, Total Testosterone Level ≤ 300ng/dL Before Treatment AND Formulary Agent(s): Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (Both Still Require A PA Also)
Metoclopramide ODT (Metozolv ODT) 5mg Tablet	Non-Preferred	Formulary Agent(s): Metoclopramide Tablet
Metoclopramide ODT (Metozolv ODT) 10mg Tablet	Non-Preferred	Formulary Agent(s): Metoclopramide Tablet

Drug	Status	Special Instructions
Metoprolol Tartrate 37.5 mg Tablet	Non-Preferred	Formulary Agent(s): Metoprolol Tartrate 25 mg, 50 mg, Or 100 mg Tablet
Metoprolol Tartrate 75 mg Tablet	Non-Preferred	Formulary Agent(s): Metoprolol Tartrate 25 mg, 50 mg, Or 100 mg Tablet
Metoprolol 1 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
METRONIDAZOLE (METROGEL) 1% TOPICAL GEL (TUBE AND PUMP)	Non-Preferred	Formulary Agents: metronidazole 0.75% topical lotion, cream, or gel
MEXILETINE 200 mg CAPSULE	Non-Preferred	Required Diagnosis = Ventricular arrhythmias
MEXILETINE 250 mg CAPSULE	Non-Preferred	Required Diagnosis = Ventricular arrhythmias
Mibelas 24 Fe, Norethindrone Acetate/Ethinyl Estradiol/Ferrous Fumarate (Minastrin 24 Fe) Chewable Tablet	Non-Preferred	Formulary Agent: a formulary birth control agent (Most similar: Balziva)
MICRHOGAM ULTR-FILTERED PLUS 50 mcg	PA required	Specialty
MICRO-BUMIN TEST KIT	Non-Preferred	Required diagnosis = Need for home albumin in urine testing
Midazolam 2 mg/2 mL Syringe	Medical Benefit	Bill Through Medical Benefit
Midazolam 5 mg/mL Syringe	Medical Benefit	Bill Through Medical Benefit
Midazolam 10 mg/2 mL Syringe	Medical Benefit	Bill Through Medical Benefit
MIDAZOLAM 2 mg/ML SYRUP	PA required	Requires diagnosis of sedation and unable to take tablet form
Midazolam 5 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Miglitol (Glyset) 25 mg Tablet	Step Therapy	Requires a 30 day trial of metformin IR or ER (Glucophage or Glucophage XR) unless renal/kidney disease/Increased Creatinine OR HbA1c (Hemaglobin A1c) with a value greater than 7.5% within the last 90 days
Miglitol (Glyset) 50 mg Tablet	Step Therapy	Requires a 30 day trial of metformin IR or ER (Glucophage or Glucophage XR) unless renal/kidney disease/Increased Creatinine OR HbA1c (Hemaglobin A1c) with a value greater than 7.5% within the last 90 days
Miglitol (Glyset) 100 mg Tablet	Step Therapy	Requires a 30 day trial of metformin IR or ER (Glucophage or Glucophage XR) unless renal/kidney disease/Increased Creatinine OR HbA1c (Hemaglobin A1c) with a value greater than 7.5% within the last 90 days
MILLIPRED 10 mg/5 mL SOLUTION	Non-Preferred	Formulary Agent: prednisolone liquid
MILLIPRED 5 mg TABLET	Non-Preferred	Formulary Agent: prednisone tablet
MILLIPRED DP 5 mg DOSE PACK 21 COUNT	Non-Preferred	Formulary Agent: prednisone tablet
MILLIPRED DP 5 mg DOSE PACK 48 COUNT	Non-Preferred	Formulary Agent: prednisone tablet
MINOCIN 100MG COMBO PACK	Non-Preferred	Formulary Agent(s): Minocycline Capsule

Drug	Status	Special Instructions
MINOCYCLINE ER (SOLODYN ER) 135 mg TABLET	Non-Preferred	Formulary Agent: minocycline
MINOCYCLINE ER (SOLODYN ER) 45 mg TABLET	Non-Preferred	Formulary Agent: minocycline
MINOCYCLINE ER (SOLODYN ER) 90 mg TABLET	Non-Preferred	Formulary Agent: minocycline
MINOXIDIL TOPICAL SOLUTION	Excluded benefit	
MIRCERA 50MCG SYRINGE	Non-Preferred	Request Must Go Through Clinical Review
MIRCERA 75MCG SYRINGE	Non-Preferred	Request Must Go Through Clinical Review
MIRCERA 100MCG SYRINGE	Non-Preferred	Request Must Go Through Clinical Review
MIRCERA 200MCG SYRINGE	Non-Preferred	Request Must Go Through Clinical Review
MIRVASO 0.33% GEL	Non-Preferred	Formulary Agent: metronidazole 0.75% for a diagnosis of rosacea
MISSION PRENATAL	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
MISSION PRENATAL FA	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
MISSION PRENATAL HP	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
MITOMYCIN 20 mg IV SOLUTION	Non-Preferred	Required Dx= Disseminated Adenocarcinoma Of The Stomach Or Pancreas OR Dx= Anal Cancer. Must Be Prescribed By Or In Consultation With An Oncologist.
MITOMYCIN 40 mg IV SOLUTION	Non-Preferred	Required Dx= Disseminated Adenocarcinoma Of The Stomach Or Pancreas OR Dx= Anal Cancer. Must Be Prescribed By Or In Consultation With An Oncologist.
MITOMYCIN 5 mg IV SOLUTION	Non-Preferred	Required Dx= Disseminated Adenocarcinoma Of The Stomach Or Pancreas OR Dx= Anal Cancer. Must Be Prescribed By Or In Consultation With An Oncologist.
MODAFINIL (PROVIGIL) 100 mg TABLET	PA required	Required diagnosis = Narcolepsy/Cataplexy/Sleep Apnea/OSA/ Shift Work Disorder
MODAFINIL (PROVIGIL) 200 mg TABLET	PA required	Required diagnosis = Narcolepsy/Cataplexy/Sleep Apnea/OSA/ Shift Work Disorder
MODERIBA PAK 1000/DAY	Non-Preferred	Request Must Go Through Clinical Review
MODERIBA PAK 1200/DAY	Non-Preferred	Request Must Go Through Clinical Review
MODERIBA PAK 600/DAY	Non-Preferred	Request Must Go Through Clinical Review
MODERIBA PAK 800/DAY	Non-Preferred	Request Must Go Through Clinical Review
MODERIBA TAB 200MG	Non-Preferred	Request Must Go Through Clinical Review
Moexipril 7.5 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary ACE Inhibitor (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Quinapril, Ramipril, Trandolapril)
Moexipril 15 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary ACE Inhibitor (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Quinapril, Ramipril, Trandolapril)
Moexipril-HCTZ 7.5-12.5 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary ACE Inhibitor/Diuretic Combination (Benazepril/Hydrochlorthiazide, Captopril/Hydrochlorthiazide, Enalapril/Hydrochlorthiazide, Fosinopril/Hydrochlorthiazide, Lisinopril/Hydrochlorthiazide, Quinapril/Hydrochlorthiazide)
Moexipril-HCTZ 15-12.5 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary ACE Inhibitor/Diuretic Combination (Benazepril/Hydrochlorthiazide, Captopril/Hydrochlorthiazide, Enalapril/Hydrochlorthiazide, Fosinopril/Hydrochlorthiazide, Lisinopril/Hydrochlorthiazide, Quinapril/Hydrochlorthiazide)

Drug	Status	Special Instructions
Moexipril-HCTZ 15-25 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary ACE Inhibitor/Diuretic Combination (Benazepril/Hydrochlorthiazide, Captopril/Hydrochlorthiazide, Enalapril/Hydrochlorthiazide, Fosinopril/Hydrochlorthiazide, Lisinopril/Hydrochlorthiazide, Quinapril/Hydrochlorthiazide)
Molindone Tablet	Non-Preferred	Required Diagnosis Of Schizophrenia
MOMETASONE FUROATE (NASONEX) 50 mcg NASAL SPRAY	Non-Preferred	Formulary Agent(s): Ages 2-3: Nasacort OTC Allergy 24HR Spray OR Ages 4-5: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 And Older: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray
MONOCLATE-P KIT	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
MONONINE VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
MONUROL 3 gM SACHET	Non-Preferred	Formulary Agents: Bactrim, ciprofloxacin, metronidazole or nitrofurantoin
Morgidox 50 mg Kit	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet WITH A Formulary Cleanser
Morgidox 100 mg Kit	Non-Preferred	Formulary Agent(s): Doxycycline Hyclate Capsule (50 mg Or 100 mg), Doxycycline Hyclate Tablet (20 mg Or 100 mg), Doxycycline Monohydrate Capsule (50 mg Or 100mg) Or Doxycycline Monohydrate (Adoxa) 75 mg Tablet WITH A Formulary Cleanser
MORPHINE SULFATE ER (KADIAN ER) 10 mg CAPSULE	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
MORPHINE SULFATE ER (KADIAN ER) 20 mg CAPSULE	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
MORPHINE SULFATE ER (KADIAN ER) 30 mg CAPSULE	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
MORPHINE SULFATE ER (KADIAN ER) 50 mg CAPSULE	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
MORPHINE SULFATE ER (KADIAN ER) 60 mg CAPSULE	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
MORPHINE SULFATE ER (KADIAN ER) 80 mg CAPSULE	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
MORPHINE SULFATE SR (KADIAN ER) 100 mg CAPSULE	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
MORPHINE SULFATE ER (MS CONTIN) 15 mg TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
MORPHINE SULFATE ER (MS CONTIN) 30 mg TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
MORPHINE SULFATE ER (MS CONTIN) 60 mg TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
MORPHINE SULFATE ER (MS CONTIN) 100 mg TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
MORPHINE SULFATE ER (MS CONTIN) 200 mg TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
Morphine Sulfate 10 mg/mL Injection	Medical Benefit	Bill Through Medical Benefit
MORPHINE SULFATE SR BEADS (AVINZA) 120 MG CAPSULE	Non-Preferred	Formulary Agent: morphine sulfate ER (MS Contin)
MORPHINE SULFATE SR BEADS (AVINZA) 30 MG CAPSULE	Non-Preferred	Formulary Agent: morphine sulfate ER (MS Contin)
MORPHINE SULFATE SR BEADS (AVINZA) 45 MG CAPSULE	Non-Preferred	Formulary Agent: morphine sulfate ER (MS Contin)
MORPHINE SULFATE SR BEADS (AVINZA) 60 MG CAPSULE	Non-Preferred	Formulary Agent: morphine sulfate ER (MS Contin)
MORPHINE SULFATE SR BEADS (AVINZA) 75 MG CAPSULE	Non-Preferred	Formulary Agent: morphine sulfate ER (MS Contin)
MORPHINE SULFATE SR BEADS (AVINZA) 90 MG CAPSULE	Non-Preferred	Formulary Agent: morphine sulfate ER (MS Contin)
MOTOFEN TABLET	Non-Preferred	Formulary Agent: atropine with diphenoxylate (Lomotil)
Movantik 12.5 mg Tablet	Non-Preferred	Formulary Agent(s): A 7 Day Trial Of: Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, Or PureLax (MiraLax) Powder In The Last 30 Days

Drug	Status	Special Instructions
Movantik 25 mg Tablet	Non-Preferred	Formulary Agent(s): A 7 Day Trial Of: Lactulose, Constulose, Enulose, Generlac, Kristalose, Smooth Lax, Polyethylene Glycol, Peg 3350, ClearLax, GentleLax, Or PureLax (MiraLax) Powder In The Last 30 Days
MOVIPREP POWDER KIT	Non-Preferred	Formulary Agents: Gavilyte-H or Peg-Prep Kit
MOXATAG ER 775 mg TABLET	Non-Preferred	Formulary Agent: amoxicillin 500 mg
MOXEZA 0.5% EYE DROPS	Non-Preferred	Formulary Agents: ciprofloxacin or ofloxacin ophthalmic
MOXIFLOXACIN (AVELOX) 400 mg TABLET	Step Therapy	Formulary Agent: ciprofloxacin or levofloxacin
MOXIFLOXACIN (VIGAMOX) 0.5% EYE DROPS	Step Therapy	Required diagnosis = cataract surgery or Corneal ulcer/Keratitis OR Required diagnosis = conjunctivitis Required trial of: ciprofloxacin or ofloxacin ophthalmic
MOZOBIL INJECTION 24 mg/1.2 mL (20 mg/ML)	Non-Preferred	Required diagnosis = Autologous transplantation in patients with non-Hodgkin lymphoma (NHL) and multiple myeloma who need hematopoietic stem cells mobilization Prescriber Specialty = Oncology
MST 600 TABLET	Non-Preferred	Formulary Agent: Mag-Ox
MUCINEX COLD & SINUS	Non-Preferred	Formulary Agent: MUCINEX ER 300 MG tablet
MUCINEX COLD-FLU & SORE THROAT	Non-Preferred	Formulary Agent: MUCINEX ER 300 MG tablet
MUCINEX FAST-MAX COLD-SINUS	Non-Preferred	Formulary Agent: MUCINEX ER 300 MG tablet
MUGARD LIQUID RINSE	Non-Preferred	Required diagnosis = Treating sores and ulcers in the mouth caused by various conditions (eg, radiation, chemotherapy, canker sores, surgery, poorly fitting dentures)
MULTAQ 400 mg TABLET	Non-Preferred	Formulary Agents: flecainide, propafenone, sotalol, or digoxin
MULTIGEN CAPELET 70-150-10 mg	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
MULTIGEN FOLIC CAPELET 70-150-1 mg	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
MULTIGEN PLUS CAPELET 151-60-1 mg	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
Multitrace-5 Concentrate 10-1,000-500-60-5,000 mcg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Multitrace-5 4-400-100-20-1,000 mcg/mL	Medical Benefit	Bill Through Medical Benefit
Muse	Excluded benefit	
Myalept 11.3 mg Vial	Non-Preferred	Required Diagnosis = Lipodystrophy
Mycamine 100 mg Vial	Medical Benefit	Bill Through Medical Benefit
Mydayis 12.5 mg	Lower Cost	Required Dignosis=Attention Deficit Hyperactivity Disorder (ADHD)
Mydayis 25 mg	Lower Cost	Required Dignosis=Attention Deficit Hyperactivity Disorder (ADHD)
Mydayis 37.5 mg	Lower Cost	Required Dignosis=Attention Deficit Hyperactivity Disorder (ADHD)
Mydayis 50 mg	Lower Cost	Required Dignosis=Attention Deficit Hyperactivity Disorder (ADHD)

Drug	Status	Special Instructions
MYDRIACYL 1% EYE DROPS DAW	Non-Preferred	Formulary Agents: 2 different manufacturers of generic tropicamide
MYKIDZ IRON FL SUSPENSION 10-0.25/2	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
MYOBLOC	Specialty	Specialty; follow policy on CareSource.com.
MYORISAN 10 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
MYORISAN 20 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
MYORISAN 40 mg CAPSULE	Non-Preferred	Requires trials of 30 days total of each group below either at the same time, separately, or overlapping Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [or previously approved for a similar non-preferrerd topical agent] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
MYOZYME	Specialty	Specialty; follow policy on CareSource.com.
MYRBETRIQ 25 mg	Non-Preferred	Formulary Agents: OXYBUTYNIN, OXYBUTYNIN ER, TOLTERODINE, TROSPIUM, or TROSPIUM SR
MYRBETRIQ 50 mg	Non-Preferred	Formulary Agents: OXYBUTYNIN, OXYBUTYNIN ER, TOLTERODINE, TROSPIUM, or TROSPIUM SR
MYTELASE 10 mg CAPELET	Non-Preferred	Formulary Agent: Prostigmin with a diagnosis of myasthenia gravis
Mytesi 125 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
NABI-HB INJECTION	Non-Preferred	Request Must Go Through Clinical Review

Drug	Status	Special Instructions
Nadolol-Bendroflumethazide (Corzide) 40-5 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Beta-Blocker/Diuretic Combination (Atenolol/Chlorthalidone, Bisoprolol/Hydrochlorothiazide, Metoprolol/Hydrochlorothiazide)
Nadolol-Bendroflumethazide (Corzide) 80-5 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Beta-Blocker/Diuretic Combination (Atenolol/Chlorthalidone, Bisoprolol/Hydrochlorothiazide, Metoprolol/Hydrochlorothiazide)
Nafcillin 10 G Vial	Medical Benefit	Bill Through Medical Benefit
NafRinse Daily Neutral 0.02% Rinse	Non-Preferred	Formulary Agent(s): ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, Or SF 5000 Plus 1.1% Cream
NAFTIFINE (NAFTIN) 1% CREAM	Non-Preferred	Formulary Agents: ketoconazole, clotrimazole, Lamisil gel, terbinafine cream
NAFTIN 1% GEL	Non-Preferred	Formulary Agents: ketoconazole, clotrimazole, Lamisil gel, terbinafine cream
NAFTIN 2% GEL	Non-Preferred	Formulary Agents: ketoconazole, clotrimazole, Lamisil gel, terbinafine cream
NAFTIN 2% CREAM	Non-Preferred	Formulary Agents: ketoconazole, clotrimazole, Lamisil gel, terbinafine cream
NAGLAZYME	Specialty	Specialty; follow policy on CareSource.com.
Nalbuphine 10 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Nalbuphine 20 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
NALFON 200 mg PULVULE	Non-Preferred	This medication has been discontinued-No longer available
NALFON 400 mg CAPSULE	Non-Preferred	Formulary Agent: FENOPROFEN 300 MG TABLET
NAMENDA XR 14MG CAPSULE	Non-Preferred	Formulary Agent: memantine hcl (Namenda) tablet
NAMENDA XR 21 MG CAPSULE	Non-Preferred	Formulary Agent: memantine hcl (Namenda) tablet
NAMENDA XR 28 MG CAPSULE	Non-Preferred	Formulary Agent: memantine hcl (Namenda) tablet
NAMENDA XR 7 MG CAPSULE	Non-Preferred	Formulary Agent: memantine hcl (Namenda) tablet
NAMENDA XR TITRATION PACK	Non-Preferred	Formulary agent: memantine hcl (Namenda) Titration Pack
NAMZARIC 7-10MG CAPSULE	Non-Preferred	Required 90 day trial of: Namenda, donepezil (Aricept), galantamine (Razadyne) or rivastigmine (Exelon)
NAMZARIC 14-10MG CAPSULE	Non-Preferred	Required 90 day trial of: Namenda, donepezil (Aricept), galantamine (Razadyne) or rivastigmine (Exelon)
NAMZARIC 21-10MG CAPSULE	Non-Preferred	Required 90 day trial of: Namenda, donepezil (Aricept), galantamine (Razadyne) or rivastigmine (Exelon)
NAMZARIC 28-10MG CAPSULE	Non-Preferred	Required 90 day trial of: Namenda, donepezil (Aricept), galantamine (Razadyne) or rivastigmine (Exelon)
NAPRELAN CR DOSECARD 500-750 mg	Non-Preferred	Required 90 day trial of: NAPRELAN CR (which require use of - NAPROXEN DR (EC-NAPROSYN) 375 mg tablet or NAPROXEN DR (EC-NAPROSYN) 500 mg tablet)
Naproxen Sodium CR (Naprelan) 375mg Tablet	Non-Preferred	Formulary Agent(s): Naproxen DR (EC-Naprosyn) 375mg Tablet Or Naproxen DR (EC-Naprosyn) 500mg Tablet

Drug	Status	Special Instructions
Naproxen Sodium CR (Naprelan) 500mg Tablet	Non-Preferred	Formulary Agent(s): Naproxen DR (EC-Naprosyn) 375mg Tablet Or Naproxen DR (EC-Naprosyn) 500mg Tablet
Naproxen Sodium CR (Naprelan) 750mg Tablet	Non-Preferred	Formulary Agent(s): Naproxen DR (EC-Naprosyn) 375mg Tablet Or Naproxen DR (EC-Naprosyn) 500mg Tablet
Naropin (Ropivacaine) 2.5 mg/mL Ampule, Infusion Or Vial	Medical Benefit	Bill Through Medical Benefit
Naropin (Ropivacaine) 5 mg/mL Ampule, Infusion Or Vial	Medical Benefit	Bill Through Medical Benefit
Naropin (Ropivacaine) 7.5 mg/mL Ampule, Infusion Or Vial	Medical Benefit	Bill Through Medical Benefit
Naropin (Ropivacaine) 10 mg/mL Ampule, Infusion Or Vial	Medical Benefit	Bill Through Medical Benefit
NASCOBAL 500 mcg NASAL SPRAY	Non-Preferred	Formulary Agent: OTC cyanocobalamin (b12) AND cyanocobalamine (B12) injection
NATACHEW 28-1MG CHEWABLE TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
NATAZIA 28 TABLET	Non-Preferred	Formulary Agents: a formulary birth control option
NATELLE-EZ	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
NATELLE ONE CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
NATESTO 5.5MG TESTOSTERONE NASAL GEL	Non-Preferred	Required 90 day trial of: Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet
NATPARA 25MCG/DOSE CARTRIDGE	Non-Preferred	Required diagnosis= hypocalcemia with hypoparathyroidism AND Required 30 day trial of: calcium and vitamin D separately taken together at the same time
NATPARA 50MCG/DOSE CARTRIDGE	Non-Preferred	Required diagnosis= hypocalcemia with hypoparathyroidism AND Required 30 day trial of: calcium and vitamin D separately taken together at the same time
NATPARA 75MCG/DOSE CARTRIDGE	Non-Preferred	Required diagnosis= hypocalcemia with hypoparathyroidism AND Required 30 day trial of: calcium and vitamin D separately taken together at the same time
NATPARA 100MCG/DOSE CARTRIDGE	Non-Preferred	Required diagnosis= hypocalcemia with hypoparathyroidism AND Required 30 day trial of: calcium and vitamin D separately taken together at the same time
NATURE-THROID 113.75mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 130mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 146.25mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet

Drug	Status	Special Instructions
NATURE-THROID 16.25mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 162.5mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 195mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 260mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 325mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 48.75mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 65mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 81.25mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NATURE-THROID 97.5mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
NEBUPENT 300 mg INHALED POWDER	PA required	Diagnosis of Pneumocystis carinii pneumonia (PCP) in high-risk, HIV-infected patients
NECON 10-11-28 TABLET	Non-Preferred	Formulary Agents: a formulary birth control option (most similar agents= Mircette, Kariva, Azurette)
NEEVO DHA GELCAP 27-1.13 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
NEOBENZ MICRO SD 5.5% CREAM	Non-Preferred	Formulary Agents: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin)
NEOBENZ MICRO WASH PLUS PACK	Non-Preferred	Formulary Agents: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin)
NEO-FRADIN 125 mg/5 mL SOLUTION	Non-Preferred	Formulary Agent: metronidazole
NEOSALUS AEROSOL FOAM	Non-Preferred	Formulary Agents: Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin)
NEOSALUS CREAM	Non-Preferred	Formulary Agents: Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin)
NEOSALUS LOTION	Non-Preferred	Formulary Agents: Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin)
NEO-SYNALAR 0.5-0.025% CREAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each
NEPHPLEX RX TABLET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
NEPHROCAPSULE QT TABLET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
NEPHRON FA TABLET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
NEPHRONEX 1 mg CAPSULE	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
NESTABS ABC TABLET	Non-Preferred	Formulary Agents: any formulary prenatal vitamin

Drug	Status	Special Instructions
NESTABS DHA, NUTRI-TAB OB +DHA, V-NATAL DHA TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
NESTABS, NUTRI-TAB OB, V-NATAL TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
NEUAC 1.2-5% GEL	Non-Preferred	Requires a trial of: BENZOYL PEROXIDE 5% GEL (Panoxyl) WITH CLINDAMYCIN, CLINDAMAX (CLEOCIN T) 1% LOTION, CLINDAMYCIN SWAB (CLEOCIN T) 1% PLEDGETS, CLINDAMYCIN PHOSPHATE 1% SOLUTION separately used together
NEUAC 1.2-5% KIT	Non-Preferred	Requires a trial of: BENZOYL PEROXIDE 5% GEL (Panoxyl) WITH CLINDAMYCIN, CLINDAMAX (CLEOCIN T) 1% LOTION, CLINDAMYCIN SWAB (CLEOCIN T) 1% PLEDGETS, CLINDAMYCIN PHOSPHATE 1% SOLUTION separately used together
Neutral Sodium Fluoride, Sodium Fluoride (Prevident) 0.2% Rinse	Non-Preferred	Formulary Agent(s): ACT AntiCavity Fluoride Rinse, ACT Restoring Fluoride Rinse, ACT Total Care Rinse, Denta 5000 Plus 1.1% Cream, Phos-Flur 0.02% Rinse, Or SF 5000 Plus 1.1% Cream
Neutrasal 538 mg	Non-Preferred	Formulary Agent(s): Pilocarpine Tablet Or OTC Saliva Substitute (i.e., Salivasure, Salese (Numoisyn) Lozenges, Aquoral Aerosol Solution, Or Caphosol, Numoisyn, Biotene, Mouthkote, Moi-Stir Solution)
NEULASTA 6 mg/0.6 mL SYRINGE	PA required	Specialty
Neulasta OnPro Kit 6 mg/0.6 mL	PA required	Medical Benefit ONLY
Neupogen 300 mcg/0.5 mL Syringe	PA required	Specialty
Neupogen 480 mcg/0.8 mL Syringe	PA required	Specialty
Neupogen 300 mcg/mL Vial	PA required	Specialty
Neupogen 480 mcg/1.6 mL Vial	PA required	Specialty
NEUPRO PATCH 1 mg PER 24 HOUR	Non-Preferred	Formulary Agents: ropinirole or pramipexole with a diagnosis of restless leg syndrome (RLS) or Parkinson's
NEUPRO PATCH 2 mg PER 24 HOUR	Non-Preferred	Formulary Agents: ropinirole or pramipexole with a diagnosis of restless leg syndrome (RLS) or Parkinson's
NEUPRO PATCH 3 mg PER 24 HOUR	Non-Preferred	Formulary Agents: ropinirole or pramipexole with a diagnosis of restless leg syndrome (RLS) or Parkinson's
NEUPRO PATCH 4 mg PER 24 HOUR	Non-Preferred	Formulary Agents: ropinirole or pramipexole with a diagnosis of restless leg syndrome (RLS) or Parkinson's
NEUPRO PATCH 6 mg PER 24 HOUR	Non-Preferred	Formulary Agents: ropinirole or pramipexole with a diagnosis of restless leg syndrome (RLS) or Parkinson's
NEUPRO PATCH 8 mg PER 24 HOUR	Non-Preferred	Formulary Agents: ropinirole or pramipexole with a diagnosis of restless leg syndrome (RLS) or Parkinson's

Drug	Status	Special Instructions
NEUVAXIN 0.0375-5% PATCH	Non-Preferred	Required 30 day trial of: Trixaicin HP, Arthritis Pain, Theragen HP, Capsuleacicin (Zostrix HP) 0.075% cream
NEVANAC 0.1% DROPTAINER	Non-Preferred	Formulary Agent: DICLOFENAC (VOLTAREN) 0.1% EYE DROPS
NEXA SELECT 29-1.25-337.5 MG CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin;
NEXAVAR 200 mg TABLET	PA required	Required diagnosis = Renal Cell Carcinoma, Hepatocellular carcinoma, Thyroid Carcinoma, or progressive differentiated thyroid cancer refractory to radioactive iodine treatment
NEXICLON XR 0.09 mg/ML SUSP	Non-Preferred	No longer available on the market
NEXICLON XR 0.17 mg TABLET	Non-Preferred	No longer available on the market
NEXIUM DR 10 mg PACKET	Non-Preferred	Formulary Agent(s): Omeprazole Capsules OR First-Omeprazole 2mg/mL Suspension AND Lansoprazole Capsules OR First-Lansoprazole 3mg/mL Suspension
NEXIUM DR 2.5 mg PACKET	Non-Preferred	Formulary Agent(s): Omeprazole Capsules OR First-Omeprazole 2mg/mL Suspension AND Lansoprazole Capsules OR First-Lansoprazole 3mg/mL Suspension
NEXIUM DR 20 mg PACKET	Non-Preferred	Formulary Agent(s): Omeprazole Capsules OR First-Omeprazole 2mg/mL Suspension AND Lansoprazole Capsules OR First-Lansoprazole 3mg/mL Suspension
NEXIUM DR 40 mg PACKET	Non-Preferred	Formulary Agent(s): Omeprazole Capsules OR First-Omeprazole 2mg/mL Suspension AND Lansoprazole Capsules OR First-Lansoprazole 3mg/mL Suspension
NEXIUM DR 5 mg PACKET	Non-Preferred	Formulary Agent(s): Omeprazole Capsules OR First-Omeprazole 2mg/mL Suspension AND Lansoprazole Capsules OR First-Lansoprazole 3mg/mL Suspension
NIACIN ER (NIASPAN ER) 1,000 mg TABLET	Non-Preferred	Formulary Agent: OTC Niacin
NIACIN ER (NIASPAN ER) 500 mg TABLET	Non-Preferred	Formulary Agent: OTC Niacin
NIACIN ER (NIASPAN ER) 750 mg TABLET	Non-Preferred	Formulary Agent: OTC Niacin
NICOMIDE 0.5MG-750MG TABLET	Non-Preferred	Formulary Agents: Formulary Acne Topicals and Formulary Multi-Vitamins
NICOTINE 21-14-7MG/24 HR PATCH KIT	Non-Preferred	Requires a trial of: nicotine patches-each strength separately
Nilutamide (Nilandron) 150 mg Tablet	PA required	Required diagnosis = metastatic prostate cancer
NIMODIPINE (Nimotop) 30 mg CAPSULE	Non-Preferred	Required diagnosis = subarachnoid hemorrhage (SAH)
NINLARO 2.3MG CAPSULE	Non-Preferred	Request Must Go Through Clinical Review
NINLARO 3MG CAPSULE	Non-Preferred	Request Must Go Through Clinical Review
NINLARO 4MG CAPSULE	Non-Preferred	Request Must Go Through Clinical Review
NISOLDIPINE ER 17 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
NISOLDIPINE ER 20 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
NISOLDIPINE ER 25.5 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
NISOLDIPINE ER 30 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
NISOLDIPINE ER 34 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine

Drug	Status	Special Instructions
NISOLDIPINE ER 40 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
NISOLDIPINE ER 8.5 mg TABLET	Non-Preferred	Formulary Agents: amlodipine, felodipine, or nifedipine
Nitromist	Non-Preferred	Formulary Agent: NITROGLYCERIN LINGUAL 0.4 mg SPRAY (NitroLingual Spray)
NOCTIVA 0.83 mcg	Non-Preferred	*30 day trial of DESMOPRESSIN (DDAVP) NASAL SPRAY or Stimate Nasal spray
NOCTIVA 1.66 mcg	Non-Preferred	*30 day trial of DESMOPRESSIN (DDAVP) NASAL SPRAY or Stimate Nasal spray
NORDITROPIN FLEXPRO 5 mg	PA required	Specialty; follow policy on CareSource.com.
NORDITROPIN FLEXPRO 10 mg	PA required	Specialty; follow policy on CareSource.com.
NORDITROPIN FLEXPRO 15 mg	PA required	Specialty; follow policy on CareSource.com.
NORDITROPIN FLEXPRO 30 mg	PA required	Specialty; follow policy on CareSource.com.
NORDITROPIN NORDIFLEX 30 mg	PA required	Specialty; follow policy on CareSource.com.
Norgestimate-Ethinyl Estradiol, Tri-Lo-Estarylla, Tri-Lo-Marzia, Tri-Lo-Sprintec, Trinessa Lo (Ortho Tri-Cyclen Lo) 0.18-25/0.215-25/0.25-25mg-mcg Tablet	Non-Preferred	Formulary Agent(s): Formulary Birth Control Agent
NORITATE 1% CREAM	Non-Preferred	Formulary Agent: METRONIDAZOLE (METROCREAM) 0.75% CREAM
NOROXIN 400 mg TABLET	Non-Preferred	Formulary Agents: ciprofloxacin or levofloxacin
NORTHERA 100MG CAPSULE	Non-Preferred	Required diagnosis of: orthostatic dizziness, lightheadedness, or the “feeling that you are about to black out” in adult patients with symptomatic neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure [Parkinson's disease, multiple system atrophy, and pure autonomic failure], dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy
NORTHERA 200MG CAPSULE	Non-Preferred	Required diagnosis of: orthostatic dizziness, lightheadedness, or the “feeling that you are about to black out” in adult patients with symptomatic neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure [Parkinson's disease, multiple system atrophy, and pure autonomic failure], dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy
NORTHERA 300MG CAPSULE	Non-Preferred	Required diagnosis of: orthostatic dizziness, lightheadedness, or the “feeling that you are about to black out” in adult patients with symptomatic neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure [Parkinson's disease, multiple system atrophy, and pure autonomic failure], dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy
NOVA MAX TEST STRIPS	Non-Preferred	Formulary Agents: FreeStyle or Precision products

Drug	Status	Special Instructions
NOVAFERRUM 10MG/ML PEDIATRIC DROPS	Non-Preferred	*Formulary Agent(s): Ferrous Sulfate 220mg/5mL Elixir
NOVANTRONE	Non-Preferred	Specialty; Follow Policy on Caresource.com
NOVOEIGHT VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
NOVOSEVEN VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
NOXAFIL 100 mg TABLET	Non-Preferred	Formulary Agent: fluconazole
NOXAFIL 40 mg/ML SUSPENSION (200 mg/5 mL)	Non-Preferred	Formulary Agent: fluconazole
NPLATE 250 mcg SUBQ SOLUTION	Specialty	Specialty; follow policy on CareSource.com.
NPLATE 500 mcg SUBQ SOLUTION	Specialty	Specialty; follow policy on CareSource.com.
Nucala 100mg Vial	Non-Preferred	Request Must Go Through Clinical Review
NUCORT 2% LOTION	Non-Preferred	Formulary Agent: HYDROCORTISONE 2.5% LOTION
NUCYNTA 100 mg TABLET	Non-Preferred	Formulary Agent: morphine sulfate IR or oxycodone or oxycodone/APAP
NUCYNTA 50 mg TABLET	Non-Preferred	Formulary Agent: morphine sulfate IR or oxycodone or oxycodone/APAP
NUCYNTA 75 mg TABLET	Non-Preferred	Formulary Agent: morphine sulfate IR or oxycodone or oxycodone/APAP
NUCYNTA ER 100 mg TABLET	Non-Preferred	Formulary Agents: morphine sulfate ER (MS Contin) or fentanyl patches
NUCYNTA ER 150 mg TABLET	Non-Preferred	Formulary Agents: morphine sulfate ER (MS Contin) or fentanyl patches
NUCYNTA ER 200 mg TABLET	Non-Preferred	Formulary Agents: morphine sulfate ER (MS Contin) or fentanyl patches
NUCYNTA ER 250 mg TABLET	Non-Preferred	Formulary Agents: morphine sulfate ER (MS Contin) or fentanyl patches
NUCYNTA ER 50 mg TABLET	Non-Preferred	Formulary Agents: morphine sulfate ER (MS Contin) or fentanyl patches
NUEDEXTA 20-10 mg CAPSULE	PA required	Required Diagnosis= Pseudobulbar Affect (PBA) Secondary To Multiple Sclerosis (MS) Or Amyotrophic Lateral Sclerosis (ALS) Or Head/Brain Trauma, Stroke, Or Alzheimer's Disease *Prescribed By Or Under The Consultation Of A Neurologist
NULOJIX 250MG VIAL	Non-Preferred	Required diagnosis= Prophylaxis of organ rejection in adults receiving a kidney transplant *Used in combination with basiliximab induction, mycophenolate mofetil [MMF], and corticosteroids *Used only in patients who are Epstein-Barr virus (EBV) seropositive
NUOX GEL	Non-Preferred	Formulary Agents: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin)
Nuplazid 17 mg Tablet	Non-Preferred	Medication Must Go Through Clinical Review
NUTROPIN AQ 20 mg/2 mL PEN	Specialty	Specialty; follow policy on CareSource.com.
NUTROPIN AQ 5 mg/ML VIAL	Specialty	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
NUTROPIN AQ NUSPIN 5 PEN	Specialty	Specialty; follow policy on CareSource.com.
NUTROPIN AQ PEN CARTRIDGE	Specialty	Specialty; follow policy on CareSource.com.
NUVESSA 1.3% VAGINAL GEL	Non-Preferred	Required trial of: metronidazole 0.75% vaginal gel (Metro-Gel Vaginal)
NUWIQ VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
NYMALIZE 60 MG/20ML	PA required	Formulary Agent: NIMODIPINE (Nimotop) 30MG CAPSULE
NYSTATIN 50,000,000 ORAL POWDER	Non-Preferred	*Required trial of: nystatin oral tablet
NYSTATIN-TRIAMCINOLONE 0.1units/gm - 0.1% CREAM	Non-Preferred	Formulary Agents: nystatin and triamcinolone separately used together
NYSTATIN-TRIAMCINOLONE 0.1units/gm - 0.1% OINTMENT	Non-Preferred	Formulary Agents: nystatin and triamcinolone separately used together
O-CAL PRENATAL	Non-Preferred	Formulary Agents: any formulary prenatal vitamin
OB COMPLETE CHEWABLE TABLET 20-1-100 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
OB Complete Gold 27.5 mg-1 mg Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
OB COMPLETE ONE SOFTGEL 40-10-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
OB COMPLETE PETITE SOFTGEL	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
OB COMPLETE PREMIER TABLET 30-20-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
OB COMPLETE WITH DHA CAPSULES	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
OBIZUR VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
OBREDON 2.5-200MG/5ML SOLUTION	Non-Preferred	Required trial of: guaifenesin-codeine 200-10MG/5mL liquid
Ocaliva 5 mg Tablet	Non-Preferred	Age 18 And Older With A Required Diagnosis Of Primary Biliary Cholangitis AND Formulary Agent Ursodiol
Ocaliva 10 mg Tablet	Non-Preferred	Age 18 And Older With A Required Diagnosis Of Primary Biliary Cholangitis AND Formulary Agent Ursodiol
OCREVUS 300 mg/10 mL IV SOLUTION	Medical Benefit	Bill Through Medical Benefit
OCTAGAM	PA required	Specialty; follow policy on CareSource.com.
OCTREOTIDE (SANDOSTATIN) 0.05 mg/ML AMPULE	PA required	Required diagnosis = Acromegaly; Carcinoid tumors; Vasoactive intestinal peptide tumors (VIPomas)

Drug	Status	Special Instructions
OCTREOTIDE (SANDOSTATIN) 0.1 mg/ML AMPULE	PA required	Required diagnosis = Acromegaly; Carcinoid tumors; Vasoactive intestinal peptide tumors (VIPomas):
OCTREOTIDE (SANDOSTATIN) 0.2 mg/ML VIAL	PA required	Required diagnosis = Acromegaly; Carcinoid tumors; Vasoactive intestinal peptide tumors (VIPomas):
OCTREOTIDE (SANDOSTATIN) 0.5 mg/ML AMPULE	PA required	Required diagnosis = Acromegaly; Carcinoid tumors; Vasoactive intestinal peptide tumors (VIPomas):
OCTREOTIDE (SANDOSTATIN) 1 mg/ML VIAL	PA required	Required diagnosis = Acromegaly; Carcinoid tumors; Vasoactive intestinal peptide tumors (VIPomas):
OCUCOAT (CELLUGEL) 2% INTRAOCULAR SOLUTION	Non-Preferred	Formulary Agent(s): Goniovisc (Gonak) 2.5% Drops
ODACTRA SL TABLET	Non-preferred	Request Must Go Through Clinical Review
ODOMZO 200MG CAPSULE	Non-Preferred	Request Must Go Through Clinical Review
OFEV 100MG CAPSULE	PA required	Request Must Go Through Clinical Review
OFEV 150MG CAPSULE	PA required	Request Must Go Through Clinical Review
OFORTA 10 mg TABLET	PA required	This medication has been discontinued-No longer available
OLANZAPINE ODT (ZYPREXA ZYDIS) 10 mg TABLET	Non-Preferred	Formulary Agent: Olanzapine (Zyprexa) Tablet
OLANZAPINE ODT (ZYPREXA ZYDIS) 15 mg TABLET	Non-Preferred	Formulary Agent: Olanzapine (Zyprexa) Tablet
OLANZAPINE ODT (ZYPREXA ZYDIS) 20 mg TABLET	Non-Preferred	Formulary Agent: Olanzapine (Zyprexa) Tablet
OLANZAPINE ODT (ZYPREXA ZYDIS) 5 mg TABLET	Non-Preferred	Formulary Agent: Olanzapine (Zyprexa) Tablet
OLANZAPINE/FLUOXETINE (SYMBYAX) 12-25 mg CAPSULE	Non-Preferred	Formulary Agent: fluoxetine/olanzapine(Zyprexa) separately taken together
OLANZAPINE/FLUOXETINE (SYMBYAX) 12-50 mg CAPSULE	Non-Preferred	Formulary Agent: fluoxetine/olanzapine(Zyprexa) separately taken together
OLANZAPINE/FLUOXETINE (SYMBYAX) 3-25 mg CAPSULE	Non-Preferred	Formulary Agent: fluoxetine/olanzapine(Zyprexa) separately taken together
OLANZAPINE/FLUOXETINE (SYMBYAX) 6-25 mg CAPSULE	Non-Preferred	Formulary Agent: fluoxetine/olanzapine(Zyprexa) separately taken together
OLANZAPINE/FLUOXETINE (SYMBYAX) 6-50 mg CAPSULE	Non-Preferred	Formulary Agent: fluoxetine/olanzapine(Zyprexa) separately taken together
OLEPTRO ER 150 mg TABLET	Non-Preferred	This medication has been discontinued
OLEPTRO ER 300 mg TABLET	Non-Preferred	This medication has been discontinued
Olopatadine (Pataday) 0.2% Eye Drops	Non-Preferred	Formulary Agents: OTC Agents With Ketotifen AND Azelastine (Optivar)
Olopatadine (Patanase) 0.6% Nasal Spray	Non-Preferred	Formulary Agent(s): Azelastine (Astelin)
Olopatadine (Patanol) 0.1% Drops	Non-Preferred	Formulary Agent(s): OTC Drops With Ketotifen AND Azelastine (Optivar)
OLYSIO 150 mg CAPSULE	Non-Preferred	Request Must Go Through Clinical Review

Drug	Status	Special Instructions
OMECLAMOX-PAK COMBO PACK	Non-Preferred	Formulary Agents: AMOXICILLIN CAP, CLARITHROMYCIN TAB AND OMEPRAZOLE capsule separately
OMEPRAZOLE-BICARB (Zegerid RX) 20-1,100 mg	Non-Preferred	Formulary Agent: omeprazole-sodium bicarb (OTC) 20/1100 mg
OMEPRAZOLE-BICARB (Zegerid RX) 40-1,100 mg	Non-Preferred	Formulary Agents: omeprazole-sodium bicarb (OTC) 20/1100 mg AND omeprazole 20 mg SEPARATELY taken together
Omeprazole-Sodium Bicarbonate (Zegerid) 20 mg-1,680 mg Powder Packets	Non-Preferred	A 30 Day Trial Of: Omeprazole Capsules Or First-Omeprazole 2 mg/mL Suspension AND Lansoprazole Capsule Or First-Lansoprazole 3 mg/mL Suspension
Omeprazole-Sodium Bicarbonate (Zegerid) 40 mg-1,680 mg Powder Packets	Non-Preferred	A 30 Day Trial Of: Omeprazole Capsules Or First-Omeprazole 2 mg/mL Suspension AND Lansoprazole Capsule Or First-Lansoprazole 3 mg/mL Suspension
OMNARIS 50 mcg NASAL SPRAY	Non-Preferred	Formulary Agent(s): Ages 2-3: Nasacort OTC Allergy 24HR Spray OR Ages 4-5: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 And Older: 2 Of The Following 4 Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray
Omnitrope 10 mg/1.5 mL Cartridge	Specialty	Specialty; follow policy on CareSource.com.
Omnitrope 5.8 mg Vial	Specialty	Specialty; follow policy on CareSource.com.
Omnitrope 5 mg/1.5 mL Cartridge	Specialty	Specialty; follow policy on CareSource.com.
Ondansetron 4 mg/2 mL Vial	Medical Benefit	Bill Through Medical Benefit
ONETOUCH AND ONETOUCH ULTRA TEST STRIPS/METER	Non-Preferred	Formulary Agents: FreeStyle or Precision products
ONEXTON 1.2-3.75% GEL PUMP	Non-Preferred	*Formulary Agent(s): Benzoyl Peroxide 5% Gel (Panoxyl) With Clindamycin, Clindamax (Cleocin T) 1% Lotion, Clindamycin Swab (Cleocin T) 1% Pledgets, Clindamycin Phosphate 1% Solution Separately Used Together At The Same Time
ONFI 10 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or zonisamide or previously approved for Lyrica, Vimpat, Stavzor, Banzel or Potiga
ONFI 2.5 mg/ML SUSPENSION	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or zonisamide or previously approved for Lyrica, Vimpat, Stavzor, Banzel or Potiga

Drug	Status	Special Instructions
ONFI 20 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or zonisamide or previously approved for Lyrica, Vimpat, Stavzor, Banzel or Potiga
ONFI 5 mg TABLET	Step Therapy	Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or zonisamide or previously approved for Lyrica, Vimpat, Stavzor, Banzel or Potiga
ONGLYZA 2.5 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
ONGLYZA 5 mg TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
ONIVYDE 43MG/10ML VIAL	Non-Preferred	Request Must Go Through Clinical Review
ONMEL 200 mg TABLET	Non-Preferred	Formulary Agent: itraconazole (Sporanox) capsule with a diagnosis of onychomycosis
Onzetra Xsail 11 mg Nasal Powder	Non-Preferred	Age 18 And Older AND A Trial Of At Least 2 Of The Following 3 Drugs: Sumatriptan Tablets, Injection Or Nasal Spray, Naratriptan, Almotriptan, Or Rizatriptan
OPANA ER 10 mg CRUSH RESISTANT TABLET	Non-Preferred	Formulary Agent: OXYMORPHONE SR (OPANA ER) non-crush resistant (which requires a trial of morphine sulfate ER (MS Contin))
OPANA ER 15 mg CRUSH RESISTANT TABLET	Non-Preferred	Formulary Agent: OXYMORPHONE SR (OPANA ER) non-crush resistant (which requires a trial of morphine sulfate ER (MS Contin))
OPANA ER 20 mg CRUSH RESISTANT TABLET	Non-Preferred	Formulary Agent: OXYMORPHONE SR (OPANA ER) non-crush resistant (which requires a trial of morphine sulfate ER (MS Contin))
OPANA ER 30 mg CRUSH RESISTANT TABLET	Non-Preferred	Formulary Agent: OXYMORPHONE SR (OPANA ER) non-crush resistant (which requires a trial of morphine sulfate ER (MS Contin))
OPANA ER 40 mg CRUSH RESISTANT TABLET	Non-Preferred	Formulary Agent: OXYMORPHONE SR (OPANA ER) non-crush resistant (which requires a trial of morphine sulfate ER (MS Contin))
OPANA ER 5 mg CRUSH RESISTANT TABLET	Non-Preferred	Formulary Agent: OXYMORPHONE SR (OPANA ER) non-crush resistant (which requires a trial of morphine sulfate ER (MS Contin))
OPANA ER 7.5 mg CRUSH RESISTANT TABLET	Non-Preferred	Formulary Agent: OXYMORPHONE SR (OPANA ER) non-crush resistant (which requires a trial of morphine sulfate ER (MS Contin))
Opdivo 40mg/4mL Vial	Non-Preferred	Request Must Go Through Clinical Review
Opdivo 100mg/10mL Vial	Non-Preferred	Request Must Go Through Clinical Review
Opium Tincture 10 mg/mL	Non-Preferred	Formulary Agent(s): 7 Day Trial Of Atropine-Diphenoxylate (Lomotil) Or Dicyclomine (Bentyl) WITH A Diagnosis Of Severe-Diarrhea or IBS (Irritable Bowel Syndrome)

Drug	Status	Special Instructions
OPSUMIT 10 mg TABLET	PA required	Required diagnosis = Pulmonary Arterial Hypertension, Age over 18 yrs old, prescribed by pulmonologist and/or cardiologist, WHO Group 1 with NYHA Functional class II or III or IV symptoms AND PAP pressures not adequately controlled using an oral vasodilator (e.g. calcium channel blocker) at maximal doses OR The member was not vasodilator sensitive as determined by a epoprostenol, adenosine, or inhaled nitric oxide challenge
Oralair Children's Starter Pack 100IR Sublingual Tablet	Non-Preferred	*Dx= Need For Skin Test Or In Vitro Testing For Pollen-Specific IgE Antibodies For Any Of The Five Grass Species And *Formulary Agent(s): Oralair 300IR Sublingual Tablet
Oralair 300IR Sublingual Tablet	Non-Preferred	*Dx= Need For Skin Test Or In Vitro Testing For Pollen-Specific IgE Antibodies For Any Of The Five Grass Species
ORAPRED ODT 10 mg TABLET	Non-Preferred	Formulary Agents: prednisone tablet or liquid or methylprednisolone tablet
ORAPRED ODT 15 mg TABLET	Non-Preferred	Formulary Agents: prednisone tablet or liquid or methylprednisolone tablet
ORAPRED ODT 30 mg TABLET	Non-Preferred	Formulary Agents: prednisone tablet or liquid or methylprednisolone tablet
ORAVIG 50 mg BUCCAL TABLET	Non-Preferred	Formulary Agents: oral nystatin tablet or suspension
ORBACTIVE 400MG VIAL	Medical Benefit	Bill through Medical Benefit
ORBIVAN 50-300-40 mg CAPSULE	Non-Preferred	Formulary Agent: Butalbital-Acetaminophen-Caffeine (Fioricet) 50-325-40mg Tablet
ORBIVAN CF 50-300 mg TABLET	Non-Preferred	Formulary Agent: BUTALBITAL-ACETAMINOPHEN (Phrenilin, Marten tablet) 50-325 MG tablet
Orencia ClickJect 125 mg/mL Auto-Injector	Specialty	Please see the state specific Pharmacy Policy Statement titled Orencia by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
Orencia 125 mg/mL Syringe	Specialty	Please see the state specific Pharmacy Policy Statement titled Orencia by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
Orencia 250 mg Vial	Specialty	Please see the state specific Pharmacy Policy Statement titled Orencia by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
ORENITRAM ER 0.125MG TABLET	Specialty	Specialty; follow policy on CareSource.com.
ORENITRAM ER 0.125MG TABLET	Specialty	Specialty; follow policy on CareSource.com.
ORENITRAM ER 0.125MG TABLET	Specialty	Specialty; follow policy on CareSource.com.
ORENITRAM ER 0.125MG TABLET	Specialty	Specialty; follow policy on CareSource.com.
ORFADIN 2 mg CAPSULE	PA required	Required diagnosis =Hereditary tyrosinemia type 1 (HT-1)
ORFADIN 5 mg CAPSULE	PA required	Required diagnosis =Hereditary tyrosinemia type 1 (HT-1)
ORFADIN 10 mg CAPSULE	PA required	Required diagnosis =Hereditary tyrosinemia type 1 (HT-1)
ORFADIN 20 mg CAPSULE	PA required	Required diagnosis =Hereditary tyrosinemia type 1 (HT-1)

Drug	Status	Special Instructions
ORKAMBI 100MG-125MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
ORKAMBI 200MG-125MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
ORLISTAT, ALLI, XENICAL	Excluded benefit	
ORPHENADINRE 30 mg/ML VIAL	Non-Preferred	Requires diagnosis of acute painful musculoskeletal conditions with an inability to use tablet
ORPHENADRINE COMPOUND FORTE TABLET 50-770-60	Non-Preferred	Formulary Agents: cyclobenzaprine, baclofen, methocarbamol, or tizanidine (carisoprodol- accepted trial not preferred agent)
ORPHENADRINE COMPOUND TABLET 25-385-30	Non-Preferred	Formulary Agents: cyclobenzaprine, baclofen, methocarbamol, or tizanidine (carisoprodol- accepted trial not preferred agent)
ORTHOVISC	Non-Preferred	Specialty; follow policy on CareSource.com. Formulary Agents: Supartz or Gel-One
OSMOPREP, VISICOL 1.5 mg TABLET	Non-Preferred	Formulary agents: Gavilyte-H or Peg-Prep Kit
OSPHENA 60 mg TABLET	Excluded benefit	
Otovel 0.3-0.025% Otic Solution	Non-Preferred	Required Diagnosis= Otitis Media With Tympanostomy Tubes Prescribed By An ENT And A Trial And Failure Of One Of The Following: Ciprodex Or Ofloxacin
OTOZIN OTIC SOLUTION 5.4-1-2-1%	Lower Cost	One time trial of: Antipyrine-Benzocaine, AuroDex, AuroGuard 5.4-1.4% otic solution
OVIDREL INJECTION 250 mcg/0.5 mL	Excluded benefit	
OXANDROLONE 10 mg TABLET	PA required	Requires diagnosis = Bone pain with osteoporosis, protein catabolism, or need for weight gain with a trial of megestrol
OXANDROLONE 2.5 mg TABLET	PA required	Requires diagnosis = Bone pain with osteoporosis, protein catabolism, or need for weight gain with a trial of megestrol
OXAYDO 5MG TABLET	Non-Preferred	Formulary Agent(s): Oxycodone IR Tablet
OXAYDO 7.5MG TABLET	Non-Preferred	Formulary Agent(s): Oxycodone IR Tablet
OXECTA 5 mg TABLET	Non-Preferred	Formulary Agent: oxycodone IR tablet
OXECTA 7.5 mg TABLET	Non-Preferred	Formulary Agent: oxycodone IR tablet
Oxiconazole Nitrate (Oxistat) 1% Cream	Non-Preferred	Required Diagnosis= Tinea Pedis, Tinea Cruris, Tinea Corporis, Or Tinea (Pityriasis) Versicolor AND Formulary Agent(s): Ketoconazole Cream, Clotrimazole Cream, Or Miconazole Cream
OXISTAT 1% LOTION	Non-Preferred	Formulary Agents: ketoconazole cream, clotrimazole cream, or miconazole cream with a diagnosis of tinea pedis, tinea cruris, tinea corporis, or tinea (pityriasis) versicolor
OXSORALEN 1% LOTION	PA required	Excluded for cosmetic use
OXSORALEN-ULTRA (methoxsalen) 10 mg CAPSULE	Non-Preferred	Formulary Agent: calcipotriene (Dovonex) with a diagnosis of psoriasis
OXTELLAR XR 150 mg TABLET	Step Therapy	Must first try non-SR oxcarbazepine (Trileptal)
OXTELLAR XR 300 mg TABLET	Step Therapy	Must first try non-SR oxcarbazepine (Trileptal)
OXTELLAR XR 600 mg TABLET	Step Therapy	Must first try non-SR oxcarbazepine (Trileptal)
OTEZLA 30MG TABLET	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Otezla by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/

Drug	Status	Special Instructions
OTEZLA STARTER PACK	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Otezla by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
OTREXUP 10 MG/0.4 ML AUTO	Non-Preferred	Formulary Agent: METHOTREXATE INJECTION
OTREXUP 15 MG/0.4 ML AUTO	Non-Preferred	Formulary Agent: METHOTREXATE INJECTION
OTREXUP 20 MG/0.4 ML AUTO	Non-Preferred	Formulary Agent: METHOTREXATE INJECTION
OTREXUP 25 MG/0.4 ML AUTO	Non-Preferred	Formulary Agent: METHOTREXATE INJECTION
OVACE PLUS 9.8% LOTION	Non-Preferred	Required trial of: sulfacetamide sodium (Klarion) 10% lotion
OVACE PLUS 10% CREAM	Non-Preferred	Required trial of: sulfacetamide sodium (Klarion) 10% lotion
OXYCODONE ER (OXYCONTIN) 10MG TABLET	PA required	Requires a diagnosis of pain with a 30 day trial of: Fenantyl Patches (Which Also Requires A PA), Morphine Sulfate ER (MS Contin) (Which Also Requires A PA) or Oxymorphone ER
OXYCODONE ER (OXYCONTIN) 15MG TABLET	PA required	Requires a diagnosis of pain with a 30 day trial of: Fenantyl Patches (Which Also Requires A PA), Morphine Sulfate ER (MS Contin) (Which Also Requires A PA) or Oxymorphone ER
OXYCODONE ER (OXYCONTIN) 20MG TABLET	PA required	Requires a diagnosis of pain with a 30 day trial of: Fenantyl Patches (Which Also Requires A PA), Morphine Sulfate ER (MS Contin) (Which Also Requires A PA) or Oxymorphone ER
OXYCODONE ER (OXYCONTIN) 30MG TABLET	PA required	Requires a diagnosis of pain with a 30 day trial of: Fenantyl Patches (Which Also Requires A PA), Morphine Sulfate ER (MS Contin) (Which Also Requires A PA) or Oxymorphone ER
OXYCODONE ER (OXYCONTIN) 40MG TABLET	PA required	Requires a diagnosis of pain with a 30 day trial of: Fenantyl Patches (Which Also Requires A PA), Morphine Sulfate ER (MS Contin) (Which Also Requires A PA) or Oxymorphone ER
OXYCODONE ER (OXYCONTIN) 60MG TABLET	PA required	Requires a diagnosis of pain with a 30 day trial of: Fenantyl Patches (Which Also Requires A PA), Morphine Sulfate ER (MS Contin) (Which Also Requires A PA) or Oxymorphone ER
OXYCODONE ER (OXYCONTIN) 80MG TABLET	PA required	Requires a diagnosis of pain with a 30 day trial of: Fenantyl Patches (Which Also Requires A PA), Morphine Sulfate ER (MS Contin) (Which Also Requires A PA) or Oxymorphone ER
OXYCODONE-IBUPROFEN 5-400 TABLET	Non-Preferred	Formulary Agent: oxycodone/acetaminophen or fentanyl
OXYMORPHONE IR (OPANA) 10 mg TABLET	Non-Preferred	Formulary Agent: morphine sulfate IR
OXYMORPHONE IR (OPANA) 5 mg TABLET	Non-Preferred	Formulary Agent: morphine sulfate IR

Drug	Status	Special Instructions
OXYMORPHONE SR 5 mg (OPANA ER) TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
OXYMORPHONE SR 7.5 mg (OPANA ER) TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
OXYMORPHONE SR 10 mg (OPANA ER) TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
OXYMORPHONE SR 15 mg (OPANA ER) TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
OXYMORPHONE SR 20 mg (OPANA ER) TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
OXYMORPHONE SR 30 mg (OPANA ER) TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change

Drug	Status	Special Instructions
OXYMORPHONE SR 40 mg (OPANA ER) TABLET	PA required	*Member is 18 years or older AND *Required Diagnosis = cancer related pain, sickle cell disease, terminally ill, or hospice OR *Member is 18 years or older AND *Diagnosis = chronic non-cancer related pain AND - Prescribed by pain management specialist - Documented inadequate response to immediate release opioid therapy (examples = hydrocodone/acetaminophen, oxycodone/acetaminophen, oxycodone, etc.) with use of IR opioid in last 30 days supported by pharmacy claims - No claims for buprenorphine-naloxone, buprenorphine, naloxone, or naltrexone in the past 12 months - Information on how strength/dose/frequency of immediate release opioid will change
OXYTROL 3.9 mg/24HR PATCH	Non-Preferred	Formulary Agents: OXYBUTYNIN, OXYBUTYNIN ER, TOLTERODINE, TROSPIUM, or TROSPIUM SR for men; Oxytrol for Women patch for women
Ozurdex 0.7mg Implant	Non-Preferred	Request Must Go Through Clinical Review
PACERONE 100 mg TABLET	Non-Preferred	Formulary Agent: amiodarone 200 MG or 400 MG TABLET
PACNEX 7% WASH	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
PACNEX HP 7% CLEANSING PADS	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
PACNEX LP 4.25% CLEANSING PADS	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
PACNEX MX 4.25% CLEANSER	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE 2.5% WASH or GEL (PANOXYL), BENZOYL PEROXIDE 4% CLEANSER (PANOXYL), BENZOYL PEROXIDE 5% GEL (PANOXYL), BENZOYL PEROXIDE 5% LOTION, BENZOYL PEROXIDE 3%, 6%, 9% CLEANSER (TRIZ), BENZOYL PEROXIDE 10% Wash (DESQUAM-X/PANOXYL), BENZOYL PEROXIDE 10% GEL (PANOXYL), BENZOYL PEROXIDE 10% LOTION, BENZOYL PEROXIDE-ERYTHROMYCIN (BENZAMYCIN) 5-3% GEL
PAIN EASE (GEBAUERS) SPRAY	PA required	Required diagnosis=Controlling pain associated with injections and certain other procedures such as dialysis

Drug	Status	Special Instructions
PAIRE OB PLUS DHA COMBO PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PALIPERIDONE ER (INVEGA ER) 1.5MG TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
PALIPERIDONE ER (INVEGA ER) 3MG TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
PALIPERIDONE ER (INVEGA ER) 6MG TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
PALIPERIDONE ER (INVEGA ER) 9MG TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
PANCREAZE 10,500 UNIT CAPSULE	Non-Preferred	Formulary Agents: VIOKACE, Zenpep or ULTRESA
PANCREAZE 16,800 UNIT CAPSULE	Non-Preferred	Formulary Agents: VIOKACE, Zenpep or ULTRESA
PANCREAZE 21,000 UNIT CAPSULE	Non-Preferred	Formulary Agents: VIOKACE, Zenpep or ULTRESA
PANCREAZE 4,200 UNIT CAPSULE	Non-Preferred	Formulary Agents: VIOKACE, Zenpep or ULTRESA
PANCREAZE 2,600 UNIT CAPSULE	Non-Preferred	Formulary Agents: VIOKACE, Zenpep or ULTRESA
PANDEL 0.1% CREAM	Non-Preferred	Formulary Agent: hydrocortisone topical
PANRETIN 0.1% GEL	PA required	Required diagnosis = Kaposi sarcoma (KS) cutaneous lesions
Pantoprazole (Protonix) 40 mg Vial	Medical Benefit	Bill Through Medical Benefit
PAREGORIC 2 mg/5 mL LIQUID	Non-Preferred	Formulary Agents: imodium or loperamide
PAROMOMYCIN 250 mg CAPSULE	Non-Preferred	Required Diagnosis = intestinal amebiasis OR Diagnosis = hepatic coma/encephalopathy
PAROXETINE MESYLATE (BRISDELLE) 7.5 mg CAPSULE	Lower Cost	Formulary Agent(s): paroxetine IR
PAROXETINE CR (PAXIL CR) 12.5 mg TABLET	Non-Preferred	Formulary Agents: non- CR paroxetine
PAROXETINE CR (PAXIL CR) 25 mg TABLET	Non-Preferred	Formulary Agents: non- CR paroxetine
PAROXETINE CR (PAXIL CR) 37.5 mg TABLET	Non-Preferred	Formulary Agents: non- CR paroxetine
PASER GRANULES 4 gM PACKET	Non-Preferred	Formulary Agent: rifampin
PAZEO 0.7% EYE DROPS	Non-Preferred	* 15 day trial of OTC Ketotifen (Alaway/Claritin Eye Drops/Refresh/RiteAid or CVS Eye Itch Eye Drops (Zaditor)/Wal-Zyr/Zyrtec Eye Drops) AND * 15 day trial of azelastine (Optivar)
PCE 333 mg DISPERTABLET	Non-Preferred	Formulary Agent: erythromycin tabs
PCE 500 mg DISPERTABLET	Non-Preferred	Formulary Agent: erythromycin tabs

Drug	Status	Special Instructions
PEDIADERM AF KIT	Non-Preferred	Formulary Agents used separately: hydrocortisone 2% lotion and an emollient lotion or ointment (Cerave; Cetaphil; Aveeno; Lubriderm, Eucerin)
PEDIADERM HC 2% KIT	Non-Preferred	Formulary Agents used separately: hydrocortisone 2% lotion and an emollient lotion or ointment (Cerave; Cetaphil; Aveeno; Lubriderm, Eucerin)
PEDIADERM TA KIT	Non-Preferred	Formulary Agents used separately: hydrocortisone 2% lotion and an emollient lotion or ointment (Cerave; Cetaphil; Aveeno; Lubriderm, Eucerin)
PEDIA-LAX SUP 2.8 gM	Non-Preferred	Formulary Agents: GLYCERIN PED SUP 1.2 gM or GLYCERIN SUPPOS 2.1 GM
PEDIPIROX-4 NAIL KIT	Non-Preferred	Formulary Agents: CICLOPIROX (Penlac, Ciclodan) 8% SOLUTION AND vitamin E separately
PEG 3350 , GAVILYTE-C (COLYTE) WITH FLAVOR PACKETS 4000 mL 240-22.72	Non-Preferred	Formulary Agents: PEG-3350, GAVILYTE-G (GOLYTELY)
PEGASYS 135 mcg/0.5 mL PROCLICK	PA required	Request Must Go Through Clinical Review
PEGASYS 180 mcg/0.5 mL KIT	PA required	Request Must Go Through Clinical Review
PEGASYS 180 mcg/0.5 mL PROCLICK	PA required	Request Must Go Through Clinical Review
PEGASYS 180 mcg/0.5 mL SYRINGE	PA required	Request Must Go Through Clinical Review
PEGASYS 180 mcg/ML VIAL	PA required	Request Must Go Through Clinical Review
PegIntron 50 mcg/0.5 mL Subcutaneous Kit	PA required	Request Must Go Through Clinical Review
PENNSAID SOLUTION 2% PUMP	Non-Preferred	*Formulary Agent(s): Voltaren 1% Gel
PENTASA 250MG CAPSULE	Non-Preferred	*Required Diagnosis = Crohn's Disease Of The Small Intestine AND *Formulary Agent(s): Mesalamine (Asacol HD), Delzicol Or Apriso ER
PENTASA 500MG CAPSULE	Non-Preferred	*Required Diagnosis = Crohn's Disease Of The Small Intestine AND *Formulary Agent(s): Mesalamine (Asacol HD), Delzicol Or Apriso ER
PENTAZOCINE-ACETAMINOPHEN 25-650 mg	Non-Preferred	Formulary Agent: ACETAMINOPHEN-CODEINE
Perforomist 20mcg/2mL Solution	Non-Preferred	Formulary Agent(s): Arcapta Neohaler
Perindopril Erbumine 2 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary ACE Inhibitor (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Quinapril, Ramipril, Trandolapril)
Perindopril Erbumine 4 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary ACE Inhibitor (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Quinapril, Ramipril, Trandolapril)
Perindopril Erbumine 8 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary ACE Inhibitor (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Quinapril, Ramipril, Trandolapril)
Perjeta 420 mg/14 mL Vial	Medical Benefit	Bill Through Medical Benefit

Drug	Status	Special Instructions
Perlane, Perlane-L, Restylane, Restylane-L Gel For Injection	Excluded Benefit	
PERTZYE 4000-14375-15125 Units	Non-Preferred	Formulary agents: Viokace, Zenpep or Ultresa
PERTZYE 8000-28750-30250 Units	Non-Preferred	Formulary Agents: Viokace, Zenpep or Ultresa
PERTZYE 16000-57500-60500 Units	Non-Preferred	Formulary Agents: Viokace, Zenpep or Ultresa
PEXEVA 10 mg TABLET	Non-Preferred	Formulary Agent: non- CR paroxetine
PEXEVA 20 mg TABLET	Non-Preferred	Formulary Agent: non- CR paroxetine
PEXEVA 30 mg TABLET	Non-Preferred	Formulary Agent: non- CR paroxetine
PEXEVA 40 mg TABLET	Non-Preferred	Formulary Agent: non- CR paroxetine
PHENDIMETRAZINE (BONTRIL PDM) 35 mg TABLET	Excluded benefit	
PHENDIMETRAZINE ER 105 mg TABLET	Excluded benefit	
PHENELZINE SULFATE (NARDIL) 15 mg TABLET	Non-Preferred	Formulary Agent: Parnate
PHENOXYBENZAMINE HYDROCHLORIDE (DIBENZYLINE) 10MG CAPSULE	Non-Preferred	Required Dx= Pheochromocytoma
PHENTERMINE (ADIPEX-P) 37.5 mg CAPSULE	Excluded benefit	
PHENTERMINE (ADIPEX-P) 37.5 mg TABLET	Excluded benefit	
PHENTERMINE 15 mg CAPSULE	Excluded benefit	
PHENTERMINE 30 mg CAPSULE	Excluded benefit	
Phenylephrine Eye Drops	Non-Preferred	Formulary Agent(s): Any Formulary Mydriatic: Atropine, Cyclopntolate, Homatropine, Tropicamide (Eye Formulations), Naphazoline 0.1%
PHISOHEX 3% CLEANSER	Non-Preferred	Formulary Agents: CHLORHEXIDINE GLUCONATE, BETASEPT (HIBICLENS) LIQUID 4% OTC
PHOSLYRA 667 mg/5 mL SOLUTION	Non-Preferred	Formulary Agent: calcium acetate (PhosLo)
Phospholine Iodide 0.125% Drops	Non-Preferred	Required Diagnosis Of Glaucoma AND Formulary Agent(s): Pilocarpine Eye Drop
PHRENILIN FORTE CAPSULE 50-650 mg	Non-Preferred	Formulary Agents: BUTALBITAL-ACETAMINOPHEN (Phrenilin, Marten tabs) 50-325 mg tablet
PICATO 0.015% Gel	Non-Preferred	Formulary Agents: FLUOROURACIL (EFUDEX) 5% CREAM with a diagnosis of actinic keratoses
PICATO 0.05% Gel	Non-Preferred	Formulary Agents: FLUOROURACIL (EFUDEX) 5% CREAM with a diagnosis of actinic keratoses
PILOPINE HS 4% EYE GEL	Non-Preferred	Formulary Agent: PILOCARPINE 4% EYE DROPS
PINNACAINE 20% OTIC DROPS	Non-Preferred	Formulary Agent: antipyrine-Benzocaine (AURODEX) OTIC SOLUTION

Drug	Status	Special Instructions
PIOGLITAZONE-GLIMEPIRIDE (DUETACT) 30-2 mg TABLET	Step Therapy	Requires a 30 day trial of metformin IR or ER (Glucophage or Glucophage XR) unless renal/kidney disease/Increased Creatinine OR HbA1c (Hemaglobin A1c) with a value greater than 7.5% from within the last 30 days
PIOGLITAZONE-GLIMEPIRIDE (DUETACT) 30-4 mg TABLET	Step Therapy	Requires a 30 day trial of metformin IR or ER (Glucophage or Glucophage XR) unless renal/kidney disease/Increased Creatinine OR HbA1c (Hemaglobin A1c) with a value greater than 7.5% from within the last 30 days
Piperacillin-Tazobactam (Zosyn) 3-0.375 G Vial	Medical Benefit	Bill Through Medical Benefit
Piperacillin-Tazobactam (Zosyn) 4-0.5 G Vial	Medical Benefit	Bill Through Medical Benefit
Piperacillin-Tazobactam (Zosyn) 36-4.5 G Vial	Medical Benefit	Bill Through Medical Benefit
Piroxicam Capsule	Non-Preferred	Formulary Agent(s): Any Two Formulary NSAIDs (Ibuprofen, Naproxen, Diclofenac, Diflunisal, Etodolac, Flurbiprofen, Indomethacin, Ketoprofen, Ketorolac, Meloxicam, Nabumetone, Oxaprozin, Sulindac)
Plegridy 63 & 94 mcg/0.5 mL Pen Injector	Non-Preferred	Specialty; Request Must Go Through Clinical Review
Plegridy 125 mcg/0.5 mL Pen Injector	Non-Preferred	Specialty; Request Must Go Through Clinical Review
Plegridy 63 & 94 mcg/0.5 mL Syringe	Non-Preferred	Specialty; Request Must Go Through Clinical Review
Plegridy 125 mcg /0.5 mL Syringe	Non-Preferred	Specialty; Request Must Go Through Clinical Review
PLEXION CLEANSING CLOTHS	Non-Preferred	Formulary Agent(s): Avar-E LS 10-2% cream, Sulfacetamide Sodium w/ Sulfur Suspension 10-5%, Sulfacetamide Sodium w/ Sulfur lotion 10-5%, Or Sulfacetamide Sodium w/ Sulfur emulsion, Avar cleanser, Rosanil, Prascion 10-5%
PNV-DHA PLUS SOFTGEL 27-1.13 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PNV-DHA PLUS SOFTGEL 27-400-1	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PNV-DHA PLUS SOFTGEL 27 mg-400	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PNV Fe Fum/docusate	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PNV-IRON TABLET 29-1.13 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PNV-IRON TABLET 29-400-1	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PODIAPN CAPSULE	Non-Preferred	Formulary Agents: METHYLFOL/ME, VITACIRC-B, FOLTANX, or L-METHYL-B6 TABLET
POLY IRON PN FORTE TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin

Drug	Status	Special Instructions
POLYGAM S/D	PA required	Specialty; follow policy on CareSource.com.
Poly-Tussin AC 10-4-10 mg/5 mL Liquid	Non-Preferred	Formulary Agent(s): Dimaphen Elixir
Poly-Vi-Flor FS 0.25MG Film	Non-Preferred	*30 Day Trial Of: Multi-Vit/Fluor, Poly-Vit-Fluor 0.25mg/mL Drops
Poly-Vi-Flor FS 0.5MG Film	Non-Preferred	*30 Day Trial Of: Multi-Vit/Fluor, Poly-Vit-Fluor 0.25mg/mL Drops
Poly-Vi-Flor FS 1MG Film	Non-Preferred	*30 Day Trial Of: Multi-Vit/Fluor, Poly-Vit-Fluor 0.25mg/mL Drops
POLY-VI-FLOR 0.25MG CHEWABLE TABLET	Non-Preferred	Formulary agent: Multivit-Fluor 0.25MG tablet
POLY-VI-FLOR 0.5MG CHEWABLE TABLET	Non-Preferred	Formulary agent: Multivit-Fluor 0.5MG tablet
POLY-VI-FLOR 1MG CHEWABLE TABLET	Non-Preferred	Formulary agent: Multivit-Fluor 1MG tablet
POLY-VI-FLOR W/ IRON 0.5-10MG CHEWABLE TABLET	Non-Preferred	*Required trial of: ESCAVITE , MULTI-VIT/FLUOR/FE (IRON), POLY-VIT/FLUOR/FE (IRON) 0.25MG-10MG/ML
POLY-VI-FLOR/IRON 0.25-7 mg/ML SUSPENSION	Non-Preferred	Formulary Agents: MULTI-VIT/FE/FL 0.25-10 mg/ML DROPS, POLYVITS/FE, ESCAVITE
POMALYST 1 mg CAPSULE	PA required	Request Must Go Through Clinical Review
POMALYST 2 mg CAPSULE	PA required	Request Must Go Through Clinical Review
POMALYST 3 mg CAPSULE	PA required	Request Must Go Through Clinical Review
POMALYST 4 mg CAPSULE	PA required	Request Must Go Through Clinical Review
Portrazza 800mg/50mL IV Solution	Non-Preferred	Required Diagnosis= Metastatic Squamous Non-Small Cell Lung Cancer (NSCLC) AND MD Specialty= Oncology
POTABLETA 500 mg	Excluded benefit	
POTASSIUM CL 25 MEQ TABLET EFFERVESCENT	Non-Preferred	Formulary Agent: a formulary potassium supplement
Potassium CL 10% Vial	Medical Benefit	Bill Through Medical Benefit
Potassium CL 20% Vial	Medical Benefit	Bill Through Medical Benefit
POTIGA 200 mg	PA required	Requires diagnosis of Partial-onset seizures in adults and currently on at least one other anti-epileptic (gabapentin, lamotrigine, divalproex (Depakote), levetiracetam (Keppra), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide) or Previously approved for Lyrica, Aptiom, Fycompa, Vimpat, Onfi or Banzel
POTIGA 300 mg	PA required	Requires diagnosis of Partial-onset seizures in adults and currently on at least one other anti-epileptic (gabapentin, lamotrigine, divalproex (Depakote), levetiracetam (Keppra), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide) or Previously approved for Lyrica, Aptiom, Fycompa, Vimpat, Onfi or Banzel

Drug	Status	Special Instructions
POTIGA 400 mg	PA required	Requires diagnosis of Partial-onset seizures in adults and currently on at least one other anti-epileptic (gabapentin, lamotrigine, divalproex (Depakote), levetiracetam (Keppra), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide) or Previously approved for Lyrica, Aptiom, Fycompa, Vimpat, Onfi or Banzel
POTIGA 50 mg	PA required	Requires diagnosis of Partial-onset seizures in adults and currently on at least one other anti-epileptic (gabapentin, lamotrigine, divalproex (Depakote), levetiracetam (Keppra), oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide) or Previously approved for Lyrica, Aptiom, Fycompa, Vimpat, Onfi or Banzel
PR NATAL 400 COMBO PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PR NATAL 400 EC COMBO PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PR NATAL 430 EC COMBO PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PRADAXA 75 MG CAPSULE	Non-Preferred	Requires A 30 Day Trial Of Eliquis tablet or Xarelto tablet
PRADAXA 110 MG CAPSULE	Non-Preferred	Requires A 30 Day Trial Of Eliquis tablet or Xarelto tablet
PRADAXA 150 MG CAPSULE	Non-Preferred	Requires A 30 Day Trial Of Eliquis tablet or Xarelto tablet
PRALUENT 75MG/ML PEN-INJECTOR	Non-Preferred	Specialty; Request Must Go Through Clinical Review
PRALUENT 150MG/ML PEN-INJECTOR	Non-Preferred	Specialty; Request Must Go Through Clinical Review
PRALUENT 75MG/ML SYRINGE	Non-Preferred	Specialty; Request Must Go Through Clinical Review
PRALUENT 150MG/ML SYRINGE	Non-Preferred	Specialty; Request Must Go Through Clinical Review
Pramipexole ER (Mirapex ER) 0.375mg Tablet	Non-Preferred	Formulary Agent(s): Non-ER Pramipexole
Pramipexole ER (Mirapex ER) 0.75mg Tablet	Non-Preferred	Formulary Agent(s): Non-ER Pramipexole
Pramipexole ER (Mirapex ER) 1.5mg Tablet	Non-Preferred	Formulary Agent(s): Non-ER Pramipexole
Pramipexole ER (Mirapex ER) 2.25mg Tablet	Non-Preferred	Formulary Agent(s): Non-ER Pramipexole
Pramipexole ER (Mirapex ER) 3mg Tablet	Non-Preferred	Formulary Agent(s): Non-ER Pramipexole
Pramipexole ER (Mirapex ER) 4.5mg Tablet	Non-Preferred	Formulary Agent(s): Non-ER Pramipexole
Pramosone 1%-1% Cream	Non-Preferred	A 30 Day Trial Of: Hydrocortisone 2.5% (Lotion, Cream Or Ointment) AND Pramoxine HCl 1% (Lotion Or Cream) Separately Used Together At The Same Time
Pramosone 2.5%-1% Lotion	Non-Preferred	A 30 Day Trial Of: Hydrocortisone 2.5% Lotion AND Pramoxine HCl 1% Lotion Separately Used Together At The Same Time
Pramosone E 1-2.5% Cream	Non-Preferred	A 30 Day Trial Of: Hydrocortisone 2.5% Lotion AND Pramoxine HCl 1% Lotion Separately Used Together At The Same Time

Drug	Status	Special Instructions
PRASCION FC PAD 10-5% CLOTH	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
PRASCION RA CREAM 10%-5%	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
PREDNISOLONE SOLUTION 10 mg/5 mL	Lower Cost	A 30 Day Trial Of: Prednisolone solution 5 mg/5 mL or 15 mg/5 mL
PREDNISOLONE SOLUTION 20 mg/5 mL	Lower Cost	A 30 Day Trial Of: Prednisolone solution 5 mg/5 mL or 15 mg/5 mL
PREDNISOLONE SOLUTION 25 mg/5 mL	Lower Cost	A 30 Day Trial Of: Prednisolone solution 5 mg/5 mL or 15 mg/5 mL
PREFERA OB TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PREFERA-OB ONE SOFTGEL	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PREFERA-OB PLUS DHA COMBO Pack 22-6-1-200	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PREFERA-OB PLUS DHA COMBO Pack 28-6-1-203	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PREGNITUDE 200-2,000MG POWDER PACK	Excluded benefit	
PRENACARE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PRENAFIRST	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PRENAISSANCE PLUS, MACNATAL CN DHA 28-1-250 mg CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Prenaissance Balance, VP-CH PNV 30-1-50 mg Capsule	Lower Cost	Formulary Agent(s): Any Formulary Prenatal Vitamin
PRENATAL-1 30-975-200MG CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PRENEXA CAPSULE 26-1.2-55	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PRENEXA, VEMAVITE, PNV-DHA, FOLCAL DHA CAPSULE 27-1.25-55-300 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PREPOPIK PAK	Non-Preferred	*Required trial within the last 30 days of: Gavilyte-H or Peg-Prep Kit
PREQUE 10 TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PRESTALIA 3.5 - 2.5 mg TABLET	Non-Preferred	Requires a diagnosis of: hypertension AND a 30-day trial of = amlodipine and perindopril taken separately OR amlodipine/benazepril
PRESTALIA 7 -0.5 mg TABLET	Non-Preferred	Requires a diagnosis of: hypertension AND a 30-day trial of = amlodipine and perindopril taken separately OR amlodipine/benazepril
PRESTALIA 14 - 10 mg TABLET	Non-Preferred	Requires a diagnosis of: hypertension AND a 30-day trial of = amlodipine and perindopril taken separately OR amlodipine/benazepril

Drug	Status	Special Instructions
PREVACID SOLUTAB 15 mg TABLET	Non-Preferred	Formulary Agent(s): Lansoprazole Capsules Or First Lansoprazole 3 mg/mL Suspension
PREVACID SOLUTAB 30 mg TABLET	Non-Preferred	Formulary Agent(s): Lansoprazole Capsules Or First Lansoprazole 3 mg/mL Suspension
Prialt 25 mcg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Prialt 100 mcg/mL Vial	Medical Benefit	Bill Through Medical Benefit
PRIFTIN 150 mg TABLET	PA required	Required diagnosis=pulmonary tuberculosis
Prilosec DR Powder Packets	Non-Preferred	Formulary Agent(s): Any Formulary PPI (Omeprazole RX Or OTC, Pantoprazole, Nexium OTC, Lansoprazole OTC) AND First-Omeprazole
PRIMLEV 10-300 mg TABLET	Non-Preferred	Formulary Agent: oxycodone with acetaminophen 10/325 mg
PRIMLEV 5-300 mg TABLET	Non-Preferred	Formulary Agent: oxycodone with acetaminophen 5/325 mg
PRIMLEV 7.5-300 mg TABLET	Non-Preferred	Formulary Agent: oxycodone with acetaminophen 7.5/325 mg
PRIMSOL 50 mg/5 mL ORAL SOLUTION	Non-Preferred	Formulary Agent: trimethoprim tablet
PRISTIQ 25MG TABLET	Non-Preferred	For Ages 8-11: Formulary Agent(s)= Fluoxetine For Ages 12-17: Formulary Agents(s)= Fluoxetine Or Escitalopram For Ages 18+: Formulary Agent(s)= Trials Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)
PRISTIQ 100 mg TABLET	Non-Preferred	For Ages 8-11: Formulary Agent(s)= Fluoxetine For Ages 12-17: Formulary Agents(s)= Fluoxetine Or Escitalopram For Ages 18+: Formulary Agent(s)= Trials Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)
PRISTIQ 50 mg TABLET	Non-Preferred	For Ages 8-11: Formulary Agent(s)= Fluoxetine For Ages 12-17: Formulary Agents(s)= Fluoxetine Or Escitalopram For Ages 18+: Formulary Agent(s)= Trials Each Of 2 Of The 3 Following Preferred Formulary Groups (One Of Which Must Have Occurred Within The Last Year) -Group-1: Generic SSRI (Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) -Group-2: Generic SNRI (Venlafaxine Tablet, Venlafaxine ER Capsule Or Duloxetine (Cymbalta); -Group-3: Bupropion XL Or SR (Wellbutrin SR Or XL)

Drug	Status	Special Instructions
PRIVIGEN 10% VIAL	PA required	Specialty; follow policy on CareSource.com.
PROAIR HFA 90MCG INHALER (8.5GM)	Non-Preferred	Formulary Agent: Ventolin Inhaler
PROAIR 90MCG RESPICLICK	Non-Preferred	Formulary Agent(s): Ventolin HFA Inhaler
Probuphine Implant	Medical Benefit	Bill Through Medical Benefit
Prochlorperazine 5 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
PROCORT CREAM 1.85-1.15%	Non-Preferred	Formulary Agents: PRAMOXINE AEROSOL 1% (Proctofoam) with Procto-Pak (PROCTOCORT) 1% CREAM separately
PROCRIT 10,000 UNITS/ML (20,000 UNITS/2 mL) VIAL	PA required	Specialty; follow policy on CareSource.com.
PROCRIT 10,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
PROCRIT 2,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
PROCRIT 20,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
PROCRIT 3,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
PROCRIT 4,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
PROCRIT 40,000 UNITS/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
PROCTOCORT 1% CREAM	Non-Preferred	Formulary Agents: 2 different manufacturers of generic Procto-Pak (PROCTOCORT) 1% CREAM
PROCTOFOAM AREOSOL HC 1-1% FOAM	Non-Preferred	Required diagnosis=Relief of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses with a trial of HYDROCORTISONE Acetate 1%/Pramoxine Hydrochloride 1% (ANALPRAM-HC) CREAM
PROCYSBI 25 mg CAPSULE	Non-Preferred	Required diagnosis=nephropathic cystinosis
PROCYSBI 75 mg CAPSULE	Non-Preferred	Required diagnosis=nephropathic cystinosis
PRODIGY METER	Non-Preferred	Formulary Agents: FreeStyle or Precision products
PRODIGY NO CODE TEST STRIPS	Non-Preferred	Formulary Agents: FreeStyle or Precision products
PRODIGY TEST STRIPS	Non-Preferred	Formulary Agents: FreeStyle or Precision products
PROFILNINE SD 1,000 UNITS VIAL	Specialty	Specialty; follow policy on CareSource.com.
PROFILNINE SD 1,500 UNITS VIAL	Specialty	Specialty; follow policy on CareSource.com.

Drug	Status	Special Instructions
PROFILNINE SD 500 UNITS VIAL	Specialty	Specialty; follow policy on CareSource.com.
Progesterone 50 mg/mL Vial	Non-Preferred	Formulary Agent(s): Progesterone Capsule OR Progesterone Vaginal Suppositories
PROGLYCEM 50 mg/ML ORAL SUSPENSION	Specialty	Required diagnosis=hypoglycemia due to extenuating circumstances
PROLASTIN 1000 mg Alpha 1-proteinase inhibitor INJECTION	Specialty	Specialty; follow policy on CareSource.com.
PROLASTIN 500 mg Alpha 1-proteinase inhibitor INJECTION	Specialty	Specialty; follow policy on CareSource.com.
PROLASTIN-C 1000 mg Alpha 1-proteinase inhibitor INJECTION	Specialty	Specialty; follow policy on CareSource.com.
PROLENSA 0.07% ophthalmic SOLUTION	Non-Preferred	Formulary Agent: DICLOFENAC (VOLTAREN) 0.1% EYE DROPS
PROLIA	Specialty	Specialty; follow policy on CareSource.com.
Promacta 12.5mg Tablet	PA required	Request Must Go Through Clinical Review
Promacta 25mg Tablet	PA required	Request Must Go Through Clinical Review
Promacta 50mg Tablet	PA required	Request Must Go Through Clinical Review
Promacta 75mg Tablet	PA required	Request Must Go Through Clinical Review
Promethazine 25 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Propantheline Tablet	Non-Preferred	Required Diagnosis Of Peptic Ulcer
PROPARACAINE 0.5% EYE DROPS	Non-Preferred	Formulary Agent: tetracain
Propranolol-HCTZ 40-25 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Beta-Blocker/Diuretic Combination (Atenolol/Chlorthalidone, Bisoprolol/Hydrochlorothiazide, Metoprolol/Hydrochlorothiazide)
Propranolol-HCTZ 80-25 mg Tablet	Non-Preferred	Formulary Agent(s): Any Formulary Beta-Blocker/Diuretic Combination (Atenolol/Chlorthalidone, Bisoprolol/Hydrochlorothiazide, Metoprolol/Hydrochlorothiazide)
PROQUIN XR 500 mg TABLET	Non-Preferred	Formulary Agents: ciprofloxacin or levofloxacin
Prosol 20% IV Solution	Medical Benefit	Bill Through Medical Benefit
PROTONIX PAK 40 mg SUSPENSION PACKET	Non-Preferred	Formulary Agents: omeprazole 40 mg daily or 20 mg twice a day or First-Omeprazole suspension, AND lansoprazole 30 mg or First-Lansoprazole suspension
ProvayBlue 1% injection solution	Blank	No alternative treatment. Medical benefit ONLY.
PROVENTIL HFA 90 mcg INHALER	Non-Preferred	Formulary Agent: Ventolin

Drug	Status	Special Instructions
PROVIDA DHA 32-1.25MG CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
PRUMYX CREAM	Non-Preferred	Formulary Agents:Cerave; Cetaphil; Aveeno; Lubriderm (Eucerin)
Prutect Emulsion	Non-Preferred	Formulary Agent(s): Woun'Dres Wound Dressing
PULMICORT 180 mcg FLEXHALER	Non-Preferred	Required 30 day trial of either: Aerospan or Asmanex
PULMICORT 90 mcg FLEXHALER	Non-Preferred	Required 30 day trial of either: Aerospan or Asmanex
PULMOZYME 1 mg/ mL Ampule	Clinical	See State Specific Policy Cystic Fibrosis at (https://www.caresource.com/providers/policies/)
PV Vitamin D 400 Unit tablet	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Purixan 2,000 mg/100 mL Oral Suspension	Non-Preferred	Required Diagnosis = Acute lymphoblastic leukemia
PYLERA CAPSULE	Non-Preferred	Will currently approve for a diagnosis of H. Pylori due to tetracycline's unavailability
PYRIDOXINE 100 MG/ML INJECTION	Medical Benefit	Bill through Medical Benefit
Qbrelis 1 mg/mL Solution	Non-Preferred	Ages 6-17: Required Diagnosis= Hypertension AND Formulary Agent(s): Lisinopril Oral Tablet OR Ages 18 And Older: Required Diagnosis= Hypertension, Heart Failure, Or Post Myocardial Infarction AND Formulary Agent(s): Lisinopril Oral Tablet
QNASL CHILDREN 40MCG SPRAY	Non-Preferred	Formulary Agent(s): Ages 2-3: Nasacort OTC Allergy 24HR Spray OR Ages 4-5: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 And Older: 2 Of The Following 4 Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray
QNASL 80 mcg SPRAY	Non-Preferred	Formulary Agent(s): Ages 2-3: Nasacort OTC Allergy 24HR Spray OR Ages 4-5: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 And Older: 2 Of The Following 4 Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray
QSYMIA 11.25-69 mg TABLET	Excluded benefit	
QSYMIA 15-92 mg TABLET	Excluded benefit	
QSYMIA 3.75-23 mg TABLET	Excluded benefit	
QSYMIA 7.5-46 mg TABLET	Excluded benefit	
QSYMIA CAPSULE 11.25-69 mg	Excluded benefit	
QSYMIA CAPSULE 15-92 mg	Excluded benefit	
QSYMIA CAPSULE 3.75-23 mg	Excluded benefit	
QSYMIA CAPSULE 7.5-46 mg	Excluded benefit	

Drug	Status	Special Instructions
QTERN TABLET 10-5 mg	Lower Cost	Formulary Agents: 30 Day Trial Of Metformin Or Allergy, Intolerance, Or Side Effect To Metformin and 60 Day Trial Of Invokana (30 Day For KY) THEN 30 Day Trial Of 10 mg Farxiga
QUAZEPAM (DORAL) 15 mg TABLET	Non-Preferred	Formulary Agents: zolpidem or zaleplon
QUFLORA 0.25MG DROPS	Non-Preferred	Formulary Agents: Multi-Vit/Flur 0.25MG/ML Drops, Poly-Vit/Flur 0.25MG/ML Drops
QUFLORA 0.5MG DROPS	Non-Preferred	Formulary Agents: Multi-Vit/Flur 0.25MG/ML Drops, Poly-Vit/Flur 0.25MG/ML Drops
Quillichew ER 20 mg Chewable Tablet	Non-Preferred	Required Diagnosis: *ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome *Age Under 6 - Off Label (Need Clinical Info To Support Use) And 30 Day Trial Of Any Combo Of: Dextroamphetamine, Dextroamphetamine ER (Dexedrine), Amphetamine Salt Combo (Adderall), Dextroamphetamine-Amphetamine ER (Adderall XR) OR *Age 6 and older *A 30 day Trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA) Note: capsules can be opened and sprinkled on a small amount of food
Quillichew ER 30 mg Chewable Tablet	Non-Preferred	Required Diagnosis: *ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome *Age Under 6 - Off Label (Need Clinical Info To Support Use) And 30 Day Trial Of Any Combo Of: Dextroamphetamine, Dextroamphetamine ER (Dexedrine), Amphetamine Salt Combo (Adderall), Dextroamphetamine-Amphetamine ER (Adderall XR) OR *Age 6 and older *A 30 day Trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA) Note: capsules can be opened and sprinkled on a small amount of food
Quillichew ER 40 mg Chewable Tablet	Non-Preferred	Required Diagnosis: *ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome *Age Under 6 - Off Label (Need Clinical Info To Support Use) And 30 Day Trial Of Any Combo Of: Dextroamphetamine, Dextroamphetamine ER (Dexedrine), Amphetamine Salt Combo (Adderall), Dextroamphetamine-Amphetamine ER (Adderall XR) OR *Age 6 and older *A 30 day Trial of: Methylphenidate ER tablet (Concerta), Methylphenidate CD capsule (Metadate CD), Methylphenidate SR capsule (Ritalin LA) Note: capsules can be opened and sprinkled on a small amount of food

Drug	Status	Special Instructions
Quillivant XR 25 mg/5 mL Suspension	Non-Preferred	Required Diagnosis: ADD/ADHD; Autism; Asperger's; Hyperkinetic Syndrome *Age Under 6 - Off Label (Need Clinical Info To Support Use) And 30 Day Trial Of Any Combo Of: Dextroamphetamine, Dextroamphetamine ER (Dexedrine), Amphetamine Salt Combo (Adderall), Dextroamphetamine-Amphetamine ER (Adderall XR) OR *Age 6 And Older 30 day trial of: Methylphenidate ER Tablet (Concerta), Methylphenidate CD Capsule (Metadate CD), Methylphenidate SR Capsule (Ritalin LA)
Quinidine Gluconate ER 324 mg Tablet	Non-Preferred	Required Diagnosis Of A Life-Threatening Arrhythmia (Atrial Fibrillation, Atrial Flutter, Ventricular Arrhythmias)
QUINIDINE SULFATE 200 mg TABLET	Non-Preferred	Required Diagnosis = life-threatening arrhythmia (atrial fibrillation, atrial flutter, suppression of ventricular arrhythmias)
QUINIDINE SULFATE 300 mg TABLET	Non-Preferred	Required Diagnosis = life-threatening arrhythmia (atrial fibrillation, atrial flutter, suppression of ventricular arrhythmias)
QUINIDINE SULF ER 300 mg TABLET	Non-Preferred	Lower Cost options: non-ER quinidine
QUININE (QUALAQUIN) 324 mg CAPSULE	Non-Preferred	Formulary Agent: mefloquine with a diagnosis of malaria OR Formulary Agents: ropinirole or pramipexole with a diagnosis of Restless Leg Syndrome
QUIXIN SOLUTION 0.5%	Non-Preferred	Formulary Agent: LEVOFLOXACIN 0.5% EYE DROPS
QVAR 40MCG HFA	Non-Preferred	Formulary Agents: Aerospan 80mcg Inhaler or Asmanex 110mcg or 220mcg Twisthaler *Members 8 y/o and younger will not require a PA*
QVAR 80MCG HFA	Non-Preferred	Formulary Agents: Aerospan 80mcg Inhaler or Asmanex 110mcg or 220mcg Twisthaler *Members 8 y/o and younger will not require a PA*
RABAVERT INJECTION (RABIES VACCINE)	Medical Benefit	Bill through Medical Benefit
RABEPRAZOLE (ACIPHEX EC) 20 mg TABLET	Non-Preferred	*A 30 Day Trial Each Within ALL Pharmacy Claims Of 2 Of The Following 4 Formulary Options: Esomeprazole (Nexium Or Nexium 20 mg OTC), Pantoprazole 40 mg, Lansoprazole 30 mg, Omeprazole 40 mg (Or 20mg BID)
RADICAVA	Lower Cost	Specialty; follow policy on CareSource.com.
RAGWITEK	PA required	Required diagnosis=ragweed pollen-induced allergic rhinitis
RAPAFLO 4 mg CAPSULE	Non-Preferred	Formulary Agents: tamsulosin, doxazosin, terazosin, or prazosin
RAPAFLO 8 mg CAPSULE	Non-Preferred	Formulary Agents: tamsulosin, doxazosin, terazosin, or prazosin
RAPIVAB 200MG/ML INJECTION	Non-Preferred	Required diagnosis: Treatment of acute, uncomplicated influenza in adults who have been symptomatic 2 days or less
Rasagiline (AZILECT) 0.5 mg TABLET	Non-Preferred	Formulary Agents: bromocriptine, amantadine, carbidopa/levodopa, pramipexole, ropinirole, selegiline
Rasagiline (AZILECT) 1 mg TABLET	Non-Preferred	Formulary Agents: bromocriptine, amantadine, carbidopa/levodopa, pramipexole, ropinirole, selegiline

Drug	Status	Special Instructions
RASUVO 7.5MG/0.15ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 10MG/0.2ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 12.5MG/0.25ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 15MG/0.3ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 17.5MG/0.35ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 20MG/0.4ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 22.5MG/0.45ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 25MG/0.5ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 27.5MG/0.55ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RASUVO 30MG/0.6ML AUTO INJECTOR	Non-Preferred	Requires a diagnosis of: RA, pJIA or psoriasis and a trial of: methotrexate injection
RAVICTI 1.1 GM/ML	Non-Preferred	*Required Diagnosis= Urea Cycle Disorders AND *Formulary Agent(s): Buphenyl 500mg Tablet Or Powder
RAYALDEE 30 MCG CAPSULE	Non-Preferred	Required diagnosis: Secondary hyperparathyroidism with stage 3 or 4 kidney disease AND Member is 18 years or older AND Meets ALL the following lab value criteria: - Total serum 25-hydroxyvitamin D level less than 30ng/mL - Serum corrected calcium less than 9.8 mg/mL AND Requires a 30 day trial (each) of at least 2 of the following alternative vitamin D analogs: - calcitriol (Rocaltrol) - doxercalciferol (Hectorol) - paricalcitol (Zemplar) For Re-Auths: Required diagnosis: Secondary hyperparathyroidism with stage 3 or 4 kidney disease AND Clinical documentation showing a biological response as indicated by the following: Total serum 25-hydroxyvitamin D level increased from baseline (initial authorization) but less than 100ng/mL
RAYOS 1 mg TABLET	Non-Preferred	Formulary Agent: prednisone tablets
RAYOS 2 mg TABLET	Non-Preferred	Formulary Agent: prednisone tablets
RAYOS 5 mg TABLET	Non-Preferred	Formulary Agent: prednisone tablets
REBETOL 40MG/ML SOLUTION	PA required	Request Must Go Through Clinical Review

Drug	Status	Special Instructions
Rebif 22 mcg/0.5 mL Prefilled Syringe	PA required	Specialty; Request Must Go Through Clinical Review
Rebif 44 mcg/0.5 mL Prefilled Syringe	PA required	Specialty; Request Must Go Through Clinical Review
Rebif Titration Pack	PA required	Specialty; Request Must Go Through Clinical Review
REBIF REBIDOSE 22 mcg/0.5 mL SYRINGE	PA required	Specialty; Request Must Go Through Clinical Review
REBIF REBIDOSE 44 mcg/0.5 mL SYRINGE	PA required	Specialty; Request Must Go Through Clinical Review
REBIF Rebidose TITRATION PACK	PA required	Specialty; Request Must Go Through Clinical Review
RECTIV 0.4% RECTAL OINTMENT	Non-Preferred	Required diagnosis= anal fissures
REGENECARE 2% WOUND GEL	Non-Preferred	Formulary Agent: lidocaine
REGIMEX 25 mg TABLET	Excluded benefit	
REGRANEX 0.01% GEL	PA required	Required diagnosis = Diabetic neuropathic ulcers
RELEEVIA MC 0.0375-5% PATCH	Non-Preferred	*30 day trial of: lidocaine (Lidoderm) 5% patch
RELEEVIA ML 4-1% PATCH	Non-Preferred	*30 day trial of: lidocaine (Lidoderm) 5% patch
Relistor 12 mg/0.6 mL Kit	Non-Preferred	Required Diagnosis= Opioid-Induced Constipation AND A 7 Day Trial Of Lactulose Within The Last 30 Days
Relistor 8 mg/0.4 mL Syringe	Non-Preferred	Required Diagnosis= Opioid-Induced Constipation AND A 7 Day Trial Of Lactulose Within The Last 30 Days
Relistor 12 mg/0.6 mL Syringe	Non-Preferred	Required Diagnosis= Opioid-Induced Constipation AND A 7 Day Trial Of Lactulose Within The Last 30 Days
Relistor Tablet 150mg	Non-Preferred	Required Diagnosis= Opioid-Induced Constipation AND A 7 Day Trial Of Lactulose Within The Last 30 Days
Relistor 12 mg/0.6 mL Vial	Non-Preferred	Required Diagnosis= Opioid-Induced Constipation AND A 7 Day Trial Of Lactulose Within The Last 30 Days
Relizorb Device	Medical Benefit	Bill through Medical Benefit
RELYYT 0.025-5% PATCH	Non-Preferred	*30 day trial of: lidocaine (Lidoderm) 5% patch
Remicade 100 mg Vial	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Remicade by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
REMODULIN 10 mg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
REMODULIN 1 mg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
REMODULIN 2.5 mg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
REMODULIN 5 mg/ML VIAL	PA required	Specialty; follow policy on CareSource.com.
RENACIDIN IRRIGATION SOLUTION	Non-Preferred	Required diagnosis = the need for dissolution of renal calculi
RENAGEL 400 mg TABLET	Non-Preferred	Formulary Agent: calcium acetate (PhosLo)

Drug	Status	Special Instructions
RENAGEL 800 mg TABLET	Non-Preferred	Formulary Agent: calcium acetate (PhosLo)
RENAX CAPELET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
Renova 0.02% Cream	Excluded benefit	
Renova 0.02% Cream Pump	Excluded benefit	
RENOVO 0.0375-5% PATCH	Non-Preferred	*30 day trial of: lidocaine (Lidoderm) 5% patch
RENVELA 0.8G POWDER PACKET	Step Therapy	Requires trial of: calcium acetate (PhosLo)
RENVELA 2.4G POWDER PACKET	Step Therapy	Requires trial of: calcium acetate (PhosLo)
RENVELA 800MG TABLET	Non-Preferred	Required Diagnosis= Reduction Or Control Of Serum Phosphorous In Patients With CKD On Dialysis AND Formulary Agent(s): Calcium Acetate (PhosLo)
Repaglinide-Metformin (Prandimet) 1-500mg Tablet	Non-Preferred	Formulary Agents: metformin IR or ER (Glucophage or Glucophage XR) unless HbA1c (Hemaglobin A1c) with a value greater than 7.5% from within the last 30 days
Repaglinide-Metformin (Prandimet) 2-500mg Tablet	Non-Preferred	Formulary Agents: metformin IR or ER (Glucophage or Glucophage XR) unless HbA1c (Hemaglobin A1c) with a value greater than 7.5% from within the last 30 days
REPATHA PUSHTRONEX SYSTEM 420 mg/ 3.5 mL	Specialty	Specialty; Request Must Go Through Clinical Review
REPATHA 140MG/ML SURECLICK	Specialty	Specialty; Request Must Go Through Clinical Review
REPATHA 140MG/ML Syringe	Specialty	Specialty; Request Must Go Through Clinical Review
REPLESTA 14,000UNIT WAFER	Non-Preferred	Formulary Agent: OTC Vitamin D3 10,000 unit product
REPLESTA 50,000UNIT WAFER	Non-Preferred	Formulary Agent: VITAMIN D2, ERGOCALCIFEROL (DRISDOL) 1.25 mg (50,000 UNIT) CAPSULE or OTC Vitamin D3 50,000 unit product
REPLESTA NX 14,000UNIT WAFER	Non-Preferred	Formulary Agent: OTC Vitamin D3 10,000 unit product
REPRONEX INJECTION 75UNIT	Excluded Benefit	
RESCULA 0.15% ophthalmic SOLUTION	Non-Preferred	Formulary Agents: Latanoprost (XALATAN) 0.005% EYE DROPS AND TIMOLOL (TIMOPTIC) or TIMOLOL (TIMOPTIC-XE)
RESPAIRE-30 CAPSULE	Non-Preferred	Formulary Agents: OTC pseudoephedrine/guaifenesin combos
RESTASIS 0.05% EYE EMULSION	Non-Preferred	Formulary Agents: OTC artificial tears
RETISERT 0.59MG IMPANT	Non-Preferred	Required diagnosis = Chronic non-infectious uveitis affecting the posterior segment of the eye
REVATIO 10MG/ML SUSPENSION	Specialty	Specialty; follow policy on CareSource.com.
REVATIO 10 mg/12.5 mL VIAL	Specialty	Specialty; follow policy on CareSource.com.
REVLIMID 20 mg CAPSULE	PA required	Request Must Go Through Clinical Review
REVLIMID 10 mg CAPSULE	PA required	Request Must Go Through Clinical Review
REVLIMID 15 mg CAPSULE	PA required	Request Must Go Through Clinical Review

Drug	Status	Special Instructions
REVLIMID 2.5 mg CAPSULE	PA required	Request Must Go Through Clinical Review
REVLIMID 25 mg CAPSULE	PA required	Request Must Go Through Clinical Review
REVLIMID 5 mg CAPSULE	PA required	Request Must Go Through Clinical Review
REXULTI 0.25MG TABLET	Non-Preferred	Requires A Diagnosis Of Schizophrenia With A Trial Of Aripiprazole (Abilify) For Major Depressive Disorder, In Addition To The Above, Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion
REXULTI 0.5MG TABLET	Non-Preferred	Requires A Diagnosis Of Schizophrenia With A Trial Of Aripiprazole (Abilify) For Major Depressive Disorder, In Addition To The Above, Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion
REXULTI 1MG TABLET	Non-Preferred	Requires A Diagnosis Of Schizophrenia With A Trial Of Aripiprazole (Abilify) For Major Depressive Disorder, In Addition To The Above, Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion
REXULTI 2MG TABLET	Non-Preferred	Requires A Diagnosis Of Schizophrenia With A Trial Of Aripiprazole (Abilify) For Major Depressive Disorder, In Addition To The Above, Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion
REXULTI 3MG TABLET	Non-Preferred	Requires A Diagnosis Of Schizophrenia With A Trial Of Aripiprazole (Abilify) For Major Depressive Disorder, In Addition To The Above, Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion
REXULTI 4MG TABLET	Non-Preferred	Requires A Diagnosis Of Schizophrenia With A Trial Of Aripiprazole (Abilify) For Major Depressive Disorder, In Addition To The Above, Concurrent Therapy With Formulary Anti-Depressants (i.e., Escitalopram, Citalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline, Venlafaxine Tablet, Venlafaxine ER Capsule, Duloxetine Or Bupropion
REYATAZ 50MG POWDER PACKET	Non-Preferred	Formulary Agent(s): Reyataz capsule
REZIRA SOLUTION	Non-Preferred	Formulary Agent: CHERATUSSIN DAC SYRUP
RHEUMATREX 2.5 mg TABLET	Non-Preferred	Formulary Agent: METHOTREXATE 2.5 mg TABLET
RHINARIS NASAL GEL 0.2%	Non-Preferred	Formulary Agent: SALINE NASAL GEL

Drug	Status	Special Instructions
BUDESONIDE (RHINOCORT) AQUA NASAL SPRAY	Non-Preferred	Formulary Agents: Age 2-3: 30 day trial of triamcinolone (Nasacort AQ) Age 4-5: 30 day trial of fluticasone (Flonase) or triamcinolone (Nasacort AQ) Age 6 and older: 30 day trial of 2 of the following 3 drugs: fluticasone (Flonase), flunisolide, or triamcinolone (Nasacort AQ)
RIBAPAK 200-400MG DOSEPACK	Non-Preferred	Request Must Go Through Clinical Review
RIBAPAK 400-400MG DOSEPACK	Non-Preferred	Request Must Go Through Clinical Review
RIBAPAK 400-600MG DOSEPACK	Non-Preferred	Request Must Go Through Clinical Review
RIBAPAK 600-600MG DOSEPACK	Non-Preferred	Request Must Go Through Clinical Review
RIBASPHERE 400MG TABLET	PA required	Request Must Go Through Clinical Review
RIBASPHERE 600MG TABLET	PA required	Request Must Go Through Clinical Review
RIBAVIRIN 200MG CAPSULE	PA required	Request Must Go Through Clinical Review
RIBAVIRIN 200MG TABLET	PA required	Request Must Go Through Clinical Review
RIFAMATE CAPSULE 300-150 mg	Non-Preferred	Formulary Agents: separately rifampin and isoniazid
Rifampin 600 mg Vial	Medical Benefit	Bill Through Medical Benefit
RIFATER TABLET 120-50-300	Non-Preferred	Formulary Agents: separately rifampin and isoniazid and pyrazinamide
RILUZOLE (RILUTEK) 50 mg TABLET	PA required	Required diagnosis = Amyotrophic lateral sclerosis
RIOMET 500 mg/5 mL LIQUID	Non-Preferred	Required diagnosis=diabetes with metformin ER
RISAMINE (CALMOSEPTINE) 0.44-20.625% OINTMENT	Non-Preferred	Formulary Agent: ZINC OXIDE OINT 20%
RISEDRONATE SODIUM (ATELVIA) DR 35 mg TABLET	Non-Preferred	Formulary agent: alendronate
RITALIN LA 10MG CAPSULE	Non-Preferred	Formulary Agent(s): Methylphenidate CD (Metadate CD) 10 mg Or 60 mg
RITALIN LA 60MG CAPSULE	Non-Preferred	Formulary Agent(s): Methylphenidate CD (Metadate CD) 10 mg Or 60 mg
RITUXAN 10 mg/ML	PA required	Specialty; follow policy on CareSource.com.
RIVASTIGMINE (EXELON) 13.3 mg/24HR PATCH	Non-Preferred	Required trial : RIVASTIGMINE (Exelon) CAPSULE
RIVASTIGMINE (EXELON) 4.6 mg/24HR PATCH	Non-Preferred	Required trial : RIVASTIGMINE (Exelon) CAPSULE
RIVASTIGMINE (EXELON) 9.5 mg/24HR PATCH	Non-Preferred	Required trial : RIVASTIGMINE (Exelon) CAPSULE
RIXUBIS VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)

Drug	Status	Special Instructions
ROBAFEN 15MG COUGH CAPSULE	Non-Preferred	Formulary Agent: Adult Robitussin Cough Syrup
ROBITUSSIN COUGH-COLD-FLU 6.25-2.5-160 mg/5 mL	Non-Preferred	Formulary Agent: ADT ROBITUSSIN COUGH-COLD D LIQUID
ROPINIROLE ER (REQUIP XL) 12 mg TABLET	Non-Preferred	Required Diagnosis= Parkinson's Disease AND Formulary Agent: Immediate Release Ropinirole
ROPINIROLE ER (REQUIP XL) 2 mg TABLET	Non-Preferred	Required Diagnosis= Parkinson's Disease AND Formulary Agent: Immediate Release Ropinirole
ROPINIROLE ER (REQUIP XL) 4 mg TABLET	Non-Preferred	Required Diagnosis= Parkinson's Disease AND Formulary Agent: Immediate Release Ropinirole
ROPINIROLE ER (REQUIP XL) 6 mg TABLET	Non-Preferred	Required Diagnosis= Parkinson's Disease AND Formulary Agent: Immediate Release Ropinirole
ROPINIROLE ER (REQUIP XL) 8 mg TABLET	Non-Preferred	Required Diagnosis= Parkinson's Disease AND Formulary Agent: Immediate Release Ropinirole
ROSADAN 0.75% KIT	Non-Preferred	Formulary Agents: metronidazole 0.75% topical lotion, cream, or gel
ROSANIL CLEANSER KIT 10-5%	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
ROSULA 10-4.5% WASH	Non-Preferred	*Formulary Agent(s): Avar-E LS 10-2% Cream, Sulfacetamide Sodium W/ Sulfur Suspension 10-5%, Sulfacetamide Sodium W/ Sulfur Lotion 10-5%, Or Sulfacetamide Sodium W/ Sulfur Emulsion, Avar Cleanser, Rosanil, Or Prascion 10-5%
ROVIN-A DHA 35 mg iron-1 mg-50 mg-300 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
ROVIN-NV DHA CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
ROXICET 5-500 CAPELET	Non-Preferred	Formulary Agent: oxycodone/acetaminophen tablet
RUBRACA 200 mg	Non-Preferred	Specialty; Request Must Go Through Clinical Review
RUBRACA 300 mg	Non-Preferred	Specialty; Request Must Go Through Clinical Review
ROZEREM 8 mg TABLET	Non-Preferred	Formulary Agents: zolpidem or zaleplon
Ruconest 2,100 Unit Vial	Non-Preferred	Specialty; Request Must Go Through Clinical Review
RYBIX ODT 50 mg TABLET	Non-Preferred	Formulary Agent: tramadol IR 50 mg
RYDAPT 25 mg TABLET	Lower Cost	Required Diagnosis=cute Myeloid Leukemia FLT3 mutation positive OR Aggressive Systemic Mastocystosis, Systemic Mastocystosis with associated Hematological Neoplasm, OR Mast Cell Leukemia
RYNATAN PEDIATRIC CHEWABLE 5 mg-4.5 mg	Non-Preferred	No longer available on the market
RYNATAN PEDIATRIC ORAL SUSPENSION 5-4.5 mg/5 mL	Non-Preferred	No longer available on the market
RYTARY 23.75-95MG CAPSULE	Non-Preferred	Required 90 day trial of: carbidopa/levodopa ER (Sinemet CR)
RYTARY 36.25-145MG CAPSULE	Non-Preferred	Required 90 day trial of: carbidopa/levodopa ER (Sinemet CR)
RYTARY 48.75-195MG CAPSULE	Non-Preferred	Required 90 day trial of: carbidopa/levodopa ER (Sinemet CR)
RYTARY 61.25-245MG CAPSULE	Non-Preferred	Required 90 day trial of: carbidopa/levodopa ER (Sinemet CR)

Drug	Status	Special Instructions
RYVENT 6MG	Lower Cost	Required Diagnosis=allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis, uncomplicated allergic skin manifestations of uticaria and angioedema; dermatographism; anaphylactic reactions adjunctive to epinephrine Formulary Agents: *KY = 30 day trial of carbinoxamine 4 mg (liquid, tablet or suspension)
RYZODEG 100 Unit/mL IV SOLUTION	Non-Preferred	Requires a *30 day trial of Basaglar or Tresiba AND 30 day trial of Novolog separately but at the same time (same 30 day consecutive period)
SABRIL 500 mg POWDER PACKET	Non-Preferred	Specialty; follow policy on CareSource.com.
SABRIL 500 mg TABLET	Non-Preferred	Specialty; follow policy on CareSource.com.
SAFYRAL TABLET	Non-Preferred	Formulary Agents: a formulary birth control option (most similar agents= Ocella, Zarah and folate separately)
SAIZEN 5 mg VIAL	Specialty	Specialty; follow policy on CareSource.com.
SAIZEN 8.8 mg CLICK	Specialty	Specialty; follow policy on CareSource.com.
SAIZEN 8.8 mg VIAL	Specialty	Specialty; follow policy on CareSource.com.
SALICYLIC ACID (SALVAX) 6% FOAM	Non-Preferred	Formulary Agents: OTC SALICYLIC ACID 6% CREAM, GEL, OR LOTION
SALICYLIC ACID 6% CREAM KIT	Non-Preferred	Formulary Agent: OTC SALICYLIC ACID 6% CREAM
SALICYLIC ACID 6% LOTION KIT	Non-Preferred	Formulary Agent: OTC SALICYLIC ACID 6% LOTION
SALICYLIC ACID WART REMOVER (VIRASAL) 26% LIQUID FILM	Non-Preferred	Formulary Agent(s): Salicylic Acid 17% Gel Or Liquid
SALICYLIC ACID WART REMOVER (VIRASAL) 27.5% LIQUID FILM	Non-Preferred	Formulary Agent(s): Salicylic Acid 17% Gel Or Liquid
SALIVAMAX 351 MG POWDER PACKET	Non-Preferred	Formulary Agent(s): Pilocarpine Tablet Or OTC Saliva Substitute (i.e., Salivasure, Salese (Numoisyn) Lozenges, Aquoral Aerosol Solution, Or Caphosol, Numoisyn, Biotene, Mouthkote, Moi-Stir Solution)
SALKERA 6% FOAM	Non-Preferred	Formulary Agents: OTC SALICYLIC ACID 6% CREAM, GEL, OR LOTION
SALSALATE 500 mg TABLET	Non-Preferred	Required Diagnosis = rhematoid arthritis or osteoarthritis
SALSALATE 750 mg TABLET	Non-Preferred	Required Diagnosis = rhematoid arthritis or osteoarthritis
SAMSCA 15 mg TABLET	PA required	Required diagnosis = Hypervolemic and euvolemic hyponatremia
SAMSCA 30 mg TABLET	PA required	Required diagnosis = Hypervolemic and euvolemic hyponatremia

Drug	Status	Special Instructions
SANCUSO 3.1 mg/24 HR PATCH	Non-Preferred	Formulary Agents: ondansetron, meclizine, promethazine, prochlorperazine, granisetron
SAPHRIS 2.5MG SUBLINGUAL TABLET	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
SAPHRIS 10 mg TABLET SUBLINGUAL	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
SAPHRIS 5 mg TABLET SUBLINGUAL	Step Therapy	Requires a diagnosis of Bipolar Disorder, Schizophrenia, or Autism with a trial of aripiprazole (Abilify)
SAVAYSA 15MG TABLET	Non-Preferred	Lower cost agents: Eliquis tablet, fondaparinux (Arixtra) syringe, or Xarelto tablet
SAVAYSA 30MG TABLET	Non-Preferred	Lower cost agents: Eliquis tablet, fondaparinux (Arixtra) syringe, or Xarelto tablet
SAVAYSA 60MG TABLET	Non-Preferred	Lower cost agents: Eliquis tablet, fondaparinux (Arixtra) syringe, or Xarelto tablet
SAVELLA 100 mg TABLET	Non-Preferred	Required diagnosis of fibromyalgia, And a 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule
SAVELLA 12.5 mg TABLET	Non-Preferred	Required diagnosis of fibromyalgia, And a 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule
SAVELLA 25 mg TABLET	Non-Preferred	Required diagnosis of fibromyalgia, And a 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule
SAVELLA 50 mg TABLET	Non-Preferred	Required diagnosis of fibromyalgia, And a 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule
SAVELLA TITRATION PACK	Non-Preferred	Required diagnosis of fibromyalgia, And a 30 day Trial of: gabapentin at accepted daily doses of 1200mg to 2400mg, amitriptyline, or duloxetine capsule
SAXENDA	Excluded benefit	Excluded benefit
SCALACORT (ALA SCALP) 2% LOTION	Non-Preferred	Formulary Agent: HYDROCORTISONE 2.5% LOTION
SCOPACE 0.4 mg TABLET	Non-Preferred	This medication has been discontinued-No longer available
Scopolamine (Transderm Scop)	Lower Cost	Required Diagnosis Of Prevention Of Nausea/Vomiting Associated With Motion Sickness Or From Anesthesia And Surgery
SCULPTRA 367.5MG INJECTION	Non-Preferred	Required diagnosis: Restoration and/or correction of the signs of facial fat loss (lipoatrophy) in HIV patients
SEA OMEGA + D SOFTGEL	Non-Preferred	Formulary Agent: OTC Fish Oil
SEA-OMEGA 30 CAPSULE	Non-Preferred	Formulary Agent: OTC Fish Oil
SEA-OMEGA 50 CAPSULE	Non-Preferred	Formulary Agent: OTC Fish Oil
SEASONALE 0.15-0.03 mg TABLET DAW	Non-Preferred	Formulary Agents: 2 different manufacturers of generic Quasense, Jolessa
SEASONIQUE 0.15-0.03-0.01 TABLET DAW	Non-Preferred	Formulary Agents: 2 different manufacturers of generic Camrese, Amethia
SE-CARE CHEWABLE TABLET 40-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
SE-CARE CONCEIVE TABLET 30 mg-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
SECONAL SODIUM 100 mg CAPSULE	Non-Preferred	Formulary Agent: phenobarbital

Drug	Status	Special Instructions
Seebri 15.6 mcg Neohaler	Non-Preferred	Required Diagnosis= COPD AND *Formulary Agent(s): Spiriva Respimat, Spiriva Handihaler, Or Tudorza
SELECT-OB+ PAK DHA 29-1-250 mg CHEWABLE TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
SELENIUM SULFIDE 2.25% SHAMPOO FOAM	Non-Preferred	Formulary Agent: SELENIUM SULFIDE (SELSUN) 2.5% LOTION/SHAMPOO
SELRX 2.3% SHAMPOO	Non-Preferred	Formulary agent: SELENIUM SULFIDE (SELSUN) 2.5% SHAMPOO
Selzentry 20 mg/mL Solution	Clinical	Requires A diagnosis Of: CCR5-tropicHIV-1 infection AND *CCR5-tropic virus verified by trophile or other validated assay for determining HIV tropism
SELZENTRY 150 MG TABLET	PA required	Requires A diagnosis Of: CCR5-tropicHIV-1 infection AND *CCR5-tropic virus verified by trophile or other validated assay for determining HIV tropism
SELZENTRY 300 MG TABLET	PA required	Requires A diagnosis Of: CCR5-tropicHIV-1 infection AND *CCR5-tropic virus verified by trophile or other validated assay for determining HIV tropism
Semprex-D 60-8 mg Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Antihistamine/Decongestant Combination (Cetirizine/Pseudoephedrine, Fexofenadine/Pseudoephedrine, Loratadine/Pseudoephedrine)
SENSIPAR 30 mg TABLET	PA required	Required diagnosis = Hypercalcemia in parathyroid carcinoma or Primary/Secondary (due to renal disease, kidney disease) Hyperparathyroidism
SENSIPAR 60 mg TABLET	PA required	Required diagnosis = Hypercalcemia in parathyroid carcinoma or Primary/Secondary (due to renal disease, kidney disease) Hyperparathyroidism
SENSIPAR 90 mg TABLET	PA required	Required diagnosis = Hypercalcemia in parathyroid carcinoma or Primary/Secondary (due to renal disease, kidney disease) Hyperparathyroidism
Sernivo 0.05% Spray	Non-Preferred	A 30 Day Trial Of: Betamethasone Valerate 0.1% Cream, Lotion, Or Ointment
SEROSTIM 4 mg VIAL	Specialty	Specialty; follow policy on CareSource.com.
SEROSTIM 5 mg VIAL	Specialty	Specialty; follow policy on CareSource.com.
SEROSTIM 6 mg VIAL	Specialty	Specialty; follow policy on CareSource.com.
SE-TAN DHA CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
SE-TAN PLUS CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
SETONET PRENATAL VITAMIN	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
SETONET-EC PRENATAL VITAMIN	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
SEVELAMER CARBONATE (RENVELA) 800MG TABLET	Lower Cost	Required Diagnosis= Reduction Or Control Of Serum Phosphorous In Patients With CKD On Dialysis AND Formulary Agent(s): Calcium Acetate (PhosLo)

Drug	Status	Special Instructions
SIGNIFOR INJECTION 0.3 mg/ML	Non-Preferred	Required diagnosis = Treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option OR Treatment of adult patients with Cushing disease for whom pituitary surgery is not an option or has not been curative
SIGNIFOR INJECTION 0.6 mg/ML	Non-Preferred	Required diagnosis = Treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option OR Treatment of adult patients with Cushing disease for whom pituitary surgery is not an option or has not been curative
SIGNIFOR INJECTION 0.9 mg/ML	Non-Preferred	Required diagnosis = Treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option OR Treatment of adult patients with Cushing disease for whom pituitary surgery is not an option or has not been curative
SILDENAFIL (REVATIO) 20 mg TABLET	PA required	Specialty; follow policy on CareSource.com.
SILENOR 3 mg TABLET	Non-Preferred	Formulary Agents: 7 day trial of zolpidem or zaleplon
SILENOR 6 mg TABLET	Non-Preferred	Formulary Agents: 7 day trial of zolpidem or zaleplon
SILIQ INJECTION 210 mg per 1.5 mL	PA Required	Please see the state specific Pharmacy Policy Statement titled Siliq by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
SIMBRINZA SUSPENSION 1-0.2% DROPS	Non-Preferred	Formulary Agent: 30 day trial of BRIMONIDINE 0.2% EYE DROP WITH DORZOLAMIDE (TRUSOPT) 2% EYE DROPS
SIMCOR 1,000-20 mg TABLET	Non-Preferred	Formulary Agent: simvastatin (Zocor) and OTC niacin separately taken together
SIMCOR 1,000-40 mg TABLET	Non-Preferred	Formulary Agent: simvastatin (Zocor) and OTC niacin separately taken together
SIMCOR 500-20 mg TABLET	Non-Preferred	Formulary Agent: simvastatin (Zocor) and OTC niacin separately taken together
SIMCOR 500-40 mg TABLET	Non-Preferred	Formulary Agent: simvastatin (Zocor) and OTC niacin separately taken together
SIMCOR 750-20 mg TABLET	Non-Preferred	Formulary Agent: simvastatin (Zocor) and OTC niacin separately taken together
SIMPONI 100 mg/ML	Specialty	Please see the state specific Pharmacy Policy Statement titled Simponi by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
SIMPONI 50 mg/0.5 mL	Specialty	Please see the state specific Pharmacy Policy Statement titled Simponi by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
SIMPONI ARIA 50 mg/4 mL	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Simponi Aria by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
SINELEE 0.0375-5% PATCH	Non-Preferred	*30 day trial of: lidocaine (Lidoderm) 5% patch

Drug	Status	Special Instructions
SINELEE 0.05-5% PATCH	Non-Preferred	*30 day trial of: lidocaine (Lidoderm) 5% patch
SINUS RELIEF CONGESTION & PAIN 5 mg-325 mg (day)/5 mg-325 mg-2 mg (night)	Non-Preferred	Formulary Agent: CHLORPHEN-PHENYLEPHRINE W/ APAP TAB 2-5-325 mg
SIRTURO 100 mg TABLET	PA required	Required diagnosis = as part of combination therapy in adults (≥18 years) with pulmonary multi-drug resistant tuberculosis
SITAVIG 50MG BUCCAL TABLET	Non-Preferred	Required one time trial of: ACYCLOVIR (ZOVIRAX) 200MG CAPSULE, ACYCLOVIR (ZOVIRAX) 400MG TABLET, OR ACYCLOVIR (ZOVIRAX) 800MG TABLET
SITZMARKS CAPSULE	Non-Preferred	Required diagnosis = Need for use as a diagnostic aid for computed tomography or x-ray examinations of the GI tract
Sivextro 200 mg Vial	Medical Benefit	Bill Through Medical Benefit
SIVEXTRO 200MG TABLET	PA required	Formulary Agent(s): Vancomycin IV Or IV/Oral Linezolid (Zyvox)
SKELID 200 mg TABLET	Non-Preferred	Formulary Agent: alendronate
SKLICE	Non-Preferred	Required diagnosis = Head Lice with trials below: Age 6 months up to 2 years old: LICE TREATMENT LIQUID 1%, permethrin (Rid Foam), spinosad (Natroba), benzyl alcohol lotion (Ulesfia) Age 2 years - 3 years: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), benzyl alcohol lotion (Ulesfia), or spinosad (Natroba) Age 4 years to 5 years old: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), benzyl alcohol lotion (Ulesfia) or spinosad (Natroba) Age 6 years and older: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), spinosad (Natroba), benzyl alcohol lotion (Ulesfia) or malathion (Ovide)
Sodium Bicarbonate 8.4% Vial	Medical Benefit	Bill Through Medical Benefit
Sodium Chloride 0.45% Injection	Medical Benefit	Bill Through Medical Benefit
Sodium Chloride 0.9% Injection	Medical Benefit	Bill Through Medical Benefit
Sodium Chloride 23.4% Injection	Medical Benefit	Bill Through Medical Benefit
SODIUM CHLORIDE 10% VIAL	Non-Preferred	Formulary Agent: SODIUM CHLORIDE 3% VIAL
SODIUM SULFACETAMIDE, SEB-PREV, RE 10 WASH, MEXAR (OVACE) 10% WASH	Non-Preferred	Formulary Agent: sulfacetamide sodium (Klarion) 10% lotion
SOLAICE 0.05-5% PATCH	Non-Preferred	*30 day trial of: lidocaine (Lidoderm) 5% patch
SOLESTA INJECTION 50-15 mL	PA required	Specialty

Drug	Status	Special Instructions
SOLIQUA PEN 100/33 UNIT-MCG/ML	Non-Preferred	Requires a 30 day trial of: Insulin Glargine (Lantus or Basaglar) AND a GLP 1 agonist (Victoza, Trulicity, Bydureon, Byettta, or Tanzeum) separately taken together at the same time
SOLIRIS (ECULIZUMAB) IV SOLUTIONN 10 mg/ML (FOR INFUSION)	PA required	Specialty
SOLODYN ER 105 mg TABLET	Non-Preferred	Requires a 30 day trial of: MINOCYCLINE ER (SOLODYN ER) tablet (which requires use of minocycline tablet)
SOLODYN ER 115 mg TABLET	Non-Preferred	Requires a 30 day trial of: MINOCYCLINE ER (SOLODYN ER) tablet (which requires use of minocycline tablet)
SOLODYN ER 55 mg TABLET	Non-Preferred	Requires a 30 day trial of: MINOCYCLINE ER (SOLODYN ER) tablet (which requires use of minocycline tablet)
SOLODYN ER 65 mg TABLET	Non-Preferred	Requires a 30 day trial of: MINOCYCLINE ER (SOLODYN ER) tablet (which requires use of minocycline tablet)
SOLODYN ER 80 mg TABLET	Non-Preferred	Requires a 30 day trial of: MINOCYCLINE ER (SOLODYN ER) tablet (which requires use of minocycline tablet)
SOLOSEC 2G	Lower Cost	Diagnosis Required: Bacterial Vaginosis
SOMATULINE INJECTION 120/.5 mL	Specialty	Specialty; follow policy on CareSource.com.
SOMATULINE INJECTION 60/0.2 mL	Specialty	Specialty; follow policy on CareSource.com.
SOMATULINE INJECTION 90/0.3 mL	Specialty	Specialty; follow policy on CareSource.com.
SOMAVERT 10MG VIAL	Specialty	Specialty; follow policy on CareSource.com.
SOMAVERT 15MG VIAL	Specialty	Specialty; follow policy on CareSource.com.
SOMAVERT 20MG VIAL	Specialty	Specialty; follow policy on CareSource.com.
SOMAVERT 25MG VIAL	Specialty	Specialty; follow policy on CareSource.com.
SOMAVERT 30MG VIAL	Specialty	Specialty; follow policy on CareSource.com.
SOMNOTE 500 mg SOFTGEL	Non-Preferred	Discontinued - could make compound with CHLORAL HYDRATE CRYSTALS or use zolpidem or zaleplon
Sonafine Emulsion	Non-Preferred	Formulary Agent(s): Woun'Dres Wound Dressing

Drug	Status	Special Instructions
Soolantra 1% Cream	Non-Preferred	Required Dx= Rosacea AND Formulary Agent(s): Metronidazole 0.75% or Tretinoin (Retin-A) OR Required Dx= Head Lice AND Formulary Agent(s): *Age 2 Months Up To 2 Years Old: Lice Treatment Liquid 1% Age 2 Years - 3 Years: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (Rid Liquid), Lice-Aid (Tegrin-LT, Lice Killing Shampoo (Pronto), Stop Lice Kit (Rid Complete Kit) *Age 4 Years To 5 Years Old: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (Rid Liquid), Lice-Aid (Tegrin-LT), Lice Killing Shampoo (Pronto), Stop Lice Kit (Rid Complete Kit) Or Spinosad (Natroba) *Age 6 Years And Older: Lice Treatment Liquid 1%, Permethrin (Rid Foam), Pyrethrins-Piperonyl Butoxide, Pronto Plus (Rid Liquid), Lice-Aid (Tegrin-LT), Lice Killing Shampoo (Pronto), Stop Lice Kit (Rid Complete Kit), Spinosad (Natroba) Or Malathion (Ovide)
SORBITOL 3% UROLOGIC IRRIGATION	PA required	Required diagnosis= urologic irrigation
SORBITOL 3.3% UROLOGIC SOLUTION	PA required	Required diagnosis= urologic irrigation
SORILUX 0.005% FOAM	Non-Preferred	Formulary Agent: calcipotriene (Dovonex)
SOTRET 10 mg	Non-Preferred	Formulary Agents: Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [Or Previously approved for and currently using: Tazorac, Benzamycin, Acanya, Akne-Mycin, or Tretinoin Microsphere] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
SOTRET 20 mg	Non-Preferred	Formulary Agents: Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [Or Previously approved for and currently using: Tazorac, Benzamycin, Acanya, Akne-Mycin, or Tretinoin Microsphere] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin

Drug	Status	Special Instructions
SOTRET 30 mg	Non-Preferred	Formulary Agents: Topicals: benzoyl peroxide 5% or 10%; benzoyl peroxide 4% or 8% liquid (Panoxyl), erythromycin/benzoyl (Benzamycin), sulfacetamide (Klaron), clindamycin topical (Cleocin T), erythromycin topical, tretinoin cream or gel or adapalene 0.1% gel or cream [Or Previously approved for and currently using: Tazorac, Benzamycin, Acanya, Akne-Mycin, or Tretinoin Microsphere] AND Orals: minocycline, doxycycline, tetracycline, or erythromycin
SOVALDI 400 MG TABLET	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Sovaldi by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
SPINRAZA 12 mg/5 mL SOLUTION	Medical Benefit	Bill through Medical Benefit
SPIRIVA 18 MCG HANDIHALER	Non-Preferred	Requires A Diagnosis Of: COPD (Emphysema, Chronic Bronchitis) AND A*30 Day Trial Of: Spiriva Respimat
SPECTRACEF 200 mg DOSE PACK	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin
SPECTRACEF 400 mg DOSE PACK	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin
SPORANOX 10 mg/ML SOLUTION	Non-Preferred	Formulary Agent: fluconazole oral solution
Spritam 250 mg Soluble Disintegrating Tablet	Non-Preferred	Formulary Agent(s): 30 Day Trial Of Levetiracetam (Keppra) Solution
Spritam 500 mg Soluble Disintegrating Tablet	Non-Preferred	Formulary Agent(s): 30 Day Trial Of Levetiracetam (Keppra) Solution
Spritam 750 mg Soluble Disintegrating Tablet	Non-Preferred	Formulary Agent(s): 30 Day Trial Of Levetiracetam (Keppra) Solution
Spritam 1,000 mg Soluble Disintegrating Tablet	Non-Preferred	Formulary Agent(s): 30 Day Trial Of Levetiracetam (Keppra) Solution
SPRIX 15.75 mg/SPRAY	PA required	Required diagnosis=moderate to Severe Pain And a 30 day trial of Ketorolac tablets
SPRYCEL 100 mg TABLET	PA required	Required diagnosis = ALL (Acute Lymphoblastic Leukemia) or Cml (Chronic Myeloid Leukemia)
SPRYCEL 140 mg TABLET	PA required	Required diagnosis = ALL (Acute Lymphoblastic Leukemia) or Cml (Chronic Myeloid Leukemia)
SPRYCEL 20 mg TABLET	PA required	Required diagnosis = ALL (Acute Lymphoblastic Leukemia) or Cml (Chronic Myeloid Leukemia)
SPRYCEL 50 mg TABLET	PA required	Required diagnosis = ALL (Acute Lymphoblastic Leukemia) or Cml (Chronic Myeloid Leukemia)
SPRYCEL 70 mg TABLET	PA required	Required diagnosis = ALL (Acute Lymphoblastic Leukemia) or Cml (Chronic Myeloid Leukemia)
SPRYCEL 80 mg TABLET	PA required	Required diagnosis = ALL (Acute Lymphoblastic Leukemia) or Cml (Chronic Myeloid Leukemia)

Drug	Status	Special Instructions
STAVZOR DR 125 mg CAPSULE	Non-Preferred	Diagnosis = Mania (due to Bipolar disorder) Formulary agent: Valproic acid OR Diagnosis= Migraine Formulary agent: propranolol OR Diagnosis= Seizure or Epilespy Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
STAVZOR DR 250 mg CAPSULE	Non-Preferred	Diagnosis = Mania (due to Bipolar disorder) Formulary agent: Valproic acid OR Diagnosis= Migraine Formulary agent: propranolol OR Diagnosis= Seizure or Epilespy Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
STAVZOR DR 500 mg CAPSULE	Non-Preferred	Diagnosis = Mania (due to Bipolar disorder) Formulary agent: Valproic acid OR Diagnosis= Migraine Formulary agent: propranolol OR Diagnosis= Seizure or Epilespy Formulary agents: gabapentin, lamotrigine (Lamictal), divalproex (Depakote), levetiracetam (Keppra), levetiracetam er (Keppra XR) oxcarbazepine (Trileptal), carbamazepine (Carbatrol), Phenytoin (Dilantin), topiramate (Topamax), VALPROIC ACID (Depakene) or Zonisamide
STAXYN 10 mg DISPERSIBLE TABLET	Excluded benefit	
STELARA 45MG/0.5ML INJECTION	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Stelara by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
STELARA 90MG/ML INJECTION	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Stelara by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
STENDRA 100 MG TABLET	Excluded benefit	
STENDRA 200 MG TABLET	Excluded benefit	
STENDRA 50 MG TABLET	Excluded benefit	
STERILE WATER FOR IRRIGATION	Non-Preferred	Required diagnosis = Need for irrigation
STIVARGA 40 mg TABLET	Non-Preferred	Required diagnosis = Metastatic colorectal cancer who have been previously treated with FOLFIRI

Drug	Status	Special Instructions
STRIANT 30 mg BUCCAL MUCOADHESIVE	Non-Preferred	Required diagnosis = hypogonadism with Total Testosterone lab value = ≤ 300 ng/dL before treatment Formulary Agents: Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both still require a PA also)
STRENSIQ 18MG/0.45ML VIAL FOR INJECTION	Non-Preferred	Request Must Go Through Clinical Review
STRENSIQ 28MG/0.7ML VIAL FOR INJECTION	Non-Preferred	Request Must Go Through Clinical Review
STRENSIQ 40MG/ML VIAL FOR INJECTION	Non-Preferred	Request Must Go Through Clinical Review
STRENSIQ 80MG/0.8ML VIAL FOR INJECTION	Non-Preferred	Request Must Go Through Clinical Review
SUBOXONE 12 mg-3 mg SUBLINGUAL FILM	Non-Preferred	Request Must Go Through Clinical Review
SUBOXONE 2 mg-0.5 mg SUBLINGUAL FILM	Non-Preferred	Request Must Go Through Clinical Review
SUBOXONE 4 mg-1 mg SUBLINGUAL FILM	Non-Preferred	Request Must Go Through Clinical Review
SUBOXONE 8 mg-2 mg SUBLINGUAL FILM	Non-Preferred	Request Must Go Through Clinical Review
SUBSYS SPRAY 1600 mcg	Non-Preferred	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
SUBSYS SPRAY 400 mcg	Non-Preferred	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
SUBSYS SPRAY 100 mcg	Non-Preferred	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
SUBSYS SPRAY 1200 mcg	Non-Preferred	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
SUBSYS SPRAY 200 mcg	Non-Preferred	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
SUBSYS SPRAY 600 mcg	Non-Preferred	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
SUBSYS SPRAY 800 mcg	Non-Preferred	Required diagnosis = breakthrough pain in adults with cancer who are receiving and are tolerant to opioid therapy
SUCLEAR KIT	Non-Preferred	Formulary Agents: Golytely, Half-Lytely, TRILYTE, GAVILYTE-N, or PEG-3350/KCL
SUCRAID 8,500 UNITS/ML SOLUTION	PA required	Required diagnosis= Sucrase deficiency
SODIUM SULFACETAMIDE (OVACE PLUS) 10% LIQUID WASH	Non-Preferred	Required trial of: sulfacetamide sodium (Klarion) 10% lotion
SODIUM SULFACETAMIDE (OVACE PLUS) 10% SHAMPOO	Non-Preferred	Required trial of: sulfacetamide sodium (Klarion) 10% lotion

Drug	Status	Special Instructions
SODIUM SULFACETAMIDE (OVACE PLUS WASH) 10% LIQUID WASH	Non-Preferred	Required trial of: sulfacetamide sodium (Klarion) 10% lotion
SULFACETAMIDE SODIUM W/ SULFUR (AVAR LS) 10-2% CLEANSER	Non-Preferred	Formulary Agent: SULFACETAMIDE SODIUM W/ SULFUR (AVAR-E LS) 10-2% CREAM
SULFACETAMIDE SODIUM W/ SULFUR (CLARIFOAM EF) 10-5% EMOLLIENT FOAM	Non-Preferred	Formulary Agents: SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
SULFACETAMIDE SODIUM W/ SULFUR (SUMADAN) 9% - 4.5%	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
SULFACETAMIDE SODIUM W/ SULFUR (SUMAXIN) CLEANSING PADS 10-4%	Step Therapy	Must first try: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
SULFACETAMIDE SODIUM W/ SULFUR WASH PLUS SKIN CLEANSER (SUMADAN KIT) 9% - 4.5%	Non-Preferred	Formulary Agents: SULFACETAMIDE SODIUM W/ SULFUR (SUMADAN) 9% - 4.5% (which requires a prior authorization) WITH a formulary skin cleanser used separately at the same time
SULFACETAMIDE SODIUM W/ SULFUR, SULFACLEANS (SUMAXIN TS) 8-4% TOPICAL SUSPENSION	Step Therapy	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
SULFACETAMIDE SODIUM W/ SULFUR, ZENCIA (SUMAXIN) WASH 9-4%	Step Therapy	Must first try: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
SODIUM SULFACETAMIDE WITH SULFUR (PLEXION) 9.8-4.8% CLEANSER	Non-Preferred	Formulary Agent(s): Avar-E LS 10-2% cream, Sulfacetamide Sodium w/ Sulfur Suspension 10-5%, Sulfacetamide Sodium w/ Sulfur lotion 10-5%, Or Sulfacetamide Sodium w/ Sulfur emulsion, Avar cleanser, Rosanil, Prascion 10-5%
SODIUM SULFACETAMIDE WITH SULFUR (PLEXION) 9.8-4.8% CREAM	Non-Preferred	Formulary Agent(s): Avar-E LS 10-2% cream, Sulfacetamide Sodium w/ Sulfur Suspension 10-5%, Sulfacetamide Sodium w/ Sulfur lotion 10-5%, Or Sulfacetamide Sodium w/ Sulfur emulsion, Avar cleanser, Rosanil, Prascion 10-5%
SODIUM SULFACETAMIDE WITH SULFUR (PLEXION) 9.8-4.8% LOTION	Non-Preferred	Formulary Agent(s): Avar-E LS 10-2% cream, Sulfacetamide Sodium w/ Sulfur Suspension 10-5%, Sulfacetamide Sodium w/ Sulfur lotion 10-5%, Or Sulfacetamide Sodium w/ Sulfur emulsion, Avar cleanser, Rosanil, Prascion 10-5%
SOTYLIZE 5MG/ML SOLUTION	Non-Preferred	*30 Day Trial Of: Sotalol (Betapace) Tablet
SULFAMYLON 8.5% CREAM	Non-Preferred	Formulary Agent: silver sulfadiazine
SULFAMYLON POWDER PACKET	Non-Preferred	Formulary Agent: silver sulfadiazine
SUMAVEL DOSEPRO 6 mg/0.5 mL	Non-Preferred	Formulary Agent: sumatriptan injection, tablet AND nasal spray

Drug	Status	Special Instructions
SUMAXIN CP KIT 10-4%	Non-Preferred	Formulary Agents: AVAR-E LS 10-2% CREAM, SULFACETAMIDE SODIUM W/ SULFUR SUSPENSION 10-5%, SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%, OR SULFACETAMIDE SODIUM W/ SULFUR EMULSION, AVAR CLEANSER , ROSANIL, PRASCION 10-5%
Sunscreen	Excluded benefit	
SUPARTZ	PA required	Specialty; follow policy on CareSource.com.
SUPPRELIN LA	Non-Preferred	Required diagnosis = Central precocious puberty
SUPRAX 100 mg CHEWABLE TABLET	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin. Covered for diagnosis of Gonorrhea and/or Chlamydia
SUPRAX 500 mg/5 mL SUSPENSION	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin. Covered for diagnosis of Gonorrhea and/or Chlamydia
SUPRAX 100 mg/5 mL SUSPENSION	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin. Covered for diagnosis of Gonorrhea and/or Chlamydia
SUPRAX 200 mg CHEWABLE TABLET	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin. Covered for diagnosis of Gonorrhea and/or Chlamydia
SUPRAX 200 mg/5 mL SUSPENSION	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin. Covered for diagnosis of Gonorrhea and/or Chlamydia
SUPRAX 400 mg TABLET	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin. Covered for diagnosis of Gonorrhea and/or Chlamydia
SUPRAX 400 mg CAPSULE	Non-Preferred	Formulary Agents: cephalexin, cefuroxime or other formulary cephalosporin.
SUPRENZA 15 mg ODT	Excluded benefit	
SUPRENZA 30 mg ODT	Excluded benefit	
SUPREP BOWEL PREP KIT	Non-Preferred	Formulary Agents: Golytely, Half-Lytely, TRILYTE, GAVILYTE-N, COLYTE/FLAVR SOLUTION, or PEG-3350/KCL
Sustol 10 mg/0.4 mL Prefilled Syringe	Non-Preferred	Required Diagnosis= Nausea/Vomiting Due To Chemotherapy Or Currently Receiving Chemotherapy AND Formulary Agent(s): Ondansetron Or Promethazine
SUTENT 12.5 mg CAPSULE	PA required	Required diagnosis = Advanced pancreatic neuroendocrine tumors; Advanced renal cell carcinoma; GI stromal tumor
SUTENT 25 mg CAPSULE	PA required	Required diagnosis = Advanced pancreatic neuroendocrine tumors; Advanced renal cell carcinoma; GI stromal tumor
SUTENT 37.5MG CAPSULE	PA required	Required diagnosis = Advanced pancreatic neuroendocrine tumors; Advanced renal cell carcinoma; GI stromal tumor
SUTENT 50 mg CAPSULE	PA required	Required diagnosis = Advanced pancreatic neuroendocrine tumors; Advanced renal cell carcinoma; GI stromal tumor
SYLATRON 296MCG KIT	PA required	Required Dx= Melanoma
SYLATRON 444MCG KIT	PA required	Required Dx= Melanoma
SYLATRON 888MCG KIT	PA required	Required Dx= Melanoma
SYMBICORT 80-4.5 MCG INHALER	Non-Preferred	Requires A Diagnosis Of Asthma or COPD (Emphysema, Chronic Bronchitis) AND A *30 Day Trial Of: Dulera (Ages 12 to 17) Or *30 Day Trial Of: Breo Ellipta or Dulera (Ages 18 and older)

Drug	Status	Special Instructions
SYMBICORT 160-4.5 MCG INHALER	Non-Preferred	Requires A Diagnosis Of Asthma or COPD (Emphysema, Chronic Bronchitis) AND A *30 Day Trial Of: Dulera (Ages 12 to 17) Or *30 Day Trial Of: Breo Ellipta or Dulera (Ages 18 and older)
SYMAX DUOTABLET (HYOMAX-DT) 0.375 mg TABLET	Non-Preferred	Formulary Agent: hyoscyamine SR 0.375 mg
SYMLIN 0.6 mg/ML VIAL	Step Therapy	Must first try a 60 day trial of Humalog, Novolog or Apidra
SYMLINPEN 120 PEN INJECTOR	Step Therapy	Must first try a 60 day trial of Humalog, Novolog or Apidra
SYMLINPEN 60 PEN INJECTOR	Step Therapy	Must first try a 60 day trial of Humalog, Novolog or Apidra
SYNAGIS 100 mg/1 mL VIAL 2013-2014	PA required	Specialty; follow policy on CareSource.com.
SYNAGIS 50 mg/0.5 mL VIAL 2013-2014	PA required	Specialty; follow policy on CareSource.com.
SYNAREL 2 mg/ML NASAL SPRAY	PA required	Required diagnosis = Endometriosis
SYNDROS (dronabinol) 5 mg/mL ORAL SOLUTION	Non-Preferred	Required Diagnosis = Anorexia associated with weight loss in patients with AIDS OR Diagnosis = Cancer chemotherapy-induced nausea and vomiting in patients who have failed conventional antiemetic treatments (examples: metoclopramide, promethazine, prochlorperazine, meclizine, oral 5-HT3 receptor antagonists) AND 30 day trial of dronabinol
Synera Patches	Non-Preferred	Required diagnosis = Local dermal analgesia on intact skin before superficial venous access and superficial dermatologic procedures
SYNERCID 500 mg INJECTION	Non-Preferred	Formulary Agent: Vancomyin IV in-patient or outpatient for diagnosis of Skin and Skin structure infections
SYNJARDY 5-500MG TABLET	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
SYNJARDY 5-1,000MG TABLET	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
SYNJARDY 12.5-500MG TABLET	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
SYNJARDY 12.5-1,000MG TABLET	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
Synjardy XR 5 mg-1,000 mg Tablet	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
Synjardy XR 10 mg-1,000 mg Tablet	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
Synjardy XR 12.5 mg-1,000 mg Tablet	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time

Drug	Status	Special Instructions
Synjardy XR 25 mg-1,000 mg Tablet	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
SYNRIBO 3.5 mg INJECTION	Non-Preferred	Required diagnosis = Philadelphia chromosome–positive acute lymphoblastic leukemia (Ph+ALL) OR chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) with T3151 mutation
SYNVISC	Specialty	Specialty; follow policy on CareSource.com. Formulary Agents: Supartz & Gel-One
SYNVISC-ONE	Specialty	Specialty; follow policy on CareSource.com. Formulary Agents: Supartz & Gel-One
SYPRINE 250 mg CAPSULE	Non-Preferred	Formulary Agent: cupirimine with a diagnosis of Wilson's disease
TABLOID 40 mg TABLET	PA required	Required diagnosis = Acute nonlymphocytic leukemias
Tabradol FusePaq 1 mg/mL Suspension	Non-Preferred	A 30 Day Trial Of: Non-ER Cyclobenzaprine Tablet
CALCIPOTRIENE-BETAMETHASONE DIPROPIONATE (TACLONEX) 0.005%/0.064% OINTMENT	Non-Preferred	Formulary Agent: calcipotriene (Dovonex)
TACLONEX SCALP 0.005%/0.064% SUSPENSION	Non-Preferred	Formulary Agent: CALCIPOTRIENE (DOVONEX) 0.005% SOLUTION
TAFINLAR 50 mg CAPSULE	PA required	Required diagnosis = BRAFV600E-mutated melanomas that are either nonresectable (stage III or stage IV), detected by an FDA approved test AND used as a single agent OR diagnosis BRAF V600K-mutated melanomas that are either nonresectable (stage III or stage IV), detected by an FDA approved test AND given in combination with Mekinist
TAFINLAR 75 mg CAPSULE	PA required	Required diagnosis = BRAFV600E-mutated melanomas that are either nonresectable (stage III or stage IV), detected by an FDA approved test AND used as a single agent OR diagnosis BRAF V600K-mutated melanomas that are either nonresectable (stage III or stage IV), detected by an FDA approved test AND given in combination with Mekinist
TAGRISSO 40MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
TAGRISSO 80MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
Taltz 80 mg/mL Auto-Injector	Non-Preferred	Request Must Go Through Clinical Review
Taltz 80 mg/mL Syringe	Non-Preferred	Request Must Go Through Clinical Review
TANDEM OB CAPSULE 106 mg-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TANZEUM 30MG/0.5ML PEN	Non-Preferred	Requires a 60 day trial of: Trulicity or Victoza (which require a 30 day trial of Metformin or Metformin ER)
TANZEUM 50MG/0.5ML PEN	Non-Preferred	Requires a 60 day trial of: Trulicity or Victoza (which require a 30 day trial of Metformin or Metformin ER)
TARCEVA 100 mg TABLET	PA required	Required diagnosis = Pancreatic Cancer
TARCEVA 150 mg TABLET	PA required	Required diagnosis = Non-Small Cell Lung Cancer
TARCEVA 25 mg TABLET	PA required	Required diagnosis = Non-Small Cell Lung Cancer OR Pancreatic Cancer
TARGRETIN 1% GEL	PA required	Required diagnosis = Cutaneous T-cell lymphoma

Drug	Status	Special Instructions
Tarka ER (TRANDOLAPRIL-VERAPAMIL ER) 1-240 mg	Non-Preferred	Formulary Agent: trandolapril and verapamil separately
Tarka ER (TRANDOLAPRIL-VERAPAMIL ER) 2-180 mg	Non-Preferred	Formulary Agent: trandolapril and verapamil separately
Tarka ER (TRANDOLAPRIL-VERAPAMIL ER) 2-240 mg	Non-Preferred	Formulary Agent: trandolapril and verapamil separately
Tarka ER (TRANDOLAPRIL-VERAPAMIL ER) 4-240 mg	Non-Preferred	Formulary Agent: trandolapril and verapamil separately
TARON EC CALCIUM DHA COMBO 28-1 mg/250 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TARON-DUO EC COMB PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TARON-EC CAL TABLET 28-1 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TARON-PREX PRENATAL DHA CAPSULE 30-1.2-265 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TASIGNA 150 mg CAPSULE	PA required	Required diagnosis = Chronic myelogenous leukemia
TASIGNA 200 mg CAPSULE	PA required	Required diagnosis = Chronic myelogenous leukemia
TAYTULLA 1 MG-20 MCG CAPSULE	Non-Preferred	Requires A 30 Day Trial Of: A Formulary Birth Control Agent
Tazarotene (Tazorac) 0.1% Cream	Non-Preferred	Required Dx= Psoriasis AND Formulary Agent: Calcipotriene (Dovonex) OR Dx= Acne AND Formulary Agent: Tretinoin Cream Or Gel OR Adapalene 0.1% Gel Or Cream
TAZORAC 0.05% CREAM	Non-Preferred	Formulary Agent: calcipotriene (Dovonex) with a diagnosis of psoriasis OR Formulary Agents: tretinoin cream or gel or adapalene 0.1% gel or cream with a diagnosis of acne
TAZORAC 0.05% GEL	Non-Preferred	Formulary Agent: calcipotriene (Dovonex) with a diagnosis of psoriasis OR Formulary Agents: tretinoin cream or gel or adapalene 0.1% gel or cream with a diagnosis of acne
TAZORAC 0.1% GEL	Non-Preferred	Formulary Agent: calcipotriene (Dovonex) with a diagnosis of psoriasis OR Formulary Agents: tretinoin cream or gel or adapalene 0.1% gel or cream with a diagnosis of acne
TECFIDERA 120 mg CAPSULE	Specialty	Specialty; Request Must Go Through Clinical Review
TECFIDERA 240 mg CAPSULE	Specialty	Specialty; Request Must Go Through Clinical Review
TECFIDERA STARTER KIT	Specialty	Specialty; Request Must Go Through Clinical Review
TECHNIVIE 12.5-75MG TABLET	Non-Preferred	Request Must Go Through Clinical Review
Teflaro 400 mg Vial	Medical Benefit	Bill Through Medical Benefit
Teflaro 600 mg Vial	Medical Benefit	Bill Through Medical Benefit

Drug	Status	Special Instructions
TEKAMLO 150 mg-10 mg TABLET	Non-Preferred	Formulary agents: losartan (Cozaar) or irbesartan (Avapro) WITH amlodipine separately, Amlodipine Besylate-Valsartan (Exforge) or Telmisartan-Amlodipine (Twynsta)
TEKAMLO 150 mg-5 mg TABLET	Non-Preferred	Formulary agents: losartan (Cozaar) or irbesartan (Avapro) WITH amlodipine separately, Amlodipine Besylate-Valsartan (Exforge) or Telmisartan-Amlodipine (Twynsta)
TEKAMLO 300 mg-10 mg TABLET	Non-Preferred	Formulary agents: losartan (Cozaar) or irbesartan (Avapro) WITH amlodipine separately, Amlodipine Besylate-Valsartan (Exforge) or Telmisartan-Amlodipine (Twynsta)
TEKAMLO 300 mg-5 mg TABLET	Non-Preferred	Formulary agents: losartan (Cozaar) or irbesartan (Avapro) WITH amlodipine separately, Amlodipine Besylate-Valsartan (Exforge) or Telmisartan-Amlodipine (Twynsta)
TEKTURNA 150 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)
TEKTURNA 300 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)
TEKTURNA HCT 150-12.5 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan/HCTZ (Hyzaar), Candesartan/HCTZ (Atacand HCT), Valsartan/HCTZ (Diovan HCT), Or Irbesartan/HCTZ (Avalide)
TEKTURNA HCT 150-25 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan/HCTZ (Hyzaar), Candesartan/HCTZ (Atacand HCT), Valsartan/HCTZ (Diovan HCT), Or Irbesartan/HCTZ (Avalide)
TEKTURNA HCT 300-12.5 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan/HCTZ (Hyzaar), Candesartan/HCTZ (Atacand HCT), Valsartan/HCTZ (Diovan HCT), Or Irbesartan/HCTZ (Avalide)
TEKTURNA HCT 300-25 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan/HCTZ (Hyzaar), Candesartan/HCTZ (Atacand HCT), Valsartan/HCTZ (Diovan HCT), Or Irbesartan/HCTZ (Avalide)
TEMAZEPAM (Restoril) 22.5 mg CAPSULE	Non-Preferred	Formulary Agents: temazepam (15 mg and 30 mg)
TEMAZEPAM (Restoril) 7.5 mg CAPSULE	Non-Preferred	Formulary Agents: temazepam (15 mg and 30 mg)
TEMOZOLOMIDE (TEMODAR) 100 mg CAPSULE	PA required	Required diagnosis = Anaplastic astrocytoma; Glioblastoma multiforme
TEMOZOLOMIDE (TEMODAR) 140 mg CAPSULE	PA required	Required diagnosis = Anaplastic astrocytoma; Glioblastoma multiforme
TEMOZOLOMIDE (TEMODAR) 180 mg CAPSULE	PA required	Required diagnosis = Anaplastic astrocytoma; Glioblastoma multiforme
TEMOZOLOMIDE (TEMODAR) 20 mg CAPSULE	PA required	Required diagnosis = Anaplastic astrocytoma; Glioblastoma multiforme
TEMOZOLOMIDE (TEMODAR) 250 mg CAPSULE	PA required	Required diagnosis = Anaplastic astrocytoma; Glioblastoma multiforme
TEMOZOLOMIDE (TEMODAR) 5 mg CAPSULE	PA required	Required diagnosis = Anaplastic astrocytoma; Glioblastoma multiforme
TERSI FOAM 2.25%	Non-Preferred	Formulary Agent: SELENIUM SULFIDE (SELSUN) 2.5% LOTION/SHAMPOO

Drug	Status	Special Instructions
TESTONE CIK IM SOLUTION 200mg/ml	Non-Preferred	Required Diagnosis = hypogonadisim And Total testosterone lab value = ≤ 300 ng/dl before treatment (must submit lab documentation) And *Baseline PSA less than 4 ng/mL (must submit lab documentation) And *Hematocrit < 54% (must submit lab documentation) And a 30-day trial of each of the following (must trial both, both require prior authorization): *testosterone cypionate, testosterone ethanate
TESTOPEL (Pellet Implant)	Non-Preferred	Required diagnosis=hypogonadism And Total Testosterone lab value = ≤ 300 ng/dL before treatment And a Trial of Testosterone TD (Fortesta) Or Testosterone (Androgel, Testim, Vogelxo) Gel Packet (both require PA)
Testosterone Cypionate 100 mg/mL Injection Oil	PA required	Requires A Diagnosis Of: Hypogonadism AND *Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only)
Testosterone Cypionate 200 mg/mL Injection Oil	PA required	Requires A Diagnosis Of: Hypogonadism AND *Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only)
Testosterone Enanthate 200 mg/mL Vial	PA required	Requires A Diagnosis Of: *Dx= Hypogonadism AND *Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment (For New Starts Only) [Dose = 50 to 400 mg every 2 to 4 weeks (FDA-approved dose range)] OR *DX = breast cancer (female) [Dose = 200 to 400 mg every 2 to 4 weeks] OR *DX = delayed puberty (male)
Testosterone TD (Androgel) 1% (25 mg/2.5 GM) Gel Packet	PA required	Required Diagnosis= Hypogonadism With Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment
Testosterone TD (Androgel, Testim, Vogelxo) 1% (50 GM) Gel Packet	PA required	Required Diagnosis= Hypogonadism With Total Testosterone Lab Value = ≤ 300 ng/dL Before Treatment
Tetrabenazine (Xenazine) 12.5mg Tablet	PA required	Required Diagnosis= Chorea Associated With Huntington's Disease OR Moderate to severe tardive dyskinesia
Tetrabenazine (Xenazine) 25mg Tablet	PA required	Required Diagnosis= Chorea Associated With Huntington's Disease OR Moderate to severe tardive dyskinesia
Tetracaine 0.5% Eye Drops	Non-Preferred	Required Diagnosis Of Local Anesthesia For Ophthalmic Procedure Of Short Duration, Minor Ophthalmic Surgical Procedure Or Diagnostic Purpose
TEVETEN 400 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)
TEVETEN 600 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)
TEVETEN HCT 600-12.5 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan/HCTZ (Hyzaar), Candesartan/HCTZ (Atacand HCT), Valsartan/HCTZ (Diovan HCT), Or Irbesartan/HCTZ (Avalide)

Drug	Status	Special Instructions
TEVETEN HCT 600-25 mg TABLET	Non-Preferred	*60 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan/HCTZ (Hyzaar), Candesartan/HCTZ (Atacand HCT), Valsartan/HCTZ (Diovan HCT), Or Irbesartan/HCTZ (Avalide)
TEV-TROPIN 5 mg VIAL	Specialty	Specialty; follow policy on CareSource.com.
TEXACORT 2.5% SOLUTION	Non-Preferred	Formulary Agent: hydrocortisone topical
THALITONE 15 mg TABLET	Non-Preferred	Formulary Agent: chlorthalidone
THALOMID 100 mg CAPSULE	PA required	Required diagnosis = Multiple myeloma or Erythema nodosum leprosum
THALOMID 150 mg CAPSULE	PA required	Required diagnosis = Multiple myeloma or Erythema nodosum leprosum
THALOMID 200 mg CAPSULE	PA required	Required diagnosis = Multiple myeloma or Erythema nodosum leprosum
THALOMID 50 mg CAPSULE	PA required	Required diagnosis = Multiple myeloma or Erythema nodosum leprosum
THEROBEC TABLET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
Thiamine Vial	Non-Preferred	Required Diagnosis Of Neuritis Of Pregnancy OR Thiamine Deficiency (Beriberi) WITH Formulary Agent(s): Thiamine Tablet
THIOLA 100 mg TABLET	Non-Preferred	For prevention of cystine (kidney) stone formation in patients with severe homozygous cystinuria
THRIVITE 19 29-1-25MG TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
THRIVITE RX 29-1MG TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Thyrogen 1.1 mg Vial	Medical Benefit	Bill Through Medical Benefit
TIMOPTIC 0.25% OCUDOSE DROP	Non-Preferred	Formulary Agent: TIMOLOL (TIMOPTIC) 0.25% EYE DROPS or TIMOLOL (TIMOPTIC-XE) 0.25% GEL EYE SOLUTION
TIMOPTIC 0.5% OCUDOSE DROP	Non-Preferred	Formulary Agent: TIMOLOL (TIMOPTIC) 0.25% EYE DROPS or TIMOLOL (TIMOPTIC-XE) 0.25% GEL EYE SOLUTION
TINIDAZOLE (TINDAMAX) 250MG TABLET	Non-Preferred	Required diagnosis= Amebiasis; Bacterial vaginosis; Giardiasis; Trichomoniasis AND Formulary Agent(s): metronidazole (Flagyl)
TINIDAZOLE (TINDAMAX) 500MG TABLET	Non-Preferred	Required diagnosis= Amebiasis; Bacterial vaginosis; Giardiasis; Trichomoniasis AND Formulary Agent(s): metronidazole (Flagyl)
TIROSINT 100 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
TIROSINT 125 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
TIROSINT 137 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
TIROSINT 13 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine

Drug	Status	Special Instructions
TIROSINT 150 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
TIROSINT 25 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
TIROSINT 50 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
TIROSINT 75 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
TIROSINT 88 mcg CAPSULE	Non-Preferred	Formulary Agents: levothyroxine, Armour thyroid, or liothyronine
Tivorbex 20mg Capsule	Non-Preferred	Formulary Agent(s): Indomethacin 25mg Or 50mg Capsule
Tivorbex 40mg Capsule	Non-Preferred	Formulary Agent(s): Indomethacin 25mg Or 50mg Capsule
TIZANIDINE (ZANAFLEX) 2 mg CAPSULE	Non-Preferred	Formulary Agent: tizanidine tablet
TIZANIDINE (ZANAFLEX) 4 mg CAPSULE	Non-Preferred	Formulary Agent: tizanidine tablet
TIZANIDINE (ZANAFLEX) 6 mg CAPSULE	Non-Preferred	Formulary Agent: tizanidine tablet
TL-ASSURE + DHA 29 mg iron-1 mg-250 mg	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TL-FOL, FOLITAB 500 TABLET	Non-Preferred	Formulary Agents: ESSENTIAL ONE DAILY tablet, ONCE DAILY tablet, STRESS FORMULA tablet, THERA-TABS tablet, THEREMS tablet, VICAP FORTE CAP
Tobi Podhaler	Non-Preferred	Formulary Agent: TOBRAMYCIN (TOBI) 300 mg/5 mL SOLUTION
Tobramycin Sulfate 10 mg/mL Injection	Medical Benefit	Bill Through Medical Benefit
Tobramycin Sulfate 80 mg/2 mL Injection	Medical Benefit	Bill Through Medical Benefit
Tobramycin Sulfate 1.2G/30 mL Injection	Medical Benefit	Bill Through Medical Benefit
Tobramycin Sulfate 2G/50 mL Injection	Medical Benefit	Bill Through Medical Benefit
Tobramycin Sulfate 0.8 mg/mL Injection In Saline	Medical Benefit	Bill Through Medical Benefit
Tobramycin Sulfate 1.2 mg/mL Injection In Saline	Medical Benefit	Bill Through Medical Benefit
Tobramycin 1.2G Vial	Medical Benefit	Bill Through Medical Benefit
TOLAK 4% CREAM	Non-Preferred	Formulary Agent(s): Fluorouracil (Efudex) 5% Cream
Tolazamide 250 mg Tablet	Non-Preferred	Formulary Agent(s): 30 Day Trial Of EACH Of The Following: Glimepiride, Glipizide, And Glyburide
Tolazamide 500 mg Tablet	Non-Preferred	Formulary Agent(s): 30 Day Trial Of EACH Of The Following: Glimepiride, Glipizide, And Glyburide
TOLCAPONE (TASMAR) 100 mg TABLET	Non-Preferred	Formulary Agent: entacapsuleone (Comtan) tablet
TOLMETIN SODIUM 200 mg TABLET	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam

Drug	Status	Special Instructions
TOLMETIN SODIUM 400 mg CAPSULE	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam
TOLMETIN SODIUM 600 mg TABLET	Non-Preferred	Required 30 day trial of one of the following: celecoxib, naproxen, ibuprofen, flurbiprofen, nabumetone, diclofenac, etodolac, indomethacin, ketoprofen, meloxicam, oxaprozin, sulindac, or piroxicam
TOPICAINE 4% GEL	Non-Preferred	Formulary Agents: LIDOCAINE SOLUTION 4% or ANECREAM, LIDOCREAM, LC-4 LIDOCAINE (LMX 4) 4% CREAM
TOPICORT 0.25% SPRAY	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
TOPIRAMATE ER (QUDEXY XR) 25MG CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate IR Tablets Or Capsules
TOPIRAMATE ER (QUDEXY XR) 50MG CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate IR Tablets Or Capsules
TOPIRAMATE ER (QUDEXY XR) 100MG CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate IR Tablets Or Capsules
TOPIRAMATE ER (QUDEXY XR) 150MG CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate IR Tablets Or Capsules
TOPIRAMATE ER (QUDEXY XR) 200MG CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate IR Tablets Or Capsules
TOUJEO SOLOSTAR 300IU/ML	Non-Preferred	Requires A 30 day trial of Basaglar or Tresiba
TOVIAZ ER 4 mg TABLET	Non-Preferred	Formulary Agents: OXYBUTYNIN, OXYBUTYNIN ER, TOLTERODINE, TROSPIUM, or TROSPIUM SR
TOVIAZ ER 8 mg TABLET	Non-Preferred	Formulary Agents: OXYBUTYNIN, OXYBUTYNIN ER, TOLTERODINE, TROSPIUM, or TROSPIUM SR
TPN S9365	Medical Benefit	Bill through Medical Benefit
TPN S9366	Medical Benefit	Bill through Medical Benefit
TPN S9367	Medical Benefit	Bill through Medical Benefit
TPN S9368	Medical Benefit	Bill through Medical Benefit
TRACLEER 125 mg TABLET	PA required	Specialty; follow policy on CareSource.com.
TRACLEER 62.5 mg TABLET	PA required	Specialty; follow policy on CareSource.com.
TRADJENTA 5MG TABLET	Non-Preferred	30 day Trial of: Alogliptin (Nesina), Alogliptin-Metformin (Kazano), or Alogliptin-Pioglitazone (Oseni)
Tramadol HCL ER (Conzip) 100 mg Capsule	Non-Preferred	Formulary Agents: tramadol IR or tramadol ER (which requires a PA)

Drug	Status	Special Instructions
Tramadol HCL ER (Conzip) 200 mg Capsule	Non-Preferred	Formulary Agents: tramadol IR or tramadol ER (which requires a PA)
Tramadol HCL ER (Conzip) 300 mg Capsule	Non-Preferred	Formulary Agents: tramadol IR or tramadol ER (which requires a PA)
TRAMADOL ER (ULTRAM ER) 100 mg TABLET	Non-Preferred	Formulary Agent: non-ER tramadol (Ultram)
TRAMADOL ER (ULTRAM ER) 200 mg TABLET	Non-Preferred	Formulary Agent: non-ER tramadol (Ultram)
TRAMADOL ER (ULTRAM ER) 300 mg TABLET	Non-Preferred	Formulary Agent: non-ER tramadol (Ultram)
TRAMADOL SR (RYZOLT ER) 100 mg TABLET	Non-Preferred	Formulary Agent: tramadol ER (Ultram ER)
TRAMADOL SR (RYZOLT ER) 200 mg TABLET	Non-Preferred	Formulary Agent: tramadol ER (Ultram ER)
TRAMADOL SR (RYZOLT ER) 300 mg TABLET	Non-Preferred	Formulary Agent: tramadol ER (Ultram ER)
TRANEXAMIC ACID 1000 MG/10ML (100 MG/ML) IV SOLUTION	Medical Benefit	Bill through Medical Benefit
TRANEXAMIC ACID (LYSTEDA) 650 mg TABLET	Non-Preferred	Must first try medroxyprogesterone
Transderm Scop	Non-Preferred	Required Diagnosis Of Prevention Of Nausea/Vomiting Associated With Motion Sickness Or From Anesthesia And Surgery
Travasol 10% Vial	Medical Benefit	Bill Through Medical Benefit
TRAVATAN Z 0.004% EYE DROP	Non-Preferred	Formulary Agent: Latanoprost 0.005% EYE DROPS
TRAVOPROST 0.004% EYE DROP	Non-Preferred	Formulary Agent: Latanoprost 0.005% EYE DROPS
TRAZODONE 300 MG TABLET	Non-Preferred	Requires A 90 Day Trial of *Trazodone 150 mg (using 2 tablets to equal 300 mg)
TRECATOR 250 mg TABLET	PA required	Required diagnosis = Tuberculosis
TRELEGY ELLIPTA 100-62.5-25MG	Lower Cost	Required Diagnosis= COPD
TRELSTAR (TRIPTORELIN PAMOATE) FOR IM SUSPENION 11.25 mg	PA required	Specialty
TRELSTAR (TRIPTORELIN PAMOATE) FOR IM SUSPENION 22.5 mg	PA required	Specialty

Drug	Status	Special Instructions
TRELSTAR (TRIPTORELIN PAMOATE) FOR IM SUSPENION 3.75 mg	PA required	Specialty
TREMFYA 100 mg/mL	Lower Cost	Formulary agent: Enbrel and Humira
Tretinoin (ATRALIN) 0.05% GEL	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
Tretinoin (Avita) 0.025% Cream	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea
Tretinoin (Avita) 0.025% Gel	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea
TRETINOIN EMOLLIENT (REFISSA) (FACIAL WRINKLES) CREAM 0.05%	Excluded benefit	
TRETINOIN MICROSPHERE (RETIN-A MICRO) 0.04% GEL	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
TRETINOIN MICROSPHERE (RETIN-A MICRO) 0.1% GEL	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
TRETIN-X 0.01% GEL W/ CLEANSER & MOISTURIZER KIT	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
TRETIN-X 0.025% CREAM W/ CLEANSER & MOISTURIZER KIT	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
TRETIN-X 0.025% GEL W/ CLEANSER & MOISTURIZER KIT	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
TRETIN-X 0.0375% CREAM	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
TRETIN-X 0.05% CREAM W/ CLEANSER & MOISTURIZER KIT	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
TRETIN-X 0.1% CREAM W/ CLEANSER & MOISTURIZER KIT	Non-Preferred	Required Diagnosis= Acne, Molluscum Contagiosum (Warts), Verruca Plana (Plantar Warts), Verruca Vulgaris (Vaginal Warts), Or Rosacea AND Formulary Agent: tretinoin (RETIN-A) gel or cream
TREXIMET 10-60 mg TABLET	Non-Preferred	Formulary Agent: naproxen and sumatriptan separately taken together
TREXIMET 85-500 mg TABLET	Non-Preferred	Formulary Agent: naproxen and sumatriptan separately taken together
TRIAMCINOLONE ACETONIDE (KENALOG) 0.147MG/G AEROSOL SPRAY	Non-Preferred	Formulary Agents: topical triamcinolone ointment/cream/lotion

Drug	Status	Special Instructions
TRI-TABS DHA COMBO PACK	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TRIANEX 0.05% OINTMENT	Non-Preferred	Formulary Agents: TRIAMCINOLONE 0.5% OINTMENT or TRIAMCINOLONE 0.1% OINTMENT
TRIAZ 3% FOAMING CLOTHS	Non-Preferred	Formulary Agents: Benzoyl Peroxide, Oscion (TRIAZ) 3% CLEANSER
TRIAZ 3% PAD	Non-Preferred	Formulary Agents: Benzoyl Peroxide, Oscion (TRIAZ) 3% CLEANSER
TRIAZ 6% FOAMING CLOTHS	Non-Preferred	Formulary Agents: Benzoyl Peroxide, Oscion (TRIAZ) 3% CLEANSER
TRIAZ 6% PAD	Non-Preferred	Formulary Agents: Benzoyl Peroxide, Oscion (TRIAZ) 3% CLEANSER
TRIAZ 9% FOAMING CLOTHS	Non-Preferred	Formulary Agents: Benzoyl Peroxide, Oscion (TRIAZ) 3% CLEANSER
TRIAZ 9% PAD	Non-Preferred	Formulary Agents: Benzoyl Peroxide, Oscion (TRIAZ) 3% CLEANSER
TRICARE PRENATAL DHA ONE SF	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TRICARE PRENATAL TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TRICARE PRENATAL COMPLEAT	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TRICITRATES ORAL SOLUTION	Non-Preferred	Formulary Agent: citric acid solution
TRIGLIDE 160 mg TABLET	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
TRIGLIDE 50 mg TABLET	Non-Preferred	Formulary Agent: fenofibrate (Lofibra)
TRI-LUMA CREAM	PA required	Required diagnosis must be non-cosmetic
TRIMESIS RX, BP FOLINATAL, FOLBECAL TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Trimipramine (SURMONTIL) 100 mg CAPSULE	Non-Preferred	Formulary Agents: amitriptyline, doxepin, nortriptyline, or clomipramine
TriMix Injection	Excluded benefit	
Trintellix 5 mg Tablet (Formerly Known As Brintellix)	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
Trintellix 10 mg Tablet (Formerly Known As Brintellix)	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
Trintellix 20 mg Tablet (Formerly Known As Brintellix)	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
TRIPHROCAP, RENAL CAPSULE, RENALPREN (NEPHROCAP) SOFTGEL	Non-Preferred	Formulary Agent: RENO CAP
TRISTART DHA 31-1-200MG CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TRIUMEQ 600 mg/50 mg/300 mg TABLET	PA required	*Requires Genetic test to confirm negative for HLA-B*5701 allele
TRIVEEN-ONE CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin

Drug	Status	Special Instructions
TRIVEEN-U	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
TROKENDI XR 100 mg CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate ER Capsules
TROKENDI XR 200 mg CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate ER Capsules
TROKENDI XR 25 mg CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate ER Capsules
TROKENDI XR 50 mg CAPSULE	Non-Preferred	Required Diagnosis= Seizures AND Formulary Agent(s): Topiramate ER Capsules
TRONOLANE 1%-5% CREAM	Non-Preferred	Formulary Agents: HYDROCORTISONE Acetate 1%/Pramoxine Hydrochloride 1% (ANALPRAM-HC) CREAM or PRAMOXINE AEROSOL 1% (PROCTOFOAM)
Trophamine 10% IV Solution	Medical Benefit	Bill Through Medical Benefit
TRUETRACK or TRUETEST TEST STRIPS/METER	Non-Preferred	Formulary Agents: FreeStyle or Precision products
TRULANCE 3 mg TABLET	Non-Preferred	*Requires trials of ALL of the following laxative therapies: Saline Laxative (magnesium citrate), 30 days of a Stimulant Laxative (bisacodyl, docusate-senna, senna), AND 30 days of Polyethylene glycol (Miralax)
TRULICITY 0.75MG/0.5ML PEN	Non-Preferred	*30 day trial of metformin or metformin ER
TRULICITY 1.5MG/0.5ML PEN	Non-Preferred	*30 day trial of metformin or metformin ER
Tubersol 5 mg/0.1 mL Vial	Medical Benefit	Bill Through Medical Benefit
TUDORZA 400MCG PRESSAIR INHALER	Non-Preferred	Required diagnosis of: COPD (Emphysema, Chronic Bronchitis) AND A*30 Day Trial Of: Spiriva Respimat
TUSSICAP 10-8 mg	Non-Preferred	Formulary Agent: benzonatate capsule
TUSSICAP 5-4 mg	Non-Preferred	Formulary Agent: benzonatate capsule
TUZISTRA XR 14.7-2.8MG/5ML SUSPENSION	Non-Preferred	Formulary Agent(s): Dextromethorphan Or Benzonatate Capsule
TYPHIM 25 MCG	Medical Benefit	Not included in BVN, covered on medical benefit
Tygacil 50 mg Vial	Medical Benefit	Bill Through Medical Benefit
TYKERB 250 mg TABLET	PA required	Required diagnosis = Breast Cancer
TYMLOS SOLUTION 3.120MCG/1.56ML	Lower Cost	Required Diagnosis= Postmenopausal Osteoporosis
TYSABRI 300 mg/15 mL IV INJECTION	Medical Benefit	Please see the state specific Pharmacy Policy Statement titled Tysabri by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
TYVASO 1.74 mg/2.9 mL SOLUTION	Specialty	Specialty; follow policy on CareSource.com.
TYVASO INHALATION REFILL KIT	Specialty	Specialty; follow policy on CareSource.com.
TYVASO INHALATION STARTER KIT	Specialty	Specialty; follow policy on CareSource.com.
TYZINE 0.1% NOSE DROPS	Non-Preferred	Formulary Agents: ANEFRIN, 12 HR NASAL, SINUS NASAL, NRS NASAL, NASAL NODRIP (NEO-SYNEPHRINE, AFRIN, DRISTAN) or SM NASAL SPRAY, SM NOSE DROPS (NEO-SYNEPHRINE)

Drug	Status	Special Instructions
TYZINE 0.1% NOSE SPRAY	Non-Preferred	Formulary Agents: ANEFRIN, 12 HR NASAL, SINUS NASAL, NRS NASAL, NASAL NODRIP (NEO-SYNEPHRINE, AFRIN, DRISTAN)or SM NASAL SPRAY, SM NOSE DROPS (NEO-SYNEPHRINE)
TYZINE PEDIATRIC 0.05% DROPS	Non-Preferred	Formulary Agents: Little Noses or Afrin Child
UCERIS 2MG FOAM	Non-Preferred	Formulary Agent(s): Budesonide EC (Entocort EC) 3mg Capsule
Uceris 9 mg Tablet	Non-Preferred	A 30 Day Trial Of: Apriso ER, Mesalamine (Asacol HD), Delzicol, Or Balsalazide (Colazal)
U-Cort (Carmol HC) 1% Cream	Non-Preferred	A 30 Day Trial Of: Hydrocortisone 1% Cream
ULESFIA 5% LOTION	Step Therapy	Required diagnosis = Head Lice with trials below: Age 6 months up to 2 years old: LICE TREATMENT LIQUID 1%, permethrin (Rid Foam), spinosad (Natroba), benzyl alcohol lotion (Ulesfia) Age 2 years - 3 years: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), benzyl alcohol lotion (Ulesfia), or spinosad (Natroba) Age 4 years to 5 years old: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), benzyl alcohol lotion (Ulesfia) or spinosad (Natroba) Age 6 years and older: LICE TREATMENT LIQUID 1%, permethrin (RID FOAM), PYRETHRINS-PIPERONYL BUTOXIDE, PRONTO PLUS (RID LIQUID), LICE-AID (TEGRIN-LT), LICE KILLING SHAMPOO (PRONTO), STOP LICE KIT (RID COMPLETE KIT), spinosad (Natroba), benzyl alcohol lotion (Ulesfia) or malathion (Ovide)
Uloric 40 mg Tablet	Step Therapy	A 30 Day Trial Of: Allopurinol
Uloric 80 mg Tablet	Step Therapy	A 30 Day Trial Of: Allopurinol
Ultimatecare One Capsule	Non-Preferred	A 30 Day Trial Of: Any Formulary Prenatal Vitamin
ULTRACIN 0.025% LOTION	Non-Preferred	Formulary Agent(s): Ziks Arthritis Pain Relief 0.025-1.12% Cream
ULTRAVATE 0.1% LOTION	Non-Preferred	Formulary Agent(s): Clobetasol 0.05% cream, gel, ointment, or lotion (requires PA), Betamethasone DP 0.05% lotion, gel or ointment, Halobetasol 0.05% cream or ointment (both require PA), Fluocinonide 0.1% (Vanos) cream (requires PA), Diflorasone 0.05% cream or ointment
Ultravate Pac 0.05%-12% Ointment	Non-Preferred	A 30 Day Trial Of: Halobetasol Cream (Which Requires A PA) WITH Lactic Acid 5% or 12% OTC
Ultravate X 0.05%-10% Cream	Non-Preferred	A 30 Day Trial Of: Halobetasol Cream (Which Requires A PA) WITH Lactic Acid 5% or 12% OTC
Ultravate X 0.05%-10% Ointment	Non-Preferred	A 30 Day Trial Of: Halobetasol Cream (Which Requires A PA) WITH Lactic Acid 5% or 12% OTC
Uptravi 200 & 800 mcg DosePak	Non-Preferred	Request Must Go Through Clinical Review
Uptravi 200 mcg Tablet	Non-Preferred	Request Must Go Through Clinical Review

Drug	Status	Special Instructions
Uptravi 400 mcg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Uptravi 600 mcg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Uptravi 800 mcg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Uptravi 1,000 mcg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Uptravi 1,200 mcg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Uptravi 1,400 mcg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Uptravi 1,600 mcg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Urea 50% Emulsion	Non-Preferred	A 30 Day Trial Of: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
Urea (Uramaxin GT) 45% Nail Gel	Non-Preferred	A 30 Day Trial Of: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
Urea (Uramaxin) 45% Cream	Non-Preferred	A 30 Day Trial Of: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
Urea (Uramaxin) 45% Lotion	Non-Preferred	A 30 Day Trial Of: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
Urea 50% NailStik	Non-Preferred	A 30 Day Trial Of: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
Urea 50% Topical Suspension	Non-Preferred	A 30 Day Trial Of: REA LO 40% CREAM or CEROVEL, X-VIATE, UREA-C40 , UREA 40% LOTION
URIBEL, URAMIT MB, URO-MP 118-10-36 mg CAPSULE	Non-Preferred	Formulary agents: URELLE tablet, UROGESIC-BLUE or UTRONA-C
UROQID-ACID NO.2 500-500 TABLET	Non-Preferred	Formulary Agent: methamine
Utibron 27.5-15.6 mcg Neohaler	Non-Preferred	Required Diagnosis= COPD AND Formulary Agent(s): Stiolto Respimat Mist Inhaler
VABOMERE 2 gm	Medical Benefit	Medical Benefit
VALCHLOR 0.016% GEL	PA required	Required diagnosis = The topical treatment of Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma with a trial of TARGRETIN 1% GEL
Valproate 100 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
Valproate 500 mg/5 mL Vial	Medical Benefit	Bill Through Medical Benefit
VALTURNA 150-160 mg TABLET	Non-Preferred	30 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)
VALTURNA 300-320 mg TABLET	Non-Preferred	30 Day Trial EACH Of 2 Of The Following 4 Within The Last Year: Losartan (Cozaar), Irbesartan (Avapro), Candesartan (Atacand), Or Valsartan (Diovan)
VANAHIST PD 0.625 mg/mL DROP	Non-Preferred	
VANATOL LQ 50-325-40MG/15ML SOLUTION	Non-Preferred	Formulary Agent(s): Butalbital-Acetaminophen-Caffeine 50-325-40mg Capsule Or Tablet
VANCOMYCIN (VANCOCIN) 125 mg CAPSULE	PA required	Required diagnosis= Severe or Severe/Complicated Clostridium Difficile (C. Diff)) Infection (initial or recurrent) OR Diagnosis = C.Diff (Clostridium Difficile) Colitis/Diarrhea AND A 5 day Trial within the last 30 days of: oral Metronidazole (Flagyl)

Drug	Status	Special Instructions
VANCOMYCIN (VANCOCIN) 250 mg CAPSULE	PA required	Required diagnosis= Severe or Severe/Complicated Clostridium Difficile (C. Diff)) Infection (initial or recurrent) OR Diagnosis = C.Diff (Clostridium Difficile) Colitis/Diarrhea AND A 5 day Trial within the last 30 days of: oral Metronidazole (Flagyl)
VANDETANIB (CAPRELSA) 100 mg TABLET	PA required	Required diagnosis = Medullary thyroid cancer
VANDETANIB (CAPRELSA) 300 mg TABLET	PA required	Required diagnosis = Medullary thyroid cancer
Vancomycin 500 mg Vial	Medical Benefit	Bill Through Medical Benefit
Vancomycin 750 mg Vial	Medical Benefit	Bill Through Medical Benefit
Vancomycin 1,000 mg Vial	Medical Benefit	Bill Through Medical Benefit
Vancomycin 5,000 mg Vial	Medical Benefit	Bill Through Medical Benefit
Vancomycin 10G Vial	Medical Benefit	Bill Through Medical Benefit
Vancomycin In Dextrose 500 mg/100 mL Vial	Medical Benefit	Bill Through Medical Benefit
Vancomycin In Dextrose 750 mg/150 mL Vial	Medical Benefit	Bill Through Medical Benefit
Vancomycin In Dextrose 1G/200 mL Vial	Medical Benefit	Bill Through Medical Benefit
Vaniqa Cream	Excluded benefit	
VANOS 0.1% CREAM	Non-Preferred	Formulary Agent: fluocinolone cream
VANOXIDE-HC LOT 5-0.5%	Non-Preferred	Formulary Agents: BENZOYL PEROXIDE and HYDROCORTISONE separately at the same time
VANTAS KIT 50 mg	Specialty	Specialty
VARITHENA FOAM 180MG/18ML	Non-Preferred	Request Must Go Through Clinical Review
VARUBI 90MG TABLET	Non-Preferred	*Dx= Nausea/Vomiting Due To Chemotherapy Or Surgery Or Currently Receiving Chemotherapy Or *Dx= Nausea/Vomiting AND A One Time Trial Of A Formulary Agent Such As Ondansetron Or Promethazine
VASCEPA 0.5G CAPSULE	Non-Preferred	A 30 Day Trial Of: Simvastatin Or Atorvastatin AND OTC Fish Oils Or Omega-3 (Lovaza)
VASCEPA 1G CAPSULE	Non-Preferred	A 30 Day Trial Of: Simvastatin Or Atorvastatin AND OTC Fish Oils Or Omega-3 (Lovaza)
Vasculera 630mg Tablet	Excluded Benefit	
VASOLEX, REVINA (XENADERM) OINTMENT	Non-Preferred	Required diagnosis = Wound debridement
Vecamyl 2.5 mg	Non-Preferred	Required Diagnosis= Malignant Hypertension Or Moderate-Severe Hypertension AND A 30 Day Trial Of: Minoxidil
VECTIBIX 100MG/5ML VIAL	Non-Preferred	Required DX= metastatic colorectal cancer
VECTIBIX 20MG/ML VIAL	Non-Preferred	Required DX= metastatic colorectal cancer
VELTASSA 8.4GM POWDER PACK FOR SUSPENSION	Non-Preferred	Required Diagnosis= Hyperkalemia AND Formulary Agent(s): Sodium Polystyrene Sulfonate
VELTASSA 16.8GM POWDER PACK FOR SUSPENSION	Non-Preferred	Required Diagnosis= Hyperkalemia AND Formulary Agent(s): Sodium Polystyrene Sulfonate

Drug	Status	Special Instructions
VELTASSA 25.2GM POWDER PACK FOR SUSPENSION	Non-Preferred	Required Diagnosis= Hyperkalemia AND Formulary Agent(s): Sodium Polystyrene Sulfonate
VELPHORO 500MG CHEWABLE TAB	Non-Preferred	Formulary Agent: calcium acetate (PhosLo)
VEMLIDY 25 mg TABLET	Non-Preferred	Required DX = Chronic hepatitis B with compensated liver disease AND a 30-day trial of Viread 300 mg with documented (chart notes) ADRs and physician would like to trial Vemlidy to see if tolerable for patient
Venclexta 10 mg Tablet	Non-Preferred	Required Diagnosis= Chronic Lymphocytic Leukemia (CLL) AND Member Is Positive For The 17p Chromosome Deletion AND Has Received At Least One Prior Therapy For CLL
Venclexta 50 mg Tablet	Non-Preferred	Required Diagnosis= Chronic Lymphocytic Leukemia (CLL) AND Member Is Positive For The 17p Chromosome Deletion AND Has Received At Least One Prior Therapy For CLL
Venclexta 100 mg Tablet	Non-Preferred	Required Diagnosis= Chronic Lymphocytic Leukemia (CLL) AND Member Is Positive For The 17p Chromosome Deletion AND Has Received At Least One Prior Therapy For CLL
Venclexta 10-50-100 mg Starting Pack	Non-Preferred	Required Diagnosis= Chronic Lymphocytic Leukemia (CLL) AND Member Is Positive For The 17p Chromosome Deletion AND Has Received At Least One Prior Therapy For CLL
VENELEX 87-788MG OINTMENT	Non-Preferred	Formulary Agent(s): Cerave, Cetaphil, Aveeno, Lubriderm (Eucerin), TheraPlex, Velvachol, NutraDerm, Ammonium Lactate, LacLotion, AmLactin, Geri-Hydrolac, AL-12 (LacHydrin, Lac-Hydrin Twelve) lotion
VENLAFAXINE ER 150 mg TABLET	Non-Preferred	Formulary Agent: venlafaxine ER capsules or Must first try the following Formulary Agent(s): fluoxetine if age 8-11; escitalopram OR fluoxetine if age 12-17; if age 18 years old and older, will require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules) 3) Dopamine Reuptake Blocking Agents (Bupropion, Bupropion SR, Bupropion XL)
VENLAFAXINE ER 225 mg TABLET	Non-Preferred	Formulary Agent: venlafaxine ER capsules or Must first try the following Formulary Agent(s): fluoxetine if age 8-11; escitalopram OR fluoxetine if age 12-17; if age 18 years old and older, will require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules) 3) Dopamine Reuptake Blocking Agents (Bupropion, Bupropion SR, Bupropion XL)
VENLAFAXINE ER 37.5 mg TABLET	Non-Preferred	Formulary Agent: venlafaxine ER capsules or Must first try the following Formulary Agent(s): fluoxetine if age 8-11; escitalopram OR fluoxetine if age 12-17; if age 18 years old and older, will require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules) 3) Dopamine Reuptake Blocking Agents (Bupropion, Bupropion SR, Bupropion XL)

Drug	Status	Special Instructions
VENLAFAXINE ER 75 mg TABLET	Non-Preferred	Formulary Agent: venlafaxine ER capsules or Must first try the following Formulary Agent(s): fluoxetine if age 8-11; escitalopram OR fluoxetine if age 12-17; if age 18 years old and older, will require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules) 3) Dopamine Reuptake Blocking Agents (Bupropion, Bupropion SR, Bupropion XL)
VENTAVIS 10 mcg/1 mL SOLUTION	PA required	Specialty; follow policy on CareSource.com.
VENTAVIS 20 mcg/1 mL SOLUTION	PA required	Specialty; follow policy on CareSource.com.
VERAMYST 27.5 mcg NASAL SPRAY	Non-Preferred	Formulary Agent(s): Ages 2-3: Nasacort OTC Allergy 24HR Spray OR Ages 4-5: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 And Older: 2 Of The Following 4 Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray
VERAPAMIL CR (VERELAN PM) 100 mg CAPSULE	Non-Preferred	Formulary Agent: VERAPAMIL CR (CALAN SR) 120 mg TABLET
VERAPAMIL CR (VERELAN PM) 200 mg CAPSULE	Non-Preferred	Formulary Agent: VERAPAMIL CR (CALAN SR) 180 mg TABLET
VERAPAMIL CR (VERELAN PM) 300 mg CAPSULE	Non-Preferred	Formulary Agent: VERAPAMIL CR (CALAN SR) 240 mg TABLET
VERDESO 0.05% FOAM	Non-Preferred	Required diagnosis= Atopic Dermatitis (Eczema) AND Must use 2 different formulary corticosteroid agents for 7 days each.
VEREGEN 15% OINTMENT	PA required	Required diagnosis = External genital and perianal warts Required trial of: Podofilox (Condylox) solution
VERIPRED 20 20 mg/5 mL SOLUTION	Non-Preferred	Formulary Agent: prednisolone 15 mg/5 mL solution
VERSACLOZ 50MG/ML SUSPENSION	Non-Preferred	Formulary Agent: clozapine tablets
VESICARE 10 mg TABLET	Non-Preferred	Formulary Agents: oxybutynin (IR or ER), tolterodine, trospium, or trospium xr
VESICARE 5 mg TABLET	Non-Preferred	Formulary Agents: oxybutynin (IR or ER), tolterodine, trospium, or trospium xr
VH ESSENTIALS UTI STICK	Non-Preferred	Required diagnosis = Suspected UTI
VIAGRA	Excluded benefit	
Viberzi 75mg Tablet	Non-Preferred	Required Diagnosis= Severe-Diarrhea OR IBS (Irritable Bowel Syndrome) AND Formulary Agent(s): Atropine-Diphenoxylate (Lomotil) Or Dicyclomine (Bentyl)

Drug	Status	Special Instructions
Viberzi 100mg Tablet	Non-Preferred	Required Diagnosis= Severe-Diarrhea OR IBS (Irritable Bowel Syndrome) AND Formulary Agent(s): Atropine-Diphenoxylate (Lomotil) Or Dicyclomine (Bentyl)
VIBRAMYCIN 50 mg/5 mL SYRUP	Non-Preferred	Formulary Agent: VIBRAMYCIN 25 mg/5 mL SUSPENSION
VICTOZA 2-PAK 18 mg/3 mL PEN	Step Therapy	Requires a 30 day trial of: metformin IR or ER (Glucophage or Glucophage XR) unless Renal/kidney disease/Increased Creatinine OR HbA1c (Hemaglobin A1c) with a value greater than 7.5% from within the last 30 days
VIEKIRA PAK 12.5-75-50 & 250MG	Non-Preferred	Request Must Go Through Clinical Review
Viekira XR 200-8.33-50 & 33.33 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Vigabatrin (SABRIL) 500 mg POWDER PACKET	Non-Preferred	Specialty; follow policy on CareSource.com.
VIIBRYD 10 mg TABLET	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
VIIBRYD 20 mg TABLET	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
VIIBRYD 40 mg TABLET	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
Viibryd 10-20 mg Titration Kit	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
VIIBRYD TITRATION KIT 10/20/40 mg	Non-Preferred	Formulary Agent(s): Require a trial of at least two of the three antidepressant catergories: 1) SSRI (Citalopram, Escitalopram, Fluoxetine, Paroxetine, Fluvoxamine, Sertraline) 2) SNRI (Duloxetine, Venlafaxine ER Capsules, Venlafaxine tablets) 3) Dopamine Reuptake Blocking Agents (Bupropion SR, Bupropion XL)
VIMIZIM 5MG/5ML INJECTION	Non-Preferred	Required diagnosis = Morquio A Syndrome or mucopolysaccharidosis(MPS) by a pediatiric specialist
Vimovo 375 mg-20 mg Tablet	Non-Preferred	A 30 Day Trial Of: Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole, OTC Nexium 20mg Or Esomeprazole (Nexium) 20 mg Or 40 mg AND Naproxen Separately Taken Together At The Same Time

Drug	Status	Special Instructions
Vimovo 500 mg-20 mg Tablet	Non-Preferred	A 30 Day Trial Of: Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole, OTC Nexium 20mg Or Esomeprazole (Nexium) 20 mg Or 40 mg AND Naproxen Separately Taken Together At The Same Time
VIMPAT 10 mg/ML SOLUTION	PA required	Required Diagnosis= Seizure or Epilepsy AND Formulary Agent(s): Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide OR Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga
VIMPAT 100 mg TABLET	Step Therapy	Required Diagnosis= Seizure or Epilepsy AND Formulary Agent(s): Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide OR Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga
VIMPAT 150 mg TABLET	Step Therapy	Required Diagnosis= Seizure or Epilepsy AND Formulary Agent(s): Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide OR Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga
VIMPAT 200 mg TABLET	Step Therapy	Required Diagnosis= Seizure or Epilepsy AND Formulary Agent(s): Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide OR Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga
VIMPAT 50 mg TABLET	Step Therapy	Required Diagnosis= Seizure or Epilepsy AND Formulary Agent(s): Gabapentin, Lamotrigine (Lamictal), Divalproex (Depakote), Levetiracetam (Keppra), Levetiracetam ER (Keppra XR), Oxcarbazepine (Trileptal), Carbamazepine (Carbatrol, Tegretol), Phenytoin (Dilantin), Topiramate (Topamax), Valproic Acid (Depakene) Or Zonisamide OR Previously Approved For And Currently Using Aptiom, Banzel, Fycompa, Lyrica, Onfi, Or Potiga
Vimizim 5mg/5mL Vial	PA required	Required Diagnosis= Morquio A Syndrome or Mucopolysaccharidosis (MPS)
VINATE AZ EXTRA TABLET	Non-Preferred	Formulary Agents: any formulary prenatal vitamin
VINATE AZ TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VINATE DHA RF	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VINATE PN CARE TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Vinblastine 1 mg/mL Vial	Medical Benefit	Bill Through Medical Benefit
VIRAZOLE 6 gM INHLATION SOLUTION	Non-Preferred	Required Diagnosis= Hospitalized Infants And Young Children With Severe Lower Respiratory Tract Infection Due To Respiratory Syncytial Virus (RSV)
Vistogard 10 GM Granules Packet	Non-Preferred	Required Diagnosis= 5-FU/Capecitabine Toxicity
Visudyne 15mg Vial	Specialty	Specialty; Follow Policy On CareSource.com
VITAFOL-NANO TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Vitafol-OB + DHA 65-1 mg & 250 mg Pack	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VITAFOL-OB	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin

Drug	Status	Special Instructions
VITAFOL-ULTRA	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VITAFOL SYRUP	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VITAFOL-ONE, REAPHIRM, PNV-FIRST CAPSULE	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VITAL-D RX TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VITAMIN D3 400 UNIT CHEWABLE TABLET	Non-Preferred	Formulary Agent(s): Vitamin D3 tablet
VITAMIN D3 1,000 UNIT CHEWABLE TABLET	Non-Preferred	Formulary Agent(s): Vitamin D3 tablet
VITUZ 5-4 mg SOLUTION	Non-Preferred	Formulary Agents: benzonatate capsule or DEXTROMETHORPHAN
VIVELLE-DOT 0.025 mg PATCH	Non-Preferred	Formulary Agents: Alora or Estradiol (Climara) patches
VIVELLE-DOT 0.0375 mg PATCH	Non-Preferred	Formulary Agents: Alora or Estradiol (Climara) patches
VIVELLE-DOT 0.05 mg PATCH	Non-Preferred	Formulary Agents: Alora or Estradiol (Climara) patches
VIVELLE-DOT 0.075 mg PATCH	Non-Preferred	Formulary Agents: Alora or Estradiol (Climara) patches
VIVELLE-DOT 0.1 mg PATCH	Non-Preferred	Formulary Agents: Alora or Estradiol (Climara) patches
Vivlodex 5 mg Capsule	Non-Preferred	Formulary Agent(s): Meloxicam Suspension OR Tablet
Vivlodex 10 mg Capsule	Non-Preferred	Formulary Agent(s): Meloxicam Suspension OR Tablet
VIVOTIF BERNA CAPSULE	Non-Preferred	Required diagnosis = For immunization of adults and children older than 6 years against disease caused by Salmonella typhi
VOL-CARE RX TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VOL-NATE TABLET	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
VOPAC 10-2% CREAM KIT	Non-Preferred	A 30 Day Trial Of: Diclofenac (Voltaren) Gel With Lidocaine 2% Gel Jelly, Lidocaine 3% Cream, Or Lidocaine 3% Lotion
VOPAC 5 5% CREAM	Non-Preferred	A 30 Day Trial Of: Diclofenac (Voltaren) Gel
VOPAC GB 5-2-5% CREAM KIT	Non-Preferred	A 30 Day Trial Of: Diclofenac (Voltaren) Gel With Lidocaine 2% Gel Jelly, Lidocaine 3% Cream, Or Lidocaine 3% Lotion
VORICONAZOLE (VFEND) 200 mg TABLET	Non-Preferred	Formulary Agents: fluconazole or itraconazole with a diagnosis of Candidemia and other Candida infections; Esophageal candidiasis; Invasive aspergillosis OR a diagnosis of Post Transplant aspergillosis prophylaxis or Fungal Meningitis
VORICONAZOLE (VFEND) 40 mg/ML SUSPENSION	Non-Preferred	Formulary Agents: fluconazole or itraconazole
VORICONAZOLE (VFEND) 50 mg TABLET	Non-Preferred	Formulary Agents: fluconazole or itraconazole with a diagnosis of Candidemia and other Candida infections; Esophageal candidiasis; Invasive aspergillosis OR a diagnosis of Post Transplant aspergillosis prophylaxis or Fungal Meningitis
Voriconazole (Vfend) 200 mg Vial	Medical Benefit	Bill Through Medical Benefit
Vosevi 400-100 mg Tablet	Lower Cost	Request Must Go Through Clinical Review
Votrient 200mg Tablet	PA required	Required Diagnosis= Renal Cell Carcinoma OR Soft Tissue Sarcoma
VP-GSTN CAP	Non-Preferred	Formulary Agent: OTC Vitamin D (CHOLECALCIFEROL) with OTC ZINC GLUCONATE TAB separately Taken Together At The Same Time
VP-PRECIP CAPSULE (TEARS AGAIN)	Non-Preferred	Formulary Agents: ICAPS CAP, ICAPS LUTEIN, PROSIGHT, OCUVITE EYE

Drug	Status	Special Instructions
Vpriv 400 Units Vial	Specialty	Specialty; Follow Policy On CareSource.com
Vraylar 1.5 mg Capsule	Step Therapy	Required Diagnosis= Bipolar I Disorder OR Schizophrenia AND 30 Day Trial Of: Aripiprazole (Abilify)
Vraylar 3 mg Capsule	Step Therapy	Required Diagnosis= Bipolar I Disorder OR Schizophrenia AND 30 Day Trial Of: Aripiprazole (Abilify)
Vraylar 4.5 mg Capsule	Step Therapy	Required Diagnosis= Bipolar I Disorder OR Schizophrenia AND 30 Day Trial Of: Aripiprazole (Abilify)
Vraylar 6 mg Capsule	Step Therapy	Required Diagnosis= Bipolar I Disorder OR Schizophrenia AND 30 Day Trial Of: Aripiprazole (Abilify)
Vraylar 1.5 mg & 3 mg Capsule Dose Pack	Step Therapy	Required Diagnosis= Bipolar I Disorder OR Schizophrenia AND 30 Day Trial Of: Aripiprazole (Abilify)
VUSION OINTMENT	Non-Preferred	Required diagnosis=Diaper Rash
VYTONE GEL	Non-Preferred	Must first try: 30 day trial of OTC Hydrocortisone-Aloe Vera with OTC anti-fungal (Clotrimazole, Tolnafate, Miconazole) used separately at the same time
VYTORIN 10-10 mg TABLET	Non-Preferred	Formulary Agents: SIMVASTATIN AND ZETIA separately Taken Together At The Same Time
VYTORIN 10-20 mg TABLET	Non-Preferred	Formulary Agents: SIMVASTATIN AND ZETIA separately Taken Together At The Same Time
VYTORIN 10-40 mg TABLET	Non-Preferred	Formulary Agents: SIMVASTATIN AND ZETIA separately Taken Together At The Same Time
VYTORIN 10-80 mg TABLET	Non-Preferred	Formulary Agents: SIMVASTATIN AND ZETIA separately Taken Together At The Same Time
WELCHOL 3.75 g PACKET	Non-Preferred	Required Diagnosis= Hyperlipidemia *30 day trial of: simvastatin, atorvastatin or rosuvastatin AND *30 day trial of: Cholesytramine or Colestipol OR Required Diagnosis= Liver Disease *30 day trial of: Colestyramine OR Required Diagnosis= Diabetes *30 day trial of metformin IR or ER
WELCHOL 625 mg TABLET	Non-Preferred	Required Diagnosis= Hyperlipidemia *30 day trial of: simvastatin, atorvastatin or rosuvastatin AND *30 day trial of: Cholesytramine or Colestipol OR Required Diagnosis= Liver Disease *30 day trial of: Colestyramine OR Required Diagnosis= Diabetes *30 day trial of metformin IR or ER
WESTHROID 32.5mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WESTHROID 48.75mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WESTHROID 65mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet

Drug	Status	Special Instructions
WESTHROID 97.5mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WESTHROID 130mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WESTHROID 195mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WP THYROID 16.25mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WP THYROID 32.5mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WP THYROID 48.75mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WP THYROID 65mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WP THYROID 81.82mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WP THYROID 97.5mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WP THYROID 113.75mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
WP THYROID 130mg TABLET	Non-Preferred	Formulary Agent(s): Armour Thyroid Tablet
Xadago 50mg	Non-Preferred	*Member Must Meet ALL Of The Following Criteria: *Dx= Parkinson's Disease *Member Had A Documented Inadequate Response Or Adverse Reaction To: Selegiline AND Rasagiline (Per Chart Notes) *Member Has Claims AND Is Currently Using Carbidopa/Levodopa
Xadago 100mg	Non-Preferred	*Member Must Meet ALL Of The Following Criteria: *Dx= Parkinson's Disease *Member Had A Documented Inadequate Response Or Adverse Reaction To: Selegiline AND Rasagiline (Per Chart Notes) *Member Has Claims AND Is Currently Using Carbidopa/Levodopa
Xalkori 200mg Capsule	PA required	Required Diagnosis= Advanced Or Metastatic Non-Small Cell Lung Cancer (NSCLC)
Xalkori 250mg Capsule	PA required	Required Diagnosis= Advanced Or Metastatic Non-Small Cell Lung Cancer (NSCLC)
XARTEMIS XR 7.5MG-325 MG	Non-Preferred	Formulary Agent: Oxycodone-Acetaminophen (Percocet) 7.5-325 MG Tablet
Xatemp 2.5 mg/mL Oral Solution	Lower Cost	Required Diagonsis: Acute Lymphoblastic Leukemia (ALL) or Polyarticular Juvenile Idiopathic Arthritis (PJIA).
Xeljanz 5 mg Tablet	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Xeljanz by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
Xeljanz XR 11 mg Tablet	Non-Preferred	Please see the state specific Pharmacy Policy Statement titled Xeljanz XR by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
Xeomin 50 Units Vial	Specialty	Specialty; Follow Policy On CareSource.com
Xeomin 100 Units Vial	Specialty	Specialty; Follow Policy On CareSource.com
Xeomin 200 Units Vial	Specialty	Specialty; Follow Policy On CareSource.com
XERAC AC 6.25%	Non-Preferred	Formulary Agents: Drysol or HyperCare
XERESE 5%-1% CREAM	Non-Preferred	Formulary Agents: Abreva for a diagnosis of cold sores
XERMELO 250 mg TABLET	Non-Preferred	Request Must Go Through Clinical Review
Xgeva 120mg/1.7mL Vial	Specialty	Specialty; Follow Policy On CareSource.com

Drug	Status	Special Instructions
Xiaflex 0.9mg Vial	Non-Preferred	Required Diagnosis= Adult Patients With Dupuytren Contracture Of Palmar Fascia With A Palpable Cord OR Peyronie's Disease
XIBROM 0.09% EYE DROPS	Non-Preferred	Formulary Agent: DICLOFENAC (VOLTAREN) 0.1% EYE DROPS
XIFAXAN 200 mg TABLET	PA required	Required Diagnosis= Traveler's Diarrhea AND Formulary Agent(s): Ciprofloxacin Or Metronidazole Tablets
XIFAXAN 550 mg TABLET	PA required	Required Diagnosis= Hepatic Encephalopathy AND Formulary Agent(s): Lactulose OR Required Diagnosis= Irritable Bowel Syndrome-Diarrhea (IBS-D) AND Formulary Agent(s): Loperamide OR Antispasmodics (Hyoscyamine, Dicylclomine) OR Tricyclic Antidepressants (Amitriptyline, Desipramine, Doxepin) OR Required Diagnosis= Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis, Diverticulitis) AND Formulary Agent(s): Ciprofloxacin Or Metronidazole Tablets OR Required Diagnosis= SIBO (Small Intestine Bacterial Overgrowth) AND Formulary Agent(s): Amoxicillin-Clavulanic Acid, Clindamycin, Metronidazole Tablets OR Tetracycline
XIGDUO XR 5MG-500MG TABLET	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
XIGDUO XR 5MG-1,000MG TABLET	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
XIGDUO XR 10MG-500MG TABLET	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
XIGDUO XR 10MG-1,000MG TABLET	Non-Preferred	Formulary Agent(s): Metformin IR Or ER THEN Invokana With Metformin Separately Taken Together At The Same Time
Xiidra 5% Ophthalmic Solution	Non-Preferred	Required Diagnosis= Dry Eye Disease AND Formulary Agent(s): OTC Artificial Tears
XOFIGO INJECTION 1000 KBQ/ML	Non-Preferred	Required Diagnosis= Castration-Resistant Prostate Cancer, Symptomatic Bone Metastases, And No Known Visceral Metastatic Disease
Xolair 150mg Vial	PA required	Specialty; Follow Policy On CareSource.com
XOLEGEL 2% GEL	Non-Preferred	Formulary Agent: ketoconazole cream
XOLOX 10-500 mg TABLET	Non-Preferred	Formulary Agent: Oxycodone-Acetaminophen 10-650 mg tablet
XULTOPHY 100/3.6	Non-Preferred	Requires a 30 day trial of: Insulin Glargine (Levemir, Tresiba, Toujeo or Basaglar) AND a GLP 1 agonist (Victoza, Trulicity, Bydureon, Byettta, or Tanzeum) separately taken together at the same time
Xtamep Oral Solution 2.5 mg/mL	Lower Cost	Required Diagnosis=Acute Lymphoblastic Leukemia (ALL) or Polyarticular Juvenile Idiopathic Arthritis (PJIA).
Xtampza ER 9 mg Capsule	Non-Preferred	Required Diagnosis= Severe Pain Requiring Around The Clock, Long-Term Opioid Treatment AND The Potential For Abuse AND 30 Day Trial of oxycodone ER (Oxycontin)
Xtampza ER 13.5 mg Capsule	Non-Preferred	Required Diagnosis= Severe Pain Requiring Around The Clock, Long-Term Opioid Treatment AND The Potential For Abuse AND 30 Day Trial of oxycodone ER (Oxycontin)
Xtampza ER 18 mg Capsule	Non-Preferred	Required Diagnosis= Severe Pain Requiring Around The Clock, Long-Term Opioid Treatment AND The Potential For Abuse AND 30 Day Trial of oxycodone ER (Oxycontin)
Xtampza ER 27 mg Capsule	Non-Preferred	Required Diagnosis= Severe Pain Requiring Around The Clock, Long-Term Opioid Treatment AND The Potential For Abuse AND 30 Day Trial of oxycodone ER (Oxycontin)

Drug	Status	Special Instructions
Xtampza ER 36 mg Capsule	Non-Preferred	Required Diagnosis= Severe Pain Requiring Around The Clock, Long-Term Opioid Treatment AND The Potential For Abuse AND 30 Day Trial of oxycodone ER (Oxycontin)
Xtandi 40mg Capsule	PA required	Required Diagnosis = Metastatic Castration-Resistant Prostate Cancer
Xuriden Granules 2 GM Packet	Non-Preferred	Required Diagnosis= Hereditary Orotic Aciduria
XYNTHA VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
XYNTHA SOLOFUSE VIAL	PA required	Required diagnosis: Hemophilia A or B AND *Member's weight in kilograms within the last 6 months must be documented on PA form (if not call out to MDO to obtain)
XYREM 500 mg/ML ORAL SOLUTION	PA required	Required diagnosis = Narcolepsy with Cataplexy or Narcolepsy without Cataplexy AND Request Must Go Through Clinical Review
XYZAL OTC ALLERGY SOLUTION 2.5MG/5ML	Lower Cost	Formulary Agent: 30 day trial of Levocetirizine
XYZAL OTC ALLERGY TABLET 5MG	Lower Cost	Formulary Agent: 30 day trial of Levocetirizine
YERVOY INJECTION 200 mg	Non-Preferred	Request Must Go Through Clinical Review
YERVOY INJECTION 50 mg	Non-Preferred	Request Must Go Through Clinical Review
YESCARTA INJECTION	Medical Benefit	Bill Through Medical Benefit
Yocon (Yohimbine)	Excluded benefit	
Yondelis 1mg Vial	Non-Preferred	Required Diagnosis= Unresectable Or Metastatic Liposarcoma Or Leiomyosarcoma Who Received A Prior Anthracycline-Containing Regimen
YOSPRALA 81-40MG TABLET	Non-Preferred	Required Diagnosis=Secondary prevention of cardiovascular and cerebrovascular events AND A 90-day trial of all of the following: - aspirin in combination with misoprostol (or contraindication to misoprostol) - aspirin in combination with ALL formulary PPI's
Zaltrap 100 mg/4 mL Vial	Non-Preferred	Required Diagnosis= Metastatic Colorectal Cancer That Is Resistant To Or Has Progressed Following An Oxaliplatin-Containing Regimen
Zaltrap 200 mg/8 mL Vial	Non-Preferred	Required Diagnosis= Metastatic Colorectal Cancer That Is Resistant To Or Has Progressed Following An Oxaliplatin-Containing Regimen
Zamicet 10-325 mg/15 mL Solution	Non-Preferred	A 30 Day Trial Of: Hydrocodone-Acetaminophen (Lortab) Solution 7.5-500 mg/15 mL
Zanosar 1 GM Vial	Medical Benefit	Bill through Medical Benefit
Zarxio 300 mcg/0.5 mL Syringe	Specialty	Specialty; Follow Policy On CareSource.com
Zarxio 480 mcg/0.8 mL Syringe	Specialty	Specialty; Follow Policy On CareSource.com
Zatean-PN DHA, PNV-DHA, Virt-PN DHA 27-1-300 mg Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Zatean-PN Plus, PNV-Omega, Virt-PN Plus Capsule	Non-Preferred	Formulary Agent(s): Any Formulary Prenatal Vitamin
Zavesca 100 mg Capsule	PA required	Specialty; Follow Policy On CareSource.com

Drug	Status	Special Instructions
Zecuity Iontophoretic 6.5 mg/4 HR Patch	Non-Preferred	A 30 Day Trial Of 2 Of The 3 Agents: Sumatriptan, Naratriptan, Or Rizatriptan At Maximum Recommended Doses
Zejula 100 mg Tablet	Lower Cost	Required Diagnosis=Maintenance treatment of recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer
Zelapar 1.25 mg ODT Tablet	Non-Preferred	A 30 Day Trial Of: Selegiline Tablet
Zelboraf 240 mg Tablet	PA required	Required Diagnosis= 4800 BRAF V600E-Mutated Metastatic Melanoma AND MD Specialty= Oncology
Zemaira 1,000 mg Vial	Specialty	Specialty; Follow Policy On CareSource.com
Zema-Pak 10 Day 1.5 mg Tablet	Non-Preferred	A 30 Day Trial Of: Dexamethasone Tablet
Zembrace SymTouch 3 mg/0.5 mL Auto-Injector	Non-Preferred	Medication Must Go Through Clinical Review
Zenatane 10 mg Capsule	Non-Preferred	A 30 Day Trial Of: Formulary Topicals AND Formulary Orals
Zenatane 20 mg Capsule	Non-Preferred	A 30 Day Trial Of: Formulary Topicals AND Formulary Orals
Zenatane 30 mg Capsule	Non-Preferred	A 30 Day Trial Of: Formulary Topicals AND Formulary Orals
Zenatane 40 mg Capsule	Non-Preferred	A 30 Day Trial Of: Formulary Topicals AND Formulary Orals
Zenzedi 2.5 mg Tablet	Non-Preferred	A 30 Day Trial Of: Dextroamphetamine, Zenzedi 5 mg Or 10 mg Tablet
Zenzedi 7.5 mg Tablet	Non-Preferred	A 30 Day Trial Of: Dextroamphetamine, Zenzedi 5 mg Or 10 mg Tablet
Zenzedi 15 mg Tablet	Non-Preferred	A 30 Day Trial Of: Dextroamphetamine, Zenzedi 5 mg Or 10 mg Tablet
Zenzedi 20 mg Tablet	Non-Preferred	A 30 Day Trial Of: Dextroamphetamine, Zenzedi 5 mg Or 10 mg Tablet
Zenzedi 30 mg Tablet	Non-Preferred	A 30 Day Trial Of: Dextroamphetamine, Zenzedi 5 mg Or 10 mg Tablet
Zeosa , Zenchent Fe, Wymzya Fe (Femcon Fe) 0.4 mg-35 mcg Chewable Tablet	Non-Preferred	A 30 Day Trial Of: A Formulary Birth Control Agent
Zepatier 50-100 mg Tablet	PA required	Please see the state specific Pharmacy Policy Statement titled Zepatier by clicking your state under Pharmacy Policies at https://www.caresource.com/providers/policies/
Zerbaxa 1-0.5G Vial	Medical Benefit	Bill Through Medical Benefit
Zetonna 37 mcg Nasal Spray	Non-Preferred	Formulary Agent(s): Ages 2-3: Nasacort OTC Allergy 24HR Spray OR Ages 4-5: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Or Nasacort OTC Allergy 24HR Spray OR Ages 6 And Older: 2 Of The Following 4 Drugs: Fluticasone (Flonase), Flonase OTC Allergy Relief Spray, Flunisolide, Or Nasacort OTC Allergy 24HR Spray
Zileuton (Zyflo CR) 600 mg Tablet	Non-Preferred	A 30 Day Trial Of: Montelukast (Singulair)
Zinbryta 150 mg/mL Prefilled Syringe	Non-Preferred	Specialty; Request Must Go Through Clinical Review
Zioptan 0.015 mg/mL Ophthalmic Solution	Non-Preferred	A 30 Day Trial Of: Latanoprost 0.005% Eye Drops
Zipsor 25 mg Capsule	Non-Preferred	A 30 Day Trial Of: Diclofenac Potassium (Cataflam) Tablet AND Diclofenac Sodium (Voltaren) Tablet
Zirgan 0.15% Ophthalmic Gel	PA required	Required Diagnosis= Acute Herpetic Keratitis (Dendritic Ulcers)

Drug	Status	Special Instructions
Zithranol 1% Shampoo	Non-Preferred	A 30 Day Trial Of: Calcipotriene (Dovonex) 0.005% Solution
Zithranol-RR 1.2% Cream	Non-Preferred	A 30 Day Trial Of: Calcipotriene (Dovonex) 0.005% Cream
Zohydro ER 10 mg Tablet	Non-Preferred	A 30 Day Trial Of: Morphine Sulfate ER (MS Contin), Oxymorphone ER Or Fentanyl Patches
Zohydro ER 15 mg Tablet	Non-Preferred	A 30 Day Trial Of: Morphine Sulfate ER (MS Contin), Oxymorphone ER Or Fentanyl Patches
Zohydro ER 20 mg Tablet	Non-Preferred	A 30 Day Trial Of: Morphine Sulfate ER (MS Contin), Oxymorphone ER Or Fentanyl Patches
Zohydro ER 30 mg Tablet	Non-Preferred	A 30 Day Trial Of: Morphine Sulfate ER (MS Contin), Oxymorphone ER Or Fentanyl Patches
Zohydro ER 40 mg Tablet	Non-Preferred	A 30 Day Trial Of: Morphine Sulfate ER (MS Contin), Oxymorphone ER Or Fentanyl Patches
Zohydro ER 50MG TABLET	Non-Preferred	A 30 Day Trial Of: Morphine Sulfate ER (MS Contin), Oxymorphone ER Or Fentanyl Patches
Zoladex 3.6 mg Implant	PA required	Request Must Go Through Clinical Review
Zoladex 10.8 mg Implant	PA required	Request Must Go Through Clinical Review
Zoledronic Acid (Reclast) 5 mg/100 mL Vial	Specialty	Specialty; Follow Policy On CareSource.com
Zoledronic Acid (Zometa) 4 mg/5 mL Vial	Specialty	Specialty; Follow Policy On CareSource.com
Zolinza 100 mg Capsule	PA required	Required Diagnosis= Cutaneous T-Cell Lymphoma (CTCL)
Zolmitriptan (Zomig) 2.5 mg Tablet	Non-Preferred	A One Time Trial Of 2 Of The 4 Agents: Sumatriptan, Naratriptan, Rizatriptan, Or Almotriptan
Zolmitriptan (Zomig) 5 mg Tablet	Non-Preferred	A One Time Trial Of 2 Of The 4 Agents: Sumatriptan, Naratriptan, Rizatriptan, Or Almotriptan
Zolmitriptan Orally Disintegrating (Zomig ZMT) 2.5 mg Tablet	Non-Preferred	A One Time Trial Of 2 Of The 4 Agents: Sumatriptan, Naratriptan, Rizatriptan, Or Almotriptan
Zolmitriptan Orally Disintegrating (Zomig ZMT) 5 mg Tablet	Non-Preferred	A One Time Trial Of 2 Of The 4 Agents: Sumatriptan, Naratriptan, Rizatriptan, Or Almotriptan

Drug	Status	Special Instructions
Zolpidem (INTERMEZZO)SUBLINGUAL TABLET 1.75 mg	Non-Preferred	A Clinical reason (OH MCD ONLY) supported by chart notes why (after a 7 day trial of) the below cannot be used: *IR zolpidem AND *zolpidem ER (which requires a 7 day trial and Clinical reason (OH MCD ONLY) supported by chart notes why unable to use IR)
Zolpidem (INTERMEZZO)SUBLINGUAL TABLET 3.5 mg	Non-Preferred	A Clinical reason (OH MCD ONLY) supported by chart notes why (after a 7 day trial of) the below cannot be used: *IR zolpidem AND *zolpidem ER (which requires a 7 day trial and Clinical reason (OH MCD ONLY) supported by chart notes why unable to use IR)
Zolpimist 5 mg Oral Spray	Non-Preferred	A 7 Day Trial Of: Non-CR Zolpidem
Zolvit 10-300 mg/15 mL Syrup	Non-Preferred	A 30 Day Trial Of: Hydrocodone-Acetaminophen (Lortab) Solution 7.5-500 mg/15 mL
Zomacton 5 mg Vial	Specialty	Specialty; Follow Policy On CareSource.com
Zomacton 10 mg Vial	Specialty	Specialty; Follow Policy On CareSource.com
Zomig 2.5 mg Nasal Spray	Non-Preferred	A One Time Trial Of: Sumatriptan Nasal Spray
Zomig 5 mg Nasal Spray	Non-Preferred	A One Time Trial Of: Sumatriptan Nasal Spray
Zontivity 2.08 mg Tablet	Non-Preferred	A 30 Day Trial Of: Clopidogrel (Plavix)
Zorbtive 8.8 mg Vial	Specialty	Specialty; Follow Policy On CareSource.com
Zorvolex 18 mg Capsule	Non-Preferred	A 30 Day Trial Of: Diclofenac Potassium (Cataflam) Tablet AND Diclofenac Sodium (Voltaren) Tablet
Zorvolex 35 mg Capsule	Non-Preferred	A 30 Day Trial Of: Diclofenac Potassium (Cataflam) Tablet AND Diclofenac Sodium (Voltaren) Tablet
Zostrix Neuropathy (Axsain) 0.25% Cream	Non-Preferred	A 7 Day Trial Of: Arthritis Pain Relief, Capsaicin, Muscle Relief, Theragen-HP, Trixaicin HP (Zostrix HP) 0.075% Cream
Zovirax 5% Cream	Non-Preferred	Required Diagnosis= Cold Sores/Oral Herpes Simplex With A 3 Day Trial Of Abreva AND A 30 Day Trial Of Acyclovir 5% Ointment (Which Also Requires A PA)
Z-Tuss AC 2 mg-9 mg/5 mL	Non-Preferred	Ages 2-6: Off-Label (Can Try Dextromethorphan) Ages 6-12: Dextromethorphan Ages Over 12: Dextromethorphan Or Benzonatate Capsule
Zubsolv 1.4-0.36 mg SL Tablet	Non-Preferred	Request Must Go Through Clinical Review
Zubsolv 2.9-0.71 mg SL Tablet	Non-Preferred	Request Must Go Through Clinical Review
Zubsolv 5.7-1.4 mg SL Tablet	Non-Preferred	Request Must Go Through Clinical Review
Zubsolv 8.6MG-2.1 mg SL Tablet	Non-Preferred	Request Must Go Through Clinical Review
Zubsolv 11.4-2.9 mg SL Tablet	Non-Preferred	Request Must Go Through Clinical Review
Zuplenz 4 mg Soluable Film	Non-Preferred	A One Time Trial Of: Ondansetron (Zofran) 4 mg Tablet Or ODTs
Zuplenz 8 mg Soluable Film	Non-Preferred	A One Time Trial Of: Ondansetron (Zofran) 8 mg Tablet Or ODTs
Zurampic 200mg Tablet	Non-Preferred	Required Diagnosis = hyperuricemia associated with gout AND a 90 day trial and failure of: allopurinol or febuxostat

Drug	Status	Special Instructions
Zyclara 3.75% Cream	Non-Preferred	Required Diagnosis= Actinic Keratosis Or Genital And Perianal Warts AND A 30 Day Trial Of: Imiquimod (Aldara) 5% Cream Packet (Which Also Requires A PA)
Zyclara 2.5% Cream Pump	Non-Preferred	Required Diagnosis= Actinic Keratosis Or Genital And Perianal Warts AND A 30 Day Trial Of: Imiquimod (Aldara) 5% Cream Packet (Which Also Requires A PA)
Zyclara 3.75% Cream Pump	Non-Preferred	Required Diagnosis= Actinic Keratosis Or Genital And Perianal Warts AND A 30 Day Trial Of: Imiquimod (Aldara) 5% Cream Packet (Which Also Requires A PA)
Zydelig 100 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Zydelig 150 mg Tablet	Non-Preferred	Request Must Go Through Clinical Review
Zyflo 600 mg FilmTab	Non-Preferred	A 30 Day Trial Of: Montelukast (Singulair)