2021 PHARMACY FORMULARY
Covered Drug List

VERSION 2021
October 1, 2021

Included inside: Covered Drug List (Formulary), separate lists of specific covered items (blood pressure kits, nebulizers, injectables, vaccines, OTCs, and medical supplies/equipment) covered under the pharmacy benefit. Also included, a pharmacy benefit summary (limits and allowances), TAR submission & requirements, and user guides for understanding the formulary and the formulary search tool (Formulary Navigator™). See the Contents page for a complete list of information included in this formulary.

NOTE: The Covered Drug List consists of commonly used retail & specialty *pharmacy* services. Drugs more commonly administered in a doctor's office, clinic or infusion center and billed primarily as medical benefits are not included in this document.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Call Member Services at **(800) 863-4155**. We are here Monday through Friday, 8 a.m. – 5 p.m. The call is free. California Relay Line [TTY (800) 735-2929 or 711]. Visit us online at www.partnershiphp.org

NONDISCRIMINATION NOTICE

Discrimination is against the law. Partnership HealthPlan of California follows Federal civil rights laws. Partnership HealthPlan of California does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

Partnership HealthPlan of California provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

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NONDISCRIMINATION NOTICE

HOW TO FILE A GRIEVANCE

If you believe that Partnership HealthPlan of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Partnership HealthPlan of California. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact Partnership HealthPlan of California between 8 a.m. – 5 p.m. by calling (800) 863-4155. Or, if you cannot hear or speak well, please call (800) 735-2929 or 711.
- In writing: Fill out a complaint form or write a letter and send it to:

Partnership HealthPlan of California
ATTN: Grievance
4665 Business Center Drive
Fairfield, CA 94534

Or

Partnership HealthPlan of California
ATTN: Grievance
3688 Avtech Parkway
Redding, CA 96002

- In person: Visit your doctor's office or Partnership HealthPlan of California and say you want to file a grievance.
- Electronically: Visit website Partnership HealthPlan of California at www.partnershiphp.org

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **(800) 368-1019**. If you cannot speak or hear well, please call **TTY/TDD (800) 537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

LANGUAGE ASSISTANCE

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (800) 863-4155 (TTY: (800) 735-2929 or 711).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 863-4155 (TTY: (800) 735-2929 or 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 863-4155 (TTY: (800) 735-2929 or 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 863-4155 (TTY: (800) 735-2929 or 711).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 863-4155 (TTY: (800) 735-2929 or 711).

LANGUAGE ASSISTANCE

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 863-4155 (TTY: (800) 735-2929 or 711) 번으로 전화해 주십시오.

繁體中文(Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(800) 863-4155 (TTY: (800) 735-2929 or 711)

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (800) 863-4155 (TTY (հեռատիպ)՝ (800) 735-2929 or 711)

فارسی (Farsi)

توجه: اگر به زبان فارسی صحبت می کنید خدمات زبانی رایگان در دسترس شما می باشد (800) 863-4155 (TTY: (800) 735-2929 or 711)

LANGUAGE ASSISTANCE

日本語 **(Japanese)**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (800) 863-4155 (TTY: (800) 735-2929 or 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 863-4155 (TTY: (800) 735-2929 or 711).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (800) 863-4155 (TTY: (800) 735-2929 or 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ةيبرعلا (Arabic)

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم (800) 863-4155 (هاتف الصم والبكم: 735-2929 (800) أو 711).

LANGUAGE ASSISTANCE

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (800) 863-4155 (TTY: (800) 735-2929 or 711) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 863-4155 (TTY: (800) 735-2929 or 711).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយឌ្ឌនកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បើអ្នក។ ចូរ ទូរស័ព្ទ (800) 863-4155 (TTY: (800) 735-2929 or 711) ។

ພາສາລາວ (Laotian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 863-4155 (TTY: (800) 735-2929 or 711)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Contents

PHC Pharmacy Information

Partnership HealthPlan of California (PHC), with direction from the Pharmacy & Therapeutics (P&T) Committee and Physician Advisory Committee (PAC), has developed the drug formulary (covered drug list) for its Medi-Cal line of business. These committees will continue to update and revise the formulary throughout the year, following evidenced-based practices. Consideration is given to quality of care and sound pharmacoeconomic principles. P & T agenda outcomes are posted quarterly on PHC's website. P & T outcomes are typically implemented the first day of the following quarter, but occasionally may be sooner or later depending on business needs. Usual implementation dates are Jan 1, April 1, July 1 and October 1.

This guide includes the basic *pharmacy* formulary (abridged, not comprehensive) for the Medi-Cal line of business for those prescription services commonly encountered in retail pharmacy or specialty pharmacy settings. Note that PHC has additional drugs available as a medical benefit, when administered directly to a member in a prescriber's office, clinic or infusion center and direct billed to PHC.

ABOUT THE 2021 PHC FORMULARY GUIDE (PDF):

Due to frequent formulary changes made throughout each calendar year, PHC does not routinely distribute annual printed copies of the formulary (available upon request). By accessing the formulary online, providers and members will be assured that current formulary information is available for reference. The 2021 Formulary Guide will be updated on a quarterly basis, to ensure continued accuracy throughout the year, regardless of formulary maintenance and P & T changes.

This formulary guide is organized by therapeutic class, with agents in alphabetical order by product label name within each class. Separate lists of covered Over-The-Counter (OTC) products, medical equipment, supplies and injectables are listed in distinct sections in the pages before the entire Covered Drug List.

Additional formulary information (limits, restrictions, drugs not listed in this guide) as well as non-formulary drug restrictions/criteria can be obtained using the PHC Pharmacy Search Tool. Prescribers and pharmacies may also call PHC Pharmacy Services department for additional information; members may contact PHC Member Services.

**Note for Epocrates App users: Remember to perform Epocrates app updates frequently so that your app is accessing the most recent formulary data.*

SUMMARY OF PHC'S PHARMACY BENEFIT:

Generic Substitution:

PHC's pharmacy benefit is a mandatory generic plan. This means that the use of generics is required for both formulary and non-formulary drug usage, when there is an FDA-approved generic equivalent available.

When a first-time generic is approved by the FDA (meaning before the approval, only the brand name was available to pharmacies), all previous prior authorizations and formulary status/limits are automatically assigned to the generic drug by PHC's PBM. At the same time, the brand name products of the equivalent drug will no longer be covered and they will reject at pharmacy point-of-sale with the message "Brand not covered, use generic".

Example 1, Non-formulary drug with new generic:

Prior to 7/2017, Renvela® was only on the market as the brand name. It was not on the formulary, so claims paid for Renvela® brand when there was an approved TAR for sevelamer carbonate. Those TARs were not approved with brand name medical necessity review, because at that time there was no generic, so by default, the brand claims approved.

After 7/2017, with the market launch of the generic, any of the previously approved TARs would only allow paid claims if the post 7/2017 claims were for generic. Any brand claims submitted after 7/2017 would deny because the TARs were not specifically approved for the brand name.

Example 2, Formulary drug with new generic:

Currently, Nexavar® is on PHC's formulary, with patent expiration in 2018. When the generic came to market in 2018, then the generic automatically "inherited" the formulary status and limits of Nexavar, so the claims for the generic will approve as long as other limits (eg, quantity) are met. And at the same time, the brand name automatically became excluded from the formulary, having been replaced by the generic.

Brand Name Requests (when a generic is available):

If a brand name is determined by a prescriber to be medically necessary, PHC will consider such requests following PHC's policy on brand name drugs (Policy MPRP4003). Policy MPRP4003 requires that members try more than one generic manufacturer as well as try formulary treatment alternatives before determining that the brand name of the same medication is medically necessary.

Allowable Number of Days Supply:

Formulary Generic Drugs: 90 days

Formulary and Non-Formulary Brand Drugs: 30 days unless criteria states otherwise.
(Exceptions are considered for larger supply of non-opioid requests only when members are stable on the regimen and medical rationale for larger supply is included on the TAR).

Non-Formulary Generic Drugs: 30-90, depending on TAR determination

Diabetic supplies (when package as #100): 100 days

Vacation Travel:

Up to a 2 month (60 day) early fill supply is available if needed for vacation travel, with a TAR. Include date of departure and duration of vacation whether visit is out of country or in US. Note that members can fill prescriptions at any pharmacy across the country if the pharmacy is able to submit claims to MedImpact.

Travel Vaccinations and Malaria Prophylaxis are available with a TAR, when member is confirmed to be traveling to a region where these preventive medications are recommended by the CDC. TAR should include region and dates of travel.

Plan Exclusions:

See the section on excluded items for a list of products that are non-benefits (exclusions). Non-benefit (not covered) items are products that have been determined to be not-covered by State Medi- Cal, or State & Federal (CMS) regulations. Such items include products for erectile dysfunction, fertility, cosmetic use, herbs, medical marijuana, food supplements & medical foods (except when the member's condition qualifies for nutritional support per PHC policy MPRP4056 and MPRP4061).

HOW TO USE PHC FORMULARY DOCUMENTS AND TOOLS

The PHARMACY FORMULARY PDF is located at:

http://www.partnershiphp.org/Providers/Pharmacy/Documents/Pharmacy%202021%20documents/PHC_Medi-Cal_Formulary%202021.pdf

Key Points:

- The formulary is updated 4 times throughout each year, after each quarterly P & T Committee meeting, when drug list changes go into effect.
- The formulary is organized by therapeutic class, with some additional product groups listed separately for convenience prior to the covered drug list (such as OTCs, injectables, vaccines, and medical supplies)
- PHC's pharmacy benefit requires generic substitution when an A-rated generic equivalent is available.
- Certain products on the PHC pharmacy formulary may require prior authorization. Although prior authorization is required, these products are preferred over other drugs in the same therapeutic class that are not on the formulary.
- Products on the PHC pharmacy formulary may have restrictions or limits, and use outside those restrictions or limits will require prior authorization with medical justification.
- Products not on the PHC pharmacy formulary may have prior authorization criteria which must be met prior to approval.
    - Non-formulary products are not included in this formulary document because they are not on the formulary. The formulary guide is intended to be a listing of the plan's covered drug list only.
    - Use the formulary search tool on PHC's website to search for drugs not found in this document.
        - The formulary search tool web address is https://client.formularynavigator.com/Search.aspx?siteCode=9588242881

Formulary Drug List Sections:

- Language Assistance Information
- PHC Pharmacy Information
- How to Use PHC Formulary Documents and Tools
- Pharmacy Formulary (Covered Drug List)
- Appendices

Understanding the Pharmacy Formulary (Covered Drug List)

- The table of contents shows the formulary contents by therapeutic class.
- There are 3 formulary "tiers" indicated in the formulary, but note that PHC does not use tiers in the traditional sense that commercial and Medicare Part D plans use the word "tier". In other plans, a "tier" may indicate a preferred status or copay. PHC members do not have copays, regardless of the tier. PHC uses tiers to divide up formulary drugs in this manner:
    - Tier 1: Formulary, with no restrictions
    - Tier 2: Formulary, with restrictions (Code 1, Step, Quantity, Age or Duration limits)
    - Tier 3: Formulary, with prior authorization required
- Column definitions:

Drug Name	Reference	Formulary Tier	Restrictions
This is the product name: Trade name if no generic is available, or generic name if there is a generic. Generics are shown in italics & lower case. Trade (Brand) names are shown in upper case.	The equivalent trade (brand) name when generic is shown as the drug name. Not all generics will list a Reference product.	As above	This will populate with the specific restrictions for the drug if Tier 2.

Items that *can* be found in the Pharmacy Formulary PDF:

Looking for:	How to find:
A specific brand or generic name drug	Use your browser's search/find function (Control-F) to search within the PDF for a specific drug.
A list of drugs within a certain treatment class that are on the PHC Pharmacy Formulary	Use the Table of Contents, which shows the corresponding page for each drug class.
List of covered Over-The-Counter (OTC) products.	See the Over-The-Counter formulary listing on page . These products are also included in the main formulary section by drug class.
List of common medical equipment and medical supplies on the PHC pharmacy formulary.	See the Medical Equipment and Supplies listing on page . Note: products not listed here may be available as a medical benefit through PHC's Utilization Management program rather than Pharmacy.
List of common injectable agents covered as both a medical benefit and a pharmacy benefit	See the Injectables listing on page. Note: This is not a comprehensive list of covered injectables. Injectables not on this list may be a pharmacy benefit or may be only available as a medical benefit. Injectables on the pharmacy formulary will also be listed within the therapeutic section of the formulary. Injectable coverage is also shown in the formulary search tool.
List of covered vaccines	See either (1) the therapeutic section, "Biologicals" on page , or (2) the vaccine section on page , titled "Covered Biologicals: Vaccines for Adult Members Over the Age of 18". Note: Routine vaccinations recommended by ACIP for pediatrics are not covered by the plan. These are provided to Medi-Cal members (including PHC members) through the Vaccines for Children program.
Preferred Hepatitis C regimens	See page , "Partnership HealthPlan of California Hepatitis C Treatment Regimens"
List of products that are not covered by the plan	See page , "Plan Exclusions"
List of products that are billed to State Medi-Cal Fee-For-Service (Carve-Out Drugs) instead of PHC	See the section titled "Carve-Out Drugs", on page
Abbreviations and Acronyms used in Managed Care Medi-Cal	See the section titled "Abbreviations, Terms, Acronyms & Symbols Used by PHC", on page
How to request an emergency fill outside of PHC business hours	See page , "TARS for Emergency Fills".
TAR submission information, fax numbers.	See page ,
What needs a TAR?	See page , "Treatment Authorization Request (TAR)" in the Abbreviations, Terms, Acronyms & Symbols section
Additional TAR submission information	Appendix A
TAR Criteria, not on formulary	Links to online criteria are provided in Appendix A
TAR Criteria format, explained	Appendix B
TAR Criteria, drugs on formulary	Appendix C

Note: Non-formulary drugs and drug criteria are not included in the Pharmacy Formulary. Information on non-formulary drugs and TAR criteria is found in other resources. See the following pages for information on using the Formulary Search Tool and TAR Criteria Table, which do include non-formulary drugs.

FORMULARY LIMITS AND RESTRICTIONS:

Below are the limits and restriction definitions which may be applied to drugs included on PHC's formulary drug list:

- **Prior Authorization**: An item may be on the formulary, yet require clinical criteria to be approved through the TAR process prior to use.
- **Step therapy**: Previous paid claim(s) in the PBM data for a prerequisite treatment(s) which is(are) to be used first before the claim will pay.
- **Code 1 restriction**: A requirement placed on a drug which limits use based on diagnosis, prescriber, clinical parameters, or other limits that cannot otherwise be implemented as specific edit. The prescriber is asked to list the qualifying diagnosis or other remark on the Rx; the pharmacy must verify the Code 1 usage with the office if not stated on the Rx. The Code 1 information as obtained from the prescriber (name, date) must be on the hardcopy Rx or in e-script notes and retrievable for audit purposes. The pharmacy is able to submit electronic override at point-of-sale (as attestation that Code 1 requirements are met), without having to submit prior authorization.
- **Quantity Limits**: The number of units (tabs, mls, gms, etc) that may be either billed per Rx fill or per day supply.
- **Duration Limits**: The number of days (consecutive or cumulative) a treatment may be limited to.
- **Fill Limits**: The number of prescription fills a treatment may be limited to.
- **Prescriber Limits**: May be used to restrict payment of a drug claim to only those claims when the prescriber is a specialist; may also be used to exempt certain specialties from formulary restrictions.
- **Specialty Pharmacy Requirement**: Certain drugs are required to be filled by PHC's contracted specialty pharmacy (certain Walgreens Specialty locations and Alliance Rx-Walgreens Prime.

Example of drug list section: how a restriction/limit will be shown

Drug Name	Reference	Formulary Tier	Restrictions
celecoxib oral capsule 100 mg, 200 mg, 50 mg	Celebrex	2	QL (2 per 1 day)

Using the online Formulary Navigator™ Search Tool

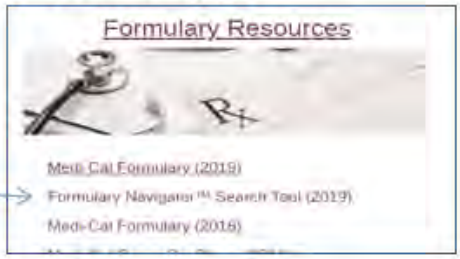
About the Formulary Navigator™ Search Tool:

The Formulary Navigator™ Search Tool is found on the PHC website and allows members and providers to enter a drug name, or click on a drug class, to find the formulary status of a drug or related drugs. This search tool is at this web address: https://client.formularynavigator.com/Search.aspx?siteTestID=1196

You can also get to the search tool by navigating through PHC's website at www.partnershiphp.org

The member section will show a Pharmacy Services menu item; after selecting that, there is a link to the pharmacy formularies which will then have the search tool link.

The provider section will show a Formularies menu item to take you directly to the Formularies page. On the Formularies page, under the Formulary Resources heading, there is a link to the search tool:



With this tool, the user can:

(1) See if a drug is on the PHC pharmacy formulary (pharmacy covered drug list),
(2) See what limits or restrictions there may be on a formulary drug,
(3) View prior authorization (TAR) criteria requirements for both formulary and non-formulary drugs when a TAR is required and
(4) Find formulary alternatives to non-formulary drugs.

The search tool includes information about:

- Drugs on PHC's formulary covered drug list
- Limits and restrictions on formulary drugs
- Drug-specific prior authorization (TAR) criteria for both formulary and non-formulary drugs when criteria as been established, and
- Information about drugs that are to be billed to State Medi-Cal ("Carve Out Drugs").

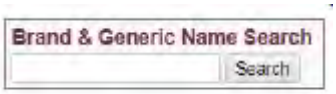
Your search might find drugs that aren't in any of these categories because the drug is not on the formulary nor does it have drug-specific criteria yet established by PHC. In those cases, you may see a "Not Listed" status. In most cases, Not Listed means the same as Not on Formulary – it is the default status for drugs the plan has not indicated as being on the formulary. To verify the status of any "not listed" drug, members may contact PHC Member Services. Any non-formulary *or* "Not Listed" drug may be requested for use by submitting a TAR; as long as the product is an FDA approved drug and not excluded from coverage (such as drugs required to billed by another payer), the drug is eligible for case-by-case review for medical necessity.

How to Use the Search Tool

The search tool may be used to find a specific drug product available in the US market, and the PHC formulary status will be indicated, with added comments about prior authorization criteria (TAR criteria), quantity limits, age limits, Code 1 restrictions and other limits.

The search tool may also be used to find a drug treatment category, and the tool will list the drug products in that category with the PHC formulary status indicated for each drug.

Lastly, the search tool may be used to find formulary alternatives for a drug that is shown as non-formulary.



A search can be started by entering a drug name in the search field, then clicking on "search".

Searching by drug name looks through a list of all available product by product name, thus drug name searches are limited by how the drug has been made available on the market. For example, if there is no generic yet on the market, searching by the generic name instead of the brand name will not find the product. Read through the search scenarios in the next section for tips on getting a successful search result.

A search can also be done alphabetically: Clicking on a letter will bring up all the drugs that start with the letter selected.

Search Scenarios and Expected Results:

Brand Name Drug, no generic on the market -- Enter the brand name of the drug. The brand name must be used in the search field if there is no FDA-approved equivalent generic on the market.

Brand Name Search, when a generic is available – Enter the brand name of the drug. Both brand and generic options will show in your result list.

Generic Search, generic is available -- Enter the generic name for the drug. All generic products containing the same name will show in your result list

Generic Search, no generic available – As previously stated in the first scenario, if you enter a generic name and the product actually isn't on the market as a generic, remember that the drug will not be found because the system is looking for an actual product that can be sold at the pharmacy.

Searching by drug treatment class – Clicking on a drug treatment class will bring up a list of all the drugs in that class, and will show the formulary coverage status. Click on a specific drug to see more details about coverage, such as limits and restrictions.

Searching for formulary alternatives: If the drug you search for is shown as not on formulary, there will be a link for the treatment class next to the drug name. Click on the treatment class and all related drugs in the class will be shown. From there, you can select a formulary alternative that is expected to have the same therapeutic effect.

Interpreting STATUS in Search Results:

When a drug is found in a search, various formulary status symbols are shown. Below the search results, a table or legend/key is shown to indicate what each symbol means. The symbols PHC uses are:

	Drug is covered, without restrictions
	Drug is covered when the claim is within the limits or requirements set by the plan. One or more limits or restrictions may apply: Quantity, Step Therapy, Code 1, Prescriber Specialty, Age, Duration of Treatment, Formulary Prior Authorization (TAR), Daily Dose.
	Drug is on the formulary but has prior authorization requirements (TAR required).
	Generic Available, meaning that the generic is on formulary even though the brand name is not (that is, generic substitution is required). This will be shown when the user searches for a brand name and there is a generic available both on the market and on the formulary.
	Non-Formulary, TAR required. Agents in this non-formulary group have an associated Prior Authorization Criteria (TAR criteria) document available.
	This means the drug is not on the formulary and a TAR is required. Some drugs have drug-specific criteria which must be met prior to approval. Click on the "PA" button in the Notes& Restrictions section of the drug listing to see the criteria.
	These drugs are not payable by PHC; instead, they must be billed to State Medi-Cal.
	NC = Not Covered. These agents have been determined to not be a covered benefit either because (1) product is not FDA approved for safety, efficacy and purity or (2) per State &/or Federal instruction, the item is not to be covered.
	MB = Medical Benefit. The drug is not payable as a pharmacy benefit without a TAR because it is a physician-administered drug and not typically supplied by pharmacies. These drugs may be available as a medical benefit; these drugs may require a TAR (prior authorization).
	NL = Not Listed on PHC's formulary. When doing a search, the search tool looks through a list of all drugs available in the US; this list is called a drug database. PHC makes the tool work by assigning a formulary status to drugs that are on this database. *Not Listed* simply means the drug is in the database but PHC has not yet entered a formulary status for the drug into the database. For example, when new drugs come onto the market, it will automatically be in the national drug database, but there will be a lag time until PHC assigns a formulary status to the drug. In most cases a Not Listed drug can be considered to be not on PHC's formulary, because new drugs must be reviewed first by the P & T committee before being placed on the formulary. Members may contact PHC Member services for clarification of NL drugs; providers may call the Pharmacy Dept. Help Desk.

Interpreting NOTES, LIMITS & RESTRICTIONS in the search results:

When a drug is on the formulary, and has a limit of some kind, the type of limit will be indicated with a symbol, which can be clicked on for more information.

Below are the different symbols used in the formulary search tool to show formulary limits and restrictions, with their definitions:

	User note that will provide information on formulary alternatives.
	User notes that provide additional coverage or TAR submission information
	Age limits that apply, if any.
	Code 1 Restriction. With information provided by the prescriber, the pharmacy can submit an attestation online at point of sale that specified criteria/restrictions are met without having to submit a TAR.
	Drugs with this indicator may be approved on TAR for multiple strengths with a single PA #, at the plan's discretion.
	Indicates medical benefit information for a physician administered drug is included in the user notes.
	When shown under the Notes & Restrictions heading, clicking on the icon will bring up the drug's TAR (PA) Criteria.
	The quantity allowed on formulary. A TAR is needed for quantities that exceed this limit.
	The Specialty Pharmacy icon indicates those drugs that are to be dispensed by PHC's contracted specialty pharmacy.
	Coverage is determined based on the prior use of PHC designated first-line therapies.

Covered Biologicals: Vaccines For Adult Members Over The Age Of 18

(AGES 0-18 ARE COVERED THROUGH THE VACCINES FOR CHILDREN PROGRAM)

Partnership HealthPlan of California provides coverage based on the latest recommendation from Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) guidelines. Children 18 years of age or younger are covered through the Vaccines for Children Program (VFC). Please contact VFC Program for additional information.

For the latest updates and news regarding vaccines, please visit CDC's ACIP website at http://www.cdc.gov/vaccines/hcp/acip-recs/index.html

BCG Vaccine, live
BCG (Tice Strain)
TheraCys

Combination
Comvax (Haemophilus B/Hepatitis B)
Twinrix

Diphtheria, Pertussis & Tetanus Adacel TDAP,
Daptacel

Hepatitis A
Havrix, Vaqta

Hepatitis B
Engerix- B
Recombivax HB

HPV
Gardasil 9 *(19-26 yrs. TAR required for ages 27-45 because ACIP does not recommend routine vaccination in this age group)*

Immune Globulin vaccines
HyperHep B S/D (Hepatitis B Immune Globulin)
HyperRHO S/D
NABI-HB
Hyperab S/D (Rabies Immune Globulin)
Imogam rabies-HT (Rabies Immune Globulin)
Imovax Rabies Vaccine (Rabies Immune Globulin)
RhoGAM (Rho (D) Immune Globulin)
MICRhoGAM Ultra-Filtered

Influenza
Afluria, Afluria Quad
EZ Flu (Flucelvax)
Fluad
Fluarix Quad
Flublok Quad
Flucelvax Quad
Flulaval Quad
Flumist Quad
Fluzone High Dose
Fluzone Quad
Fluzone Quad Pedi

Measles/Mumps/Rubella
MMRII (Measles, mumps & Rubella)

Meningococcal
Bexsero
Menveo
Menomune
Trumenba

Pneumococcal
Pneumovax 23
Prevnar 13

Poliomyelitis vaccine
IPOL

Rabies
Imovax RabAvert

Tetanus/Diphtheria (Td)
Tenivac
Tetanus Diphtheria Toxoids

Tetanus Toxoid
Tetanus Toxoid Adsorbed

Varicella
Varivax vaccine
VariZIG, post exposure/high risk

Zoster vaccine ("shingles")
Shingrix (limited to ages >/= 50)
Zostavax (limited to age >/= 60 and contraindication to Shingrix)

PHC MEDICAL SUPPLY/DME PHARMACY FORMULARY 2021

Pharmacy claims for medical supply and DME prescriptions not listed below will require an approved TAR for payment as a pharmacy claim. Pharmacy claims for medical supply and DME items and non-formulary products approved by TAR (excluding incontinence supplies, disposable gloves, and ostomy supplies) with a National Drug Code (NDC) number must be billed to PHC's Pharmacy Benefit Manager (PBM). Items without an NDC number, all incontinence supplies, disposable gloves, and ostomy supplies, must be billed directly to the PHC Claims Department.

If a member has Medicare Part B &/or D, the provider must bill Medicare as the primary insurer for Part B or D covered medical supply and DME items. PHC may be billed for a 20% Part **B** copay or deductible, *after* the Part B carrier claim has adjudicated and the member's deductible &/or copay have been determined. Part D copays are not reimbursable by PHC.

COVERED MEDICAL SUPPLY / DME ITEMS

Alcohol Wipes, Rubbing Alcohol (Qty limits apply)

Blood Glucose Monitor

Formulary limited to Abbott Diagnostic products

- *Freestyle Lite*
- *Freestyle Freedom Lite*
- *Freestyle InsuLinx*
- *Precision X-tra*

For institutional settings Optium is available

Blood Glucose Test Strips

Formulary limited to Abbott Diagnostic products

- *Freestyle Lite*
- *Freestyle Freedom Lite*
- *Freestyle InsuLinx*
- *Precision X-Tra*
- *Code 1: limited to a maximum of 4 per day testing for members with DM not on insulin, and 8 per day for members with DM and on insulin. Members with gestational diabetes are allowed up to 8 per day.*

Lancets & Lancet Devices

Novopen Injectors

Urine Test Strips

- Diastix
- Ketostix
- Keto-Diastix

Insulin Syringes

Injection supplies other than Insulin syringes

- Disposable Syringes
- Disposable Needles
- Disposable Syringe w/ Needle

Blood pressure monitoring devices/cuffs

- *Code 1 for HTN*
- *Claim limit: $100 or less.*
  Product list follows on next page

Bedwetting Alarm

- *Limited to members age 7 and older*

Bandages

- Non-medicated Gauze, Pad, Sponge type

Humidifiers & Vaporizers *(claim limit $40)*

Nebulizers *(claim limit $100)*

Diaphragms

Inhaler Assist Devices ("Spacers")

- *Limited to $20 reimbursement per spacer*

Disinfectant: Cetylcide II (Qty limits apply)

Hydrogen Peroxide, 3% (Qty limits apply)

Peak Flow Meters

Pill Cutters

Sharps containers

Thermometers, limited to claims </= $10

Locking caps for controlled medications (5 per year)

Lock box for medications (1 per year)

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

NDC CODE	MANUFACTURER or LABELER	GENERIC NAME	BRAND NAME	LABEL NAME
93764-0011-54	A & D Medical	Medical Supply, Miscellaneous	Blood Pressure Cuff	Blood Pressure Cuff - Small
93764-0601-58	A & D Medical	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor
93764-0603-36	A & D Medical	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor
93764-0600-56	A & D Medical	Blood Pressure Test Kit-Small	Blood Pressure Monitor	Blood Pressure Monitor Kit
93764-0601-57	A & D Medical	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor-Medium
93764-0601-55	A & D Medical	Blood Pressure Test Kit-Large	Quick Response	Quick Response BP Monitor
87701-0402-63	Amerisource-GNP	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	GNP Blood Pressure Monitor
72217-0004-01	Arise Medical	Blood Pressure Test Kit-Wrist	Procare Wrist BP Monitor	Procare Blood Pressure Monitor
50428-2712-37	CVS	Blood Pressure Test Kit-Wrist	Blood Pressure Cuff	CVS Blood Pressure Cuff, Large
50428-0333-43	CVS	Blood Pressure Test Kit	Blood Pressure Monitor Manual	CVS Blood Pressure Manual Kit
50428-0329-14	CVS	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	CVS Blood Pressure Monitor
50428-0407-14	CVS	Blood Pressure Test Kit-Large	Blood Pressure Monitor	CVS Blood Pressure Monitor
50428-7088-84	CVS	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	CVS Blood Pressure Monitor
50428-8002-31	CVS	Blood Pressure Test Kit-Large	Blood Pressure Monitor	CVS Blood Pressure Monitor
50428-8008-24	CVS	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	CVS Blood Pressure Monitor

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

NDC CODE	MANUFACTURER or LABELER	GENERIC NAME	BRAND NAME	LABEL NAME
50428-8002-32	CVS	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	CVS Manual Blood Pressure Kit
50428-0535-60	CVS	Blood Pressure Test Kit-Large	Series 100 BP Monitor	CVS Series 100 BP Monitor
50428-0283-92	CVS	Blood Pressure Test Kit-Large	Series 400 BP Monitor	CVS Series 400 BP Monitor
50428-0251-83	CVS	Blood Pressure Test Kit-Wrist	Series 400W BP Monitor	CVS Series 400W BP Monitor
50428-0416-81	CVS	Blood Pressure Test Kit-Large	Series 600 BP Monitor	CVS Series 600 BP Monitor
10939-0953-78	CVS	Blood Pressure Test Kit-Large	Series 200 BP Monitor	CVS Series 200 BP Monitor
52569-0143-73	CVS	Blood Pressure Test Kit-Large	Series 200 BP Monitor	CVS Series 200 BP Monitor
16042-0011-60	Foracare	Blood Pressure Test Kit-Large	Fora Test N'Go BP	Fora Test N'Go BP Monitor Syst
98939-0002-76	Foracare Inc	Blood Pressure Test Kit-Medium	Fora P20	Fora P20 Blood Pressure System
70393-0901-01	Future Diagnostics	Blood Pressure Test Kit-Large	Caretouch BP Monitor	Caretouch Wrist BP Monitor
70393-0902-01	Future Diagnostics	Blood Pressure Test Kit-Wrist	Caretouch Wrist BP Monitor	Procare Wrist BP Monitor
91237-0001-07	Home Aide Diagnostic	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Wrist Blood Pressure Monitor
96295-0129-30	Leader	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Wrist Blood Pressure Monitor
67056-0875-01	Mabis Healthcare	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Caretouch BP Monitor
08496-0213-01	MHC Medical	Blood Pressure Test Kit-Large	Surelife Arm BP Monitor	Surelife Arm BP Monitor

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

NDC CODE	*MANUFACTURER or LABELER*	*GENERIC NAME*	*BRAND NAME*	*LABEL NAME*
08496-0214-01	*MHC Medical*	*Blood Pressure Test Kit-Large*	*Surelife Talking Arm BP Monitor*	*Surelife Talking Arm BP Monitor*
08496-0212-01	*MHC Medical*	*Blood Pressure Test Kit-Wrist*	*Surelife Talking Wrist BP Monitor*	*Surelife Talking Wrist BP Monitor*
08496-0211-01	*MHC Medical*	*Blood Pressure Test Kit-Wrist*	*Surelife Wrist BP Monitor*	*Surelife Wrist BP Monitor*
42632-0013-13	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*Advanced Automatic BP Monitor*
42632-0351-06	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*Advanced Automatic BP Monitor*
42632-0033-33	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*Automatic Blood Pressure Monitor*
42632-0750-00	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*Automatic Blood Pressure Monitor*
42632-0006-06	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*Blood Pressure Monitor*
42632-0012-12	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*Blood Pressure Monitor*
42632-0021-21	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*Blood Pressure Monitor*
42632-0410-09	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*Blood Pressure Monitor*
42632-0005-05	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*CVS Blood Pressure Monitor*
42632-0032-32	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*CVS Blood Pressure Monitor*
42632-0007-07	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*Deluxe Blood Pressure Monitor*
42632-0018-18	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*Deluxe Blood Pressure Monitor*

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

NDC CODE	MANUFACTURER or LABELER	GENERIC NAME	BRAND NAME	LABEL NAME
42632-0351-02	Microlife	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Deluxe Blood Pressure Monitor
42632-0022-22	Microlife	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	HM Blood Pressure Monitor
42632-0023-23	Microlife	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	HM Blood Pressure Monitor
42632-0024-24	Microlife	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	HM Blood Pressure Monitor
42632-0026-26	Microlife	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	HM Blood Pressure Monitor
42632-0025-25	Microlife	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	HM Wrist Blood Presr Monitor
42632-0001-01	Microlife	Blood Pressure Test Kit-Medium	Incontrol BP Monitor	Incontrol Blood Pressure Mon
42632-0002-02	Microlife	Blood Pressure Test Kit-Medium	Incontrol BP Monitor	Incontrol Blood Pressure Mon
42632-0011-11	Microlife	Blood Pressure Test Kit-Medium	Incontrol BP Monitor	Incontrol Blood Pressure Mon
41220014072	Microlife	Blood Pressure Test Kit-wrist	Incontrol BP Monitor	Incontrol Blood Pressure Mon
41220014074	Microlife	Blood Pressure Test Kit-wrist	Incontrol BP Monitor	Incontrol Blood Pressure Mon
41220014080	Microlife	Blood Pressure Test Kit-large	Incontrol BP Monitor	Incontrol Blood Pressure Mon
41220014082	Microlife	Blood Pressure Test Kit-large	Incontrol BP Monitor	Incontrol Blood Pressure Mon
42632-0010-10	Microlife	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Kroger Blood Pressure Monitor
42632-0017-17	Microlife	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Premium Blood Pressure Monitor

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

NDC CODE	*MANUFACTURER or LABELER*	*GENERIC NAME*	*BRAND NAME*	*LABEL NAME*
42632-0039-39	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*Premium Blood Pressure Monitor*
42632-0396-00	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*Premium Blood Pressure Monitor*
42632-0004-04	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*PV Blood Pressure Monitor-Med*
42632-0008-08	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*QC Blood Pressure Monitor*
42632-0003-03	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*RA Blood Pressure Monitor*
42632-0014-14	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*RA Deluxe BP Monitor*
42632-0015-15	*Microlife*	*Blood Pressure Test Kit-Large*	*Blood Pressure Monitor*	*RA Premium BP Monitor*
42632-0009-09	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*SM Blood Pressure Monitor*
42632-0027-27	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*SM Blood Pressure Monitor*
42632-0028-28	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*SM Blood Pressure Monitor*
42632-0029-29	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*SM Blood Pressure Monitor*
42632-0031-31	*Microlife*	*Blood Pressure Test Kit-Medium*	*Blood Pressure Monitor*	*SM Blood Pressure Monitor*
42632-0030-30	*Microlife*	*Blood Pressure Test Kit-Wrist*	*Blood Pressure Monitor*	*SM Wrist Blood Presr Monitor*
42632-0016-16	*Microlife*	*Blood Pressure Test Kit-Wrist*	*Blood Pressure Monitor*	*Wrist Blood Pressure Monitor*
42632-0017-74	*Microlife*	*Blood Pressure Test Kit-Wrist*	*Blood Pressure Monitor*	*Wrist Blood Pressure Monitor*

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

NDC CODE	MANUFACTURER or LABELER	GENERIC NAME	BRAND NAME	LABEL NAME
42632-0020-20	Microlife	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Wrist Blood Pressure Monitor
73796-0800-34	Omron	Medical Supply, Miscellaneous	Blood Pressure Cuff	Blood Pressure Cuff - Adult
73796-0010-40	Omron	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor
73796-0043-22	Omron	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor
73796-0267-86	Omron	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor
73796-0271-04	Omron	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor
73796-0274-24	Omron	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor
73796-0276-04	Omron	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor
73796-0278-54	Omron	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor
73796-0705-36	Omron	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor
73796-0267-61	Omron	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor - 7 Series, Comfit Cuff
73796-0710-02	Omron	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor-3 Series
73796-0267-25	Omron	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Blood Pressure Monitor-5 Series Wireless
73796-0000-18	Omron	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor-Medium
73796-0010-42	Omron	Blood Pressure Test Kit-Large	Self-Taking Blood Pressure	Self-Taking Blood Pressure Kit

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

NDC CODE	MANUFACTURER or LABELER	GENERIC NAME	BRAND NAME	LABEL NAME
73796-0266-29	Omron	Blood Pressure Test Kit-Wrist	Wrist Blood Pressure Monitor	Wrist BP Monitor 3 Series
73796-0266-52	Omron	Blood Pressure Test Kit-Wrist	Wrist Blood Pressure Monitor	Wrist BP Monitor 7 Series
11822-0489-32	Rite Aid	Blood Pressure Test Kit-Medium	Blood Pressure Cuff Monitor	RA Blood Pressure Cuff Monitor
11822-5140-90	Rite Aid	Blood Pressure Test Kit-Medium	Blood Pressure Cuff Monitor	RA Blood Pressure Cuff Monitor
11822-0489-33	Rite Aid	Blood Pressure Test Kit-Medium	Blood Pressure Cuff Monitor	RA Blood Pressure Cuff Monitor
11822-4893-33	Rite Aid	Blood Pressure Test Kit	Blood Pressure Monitor	RA Blood Pressure Monitor
98302-0001-30	Simple Diagnostic	Blood Pressure Test Kit-Medium	Clever Chek	Clever Chek Blood Pressure Mon
98302-0001-42	Simple Diagnostic	Blood Pressure Test Kit-Wrist	Clever Choice	Clever Choice Wrist Presr Kit
38703-0001-61	Sunmark	Blood Pressure Test Kit-Wrist	Blood Pressure Kit	Blood Pressure Kit
38703-0168-22	Sunmark	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	SM Blood Pressure Monitor
11917-0068-77	Walgreens	Blood Pressure Test Kit	Blood Pressure Kit	Blood Pressure Manual Kit
11917-0081-96	Walgreens	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Blood Pressure Monitor
11917-0100-45	Walgreens	Blood Pressure Kit Med,Large	Blood Pressure Monitor	Blood Pressure Monitor
11917-0112-11	Walgreens	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor
11917-0144-84	Walgreens	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

NDC CODE	MANUFACTURER or LABELER	GENERIC NAME	BRAND NAME	LABEL NAME
11917-0144-87	Walgreens	Blood Pressure Kit Med,Large	Blood Pressure Monitor	Blood Pressure Monitor
11917-0112-08	Walgreens	Blood Pressure Kit Med,Large	Deluxe Arm BP Monitor	Deluxe Arm BP Monitor
11917-0144-85	Walgreens	Blood Pressure Kit Med,Large	Deluxe Arm BP Monitor	Deluxe Arm BP Monitor
11917-0112-10	Walgreens	Blood Pressure Kit Med,Large	Premium Arm BP Monitor	Premium Arm BP Monitor
11917-0102-19	Walgreens	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Wrist Blood Pressure Monitor
11917-0112-13	Walgreens	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Wrist Blood Pressure Monitor
05388-0043-86	Walmart Stores	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Relion BP100 Monitor
49035-4386-01	Walmart Stores	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Relion BP100 Monitor
49035-6266-01	Walmart Stores	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Relion BP200W Wrist Monitor
81131-0062-66	Walmart Stores	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Relion BP200W Wrist Monitor
81131-0895-40	Walmart Stores	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Relion Deluxe BP Monitor
05388-0044-26	Walmart Stores	Blood Pressure Test Kit-Large	Blood Pressure Monitor	Relion Premium BP Monitor
05388-0577-22	Walmart Stores	Blood Pressure Test Kit-Wrist	Blood Pressure Monitor	Relion Wrist BP Monitor
82891-0372-00	Zewa, Inc	Blood Pressure Test Kit-Medium	Blood Pressure Monitor	Blood Pressure Monitor

PHC Formulary Blood Pressure Kits and Monitors

Restrictions:
(1) Limited to one monitor every 2 years.
(2) Must be billed as a pharmacy claim to MedImpact (not direct billed to PHC).

82891-0388-01	*Zewa, Inc*	*Blood Pressure Kit-Extra Large*	*Blood Pressure Monitor*	*Blood Pressure Monitor Kit*

Following are the specific NDCs available without a TAR for nebulizer products. Pharmacies may submit a TAR for a product not on this list, but note that the claim reimbursement limit $100 for nebulizers. TARs for equipment over the claim limit will require additional medical justification.

NDC CODE	BRAND NAME	GENERIC NAME
73796-0099-11	A.I.R.S. NEBULIZER	NEBULIZER ACCESSORIES
04351-0440-50	AEROECLIPSE II	NEBULIZER
73796-0099-12	AIRS DISPOSABLE NEBULIZER	NEBULIZER
44229-0220-36	BABY NEBULIZER	NEBULIZER
44229-0220-37	BABY NEBULIZER	NEBULIZER
44229-0220-38	BABY NEBULIZER	NEBULIZER
73796-0453-30	COMP-AIR ELITE COMPRESSOR SYST	NEBULIZER AND COMPRESSOR
73796-0453-25	COMP-AIR NEBULIZER COMPRESSOR	NEBULIZER AND COMPRESSOR
73796-0458-01	COMP-AIR NEBULIZER COMPRESSOR	NEBULIZER AND COMPRESSOR
16958-0620-04	DEVILBISS DISPOSABLE NEBULIZER	NEBULIZER
08373-0312-00	INNOSPIRE ESSENCE	NEBULIZER AND COMPRESSOR
08373-9966-00	INNOSPIRE ESSENCE	NEBULIZER AND COMPRESSOR
44229-0220-18	LC D NEBULIZER SET	NEBULIZER
44229-0220-19	LC D NEBULIZER SET	NEBULIZER
44229-0220-28	LC PLUS	NEBULIZER
83490-0220-28	LC PLUS	NEBULIZER
83490-0229-54	LC PLUS	NEBULIZER
44229-0230-01	LC SPRINT NEBULIZER	NEBULIZER
83490-0230-01	LC SPRINT NEBULIZER	NEBULIZER
44229-0220-82	LC STAR	NEBULIZER
08373-1431-00	MICRO PLUS	NEBULIZER
08373-6435-00	MINI PLUS NEBULIZER	NEBULIZER
44229-0280-11	PARI LC SPRINT SINUS	NEBULIZER
83490-0280-11	PARI LC SPRINT SINUS	NEBULIZER
83490-0860-17	PRONEB ULTRA II	NEBULIZER AND COMPRESSOR
96295-0118-07	PULMONEB LT COMPRESSOR NEBUL	NEBULIZER AND COMPRESSOR
08373-2456-00	SAMI THE SEAL	NEBULIZER AND COMPRESSOR
08373-0008-00	SIDESTREAM	NEBULIZER
08373-2299-00	SIDESTREAM	NEBULIZER
08373-8125-00	SIDESTREAM	NEBULIZER
08373-2286-00	SIDESTREAM NEBULIZER	NEBULIZER
08373-0870-00	SIDESTREAM PLUS	NEBULIZER
44229-0221-32	SINUSTAR	NEBULIZER
83490-0221-32	SINUSTAR	NEBULIZER
83490-0470-06	TREK S COMPACT COMPRESSOR	NEBULIZER AND COMPRESSOR
44229-0310-58	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR

Formulary nebulizer products, continued

NDC CODE	BRAND NAME	GENERIC NAME
44229-0310-59	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
44229-0310-62	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
44229-0310-64	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
44229-0310-65	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
44229-0310-67	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
44229-0310-71	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
44229-0312-02	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0310-58	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0310-59	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0310-62	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0310-64	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0310-65	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0310-67	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0310-71	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0312-02	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR
83490-0312-03	VIOS AEROSOL DELIVERY SYSTEM	NEBULIZER AND COMPRESSOR

OSTOMY SUPPLIES:

All ostomy supplies must be billed to the PHC Claims Department. A TAR submitted to the Utilization Department is required if monthly cumulative cost for all related supplies exceeds $150.00.

INCONTINENCE SUPPLIES:

All incontinence supplies must be billed to the PHC Claims Department. A TAR submitted to the Utilization Management Department is required if monthly cumulative cost for all related supplies exceeds $50.00. Washes and creams will only be authorized if the physician indicates medical necessity such as skin breakdown.

DISPOSABLE GLOVES:

All disposable gloves must be billed to the PHC claims department. Maximum dispensing is 100 gloves per month.

NUTRITIONAL SUPPLEMENTS (ENSURE, GLUCERNA, BOOST, ETC.)

A pharmacy TAR is required for all nutritional supplements to be used on an out-patient basis. TARs should be submitted with clinic notes which include all specialists' consult notes and lab reports. Please review the required criteria for *Oral Nutritional Supplements* and *Enteral (tube-fed) Nutritional Supplements* in the TAR Criteria Table. Supplements for members currently in an acute care hospital or LTC/ICF facility are included in the per diem rate or capitation paid to the facility, thus are not eligible for TAR consideration.

INJECTABLE DRUG **_PHARMACY_** FORMULARY

SIMPLE INTRAVENOUS SOLUTIONS

Simple intravenous solutions are typically used for hydration therapy. Included on the formulary are commercially available (non-compounded) solutions such as Normal Saline, Dextrose (up to 10% in Water) and Lactated Ringer's Solution; commercially prepared solutions of potassium chloride in such solutions are also included in this definition. Simple intravenous solutions should be billed using the product's National Drug Code (NDC) number.

PARENTERAL NUTRITION SOLUTIONS (TPN OR HYPERALIMENTATION)

Parenteral nutrition solutions are intravenously or intra-arterially administered nutritional products that typically are suspensions or solutions of amino acids or protein, dextrose, lipids, electrolytes, vitamin &/or mineral supplements and trace elements.

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

Adjuncts to parenteral nutrition are other drugs which are physically mixed into a parenteral nutrition solution at any time prior to administration. Bill for these products as part of the parenteral nutrition billing.

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim, and will require a TAR for claims over $60 and when non-formulary ingredients are included.

SEPARATELY ADMINISTERED INTRAVENOUS LIPIDS

Intravenous lipid solutions or suspensions that are administered separately from parenteral nutrition solutions (that is, are not physically mixed into the parenteral nutrition solution container) should be billed using the product's NDC number.

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

INTRAVENOUS SOLUTIONS OF UNLISTED ANTIBIOTICS & OTHER UNLISTED DRUGS (NOT ON FORMULARY, TAR REQUIRED)

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

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim. Compounded solutions must be billed as a compound claim, and will require a TAR for claims over $60 and when non-formulary ingredients are included.

The following injectable drugs are included in PHC's Pharmacy Formulary. These drugs are payable through the PBM (MedImpact) without prior authorization in most cases; however, many do have utilization restrictions such as claim dollar limits, quantity limits, age restrictions, Code-1 restrictions, step therapy edits or other utilization edits. A Treatment Authorization Request (TAR) will be needed if the request does not meet the drug's formulary limits. This is **not** a complete listing of *all* injectable drugs that may be covered through PHC's *medical* benefit when administered in a physician's office, clinic or outpatient facility. Please contact PHC Claims Department with the appropriate HCPCS billing code for medical claims billing requirements for drugs not listed here.

Parenteral compounded prescriptions dispensed by a pharmacy: Claims are submitted electronically via MedImpact as a compounded prescription (see the pharmacy provider manual for details on submitting a compounded drug). An IV admixture is not considered a compound and shouldn't be billed as such. Note that a TAR is required for non-formulary ingredient compounds, or when a compound consists of formulary ingredients but the claim exceeds $300 (total compound claim).

Symbol Key: ♦ Provided by Vaccines for Children program for ages 0-18; PHC benefit for ages >/= 19.
Ψ = Quantity, Duration or Age Limits © Code 1 ♣ = Step therapy required

The PHC formulary search tool can be used to see the limit specifications and other less common formulary injectables not included in this abbreviated list.

ACETAZOLAMIDE SODIUM
ALDESLEUKIN
ALTEPLASE 2 mg (Cathflo)
AMIFOSTINE CRYSTALLINE
AMIKACIN SULFATE
AMINO ACIDS 10 %, 15 %, 20 % Ψ
AMINO ACIDS/DEXTROSE 5%-20% Ψ
AMINOPHYLLINE
AMPHOTERICIN B
AMPICILLIN SODIUM
AMPICILLIN SODIUM/SULBACTAM NA
ARSENIC TRIOXIDE Ψ
ATRACURIUM BESYLATE
ATROPINE SULFATE
AZACITIDINE
AZITHROMYCIN Ψ
AZTREONAM
AZTREONAM/DEXTROSE-WATER
BACTERIOSTATIC SODIUM CHLORIDE
BCG LIVE ♦
BETAMET ACET/BETAMET NA PH
BEVACIZUMAB (Avastin)
BLEOMYCIN SULFATE
BORTEZOMIB
BUPIVACAINE HCL
BUPIVACAINE HCL/EPINEPHRINE
BUPIVACAINE HCL/EPINEPHRINE/PF
BUPIVACAINE HCL/PF
BUTORPHANOL TARTRATE Ψ
CALCITRIOL
CALCIUM CHLORIDE
CAPROMAB PENDETIDE
CARBOPLATIN
CARMUSTINE
CEFAZOLIN SODIUM
CEFAZOLIN SODIUM/DEXTROSE, ISO
CEFEPIME HCL
CEFOTAXIME SODIUM
CEFOTAXIME SODIUM/D5W
CEFOTETAN DISODIUM
CEFOXITIN SODIUM
CEFOXITIN SODIUM/D5W
CEFTAZIDIME NA/DEXTROSE, ISO
CEFTAZIDIME PENTAHYDRATE
CEFTRIAXONE NA/DEXTROSE, ISO
CEFTRIAXONE SODIUM
CEFUROXIME SODIUM
CEFUROXIME SODIUM/WATER
CETUXIMAB
CHLOROPROCAINE HCL
CHLOROPROCAINE HCL/PF
CHLOROPROCAINE HCL/PF
CHLOROTHIAZIDE SODIUM
CIPROFLOXACIN LACTATE/D5W
CISPLATIN
CLADRIBI
CLINDAMYCIN PHOSPHATE
CLOFARABINE
CYANOCOBALAMIN

CYCLOPHOSPHAMIDE
CYTARABINE
CYTARABINE LIPOSOME
DACARBAZINE Ψ
DACTINOMYCIN
DAUNORUBICIN HCL
DEFEROXAMINE MESYLATE
DEXAMETHASONE SOD PHOSPHATE
DEXTROSE 10%-0.25NORMAL SALINE
DEXTROSE 10%-0.5 NORMAL SALINE
DEXTROSE 10%-WATER
DEXTROSE 2.5%-0.5NORMAL SALINE
DEXTROSE 5%-0.25 NORMAL SALINE
DEXTROSE 5%-0.33 NORMAL SALINE
DEXTROSE 5%-0.5 NORMAL SALINE
DEXTROSE 5%-LACTATED RINGERS
DEXTROSE 5%-NORMAL SALINE
DEXTROSE 5%-WATER
DEXTROSE 50%-WATER
DEXTROSE 70%-WATER
DICYCLOMINE HCL
DIGOXIN
DIHYDROERGOTAMINE MESYLATE
DILUENT, HIB VAC, TET-CONJ, NACL ♦
DILUENT, HIB, TET-CONJ, 0.9% NACL ♦
DIMENHYDRINATE
DIPH, PERTUSS (ACELL), TET VAC/PF ♦
DIPHENHYDRAMINE HCL
DIPHTH, PERTUSS (ACELL), TET PED ♦
DIPHTH, PERTUSS (ACELL), TET VAC ♦
DOBUTAMINE HCL
DOBUTAMINE HCL/D5W
DOPAMINE HCL
DOXAPRAM HCL
DOXERCALCIFEROL
DOXORUBICIN HCL
DOXORUBICIN HCL LIPOSOMAL
DOXYCYCLINE HYCLATE
DP (A) T-POLIO/HIB CONJ-TET/PF Ψ
DROPERIDOL
EDROPHONIUM CHLORIDE
ENOXAPARIN SODIUM Ψ
EPHEDRINE SULFATE
EPINEPHRINE Ψ
EPIRUBICIN HCL
EPOETIN ALPHA (Retacrit on formulary) ©, Ψ
ERYTHROMYCIN LACTOBIONATE
ESTRADIOL CYPIONATE
ETOMIDATE
ETOPOSIDE
PHOSPHATE
ETOPOSIDE Ψ
FAMOTIDINE Ψ
FAT EMULSIONS (Intralipid 20%) Ψ
FENTANYL/ROPIVACAINE/NS/PF Ψ
FLOXURIDINE
FLU VACCINES ♦
- AFLURIA, AFLURIA QUAD
- EZ FLU (FLUCELVAX)
- FLUAD
- FLUARIX QUAD
- FLUBLOK QUAD
- FLUCELVAX QUAC
- FLULAVAL QUAD
- FLUMIST QUAD
- FLUZONE HIGH DOSE
- FLUZONE QUAD
- FLUZONE QUAD PEDI

FLUDARABINE
PHOSPHATE
FLUOROURACIL
FOLIC ACID
FONDAPARINUX SODIUM Ψ
FULVESTRANT
FUROSEMIDE
GANCICLOVIR SODIUM
GEMCITABINE HCL
GENTAMICIN SULFATE
GLUCAGON, HUMAN RECOMBINANT
GLYCOPYRROLATE
GOSERELIN ACETATE
GRANISETRON
HAEMOPH B POLY CONJ-TET TOX/PF ♦
HAEMOPH B POLYSAC CONJ-MENING ♦
HAEMOPH B POLYSAC CONJ-TET TOX ♦
HEPARIN SODIUM, PORCINE
HEPARIN SODIUM, PORCINE/NS
HEPARIN SODIUM, PORCINE/PF
HEPATITIS A & B VACCINE/PF
HEPATITIS A VIRUS VACCINE/PF
HEPATITIS B IMMUNE GLOBULIN
HEPATITIS B VIRUS VACCINE-PF ♦
HPV VACCINE 9-VALENT/PF ♦, Ψ
HUM INSULIN NPH/REG INSULIN HM
HUMAN PAPILLOMAV VACC 16 &18/PF ♦, Ψ

HUMAN PAPILLOMAVIRUS VACC, QVAL ♦, Ψ
HYALURONATE SODIUM
HYALURONIDASE
HYDRALAZINE HCL
HYDROCORTISONE SOD SUCCINATE
HYDROMORPHONE HCL Ψ
HYDROMORPHONE HCL/PF Ψ
HYDROXYZINE HCL
IDARUBICIN HCL IFOSFAMIDE
IFOSFAMIDE/MESNA
INSULIN GLARGINE, HUM. REC.ANALOG Ψ; Basaglar only.
INSULIN LISPRO (Admelog, AG Humalog) Ψ
INSULIN NPH HUM/REG HUM Ψ
INSULIN NPH HUMAN ISOPHANE Ψ
INSULIN REGULAR, HUMAN Ψ
INSULN ASP PRT/INSULIN ASPART Ψ
ISONIAZID
KETOROLAC TROMETHAMINE
LEUCOVORIN CALCIUM
LEVOFLOXACIN
LEVOFLOXACIN/DEXTROSE 5%-WATER
LIDOCAINE HCL
LIDOCAINE HCL/EPINEPHRINE
LIDOCAINE HCL/EPINEPHRINE/PF
LIRAGLUTIDE (VICTOZA) ♣, Ψ
LORAZEPAM Ψ
MAGNESIUM CHLORIDE
MAGNESIUM SULFATE
MAGNESIUM SULFATE/D5W
MANNITOL
MEASLES, MUMPS & RUBELLA VACCINE ♦, Ψ
MECHLORETHAMINE HCL
MEDROXYPROGESTERONE ACET
MELPHALAN HCL
MENINGOCOCCAL B VACC, 4-COMP/PF ♦
MEPERIDINE HCL Ψ
MEPERIDINE HCL/PF Ψ
MEPIVACAINE HCL
MESNA
METHADONE HCL Ψ METHOHEXITAL SODIUM Ψ METHOTREXATE SODIUM
METHOTREXATE SODIUM/PF
METHYLERGONOVINE MALEATE
METHYLPREDNISOLONE ACETATE
METHYLPREDNISOLONE SOD SUCC
METOCLOPRAMIDE HCL
METOPROLOL TARTRATE
MINOCYCLINE HCL
MITOMYCIN
MITOXANTRONE HCL Ψ
MORPHINE SULFATE Ψ
MULTIVITAMINS Ψ
N. MENINGITIDIS B, LIPID FHBP RC ♦
NAFCILLIN SODIUM
NAFCILLIN SODIUM/D2.4W
NALBUPHINE HCL
NEOSTIGMINE METHYLSULFATE
NORMAL SALINE ISOPHANE
ONDANSETRON HCL
OXACILLIN SODIUM
OXACILLIN SODIUM/DEX-WATER
OXALIPLATIN
OXYMORPHONE HCL
OXYTOCIN
PACLITAXEL PROTEIN-BOUND Ψ
PACLITAXEL, SEMI-SYNTHETIC Ψ
PAMIDRONATE DISODIUM
PARICALCITOL
PEGASPARGASE Ψ
PEN G BENZ/PEN G PROCAINE
POT/DEXTROSE-WATER
PENICILLIN G BENZATHINE Ψ
PENICILLIN G POTASSIUM
PENICILLIN G PROCAINE
PENICILLIN G SODIUM
PENTAZOCINE LACTATE Ψ
PENTOSTATIN
PERTUSSIS – *see Dipht/Pertus/Tet, DPT*
PHENOBARBITAL SODIUM Ψ
PHENYLEPHRINE HCL
PHENYTOIN SODIUM
PHYSOSTIGMINE SALICYLATE
PHYTONADIONE
PIPERACILLIN SODIUM/TAZOBACTAM
PIPERACILLIN/TAZOBACTAM/DEX-IS
POLIOMYELITIS VAC, KILLED ♦
PORFIMER SODIUM
POTASSIUM CHLORIDE
POTASSIUM CHLORIDE/D5-0.33NS
POTASSIUM CHLORIDE/D5-0.5NS
POTASSIUM CHLORIDE/D5LR POTASSIUM

CHLORIDE/D5-NS POTASSIUM
CHLORIDE/D5W POTASSIUM
CHLORIDE/NS POTASSIUM PHOS, M-
BASIC-D-BASIC PROCAINAMIDE HCL
PROCHLORPERAZINE EDISYLATE
PROGESTERONE
PROMETHAZINE HCL
PROTAMINE SULFATE
PYRIDOXINE HCL
QUINIDINE GLUCONATE
RABIES VACCINE (PCEC)/PF ♦
RABIES VACCINE, HUMAN DIPLOID ♦
RANITIDINE HCL
RHO (D) IMMUNE GLOBULIN
RINGERS SOLUTION, LACTATED
ROCURONIUM BROMIDE
ROPIVACAINE HCL
ROPIVACAINE HCL/PF
SODIUM BICARBONATE
SODIUM CHLORIDE 0.45%
SODIUM CHLORIDE 0.9%
SODIUM CHLORIDE 3%
SODIUM CHLORIDE 5%
STREPTOMYCIN SULFATE
STREPTOZOCIN
SUCCINYLCHOLINE CHLORIDE
SULFAMETHOXAZOLE/TRIMETHOPRIM
SUMATRIPTAN SUCCINATE Ψ
TACROLIMUS
TEMOZOLOMIDE Ψ
TENIPOSIDE Ψ
TERBUTALINE SULFATE
TETANUS AND DIPHTHERIA TOXOID ♦
TETRACAINE HCL
THIAMINE HCL
THIOTEPA
TOBRAMYCIN SULFATE
TOPOTECAN HCL
TRIAMCINOLONE ACETONIDE
TRIAMCINOLONE HEXACETONIDE
TRIPTORELIN PAMOATE
VALRUBICIN
VANCOMYCIN HCL
VARICELLA VACC/PF ♦
VARICELLA-ZOSTER GE (Shingrix)
VARICELLA-ZOSTER IG/MALTOSE ♦
VARICELLA-ZOSTER IMMUNE GLOB♦
VASOPRESSIN
VECURONIUM BROMIDE
VERAPAMIL HCL
VINBLASTINE SULFATE
VINCRISTINE SULFATE
VINORELBINE TARTRATE
WATER FOR INJ., BACTERIOSTATIC
WATER FOR INJECTION, STERILE
WATER/ME-PARABEN/PROPYLPARABEN
ZIDOVUDINE
ZOSTER VACCINE LIVE/PF Ψ (Zostavax)

OVER-THE-COUNTER DRUG FORMULARY

Available to PHC Medi-Cal members not residing in LTC/SNF facility.

LTC/SNF PHARMACIES PLEASE NOTE:
Over-the-counter (OTC) drugs are included in the per-diem rate for recipients in nursing facilities, including subacute patients. Except for insulin, providers cannot separately bill any OTC drugs for recipients in these facilities.

OTC PHC REIMBURSEMENT REQUIREMENT:
Even though the products in this section are available to the public without prescription due to OTC status, a prescription is *required* for PHC payment. OTCs to be billed to PHC therefore must follow all the same legal and regulatory/ policy requirements as any prescription (Rx by legal prescriber, refills authorized by prescriber, document retention, etc). The products noted on the following pages are payable without prior authorization (TAR) when a prescription has been provided to the pharmacy.

Symbol Key: Ψ = Quantity, Duration or Age Limit © = Code 1 Restriction

ANALGESICS

ACETAMINOPHEN (Tylenol, MAPAP, Q-PAP, Pain & Fever, Feverall, etc) oral tablets, chewable, liquids, suppositories (all strengths)

ASPIRIN (Bayer, St. Josephs, Ecotrin, etc) oral tablets (325, 500), Enteric Coated/DR tabs (81, 325, 500, 650 mg), chewable (81 mg), suppositories (300, 600 mg)

ASPIRIN/CAL/MAG/ +/- AL HYDROX (Bufferin, Ascriptin, Tri-Buffered ASA, etc) oral tablets (325, 500 mg)

ANTACIDS & ANTIFLATULENTS

ALUMINUM HYDROXIDE (AlternaGEL) susp.
ALUMINUM HYDROX/MAG HYDROX (Aludrox) susp.
CALCIUM CARBONATE (Tums, Tums-XTR) chew.
CALCIUM CARB/MAG CARB (MasAnti) susp.
CALCIUM CARB/MAG HYDROX (Mi-Acid DS) chew
MAG CARB/AL HYDROX/ALGINATE (Gaviscon) susp.
MAG HYDROX/AL HYDROX/SIMETH (Maalox, Mylanta, Reg & DS) susp.
MAG HYDROX/AL HYDROX/SIMETH (Gelusil, Almacone) chew
SIMETHICONE (Gas-X, Infant's Mylicon) chew, capsules, drops

ANTIDIARRHEALS

ATTAPULGITE (Kaopectate) susp.
BISMUTH SUBSALICYLATE (Pepto Bismol) susp, tablets
KAOLIN/PECTIN susp

CONTRACEPTIVES

CONDOMS (Male and Female)
SPERMICIDES/NONOXYNOL-9 (Gynol II, Conceptrol, VCF)

ANTIEMETICS/MOTION SICKNESS

MECLIZINE chewable (25 mg), oral (12.5 mg).

Note: Rx 25 mg oral tab is also formulary.

ANTIHISTAMINES

CETIRIZINE tablets (5, 10 mg), liquid (5 mg/5 ml), (Brand not a covered benefit)

Note: Cetirizine chewable tablets are not a covered benefit (no TAR exceptions).

CHLORPHENIRAMINE (Chlor-Trimeton, Aller- Chlor, Allergy 4 HR, etc) tablets (4, 8, 12 mg), liquid (2 mg/5 ml)

DIPHENHYDRAMINE (Benadryl, Q-Dryl, Diphenhist, etc) capsules, tablets (25, 50 mg), chewable (12.5 mg), liquid (12.5 mg/5 ml)

FEXOFENADINE tablets (30, 60, 180 mg), Ψ

LORATADINE (Alavert, Clear-Atadine, Non- Drowsy Allergy, etc) tablets (10 mg), liquid (5 mg/5 ml). (Brand not a covered benefit).

DOXYLAMINE

PYRILAMINE MALEATE

TRIPROLIDINE HCL

ANTHELMINTIC

PYRANTEL PAMOATE suspension (Reese's Pinworm)

COLD / FLU

SALINE NASAL spray, drops (Ocean, Ayr, Saline Mist, etc)

BROMPHENIRAMINE/PHENYLEPRINE liquid

CHLORPHENIRAMINE/PHENLEPHRINE liquid

DEXBROMPHENIRAMINE MALEATE tablets, liquid

DEXBROMPHENIRAMINE/PHENYLEPHRINE tablets

DOXYLAMINE/PHENYLEPHRINE HCL tablets

PHENYLEPHRINE HCL/TRIPROLIDINE

BROMPHENIRAMINE/PHENYLEPHRINE/DM solution (1 mg/2.5 mg/5 mg/5 ml), liquid (2mg/10 mg/5 mg/5 ml, 4 mg/7.5mg/15 mg/5 ml)

BROMPHENIRAMINE/PSEUDOEPHEDRINE/DM elixir (1 mg/15 mg/5 mg/5 ml)

NOTE: The following are limited to use in children aged 4 yrs and older; use of these products is not recommended by the FDA for use in ages 0 through 3 years.

GUAIFENESIN Ψ (Mucinex, plain Robitussin) tabs, liquid

PHENYLEPHRINE Ψ (Sudafed PE) tablets (5mg), liquid (2.5 mg/5 ml)

PSEUDOEPHEDRINE Ψ (Sudafed, SudoGest) tablets (30, 60 mg), liquid (15 mg/5 ml).

COLD / FLU ***continued***

CHLORPHENIRAMINE/PSEUDOEPHEDRINE/DM liquid (1 mg/15 mg/5 mg/5 ml, 2 mg/30mg/10 mg/5 ml)

CHLORPHENIRAMINE/PHENYLEPHRINE/DM liquid (4 mg/10 mg/15 mg/5 ml)
D-METHORPHAN/PE/DEXBROMPHENIRAMINE liquid (15 mg/7.5 mg/2 mg/5 ml)
TRIPROLIDINE/PHENYLEPHRINE/DM liquid (2.5 mg/10 mg/20 mg/5 ml)

GUAIFENESIN/DEXTROMETHORPHAN liquid (100 mg/10 mg/5 ml liquid, 200 mg/10mg/5 ml)

DEXTROMETHORPHAN/PHENYLEPHRINE liquid (5 mg/2.5 mg/5 ml)

GUAIFENESIN/DEXTROMETHORPHAN/PE (PHENYLEPHRINE) Tablets (198 mg/9 mg/5 mg, 200 mg/10mg/5 mg, 385 mg/17 mg/5 mg, 400 mg/15mg/10 mg, 400 mg/17 mg/5 mg

GUAIFENESIN/DEXTROMETHORPHAN/PSEUDOEPHEDRINE Liquid: Concentrations per 5 ml: 75 mg/5mg/2.5 mg, 100 mg/10 mg/5 mg, 200 mg/10mg/5 mg. Concentrations per 15 ml: 200mg/18 mg/10 mg, 396 mg/18 mg/10 mg

DIABETIC SUPPLIES: SEE MEDICAL SUPPLIES / DME

Members eligible for Medicare: PHC covers the 20% copay; the member's Medicare plan is to be billed as primary, except when the member resides in a long-term care or skilled nursing facility**.**

INSULIN

Ψ OTC Insulins: Vials are limited to 40ml per 30-day supply (4 vials of 10ml each); KwikPens are limited to 45ml per 30-day supply (3 boxes).

Humulin N u100 vial
Humulin N KwikPen u100
Humulin R vial u100 vial
Humulin 70-30 u100 vial
Humulin 70-30 KwikPen
u100 Novolin R 100u/ml
u100 vial Novolin N 100u/ml
u100 vial Novolin 70-30 u100 vial

GASTROINTESTINAL AGENTS

ESOMEPRAZOLE MAGNESIUM 20 mg DR capsules (Nexium 24hr)

LANSOPRAZOLE OTC 15 mg ER capsules *(Brand Prevacid 24H is not covered, no TAR exceptions)*

LANSOPRAZOLE OTC 15 mg SOLUBLE TAB ©, Limit 2 per day dosing

OMEPRAZOLE 20 mg tablets and soluble tablets

OMEPRAZOLE MAGNESIUM 20 mg capsules *(Brand Prilosec is not covered, no TAR exceptions)*

OMEPRAZOLE/SODIUM BICARB 20 mg capsules (Zegerid OTC)

HABIT ABATEMENT

NICOTINE PATCHES Ψ (Nicoderm CQ) Transdermal patches (7 mg, 14 mg and 21 mg)
Limit: Limited to a maximum of 180 patches within a 1-year period.

NICOTINE PATCHES Ψ (22 mg)
Limit: Limited to a maximum of 90 patches within a 1-year period.

NICOTINE LOZENGE Ψ (Nicorette) buccal lozenge (2 & 4 mg)
Limit: Limited to a maximum of 2100 pieces within a 1-year period.

NICOTINE GUM Ψ (Nicotrol) chewing gum (2 & 4 mg)

Limit: Limited to a maximum of 2100 pieces within a 1-year period

LAXATIVES, STOOL SOFTENERS

BISACODYL (Dulcolax) tablets (5 mg), supp (10 mg)

CASANTHRANOL/DSS (DOK Plus) tablets, capsules (30/100 mg)

CASANTHRANOL/DSS POTASSIUM (Dialose Plus) tablets, capsules (30/100 mg)

DOCUSATE CALCIUM (Surfak, Kao-Tin) capsules (240 mg)

DOCUSATE POTASSIUM (Dialose) capsules (100 mg)

DOCUSATE SODIUM (Colace) capsules (100, 200 mg), oral liquid (50mg/5 ml, 60mg/15 ml)

GLYCERIN suppositories (Adult, Pediatric), rectal solution (2.8 g/2.7 ml)

MAGNESIUM CITRATE (Citrate of Magnesia, Citroma) oral liquid

MAGNESIUM HYDROXIDE (Milk of Magnesia) oral suspension

SODIUM PHOSPHATE, MONO-DIBASIC ENEMA, aka SALINE ENEM A (Fleet, Pedia-Lax)

SODIUM PHOSPHATE, MONO-DIBASIC ORAL SOLN (Fleet Phospho Soda, Phosphate Laxative)

POLYETHYLENE GLYCOL 3350 Ψ (Miralax, Clear Lax) powder (17 g/dose) Limit: 255 g per fill

PSYLLIUM HUSK & SEED (Metamucil, Konsyl) powder, with or without sugar or aspartame

SENNOSIDES (Senokot, Senna Lax, Senna-Gen) tablets, capsules (8.6 mg), syrup (8.8 mg/5 ml)

SENNOSIDES / DSS (Senokot-S, Senna-S, Senna Plus tablets (8.6/50 mg)

NASAL

BUDESONIDE (Rhinocort Allergy)
CROMOLYN SODIUM (Nasalcrom)
SODIUM CHLORIDE NASAL spray, drops (Ayr, Ocean)
TRIAMCINOLONE ACETONIDE spray (Nasacort)

OPHTHALMICS

ARTIFICIAL TEAR DROPS, multidose dropper bottles and gel drops

Carboxymethylcellulose/Glycerin/Poly80 (Refresh Optive Advanced)
Carboxymethylcellulose/Glycerin (Refresh Optive, Lubricant Eye, Lubricating Eye Drops)
Carboxymethylcellulose Sodium (Refresh Tears, Lubricant Eye Drops, Moisturizing Lubricant, Ultra Fresh, Thera Tears, Restore Tears)

OPHTHALMICS, *continued*

ARTIFICIAL TEAR DROPS, multidose dropper bottles and gel drops

Dextran 70/Hypromellose (Artificial Tears, GenTeal Tears, Nature's Tears, Natural Balance Tears, Tears Naturale-II, Tears Pure)
Dextran/Hypromellose/Glycerin (Tears Naturale Forte)
Hypromellose (GenTeal Mild, GenTeal Mild to Moderate, Nature's Tears, Pure & Gentle, Retain HPMC)
Polyvinyl Alcohol/Povidone (Artificial Tears)
Propylene Glycol (Systane Balance, Lubricant Eye Drops)
Propylene Glycol/Peg 400 (Lubricant Eye, Lubricating Tears, Lubricating Relief, Lubricating Tears, Systane, Systane Ultra, Ultra Lubricant Eye)
Mineral Oil/Light Mineral Oil (Soothe XP)

PRESERVATIVE FREE UNIT DOSE DROPPERETTES: Limited to 4 doses per day (120 per 30 days) Carboxymethyl/gly/poly80/pf (Refresh Optive Advanced)
Carboxymethylcell/glycerin/pf (Lubricant Eye, Refresh Optive Sensitive)
Carboxymethylcellulose sodium (Lubricant Plus, Lubricating Plus, Refresh Celluvisc, Refresh Plus, Retain CMC, Revive Plus, Thera Tears)
Dextran 70/hypromellose/pf (Artificial Tears, Bion Tears, GenTeal Tears, Natural Tears, Tears Naturale Free)
Polyvinyl alcohol/povidone/pf (Refresh Classic)
Propylene glycol/peg 400/pf (Lubricant Eye, Systane, Systane Ultra)

MINERAL OIL & WHITE PETROLATUM lubricating eye ointment (GenTeal PM, Lubricant Eye, Lubrifresh PM, Puralube, Lacri-Lube, Refresh P.M., Retaine PM, Soothe, Systane, Tears Again, Tears Naturale PM, Ultra Fresh PM)

KETOTIFEN (Zaditor, Alaway) drops

NAPHAZOLINE (Clear Eyes, Naphcon)

NAPHAZOLINE / PHENIRAMINE (Naphcon-A, Visine-A, Opcon-A)

SODIUM CHLORIDE (Muro-128) drops, ointment (2%, 5%)

TETRAHYDROZOLINE (Visine, Murine Plus, Opti-Clear) drops.

TOPICALS

ADAPALENE GEL 0.1% (Differin)
ALUMINUM ACETATE solution
AMMONIUM LACTATE 12% lotion, cream (Amlactin)
BACITRACIN ointment
BACITRACIN/POLYMIXIN ointment (Polysporin)
BENZOYL PEROXIDE (Persa-Gel, Acne Clear, Panoxyl, Benoxyl 10) cleanser (5 & 10%), cream (10%), gel (2.5, 5 & 10%), lotion (5 & 10%)
CALAMINE lotion
CALAMINE / ZINC OXIDE suspension
CALCIUM ACETATE/ALUMINUM SULF. (Domeboro, Boropak) powder pack for solution
CAPSAICIN 0.025%, 0.075%, 0.1% cream
CHLORHEXIDINE 4% (Hibiclens, Betasept)

Topicals, continued

CLOTRIMAZOLE (Desenex, Lotrimin AF) cream
HYDROCORTISONE (Cortaid, Anti-Itch, Cortizone-10) cream, lotion, ointment (0.5 & 1%)
LANOLIN (Lan-o-soothe, Tender Care)
LIDOCAINE 4% CREAM (LC-4, Anecream)
MENTHOL/ZINC OXIDE 0.44-20.6% oint (Calmoseptine) Ψ
MICONAZOLE (Micatin, Lotrimin AF, Baza) cream, powder, spray (2%)
MINOIL/LANOLIN/W.PET/CERES (Original Eucerin) cream, lotion
SODIUM CHLORIDE IRRIG/DECYL GLUC. (Sea-Cleans) solution
PARAB/CET ALC/STRYL ALC/PG/SLS liquid (Cetaphil Cleanser, Ceta-Klenz, Gentle Skin Cleanser)
PERMETHRIN Ψ(NIX, Lice Cream Rinse) liquid (1%) *Limit: Limited to a max of 60 mL/ 90 days*
PIPERONYL BUTOX/PYRETHRINS (Rid) liquid, shampoo (4%/0.33%)
TERBINAFINE (Lamisil AT) cream (1%)
TOLNAFTATE (Tinactin) cream, powder, solution, spray powder (1%)
ZINC OXIDE 12.8% oint (Triple Paste); 13% cr (Desitin); 16% oint (Boudreaux's); 40% paste (Desitin) Ψ
ISOPROPYL ALCOHOL
ALCOHOL PADS AND WIPES
CETYLCIDE II
HYDROGEN PEROXIDE

UROLOGY

OXYBUTYNIN 3.9 mg/24hr patch (Oxytrol OTC patch) Ψ *Limit: 8 patches per month*

VAGINAL ANTIFUNGALS

BUTOCONAZOLE (Mycelex-3) cream/app (2%)
CLOTRIMAZOLE (Mycelex-7, Gyne-Lotrimin, Clotrimazole-7, Clotrimazole-3) cream/app (1%, 2%), vag. Tablet (100 mg), combo pack (1%/100 mg)
MICONAZOLE (Monistat 7, 3, & 1 day) cream (2%), vag. Supp. (100 mg), combo pack (200 mg/2% & 1200 mg/2%)

-

VITAMINS & MINERALS

ALUMINUM HYDROXIDE (ALUCAPS) capsules
AQUADEKS 400 mcg/ml, 100-350 mcg chew, 100-700 mcg cap ,Ψ © **Limited to Cystic Fibrosis**
CALCIUM/D3/MINERALS (Caltrate 600+D Plus, Calcium 600+D Plus Minerals) tablet (600/800, 600/400)
CALCIUM CARBONATE (Oyst-Cal 500, Oysco 500, Caltrate 600) tablets (500 & 600 mg elemental), chewable (300 mg & 500 mg elemental), suspension (500 mg/5ml)
CALCIUM CARBONATE/D2 tablets, capsules (250/125, 500/125, 500/200, 600/200)
CALCIUM CARBONATE/D3 tablets, capsules (250/125, 500/125, 500/200, 500/400, 600/125, 600/200, 600/400, 600/800)

CALCIUM CITRATE tablets (200, 250 mg)
CALCIUM CITRATE/D2 tablets (600/200, 250/100)
CALCIUM CITRATE/D3 tablets (200/125)
CALCIUM GLUCONATE tablets (45 mg, 60 mg, 61 mg)
CALCIUM LACTATE tablets (48 mg)
CALCIUM PHOSPHATE tablets (500 mg)
CALCIUM/MAGNESIUM tablets (300/300 mg)
CHOLECALCIFEROL (D3) capsules (1000, 2000units), drops (400/ml, 5000/ml), tablets (400, 1000, 2000, 4000, 5000, 10K, 14K, 25K, 50K units) Ψ
CYANOCOBALAMIN VIT B12 (500, 1000, 1500, 2000, 2500, 3000, 5000 mcg oral; 1000 mcg/ml injection) Ψ,© **Limited to prevention or treatment of B12 deficiency**
FERROUS GLUCONATE (Fergon) tablets (240, 325, 324mg)
FERROUS SULFATE (Fer-In-Sol, FeroSul) drops (15 mg/ml, 15 mg/0.6 ml), liquid (220 mg/ 5ml, 300 mg/5 ml), regular & DR tablets (324, 32 5mg)
FOLIC ACID tablets (0.4, 0.8 & 1 mg)
FOLIC ACID/B-COMP/C, RENAL© (Nephro-Vite, Nephrocaps, Dialyvite 800, Rena-Vite) capsules, tablets. © **Limit: Code 1 requirement – available only for members in dialysis)**
LEVOCARNITINE 1 g/10 ml, 330 mg tab (500 mg: Use formulary RX tablets)
LEVOCARNITINE TARTRATE 250 mg cap (330 mg & 500 mg *tartrate*: Use formulary RX forms)
MAGNESIUM OXIDE (M AG-OX) tablets (400 mg)
MULTIVITAMINS, CHILDRENS, with or without iron, (Poly-Vi-Sol, Poly-Vitamin, Animal Shapes, Gummi Bear, Flintstones, Kid's Vitamins) chewable, drops *Limited to ages 0-7* Ψ
MULTIVITAMIN A/C/D (Tri-Vitamin, Tri- Vi-Sol) drops *Limited to ages 0-7* Ψ
NIACIN IR & ER tablets & capsules (100, 125, 250, 500 mg)
PRENATAL VITAMINS © (Prenavite, Stuart) © **Limit: Code 1 requirement: pregnancy & lactation**
Note: Not limited to OTC prenatals. Various generic Rx prenatal products are on formulary as well.
PYRIDOXINE VIT B-6 tablets (25, 50, 100 mg)
THIAMINE VIT B-1 (100, 250, 500 mg tab; 100 mg/ml injection)

MISCELLANEOUS

ORLISTAT Ψ © (Alli) capsules, 60 mg.

Limits: Code 1-- Rx must document patient has a BMI>30, member is following a reduced fat diet, following an exercise program, and has been counseled by Pharmacist on the proper use of the medication with diet to optimize results.

Limited to 180 per month; recommended for members to initially try 1 capsule TID before considering 2 TID (120mg dose).

ELECTROLYTE REPLACEMENT (Pedialyte), liquid
RUBBING ALCOHOL, ALCOHOL PADS/SWABS (Qty limits apply)
SHARPS CONTAINER
TABLET CUTTER

March 1, 2019

Re: **Authorization for the use of Mavyret/Zepatier/Epclusa/Harvoni/Viekira/Sovaldi/Daklinza/ Technivie/Vosevi in the Treatment of Hepatitis C**

Dear Prescriber,

As of July 1, 2018, the State of California's Department of Health Care Services (DHCS) updated the Treatment Policy for the Management of Chronic Hepatitis C to give current guidance for the usage of Hepatitis C treatments.

Due to the extraordinary cost associated with these products, the State developed prior authorization criteria which reference the most recent guidelines and reports published by the American Association of the Study of Liver Diseases (AASLD) for approval of these medications. These guidelines set the treatment considerations and choice of regimen and duration of therapy for patients infected with Hepatitis C virus. Please refer to the AASLD website, www.hcvguidelines.org.

DHCS criteria for the identification of treatment candidates follow the AASLD recommendations, where evidence supports treatment for all chronically infected individuals with Hepatitis C Virus aged 12 years and above, except those with limited life expectancy (<12 months) who cannot be remediated by HCV therapy, liver transplantation, or another directed therapy.

1. If there is a high probability of cirrhosis (e.g. biopsy, imaging, APRI >1.5, FIB-4 >3.25, Fibrosure > .74), please provide a CTP score: http://www.mdcalc.com/child-pugh-score-for-cirrhosis-mortality/.

2. Clinical/abdominal findings "suggestive of" cirrhosis will require ALL OF THE FOLLOWING:
   a. Physical exam findings that suggest advanced liver disease (such as palpable left lobe, splenomegaly, palmar erythema)
   b. AND low platelet count (<100,000/mm^3)
   c. AND abdominal imaging findings that are consistent with cirrhosis including surface abnormalities, features of portal hypertension and ascites.

3. Pre and post liver transplantation treatment will be considered on a case-by-case basis (transplant specialist referral required).

4. Pediatric population (e.g. 12-17 years of age) HCV treatment regimen will be reviewed on a case-by-case basis and must meet minimum age approved by the FDA.

5. Populations Unlikely to Benefit from HCV Treatment:

a. Patients with limited life expectancy for whom HCV therapy would not improve symptoms or prognosis do not require treatment. Little evidence exists to support initiation of HCV treatment in patients with limited life expectancy (less than 12 months) due to non–liver-related comorbid conditions. For these patients, the benefits of HCV treatment are unlikely to be realized, and palliative care strategies should take precedence.

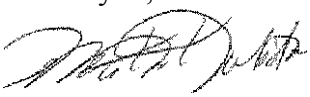
6. Note the PHC preferred treatment regimens and specialty pharmacy information, which are listed in the new TAR supplemental form for Hepatitis C Treatment.

Checklist to submit with new prescriptions, together with HCV TAR Supplemental information form:

- HCV Genotype
- HCV Viral Load
- Chemistry panel (Platelets, AST, ALT), CBC; if cirrhosis is present, also include INR, CTP score, total bilirubin, and albumin.
- If genotype is 1a, mixed 1a/b, or indeterminate 1, *and* requested regimen includes elbasvir (i.e., Zepatier): Hepatitis C Viral RNA Genotype 1 NS5A Drug Resistance assay is required.
- Request for Epclusa for genotype 3 may require submission of Genotype 3 NS5A Drug Resistance assay (please refer to PHC hepatitis C matrix for details)
- Documentation, as may be required, for: Ribavirin intolerance / ineligible, ascites, esophageal varices, hepatic encephalopathy.
- Letter of clinician experience in the treatment of HCV (once only per clinician)
    - *See the attached HCV TAR Supplemental Form for additional submission requirements.*

By working together with our hepatitis treating clinicians, patients eligible for HCV treatment can have the elements for authorization for medical treatment ready at the time of consultation- reducing delays in authorization.

Thank you,



Marshall Kubota, MD
Regional Medical Director
Partnership HealthPlan of California
mkubota@partnershiphp.org

Partnership HealthPlan of California Hepatitis C Treatment Regimens – Naïve to prior treatment and IFN experienced Effective: 3/1/2019

Member Name: _____ ID#: _____ DOB: _____

Physician: _____ Specialty: _____

Office Contact Person: _____ Title: _____

Email: _____ Phone: _____

PHC Preferred Hepatitis C Treatments:

- Treatments in DARK BOLD BLUE are PHC's exclusively preferred (PHC 1st line) regimens for the indicated genotype/stage. Zepatier and authorized generic of Epclusa (Sofosbuvir/Velpatasvir) are Partnership HealthPlan's exclusively preferred Hepatitis C regimens for the indicated genotype/stage as noted on the matrix.

- Treatments in italics and followed by asterisk(*) indicate that the regimen is not yet approved by the FDA and is considered "unlabeled" or off-label usage, although usage is supported by AASLD guidelines.

- "Treatment Experienced" is defined as having had a prior null response, rebound or relapse after ETR (End Treatment Response) to HCV treatment. Listing only IFN/RBV experienced; all other regimen experienced will be reviewed on a case-by-case basis.

IFN = Interferon	RBV = Ribavirin	RBV WB = Ribavirin (wt based)	
Dac = Daclatasvir	RBV LD = Ribavirin (low initial dose of 600mg, increase as tolerated)		
Sof = Sofosbuvir	VL = Viral Load	Wks = Weeks	
RAVs = Resistance Associated Variants – Applicable to Zepatier		AASLD Alternative Regimens = *Italicized* (not all alternative regimens are included in the matrix)	

Partnership HealthPlan of California Hepatitis C Treatment Regimens for Adults - Naïve to prior treatment and IFN experienced, Effective 3/1/19

Genotype	Stage 0-4, unconfirmed cirrhosis		Cirrhosis -definitive (bx, US, FibroSure/Test ≥ 0.75, findings of portal HTN, ascites, varices, encephalopathy)			
			CTP A (Score 5-6)		CTP B (7-9) / C (10-15)	
	Naïve	IFN/RBV experienced	Naïve	IFN/RBV experienced	Naïve	IFN/RBV experienced
GT 1a, mixed a/b or indeterminate GT 1	**Zepatier (no baseline NS5A RAVs) x 12 weeks**				**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**	**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**
	Sofosbuvir/Velpatasvir (Epclusa) x 12 wks				Ledipasvir/Sofosbuvir (Harvoni) + RBV LD x 12 wks	
	Ledipasvir/Sofosbuvir (Harvoni) x 8 wks (HCV VL <6 million, non-black, HIV-uninfected)	Mavyret x 8 wks	Ledipasvir/Sofosbuvir (Harvoni) x 12 weeks	Mavyret x 12 wks	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant
	Mavyret x 8 wks	Ledipasvir/Sofosbuvir (Harvoni) x 12 wks	Mavyret x 12 wks		Ledipasvir/Sofosbuvir (Harvoni) x 24 wks if RBV intolerant	
GT 1b	**Zepatier x 12 weeks**				**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB x 12 weeks**	**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**
	Sofosbuvir/Velpatasvir (Epclusa) x 12 wks				Ledipasvir/Sofosbuvir (Harvoni) + RBV LD x 12 wks	
	Ledipasvir/Sofosbuvir (Harvoni) x 8 wks (HCV VL <6 million, non-black, HIV-uninfected)	Mavyret x 8 weeks	Ledipasvir/Sofosbuvir (Harvoni) x 12 wks	Mavyret x 12 wks	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant
	Mavyret x 8 wks	Ledipasvir/Sofosbuvir (Harvoni) x 12 wks	Mavyret x 12 wks		Ledipasvir/Sofosbuvir (Harvoni) x 24 wks if RBV intolerant	
GT 2	**Sofosbuvir/Velpatasvir (Epclusa) x 12 weeks**		**Sofosbuvir/Velpatasvir (Epclusa) x 12 weeks**		**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB x 12 weeks**	**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**
	Mavyret x 8 wks		Mavyret x 12 wks		Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant
					Dac / Sof / RBV LD x 12 wks	
GT 3	**Sofosbuvir/Velpatasvir (Epclusa) x 12 weeks**	**Sofosbuvir/Velpatasvir (Epclusa) x 12 weeks (RAS testing for Y93H required)**	**Sofosbuvir/Velpatasvir (Epclusa) x 12 weeks (RAS testing for Y93H required)**	**Vosevi x 12 weeks**	**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB x 12 weeks**	**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**
	Mayret x 8 wks	*Sofosbuvir/Velpatasvir (Epclusa) + RBV WB x 12 wks (when Y93H present)*	Mavyret x 12 wks	Zepatier / Sovaldi x 12 wks*	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant	
		Mavyret x 16 wks	*Sofosbuvir/Velpatasvir (Epclusa) + RBV WB x 12 wks (when Y93H present)*	*Sofosbuvir/Velpatasvir (Epclusa) + RBV x 12 wks*	Dac / Sof / RBV LD x 12 wks	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant
				Mavyret x 16 wks		
GT 4	**Zepatier x 12 weeks**	**Zepatier x 12 weeks* (virologic relapse after prior peginterferon/ribavirin)**	**Zepatier x 12 weeks**	**Zepatier x 12 weeks* (virologic relapse after prior peginterferon/ribavirin)**	**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**	**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**
	Sofosbuvir/Velpatasvir (Epclusa) x 12 wks		Sofosbuvir/Velpatasvir (Epclusa) x 12 wks	Sofosbuvir/Velpatasvir (Epclusa) x 12 wks	Ledipasvir/Sofosbuvir (Harvoni) + RBV LD x 12 wks	
	Mavyret x 8 wks		Ledipasvir/Sofosbuvir (Harvoni) x 12 wks	Mavyret x 12 wks	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant
	Ledipasvir/Sofosbuvir (Harvoni) x 12 wks		Mavyret x 12 wks		Ledipasvir/Sofosbuvir (Harvoni) x 24 wks* if RBV intolerant	
GT 5 & 6	**Sofosbuvir/Velpatasvir (Epclusa) x 12 weeks**				**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**	**Sofosbuvir/Velpatasvir (Epclusa) + RBV WB X 12 weeks**
					Ledipasvir/Sofosbuvir (Harvoni) + RBV LD x 12 wks	
	Mavyret x 8 wks		Ledipasvir/Sofosbuvir (Harvoni) x 12 wks		Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant	Sofosbuvir/Velpatasvir (Epclusa) x 24 wks* if RBV intolerant
	Ledipasvir/Sofosbuvir (Harvoni) x 12 wks		Mavyret x 12 wks		Ledipasvir/Sofosbuvir (Harvoni) x 24 wks* if RBV intolerant	
Pre/Post Liver Transplant	**Case by Case Review, Transplant Specialist Referral Required**					

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TAR Supplemental Form for Hepatitis C Treatment: Effective 3-1-19

II. Patient readiness: Have the following been completed? Yes_____No _____

- **Patients shall be evaluated for readiness to initiate treatment.**
- **Patients selected for treatment shall be able and willing to strictly adhere to treatment protocols prescribe by their provider.**
- **Caution shall be exercised with patients who have a history of treatment failure with prior hepatitis C treatment due to non-adherence with treatment regimen and appointments.**
- **Patient shall be educated regarding the potential risks and benefits of hepatitis C virus therapy, as well at the potential for resistance and failed therapy if medication is not taken as prescribed.**

III. Requested regimen: _____

For Duration of: _____ weeks

IV. Status information; *complete the following*:

	YES	NO	N/A
Hepatic Information			
• HCV genotype 1a 1b 1-indeterminant 2 3 4 5 6 (circle genotype)			
• Has the patient been infected for more than 6 months or assumed so- *NOT required* but resolution of acute cases of HCV without treatment should be considered.			
• **REQUIRED: Limited Life Expectancy –** does patient have a limited life expectancy (< 12 months) which cannot be remediated by HCV therapy, liver transplantation, or another directed therapy?			
• If genotype 1a, 1b, or 1-indeterminant & viral load <6 million IU/mL: Patient is African American			
• Does patient have cirrhosis or suspected to have cirrhosis?			
o Abdominal ultrasound or liver biopsy included			
o APRI score of _____ calculator available at --- http://www.hepatitisc.uw.edu/page/clinical-calculators/apri			
o Fibro Sure / Fibro Test / FibroScan result of _____ which is consistent with F0-F3 or F4 (circle one)			
o **If proven cirrhosis** provide the numeric CTP score in the appropriate column at right. Calculator available at http://www.mdcalc.com/child-pugh-score-for-cirrhosis-mortality/ CTP A is score 5-6, CTP B is 7-9 and CTP C is 10-15	**A**	**B**	**C**
Indicate result of (or absence of) prior HCV treatment (Submit clinic notes and evaluation of nature of failure): Naïve ☐ Null responder ☐ Partial responder ☐ Relapse ☐ LTFU or Failed to Complete ☐			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TAR Supplemental Form for Hepatitis C Treatment: Effective 3-1-19

	YES	NO	N/A
Renal function – Is the GFR or eGFR ≥ 30 ml/min			
Transplantation			
• Is the patient a transplant recipient (any type)			
• Is this 1. Pre-liver transplant -or- 2. Post liver transplant treatment (circle one)			
Pregnancy prevention – if ribavirin is used			
• Patient has been counseled on the risks to the fetus if pregnancy occurs during treatment or within 6 months of completion of treatment **(Pregnancy Category X)**			
• Patient is infertile or not sexually active			
• Will the patient (female) use effective contraception during treatment and continue for 6 months afterwards?			
• Male –Will the female partner(s) of treated men use effective contraception during treatment and continue for 6 months afterwards?			
Clinician Experience and Attestation			
• Is the treating clinician a specialist? *Check one or more:* ☐ Gastroenterologist ☐ Hepatologist ☐ ID ☐ HIV clinician ☐ None of the above (this selection requires submission of a letter detailing the clinician's experience in the treatment of HCV) ☞ ***To the best of my knowledge, the information provided in this form is (1) true, accurate and complete and (2) the requested services are medically indicated and necessary to the health of the patient.*** **Signature of the prescriber:**_____ **Date:**_____			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TAR Supplemental Form for Hepatitis C Treatment: Effective 3-1-19

V. Additional required documentation:

Please submit the following data in original form:

- **If Genotype is 1a, mixed 1a/b, or indeterminate 1, *and* requested regimen includes elbasvir (i.e. Zepatier): Hepatitis C Viral RNA Genotype 1 NS5A Drug Resistance assay is required.**
- **HCV genotype**
- **HCV Viral Load (VL)**
- **Chem panel (AST with reference range, ALT, Platelet, total bilirubin, albumin), CBC, - If cirrhosis: INR and CTP score**
- **Documentation, as may be required, for Ribavirin intolerance / ineligible, ascites, esophageal varices, hepatic encephalopathy**
- **Letter of clinician experience in the treatment of HCV (once only per clinician)**
- **Request for Ecplusa for genotype 3 may require submission of genotype 3 NS5A resistance test result (please refer to matrix)**

In-therapy lab requirements:

- **All regimens: baseline; start of treatment HCV VL; 12 week SVR VL (to detect relapse vs reinfection)**
- **All regimens: 4 week HCV VL – if detectable then 6 week VL**
- **Regimens lasting more than 12 weeks: 12 week HCV VL**

VI. Case Management

- **Please describe the HCV case management plans for this patient to assure adherence to the treatment protocol and responsibility for medications.**
  - **Visit frequency should include initiation, and at least monthly until end of treatment. End of treatment visit. 12 week SVR Measurement.**
  - **Case management: in lieu of clinical visits, weekly phone call contacts will be required for continued refill of medications – chart documentation will be requested through the Treatment Authorization Request (TAR).**

VII. Patient responsibility

- **Lost medications might not be replaced and treatment authorization may be revoked**
- **Evidence of lack of adherence may result in treatment authorization revocation**
- **Missed appointments and lab data points may result in treatment authorization revocation**
- **Lack of compliance with case management may result in treatment authorization revocation**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TAR Supplemental Form for Hepatitis C Treatment: Effective 3-1-19

VIII. DHCS Policy: Unlabeled Use of Medication (aka, Off-label use of an FDA approved drug):

- Authorization for off-label uses of drugs shall not be granted unless the requested use represents reasonable and current prescribing practices. The determination of reasonable and current prescribing practices shall be based on:
  - Reference to current medical literature
  - Consultation with provider organizations, academic and professional specialists.

IX. Specialty Pharmacy Requirement:

- **HCV Rx and ALL the required documentation should be submitted to our specialty pharmacy:**

WALGREENS SPECIALTY PHARMACY #15987
Phone number: 916-738-3300
Fax number: 916-738-3302

Plan Exclusions

The following categories are not included in PHC's Pharmacy Drug Benefit for Medi-Cal (MC) lines of business.

FERTILITY & ERECTILE DYSFUNCTION AGENTS

The following agents, when used for the treatment of infertility (per State Operational Instructional Letter, #404-07) or erectile dysfunction (per State Medi-Cal All Plan Letter # 05009, effective Jan 1, 2006) are not covered benefits. This is a partial list for example purposes only -- any agent used to treat infertility or ED is not a covered benefit:

Aldosterone (Muse, Caverject, Edext)	Menotropins (Menopur)
Avanafil (Stendra)	Sildenafil 25,50,100mg (Viagra)
Chorionic Gonadotropin, Human (Pregnyl)	Tadalafil (Cialis)
Clomiphene Citrate (Clomid)	Urofollitropin (Bravelle)
Follitropin Alfa (Follistim AQ)	Vardenafil (Levitra, Staxyn)
HCG (Ovidrel)	Yohimbine (Testomar)

COSMETIC USE PRODUCTS

PHC covers only medications that are medically necessary, therefore agents for the treatment of cosmetic conditions are not considered to be a covered benefit. Medical necessity is defined as: Reasonable necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through diagnosis or treatment of disease, illness or injury. The following is a partial list for example purposes only -- any agent used for cosmetic purposes in the absence of documentation establishing medical necessity, is not a covered benefit.

Eflornithine (Vaniqa)	Minoxidil, topical (Rogaine)
Finasteride (Propecia)	Tretinoin micro (Renova)
Hydroquinone (Epiquin, Tri-Luma)	Bimatoprost (Latisse)

HERBAL PRODUCTS, DIETARY AIDS/SUPPLEMENTS

Non-drug products which are not FDA approved & are classified as dietary supplements, are not covered under PHC's drug benefit for Medi-Cal members. These products typically have the following disclaimers on the label: "This product has not been evaluated by the FDA for safety, purity & efficacy" &/or "This product is not intended to diagnose, treat, cure or prevent any disease". Note: CCS-Medi- Cal members may be afforded special consideration for medically necessary treatments included in this list, *unless* DHCS has specified that the product is not a benefit for CCS (deemed by DHCS as "not payable, even with an approved SAR").

Herbal products (eg, St. John's Wort, Valerian, etc)	Glucosamine/chondroitin
Probiotics (acidophilus)	MSM
Coenzyme Q	SAM-e
Fish oil	Melatonin
Oral N-acetylcysteine	Tumeric
Certain B-vitamin & Folic Acid combinations, as listed in State OIL# 180-14, with the exception of those remaining on PHC formulary for dialysis patients.	

CARVE-OUT DRUGS

Certain medications belonging to classes of antiviral (HIV/AIDS, Hepatitis B), antipsychotics, opioid antagonists and antihemophilic blood factors are covered by State Medi-Cal rather than PHC, therefore these are classified as "carve-out" drugs. This classification is drug-specific, not diagnosis specific. For example, if a buprenorphine prescription is written to treat a condition other than dependency or addiction, the drug is still considered to be the responsibility of State Medi-Cal and is not covered by PHC. Claims and TARs for *PHC MEDI-CAL* members must be submitted to State Medi-Cal.

ANTIRETROVIRAL Carve-Out Drugs	
Abacavir/Lamivudine (Epzicom)	Emtricitabine/Rilpivirine/ Tenofovir Dis. (Complera)
Abacavir Sulfate (Ziagen)	Emtricitabine/Tenofovir Alafenamide (Descovy)
Abacavir /Dolutegravir/Lamivudine (Triumeq)	Emtricitabine (Emtriva)
Atazanavir Sulfate (Reytaz)	Enfuvirtide (Fuzeon)
Atazanavir/Cobicistat (Evotaz)	Etravirine (Intelence)
Bictegravir/Emtricitabine/Tenofovir Alf (Biktarvy)	Fosamprenavir Calcium (Lexiva)
Cabotegravir/Rilpivirine (Cabenuva)	Fostemsavir (Rukobia)
Cobicistat (Tybost)	Ibalizumab-uiyk (Trogarzo)
Darunavir Ethanoate (Prezista)	Indinavir Sulfate (Crixivan)
Darunavir/Cobicistat (Prezcobix)	Lamivudine (Epivir)
Darunavir/Cobi/Emtri/Tenofovir Alf (Symtuza)	Lamivudine/Tenofovir Dis. (Cimduo)
Delavirdine Mesylate (Rescriptor)	Lamivudine/ Tenofovir disoproxil fumarate (Temixys)
Dolutegravir (Tivicay)	Maraviroc (Selzentry)
Dolutegravir (Tivicay PD)	Nelfinavir Mesylate (Viracept)
Dolutegravir/Lamivudine (Dovato)	Nevirapine (Viramune)
Dolutegravir/Rilpivirine (Juluca)	Raltegravir Potassium (Isentress)
Doravine (Pifeltro)	Rilpivirine Hydrochloride (Edurant)
Doravirine/Lamivudine/Tenofovir Dis. (Delstrigo)	Ritonavir (Norvir)
Efavirenz (Sustiva)	Saquinavir (Fortovase)
Efavirenz/Emtricitabine/Tenofovir Dis. (Atripla)	Saquinavir Mesylate (Invirase)
Efavirenz/Lamivudine/Tenofovir Dis. (Symfi)	Stavudine (Zerit)
Efavirenz/Lamivudine/Tenofovir Dis. (Symfi Lo)	Tenofovir Alafenamide Fumarate (Vemlidy)
Elvitegravir (Vitekta)	Tenofovir Disoproxil/Emtricitabine (Truvada)
Elvitegravir/Cobicistat/Emtricitabine /Tenofovir alafenamide (Genvoya)	Tenofovir Disoproxil Fumarate (Viread)
Elvitegravir/Cobicistat/Emtricitabine/ Tenofovir Dis. (Stribild)	Tipranavir (Aptivus)
Emtricitabine/Rilpivirine/Tenofovir Alf. (Odefsey)	Zidovudine/Lamivudine (Combivir)
	Zidovudine/Lamivudine/ Abacavir (Trizivir)

DETOX/DEPENDENCY Carve-Out Drugs	
Acamprosate (Campral)	Lofexidine HCl (Lucemyra)
Buprenorphine extended release injection (Sublocade)	Naloxone HCl Injection (Narcan)
Buprenorphine (Subutex, Belbuca, Buprenex)	Naloxone Nasal Spray (Narcan Nasal)
Buprenorphine/Naloxone (Suboxone)	Naloxone 0.4mg/0.4mL Injector (Evzio)
Buprenorphine implant (Probuphine)	Naltrexone PO/IV (ReVia, Vivitrol)
Buprenorphine transdermal patch, *regardless of indication* (Butrans)	Naltrexone Microsphere injectable suspension (Vivitrol)
Disulfiram (Antabuse)	

PSYCHIATRIC Carve-Out Drugs		
Amantadine HCL (Symmetrel)	Isocarboxazid (Marplan)	Pimavanserin (Nuplazid)
Aripiprazole (Abilify)	Lithium Carbonate	Pimozide (Orap)
Aripiprazole Lauroxil (Aristada)	Lithium Citrate	Quetiapine (Seroquel, Seroquel XR)
Asenapine (Saphris)	Loxapine Succinate (Loxitane)	Benztropine Mesylate (Cogentin)
Risperidone (Risperdal, Risperdal Consta)	Lurasidone Hydrochloride (Latuda)	Selegiline (transdermal only) (Emsam)
Brexpiprazole (Rexulti)	Molindone HCl (Moban)	Thioridazine HCl (Mellaril)
Cariprazine (Vraylar)	Olanzapine (Zyprexa)	Thiothixene (Navane)
Chlorpromazine HCl (Thorazine)	Clozapine (Clozaril, FazaClo)	Tranylcypromine Sulfate (Parnate)
Paliperidone (Invega, Invega Sustenna)	Olanzapine/Fluoxetine HCl (Symbyax)	Olanzapine Pamoate (Zyprexa Relprevv)
Fluphenazine PO/IV (Prolixin)	Trifluoperazine HCl (Stelazine)	Trihexyphenidyl (Artane)
Haloperidol (Haldol)	Perphenazine (Trilafon)	Ziprasidone (Geodon)
Iloperidone (Fanapt)	Phenelzine Sulfate (Nardil)	Ziprasidone Mesylate (Geodon IM)

BLOOD FACTORS & CLOTTING FACTOR DISORDER TREATMENT Carve-Out Drugs	
Anti-inhibitor	Factor IX complex
Coagulation factor X (human)	Factor X (human), per IU
Emicizumab-kxwh (Hemlibra)	Factor XIII (antihemophilic factor, human)
Factor VIIa (antihemophilic factor, recombinant)	Factor XIII A-Subunit (recombinant)
Factor VIII (antihemophilic factor, human)	Hemophilia clotting factor, not otherwise classified
Antihemophilic factor VIII/von Willebrand factor complex (human)	Injection, factor VIII (antihemophilic factor, recombinant)
Factor VIII (antihemophilic factor, recombinant)	Injection, factor VIII, fc fusion protein (recombinant)
Factor VIII (antihemophilic factor, recombinant) (Afstyla), per IU	Injection, factor VIII (antihemophilic factor, recombinant), pegylated-aucl (Jivi), 1 IU
Factor VIII (antihemophilic factor, recombinant) (Novoeight)	Injection Factor IX, (antihemophilic factor, recombinant), glycopegylated, (Rebinyn), 1 IU
Injection, factor IX fusion protein (recombinant)	Injection Factor IX, (recombinant) (Rixubis)
Factor VIII (antihemophilic factor, recombinant) (Nuwiq), per IU	Factor IX (antihemophilic factor, purified, non-recombinant)
Factor VIII (antihemophilic factor, recombinant) PEGylated, per IU	Factor IX (antihemophilic factor, recombinant) (Rixubis)
Factor IX (antihemophilic factor, recombinant)	Von Willebrand factor (recombinant) (Vonendi), per IU
Factor IX albumin fusion protein, (recombinant), (Idelvion), per IU	Von Willebrand factor complex (human), Wilate
	Von Willebrand factor complex (Humate-P)

SUPPLEMENTAL INFORMATION FOR PROVIDERS

I. ABBREVIATIONS, TERMS, ACRONYMS & SYM BOLS USED BY PHC:

BRAND NAMES: Trade name/patent drugs. Unless otherwise stated, ***the brand names shown in the formulary guide are non-formulary when an equivalent generic is approved by the FDA.*** Brand names used in this formulary guide are *representative only*, for ease of drug recognition by providers. Generic products must be dispensed whenever possible, as required by the Formulary Utilization Management Initiative (refer to State's Medi-Cal program). TAR consideration for brand names may require any or all of the following per PHC policy #MPRP4033: Prescriber's evaluation & assessment of signs/symptoms of generic failure, documentation that generic has actually been dispensed (e.g., copy of pharmacy profile), completion of FDA MedW atch form to document problem with a generic product, trial of more than one generic source product, trial of alternate products in same therapeutic category.

CARVE-OUT DRUGS: These are prescription services that are not included in PHC's scope of coverage, but are covered (or covered with prior authorization) by State Medi-CaI Fee-For-Service. These drugs remain a potential benefit for eligible PHC members *through State Medi-Cal*, but PHC is not financially responsible and all claims for these drugs (including secondary copays) must be reimbursed through the State Medi-Cal program. Note that carve-out status is assigned to specific drugs by DHCS, regardless of indication for use.

CCS: California Children's Services-- a state program for children up to 21 years old with certain health problems.

CCS ELIGIBLE PHARMACY SERVICES: CCS covered prescriptions include agents in the following treatment categories: cardiology, neurology, endocrinology, oncology, hematology, metabolism disorders, gastroenterology, ophthalmology, rheumatology & other connective tissue/musculoskeletal disorders, pulmonology, nephrology, immunology and severe skin/subcutaneous conditions. Disabling injuries may also be eligible for CCS services.

CMS: Centers for Medicare & Medicaid Services. The US Federal agency which administers Medicare (A, B & D), Medicaid/Medi-Cal and the Children's Health Insurance programs.

CODE 1 MEDICATIONS: Code 1 medications are formulary, but the use is limited to a specific medical condition, failure/intolerance to 1st line therapy, member's place of residence, or other stipulated restriction(s). Although Code 1 restricted drugs do not require a TAR when the Code 1 restriction is met, pharmacy providers must maintain documentation that the drug is being dispensed according to the Code 1 restriction. Any other use of the drug is considered non-formulary and requires a TAR. To facilitate filling of a Code 1 prescription, prescribers should write the member's diagnosis, and any other Code 1 criteria if met, on the prescription.

DESI: Drug Efficacy Study Implementation. A program started in the 1960's by the FDA with the goal of evaluating all medications for efficacy as well as safety. The program was intended to classify all drugs placed on the market prior to 1962, which had been in use without any prior efficacy studies. A DESI drug is any drug that lacks substantial evidence of effectiveness and safety.

DISPENSING LIMITS: Formulary use of the medication is limited to the specified dispensing quantity, duration of use or member age. An approved TAR is required for dispensing a drug that exceeds the designated limit.

DOLLAR LIMITS: PHC's Medi-Cal have an online adjudication limit of $1,000 for any single claim, for most drugs. Claims submitted for more than $1,000 will require a TAR, even if on formulary. Formulary claims exceeding $1,000 or alternative established limit are subject to TAR review by PHC for

verification of dose/prescribing for safety (e.g., does drug match the diagnosis, is the dose appropriate), billing errors, medical necessity, potential cost-benefit considerations with other formulary agents, etc. Compound prescription claims using formulary ingredients have a $60 limit (see PHC's Pharmacy Procedure Manual for instructions on submitting compound claims & TARs), with TAR required on claims > $60.

DUAL ELIGIBLE: Medi-Cal members who are also eligible for Medicare, whether or not they are actually enrolled in Medicare. Medi-Cal is always secondary to Medicare, thus if patient is eligible for Medicare, Medicare must be billed before PHC. Dual eligible individuals are required to join either a Medicare prescription drug plan or a Medicare Advantage plan, and there is a process by which CMS auto-enrolls members into Medicare upon becoming eligible. However, if a member is not yet enrolled in Medicare, but is eligible for Medicare, there is a process by which pharmacies can enroll patients in Part D at Point- of-Sale (LINET program, administered by Humana). CMS Excluded drugs may be submitted to PHC for Medi-Cal coverage consideration, however note that many DESI drugs are also exempt from Medi-Cal &/or PHC benefits; drugs that are non-formulary on member's Part D (but not excluded per CMS) must go through the prior authorization procedures with the Part D plan (including Part D Appeals) rather than PHC. Pharmacies may submit a TAR to PHC for consideration of Part B copays & deductibles; PHC is federally prohibited from paying any Part D copays or deductibles.

eCOB: Electronic coordination of benefits. The ability to transmit & adjudicate electronically (online) the portion of the primary insurance claim that is the patient's responsibility, to the secondary insurance.
Co- pays over $300 require a TAR when PHC is the secondary payer; please note on the TAR the copay and submit with an eCOB form, including any/all known reason(s) for the high copay (deductibles, non-formulary w/ primary, etc). If Rx is non-formulary or non-preferred with the primary, prior auth should be sought with the primary before submitting a TAR to PHC. PHC formulary restrictions may be applied. If Rx is "refill too soon" or "M/I day supply" or any other administrative denial with the primary, those issues must be resolved with the primary before submitting claim to PHC. Per CMS Federal regulations, PHC is *not* responsible for any Part D copays, deductibles or "donut hole" (gap) amounts.

F: Formulary. Note that additional restrictions may apply. A formulary agent may be subject to dollar limit, age, quantity, dosage form, Code 1, specific NDC requirement, CCS referral, or other limitations which necessitate a TAR despite formulary status.

EXCLUDED DRUGS: These are agents that have been excluded from Part D by Federal CMS regulation, and are typically not a covered benefit by Medicare D plans. Excluded Drugs include: drugs covered exclusively by Part A or B, drugs with "less than effective" DESI status, OTCs, Rx vitamin & mineral supplements (except niacin, prenatal & fluoride products), cough & cold agents, fertility agents, agents for weight gain/loss (except megestrol), agents for cosmetic use.

Drugs which are excluded from PART D coverage per CMS may be eligible for coverage through the member's secondary Medi-Cal (PHC) coverage, depending on the drugs' PHC formulary status (eg, some drugs which are excluded from CMS for Part D are also excluded from PHC coverage due to state operational instruction determination).

Note: A Part D plan pharmacy message denial stating "Formulary Exempt" or "Excluded from formulary" in not the same as "CMS Excluded". An agent may be non-formulary on a specific Part D plan, but not CMS excluded. Conversely, a drug may be a CMS excluded drug, but a Part D plan may *choose* to include it on the formulary. Since Medicare is primary over Medicaid/Medi- Cal programs, PHC requires that prior auth (CDF) be sought with the member's primary Part D insurance, for any non-formulary drug (with the exception of excluded drug classes), including any necessary appeals *before submitting* a TAR to PHC.

MAC: Maximum Allowable Cost. Used to calculate reimbursement rates for generically available products. Third party payers utilize MAC pricing for many generics rather than the manufacturers' AWPs. MAC lists are not standardized – each PBM or insurer determines its own MAC. MAC pricing is a contractural agreement between a PBM and the pharmacy provider.

MC: Medi-Cal. Used in this document to designate PHC's Medi-Cal line of business. PHC contracts with the STATE to provide medical services to the Medi-Cal eligible population in certain counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity & Yolo. PHC is a separate entity from "State Medi-Cal". PHC utilizes its own formulary & criteria derived from evidenced-based medicine and approved by both a Pharmacy & Therapeutics Committee and a Physicians' Advisory Committee, and is made comparable to the State Medi-Cal contract drug list by including at least one drug to treat each therapeutic class covered by State Medi-Cal.

NEW STARTS: Depending on context, can be either an initial claim/TAR with PHC or patient new to treatment.

NF: Non-Formulary. A TAR (Treatment Authorization Request, also referred to as a prior authorization) is required for coverage.

NL: Not listed. This term is used in PHC's formulary search tool and simply indicates the drug has not been found in the plan's formulary (i.e., not yet entered into the Search Tool's data base). This usually equates to not being on formulary (NF).

OVER-THE-COUNTER MEDICATION (OTC's) & Medical Supplies: PHC's Medi-Cal formulary offers a selection of covered OTC items & medical supplies. A prescription is required for both formulary OTC claims and non- formulary OTC requests. PHC's Medi-Cal formulary includes "wrap benefit" coverage for dual eligible members (members with both Medi-Cal and Medicare) – this allows Medi-Cal members to obtain formulary OTC products at no charge if the product is excluded from Medicare by being over-the-counter.

PBM: Pharmacy Benefits Manager. A PBM is a third party administrator of prescription drug plans. The PBM for PHC is MedImpact. The PBM is primarily responsible for processing and paying drug claims. MedImpact is a separate entity from PHC, contracted by PHC for online claims adjudication, provider reimbursement & support.

PDP: Prescription Drug Plan, usually used in reference to a member's Medicare Part D plan, but could refer to any primary drug benefit.

QL: Quantity Limit. A drug may be limited to maximum daily, monthly, yearly or lifetime usage.

SECONDARY INSURANCE: When patients have more than one medical &/or prescription insurance, one is assigned as the primary and the other is secondary—meaning reimbursement for services is the responsibility of the primary insurance first. The secondary is billed only after the primary. A secondary insurance may utilize its own formulary restrictions. State funded programs are always secondary to any private or federal insurance plans—*i.e.*, they are the payers of last resort. All reimbursement issues should be resolved with the primary insurance before submitting a TAR to PHC – this includes using the allowed day's supply, using the primary's formulary preferred agents, obtaining prior auth from the primary for non-preferred or non-formulary items, *etc*. **NOTE:** Discount plans are NOT to be considered primary to PHC, and the member's discounted price is NOT to be submitted to PHC as a "copay". **Discount Rx programs CANNOT be used in conjunction with any state or federally funded program, including PHC.**

STEP AGENT, OR STEP THERAPY EDIT: Online approval without a TAR requires prior treatment with prerequisite drug therapy. Member must have had a previous trial of one or more designated 1st line agent(s) *paid by MedImpact* within a designated time frame in order for claim to adjudicate without a TAR. TARs submitted for STEP agents are needed when there is no qualifying claim in the claim history look-back period; in the event that a TAR is needed for a STEP item, additional criteria may have been established by P & T, over & above what is equal to the electronic step edit.

TREATMENT AUTHORIZATION REQUEST (TAR): A prior authorization request form for PHC services. The following are examples of claims which require prior authorization (TAR) before reimbursement can be made:

- Drugs on the formulary but are listed as "PA Required" (prior authorization required).
- Drugs shown as "NL" (not listed) in the online formulary search tool
- Drugs listed in the formulary search tool for informational purposes, but status is non-formulary ("NF")
- Brand name drugs when an equivalent generic is available
    - *NOTE: If a prior authorization is obtained for a single-source drug (no generic available at the time of TAR review), that authorization is for the drug entity only (generic component) which happens to only be available as brand at the time of review. If during the life of the TAR or upon TAR renewal, a generic equivalent has been approved by the FDA and is available in the market, generic substitution is required for the TAR to continue to allow paid claims. If continued use of brand is medically necessary, a new TAR must then be submitted for the brand with adequate documentation of medical necessity per PHC Policy MPRP4033.*
- Prescriptions not meeting a Code 1 restriction
- Prescriptions exceeding a designated dispensing limit such as (but not limited to): quantity, number of fills, prescriber specialty, day supply
- Any single claim that exceeds plan dollar limit
- Non-formulary agents that were previously approved by another plan
- Agents that are STEP with no claims for the prerequisite step therapies on member's PHC profile within the historical look-back period

Prior authorizations must be requested by the provider (pharmacy or prescriber) by completing the TAR submission process, either by PARx online TAR application or FAX. **Retroactive TAR's are best submitted to PHC within fifteen (15) business days of the requested start date of service (claims over 15 days and under 365 days will still be reviewed for medical necessity).** To facilitate prompt determination of the TAR, and to minimize the need for communication between the all involved parties (prescriber, pharmacy & PHC), prescribers are encouraged to include the following information, as appropriate, on the front or back of the written prescription, or as additional info faxed to patient's pharmacy for medications requiring a TAR.

KEY TAR COMPONENTS:

- Diagnosis:
  - TARs must have an *accurate* diagnosis (preferably with specific ICD-10) *provided by the physician*. The diagnosis info must be specific for the patient & drug in question. Dispensing pharmacy staff is asked NOT to complete this section on the TAR without checking with the prescriber, as many drugs have multiple indications & the diagnosis should never be assumed based on a common use. An incorrect diagnosis may cause further delay of the review process, or even a denial of the request.

    ONLINE TAR SUBMISSION: If the prescriber does not provide an ICD-10, the pharmacy must use default ICD # 000000, and include diagnosis description (as provided by the prescriber) in the written justification portion of the TAR.
- Other Formulary Medications tried *and nature of the failure*. Important to distinguish between side effects, partial but inadequate response or not effective.
- Clinical Justification for the use of a non-formulary drug, including relevant lab results & medical history.

TAR's submitted to PHC without the above information may be denied due to insufficient information for clinical review or may be deferred by PHC for further information, awaiting a response from the provider. If denied due to insufficient information, the request may be resubmitted with a new *completed* TAR form & the required information at any time, since the new submission is treated as a new TAR.

$1,000 CLAIM LIMIT EXEMPTIONS: In general, PHC claims are limited to $1,000 per claim; claims over that amount are subject to screening for correct billing procedure, safety (FDA approved use, dosing, age) and medical necessity, regardless of formulary status. There are some drugs which PHC has specifically assigned a higher limit to, in order to avoid dispensing delays.

II. TARS for Emergency Fills

5-Day Emergency Fills:

Emergency authorizations for TAR's outside of PHC's normal business hours may be requested from MedImpact (PHC's contracted PBM) at (800) 788-2949.

MedImpact will authorize up to a 5-day supply of medication when the pharmacy determines it will put the member at risk to not have the medication. MedImpact is available 24/7, with the exclusion of holidays. PHC will also authorize a retroactive TAR for up to a 5-day supply dispensed during non-business hours when medically necessary.

PHC does not require that the situation meet a *legal* (i.e., pharmacy law) definition of "emergency" -- it is the judgment of the dispensing pharmacist that determines the need for emergency authorization in order to avoid pain, suffering, severe emotional distress, or worsening of any medical condition that could result in the need for emergency medical treatment.

III. TAR SUBMISSION TIPS

e-PA ONLINE TAR, available to pharmacy providers: https://epa.partnershiphp.org

TAR Source	TAR FAX #	Please note:
Pharmacy	**(707) 419-7900**	**Use only when the dispensing pharmacy's internet is down or pharmacy does not yet have a PARx account.**
Medical office	**(707) 863-4330**	**Use for TAR submissions requesting authorization for drug services administered in the office, clinic or infusion center setting.**

IMPORTANT: **FAXED TARs for different drugs &/or different patients need to be faxed separately, rather than in a bulk/group fax. Multiple TAR pages in a single fax are ok, as long as all pages pertain to a single request**.

- TAR forms are available online (link: Printable PHC TAR Form) or by calling PHC pharmacy services department.
- Complete TARs NEATLY & ACCURATELY. Incomplete TARs will be returned for resubmission (i.e., administratively denied) if any of the following are missing or illegible: Member Name, ID#, Date of Birth, Diagnosis, Medical Justification, Drug Name/Strength/Sig, NDC, prescriber DEA/NPI & contact info.
- Providers may fax multiple sheets of paper if additional writing space is needed – make sure the member's name &/or TAR # is included on all additional sheets to help ensure they get attached to the correct TAR. Additional sheets received from a prescriber (labs, notes, etc) may be uploaded to a PARx TAR (online pharmacy TAR), if the pharmacy has the capability to scan & save documents.
- **Pharmacies:** TARs must include the prescriber's full contact info –
  - Name, NPI, specialty, phone & fax (when a prescriber has multiple offices: make sure to enter the phone/fax for the location the member is seen at).
- **Medical providers submitting TARs for manual billing to PHC claims dept:**

  The TAR form must include:
  - Accurate billing code, drug name & NDC if available
  - Provider & member information
    - # of billing units needed *per dose*
  - The number of doses requested
    - The strength & administration directions
  - The expected duration of treatment (end date or # of cycles & duration of each cycle)

  The above information must be on the TAR form itself. Writing "see attached" on the TAR rather than completing the TAR causes delays in TAR review.

  Attachments (such as notes from medical record) can be included, but they do not replace the need to complete a TAR; attachments are for the purpose of providing *additional* clinical information for medical justification, disease & treatment history and dose-calculation verification.

Partnership Health Plan of California

Table of Contents

Formulary Tier
1 = Formulary
2 = Formulary, with restrictions
3 = Formulary, Prior Authorization required

Restrictions
AL = Age Limit
C-1 = Code-1 Restriction
QL = Quantity Limit
ST = Step Edit Restriction

BENEFIT LIMITS ON OPIOID (NARCOTIC) ANALGESIC (PAIN) & ANTITUSSIVE (COUGH) AGENTS IN ADDITION TO THE LISTED FORMULARY LIMITS:

- Oral liquids with hydrocodone or codeine: Limited to 240 ml in a 90 day period. Daily formulary quantity limits also apply.
- Oral tablets, capsules in immediate-release formulations, such as acetaminophen/codeine, acetaminophen/ hydrocodone, morphine sulfate: #30 in 90 day period. Daily formulary quantity limits also apply.
- Both immediate-release and extended -elease opiates: Limited to a 7-day supply on the initial fill when there are no other opiate fills in the member's claim history in the previous 90 days. Daily formulary quantity limits also apply.

Drug Name	Reference	Formulary Tier	Restrictions
Analgesics: Also see the OTC section for additional covered products			
acetaminophen-codeine oral solution 120 mg-12 mg /5 mL (5 mL), 240 mg-24 mg /10 mL (10 mL)		2	C-1 (CODE-1 RESTRICTION: Limited to post-surgical use, 2 fills per year & 240ml per fill with maximum daily dose limit of 90 mL. Limited to adults (age 18 and older). The American Academy of Pediatrics does not recommend the use of codeine in children. QL (240 ML per 1 Fill); AL (Min 18 years)
acetaminophen-codeine oral solution 120-12 mg/5 mL		2	C-1 (CODE-1 RESTRICTION: Limited to post-surgical use.); QL (240 ML per 1 Fill); AL (Min 18 Years)

Drug Name	Reference	Formulary Tier	Restrictions
acetaminophen-codeine oral solution 300 mg-30 mg /12.5 mL		2	C-1 (CODE-1 RESTRICTION: Limited to post-surgical use, 2 fills per year & 240 ml per fill with maximum daily dose limit of 90 mL and 240 mL per 90 days. The American Academy of Pediatrics does not recommend the use of codeine in children. AL (Min 18 Years) QL (240 ml)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg		2	QL (12 EA per 1 day); AL (Min 18 Years)
acetaminophen-codeine oral tablet 300-60 mg		2	QL (6 EA per 1 day); AL (Min 18 Years)
butalbital-acetaminophen-caff oral tablet	Esgic	2	QL (6 EA per 1 day)
butalbital-aspirin-caffeine oral capsule		2	QL (6 EA per 1 day)
diclofenac potassium	Cataflam	1	
diflunisal		1	
dihydroergotamine injection	D.H.E.45	2	QL (10 ML per 30 days)
Elmiron		2	ST
Endocet oral tablet 10-325 mg, 5-325 mg		2	QL (8 EA per 1 day)
ergotamine-caffeine	Cafergot	2	QL (40 EA per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr		3	PA
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr		2	ST; QL (10 EA per 30 days)

Drug Name	Reference	Formulary Tier	Restrictions
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 mL		2	C-1 (CODE-1 RESTRICTION: For post-surgical use, such as oral surgery (eg, unable to swallow tablets); limited to 240 mL per fill and per 90 days. All short-acting liquid/syrup narcotics on PHC drug list are limited to a cumulative qty limit #240 ml (liquids/syrups) in 90 days.)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg		2	QL (8 EA per 1 day)
hydromorphone (PF) injection solution 10 mg/mL		1	
hydromorphone injection solution 2 mg/mL		1	
hydromorphone injection syringe 1 mg/mL, 2 mg/mL, 4 mg/mL		1	
hydromorphone oral tablet 2 mg	Dilaudid	2	QL (10 EA per 1 day)
hydromorphone oral tablet 4 mg	Dilaudid	2	QL (5 EA per 1 day)
hydromorphone oral tablet 8 mg	Dilaudid	2	QL (2 EA per 1 day)
hydromorphone rectal		2	QL (12 EA per 1 Fill)
Infumorph P/F injection solution 25 mg/mL		1	
ketorolac intramuscular solution		1	
ketorolac intramuscular syringe		1	
ketorolac oral		2	QL (4 EA per 1 day); AL (Min 18 Years)
morphine (PF) injection solution 0.5 mg/mL, 1 mg/mL	Duramorph (PF)	1	
morphine concentrate oral solution		2	QL (4.5 ML per 1 day)
morphine injection syringe 10 mg/mL		1	
morphine intravenous pt controlled analgesia syring		1	

Drug Name	Reference	Formulary Tier	Restrictions
morphine intravenous solution 50 mg/mL		1	
morphine oral solution 10 mg/5 mL		2	QL (45 ML per 1 day)
morphine oral solution 20 mg/5 mL (4 mg/mL)		2	QL (22.5 ML per 1 day)
morphine oral tablet 15 mg		2	QL (6 EA per 1 day)
morphine oral tablet 30 mg		2	QL (3 EA per 1 day)
morphine oral tablet extended release 15 mg	MS Contin	2	QL (6 EA per 1 day)
morphine oral tablet extended release 30 mg	MS Contin	2	QL (3 EA per 1 day)
nalbuphine		1	
naratriptan oral tablet 1 mg	Amerge	2	QL (9 EA per 1 month)
naratriptan oral tablet 2.5 mg	Amerge	2	QL (9 EA per 30 days)
oxycodone oral capsule		2	QL (6 EA per 1 day)
oxycodone oral tablet 10 mg		2	QL (6 EA per 1 day)
oxycodone oral tablet 15 mg	Roxicodone	2	QL (4 EA per 1 day)
oxycodone oral tablet 20 mg		2	QL (3 EA per 1 day)
oxycodone oral tablet 30 mg	Roxicodone	2	QL (2 EA per 1 day)
oxycodone oral tablet 5 mg	Roxicodone	2	QL (6 EA per 1 day)
oxycodone-acetaminophen oral tablet 10-325 mg	Endocet	2	QL (6 EA per 1 day)
oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg	Endocet	2	QL (8 EA per 1 day)
rizatriptan	Maxalt	2	QL (12 EA per 30 days)
sumatriptan	Imitrex	2	QL (6 EA per 30 days)
sumatriptan succinate oral	Imitrex	2	QL (9 EA per 30 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 mL	Imitrex STATdose Refill	2	QL (2 ML per 1 Fill)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 mL	Imitrex STATdose Refill	2	QL (1 ML per 15 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 mL	Imitrex STATdose Pen	2	QL (2 ML per 1 Fill)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 mL	Imitrex STATdose Pen	2	QL (1 ML per 15 days)

Drug Name	Reference	Formulary Tier	Restrictions
sumatriptan succinate subcutaneous solution	Imitrex	2	QL (2.5 ML per 15 days)
tramadol oral tablet 50 mg	Ultram	2	QL (8 EA per 1 day)
tramadol-acetaminophen	Ultracet	2	QL (8 EA per 1 day)
zolmitriptan oral		2	QL (6 EA per 1 month)
Anesthetics			
lidocaine (PF) injection solution		1	
lidocaine (PF) injection syringe 10 mg/mL (1 %), 200 mg/10 mL (2 %), 50 mg/5 mL (1 %), 60 mg/3 mL (2 %)		1	
lidocaine HCl injection solution 20 mg/mL (2 %)	Xylocaine	1	
lidocaine HCl mucous membrane jelly		1	
lidocaine topical adhesive patch,medicated 5 %	Lidoderm	2	QL (2 EA per 1 day); AL (Min 18 Years)
lidocaine topical ointment		1	
Lidocaine Viscous		1	
lidocaine-prilocaine topical cream		2	QL (30 GM per 30 days)
Lidopin topical cream 3 %		2	QL (85 GM per 15 days)
phenazopyridine oral tablet 100 mg, 200 mg	Pyridium	1	
ropivacaine (PF) injection solution	Naropin (PF)	1	
ropivacaine (PF)-NaCl,iso-osm injection		1	
Xylocaine injection solution 5 mg/mL (0.5 %)		1	
Antiarthritics			
allopurinol	Zyloprim	1	
celecoxib oral capsule 100 mg, 200 mg, 50 mg	Celebrex	2	QL (2 EA per 1 day)
celecoxib oral capsule 400 mg	Celebrex	2	QL (1 EA per 1 day)
colchicine oral capsule	Mitigare	2	QL (60 EA per 23 days)
colchicine oral tablet	Colcrys	2	QL (2 EA per 1 day)
diclofenac sodium oral		1	
etodolac oral capsule		1	
etodolac oral tablet	Lodine	1	

Drug Name	Reference	Formulary Tier	Restrictions
etodolac oral tablet extended release 24 hr 400 mg, 500 mg		1	
febuxostat	Uloric	2	QL (1 EA per 1 day)
flurbiprofen oral tablet 100 mg		1	
IBU		1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	IBU	1	
indomethacin oral capsule		1	
indomethacin oral capsule, extended release		2	QL (2 EA per 1 day); AL (Min 15 Years)
ketoprofen oral capsule 50 mg, 75 mg		1	
leflunomide	Arava	1	
meclofenamate oral capsule 100 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of dysmenorrhea; note that the recommended treatment duration is up to 6 consecutive days, initiated at start of cycle.); QL (21 TABLETS per 1 FILL)
meloxicam oral tablet 15 mg	Mobic	2	QL (1 EA per 1 day)
meloxicam oral tablet 7.5 mg	Mobic	2	QL (2 EA per 1 day)
nabumetone	Relafen	1	
naproxen oral suspension	Naprosyn	2	QL (120 ML per 1 FILL); AL (Max 12 Years)
naproxen oral tablet		1	
naproxen oral tablet,delayed release (DR/EC)	EC-Naprosyn	1	
naproxen sodium oral tablet 275 mg		1	
naproxen sodium oral tablet 550 mg	Anaprox DS	1	
oxaprozin	Daypro	1	
piroxicam	Feldene	1	
probenecid		1	
probenecid-colchicine		1	

Drug Name	Reference	Formulary Tier	Restrictions
Ridaura		2	C-1 (CODE-1 RESTRICTION: Limited to adults with Active Rheumatoid Arthritis unresponsive to NSAID. QL (3 EA per 1 day); AL (Min 18 Years)
salsalate	Disalcid	1	
sulindac		1	
Xeljanz oral tablet		3	PA
Xeljanz XR		3	PA
Antiasthmatics			
ALBUTEROL HFA 90 MCG INHALER	ProAir HFA	2	QL (1 UNIT per 15 days)
albuterol sulfate inhalation HFA aerosol inhaler 90 mcg/actuation	ProAir HFA	2	QL (1 Unit per 15 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL		2	QL (4 Vials per 1 day)
albuterol sulfate inhalation solution for nebulization 2.5 mg /3 mL (0.083 %)		2	QL (225 ML per 25 days)
albuterol sulfate inhalation solution for nebulization 2.5 mg/0.5 mL		2	QL (40 EA per 25 days)
albuterol sulfate inhalation solution for nebulization 5 mg/mL		2	QL (40 ML per 25 days)
albuterol sulfate oral syrup		1	
albuterol sulfate oral tablet		1	
albuterol sulfate oral tablet extended release 12 hr 4 mg		1	
Alvesco inhalation HFA aerosol inhaler 160 mcg/actuation		2	QL (3 Inhaler per 90 days)
Alvesco inhalation HFA aerosol inhaler 80 mcg/actuation		2	QL (3 Inhalers per 90 days)
aminophylline intravenous		1	

Drug Name	Reference	Formulary Tier	Restrictions
Anoro Ellipta		2	C-1 (CODE-1 RESTRICTION: Restricted to adults, 18 years and older, use only for treatment of COPD, 1 unit per 30 days.); QL (1 UNIT per 30 days); AL (Min 18 Years)
Arnuity Ellipta inhalation blister with device 100 mcg/actuation		2	QL (3 Inhalations per 90 days)
Arnuity Ellipta inhalation blister with device 200 mcg/actuation, 50 mcg/actuation		2	QL (3 Inhalers per 90 days)
Asmanex HFA inhalation HFA aerosol inhaler 100 mcg/actuation, 200 mcg/actuation		2	QL (3 Inhalers per 90 days)
Asmanex HFA inhalation HFA aerosol inhaler 50 mcg/actuation		2	QL (3 Inhalers per 90 days); AL (Min 5 Years)
Asmanex Twisthaler inhalation aerosol powdr breath activated 110 mcg/ actuation (30), 220 mcg/ actuation (120), 220 mcg/ actuation (14), 220 mcg/ actuation (60)		2	QL (3 Inhalers per 90 days)
Asmanex Twisthaler inhalation aerosol powdr breath activated 220 mcg/ actuation (30)		2	QL (3 EA per 90 days)
Atrovent HFA		2	QL (12.9 GM per 30 days)
Bevespi Aerosphere		2	QL (1 UNIT per 1 Month); AL (Min 18 Years)
budesonide inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL	Pulmicort	2	QL (4 ML per 1 day)
budesonide inhalation suspension for nebulization 1 mg/2 mL	Pulmicort	2	QL (2 ML per 1 day)
budesonide-formoterol	Symbicort	2	QL (30.6 GM per 90 days)
Combivent Respimat		2	QL (4 GM per 20 days)
cromolyn inhalation		1	

Drug Name	Reference	Formulary Tier	Restrictions
Dulera inhalation HFA aerosol inhaler 100-5 mcg/actuation, 200-5 mcg/actuation		2	QL (39 GM per 90 days)
Dulera inhalation HFA aerosol inhaler 50-5 mcg/actuation		2	QL (39 GM per 90 days); AL (Min 5 Years)
Elixophyllin		1	
Flovent Diskus		2	QL (3 Inhalers per 90 days)
Flovent HFA inhalation HFA aerosol inhaler 110 mcg/actuation, 220 mcg/actuation		2	QL (12 GRAMS per 30 days)
Flovent HFA inhalation HFA aerosol inhaler 44 mcg/actuation		2	QL (10.6 GRAMS per 30 days)
fluticasone propion-salmeterol inhalation aerosol powdr breath activated	AirDuo RespiClick	2	QL (3 Inhalers per 90 days)
fluticasone propion-salmeterol inhalation blister with device	Wixela Inhub	2	QL (3 Inhalers per 90 days); AL (Min 4 Years)
Incruse Ellipta		2	QL (1 UNIT per 30 days); AL (Min 18 Years)
ipratropium bromide inhalation		2	QL (20 ML per 1 day)
ipratropium-albuterol		2	QL (540 ML per 30 days); AL (Min 18 Years)
levalbuterol HCl inhalation solution for nebulization 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/3 mL	Xopenex	2	QL (225 ML per 25 days)
levalbuterol tartrate	Xopenex HFA	2	QL (15 GM per 15 days)
metaproterenol oral syrup		1	
montelukast oral granules in packet	Singulair	2	C-1 (CODE-1 RESTRICTION: For the treatment of asthma or allergic rhinitis in children unable to chew and swallow chewable montelukast.); QL (1 EA per 1 day); AL (Max 5 Years)

Drug Name	Reference	Formulary Tier	Restrictions
montelukast oral tablet	Singulair	1	
montelukast oral tablet,chewable	Singulair	1	
ProAir RespiClick		2	QL (2 UNITS per 1 Month)
Pulmicort Flexhaler		2	QL (3 Inhalers per 90 days)
Qvar RediHaler		2	QL (3 Inhalers per 90 days)
Serevent Diskus		2	C-1(CODE-1 RESTRICTION: Limitedtothe treatmentofCOPD inmembersnoton anotherconcurrent LABA-containing product. For Asthma, use combination LABA-ICS after ICS (inhaled corticosteroid) failure (eg, Dulera, Symbicort).); QL (60 EA per 30 days); AL (Min 4 Years)
Spiriva Respimat		2	QL (3 Inhalers per 90 days); AL (Min 6 Years)
Spiriva with HandiHaler		1	
Stiolto Respimat		2	C-1 (CODE-1 RESTRICTION: Limited to adult use only, for treatment of COPD.); QL (4 GM per 1 FILL); AL (Min 18 Years)
Striverdi Respimat		2	QL (1 UNIT per 30 days); AL (Min 18 Years)
terbutaline		1	
Theo-24		1	
theophylline oral elixir	Elixophyllin	1	
theophylline oral solution		1	

Drug Name	Reference	Formulary Tier	Restrictions
theophylline oral tablet extended release 12 hr 450 mg		1	
Trelegy Ellipta		2	QL (3 EA per 90 days); AL (Min 18 Years)
Tudorza Pressair		2	ST; QL (1 EA per 30 days); AL (Min 18 Years)
Wixela Inhub		2	QL (3 Inhalers per 90 days); AL (Min 4 Years)
zafirlukast	Accolate	1	
Antibiotics			
amikacin injection solution 1,000 mg/4 mL, 500 mg/2 mL		1	
amoxicillin oral capsule		1	
amoxicillin oral suspension for reconstitution		1	
amoxicillin oral tablet		1	
amoxicillin oral tablet,chewable 125 mg, 250 mg		1	
amoxicillin-pot clavulanate oral suspension for reconstitution	Augmentin ES-600	1	
amoxicillin-pot clavulanate oral tablet		1	
amoxicillin-pot clavulanate oral tablet,chewable		1	
ampicillin oral capsule		1	
ampicillin sodium		1	
azithromycin intravenous	Zithromax	2	QL (3 EA per 1 FILL)
azithromycin oral packet	Zithromax	1	
azithromycin oral suspension for reconstitution 100 mg/5 mL	Zithromax	2	QL (15 ML per 5 days); AL (Max 5 Years)
azithromycin oral suspension for reconstitution 200 mg/5 mL	Zithromax	2	QL (60 ML per 5 days); AL (Max 17 Years)
azithromycin oral tablet 250 mg	Zithromax	2	QL (6 EA per 1 FILL)
azithromycin oral tablet 500 mg	Zithromax	2	QL (3 EA per 1 FILL)

Drug Name	Reference	Formulary Tier	Restrictions
azithromycin oral tablet 600 mg		2	QL (8 EA per 1 FILL)
bacitracin-polymyxin B ophthalmic (eye)	Polycin	1	
Bleph-10		1	
Blephamide		1	
Blephamide S.O.P.		1	
cefaclor oral capsule		1	
cefaclor oral suspension for reconstitution 250 mg/5 mL, 375 mg/5 mL		1	
cefdinir oral capsule		2	QL (2 EA per 1 day)
cefdinir oral suspension for reconstitution		1	
cefixime oral capsule	Suprax	2	C-1 (CODE-1 RESTRICTION: For the treatment of uncomplicated gonorrhea (cervical/urethral/rectal)); QL (2 EA per 23 days)
cefixime oral suspension for reconstitution 100 mg/5 mL	Suprax	1	
cefixime oral suspension for reconstitution 200 mg/5 mL	Suprax	2	QL (10 Days per 1 Fill); AL (Min 1 Years and Max 12 Years)
cefpodoxime oral tablet 200 mg		2	QL (2 EA per 1 FILL)
cefuroxime axetil oral tablet		1	
cefuroxime sodium intravenous recon soln 7.5 gram		1	
cephalexin oral capsule 250 mg, 500 mg		1	
cephalexin oral suspension for reconstitution		1	
cephalexin oral tablet 250 mg		1	
chloramphenicol sod succinate		1	
ciprofloxacin HCl ophthalmic (eye)	Ciloxan	1	
ciprofloxacin HCl oral	Cipro	2	QL (2 EA per 1 day)
ciprofloxacin HCl otic (ear)	Cetraxal	2	QL (14 EA per 1 Rx)
ciprofloxacin in 5 % dextrose		1	

Drug Name	Reference	Formulary Tier	Restrictions
ciprofloxacin-dexamethasone	Ciprodex	2	QL (7.5 ML per 1 Fill)
clarithromycin oral suspension for reconstitution		2	C-1 (CODE-1 RESTRICTION: Limited to members for the treatment of H. Pylori, not to exceed 14 days of treatment.); QL (20 ML per 1 day); AL (Max 18 Years)
clarithromycin oral tablet 250 mg		2	C-1 (CODE-1 RESTRICTION: Limited to treatment of H. pylori.); QL (2 EA per 1 day)
clarithromycin oral tablet 500 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of H. pylori. Quantity limit of 2 per day up to 14 days with maximum quantity of #28 tablets per fill. Fill limit: 2 fills per year.); QL (2 TAB per 1 day)
clindamycin HCl	Cleocin HCl	1	
clindamycin palmitate HCl	Clindamycin Pediatric	1	
Clindamycin Pediatric		1	
clindamycin phosphate topical gel		1	
clindamycin phosphate topical lotion	Cleocin T	1	
clindamycin phosphate topical solution	Cleocin T	1	
clindamycin phosphate topical swab	Clindacin ETZ	2	QL (60 Swabs per 1 Month)
clindamycin phosphate vaginal	Cleocin	1	
Clindesse		1	
cycloserine		1	
dapsone oral		1	
dicloxacillin		1	
Doxy-100		1	

Drug Name	Reference	Formulary Tier	Restrictions
doxycycline hyclate oral capsule	Morgidox	2	C-1 (CODE-1 RESTRICTION: Using 07 override is attesting member is not being treated for a chronic tick-borne illness. Using antibiotics for chronic tick-related disease is not recommended by the CDC nor the FDA.)
doxycycline hyclate oral tablet 100 mg		2	C-1 (CODE-1 RESTRICTION: Using 07 override is attesting member is not being treated for a chronic tick-borne illness. Using antibiotics for chronic tick-related disease is not recommended by the CDC nor the FDA.)
doxycycline monohydrate oral capsule 100 mg	Mondoxyne NL	2	C-1 (CODE-1 RESTRICTION: Using 07 override is attesting member is not being treated for a chronic tick-borne illness. Using antibiotics for chronic tick-related disease is not recommended by the CDC nor the FDA.)
doxycycline monohydrate oral capsule 50 mg	Monodox	2	C-1 (CODE-1 RESTRICTION: Using 07 override is attesting member is not being treated for a chronic tick-borne illness. Using antibiotics for chronic tick-related disease is not recommended by the CDC nor the FDA.)

Drug Name	Reference	Formulary Tier	Restrictions
doxycycline monohydrate oral tablet 100 mg	Avidoxy	2	C-1 (CODE-1 RESTRICTION: Using 07 override is attesting member is not being treated for a chronic tick-borne illness. Using antibiotics for chronic tick-related disease is not recommended by the CDC nor the FDA.)
doxycycline monohydrate oral tablet 50 mg		2	C-1 (CODE-1 RESTRICTION: Using 07 override is attesting member is not being treated for a chronic tick-borne illness. Using antibiotics for chronic tick-related disease is not recommended by the CDC nor the FDA.)
doxycycline monohydrate oral tablet 75 mg		2	C-1 (CODE-1 RESTRICTION: Using 07 override is attesting member is not being treated for a chronic tick-borne illness. Using antibiotics for chronic tick-related disease is not recommended by the CDC nor the FDA.)
Ery-Tab oral tablet,delayed release (DR/EC) 333 mg		2	QL (3 EA per 1 day)
Ery-Tab oral tablet,delayed release (DR/EC) 500 mg		2	QL (4 EA per 1 day)
Erythrocin		1	
erythromycin ethylsuccinate oral suspension for reconstitution	EryPed 400	2	QL (100 ML per 14 days)
erythromycin ethylsuccinate oral tablet	E.E.S. 400	2	QL (8 EA per 1 day)
erythromycin ophthalmic (eye)		1	

Drug Name	Reference	Formulary Tier	Restrictions
erythromycin oral capsule,delayed release(DR/EC)		2	QL (4 EA per 1 day)
erythromycin stearate oral tablet 250 mg	Erythrocin (as stearate)	2	QL (4 EA per 1 day)
erythromycin with ethanol topical gel	Erygel	1	
erythromycin with ethanol topical solution		1	
erythromycin-benzoyl peroxide	Benzamycin	1	
ethambutol	Myambutol	1	
Firvanq oral recon soln 25 mg/mL		2	C-1 (CODE-1 RESTRICTION: Limited to treatment for members with Clostridium Difficile Infection (C. Diff) or Staph aureus Enterocolitis.); QL (20 ML per 1 day)
fosfomycin tromethamine	Monurol	2	QL (1 EA per 1 Rx)
Gentak ophthalmic (eye) ointment		1	
gentamicin injection		1	
gentamicin ophthalmic (eye)		1	
isoniazid		1	
levofloxacin in D5W		1	
levofloxacin intravenous		1	
levofloxacin oral tablet 250 mg, 500 mg		1	
levofloxacin oral tablet 750 mg		2	QL (10 EA per 1 FILL)
linezolid oral tablet	Zyvox	2	C-1 (CODE-1 RESTRICTION: Limited to hospital discharge or ED prescriptions, or outpatient treatment of VRE or MRSA Cellulitis.); QL (2 EA per 1 day)
methenamine hippurate	Hiprex	1	
metronidazole oral tablet		1	
metronidazole vaginal	Metrogel Vaginal	1	
minocycline oral capsule 100 mg, 50 mg		1	
Monurol		2	QL (1 EA per 1 Rx)

Drug Name	Reference	Formulary Tier	Restrictions
Moxeza		1	
moxifloxacin ophthalmic (eye) drops	Vigamox	1	
moxifloxacin oral		2	QL (14 EA per 28 days)
mupirocin	Centany	2	QL (66 GM per 1 Fill)
neomycin		2	QL (24 EA per 1 day)
neomycin-polymyxin B-dexameth	Maxitrol	1	
neomycin-polymyxin-gramicidin		1	
neomycin-polymyxin-HC otic (ear)		1	
nitrofurantoin macrocrystal	Macrodantin	1	
nitrofurantoin monohyd/m-cryst	Macrobid	1	
ofloxacin ophthalmic (eye)	Ocuflox	2	QL (5 ML per 30 days)
ofloxacin oral tablet 400 mg		2	QL (28 EA per 30 days)
ofloxacin otic (ear)		1	
penicillin G potassium	Pfizerpen-G	1	
penicillin V potassium		1	
Pfizerpen-G		1	
Polycin		1	
polymyxin B sulf-trimethoprim	Polytrim	1	
Priftin		2	C-1 (CODE-1 RESTRICTION: Limited for Latent TB in conjunction with INH. Limited to 6 tablets (900mg) per week, 4 week fills per Rx, 3 Rxs per lifetime); QL (6 TABS per 7 days)
pyrazinamide		1	
rifabutin	Mycobutin	1	
rifampin oral		1	
silver sulfadiazine	SSD	1	
SSD		1	
sulfacetamide sodium ophthalmic (eye)		1	
sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)	Avar	2	QL (340.2 ML per 1 Fill); AL (Min 12 Years)

Drug Name	Reference	Formulary Tier	Restrictions
sulfacetamide-prednisolone		1	
sulfamethoxazole-trimethoprim	Bactrim	1	
tetracycline oral capsule 500 mg		2	C-1 (CODE-1 RESTRICTION: Limited to treatment of H. pylori); QL (4 EA per 1 day)
TobraDex ophthalmic (eye) ointment		1	
tobramycin in 0.225 % NaCl	Tobi	3	PA
tobramycin ophthalmic (eye)	Tobrex	1	
tobramycin sulfate		1	
tobramycin with nebulizer	Kitabis Pak	3	PA
tobramycin-dexamethasone	TobraDex	1	
Tobrex ophthalmic (eye) ointment		1	
trimethoprim		1	
Ustell		1	
vancomycin intravenous recon soln 500 mg, 750 mg		1	
vancomycin oral capsule 125 mg	Vancocin	2	QL (40 EA per 1 Fill)
vancomycin oral recon soln	Firvanq	2	C-1 (CODE-1 RESTRICTION: Limited to treatment for members with Clostridium Difficile Infection (C. Diff) or Staph aureus Enterocolitis.); QL (10 ML per 1 day)
Zosyn in dextrose (iso-osm)		1	
Anticoagulants			
Eliquis DVT-PE Treat 30D Start		2	QL (74 EA per 30 days)
Eliquis oral tablet 2.5 mg		2	QL (2 EA per 1 day)
Eliquis oral tablet 5 mg		2	QL (74 EA per 30 days)

Drug Name	Reference	Formulary Tier	Restrictions
enoxaparin subcutaneous solution	Lovenox	2	C-1 (CODE-1 RESTRICTION: Limited to members requiring a dose smaller than available using prefilled syringes (weight less than 30 kg).)
enoxaparin subcutaneous syringe	Lovenox	1	
fondaparinux	Arixtra	2	QL (10 Day Supply per 1 Rx)
Heparin LockFlush(Porcine)(PF)		1	
heparin, porcine (PF) intravenous syringe 100 unit/mL	Heparin LockFlush(Porcine)(PF)	1	
Jantoven		1	
Pradaxa		2	QL (2 EA per 1 day)
Savaysa		2	C-1 (CODE-1 RESTRICTION: Limited to use in members with A.Fib/Flutter (stroke/emboli risk reduction), or treatment of DVT/PE.); QL (1 EA per 1 day)
warfarin	Jantoven	1	
Xarelto DVT-PE Treat 30d Start		2	QL (2 EA per 1 day)
Xarelto oral tablet 10 mg, 20 mg		2	QL (1 EA per 1 day)
Xarelto oral tablet 15 mg, 2.5 mg		2	QL (2 EA per 1 day)
Antidotes			
Movantik		2	C-1 (CODE-1 RESTRICTION: Limited to treatment of opioid induced constipation following trial and failure to a stimulant laxative and osmotic laxative.); QL (1 EA per 1 day); AL (Min 18 Years)

Drug Name	Reference	Formulary Tier	Restrictions
Symproic		2	C-1 (CODE-1 RESTRICTION: Limited to treatment of opioid induced constipation following trial and failure to a stimulant laxative and osmotic laxative.); QL (1 EA per 1 day); AL (Min 18 Years)
Antifungals: Also see the OTC section for additional covered products			
ciclopirox topical cream	Ciclodan	2	QL (90 GM per 1 Fill)
ciclopirox topical solution	Ciclodan	2	QL (6.6 ML per 30 days)
clotrimazole mucous membrane		1	
clotrimazole-betamethasone topical cream		2	QL (45 GM per 1 Rx)
econazole		1	
fluconazole oral suspension for reconstitution	Diflucan	2	QL (15 ML per 1 day); AL (Max 12 Years)
fluconazole oral tablet 100 mg, 50 mg	Diflucan	2	QL (1 EA per 1 day)
fluconazole oral tablet 150 mg	Diflucan	2	QL (2 EA per 1 day)
fluconazole oral tablet 200 mg	Diflucan	2	QL (4 EA per 1 day)
griseofulvin microsize		1	
griseofulvin ultramicrosize		1	
itraconazole oral capsule	Sporanox	2	QL (4 EA per 1 day)
ketoconazole oral		1	
ketoconazole topical cream		1	
ketoconazole topical shampoo		1	
Miconazole-3 vaginal suppository		1	
Nyamyc		1	
nystatin		1	
nystatin-triamcinolone		1	
Nystop		1	
terbinafine HCl oral		1	
terconazole		1	

Drug Name	Reference	Formulary Tier	Restrictions
voriconazole oral suspension for reconstitution	Vfend	2	QL (17.5 ML per 1 day); AL (Min 2 Years and Max 12 Years)
voriconazole oral tablet 200 mg	Vfend	2	QL (2 EA per 1 day); AL (Min 2 Years)
voriconazole oral tablet 50 mg	Vfend	2	QL (6 EA per 1 day); AL (Min 2 Years)
Antihistamine And Decongestant Combination: Also see the OTC section for additional covered antihistamines			
Promethazine VC		1	
Antihistamines: Also see the OTC section for additional covered antihistamines			
azelastine ophthalmic (eye)		2	QL (6 ML per 25 days)
clemastine oral tablet 2.68 mg		1	
cyproheptadine		1	
desloratadine oral tablet	Clarinex	1	
diphenhydramine HCl injection solution 50 mg/mL		1	
epinastine		2	QL (5 ML per 25 days)
hydroxyzine HCl oral		1	
hydroxyzine pamoate		1	
levocetirizine oral solution	Xyzal	1	
promethazine oral		1	
Antihyperglycemics			
acarbose	Precose	1	
Admelog SoloStar U-100 Insulin		2	QL (45 ML per 1 Fill)
Admelog U-100 Insulin lispro		2	QL (40 ML per 1 Fill)
alogliptin oral tablet 12.5 mg, 6.25 mg	Nesina	2	AL (Min 18 Years)
alogliptin oral tablet 25 mg	Nesina	2	QL (1 EA per 1 day); AL (Min 18 Years)
alogliptin-metformin	Kazano	2	QL (2 EA per 1 day); AL (Min 18 Years)
alogliptin-pioglitazone	Oseni	2	ST; QL (1 EA per 1 day); AL (Min 18 Years)
glimepiride	Amaryl	1	
glipizide	Glucotrol XL	1	
glyburide		1	

Drug Name	Reference	Formulary Tier	Restrictions
glyburide-metformin		1	
Humalog Junior KwikPen U-100		2	C-1 (CODE-1 RESTRICTION: Limited to members needing half-unit dosing increments.); QL (45 ML per 30 days)
Humalog KwikPen Insulin subcutaneous insulin pen 200 unit/mL (3 mL)		2	QL (30 ML per 30 days)
Humalog Mix 50-50 Insuln U-100		2	QL (45 ML per 30 days)
Humalog Mix 50-50 KwikPen		2	QL (45 ML per 30 days)
Humalog Mix 75-25 KwikPen		2	
Humalog Mix 75-25(U-100)Insuln		2	QL (40 ML per 30 days)
Humalog U-100 Insulin subcutaneous cartridge		2	QL (45 ML per 30 days)
Humulin R U-500 (Conc) Insulin		2	QL (20 ML per 30 days)
Humulin R U-500 (Conc) Kwikpen		2	QL (18 ML per 30 days)
insulin aspart U-100 subcutaneous cartridge	Novolog PenFill U-100 Insulin	2	QL (40 ML per 1 Fill)
insulin aspart U-100 subcutaneous insulin pen	Novolog Flexpen U-100 Insulin	2	QL (45 ML per 1 Fill)
insulin aspart U-100 subcutaneous solution	Novolog U-100 Insulin aspart	2	QL (40 ML per 1 Fill)
insulin lispro protamin-lispro	Humalog Mix 75-25 KwikPen	2	QL (45 ML per 1 day)
insulin lispro subcutaneous insulin pen	Admelog SoloStar U-100 Insulin	2	QL (45 ML per 1 Fill)
insulin lispro subcutaneous insulin pen, half-unit	Humalog Junior KwikPen U-100	2	C-1 (CODE-1 RESTRICTION: Limited to members needing half-unit dosing increments.); QL (45 ML per 30 days)
insulin lispro subcutaneous solution	Admelog U-100 Insulin lispro	2	QL (40 ML per 1 Fill)

Drug Name	Reference	Formulary Tier	Restrictions
metformin oral tablet		1	
metformin oral tablet extended release 24 hr		1	
miglitol		1	
nateglinide		1	
Novolog Flexpen U-100 Insulin		2	QL (45 ML per 1 Fill)
Novolog Mix 70-30 U-100 Insuln		2	QL (40 ML per 30 days)
Novolog Mix 70-30FlexPen U-100		2	QL (45 ML per 30 days)
pioglitazone	Actos	1	AL (Min 18 Years)
repaglinide		1	
Segluromet		2	QL (2 EA per 1 day); AL (Min 18 Years)
Semglee Pen U-100 Insulin		2	QL (45 ML per 1 Fill)
Semglee U-100 Insulin		2	QL (40 ML per 1 Fill)
Steglatro		2	QL (1 EA per 1 day); AL (Min 18 Years)
SymlinPen 120		2	QL (2 pens per 1 fill)
SymlinPen 60		2	QL (2 Pens per 1 fill)
Trulicity subcutaneous pen injector 0.75 mg/0.5 mL, 1.5 mg/0.5 mL		2	QL (2 ML per 28 days); AL (Min 18 Years)
Trulicity subcutaneous pen injector 3 mg/0.5 mL, 4.5 mg/0.5 mL		2	QL (2 ML per 28 Dayss); AL (Min 18 Years)
Victoza 2-Pak		2	QL (6 ML per 30 days); AL (Min 10 Years)
Victoza 3-Pak		2	QL (9 ML per 30 days); AL (Min 10 Years)
Antiinfectives/Miscellaneous			
atovaquone	Mepron	2	C-1 (CODE-1 RESTRICTION: Limited to use in PCP prophylaxis in members with HIV/AIDS)

Drug Name	Reference	Formulary Tier	Restrictions
atovaquone-proguanil	Malarone Pediatric	2	C-1 (CODE-1 RESTRICTION: Limited to malaria prophylaxis when traveling to regions of infection risk per CDC or other travel advisories.); QL (1 EA per 1 day)
chloroquine phosphate		2	QL (1 EA per 1 day)
hydroxychloroquine oral tablet 200 mg	Plaquenil	1	
ivermectin oral	Stromectol	2	QL (20 TABS per 1 RX)
mefloquine		2	C-1 (CODE-1 RESTRICTION: Limited to malaria prophylaxis when traveling to regions of infection risk per CDC or other travel advisories); QL (1 EA per 1 Week)
paromomycin	Humatin	2	C-1 (CODE-1 RESTRICTION: Limited to treatment of cryptosporidium in HIV infected patients, treatment of intestinal amebiasis, or management of hepatic coma.); QL (21 Days per 1 Fill)
praziquantel	Biltricide	2	QL (3 EA per 1 prescription)
primaquine		1	
tinidazole		2	QL (4 EA per 1 day)
Antiinflam.Tumor Necrosis Factor Inhibiting Agents			
Enbrel Mini		3	PA
Enbrel subcutaneous recon soln		3	PA
Enbrel subcutaneous syringe		3	PA
Enbrel SureClick		3	PA
Humira Pen		3	PA
Humira Pen Crohns-UC-HS Start		3	PA

Drug Name	Reference	Formulary Tier	Restrictions
Humira Pen Psor-Uveits-Adol HS		3	PA
Humira subcutaneous syringe kit 40 mg/0.8 mL		3	PA
Humira(CF)		3	PA
Humira(CF) Pedi Crohns Starter		3	PA
Humira(CF) Pen		3	PA
Humira(CF) Pen Crohns-UC-HS		3	PA
Humira(CF) Pen Psor-Uv-Adol HS		3	PA
Antineoplastics			
abiraterone oral tablet 250 mg	Zytiga	2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Adrucil intravenous solution 2.5 gram/50 mL		1	
Afinitor Disperz		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of FDA approved oncology indications or per NCCN treatment guidelines. Limited to a 14 day supply for the first 2 months of treatment. Submit TAR after first 2 months for 28 days if dose is stable.); QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Afinitor oral tablet 10 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of FDA approved oncology indications or per NCCN treatment guidelines. Limited to a 14 day supply for the first 2 months of treatment. Submit TAR after first 2 months for 28 days if dose is stable.); QL (1 EA per 1 day)
Alecensa		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (8 EA per 1 day)
anastrozole	Arimidex	1	
Avastin		2	
azacitidine	Vidaza	1	
Balversa oral tablet 3 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (3 EA per 1 day)
Balversa oral tablet 4 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (2 EA per 1 day)
Balversa oral tablet 5 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (1 EA per 1 day)
bicalutamide	Casodex	1	
Blincyto intravenous kit		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Blincyto intravenous recon soln		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (1 EA per 1 day)
Bosulif oral tablet 100 mg		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (3 EA per 1 day)
Bosulif oral tablet 400 mg, 500 mg		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (1 EA per 1 day)
Braftovi		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (6 EA per 1 day)
Brukinsa		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Cabometyx		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (1 EA per 1 day)
capecitabine	Xeloda	1	
Copiktra		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (2 EA per 1 day)
cyclophosphamide oral capsule		1	
Emcyt		1	
Erivedge		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (1 EA per 1 day)
Erleada		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer); QL (4 EA per 1 day)
erlotinib	Tarceva	2	QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Etopophos		1	
everolimus (antineoplastic)	Afinitor	2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of FDA approved oncology indications or per NCCN treatment guidelines. Limited to a 14 day supply for the first 2 months of treatment. Submit TAR after first 2 months for 28 days if dose is stable.); QL (1 EA per 1 Day)
exemestane	Aromasin	1	
Firmagon kit w diluent syringe		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer per FDA approved indications)
Firmagon subcutaneous recon soln 120 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer per FDA approved indications)
fludarabine intravenous recon soln		1	
fluorouracil intravenous		1	
fluorouracil topical cream 5 %	Efudex	1	
fluorouracil topical solution		1	
flutamide		1	
gemcitabine intravenous recon soln 200 mg		1	
Gilotrif		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Gleostine		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (2 EA per 1 FILL)
Halaven		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer per FDA approved indications)
hydroxyurea	Hydrea	1	
Ibrance oral capsule 100 mg, 125 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of advanced breast cancer which is ER positive, HER2 negative in women who are concurrently taking either letrozole or fulvestrant.); QL (21 EA per 28 days); AL (Min 18 Years)
Ibrance oral capsule 75 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of advanced breast cancer which is ER (+), HER2 (-) in women who are concurrently taking either letrozole or fulvestrant.); QL (21 EA per 28 days); AL (Min 18 Years)

Drug Name	Reference	Formulary Tier	Restrictions
Ibrance oral tablet		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of advanced breast cancer which is ER positive, HER2 negative in women who are concurrently taking either letrozole or fulvestrant.); QL (21 EA per 28 days); AL (Min 18 Years)
Iclusig		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (1 EA per 1 day)
imatinib oral tablet 100 mg	Gleevec	2	QL (2 EA per 1 day)
imatinib oral tablet 400 mg	Gleevec	2	QL (1 EA per 1 day)
Imbruvica oral capsule 140 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Imbruvica oral capsule 70 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer); QL (1 EA per 1 day)
Imbruvica oral tablet		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer); QL (1 EA per 1 day)
Inlyta		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (4 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Iressa		2	C-1 (CODE-1 RESTRICTION: Limited to members with metastatic non-small cell lung cancer and EGFR exon 19 deletion or exon 21 mutation.); QL (1 EA per 1 day)
Ixempra		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer per FDA approved indications)
Kisqali		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (3 EA per 1 day)
lapatinib	Tykerb	2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (6 EA per 1 day)
Lenvima oral capsule 10 mg/day (10 mg x 1), 4 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (1 EA per 1 day)
Lenvima oral capsule 12 mg/day (4 mg x 3), 18 mg/day (10 mg x 1-4 mg x2), 24 mg/day(10 mg x 2-4 mg x 1)		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (3 EA per 1 day)
Lenvima oral capsule 14 mg/day(10 mg x 1-4 mg x 1), 20 mg/day (10 mg x 2), 8 mg/day (4 mg x 2)		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (2 EA per 1 day)
letrozole	Femara	1	
Leukeran		1	

Drug Name	Reference	Formulary Tier	Restrictions
Lorbrena oral tablet 100 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (2 EA per 1 day)
Lorbrena oral tablet 25 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (3 EA per 1 day)
Lynparza		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Lysodren		2	AL (Min 19 Years)
Matulane		2	AL (Min 19 Years)
megestrol oral tablet		1	
Mekinist oral tablet 0.5 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Mekinist oral tablet 2 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (1 EA per 1 day)
Mektovi		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer); QL (6 EA per 1 day)
melphalan	Alkeran	1	
mercaptopurine		1	
methotrexate sodium		1	
methotrexate sodium (PF)		1	
Myleran		1	
Nexavar		2	QL (4 EA per 1 day)
Nilandron		1	

Drug Name	Reference	Formulary Tier	Restrictions
Ninlaro		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (3 CAPS per 28 days)
Orgovyx		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (32 EA per 30 days)
Piqray oral tablet 200 mg/day (200 mg x 1)		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (1 EA per 1 day)
Piqray oral tablet 250 mg/day (200 mg x1-50 mg x1), 300 mg/day (150 mg x 2)		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (2 EA per 1 day)
Retevmo oral capsule 40 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (6 EA per 1 day)
Retevmo oral capsule 80 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Rituxan		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer. All other indications require a TAR.)
Rydapt		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (8 EA per 1 day)
Sprycel oral tablet 100 mg, 140 mg, 50 mg, 70 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Sprycel oral tablet 20 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (3 EA per 1 day)
Sprycel oral tablet 80 mg		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (2 EA per 1 day)
Stivarga		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Sutent		2	QL (1 EA per 1 day)
Tabloid		1	
Tafinlar		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Tagrisso		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (2 EA per 1 day)
tamoxifen		1	
Targretin oral		1	
Tasigna oral capsule 150 mg, 200 mg		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (2 EA per 1 day)
Tasigna oral capsule 50 mg		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (4 EA per 1 day)
temozolomide	Temodar	1	
Tibsovo		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (2 EA per 1 day)
Tice BCG		1	

Drug Name	Reference	Formulary Tier	Restrictions
topotecan intravenous solution 4 mg/4 mL (1 mg/mL)		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.)
toremifene	Fareston	1	
tretinoin (antineoplastic)		2	AL (Min 19 Years)
Trexall oral tablet 10 mg, 5 mg, 7.5 mg		1	
Trexall oral tablet 15 mg		1	
valrubicin	Valstar	1	
Venclexta		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (6 EA per 1 day)
Venclexta Starting Pack		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (42 EA per 28 days)
Verzenio		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (2 EA per 1 day)
vinblastine		1	
Vitrakvi oral capsule 100 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (2 EA per 1 day)
Vitrakvi oral capsule 25 mg		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (6 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Vitrakvi oral solution		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (10 ML per 1 day)
Votrient		2	QL (4 EA per 1 day)
Xatmep oral solution 2.5 mg/mL		2	C-1 (Code 1: Limited to treatment of cancer without a TAR (TAR required for other indications).); QL (60 ML per 28 days)
Xatmep oral solution 2.5 mg/mL		2	C-1 (Code 1: Limited to treatment of cancer without a TAR (TAR required for other indications).); QL (60 ML per 28 days); AL (Max 18 Years)
Xospata		2	C-1 (Code-1 Restriction: Limited to the treatment of cancer.); QL (3 EA per 1 day)
Xtandi oral capsule		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (6 EA per 1 day)
Xtandi oral tablet 40 mg		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (6 EA per 1 day)
Xtandi oral tablet 80 mg		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (3 EA per 1 day)
Zaltrap		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer per FDA approved indications)

Drug Name	Reference	Formulary Tier	Restrictions
Zejula		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer); QL (3 EA per 1 day)
Zelboraf		2	C-1 (Code 1: Limited to the treatment of cancer.); QL (4 EA per 1 day)
Zydelig		2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of cancer.); QL (2 EA per 1 day)
Antiparasitics: Also see OTC section for additional pinworm, lice, & scabies treatments			
malathion	Ovide	2	QL (118 ML per 90 days)
permethrin	Elimite	1	
spinosad	Natroba	2	QL (240 ML per 90 days)
Antiparkinson Drugs			
bromocriptine	Parlodel	1	
carbidopa-levodopa oral tablet		1	
carbidopa-levodopa oral tablet extended release		1	
carbidopa-levodopa oral tablet,disintegrating		3	PA
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg	Stalevo 50	2	ST; QL (8 EA per 1 day)
carbidopa-levodopa-entacapone oral tablet 18.75-75-200 mg	Stalevo 75	2	ST; QL (8 EA per 1 day)
carbidopa-levodopa-entacapone oral tablet 25-100-200 mg	Stalevo 100	2	ST; QL (8 EA per 1 day)
carbidopa-levodopa-entacapone oral tablet 31.25-125-200 mg	Stalevo 125	2	ST; QL (8 EA per 1 day)
carbidopa-levodopa-entacapone oral tablet 37.5-150-200 mg	Stalevo 150	2	ST; QL (8 EA per 1 day)
carbidopa-levodopa-entacapone oral tablet 50-200-200 mg	Stalevo 200	2	ST; QL (6 EA per 1 day)
entacapone	Comtan	2	QL (8 EA per 1 day); AL (Min 18 Years)
pramipexole oral tablet	Mirapex	1	

Drug Name	Reference	Formulary Tier	Restrictions
rasagiline	Azilect	3	PA
ropinirole oral tablet		1	
selegiline HCl oral tablet		2	C-1 (CODE-1 RESTRICTION: Treatment of Parkinsons Disease with concurrent use of levodopa/carbidopa, and prescribed or recommended by a neurologist.); QL (2 EA per 1 day)
Antiplatelet Drugs			
anagrelide	Agrylin	1	
Brilinta oral tablet 60 mg		2	C-1 (CODE-1 RESTRICTION: Limited to use in Acute Coronary Syndrome or history of MI, & initially prescribed or recommended by a cardiologist (continuation by PCP is OK). Check profile, member should also be taking aspirin.); QL (2 EA per 1 day)
Brilinta oral tablet 90 mg		2	C-1 (CODE-1 RESTRICTION: Limited to hospital discharge order OR when treatment is initiated or recommended by a cardiologist. Continuing care allowed by primary care)
cilostazol		1	
clopidogrel oral tablet 75 mg	Plavix	1	
dipyridamole oral		1	
prasugrel	Effient	2	QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Antivirals			
acyclovir oral capsule		1	
acyclovir oral suspension		2	QL (400 ML per 5 days); AL (Max 17 Years)
acyclovir oral tablet		1	
acyclovir topical ointment	Zovirax	2	QL (15 GM Max Qty Per Fill Retail)
didanosine oral capsule,delayed release(DR/EC) 250 mg, 400 mg		1	
entecavir	Baraclude	2	C-1 (CODE-1 RESTRICTION: Restricted to treatment of chronic Hepatitis B virus infection.); QL (1 EA per 1 day)
famciclovir		2	QL (3 EA per 1 day)
oseltamivir oral capsule	Tamiflu	2	QL (10 EA per 1 Fill)
oseltamivir oral suspension for reconstitution	Tamiflu	2	QL (180 ML per 1 Fill); AL (Max 12 Years)
Relenza Diskhaler		2	QL (1 FILL per 1 Year)
Retrovir intravenous		1	
ribavirin 200 mg oral capsule		3	PA; AL (Min 18 Years)
ribavirin oral tablet 200 mg		3	PA; AL (Min 18 Years)
sofosbuvir-velpatasvir	Epclusa	3	PA; QL (1 FILL per 14 days); AL (Min 18 Years)
trifluridine		1	
valacyclovir	Valtrex	1	
valganciclovir oral recon soln	Valcyte	2	QL (264 ML per 28 days); AL (Max 12 Years)
valganciclovir oral tablet	Valcyte	2	QL (4 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Xofluza oral tablet 20 mg, 40 mg		2	C-1(CODE-1 RESTRICTION: Limitedtotreatment of acute uncomplicated influ-enza in patient = 12 years of age who have been symptomatic for no more than 48 hours.); QL (2 EA per 1 FILL); AL (Min 12 Years)
Zepatier		3	PA; QL (1 fill per 14 days); AL (Min 18 Years)
zidovudine	Retrovir	1	
Autonomic Drugs			
atracurium		1	
bethanechol chloride		1	
cevimeline	Evoxac	2	QL (3 EA per 1 day)
cisatracurium intravenous solution	Nimbex	1	
dextroamphetamine-amphetamine oral capsule,extended release 24hr	Adderall XR	2	QL (1 EA per 1 day)
dextroamphetamine-amphetamine oral tablet	Adderall	2	QL (60 EA per 1 Month); AL (Min 4 Years and Max 17 Years)
donepezil oral tablet 10 mg, 5 mg	Aricept	2	AL (Min 18 Years)
donepezil oral tablet 23 mg	Aricept	2	QL (1 EA per 1 day); AL (Min 18 Years)
donepezil oral tablet,disintegrating		2	AL (Min 18 Years)
epinephrine injection auto-injector 0.15 mg/0.15 mL	Auvi-Q	2	QL (2 EA per 30 days)
epinephrine injection auto-injector 0.15 mg/0.3 mL	EpiPen Jr	2	QL (2 INJECTORS per 30 days)
epinephrine injection auto-injector 0.3 mg/0.3 mL	Auvi-Q	2	QL (2 INJECTIONS per 30 days)
epinephrine injection solution	Adrenalin	1	
epinephrine injection syringe 0.1 mg/mL		1	
midodrine		2	QL (3 EA per 1 day)
norepinephrine bitart in water		1	
norepinephrine bitartrate	Levophed (bitartrate)	1	

Drug Name	Reference	Formulary Tier	Restrictions
norepinephrine bitartrate-D5W intravenous solution 16 mg/250 mL (64 mcg/mL), 4 mg/250 mL (16 mcg/mL), 8 mg/250 mL (32 mcg/mL), 8 mg/500 mL (16 mcg/mL)		1	
norepinephrine bitartrate-NaCl intravenous solution 16 mg/250 mL (64 mcg/mL), 32 mg/250 mL (128 mcg/mL), 4 mg/250 mL (16 mcg/mL), 8 mg/250 mL (32 mcg/mL), 8 mg/500 mL (16 mcg/mL)		1	
pilocarpine HCl oral	Salagen (pilocarpine)	1	
pyridostigmine bromide oral tablet 60 mg	Mestinon	2	C-1 (CODE-1 RESTRICTION: Limited to members with Myasthenia Gravis or congenital forms of myasthenic syndrome.); QL (25 EA per 1 day)
pyridostigmine bromide oral tablet extended release	Mestinon Timespan	2	C-1 (CODE-1 RESTRICTION: Limited to the treatment of Myasthenia Gravis or congenital forms of myasthenic syndrome.); QL (6 EA per 1 day)
Biologicals: ACIP recommended pediatric vaccines with age limit of 19 are available to children through VFC*			
ActHIB (PF)		2	AL (Min 19 Years)
Adacel(Tdap Adolesn/Adult)(PF)		2	AL (Min 19 Years)
BCG vaccine, live (PF)		2	AL (Min 19 Years)
Boostrix Tdap		2	AL (Min 19 Years)
Daptacel (DTaP Pediatric) (PF)		1	
Engerix-B (PF)		2	AL (Min 19 Years)
Engerix-B Pediatric (PF)		2	AL (Min 19 Years)

***VFC**: Vaccines for Children. For more information on the VFC program for Medi-Cal beneficiaries, see the Medi-Cal Provider Manual, General Medicine, Part 2: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/vaccine.pdf

Drug Name	Reference	Formulary Tier	Restrictions
Gardasil 9 (PF)		2	C-1 (CODE-1 RESTRICTION: Limited to either (1) Member is less than age <46, OR (2) Member has HIV, any age.); AL (Min 19 Years)
Havrix (PF) intramuscular syringe		2	AL (Min 19 Years)
Heplisav-B (PF) intramuscular syringe		2	AL (Min 18 Years)
HyperHEP B		1	
HyperHEP B Neonatal		1	
HyperRAB S/D (PF)		1	
Imogam Rabies-HT (PF)		1	
Infanrix (DTaP) (PF) intramuscular syringe		2	AL (Min 19 Years)
IPOL		2	AL (Min 19 Years)
Menactra (PF) intramuscular solution		2	C-1 (CODE-1 RESTRICTION: Member is at increased risk of infection per CDC recommendations.); AL (Min 19 Years)
Menveo A-C-Y-W-135-Dip (PF)		2	AL (Min 19 Years)
Menveo MenA Component (PF)		2	AL (Min 19 Years)
Menveo MenCYW-135 Compnt (PF)		2	AL (Min 19 Years)
MICRhoGAM Ultra-Filtered PLUS		2	AL (Min 19 Years)
M-M-R II (PF)		2	AL (Min 19 Years)
Nabi-HB		1	
Pedvax HIB (PF)		2	AL (Min 19 Years)
Pentacel ActHIB Component (PF)		2	AL (Min 19 Years)

Drug Name	Reference	Formulary Tier	Restrictions
Pneumovax-23		2	C-1 (CODE-1 RESTRICTION: Limited to all adults age 60 years and older OR adults in high-risk group members with underlying medical condition or other risk factors as described according to the recommendations of CDCs Advisory Committee on Immunization Practices (ACIP)); AL (Min 65 Years)
Prevnar 13 (PF)		2	C-1 (CODE-1 RESTRICTION: Limited to all adults age 65 years and older OR adults in high-risk group members with underlying medical condition or other risk factors as described according to the recommendations of CDCs Advisory Committee on Immunization Practices (ACIP)); AL (Min 19 Years)
ProQuad (PF)		2	AL (Min 19 Years)
RabAvert (PF)		1	
Recombivax HB (PF)		2	AL (Min 19 Years)
RhoGAM Ultra-Filtered PLUS		2	AL (Min 19 Years)
Shingrix (PF)		2	QL (2 DOSES per 1 LIFETIME); AL (Min 50 Years)
Shingrix gE Antigen Component		2	QL (2 DOSES per 1 LIFETIME); AL (Min 50 Years)

Drug Name	Reference	Formulary Tier	Restrictions
Tenivac (PF)		2	AL (Min 19 Years)
tetanus,diphtheria tox ped(PF)		2	AL (Min 19 Years)
Typhim VI		2	C-1 (CODE-1 RESTRICTION: Member is at increased risk of infection per CDC recommendations)
Vaqta (PF) intramuscular suspension		2	AL (Min 19 Years)
Zostavax (PF)		2	C-1 (CODE-1 RESTRICTION: Limited to member ages 60 and older with contraindication to Shingrix.); AL (Min 60 Years)
Blood			
Droxia		1	
pentoxifylline		1	
tranexamic acid oral	Lysteda	2	QL (6 EA per 1 day)
Cardiac Drugs			
amiodarone in dextrose 5 % intravenous solution 150 mg/100 mL (1.5 mg/mL), 450 mg/250 mL (1.8 mg/mL), 900 mg/500 mL (1.8 mg/mL)		1	
amiodarone oral tablet 200 mg, 400 mg	Pacerone	1	
amlodipine	Norvasc	1	
Cartia XT		1	
Digox		1	
digoxin		1	
diltiazem HCl in 0.9% NaCl intravenous solution 125 mg/125 mL (1 mg/mL)		1	
diltiazem HCl intravenous		1	
diltiazem HCl oral capsule,ext.rel 24h degradable 180 mg, 240 mg	DILT-XR	1	
diltiazem HCl oral capsule,extended release 24 hr	Taztia XT	1	
diltiazem HCl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	Cartia XT	1	
diltiazem HCl oral tablet	Cardizem	1	

Drug Name	Reference	Formulary Tier	Restrictions
diltiazem in dextrose 5 % intravenous solution 125 mg/125 mL (1 mg/mL)		1	
DILT-XR		1	
felodipine		1	
flecainide		1	
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg		1	
isosorbide dinitrate oral tablet 5 mg	Isordil Titradose	1	
isosorbide mononitrate		1	
Katerzia		2	C-1 (CODE-1 RESTRICTION: For pediatric use when child is unable to swallow tablets or when tube administration is required.); AL (Max 12 Years)
Lanoxin injection solution 250 mcg/mL (0.25 mg/mL)		1	
Lanoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)		1	
Lanoxin Pediatric		1	
lidocaine (PF) intravenous	Xylocaine (Cardiac) (PF)	1	
mexiletine		1	
milrinone		2	C-1 (CODE-1 RESTRICTION: Limited to treatment of heart failure.)
Minitran		1	
Multaq		2	ST; QL (2 EA per 1 day)
Nexterone		1	
nifedipine	Procardia XL	1	
nitroglycerin in 5 % dextrose intravenous solution 50 mg/250 mL (200 mcg/mL)		1	
nitroglycerin oral	Nitro-Time	1	
nitroglycerin sublingual	Nitrostat	1	
nitroglycerin transdermal patch 24 hour	Minitran	1	
nitroglycerin translingual	Nitrolingual	1	

Drug Name	Reference	Formulary Tier	Restrictions
Pacerone oral tablet 200 mg, 400 mg		1	
procainamide injection		1	
propafenone oral tablet		1	
quinidine gluconate oral		1	
quinidine sulfate oral tablet		1	
ranolazine oral tablet extended release 12 hr 1,000 mg, 500 mg	Ranexa	2	QL (2 EA per 1 day); AL (Min 18 Years)
Taztia XT		1	
verapamil intravenous		1	
verapamil oral capsule,ext rel. pellets 24 hr	Verelan	1	
verapamil oral tablet		1	
verapamil oral tablet extended release	Calan SR	1	
Cardiovascular			
acebutolol		1	
amlodipine-benazepril		1	
amlodipine-valsartan	Exforge	1	
atenolol	Tenormin	1	
atenolol-chlorthalidone	Tenoretic 100	1	
atorvastatin	Lipitor	1	
benazepril		1	
benazepril-hydrochlorothiazide	Lotensin HCT	1	
Biorphen		1	
bisoprolol fumarate		1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg	Ziac	2	QL (1 EA per 1 day)
bisoprolol-hydrochlorothiazide oral tablet 2.5-6.25 mg, 5-6.25 mg	Ziac	1	
candesartan	Atacand	2	QL (1 EA per 1 day)
captopril		1	
carvedilol	Coreg	1	
cholestyramine (with sugar) oral powder	Questran	1	
Cholestyramine Light oral powder		1	
clonidine HCl oral tablet		1	
colestipol oral granules	Colestid	1	
colestipol oral tablet	Colestid	1	
doxazosin	Cardura	1	

Drug Name	Reference	Formulary Tier	Restrictions
Emerphed		1	
enalapril maleate oral tablet	Vasotec	1	
enalaprilat intravenous solution		1	
enalapril-hydrochlorothiazide	Vaseretic	1	
Entresto		2	QL (2 EA per 1 day); AL (Min 18 Years)
Epaned		2	C-1 (CODE-1 RESTRICTION: For pediatric use when child is unable to swallow tablets or when tube administration is required.); AL (Max 12 Years)
ephedrine sulfate intravenous	Akovaz	1	
ephedrine sulfate-0.9%NaCl(PF) intravenous syringe 10 mg/mL (1 mL), 100 mg/10 mL (10 mg/mL), 15 mg/3 mL (5 mg/mL), 25 mg/5 mL (5 mg/mL), 50 mg/10 mL (5 mg/mL), 50 mg/5 mL (10 mg/mL)		1	
ergoloid		1	
ezetimibe	Zetia	2	AL (Min 10 Years)
fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg		1	
fenofibrate nanocrystallized oral tablet 145 mg, 48 mg	Tricor	2	QL (1 EA per 1 day)
fenofibrate oral tablet 160 mg, 54 mg		1	
fosinopril		2	QL (1 EA per 1 day)
gemfibrozil	Lopid	1	
guanfacine oral tablet		1	
hydralazine		1	
irbesartan	Avapro	1	
irbesartan-hydrochlorothiazide	Avalide	1	
labetalol intravenous solution		1	
labetalol intravenous syringe 20 mg/4 mL (5 mg/mL), 25 mg/5 mL (5 mg/mL)		1	
labetalol oral		1	
lisinopril	Prinivil	1	
lisinopril-hydrochlorothiazide	Zestoretic	1	

Drug Name	Reference	Formulary Tier	Restrictions
losartan	Cozaar	1	
losartan-hydrochlorothiazide	Hyzaar	1	
lovastatin		1	
methyldopa		1	
metoprolol succinate	Toprol XL	1	
metoprolol tartrate intravenous solution		1	
metoprolol tartrate oral tablet 100 mg, 50 mg	Lopressor	1	
metoprolol tartrate oral tablet 25 mg, 75 mg		1	
minoxidil oral		1	
nadolol	Corgard	1	
niacin oral tablet extended release 24 hr	Niaspan Extended-Release	1	
Niacor		1	
Nipride RTU		1	
olmesartan	Benicar	2	QL (1 EA per 1 day)
olmesartan-hydrochlorothiazide	Benicar HCT	2	QL (1 EA per 1 day)
phenylephrine HCl in 0.9% NaCl intravenous solution 1 mg/10 mL (100 mcg/mL), 10 mg/250 mL (40 mcg/mL), 100 mg/250 mL (400 mcg/mL), 20 mg/250 mL (80 mcg/mL), 25 mg/250 mL (100 mcg/mL), 300 mg/250 mL (1,200 mcg/mL), 40 mg/250 mL (160 mcg/mL), 50 mg/250 mL (200 mcg/mL), 80 mg/250 mL (320 mcg/mL)		1	
phenylephrine HCl in 0.9% NaCl intravenous syringe 0.4 mg/10 mL (40 mcg/mL), 0.5 mg/5 mL (100 mcg/mL), 0.8 mg/10 mL (80 mcg/mL), 1 mg/10 mL (100 mcg/mL), 100 mcg/10 mL (10 mcg/mL), 20 mg/50 mL (400 mcg/mL)		1	
phenylephrine in sterile water intravenous syringe 60 mg/50 mL (1,200 mcg/mL)		1	
pindolol		1	
pravastatin		1	
prazosin	Minipress	1	
Prevalite oral powder		1	
propranolol oral		1	

Drug Name	Reference	Formulary Tier	Restrictions
Qbrelis		2	C-1 (CODE-1 RESTRICTION: For pediatric use when child is unable to swallow tablets or when tube administration is required.); AL (Max 12 Years)
quinapril	Accupril	1	
ramipril	Altace	1	
rosuvastatin	Crestor	2	QL (1 EA per 1 day)
simvastatin oral tablet	Zocor	1	
sodium nitroprusside	Nitropress	1	
Sorine		1	
Sotalol AF		1	
sotalol oral	Sorine	1	
telmisartan	Micardis	2	QL (1 EA per 1 day)
telmisartan-hydrochlorothiazid	Micardis HCT	2	QL (1 EA per 1 day)
terazosin		1	
valsartan	Diovan	1	
valsartan-hydrochlorothiazide	Diovan HCT	1	
Central Nervous System (CNS) Drugs			
caffeine citrate oral		1	
carbamazepine oral capsule, ER multiphase 12 hr	Carbatrol	1	
carbamazepine oral suspension 100 mg/5 mL	Tegretol	1	
carbamazepine oral suspension 100 mg/5 mL (5 mL)		1	
carbamazepine oral tablet	Epitol	1	
carbamazepine oral tablet extended release 12 hr	Tegretol XR	1	
carbamazepine oral tablet,chewable		1	
Celontin oral capsule 300 mg		1	
clobazam oral tablet	Onfi	2	QL (2 EA per 1 day)
clonazepam oral tablet	Klonopin	2	QL (4 EA per 1 day)
clonazepam oral tablet,disintegrating		2	QL (3 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
dalfampridine	Ampyra	2	C-1 (CODE-1 RESTRICTION: Limited to members diagnosed with ms (dx made by or in consultation with a neurologist) and having impaired walking speed.); QL (2 EA per 1 day); AL (Min 18 Years)
diazepam rectal	Diastat AcuDial	2	C-1 (CODE-1 RESTRICTION: Limited to members with epilepsy maintained on antiepileptic agents but requiring occasional STAT treatment for break-through seizures.); QL (4 EA per 30 days)
Dilantin		1	
Dilantin Extended		1	
Dilantin Infatabs		1	
Dilantin-125		1	
divalproex	Depakote	1	
ethosuximide	Zarontin	1	
felbamate oral tablet	Felbatol	2	QL (6 EA per 1 day); AL (Min 2 Years)
Fycompa oral tablet		2	ST; QL (1 EA per 1 day); AL (Min 4 Years)
gabapentin oral capsule 100 mg	Neurontin	2	QL (36 EA per 1 day)
gabapentin oral capsule 300 mg	Neurontin	2	QL (12 EA per 1 day)
gabapentin oral capsule 400 mg	Neurontin	2	QL (9 EA per 1 day)
gabapentin oral solution 250 mg/5 mL	Neurontin	2	C-1 (CODE-1 RESTRICTION: Limited to treatment of seizures.); AL (Min 1 Years and Max 12 Years)
gabapentin oral tablet 600 mg	Neurontin	2	QL (6 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
gabapentin oral tablet 800 mg	Neurontin	2	QL (4 EA per 1 day)
lamotrigine oral tablet	Lamictal	1	
lamotrigine oral tablet, chewable dispersible	Lamictal	1	
levetiracetam oral	Keppra	1	
memantine oral tablet	Namenda	2	QL (2 EA per 1 day)
memantine oral tablets,dose pack	Namenda Titration Pak	1	
Nayzilam		2	QL (4 Units per 30 days); AL (Min 12 Years)
oxcarbazepine	Trileptal	1	
Phenytek		1	
phenytoin oral suspension		1	
phenytoin oral tablet,chewable	Dilantin Infatabs	1	
phenytoin sodium		1	
phenytoin sodium extended	Phenytek	1	
pregabalin oral capsule 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Lyrica	2	QL (4 EA per 1 day)
pregabalin oral capsule 200 mg	Lyrica	2	QL (3 EA per 1 day)
pregabalin oral capsule 225 mg, 300 mg	Lyrica	2	QL (2 EA per 1 day)
primidone	Mysoline	1	
riluzole	Rilutek	2	C-1 (CODE-1 RESTRICTION: Restricted to treatment of Amyotrophic Lateral Sclerosis (ALS) in adults 18 years and older and limited to 2 tablets per day.); QL (2 EA per 1 day); AL (Min 18 Years)
tiagabine	Gabitril	1	
topiramate oral capsule, sprinkle	Topamax	1	
topiramate oral tablet	Topamax	1	
valproic acid		1	
valproic acid (as sodium salt) oral solution 250 mg/5 mL, 250 mg/5 mL (5 mL)		1	

Drug Name	Reference	Formulary Tier	Restrictions
Valtoco		2	C-1 (Code 1 Restriction: Limited to members with epilepsy, who are maintained on anti-epileptic agents but are requiring occasional STAT treatment for breakthrough seizures.); QL (4 EA per 28 days)
vigabatrin	Sabril	3	PA
Vimpat oral tablet		2	QL (2 EA per 1 day); AL (Min 17 Years)
zonisamide	Zonegran	1	
Colony Stimulating Factors			
Granix		3	PA
Nivestym		3	PA
Retacrit injection solution 10,000 unit/mL, 2,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL		2	C-1 (Code 1 Restriction: Anemia due to chronic renal failure, Zidovudine or cancer chemotherapy when iron status is normal & Hbg < 10.0.); QL (3 ML per 7 days)
Retacrit injection solution 40,000 unit/mL		2	C-1 (CODE-1 RESTRICTION: Anemia due to chronic renal failure, Zidovudine or cancer chemotherapy when iron status is normal & Hbg < 10.0.); QL (4 ML per 28 days)
Udenyca		3	PA
Zarxio		3	PA
Contraceptives: Daily oral tablets, vaginal rings, and patches may be filled as 1 year supply upon request			
Altavera (28)		1	
Alyacen 1/35 (28)		1	
Alyacen 7/7/7 (28)		1	
Amethia		1	

Drug Name	Reference	Formulary Tier	Restrictions
Annovera		2	QL (2 EA per 1 year)
Apri		1	
Aranelle (28)		1	
Ashlyna		1	
Aubra		1	
Aubra EQ		1	
Aurovela 1.5/30 (21)		1	
Aurovela 1/20 (21)		1	
Aurovela 24 Fe		1	
Aurovela Fe 1-20 (28)		1	
Aviane		1	
Azurette (28)		1	
Balziva (28)		1	
Blisovi 24 Fe		1	
Blisovi Fe 1.5/30 (28)		1	
Blisovi Fe 1/20 (28)		1	
Briellyn		1	
Camila		1	
Camrese		1	
Camrese Lo		1	
Caya Contoured		1	
Caziant (28)		1	
Chateal (28)		1	
Cryselle (28)		1	
Cyclafem 1/35 (28)		1	
Cyclafem 7/7/7 (28)		1	
Cyred		1	
Dasetta 1/35 (28)		1	
Dasetta 7/7/7 (28)		1	
Daysee		1	
Deblitane		1	
Depo-SubQ provera 104		1	
desog-e.estradiol/e.estradiol	Azurette (28)	1	
desogestrel-ethinyl estradiol	Apri	1	
drospirenone-e.estradiol-lm.FA	Beyaz	1	
drospirenone-ethinyl estradiol	Ocella	1	
Elinest		1	

Drug Name	Reference	Formulary Tier	Restrictions
Ella		1	
EluRyng		1	
Enpresse		1	
Enskyce		1	
Errin		1	
Estarylla		1	
ethynodiol diac-eth estradiol	Kelnor 1/35 (28)	1	
etonogestrel-ethinyl estradiol	EluRyng	1	
Falmina (28)		1	
FemCap vaginal device 22 mm		2	QL (1 EA per 1 Fill)
FemCap vaginal device 26 mm, 30 mm		2	QL (1 EA per 1 Fill)
Gemmily		1	
Hailey		1	
Hailey 24 Fe		1	
Heather		1	
Jencycla		1	
Jolessa		2	
Juleber		1	
Junel 1.5/30 (21)		1	
Junel 1/20 (21)		1	
Junel FE 1.5/30 (28)		1	
Junel FE 1/20 (28)		1	
Junel Fe 24		1	
Kaitlib Fe		1	
Kariva (28)		1	
Kelnor 1/35 (28)		1	
Kelnor 1-50 (28)		1	
Kurvelo (28)		1	
Kyleena		2	QL (1 EA per 365 days)
L norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)	Camrese Lo	1	
L norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	Amethia	1	
Larin 1.5/30 (21)		1	
Larin 1/20 (21)		1	

Drug Name	Reference	Formulary Tier	Restrictions
Larin 24 Fe		1	
Larin Fe 1.5/30 (28)		1	
Larin Fe 1/20 (28)		1	
Layolis Fe		1	
Leena 28		1	
Lessina		1	
Levonest (28)		1	
levonorgestrel-ethinyl estrad	Altavera (28)	1	
levonorg-eth estrad triphasic	Enpresse	1	
Levora-28		1	
Liletta		1	
Lo Loestrin Fe		1	
Loestrin 1.5/30 (21)		1	
Loestrin 1/20 (21)		1	
Loestrin Fe 1.5/30 (28-Day)		1	
Loryna (28)		1	
LoSeasonique		1	
Low-Ogestrel (28)		1	
Lutera (28)		1	
Lyza		1	
Marlissa (28)		1	
medroxyprogesterone intramuscular suspension	Depo-Provera	1	
medroxyprogesterone intramuscular syringe	Depo-Provera	2	
Merzee		1	
Mibelas 24 Fe		1	
Microgestin 1.5/30 (21)		1	
Microgestin 1/20 (21)		1	
Microgestin Fe 1.5/30 (28)		1	
Microgestin FE 1/20 (28)		1	
Mirena		1	
Mono-Linyah		1	
Natazia		1	
Necon 0.5/35 (28)		1	
Nexplanon		2	
Nora-BE		1	

Drug Name	Reference	Formulary Tier	Restrictions
noreth-ethinyl estradiol-iron oral tablet,chewable 0.8mg-25mcg(24) and 75 mg (4)	Kaitlib Fe	1	
norethindrone (contraceptive)	Camila	1	
norethindrone ac-eth estradiol oral tablet 1.5-30 mg-mcg	Aurovela 1.5/30 (21)	1	
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	Aurovela 1/20 (21)	1	
norethindrone-e.estradiol-iron oral capsule	Gemmily	1	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)	Aurovela Fe 1-20 (28)	1	
norethindrone-e.estradiol-iron oral tablet,chewable	Mibelas 24 Fe	1	
norgestimate-ethinyl estradiol	Estarylla	1	
Nortrel 0.5/35 (28)		1	
Nortrel 1/35 (21)		1	
Nortrel 1/35 (28)		1	
Nortrel 7/7/7 (28)		1	
Ocella		1	
Orsythia		1	
ParaGard T 380A		1	
Philith		1	
Pimtrea (28)		1	
Pirmella		1	
Portia 28		1	
Previfem		1	
Quartette		1	
Reclipsen (28)		1	
Simliya (28)		1	
Simpesse		1	
Skyla		2	
Slynd		1	
Sprintec (28)		1	
Sronyx		1	
Syeda		1	
Tarina 24 Fe		1	
Tarina Fe 1/20 (28)		1	
Tarina Fe 1-20 EQ (28)		1	

Drug Name	Reference	Formulary Tier	Restrictions
Tilia Fe		1	
Tri Femynor		1	
Tri-Estarylla		1	
Tri-Legest Fe		1	
Tri-Linyah		1	
Tri-Lo-Estarylla		1	
Tri-Lo-Marzia		1	
Tri-Lo-Mili		1	
Tri-Lo-Sprintec		1	
Tri-Mili		1	
Tri-Previfem (28)		1	
Tri-Sprintec (28)		1	
Trivora (28)		1	
Tri-VyLibra		1	
Tri-VyLibra Lo		1	
Twirla		2	
Velivet Triphasic Regimen (28)		1	
Viorele (28)		1	
Vyfemla (28)		1	
Wera (28)		1	
Wide-Seal Diaphragm 60		1	
Wide-Seal Diaphragm 65		1	
Wide-Seal Diaphragm 70		1	
Wide-Seal Diaphragm 75		1	
Wide-Seal Diaphragm 80		1	
Wide-Seal Diaphragm 85		1	
Wide-Seal Diaphragm 90		1	
Wide-Seal Diaphragm 95		1	
Wymzya Fe		1	
Xulane		1	
Zarah		1	
Zovia 1/35E (28)		1	
Cough/Cold Preparations: Also see the OTC section for additional covered products			
benzonatate oral capsule 100 mg	Tessalon Perles	1	
benzonatate oral capsule 200 mg		1	
promethazine-codeine		2	QL (240 ML per 1 Fill); AL (Min 18 Years)

Drug Name	Reference	Formulary Tier	Restrictions
promethazine-DM		1	
promethazine-phenyleph-codeine	Promethazine VC-Codeine	2	QL (30 ML per 1 day); AL (Min 18 Years)
Diagnostic			
BinaxNOW COVD Ag Card Home Tst	Covered through the medical benefit, not pharmacy.		
BinaxNOW COVID-19 Ag Card	Covered through the medical benefit, not pharmacy.		
GlucaGen Diagnostic Kit		1	
glucagon HCl		1	
ID NOW COVID-19 Test Kit	Covered through the medical benefit, not pharmacy.		
Diuretics			
acetazolamide		1	
acetazolamide sodium		1	
amiloride		1	
amiloride-hydrochlorothiazide		1	
bumetanide oral		1	
chlorothiazide sodium	Diuril IV	1	
chlorthalidone oral tablet 25 mg, 50 mg		1	
Diuril		1	
furosemide injection		1	
furosemide oral solution 10 mg/mL		1	
furosemide oral tablet	Lasix	1	
hydrochlorothiazide		1	
indapamide		1	
mannitol 25 % intravenous solution		1	
methazolamide		1	
metolazone		1	
spironolactone	Aldactone	1	
spironolacton-hydrochlorothiaz	Aldactazide	1	
torsemide oral		1	
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg		1	
triamterene-hydrochlorothiazid oral tablet	Maxzide-25mg	1	
Ear, Eye, Nose (EENT) Preps: Also see the OTC section for additional covered products			
acetic acid otic (ear)		1	
Alomide		2	ST
Amvisc		1	

Drug Name	Reference	Formulary Tier	Restrictions
Amvisc Plus		1	
apraclonidine		2	QL (5 ML per 15 days)
atropine ophthalmic (eye) drops	Isopto Atropine	1	
atropine ophthalmic (eye) ointment		1	
azelastine nasal		1	
betaxolol ophthalmic (eye)		2	QL (10 ML per 1 Month)
Betoptic S		1	
brimonidine ophthalmic (eye) drops 0.2 %		1	
brinzolamide	Azopt	2	ST; QL (10 ML per 30 days)
bromfenac		1	
Combigan		2	QL (5 ML per 28 days)
cromolyn ophthalmic (eye)		1	
Cyclogyl ophthalmic (eye) drops 0.5 %		1	
cyclopentolate ophthalmic (eye) drops 1 %, 2 %	Cyclogyl	1	
dexamethasone sodium phosphate ophthalmic (eye)		1	
diclofenac sodium ophthalmic (eye)		1	
dorzolamide	Trusopt	2	QL (10 ML per 30 days)
dorzolamide-timolol	Cosopt	2	QL (10 ML per 30 days)
dorzolamide-timolol (PF) ophthalmic (eye) dropperette	Cosopt (PF)	2	QL (60 EA per 30 days)
flunisolide		1	
fluocinolone acetonide oil	DermOtic Oil	2	QL (40 ML per 14 days)
fluorometholone	FML Liquifilm	1	
FML Forte		1	
FML Liquifilm		1	
FML S.O.P.		1	
Homatropaire		1	
hydrocortisone-acetic acid		1	
Iopidine ophthalmic (eye) dropperette		2	QL (24 ml per 1 Month)

Drug Name	Reference	Formulary Tier	Restrictions
ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)		2	QL (1 UNIT per 1 Month)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)		2	QL (1 Unit per 1 Month)
ketorolac ophthalmic (eye) drops 0.5 %	Acular	1	
latanoprost	Xalatan	1	
levobunolol ophthalmic (eye) drops 0.5 %		2	QL (10 ML per 30 days)
Lumigan ophthalmic (eye) drops 0.01 %		2	ST; QL (2.5 ML per 30 days)
metipranolol		2	QL (5 ML per 15 days)
mometasone nasal	Nasonex	1	
olopatadine nasal	Patanase	1	
pilocarpine HCl ophthalmic (eye) drops 1 %, 2 %, 4 %	Isopto Carpine	1	
Pred Mild		1	
prednisolone acetate	Pred Forte	1	
prednisolone sodium phosphate ophthalmic (eye)		1	
Rhopressa		2	ST; QL (2.5 ML per 28 days)
Rocklatan		2	ST; QL (2.5 ML per 28 days)
Simbrinza		2	QL (8 ML per 28 days)
timolol maleate ophthalmic (eye) drops	Timoptic	2	QL (5 ML per 15 days)
timolol maleate ophthalmic (eye) gel forming solution	Timoptic-XE	2	QL (10 ML per 30 days)
travoprost	Travatan Z	2	QL (2.5 ML per 30 days)
Xiidra		3	PA; AL (Min 18 Years)
Zioptan (PF)		2	ST; QL (1 EA per 1 day)
Electrolyte/Caloric/H2O			
Auryxia		2	ST; QL (6 TABLETS per 1 day); AL (Min 18 Years)

Drug Name	Reference	Formulary Tier	Restrictions
Baqsimi		2	QL (2 UNITS per 1 Fill); AL (Min 4 Years)
BD PosiFlush Normal Saline 0.9		1	
BD Pre-Filled Normal Saline		1	
BD Pre-Filled Saline Blunt Can		1	
Cal-Citrate		1	
Calcium 500 + D oral tablet		1	
Calcium 500 oral tablet,chewable		1	
Calcium 500 With D		1	
Calcium 600		1	
Calcium 600 + D(3) oral tablet 600 mg(1,500mg) -200 unit, 600 mg(1,500mg) -400 unit		1	
Calcium 600 + Minerals oral tablet 600 mg calcium- 200 unit		1	
calcium acetate(phosphat bind)		1	
calcium carbonate oral tablet 500 mg calcium (1,250 mg)	Natural Calcium	1	
calcium carbonate oral tablet 600 mg calcium (1,500 mg)	Calcium 600	1	
calcium carbonate oral tablet,chewable 500 mg calcium (1,250 mg)	Calcium 500	1	
calcium carbonate-vitamin D3 oral tablet 500 mg(1,250mg) -200 unit	Calcium 500 + D	1	
calcium carbonate-vitamin D3 oral tablet 600 mg(1,500mg) -200 unit, 600 mg(1,500mg) -400 unit	Calcium 600 + D(3)	1	
calcium carbonate-vitamin D3 oral tablet 600 mg(1,500mg) -800 unit	Caltrate with Vitamin D3	1	
calcium citrate oral tablet 200 mg (950 mg)		1	
calcium citrate-vitamin D3 oral tablet 200 mg-3.125 mcg (125 unit)		1	
calcium gluconate oral tablet 60 mg calcium (650 mg)		1	
Calcium with Vitamin D		1	
calcium-magnesium		1	
Caltrate with Vitamin D3		1	
Children's Iron		1	
Cytra-2		1	

Drug Name	Reference	Formulary Tier	Restrictions
Denta 5000 Plus		2	QL (51 GM per 30 days)
DentaGel		1	
dextrose 20 % in water (D20W)		1	
dextrose 30 % in water (D30W)		1	
dextrose 40 % in water (D40W)		1	
Effer-K		1	
Enfamil Enfalyte		1	
FE C Plus		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Ferate		1	
Fergon oral tablet 240 mg (27 mg iron)		1	
FeroSul oral tablet		1	
Ferro-Time		1	
ferrous gluconate oral tablet 240 mg (27 mg iron)	Ferate	1	
ferrous gluconate oral tablet 324 mg (37.5 mg iron), 324 mg (38 mg iron)		1	
ferrous sulfate oral drops	Children's Iron	1	
ferrous sulfate oral liquid		1	
ferrous sulfate oral solution		1	
ferrous sulfate oral tablet	FeroSul	1	
ferrous sulfate oral tablet,delayed release (DR/EC)		1	
fluoride (sodium) dental gel	DentaGel	1	
fluoride (sodium) oral drops		1	
fluoride (sodium) oral tablet,chewable	Ludent Fluoride	2	AL (Max 7 Years)
GlucaGen HypoKit		1	
Glucagon Emergency Kit (human)		1	
Gvoke HypoPen 1-Pack subcutaneous auto-injector 0.5 mg/0.1 mL		2	QL (0.2 ML per 1 Fill); AL (Min 2 Years)
Gvoke HypoPen 1-Pack subcutaneous auto-injector 1 mg/0.2 mL		2	QL (0.4 ML per 1 Fill); AL (Min 2 Years)

Drug Name	Reference	Formulary Tier	Restrictions
Gvoke HypoPen 2-Pack subcutaneous auto-injector 0.5 mg/0.1 mL		2	QL (0.2 ML per 1 Fill); AL (Min 2 Years)
Gvoke HypoPen 2-Pack subcutaneous auto-injector 1 mg/0.2 mL		2	QL (0.4 ML per 1 Fill); AL (Min 2 Years)
Gvoke PFS 1-Pack Syringe subcutaneous syringe 0.5 mg/0.1 mL		2	QL (0.2 ML per 1 Fill); AL (Min 2 Years)
Gvoke PFS 1-Pack Syringe subcutaneous syringe 1 mg/0.2 mL		2	QL (0.4 ML per 1 Fill); AL (Min 1 Years)
Gvoke PFS 2-Pack Syringe subcutaneous syringe 0.5 mg/0.1 mL		2	QL (0.2 ML per 1 Fill); AL (Min 2 Years)
Gvoke PFS 2-Pack Syringe subcutaneous syringe 1 mg/0.2 mL		2	QL (0.4 ML per 1 Fill); AL (Min 2 Years)
Icar-C Plus		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Infed		2	C-1 (CODE-1 RESTRICTION: Limited to member with CKD or ESRD who also have iron deficiency anemia. Iron deficiency anemia without renal disease requires a TAR (submit documentation of failure or contraindication to oral iron).)
Iron 100 Plus		1	
iron oral tablet 325 mg (65 mg iron)		1	
Klor-Con M10		1	
Klor-Con M20		1	
K-Phos No 2		1	

Drug Name	Reference	Formulary Tier	Restrictions
K-Phos Original		1	
levocarnitine tartrate oral capsule 500 mg	L-Carnitine (tartrate)	1	
Ludent Fluoride		2	AL (Max 7 Years)
magnesium oxide oral tablet 500 mg	Phillips	1	
Natural Calcium		1	
Normal Saline Flush		1	
Oralyte		1	
Oysco 500/D		1	
Oyster Shell Calcium		1	
Oyster Shell Calcium 500		1	
Oyster Shell Calcium-Vit D3 oral tablet		1	
Parva-Cal 500		1	
Pedialyte Advanced Care		1	
Pedialyte Freezer Pops		1	
Pedialyte oral solution		1	
Pediatric Electrolyte oral solution		1	
Phillips		1	
Phospha 250 Neutral		1	
Phosphorous Supplement		1	
Plenamine		2	C-1 (CODE-1 RESTRICTION: Limited to members discharged from acute hospital within the past 10 days and RX is continuation of same product started in the hospital.); QL (1 Fill per 120 days)
potassium chloride in 0.9%NaCl intravenous parenteral solution 20 mEq/L, 40 mEq/L		1	
potassium chloride in 5 % dex intravenous parenteral solution 30 mEq/L, 40 mEq/L		1	
potassium chloride in LR-D5		1	
potassium chloride oral capsule, extended release		1	
potassium chloride oral tablet extended release 10 mEq, 8 mEq	K-Tab	1	

Drug Name	Reference	Formulary Tier	Restrictions
potassium chloride oral tablet,ER particles/crystals 10 mEq	Klor-Con M10	1	
potassium chloride oral tablet,ER particles/crystals 20 mEq	Klor-Con M20	1	
potassium chloride-D5-0.2%NaCl		1	
potassium chloride-D5-0.3%NaCl intravenous parenteral solution 20 mEq/L		1	
potassium chloride-D5-0.9%NaCl		1	
potassium citrate	Urocit-K 10	1	
potassium gluconate oral tablet 2.5 mEq, 595 mg (99 mg)		1	
potassium, sodium phosphates	Phosphorous Supplement	1	
sevelamer carbonate oral tablet	Renvela	2	QL (16 EA per 1 day)
SF		1	
SF 5000 Plus		2	QL (51 GM per 30 days)
sodium chloride 0.45 % intravenous parenteral solution		1	
sodium chloride 0.9 % (flush) injection syringe	BD PosiFlush Normal Saline 0.9	1	
sodium chloride 3 %		1	
sodium chloride 5 %		1	
sodium ferric gluconat-sucrose	Ferrlecit	2	C-1 (CODE-1 RESTRICTION: Limited to member with CKD or ESRD who also have iron deficiency anemia. Iron deficiency anemia without renal disease requires a TAR (submit documentation of failure or contraindication to oral iron).)
sodium polystyrene sulfonate oral powder		1	
SPS (with sorbitol) oral		1	
SSKI		1	
Super Calcium		1	

Drug Name	Reference	Formulary Tier	Restrictions
Tricitrates		1	
Velphoro		2	ST; AL (Min 21 Years)
Veltassa		3	PA; QL (1 PACK per 1 day)
Venofer		2	C-1 (CODE-1 RESTRICTION: Limited to member with CKD or ESRD who also have iron deficiency anemia. Iron deficiency anemia without renal disease requires a TAR (submit documentation of failure or contraindication to oral iron).)
Virtrate-3		1	
Gastrointestinal (See OTC section for additional covered gastrointestinal items)			
Akynzeo (netupitant)		2	C-1 (CODE-1 RESTRICTION: Limited to use in conjunction with high or moderate emetic risk cancer chemotherapy.); QL (1 EA per 1 Rx)
Aloxi		2	C-1 (CODE-1 RESTRICTION: Limited to use for theprevention of chemotherapy induced acute & delayed N/V)
Anucort-HC		1	

Drug Name	Reference	Formulary Tier	Restrictions
aprepitant oral capsule 125 mg		2	C-1 (CODE-1 RESTRICTION: Limited for use in conjunction with high or moderate emetogenic chemotherapy.Dispensed quantity shall be limited to the quantity needed for days 1-3 of a single chemotherapy Cycle.); QL (1 EA per 1 Fill)
aprepitant oral capsule 40 mg		2	C-1 (CODE-1 RESTRICTION: Limited to use for prophylaxis of post-operative nausea & vomiting, to be taken within 3 hours of anesthesia.); QL (1 EA per 1 Fill)
aprepitant oral capsule 80 mg	Emend	2	C-1 (CODE-1 RESTRICTION: Limited for use in conjunction with high or moderate emetogenic chemotherapy.Dispensed quantity shall be limited to the quantity needed for days 1-3 of a single chemotherapy Cycle.); QL (2 EA per 1 Fill)

Drug Name	Reference	Formulary Tier	Restrictions
aprepitant oral capsule,dose pack	Emend	2	C-1 (CODE-1 RESTRICTION: Limited for use in conjunction with high/moderate emetogenic chemotherapy. Dispensed quantity is limited to the quantity needed for days 1-3 of a single chemotherapy Cycle.); QL (3 EA per 1 Fill)
atropine injection syringe 0.05 mg/mL, 0.1 mg/mL		1	
balsalazide	Colazal	1	
Bonjesta		2	C-1 (CODE-1 RESTRICTION: Restricted for pregnancy.); QL (2 EA per 1 day); AL (Min 18 Years)
chlordiazepoxide-clidinium	Librax (with clidinium)	1	
cimetidine HCl oral		1	
cimetidine oral tablet 300 mg, 400 mg, 800 mg		1	
Cinvanti		2	C-1 (CODE-1 RESTRICTION: Limited to prevention of nausea caused by chemotherapy.); QL (18 ML per 1 Rx)
Compro		2	QL (6 EA per 23 days)
Constulose		1	

Drug Name	Reference	Formulary Tier	Restrictions
Creon		2	C-1 (CODE-1 RESTRICTION: Restricted to members with pancreatic insufficiency secondary to cystic fibrosis, chronic pancreatitis or pancreatectomy.)
dicyclomine oral capsule		1	
dicyclomine oral solution		1	
dicyclomine oral tablet		1	
diphenoxylate-atropine	Lomotil	1	
doxylamine-pyridoxine (vit B6)	Diclegis	2	C-1 (CODE-1 RESTRICTION: Restricted for pregnancy with quantity limit of #60 per fill and 2 fills per year.); QL (60 EA per 1 Fill)
dronabinol oral capsule 2.5 mg, 5 mg	Marinol	2	ST; QL (4 EA per 1 day)
Enulose		1	
esomeprazole magnesium oral capsules, delayed release(DR/EC) 20 & 40 mg	Nexium	1	
famotidine (PF)-NaCl (iso-os)		1	
famotidine intravenous solution		1	
famotidine oral tablet 40 mg	Pepcid	2	QL (2 EA per 1 day)
Gavilyte-C		1	
GaviLyte-N		1	
Generlac		1	
glycopyrrolate injection		1	
glycopyrrolate oral tablet 1 mg, 2 mg		1	

Drug Name	Reference	Formulary Tier	Restrictions
granisetron HCl intravenous solution 1 mg/mL		2	C-1 (CODE-1 RESTRICTION: Limited to use in conjunction with cancer chemotherapy, cancer radiation or treatment of breakthrough N/V not responsive to other formulary antiemetics.); QL (12 ML Max Qty Per Fill Retail)
granisetron HCl oral		2	C-1 (CODE-1 RESTRICTION: Limited to use in conjunction with cancer chemotherapy, cancer radiation or treatment of breakthrough N/V not responsive to other formulary antiemetics.); QL (30 EA Max Qty Per Fill Retail)
hydrocortisone acetate rectal suppository 25 mg	Anucort-HC	1	
hyoscyamine sulfate oral drops	Hyosyne	2	QL (6 ML per 1 day); AL (Max 12 Years)
hyoscyamine sulfate oral elixir	Hyosyne	2	QL (30 ML per 1 day); AL (Max 12 Years)
hyoscyamine sulfate oral tablet	Oscimin	1	
hyoscyamine sulfate oral tablet extended release 12 hr	Levbid	1	
hyoscyamine sulfate oral tablet,disintegrating	Anaspaz	1	
hyoscyamine sulfate sublingual	Oscimin SL	1	
lactulose oral solution	Constulose	1	
lansoprazole oral capsule,delayed release(DR/EC) 30 mg	Prevacid	1	
lansoprazole oral tablet,disintegrat, delay rel 15 mg & 30 mg	Prevacid SoluTab	2	Code 1; QL(2 EA in 1 Day); AL(min 1 year)

Drug Name	Reference	Formulary Tier	Restrictions
mesalamine oral tablet,delayed release (DR/EC) 1.2 gram	Lialda	2	QL (4 EA per 1 day); AL (Min 18 Years)
mesalamine oral tablet,delayed release (DR/EC) 800 mg	Asacol HD	2	QL (6 EA per 1 day); AL (Min 18 Years)
mesalamine rectal enema	Rowasa	2	C-1 (CODE-1 RESTRICTION: Limited to active disease and Rx written and/or recommended by gastroenterologist.); QL (56 Days per 1 Year)
mesalamine rectal suppository	Canasa	2	QL (42 EA per 1 Fill)
metoclopramide HCl oral solution		1	
metoclopramide HCl oral tablet	Reglan	1	
misoprostol	Cytotec	2	QL (120 EA per 1 MONTH)
nizatidine oral solution, capsules		2	Solution only: ST; AL (Max 12 Years)
omega-3 acid ethyl esters	Lovaza	2	QL (4 EA per 1 day)
omeprazole oral capsule,delayed release(DR/EC) 10 mg		1	
omeprazole oral capsule,delayed release(DR/EC) 20 mg		1	
omeprazole oral capsule,delayed release(DR/EC) 40 mg		1	
ondansetron		2	QL (3 EA per 1 day)
ondansetron HCl intravenous		1	
ondansetron HCl oral solution		2	C-1 (CODE-1 RESTRICTION: Limited to use with oncology treatment (any age) or for pediatric nausea/vomiting for any cause in ages less than 13 yrs old. ODT tablets are a preferred alternative if Code 1 not met.); QL (50 ML per 30 days)
ondansetron HCl oral tablet 24 mg		2	QL (9 EA per 30 days)

Drug Name	Reference	Formulary Tier	Restrictions
ondansetron HCl oral tablet 4 mg	Zofran	2	QL (3 EA per 1 day)
ondansetron HCl oral tablet 8 mg		2	QL (3 EA per 1 day)
Oscimin oral tablet		1	
Oscimin SL		1	
Pancreaze oral capsule,delayed release(DR/EC) 10,500-35,500- 61,500 unit, 16,800-56,800- 98,400 unit, 21,000-54,700- 83,900 unit, 4,200-14,200-24,600 unit		2	C-1 (CODE-1 RESTRICTION: Restricted to members with pancreatic insufficiency secondary to cystic fibrosis, chronic pancreatitis or pancreatectomy.)
Pancreaze oral capsule,delayed release(DR/EC) 2,600-8,800- 15,200 unit		2	C-1 (CODE-1 RESTRICTION: Restricted to members with pancreatic insufficiency secondary to cystic fibrosis, chronic pancreatitis or pancreatectomy_)
pantoprazole oral tablet,delayed release (DR/EC)	Protonix	1	
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	GaviLyte-G	1	
Pertzye		2	C-1 (CODE-1 RESTRICTION: Restricted to members with pancreatic insufficiency secondary to cystic fibrosis, chronic pancreatitis or pancreatectomy.)
prochlorperazine	Compro	2	QL (6 EA per 23 days)
prochlorperazine Edisylate		1	
prochlorperazine maleate	Compazine	1	
Proctofoam HC		1	

Drug Name	Reference	Formulary Tier	Restrictions
promethazine rectal suppository 12.5 mg, 25 mg	Promethegan	2	QL (6 EA per 1 Month)
Promethegan rectal suppository 12.5 mg, 25 mg		2	QL (6 EA per 1 Month)
Promethegan rectal suppository 50 mg		2	QL (3 EA per 1 Month)
rabeprazole oral tablet,delayed release (DR/EC)	AcipHex	1	
scopolamine patches	Transderm-Scop	2	QL (1 EA per 3 days); AL (Min 18 Years)
sucralfate oral tablet	Carafate	1	
sulfasalazine oral tablet	Azulfidine	1	
Suprep Bowel Prep Kit		2	QL (2 Fills per 365 days)
TriLyte With Flavor Packets		1	
ursodiol oral capsule 300 mg		1	
ursodiol oral tablet	URSO 250	1	
Varubi oral		2	C-1 (CODE-1 RESTRICTION: Limited to use in conjunction with high or moderate emetic risk cancer chemotherapy); QL (2 EA per 1 Rx)
Viokace		2	C-1 (CODE-1 RESTRICTION: Restricted to members with pancreatic insufficiency secondary to cystic fibrosis, chronic pancreatitis or pancreatectomy.)

Drug Name	Reference	Formulary Tier	Restrictions
Zenpep oral capsule,delayed release(DR/EC) 10,000-32,000 -42,000 unit, 15,000-47,000 -63,000 unit, 20,000-63,000- 84,000 unit, 25,000-79,000-105,000 unit, 3,000-10,000 -14,000-unit, 40,000-126,000- 168,000 unit, 5,000-17,000- 24,000 unit		2	C-1 (CODE-1 RESTRICTION: Restricted to members with pancreatic insufficiency secondary to cystic fibrosis, chronic pancreatitis or pancreatectomy.)
Hormones			
Alora		2	QL (1 EA per 1 day)
betamethasone acet,sod phos	Celestone Soluspan	1	
budesonide oral capsule,delayed,extend.release	Entocort EC	2	QL (3 EA per 1 day)
cabergoline		2	QL (4 EA per 7 days)
calcitonin (salmon) nasal		2	QL (3.7 ML per 30 days); AL (Min 18 Years)
Climara Pro		1	
CombiPatch		2	QL (1 EA per 1 day)
Cortifoam		1	
Covaryx		2	QL (1 EA per 1 day)
Covaryx H.S.		2	QL (1 EA per 1 day)
Crinone		2	C-1 (Code-1 Restriction: Reimbursable only for amenorrhea. Prescriptions intended for fertility (facilitation of achieving pregnancy) are not a covered benefit.)
desmopressin oral	DDAVP	2	QL (1 EA per 1 day); AL (Min 7 Years)
Dexamethasone Intensol		1	
dexamethasone oral elixir		1	
dexamethasone oral solution		1	
dexamethasone oral tablet	Decadron	1	
dexamethasone sodium phosphate injection solution		1	
EEMT		2	QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
EEMT HS		2	QL (1 EA per 1 day)
estradiol oral	Estrace	1	
estradiol transdermal patch semiweekly	Alora	2	QL (1 EA per 1 day)
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	Climara	2	QL (1 EA per 1 day)
estradiol transdermal patch weekly 0.0375 mg/24 hr, 0.06 mg/24 hr	Climara	1	
estradiol vaginal	Estrace	1	
estradiol-norethindrone acet	Amabelz	1	
Estring		1	
estrogens-methyltestosterone	Covaryx	2	QL (1 EA per 1 day)
Femhrt Low Dose		1	
Femring		1	
fludrocortisone		1	
Fyavolv oral tablet 0.5-2.5 mg-mcg		1	
hydrocortisone oral	Cortef	1	
hydrocortisone rectal	Cortenema	1	
Jinteli		1	
Kenalog injection		1	
Makena		3	PA
Makena (PF)		3	PA
Medrol oral tablet 2 mg		1	
medroxyprogesterone oral	Provera	1	
methylprednisolone	Medrol	1	
Millipred DP		1	
Mimvey		1	
Norditropin FlexPro		3	PA; AL (Min 2 Years)
norethindrone acetate	Aygestin	1	
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg	Femhrt Low Dose	1	
octreotide acetate	Sandostatin	2	QL (3 ML per 1 day); AL (Min 18 Years)
prednisolone oral solution		1	
prednisolone sodium phosphate oral solution 15 mg/5 mL (3 mg/mL)		1	
prednisolone sodium phosphate oral solution 5 mg base/5 mL (6.7 mg/5 mL)	Pediapred	1	

Drug Name	Reference	Formulary Tier	Restrictions
prednisone oral tablet		1	
prednisone oral tablets,dose pack		1	
progesterone micronized	Prometrium	2	QL (1 EA per 1 day)
Solu-Cortef		1	
Solu-Cortef Act-O-Vial (PF)		1	
Testopel		2	QL (6 EA per 1 Fill)
testosterone cypionate intramuscular oil 100 mg/mL, 200 mg/mL	Depo-Testosterone	3	PA; AL (Min 12 Years)
testosterone enanthate		3	PA; AL (Min 12 Years)
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)	Vogelxo	3	PA; AL (Min 18 Years)
triamcinolone acetonide injection suspension 40 mg/mL	Kenalog	1	
Uceris rectal		2	QL (4.8 GM per 1 day)
Yuvafem		1	
Immunosuppressants			
azathioprine	Imuran	1	
cyclosporine modified	Gengraf	1	
cyclosporine oral capsule	Sandimmune	1	
Gengraf		1	
mycophenolate mofetil oral capsule	CellCept	1	
mycophenolate mofetil oral suspension for reconstitution	CellCept	2	QL (9 ML per 1 day); AL (Max 17 Years)
mycophenolate mofetil oral tablet	CellCept	1	
mycophenolate sodium	Myfortic	1	
pimecrolimus	Elidel	2	QL (60 GM Max Qty Per Fill Retail)
Sandimmune oral capsule 25 mg		1	
Sandimmune oral solution		1	
tacrolimus oral	Prograf	1	
tacrolimus topical ointment 0.03 %	Protopic	2	QL (60 GM Max Qty Per Fill Retail)
tacrolimus topical ointment 0.1 %	Protopic	2	QL (60 GM Max Qty Per Fill Retail); AL (Min 20 Years)
Miscellaneous Medical Supplies, Devices, Non-Drug **Also see the DME/Supply section of the introductory material (preceding this covered drug section)**			
Accu-Chek Spirit Adapter		1	

Drug Name	Reference	Formulary Tier	Restrictions
Accu-Chek Spirit Clip Case		1	
Ace Aerosol Cloud Enhancer		2	QL (2 EA per 365 days)
Aerochamber MV		2	QL (2 EA per 365 days)
Aerochamber Plus Flow-Vu		2	QL (2 EA per 365 days)
Aerochamber Plus Z Stat		2	QL (2 EA per 365 days)
AeroChamber Plus Z Stat Lg Msk		2	QL (2 EA per 365 days)
AeroChamber Plus Z Stat Md Msk		2	QL (2 EA per 365 days)
AeroChamber Plus Z Stat Sm Msk		2	QL (2 EA per 365 days)
Aerochamber with Flowsignal		2	QL (2 EA per 365 days)
AeroChamber Z-Stat Plus-Flw Sg		2	QL (2 EA per 365 days)
AeroEclipse II Nebulizer		1	
Aerogear Action Asthma Kit		1	
AeroTrach Plus		2	QL (2 EA per 365 days)
Airs Disposable Nebulizer		1	
Allergist Tray 1/2 mL 27Gx3/8"		1	
Allergist Tray Intradermal Bev		1	
Allergist Tray Regular Bevel		1	
Allevyn		1	
Allevyn Adhesive Dressing		1	
Allevyn Ag		1	
Allevyn Ag Adhesive		1	
Allevyn Ag Gentle Dressing		1	
Allevyn Heel		1	
Allevyn Life Dressing		1	
Altera Nebulizer		1	
Altera Nebulizer System		1	
Amielle Vaginal Trainer		1	
Asthmapack Children's		1	
BD Allergist Tray Reg Bevel syringe		1	

Drug Name	Reference	Formulary Tier	Restrictions
BD SafetyGlide Allergist Tray syringe 1 mL 27 x 1/2"		1	
BreatheRite Valved MDI Chamber		2	QL (2 EA per 365 days)
BreatheRite Valved MDI Spacer		2	QL (2 EA per 365 days)
Comp-Air Nebulizer Compressor		1	
Curity AMD		1	
Curity Iodoform Packing Strip		1	
Devilbiss Disposable Nebulizer		1	
DeVilbiss Pulmo-Aide Compressr		1	
Devilbiss Traveler Compressor		1	
EasiVent Holding Chamber		2	QL (2 EA per 365 days)
EasiVent Mask Large		2	QL (2 EA per 365 days)
EasiVent Mask Medium		2	QL (2 EA per 365 days)
EasiVent Mask Small		2	QL (2 EA per 365 days)
Eclipse Syringe syringe 3 mL 21 gauge x 1"		1	
InnoSpire Elegance		1	
InnoSpire Essence		1	
InterLink Syringe and Cannula		1	
LC Plus		1	
LiteAire MDI Chamber		2	QL (2 EA per 365 days)
Magellan Insulin Safety Syrng syringe 0.3 mL 29 x 1/2"		1	
MicroAir Mesh Nebulizer		1	
Mini Plus Nebulizer		1	
Mini Wright Peak Flow Meter		1	
Monoject Control Syringe Luer		1	
Monoject Regular Luer syringe 12 mL		1	
Monoject Safety Syringes syringe 6 mL		1	
Monoject Smartip Cannula syringe 3 mL, 6 mL		1	
Monoject Syringe syringe 6 mL 22 x 1 1/2"		1	

Drug Name	Reference	Formulary Tier	Restrictions
Monoject TB Luer Lok		1	
Optichamber Adult Mask-Large		2	QL (2 EA per 365 days)
OptiChamber Diamond Lg Mask		2	QL (2 EA per 365 days)
OptiChamber Diamond VHC		2	QL (2 EA per 365 days)
OptiChamber Diamond-Med Msk		2	QL (2 EA per 365 days)
OptiChamber Diamond-Sml Mask		2	QL (2 EA per 365 days)
Pari Baby Conv Kit - Size 3		1	
Pari LC Sprint Nebulizer Set		1	
Pari LC Sprint Sinus		1	
Pari Sinus Aerosol System		1	
Pari Trek S Combo Pack		1	
Pari Trek S Compact Compressor		1	
Pen Needle needle 30 gauge x 5/16"		1	
POCKET CHAMBER		2	QL (2 EA per 365 days)
PrimeAire		2	QL (2 EA per 365 days)
Prodigy Mini-Mist Nebulizer		1	
Proneb Ultra II Filter Assem		1	
Replicare Dressing		1	
RepliCare Thin		1	
RepliCare Ultra Dressing		1	
Restore Calcium Alginate topical bandage 4 X 4 3/4 "		1	
Restore topical bandage 1 X 12 ", 2 X 2 "		1	
Sami The Seal		1	
Sidestream		1	
Sidestream Nebulizer		1	
Sidestream Plus		1	
Silicone Mask - Infant		2	QL (2 EA per 365 days)
Sinustar Nebulizer		1	
Spectragel		1	

Drug Name	Reference	Formulary Tier	Restrictions
SurGuard2 Safety syringe 1 mL 26 gauge x 3/8", 1 mL 27 gauge x 1/2", 10 mL 20 gauge x 1 1/2", 10 mL 20 gauge x 1", 10 mL 21 gauge x 1 1/2", 3 mL 20 gauge x 1 1/2", 3 mL 20 gauge x 1", 3 mL 21 gauge x 1", 3 mL 22 gauge x 1 1/2", 3 mL 22 gauge x 1", 3 mL 23 gauge x 1", 3 mL 25 gauge x 1", 3 mL 25 gauge x 5/8", 5 mL 20 gauge x 1 1/2", 5 mL 20 gauge x 1", 5 mL 21 gauge x 1 1/2"		1	
Truzone Peak Flow Meter		1	
Tuberculin Syringe syringe 1 mL 25 gauge x 1"		1	
Vortex Holding Chamber		2	QL (2 EA per 365 days)
Xeroform Petrolatum Dressing topical bandage 5 X 9 "		1	
Muscle Relaxants			
baclofen oral tablet 10 mg, 20 mg		1	
baclofen oral tablet 5 mg		2	QL (3 EA per 1 day)
chlorzoxazone oral tablet 500 mg		1	
cyclobenzaprine oral tablet 10 mg, 5 mg		2	QL (90 EA per 30 days)
dantrolene oral	Dantrium	1	
methocarbamol oral tablet 500 mg		2	QL (8 EA per 1 day)
methocarbamol oral tablet 750 mg		2	QL (6 EA per 1 day)
orphenadrine citrate oral		2	QL (2 EA per 1 day)
tizanidine oral tablet		1	
Pre-Natal Vitamins: OTC pre-natal vitamins are also covered, though not listed here. See OTC section.			
CompleteNate		2	AL (Min 12 Years and Max 50 Years)
KPN oral tablet		2	AL (Min 12 Years and Max 50 Years)
M-Natal Plus		2	AL (Min 12 Years and Max 50 Years)
Mynatal		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)

Drug Name	Reference	Formulary Tier	Restrictions
Mynatal Plus		2	AL (Min 12 Years and Max 50 Years)
Mynatal-Z		2	AL (Min 12 Years and Max 50 Years)
O-Cal Prenatal		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Perry Prenatal		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
PNV 29-1		2	AL (Min 12 Years and Max 50 Years)
PNV cmb#95-ferrous fumarate-FA	Prenatal	2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Prenatabs FA		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Prenatabs Rx		2	AL (Min 12 Years and Max 50 Years)

Drug Name	Reference	Formulary Tier	Restrictions
Prenatal 19		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Prenatal Low Iron		2	AL (Min 12 Years and Max 50 Years)
Prenatal oral tablet 28 mg iron- 800 mcg		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Prenatal Plus		2	AL (Min 12 Years and Max 50 Years)
Prenatal Plus (calcium carb)		2	AL (Min 12 Years and Max 50 Years)
Prenatal Tablet		2	AL (Min 12 Years and Max 50 Years)
Prenatal Vitamin oral tablet 27 mg iron-0.8 mg		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Prenatal Vitamin oral tablet 27 mg iron-800 mcg		2	AL (Min 12 Years and Max 50 Years)
Prenatal Vitamin Plus Low Iron		2	AL (Min 12 Years and Max 50 Years)
Prenatal Vitamin with Minerals		2	AL (Min 12 Years and Max 50 Years)
prenatal vit-iron fum-folic ac	Prenatal Tablet	2	AL (Min 12 Years and Max 50 Years)

Drug Name	Reference	Formulary Tier	Restrictions
prenatal vits96-iron fum-folic		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Prenatal with DHA-Folic Acid		2	AL (Min 12 Years and Max 50 Years)
PrePlus		2	AL (Min 12 Years and Max 50 Years)
Se-Natal 19 Chewable		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
Thrivite Rx		2	AL (Min 12 Years and Max 50 Years)
TriCare		2	AL (Min 12 Years and Max 50 Years)
Psychotherapeutic Drugs			
amitriptyline		1	
atomoxetine	Strattera	2	QL (1 EA per 1 Day)
bupropion HCl oral tablet		2	QL (3 EA per 1 day)
bupropion HCl oral tablet extended release 24 hr 150 mg, 300 mg	Wellbutrin XL	2	QL (1 EA per 1 day)
bupropion HCl oral tablet sustained-release 12 hr	Wellbutrin SR	2	QL (2 EA per 1 day)
buspirone		1	
chlordiazepoxide HCl oral capsule 10 mg, 5 mg		2	QL (4 EA per 1 day)
chlordiazepoxide HCl oral capsule 25 mg		2	QL (120 EA Max Qty Per Fill Retail)
citalopram oral tablet	Celexa	1	
clomipramine oral capsule 25 mg	Anafranil	2	QL (5 EA per 1 day)
clomipramine oral capsule 50 mg	Anafranil	2	QL (4 EA per 1 day)
clomipramine oral capsule 75 mg	Anafranil	2	QL (3 EA per 1 day)
clonidine HCl oral tablet extended release 12 hr	Kapvay	1	

Drug Name	Reference	Formulary Tier	Restrictions
clorazepate dipotassium		2	ST; QL (4 EA per 1 day)
desipramine	Norpramin	1	
desvenlafaxine succinate	Pristiq	2	QL (1 EA per 1 day)
dexmethylphenidate oral capsule,ER biphasic 50-50 10 mg, 15 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg	Focalin XR	2	QL (1 EA per 1 day); AL (Min 6 Years and Max 17 Years)
dexmethylphenidate oral capsule,ER biphasic 50-50 20 mg	Focalin XR	2	QL (1 EA per 1 day)
dexmethylphenidate oral tablet	Focalin	2	QL (60 EA per 1 Month); AL (Min 4 Years and Max 17 Years)
Diazepam Intensol		2	C-1 (CODE-1 RESTRICTION: Limited to members in which tube administration is required); QL (8 ML per 1 day)
diazepam oral concentrate	Diazepam Intensol	2	C-1 (CODE-1 RESTRICTION: Limited to members in which tube administration is required); QL (8 ML per 1 day)
diazepam oral solution		2	C-1 (CODE-1 RESTRICTION: Limited to members in which tube administration is required); QL (40 ML per 1 day)
diazepam oral tablet	Valium	2	QL (4 EA per 1 day)
doxepin oral capsule 10 mg, 100 mg, 25 mg, 50 mg, 75 mg		1	
doxepin oral concentrate		1	
duloxetine oral capsule,delayed release(DR/EC) 20 mg, 30 mg, 60 mg	Cymbalta	1	
escitalopram oxalate oral tablet	Lexapro	1	
fluoxetine oral capsule 10 mg	Prozac	2	QL (8 EA per 1 day)
fluoxetine oral capsule 20 mg	Prozac	2	QL (4 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
fluoxetine oral capsule 40 mg	Prozac	2	QL (2 EA per 1 day)
fluoxetine oral solution		2	QL (20 ML per 1 day)
fluvoxamine oral tablet		1	
guanfacine oral tablet extended release 24 hr	Intuniv ER	1	
imipramine HCl		1	
Lorazepam Intensol		2	C-1 (CODE-1 RESTRICTION: Limited to members in which tube administration is required); QL (4 ML per 1 day)
lorazepam oral concentrate	Lorazepam Intensol	2	C-1 (CODE-1 RESTRICTION: Limited to members in which tube administration is required); QL (4 ML per 1 day)
lorazepam oral tablet	Ativan	2	QL (4 EA per 1 day)
methylphenidate HCl oral capsule, ER biphasic 30-70		2	QL (1 EA per 1 day)
methylphenidate HCl oral capsule,ER biphasic 50-50	Ritalin LA	2	QL (1 EA per 1 day)
methylphenidate HCl oral tablet	Ritalin	2	QL (60 EA per 1 Month); AL (Min 4 Years and Max 17 Years)
methylphenidate HCl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg	Concerta	2	QL (2 EA per 1 day); AL (Min 6 Years and Max 65 Years)
methylphenidate HCl oral tablet extended release 24hr 54 mg	Concerta	2	QL (1 EA per 1 day); AL (Min 6 Years and Max 65 Years)
mirtazapine	Remeron	1	
modafinil	Provigil	2	QL (2 EA per 1 day); AL (Min 18 Years)
nefazodone		2	AL (Min 18 Years)
nortriptyline	Pamelor	1	
oxazepam		2	QL (90 EA per 30 days)

Drug Name	Reference	Formulary Tier	Restrictions
paroxetine HCl oral tablet	Paxil	1	
perphenazine-amitriptyline		1	
protriptyline		1	
sertraline	Zoloft	1	
trazodone oral tablet 100 mg, 150 mg, 50 mg		1	
Trintellix		2	ST; QL (1 EA per 1 day); AL (Min 18 Years)
venlafaxine oral capsule,extended release 24hr	Effexor XR	1	
venlafaxine oral tablet		1	
Viibryd oral tablet 10 mg		2	QL (2 EA per 1 day); AL (Min 18 Years)
Viibryd oral tablet 20 mg, 40 mg		2	QL (1 EA per 1 day); AL (Min 18 Years)
Viibryd oral tablets,dose pack 10 mg (7)- 20 mg (23)		2	QL (1 EA per 1 day); AL (Min 18 Years)
Vyvanse oral capsule		2	QL (1 EA per 1 day); AL (Min 6 Years and Max 17 Years)
Sedative/Hypnotics			
eszopiclone	Lunesta	2	QL (1 EA per 1 day); AL (Min 18 Years)
flurazepam		2	QL (1 EA per 1 day)
phenobarbital		1	
temazepam oral capsule 15 mg	Restoril	2	QL (2 EA per 1 day)
temazepam oral capsule 30 mg	Restoril	2	QL (1 EA per 1 day)
zaleplon		2	QL (1 EA per 1 day); AL (Min 18 Years)
zolpidem oral tablet	Ambien	1	
zolpidem oral tablet,ext release multiphase	Ambien CR	2	QL (1 EA per 1 day); AL (Min 18 Years)
Skin Preps: Also see the OTC section for additional covered topical (skin) products			
acetic acid irrigation		1	
adapalene topical gel 0.3 %	Differin	1	
Ala-Cort topical cream 1 %		1	
alclometasone		1	
Amnesteem		2	QL (2 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
azelaic acid	Finacea	2	QL (50 GM per 1 Fill); AL (Min 18 Years)
betamethasone dipropionate		1	
betamethasone valerate topical cream		1	
betamethasone valerate topical lotion		1	
betamethasone valerate topical ointment		1	
calcipotriene scalp		1	
calcipotriene topical cream	Dovonex	1	
calcipotriene topical ointment		1	
Claravis		2	QL (2 CAPSULES per 1 day)
clindamycin-benzoyl peroxide topical gel 1.2 %(1 % base) -5 %	Neuac	2	QL (45 GM per 1 Fill)
clobetasol scalp		1	
clobetasol topical cream	Temovate	1	
clobetasol topical ointment	Temovate	1	
clobetasol-emollient topical cream		1	
Condylox topical gel		2	C-1 (CODE-1 RESTRICTION: Must have diagnosis of anogenital warts or perianal warts.); QL (3.5 GM Max Qty Per Fill Retail)
desonide topical cream	DesOwen	1	
desonide topical lotion	DesOwen	2	QL (118 ML per 1 Fill)
desonide topical ointment		1	
desoximetasone topical cream 0.25 %	Topicort	2	QL (60 GM per 1 Fill)
Drithocreme HP		1	
Eucerin		1	
Eucerin Original		1	
fluocinolone		1	
fluocinolone and shower cap	Derma-Smoothe/FS Scalp Oil	1	
fluocinonide topical cream 0.05 %		1	

Drug Name	Reference	Formulary Tier	Restrictions
fluocinonide topical cream 0.1 %	Vanos	2	QL (60 GM per 1 Fill); AL (Min 12 Years)
fluocinonide topical gel		1	
fluocinonide topical ointment		1	
fluocinonide topical solution		1	
fluticasone propionate topical cream	Cutivate	2	QL (60 GM per 1 Rx)
fluticasone propionate topical ointment		2	QL (60 GM per 1 Fill); AL (Min 18 Years)
halobetasol propionate topical cream		2	QL (50 GM per 1 Fill)
halobetasol propionate topical ointment		2	QL (50 GM per 1 Fill)
hydrocortisone butyrate topical solution		2	QL (60 ML per 1 Fill)
hydrocortisone topical cream 2.5 %		1	
hydrocortisone topical lotion 2.5 %		1	
hydrocortisone topical ointment 2.5 %		1	
imiquimod topical cream in packet 5 %	Aldara	1	
isotretinoin oral capsule 10 mg, 20 mg, 40 mg	Amnesteem	2	QL (2 EA per 1 day)
isotretinoin oral capsule 30 mg	Claravis	2	QL (2 EA per 1 day)
Kenalog topical		1	
metronidazole topical cream	MetroCream	1	
metronidazole topical gel	Metrogel	1	
Minerin		1	
mometasone topical		1	
Myorisan		2	QL (2 CAPSULES per 1 day)
neomycin-polymyxin B GU		1	
podofilox		2	C-1 (CODE-1 RESTRICTION: Must have diagnosis of genital warts.); QL (3.5 ML per 1 Fill)
prednicarbate topical cream		1	
prednicarbate topical ointment		2	QL (60 GM per 1 Fill)
Procto-Pak		1	

Drug Name	Reference	Formulary Tier	Restrictions
Santyl		1	
selenium sulfide topical lotion		1	
tretinoin topical cream	Retin-A	2	QL (45 GM per 30 days); AL (Max 39 Years)
tretinoin topical gel 0.01 %	Retin-A	2	QL (45 GM per 30 days); AL (Max 39 Years)
tretinoin topical gel 0.025 %	Avita	2	QL (45 GM per 30 days); AL (Max 39 Years)
triamcinolone acetonide topical cream	Triderm	1	
triamcinolone acetonide topical lotion		1	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %		1	
Triderm topical cream 0.1 %		1	
urea topical cream 40 %		2	QL (85 GM per 1 Fill)
Xalix topical film-soln 28%		1	
Zenatane		2	QL (2 caps per 1 day
Smoking Deterrents (see OTC section for nicotine replacement products)			
bupropion HCl (smoking deter)		2	QL (2 EA per 1 day)
Thyroid Preps			
Armour Thyroid oral tablet 120 mg, 15 mg, 180 mg, 30 mg, 60 mg, 90 mg		1	
Armour Thyroid oral tablet 240 mg, 300 mg		2	QL (1 EA per 1 day)
levothyroxine oral tablet	Euthyrox	1	
liothyronine oral	Cytomel	1	
methimazole oral tablet 10 mg, 5 mg	Tapazole	1	
NP Thyroid oral tablet 30 mg, 60 mg, 90 mg		1	
propylthiouracil		1	
Westhroid oral tablet 130 mg, 32.5 mg, 65 mg, 97.5 mg		1	
Westhroid oral tablet 195 mg		2	QL (1 EA per 1 day)
Unclassified Drug Products			
Acetadote (acetylcysteine 200 mg/ml IV vial		3	PA

Drug Name	Reference	Formulary Tier	Restrictions
alendronate oral solution		2	C-1 (CODE-1 RESTRICTION: limited to members unable to swallow tablets.)
alendronate oral tablet 10 mg, 5 mg		1	
alendronate oral tablet 35 mg		2	QL (4 EA per 28 days)
alendronate oral tablet 70 mg	Fosamax	2	QL (4 EA per 28 days)
alfuzosin	Uroxatral	2	AL (Min 35 Years)
Bacteriostatic Water(Parabens)		1	
Carnitor (sugar-free)		1	
Cetylcide II Concentrate		2	QL (15 ML per 30 days)
Chemet		2	C-1 (CODE-1 RESTRICTION: Restricted to treatment of documented lead poisoning, with blood lead level greater than 45mcg/dl.); QL (103 EA Max Qty Per Fill Retail)
chlorhexidine gluconate mucous membrane	Periogard	1	
cinacalcet oral tablet 30 mg	Sensipar	2	C-1 (CODE-1 RESTRICTION: Restricted to Primary or Secondary hyperparathyroidism or hypercalcemia in presence of parathyroid cancer. In CKD/secondary disease, must be on dialysis.); QL (1 EA per 1 day); AL (Min 18 Years)
cinacalcet oral tablet 60 mg	Sensipar	2	QL (2 EA per 1 day); AL (Min 18 Years)

Drug Name	Reference	Formulary Tier	Restrictions
cinacalcet oral tablet 90 mg	Sensipar	2	C-1 (CODE-1 RESTRICTION: Restricted to Primary or Secondary hyperparathyroidism or hypercalcemia in presence of parathyroid cancer. In CKD/secondary disease, must be on dialysis.); QL (2 EA per 1 day); AL (Min 18 Years)
darifenacin oral tablet extended release 24 hr 15 mg		2	ST; QL (1 Tablet per 1 day); AL (Min 18 Years)
darifenacin oral tablet extended release 24 hr 7.5 mg		2	ST; QL (1 tablet per 1 day); AL (Min 18 Years)
deferasirox oral tablet, dispersible	Exjade	3	PA
doxercalciferol intravenous	Hectorol	1	
doxercalciferol oral capsule 0.5 mcg, 2.5 mcg		1	
doxycycline hyclate oral tablet 20 mg		2	QL (2 EA per 1 day); AL (Min 18 Years)
dutasteride	Avodart	1	
finasteride oral tablet 5 mg	Proscar	1	
ibandronate oral	Boniva	2	QL (1 EA per 28 days)
leucovorin calcium injection recon soln		1	
leucovorin calcium oral		1	
levocarnitine (with sugar)	Carnitor	1	
levocarnitine oral solution 1 gram/10 mL	Acticarnitine SF	1	
magnesium hydroxide (bulk)		1	
megestrol oral suspension 400 mg/10 mL (40 mg/mL)		2	QL (20 ML per 1 day)
Mesnex oral		1	
oxybutynin chloride oral syrup		1	
oxybutynin chloride oral tablet		1	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	Ditropan XL	2	QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
oxybutynin chloride oral tablet extended release 24hr 15 mg		2	QL (2 EA per 1 day)
pamidronate intravenous solution 60 mg/10 mL (6 mg/mL)		1	
paricalcitol	Zemplar	1	
Periogard		1	
Pulmozyme		2	C-1 (CODE-1 RESTRICTION: Limited to members with a documented diagnosis of Cystic Fibrosis, and when prescribed by a board certified pulmonologist.); QL (2 Doses per 1 day)
raloxifene	Evista	1	
risedronate oral tablet 35 mg	Actonel	2	QL (4 EA per 28 days)
Savella		2	ST; QL (2 EA per 1 day); AL (Min 18 Years)
Shingrix Adjuvant Component-PF		2	QL (2 DOSES per 1 LIFETIME); AL (Min 50 Years)
sodium chlor 0.9% bacteriostat		1	
sodium chloride inhalation	NebuSal	1	
solifenacin	Vesicare	1	
Sterile Water for Injection		1	
tamsulosin	Flomax	1	
tolterodine oral capsule,extended release 24hr	Detrol LA	2	QL (1 EA per 1 day)
tolterodine oral tablet	Detrol	2	QL (2 Tablets per 1 day)
triamcinolone acetonide dental	Oralone	1	
trospium oral capsule,extended release 24hr		2	QL (1 EA per 1 day)
trospium oral tablet		2	QL (2 EA per 1 day)
water for inject, bacteriostat		1	
water for injection, sterile injection solution	Sterile Water for Injection	1	
water for injection, sterile intravenous		1	

Drug Name	Reference	Formulary Tier	Restrictions
Vitamins: Also see the OTC section for additional covered items			
ANIMAL CHEWS		2	AL (Max 2 Years)
Animal Shape Vitamins		2	AL (Max 8 Years)
AquADEKs		2	C-1 (CODE-1 RESTRICTION: Limited to members with Cystic Fibrosis, &/or members with CCS, GHPP or EPSDT.)
AquADEKs Pediatric		2	C-1 (CODE-1 RESTRICTION: Limited to members with Cystic Fibrosis, &/or members with CCS, GHPP or EPSDT.)
calcitriol intravenous solution 1 mcg/mL		1	
calcitriol oral capsule	Rocaltrol	1	
Children's Chew Multivitamin		2	AL (Max 7 Years)
Children's Chewable Vitamin		2	AL (Max 8 Years)
cholecalciferol (vitamin D3) oral capsule 1,250 mcg (50,000 unit)	D3-50 Cholecalciferol	2	QL (1 EA per 1 Week)
cholecalciferol (vitamin D3) oral capsule 10 mcg (400 unit), 25 mcg (1,000 unit)	Vitamin D3	2	QL (2 EA per 1 day)
cholecalciferol (vitamin D3) oral capsule 125 mcg (5,000 unit)	Dialyvite Vitamin D	2	QL (1 EA per 1 day)
cholecalciferol (vitamin D3) oral capsule 250 mcg (10,000 unit)	IS-D-10,000	2	QL (1 EA per 1 day)
cholecalciferol (vitamin D3) oral capsule 50 mcg (2,000 unit)	D3-2000	2	QL (2 EA per 1 day)
cholecalciferol (vitamin D3) oral drops 125 mcg/mL (5,000 unit/mL)		1	
cholecalciferol (vitamin D3) oral tablet 10 mcg (400 unit)	Delta D3	2	QL (2 EA per 1 day)
cholecalciferol (vitamin D3) oral tablet 125 mcg (5,000 unit)	Vitamin D3	2	QL (1 EA per 1 day)
cholecalciferol (vitamin D3) oral tablet 25 mcg (1,000 unit)	Vitamin D3	2	QL (2 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
cholecalciferol (vitamin D3) oral tablet 250 mcg (10,000 unit), 75 mcg (3,000 unit)		2	QL (1 EA per 1 day)
cholecalciferol (vitamin D3) oral tablet 50 mcg (2,000 unit)	D3 DOTS	2	QL (2 EA per 1 day)
cholecalciferol (vitamin D3) oral tablet,chewable	Vitamin D3	2	QL (2 EA per 1 day)
cholecalciferol (vitamin D3) oral tablet,disintegrating		2	QL (1 EA per 1 day)
cholecalciferol (vitamin D3) sublingual		1	
cyanocobalamin (vitamin B-12) injection		1	
cyanocobalamin (vitamin B-12) oral capsule 5,000 mcg		1	
cyanocobalamin (vitamin B-12) oral tablet 1,000 mcg	Vitamin B-12	2	QL (2 EA per 1 day)
cyanocobalamin (vitamin B-12) oral tablet 2,000 mcg		2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 2 days)
cyanocobalamin (vitamin B-12) oral tablet 2,500 mcg		2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 1 day)
cyanocobalamin (vitamin B-12) oral tablet 500 mcg	B-12 DOTS	2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 3 days)
cyanocobalamin (vitamin B-12) oral tablet,chewable 2,500 mcg		2	C-1 (CODE-1 RESTRICTION: For treatment of B12 deficiency.); QL (2 EA per 1 day)
cyanocobalamin (vitamin B-12) oral tablet,disintegrating		2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
cyanocobalamin (vitamin B-12) sublingual tablet 1,000 mcg, 500 mcg		2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 1 day)
cyanocobalamin (vitamin B-12) sublingual tablet 2,500 mcg	Vitamin B-12	2	C-1 (CODE-1 RESTRICTION: Prevention o rtreatment of B12 deficiency.); QL (2 EA per 1 day)
cyanocobalamin (vitamin B-12) sublingual tablet 3,000 mcg		2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 4 days)
cyanocobalamin (vitamin B-12) sublingual tablet,disintegrating		2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 1 day)
cyanocobalamin-cobamamide	B-12 Plus	2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 1 day)
D3 DOTS		2	QL (2 EA per 1 day)
D3-2000		2	QL (2 EA per 1 day)
D3-50 Cholecalciferol		2	QL (1 EA per 1 Week)
Delta D3		2	QL (2 EA per 1 day)
Dialyvite		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only. For ages 20 years and younger: CCS review/referral required.)

Drug Name	Reference	Formulary Tier	Restrictions
Dialyvite 800 oral tablet		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
D-Vi-Sol		1	
Endur-Acin oral tablet extended release 250 mg, 500 mg		1	
ergocalciferol (vitamin D2) oral capsule 1,250 mcg (50,000 unit)	Vitamin D2	2	QL (8 EA per 28 days)
ergocalciferol (vitamin D2) oral tablet 10 mcg (400 unit)		2	QL (2 EA per 1 day)
ergocalciferol (vitamin D2) oral tablet 50 mcg (2,000 unit)		1	
Folbee Plus oral tablet 5 mg		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
folic acid injection		1	
folic acid oral tablet 400 mcg, 800 mcg		1	
Full Spectrum B-Vitamin C		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Little Animals		1	
mecobalamin (vitamin B12) oral tablet,disintegrating		2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 1 day)
mecobalamin (vitamin B12) sublingual		2	C-1 (CODE-1 RESTRICTION: Prevention ortreatment of B12 deficiency.); QL (2 EA per 1 day)
Multi-Vit with Fluoride-Iron		2	AL (Max 8 Years)

Drug Name	Reference	Formulary Tier	Restrictions
Multi-Vitamin With Fluoride oral tablet,chewable		2	AL (Max 7 Years)
Mynephrocaps		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Mynephron		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Nephplex Rx		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Nephronex-SL		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Nephro-Vite		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Nephro-Vite Rx		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
niacin oral capsule, extended release		1	
niacin oral tablet 100 mg, 250 mg, 50 mg		1	
niacin oral tablet extended release	Endur-Acin	1	
niacinamide oral tablet	Niacin (niacinamide)	1	
Pedia Poly-Vite with Iron oral drops		2	AL (Min 1 Days and Max 7 Years)

Drug Name	Reference	Formulary Tier	Restrictions
phytonadione (vitamin K1) oral tablet 5 mg	Mephyton	2	QL (2 EA per 1 day); AL (Min 18 Years)
PNV-DHA		2	AL (Min 12 Years and Max 50 Years)
Poly-Vi-Sol oral drops		2	AL (Min 1 Days and Max 7 Years)
Poly-Vi-Sol with Iron		2	AL (Min 1 Days and Max 7 Years)
Poly-Vita With Iron		2	AL (Min 1 Days and Max 7 Years)
Prenatal-U		2	C-1 (CODE-1 RESTRICTION: Limited to use during pregnancy or lactation. Not all formulations are covered and must use a generic product.)
pyridoxine (vitamin B6) injection		1	
pyridoxine (vitamin B6) oral tablet	Vitamin B-6	1	
Renal Caps		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Renal Vitamin		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Renal-Vite		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)

Drug Name	Reference	Formulary Tier	Restrictions
Rena-Vite		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Rena-Vite Rx		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Reno Caps		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Thera-D		2	QL (2 EA per 1 day)
thiamine HCl (vitamin B1) injection		1	
thiamine HCl (vitamin B1) oral tablet 100 mg, 50 mg	Vitamin B-1	2	C-1 (CODE-1 RESTRICTION: Prevention or treatment of thiamine deficiency during pregnancy, lactation, alcoholism, gastric surgery or severe liver disease.)
thiamine HCl (vitamin B1) oral tablet 250 mg	Vitamin B-1	2	C-1 (CODE-1 RESTRICTION: Prevention or treatment of thiamine deficiencyduring pregnancy, lactation, alcoholism, gastricsurgery or severe liver disease.)

Drug Name	Reference	Formulary Tier	Restrictions
thiamine HCl (vitamin B1) oral tablet 500 mg		2	C-1 (CODE-1 RESTRICTION: Prevention or treatment of thiamine deficiencyduring pregnancy, lactation, alcoholism, gastricsurgery or severe liver disease.)
Triphrocaps		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only. For ages 20 years and younger: CCS review/referral required.)
Tri-Vi-Sol		2	AL (Min 1 Days and Max 7 Years)
Tri-Vitamin With Fluoride		2	AL (Max 7 Years)
Virt-Caps		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only.)
Virt-PN DHA		2	AL (Min 12 Years and Max 50 Years)
Vitamin B-1 oral tablet 50 mg		2	C-1 (CODE-1 RESTRICTION: Prevention or treatment of thiamine deficiency during pregnancy, lactation, alcoholism, gastric surgery or severe liver disease.)
Vitamin B-6 oral tablet		1	
Vitamin D2		2	QL (8 EA per 28 days)
Vitamin D3 oral capsule 10 mcg (400 unit)		2	QL (1 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
Vitamin D3 oral capsule 25 mcg (1,000 unit), 50 mcg (2,000 unit)		2	QL (2 EA per 1 day)
Vitamin D3 oral tablet 10 mcg (400 unit), 25 mcg (1,000 unit), 50 mcg (2,000 unit)		2	QL (2 EA per 1 day)
Vitamin D3 oral tablet 125 mcg (5,000 unit)		2	QL (1 EA per 1 day)
Vitamin D3 oral tablet,chewable		2	QL (1 EA per 1 day)
vitamin K		1	
Vitamin K1 injection		1	
Vitamins A,C,D and Fluoride oral drops 0.25 mg fluor. (0.55 mg)/mL		2	AL (Max 7 Years)
VP-Vite Rx		2	C-1 (CODE-1 RESTRICTION: Limited to hemodialysis and peritoneal dialysis patients only. For ages 20 years and younger: CCS review/referral required.)
Zatean-Pn DHA		2	AL (Min 12 Years and Max 50 Years)

Medical Benefit

Drug Name	Reference	Formulary Tier	Restrictions
Abraxane		2	AL (Min 19 Years)
acetylcysteine		1	
Alimta intravenous recon soln 500 mg		2	
amphotericin B		1	
ampicillin-sulbactam	Unasyn	1	
Aristospan Intra-Articular		1	
Aristospan Intralesional		1	
atropine injection solution		1	
aztreonam	Azactam	1	
Bicillin C-R		1	
Bicillin L-A intramuscular syringe 1,200,000 unit/2 mL		2	QL (2 ML per 30 days)
Bicillin L-A intramuscular syringe 2,400,000 unit/4 mL		2	QL (4 ML per 30 days)
Bicillin L-A intramuscular syringe 600,000 unit/mL		2	QL (1 ML per 30 days)
bleomycin		1	
bupivacaine (PF) injection solution 0.5 % (5 mg/mL)	Marcaine (PF)	1	
bupivacaine (PF) injection solution 0.75 % (7.5 mg/mL)	Sensorcaine-MPF	1	
bupivacaine HCl injection solution 0.5 % (5 mg/mL)	Marcaine	1	
bupivacaine-epinephrine	Sensorcaine-Epinephrine	1	
bupivacaine-epinephrine (PF)	Marcaine-Epinephrine (PF)	1	
butorphanol injection		1	
calcium chloride		1	
carboplatin		1	
Cathflo Activase		1	
cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 mL		1	
cefazolin injection recon soln 1 gram, 10 gram, 20 gram, 500 mg		1	
cefazolin intravenous		1	
cefepime injection		1	
cefotaxime injection recon soln 1 gram		1	
cefotetan		1	

Drug Name	Reference	Formulary Tier	Restrictions
cefoxitin		1	
ceftazidime	Tazicef	1	
ceftriaxone in dextrose,iso-os		1	
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg		1	
ceftriaxone intravenous		1	
cefuroxime sodium injection recon soln 750 mg		1	
cisplatin intravenous solution		1	
cladribine		1	
Claforan intravenous recon soln		1	
clindamycin phosphate injection	Cleocin	1	
Clolar		1	
cyclophosphamide intravenous recon soln		1	
cytarabine		1	
cytarabine (PF)		1	
D10 %-0.45 % sodium chloride		1	
D2.5 %-0.45 % sodium chloride		1	
D5 % and 0.9 % sodium chloride		1	
D5 %-0.45 % sodium chloride		1	
dacarbazine		1	
daunorubicin intravenous solution		1	
deferoxamine injection recon soln 500 mg	Desferal	1	
Demerol (PF) injection syringe		1	
Depo-Estradiol		1	
Depo-Medrol injection suspension 20 mg/mL		1	
dexamethasone sodium phos (PF) injection solution		1	
dextrose 10 % and 0.2 % NaCl		1	
dextrose 10 % in water (D10W)		1	
dextrose 5 % in water (D5W)		1	
dextrose 5 %-lactated ringers		1	
dextrose 5%-0.2 % sod chloride		1	
dextrose 5%-0.3 % sod.chloride		1	
dextrose 50 % in water (D50W) intravenous parenteral solution		1	

Drug Name	Reference	Formulary Tier	Restrictions
dextrose 70 % in water (D70W)		1	
dimenhydrinate injection solution		1	
dobutamine in D5W intravenous parenteral solution 1,000 mg/250 mL (4,000 mcg/mL), 250 mg/250 mL (1 mg/mL), 500 mg/250 mL (2,000 mcg/mL)		1	
dobutamine intravenous solution 250 mg/20 mL (12.5 mg/mL)		1	
dopamine intravenous solution		1	
Dover Red Rubber Robinson Cath		1	
doxapram	Dopram	1	
doxorubicin intravenous solution	Adriamycin	1	
droperidol injection solution		1	
epirubicin intravenous solution 50 mg/25 mL	Ellence	1	
Erbitux		1	
etoposide	Toposar	2	AL (Min 19 Years)
Female Catheter		1	
floxuridine		1	
fludarabine intravenous solution		2	
Fortaz injection recon soln 500 mg		1	
ganciclovir sodium intravenous recon soln	Cytovene	1	
gemcitabine intravenous recon soln 1 gram		1	
gentamicin sulfate (ped) (PF)		1	
Hep Flush-10 (PF)		1	
heparin (porcine) injection cartridge		1	
heparin (porcine) injection solution		1	
heparin flush(porcine)-0.9NaCl		1	
heparin lock flush (porcine)		1	
heparin, porcine (PF) injection solution 1,000 unit/mL		1	
heparin, porcine (PF) injection syringe 5,000 unit/0.5 mL		1	
heparin, porcine (PF) intravenous solution 100 unit/mL (1 mL)		1	
heparin, porcine (PF) intravenous syringe 10 unit/mL	Heparin LockFlush(Porcine)(PF)	1	

Drug Name	Reference	Formulary Tier	Restrictions
HyperRHO S/D		2	AL (Min 19 Years)
idarubicin	Idamycin PFS	1	
ifosfamide intravenous recon soln	Ifex	1	
Infuvite Pediatric		2	AL (Max 7 Years)
ketorolac injection		1	
lactated Ringers irrigation		1	
lidocaine HCl injection solution 10 mg/mL (1 %)	Xylocaine	1	
lidocaine-epinephrine	Xylocaine with Epinephrine	1	
lorazepam injection	Ativan	1	
M.V.I. Pediatric		1	
magnesium chloride injection		1	
magnesium sulfate in D5W intravenous piggyback 1 gram/100 mL		1	
magnesium sulfate in water		1	
magnesium sulfate injection		1	
mannitol 10 %	Osmitrol 10 %	1	
mannitol 20 %	Osmitrol 20 %	1	
mannitol 5 %	Osmitrol 5 %	1	
Marcaine injection solution 0.25 % (2.5 mg/mL)		1	
Marcaine-Epinephrine injection solution 0.5 %-1:200,000		1	
melphalan HCl	Alkeran (as HCl)	1	
meperidine (PF) injection solution 100 mg/mL, 25 mg/mL, 50 mg/mL		1	
meperidine injection cartridge		1	
mesna	Mesnex	1	
methylergonovine injection		1	
methylprednisolone acetate	Depo-Medrol	1	
methylprednisolone sodium succ injection recon soln 125 mg, 40 mg		1	
methylprednisolone sodium succ intravenous recon soln 1,000 mg	Solu-Medrol	1	
metoclopramide HCl injection		1	
Minocin intravenous		1	
mitomycin intravenous recon soln 20 mg	Mutamycin	2	QL (3 EA per 1 day)

Drug Name	Reference	Formulary Tier	Restrictions
mitomycin intravenous recon soln 40 mg	Mutamycin	1	
mitomycin intravenous recon soln 5 mg	Mutamycin	2	
mitoxantrone		2	AL (Min 19 Years)
morphine injection solution 8 mg/mL		1	
nafcillin		1	
nafcillin in dextrose iso-osm		1	
Nesacaine injection solution 10 mg/mL (1 %)		1	
Nesacaine-MPF injection solution 20 mg/mL (2 %)		1	
Osmitrol 15 %		1	
oxacillin		1	
oxacillin in dextrose(iso-osm)		1	
oxaliplatin intravenous recon soln		1	
oxaliplatin intravenous solution 100 mg/20 mL, 50 mg/10 mL (5 mg/mL)		1	
oxytocin injection solution	Pitocin	1	
paclitaxel		2	AL (Min 19 Years)
pamidronate intravenous recon soln		1	
penicillin G pot in dextrose		1	
penicillin G procaine intramuscular syringe 600,000 unit/mL		1	
penicillin G sodium		1	
phenobarbital sodium injection solution		1	
phenylephrine HCl injection	Vazculep	1	
Photofrin		1	
physostigmine salicylate		1	
phytonadione (vitamin K1) injection syringe		1	
piperacillin-tazobactam		1	
Pitocin		1	
Polocaine injection solution		1	
Polocaine-MPF		1	
potassium chlorid-D5-0.45%NaCl		1	
potassium chloride in 5 % dex intravenous parenteral solution 20 mEq/L		1	

Drug Name	Reference	Formulary Tier	Restrictions
potassium chloride in water intravenous piggyback		1	
potassium chloride intravenous		1	
potassium phosphate m-/d-basic intravenous solution 3 mmol/mL		1	
progesterone		1	
Prograf intravenous		1	
Proleukin		2	
proparacaine	Alcaine	1	
protamine		1	
Provisc		1	
Quelicin injection solution		1	
Robinson Clear Vinyl Catheter		1	
rocuronium		1	
Self-Catheter, Female 14 Fr		1	
Sensorcaine injection solution 0.25 % (2.5 mg/mL)		1	
Sensorcaine-Epinephrine		1	
Sensorcaine-MPF injection solution 0.75 % (7.5 mg/mL)		1	
Sensorcaine-MPF/Epinephrine injection solution 0.25 %-1:200,000, 0.75 %-1:200,000		1	
sodium bicarbonate intravenous solution 1 mEq/mL (8.4 %)		1	
sodium chloride 0.9 %		1	
sodium chloride intravenous		1	
Solu-Medrol intravenous recon soln 2 gram		1	
Tazicef		1	
Toposar		1	
topotecan intravenous recon soln	Hycamtin	1	
TOUCH-TROL		1	
vancomycin intravenous recon soln 1,000 mg, 10 gram, 5 gram		1	
vecuronium bromide		1	
Velcade		1	
Vidaza		2	
vinorelbine	Navelbine	1	

Drug Name	Reference	Formulary Tier	Restrictions
Xylocaine-MPF/Epinephrine injection solution 1 %-1:200,000		1	
Zanosar		2	
Zoladex		1	
zoledronic acid intravenous solution		2	C-1 (CODE-1 RESTRICTION: Restricted to (1) Hypercalcemia my malignancy, (2) Multiple Myeloma, or (3) Bone metastases from solid tumors. Quantity limit of 1 vial per fill and a minimum of 7 days between fills.)
zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 mL	Reclast	2	C-1 (CODE-1 RESTRICTION: Treatment or prevention of osteoporosis, or for the treatment of paget's disease); QL (100 ML per 1 Fill)

APPENDIX A:
Prior Authorization: Treatment Authorization Requests (TAR)

I. Non-formulary drugs with established criteria (requirements) for use:

a. The criteria established for non-formulary drugs are **not** included in this document, as this formulary guide includes formulary drugs only (drugs on PHC's covered drug list). For non-formulary drugs, please use the Formulary Search Tool on the PHC website to find TAR requirements, or use one of PHCs criteria documents shown below.

i. The PHC formulary search tool is located at: https://client.formularynavigator.com/Search.aspx?siteCode=9588242881

ii. The PHC TAR Criteria table is located at: http://www.partnershiphp.org/Providers/Pharmacy/Documents/Pharmacy%202019%20documents/PA%20Criteria%20Table%202020.pdf

iii. Requests for use that is not included in the criteria documents, such as off-label indications or dosing, shall be reviewed and considered for medical necessity on a case-by-case basis, following the outlined guidelines in section II.b.i. and section III, below.

II. Non-formulary drugs without established criteria (requirements):

a. Non-Listed (and non-formulary) Drug Requests -- Drugs without established criteria and not on formulary are **not** included in this document. In addition, such drugs *may not* be found in the Search Tool. If there is no PHC information yet assigned to a drug, the Formulary Navigator™ Search Tool will return the search request as "Not Listed".

b. Any drug that does not have established criteria, regardless of the Search Tool classification being Not Listed (NL) or Non-Formulary (NF), will be considered on a case-by-case basis through the prior authorization process (TAR/treatment authorization request), as long as the drug is FDA approved and not excluded from coverage by State or Federal regulation, amendment, contractural requirements with the Department of Health Care Services (DHCS) or other legal citation (see section of this document called "Plan Exclusions" for more details).

i. Case-by-case means that the medical necessity of the specific product for the individual member on a submitted TAR will be reviewed by considering the member's own medical history, such as:medication allergies, disease history, treatment history, concurrent medications, and concurrent disease state(s) in combination, as well as the prescriber's area of expertise or scope of practice. In addition, case-by-case consideration will take into account the availability of preferred alternative treatments (whether formulary or non-formulary) which should be tried first, nature offailure with preferred alternatives, effectiveness of preferred alternatives, as well as established guidelines found in either the package labeling or clinical or policy resources such as:

1. When a drug does not have established criteria, the TAR request for the drug will be reviewedand approved or denied based on FDA approved indications, national treatment guidelines, equivalent therapeutic alternatives, cost effectiveness, &/or PHC policies that have specific guidance on coverage of drug therapies. Examples of coverage policies used in medical determinations include (but are not limited to): Policy MPRP4033 - Brand Name Requests, orPolicy MPRP4049 – Chronic Opioid Therapy in Chronic Non-Cancer Pain.
2. In addition, the plan may use other industry-standard clinical resources, including (but notlimited to): Lexi-Drug, Elsevier/Gold Standard Clinical Pharmacology, NCCN (National Comprehensive Cancer Network), UpToDate and Facts and Comparisons.

c. Trial of formulary alternatives: There is no set number of medications on the formulary that must be tried before a non-formulary medication can be approved, because it depends on each drug, as to how many treatment alternatives are available, the pharmacologic and therapeutic similarities between the different treatments, and also depends greatly on the member's reason for failure withany alternatives that have been tried. Sometimes there are numerous alternatives for a particular drug, and other times only one or two. The number of trials required will be based on the clinicaljudgement of the physician or clinical pharmacist reviewer.

d. Clinical documentation or laboratory evidence supporting an established contraindication to preferred treatment alternative(s) may be required for those who are unable to use preferred alternative(s).

III. Off-Label (Unlabeled) Uses:

a. The regulatory body that oversees Medi-Cal programs, DHCS (California Department of Health Care Services) has issued the following regarding the use of FDA-approved drugs for indications (diseases or conditions) that have not been approved for use by the FDA:

> Per Title 22 CCR 51313 (4) Authorization for unlabeled use of drugs shall not be granted unless the requested unlabeled use represents reasonable and current prescribing practices. The determination of reasonable and current prescribing practices shall be based on:
>
> (A) Reference to current medical literature.
>
> (B) Consultation with provider organizations, academic and professional specialists.
>
> Off-label use of medications not approved by the FDA for the diagnosis in question is not covered unless:
>
> - FDA approved alternatives have first been medically ruled out (cannot be used in a particular situation for medical reasons such as allergy, serious drug interactions, previous adverse effects, or other contraindications).
> - There are no FDA approved alternatives and the medication requested is the least costly treatment that is demonstrated to be possibly effective in treating the diagnosed condition.
>
> This is a reminder that only medication [services] approved by the FDA for the indication listed as the diagnosis can be [reimbursed], unless the use of that drug can be medically ruled out. Off-label use has been the source of lawsuits, manufacturer prosecution from the DOJ, and manufacturer disputes of rebates.

I. Self-Administered Medications:

Drugs that are FDA approved for self-administration, including injectables designated as self-injectable, are coverable as a pharmacy benefit when applicable prior authorization criteria is met, unless otherwise excluded from coverage. Exclusions include (but are not limited to), treatment of erectile or other sexual dysfunction, fertility, cosmetic use, dietary supplements, and those drugs carved-out to State Medi-Cal. Oral, topical, nasal, and self-injected medications must be provided to the member by a pharmacy and billed as a pharmacy benefit rather than a medical office or clinic billing as a medical benefit whenever possible. If a member requires training or observation of the first dose, and that dose will be direct billed to PHC as a medical drug claim, a Treatment Authorization Request (TAR) can be submitted to PHC for medical coverage of the initial dose (applicable criteria for use must be met); in addition to clinical criteria documentation, the TAR should also include reasons why the member is unable to obtain the product from a pharmacy.

II. TAR Submission (Prior Authorization):

a. TARs may be submitted to the plan using form that can be printed and faxed, or through Partnership's pharmacy "ePA" system for online TAR submission (aka Partnership HealthPlan PAS).
b. TAR forms require information that must be supplied directly to the plan by the member's providers (both pharmacy and prescribing providers).
c. Members can request that a TAR be started for them through the PHC Member Portal.
d. General information on what needs to be included on a TAR is included in the introductory materials at the beginning of the formulary (page 49, Key TAR Components). Specific information needed on a TAR is in the criteria documents, when a drug has criteria.

IV. Drugs on Formulary, with PA Requirement (F-PA):

Drugs in this section are on the formulary as being preferred over non-formulary drugs in same class; however, clinical criteria have been established for use. Please submit TARs which include documentation showing the criteria for use is met, or evidence from the medical record that indicates an exception to the criteria is medically necessary.

F-PA Drugs (click on a drug to navigate to the criteria within this document)

Important – Read* Criteria Field Definitions and Examples *first, before viewing drug-specific criteria:

• Requirements for Adalimumab (Humira)	• Requirements for Golimumab IV vials (Simponi Aria)
• Requirements for Carbidopa-levodopa Disintegrating Tablet (Parcopa)	• Requirements for Golimumab Subcutaneous Prefilled Syringes and Pens (Simponi)
• Requirement for Certolizumab Pegol (Cimzia)	• Requirements for Hydroxyprogesterone Caproate (Makena)
• Requirements for Deferasirox (Exjade)	• Requirements for Lifitegrast (Xiidra)
• Requirements for Elbasvir/Grazoprevir (Zepatier) and Sofosbuvir-Velpatasvir (Epclusa)	• Requirements for Pegfilgrastim-jmdb (Fulphila) and Pegfilgrastim-cbqv (Udenyca)
	• Requirements for Rasagiline (Azilect)
• Requirements for Etanercept (Enbrel)	• Requirements for Testosterone Gel (Testim, Vogelxo) and Testosterone Cypionate Intramuscular Oil)
• Requirements for Fentanyl Transdermal Patches (50, 75, & 100mcg/24 hr)	• Requirements for Testosterone Transdermal Patch (Androderm) and Testosterone Gel (Androderm)
• Requirements for Filgrastim-aafi (Nivestym) and Filgrastim-sndz (Zarxio)	• Requirements for Tobramycin, nebulizer sol. (Tobi & Kitabis Pak)
• Requirements for Tbo-Filgrastim (Granix)	• Requirements for Tofacitinib (Xeljanz, Xeljanz XR)
• Requirements for Growth Hormone (Norditropin)	• Requirements for Vigabatrin (Sabril) tablet, packet

APPENDIX B: Understanding PHC TAR Criteria Format

Criteria Field Definitions and Examples

Field	Description	Examples – ***including, but not limited to***:
Group Description	This is the name of the TAR/PA criteria document. One PA Group can apply to multiple drugs which have the same expected uses.	The group description will include the drugs which the criteria apply to, whenever space allows. Example: *Requirements for mesalamine (Apriso, Delzicol, Pentasa).* Names that would be too long may be shortened and in that case, not all drugs covered by the criteria would be in the title, or perhaps a drug class is used in the title instead of drug names.
Covered Use(s)	Diagnoses for which coverage is considered.	Tadalafil (generic for either Adcirca or Cialis): For Adcirca, the only covered use is pulmonary hypertension. For Cialis, PHC only approves (when requirements are met) when the reason for use benign prostatic hypertrophy (enlarged prostate). The Covered use section may or may not include all FDA approved uses, depending on PHC established criteria for use.
Exclusion Criteria	Reasons for non-approval even if other criteria is met.	Being opiate naïve is a reason to deny a request for fentanyl patches, since that is a contraindication for use.
Required Medical Information	Information from medical chart or record that should be submitted with the TAR.	Clinic notes, lab reports or other medical documentation as required by specific drug criteria.
Age Restriction	Limited age(s) based on FDA approved use; additional justification may be required for use outside of age restriction.	Drugs such as those not FDA approved for use in the pediatric population would have an age limit of >/= 18yrs. The plan recognizes that there may be instances in which a member <18 requires treatment, and those cases would be reviewed on a case-by-case basis with information provided in the TAR request regarding need for exception to the age criteria.
Prescriber Restriction	When limited to use by certain specialist(s); additional justification may be required for use by non-specialist.	Drugs to treat rheumatoid arthritis being limited to rheumatologists.
Coverage Duration	The maximum duration a *TAR* may be approved for in a single review instance.	Adalimumab is limited on the first TAR approval to 3 months' duration. Upon renewal, when efficacy & tolerability is established, subsequent TARs may be approved for up to 12 months before a renewal is needed. At least annual renewal is required for most TARs (if not sooner when specified in the criteria).
Other Criteria	Additional or general requirements not listed in the other sections.	Inclusion of specialty pharmacy requirements or Rx quantity restrictions.

APPENDIX C: F-PA Drugs -- Pre-Authorization Requirements for Formulary Drugs Needing a TAR

Requirements for Carbidopa-Levodopa Disintegrating Tablet (Parcopa)

Products Affected

- *carbidopa-levodopa oral tablet,disintegrating*

PA Criteria	Criteria Details
Covered Uses	Treatment of Parkinsons disease, post-encephalitic parkinsonism, and parkinsonism that may follow carbon monoxide intoxication or manganese intoxication
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Contraindication to formulary levodopa/carbidopa IR-Sinemet (such as difficulty swallowing tablets).

Requirements for Certolizumab Pegol (Cimzia)

Products Affected

- Cimzia
- Cimzia Powder for Reconst
- Cimzia Starter Kit

PA Criteria	Criteria Details
Covered Uses	1)Ankylosing Spondylitis (AS) 2)Non-radiographic axial spondyloarthritis (nr-AxSpA) 3)Moderate to severely active Crohn's disease (CD) 4)Active plaque psoriasis (PSO) 5)Active psoriatic arthritis (PsA) 6)Moderate to severely active rheumatoid Arthritis (RA)
Exclusion Criteria	o Demyelinating disease (e.g., MS, optic neuritis). o Moderate to severe heart failure (NYHA Class III/IV). o Malignancy. o Active, serious infection, or latent (untreated) tuberculosis. o Combination with another monoclonal antibody/biologic therapy.

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PA Criteria	Criteria Details
Required Medical Information	For all indications:1)Specialist's clinic notes documenting disease course with evidence of active disease and/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2)Treatment plan. 3)Disease Activity Score. 4)Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg, Quanti FERON-TB Gold test). Moderate to severe CD: Documented therapeutic failure to induce remission with at least one of:o Corticosteroid, or o Thiopurine (azathioprine or 6-mercaptopurine), or o Methotrexate. Active PSO: 1)Documentation of 10% or greater BSA affected OR 2)Documentation of less than 10% BSA affecting sensitive areas (palms of hands, soles of feet,head/neck, genitalia), OR 3)Therapeutic failure after a 3-month trial of 2 or more non-biologic therapies (unless contraindicated):a.Methotrexate b.Cyclosporin c.Acitretin (TAR required) d.Phototherapy in conjunction with methoxsalen (TAR required). Active PsA: 1)Rheumatologist clinic notes to confirm diagnosis of PsA AND 2)Severe psoriatic arthritis with erosive disease and functional limitation or 3)Moderate to severe axial involvement or 4)Documented therapeutic failure after a minimum 3-month trial of methotrexate, or other oral DMARD (disease-modifying anti-rheumatic drug) if member is unable to take methotrexate (MTX). Moderate to severe active RA:Documentation of trial and failure of, or contraindication to, a minimum of a 3-month trial of methotrexate, or other oral DMARD if member is unable to take methotrexate. Active AS & nr-AxSpA: Adequate trial of at least two prescription-strength NSAIDs or COX-2 inhibitor.
Age Restrictions	18 years and older
Prescriber Restrictions	AS & nr- AxSpA: Rheumatologist. PSO: Dermatologist. PsA: Rheumatologist (prescribed or recommend by). A dermatologist may continue treatment that was initiated based on a rheumatologist recommendation. RA: Rheumatologist
Coverage Duration	Initial: 6 months. Renewal: 12 months thereafter, with documentation of efficacy

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PA Criteria	Criteria Details
Other Criteria	Specialty Pharmacy Requirement: AllianceRx/Walgreens PrimeOff-Label Requests:Requested dose and duration should be consistent with package labeling and/or nationally recognized treatment guidelines.Requests exceeding standard package labeling recommendations (including pediatric use) are off label and will be considered for medical necessity on a case-by-case basis.For further explanation of case-by-case review and off-label use, please see theAppendix A section of the PHC Medi-Cal Formulary in the PDF. Medical Offices:Certolizumab Pegol (Cimzia) pens and prefilled syringes are FDA approved as a self-administered injection and should be provided to the member by a pharmacy.Although certolizumab pegol/J0717 is included on the State Medi-Cal covered code list for medical claims (TAR required) without regard to dosage form, PHC intends J0717 to be used for the Lypholized powder vials, which are not indicated for self-administration.Members should be transitioned from vials to pens or syringes as soon as practical for the member to receive from a pharmacy.If the healthcare provider prefers to administer the pens or prefilled syringes, please have member obtain Cimzia from a pharmacy and bring to the clinic for administration (pharmacy TAR required).Medical Drug Billing:Dose limits & billing requirements (approved TAR is required), for Lypholized powder vials for subcutaneous injection, when member is unable to use pens/syringes from a pharmacy.

Requirements for Deferasirox (Exjade)

Products Affected

- deferasirox oral tablet, dispersible

PA Criteria	Criteria Details
Covered Uses	For the treatment of chronic iron overload due to blood transfusions or non-transfusion-dependent thalassemia (NTDT) syndromes.
Exclusion Criteria	For transfusional iron overload: Serum ferritin less than 500 mcg/L. For iron overload in NTDT: Serum ferritin less than 300 mcg/L.
Required Medical Information	Initial requests: clinical documentation for the following must be provided: (1) Diagnosis and serum ferritin level. (2) Documentation of body weight. Renewal requests: Clinical documentation of serum ferritin level and body weight. Dose escalations: Subject to short-term approval (1 week) if pharmacy claims indicate a potential adherence issue may have resulted in a lack of response to prior dose. Prescriber may be asked to consider potential for improved adherence vs. dose increase before approval greater than short term.
Age Restrictions	For transfusional iron overload: 2 years and older. For iron overload in NTDT: 10 years and older.
Prescriber Restrictions	Hematology specialists
Coverage Duration	6 months with documentation of serum ferritin level
Other Criteria	Additional requirements for transfusional iron overload: Documented treatment plan for blood transfusions, including frequency and expected treatment duration. Dose escalations: subject to short-term approval (1 week) if pharmacy claims indicate a potential adherence issue may have resulted in a lack of response to prior dose. Prescriber may be asked to consider potential for improved adherence vs. dose increase before approval greater than short term. Quantity limit per month: maximum FDA recommended dosing of 40 mg/kg of body weight per day. Limited to 30 day supply per fill. LDD requirement applies only to the brand name products.

Requirements for Elbasvir-Grazoprevir (Zepatier) and Sofosbuvir-Velpatasvir (Epclusa)

Products Affected

- sofosbuvir-velpatasvir
- Zepatier

PA Criteria	Criteria Details
Covered Uses	For treatment of chronic Hepatitis C Virus (HCV).
Exclusion Criteria	Limited life expectancy (less than 12 months) which cannot be remediated by HCV therapy, liver transplantation, or another directed therapy. Failure to comply with treatment regimen (e.g. multiple missed doses), medication loss, missed appointments, missed lab data sets and/or non-compliance with case management may result in revocation of treatment authorization.
Required Medical Information	Specifics are listed on PHC HCV TAR supplemental form on PHC website. A completed TAR Supplemental Form must be submitted to specialty pharmacy for initial TAR request. Most recent original data reports (including reference ranges) for the following: (1) HCV genotype & viral load. (2) Chemistry which includes AST, ALT, Total Bilirubin, Albumin. (3) CBC with Platelets. (4) If cirrhosis, include INR and CTP score. If applicable: (5) Request for Zepatier for genotype 1a, mixed 1a/b, or indeterminate 1 infection will require submission of HCV RNA Genotype 1 NS5A Drug Resistance Assay result. (6) Request for generic Epclusa for genotype 3 may require resistance-associated substitutions (RAS) testing for Y93H mutation (Genotype 3 NS5A resistance test). (7) Documentation of pregnancy prevention while on Ribavirin therapy. (8) Documentation of Interferon and/or Ribavirin intolerance or other ineligible rationale may be required.
Age Restrictions	Treatment candidate must be at least the minimum age approved by the FDA for use of the medication.
Prescriber Restrictions	Specialist in the area of Gastroenterology, Hepatology, Infectious Disease, HIV OR non-specialist with documentation of adequate training and experience in the treatment of HCV (e.g. Project ECHO).

PA Criteria	Criteria Details
Coverage Duration	Dependent upon genotype, prior treatment (if any), cirrhosis status, regimen and response.
Other Criteria	Must be dispensed through PHCs contracted specialty pharmacy (Walgreens Specialty Pharmacy). 14-day dispensing limitation per fill. Prescriber has considered patient readiness, transplant status, pregnancy risks, renal function, life expectancy, case management, patient responsibilities and prescribers experience (the latter required one-time for non-specialist prescribers) as indicated in the HCV TAR Supplement Form. In-Therapy HCV Viral Load (VL) testing require: (1) Baseline VL or start of treatment VL if baseline older than 12 months. (2) 4-wk for all regimen. (3) 6-wk if detectable at 4 wks for 12 wk regimen OR 12-wk if detectable at 4 wks for 16 wk regimen. (4) 12-wk if on regimen lasting beyond 16 weeks. Requests for non-AASLD regimens: current medical literature supporting the regimen should be submitted. PHC Preferred Regimens: See HCV treatment matrix on PHC website for all preferred regimens for adults.

Requirements for Etanercept (Enbrel)

Products Affected

- Enbrel Mini
- Enbrel subcutaneous recon soln
- Enbrel subcutaneous syringe
- Enbrel SureClick

PA Criteria	Criteria Details
Covered Uses	Ankylosing Spondylitis (AS), Plaque Psoriasis (PP): The treatment of moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate, Polyarticular Juvenile Idiopathic Arthritis (JIA), Psoriatic arthritis (PA), Rheumatoid Arthritis (RA).
Exclusion Criteria	Active, serious infection, latent (untreated) tuberculosis, demyelinating disease (e.g., MS, optic neuritis), moderate to severe heart failure (NYHAClass III/IV).
Required Medical Information	Specialists clinic notes documenting disease course, previous therapies tried and responses, current evaluation (lab and imaging reports as appropriate), treatment plan. Prescriber is aware of immunosuppression risks specific to latent TB infection and has ordered TST (Tuberculin Skin Test, AKA PPD) or Interferon-Gamma Release Assay (eg, Quanti FERON-TB Gold test).
Age Restrictions	For patient ages 18 years and older: AS, PP, PA, RA For 2 years and older: JIA.
Prescriber Restrictions	1) Rheumatologist: AS, JIA, PA, RA. 2)Dermatologist: PP, PA.
Coverage Duration	Initial: 3 months approval. Renewal: 12 months with documentation.

PA Criteria	Criteria Details
Other Criteria	AS: Diagnosis of ankylosing spondylitis confirmed with radiographic sacroiliitis on plain radiography, with disease that remains active despite an adequate trial of at least two formulary NSAIDs/COX-2 inhibitors. An adequate trial of NSAIDs would consist of lack of response (or intolerance) to at least 2 different NSAIDs over 1 month, or incomplete response to at least 2 different NSAIDs over 2 months. JIA: Diagnosis of active polyarticular JIA in pediatric patients greater than/equal to 2 years. PP: Diagnosis of chronic plaque psoriasis (at least 1 year) in adults who are candidates for systemic therapy or phototherapy, and when other systemic therapies are less appropriate. Items (1) and (2) must be met: 1.) Patient has documented severe disease greater than 10% BSA affected or (b) less than 10% BSA affected with involvement of sensitive areas that significantly impact quality of life (palms of hands, soles of feet, head/neck, genitalia), OR (c) overlapping confirmed diagnosis of psoriatic arthritis AND 2.) Patient has documented therapeutic failure of three months' trial, or inability to use, at least two preferred therapies: methotrexate, cyclosporin, acitretin (Soriatane) (non-formulary, TAR required), phototherapy w/methoxsalen (Oxsoralen)(non-formulary, TAR required). For renewal request: submit clinical documentation that supports a decrease or stabilization in percent of body surface area involvement when compared to baseline. PA: Diagnosis of active psoriatic arthritis in adults with documentation of trial and failure of, or contraindication to, a minimum of a 3 month trial of methotrexate or other oral DMARD if patient is unable to take methotrexate.RA: Limited to established RA (great than/equal to 6 months duration) with clinical documentation of active disease despite having a minimum of a 3 month trial to combination conventional oral DMARD therapy (double or triple therapy which would include MTX). Initial: 3 months approval. Renewal: 12 months with documentation of improvement in symptoms. Subsequent annual approvals with updated specialists notes documenting continued benefit.

Requirements for Fentanyl Transdermal Patches (50, 75 & 100 mcg/24 hr)

Products Affected

- fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr

PA Criteria	Criteria Details
Covered Uses	Around-the-clock pain control
Exclusion Criteria	Opioid-naive patients (taking less than the equivalent of 60 mg morphine per day for at lease one week).
Required Medical Information	Requested doses 100 mcg/hr or greater require: A) Diagnosis of cancer pain or B) Pain management consult (either as a visit or PCP can confer over the phone w/ specialist), AND C) urine tox screen, cures report and opioid use agreement. Please note fentanyl transdermal is contra-indicated and not approved for opiate naive patients: Opiate naive is defined as taking less than the equivalent of 60 mg/day oral morphine for at least one week.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	TBD
Other Criteria	Limited to the treatment of severe pain for: (1) Members with a diagnosis of cancer, or (2) Members requiring a non-oral route of medication or (3) Requested dose is less than 100 mcg/hr and member has had an adequate trial with failure of morphine-LA. Requested doses 100 mcg/hr or more require: (1) Diagnosis of cancer pain, or (2) Pain management consult (either as a visit or PCP can confer over the phone w/ specialist), AND (3) A urine tox screen, cures report and opioid use agreement. NOTE: For all diagnosis (including CA, initial fills are limited to every 72 hour application (10 per 30 days).

Requirements for Filgrastim-aafi (Nivestym) and Filgrastim-sndz (Zarxio)

Products Affected

- Nivestym
- Zarxio

PA Criteria	Criteria Details
Covered Uses	Prevention or treatment of chemotherapy-induced neutropenia. Acute myeloid leukemia (AML) following induction or consolidation chemotherapy. Bone marrow transplantation (BMT). Severe chronic neutropenia. Peripheral blood progenitor cell collection and therapy.
Exclusion Criteria	None
Required Medical Information	For prevention or treatment of chemotherapy-induced neutropenia: Request must include clinic notes documenting diagnosis, specific chemotherapy regimen with dose and frequency, current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable), and member-specific risk factors for developing neutropenia (if any). For chemotherapy regimens not identified as having high risk (greater than 20%) or intermediate risk (10-20%) of febrile neutropenia (FN) in the absence of any associated patient risk factors, clinical literature supporting intermediate to high risk of FN may be required. For all other indications or off-label use: Requests must include accurate diagnosis as provided by prescriber, all necessary/relevant clinical documentation to support medical justification (e.g. clinic notes, lab reports including absolute neutrophil count (ANC), specialist consults, insurance approval of stem cell transplant, etc).
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	TBD based on chemotherapy regimen, up to a maximum of 6 months per authorization.

PA Criteria	Criteria Details
Other Criteria	Must meet ONE of the following for prevention or treatment of chemotherapy-induced neutropenia (all other requests for a FDA approved indication or for an off-label use will be reviewed on a case-by-case basis): (1) Primary prophylaxis of febrile neutropenia in member receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20% (high risk) or at least 10-20% (intermediate risk) if member has at leastone risk factor for developing neutropenia as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. (2) Secondary prophylaxis of febrile neutropenia in member who experienced neutropenic complication from prior chemotherapy and did not receive primary prophylaxis with a myeloid growth factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome. (3) Treatment of febrile neutropenia in patients who received chemotherapy and have at least one risk factor for poor clinical outcomes or for developing infection-associated complications as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. NOTE: There are no studies that have addressed therapeutic use of Filgrastim for febrile neutropenia in patients who have already received prophylactic pegfilgrastim. However, pharmacokinetic data of pegfilgrastim demonstrated high levels during neutropenia and suggest that additional granulocyte colony-stimulating factors (G-CSF) may not be beneficial: but in patients with prolonged neutropenia additional G-CSF may be considered.

Requirements for Golimumab Subcutaneous Prefilled Syringes and Pens (Simponi)

Products Affected

- Simponi subcutaneous pen injector 100 mg/mL
- Simponi subcutaneous syringe 100 mg/mL

PA Criteria	Criteria Details
Covered Uses	1)Active ankylosing spondylitis (AS). 2)Active psoriatic arthritis (PsA). 3)Moderate to severely active rheumatoid arthritis (RA). 4)Moderate to severely active ulcerative colitis (UC).
Exclusion Criteria	(1) Demyelinating disease (e.g., MS, optic neuritis). (2) Moderate to severe heart failure (NYHA Class III/IV). (3) Malignancy. (4) Active, serious infection, or latent (untreated) tuberculosis. (5) Combination with another monoclonal antibody/biologic therapy.
Required Medical Information	For all indications: 1)Specialist's clinic notes documenting disease course (activity, progression, severity),with evidence of active disease &/or inflammation as appropriate by diagnosis(imaging, labs, or other findings as indicated). 2)Treatment plan. 3)Disease Activity Score. 4)Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg,Quanti FERON-TB Gold test). Active AS: Adequate trial of at least two prescription-strength NSAIDs or COX-2 inhibitors.Active PsA:1) Rheumatology clinic notes to confirm diagnosis of PsA AND one of: a.Severe psoriatic arthritis with erosive disease and functional limitation, or b.Moderate to severe axial involvement, or c.Documentation of trial and failure of, or contraindication to, a minimum 3-month trial of methotrexate, or other oral DMARD (disease-modifyinantirheumatic drug) if member is unable to take methotrexate (eg, leflunomideor sulfasalazine) Moderate to severely active RA: Documentation of trial and failure of, or contraindication to, a minimum 3-month trial of methotrexate, or other oral DMARD if member is unable to take methotrexate (eg,leflunomide or sulfasalazine).Moderate to severely active UC: Documentation therapeutic failure to induce remission with, or contraindication to, 5-aminosalicylates (5-ASAs: sulfasalazine, mesalazine).

PA Criteria	Criteria Details
Age Restrictions	PsA: 2 years and older. All other indications: 18 years and older.
Prescriber Restrictions	1)AS, RA: Rheumatologist. 2)PsA: Rheumatologist (prescribed or recommend by), dermatologist may continuetreatment that was initiated based on a rheumatologist's recommendation. 3)UC: Gastroenterologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months thereafter, with documentation of efficacy
Other Criteria	Off-Label Requests: Requested dose and duration should be consistent with package labeling and/or nationally recognized treatment guidelines. Requests exceeding standard package labeling recommendations (including pediatric use) are off label and will be considered for medical necessity on a case-by-case basis. For further explanation of case-by-case review and off-label use, please see the Appendix A section of the PHC Medi-Cal Formulary in the PDF. Medical Offices: PHC requires Simponi to be provided to the member by a pharmacy because golimumab (Simponi) pens and prefilled syringes are FDA approved as self-administered injections and subcutaneous golimumab is not in the State Medi-Cal covered code list for the medical drug benefit.If the healthcare provider prefers to administer subcutaneous Simponi, please have member obtain Simponi pen/syringe from a pharmacy and bring to the clinic for administration (pharmacy TAR required).

Requirements for tbo-Filgrastim (Granix)

Products Affected

- Granix

PA Criteria	Criteria Details
Covered Uses	Prevention or treatment of chemotherapy-induced neutropenia.
Exclusion Criteria	N/A
Required Medical Information	Clinic notes documenting diagnosis, specific chemotherapy regimen with dose and frequency, current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable), and member-specific risk factors for developing neutropenia (if any). For chemotherapy regimens not identified as having high risk (greater than 20%) or intermediate risk (10-20%) of febrile neutropenia (FN) in the absence of any associated patient risk factors, clinical literature supporting intermediate to high risk of FN may be required.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	TBD based on chemotherapy regimen, up to a maximum of 6 months per authorization.

PA Criteria	Criteria Details
Other Criteria	Must meet ONE of the following: (1) Primary prophylaxis of febrile neutropenia in member receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20% (high risk) or at least 10-20% (intermediate risk) if member has at least one risk factor for developing neutropenia as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. (2) Secondary prophylaxis of febrile neutropenia in member who experienced neutropenic complication from prior chemotherapy and did not receive primary prophylaxis with a myeloid growth factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome. (3) Treatment of febrile neutropenia in patients who received chemotherapy and have at least one risk factor for poor clinical outcomes or for developing infection-associated complications as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. Please note: Tbo-filgrastim (Granix) has only been studied for prophylactic use. NOTE: Requests for off-label use will be reviewed on a case-by-case basis. There are no studies that have addressedtherapeutic use of Filgrastim for febrile neutropenia in patients who have already received prophylactic pegfilgrastim. However, pharmacokinetic data of pegfilgrastim demonstrated high levels during neutropenia and suggest that additional granulocyte colony-stimulating factors (G-CSF) may not be beneficial: but in patients with prolonged neutropenia additional G-CSF may be considered.

Requirements for Growth Hormone (Norditropin)

Products Affected

- Norditropin FlexPro

PA Criteria	Criteria Details
Covered Uses	Treatment of Growth Hormone Deficiency, Noonan Syndrome with growth failure (FDA indication for Norditropin only), Prader-Willi Syndrome, Turner Syndrome (TS) with growth failure/short stature, Small for Gestational Age (SGA) when catch up growth is not achieved by age 2.
Exclusion Criteria	Dose that exceeds the maximum recommended dosing, off label uses, Idiopathic short stature (non-growth hormone deficient short stature).
Required Medical Information	Documentation of current (within the past year) bone age to indicate open epiphyses, current lab report to show IGF-1 and IGFBP-3 (for pediatric treatment, to indicate pituitary gland dysfunction) below normal of the reference range provided, diminished peak serum GH response below 7.5ng/ml to at least 2 provocative stimuli or documentation of Prader-Willi syndrome, Turner Syndrome.Small for Gestational Age: height remains greater than 2 standard deviations (SD) below the mean for age and sex Submit Baseline height with where patient is on the growth curve (percentile), and predicted adult height. For adults with documented organic pituitary disease: Submit low age-adjusted IGF-1 together with documentation of organic pituitary disease. For adults without documented organic pituitary disease: Abnormal provocative test results are required. Submit at least 2 abnormal results from validated provocative tests that elicit GH release: Insulin-tolerance less than 5mcg/L, Glucagon stimulation test less than 3mcg/L, Ghrelin receptor agonist (macimorelin) less than 2.8 mcg/L, low age-adjusted IGF-1.
Age Restrictions	2 years and older
Prescriber Restrictions	Endocrinologist
Coverage Duration	Initial approval: 6 months. Renewals: 12 months

PA Criteria	Criteria Details
Other Criteria	Renewal requirements: Pediatric: Growth failure, short stature--documentation of growth velocity 2.0 cm/yr or greater, height difference from baseline to current, and for dose changes, current lab report with IGF-1 and IGFBP-3 level. OR Adults with growth hormone deficiency, when dose change is requested: current lab report with IGF-1 and IGFBP-3 levels. Treatment of short stature therapy due to growth hormone deficiency should be considered for discontinuation when patient has reached satisfactory height OR when epiphyses have fused (bone age of 16 years and older for males and 14 years and older for females with growth velocity is less than 2.0 cm/year. Renewals at these endpoints should include treatment/discontinuation plan (1-time authorization allowed to avoid abrupt discontinuation, but rationale for continuation will be required for continued use).

Requirements for Humira

Products Affected

- Humira Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira subcutaneous syringe kit 40 mg/0.8 mL
- Humira(CF)
- Humira(CF) Pedi Crohns Starter
- Humira(CF) Pen
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Psor-Uv-Adol HS

PA Criteria	Criteria Details
Covered Uses	Adalimumab (Humira): Ankylosing spondylitis (AS), Hidradenitis suppurativa (HS), Inflammatory Bowel Disease--Crohns (CD) or Ulcerative Colitis (UC), Juvenile idiopathic arthritis (JIA), Plaque psoriasis (PP): The treatment of moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate, Psoriatic arthritis (PA), Rheumatoid arthritis (RA), Uveitis.
Exclusion Criteria	Active, serious infection, latent (untreated) tuberculosis, demyelinating disease (e.g., MS, optic neuritis), moderate to severe heart failure (NYHAClass III/IV).
Required Medical Information	Specialists clinic notes documenting disease course, previous therapies tried and responses, current evaluation (lab and imaging reports as appropriate), treatment plan. Prescriber is aware of immunosuppression risks specific to latent TB infection and has ordered TST (Tuberculin Skin Test, AKA PPD) or Interferon-Gamma Release Assay (eg, Quanti FERON-TB Gold test).
Age Restrictions	For ages 18 years and older: AS, HS, PP, PA, RA, UC and Uveitis.For ages 6 years and older: CD and for those 2 years and older: JIA.TAR review includes referral to CCS when appropriate for ages 0- 20.
Prescriber Restrictions	1) Rheumatologist: AS, JIA, PA, RA. 2) Dermatologist: HS, PP 3) Gastroenterologist: CD, UC. 4) Ophthalmologist or Ocular immunologist: Uveitis
Coverage Duration	Initial: 3 months approval. Renewal: 12 months with documentation,

PA Criteria	Criteria Details
Other Criteria	AS: Confirmed w/radiographic sacroiliitis on plain radiography, w/disease that remains active despite an adequate trial of at least 2 formulary NSAIDs/COX-2 inhibitors which consists of lack of response (or intolerance) to at least 2 different NSAIDs over 1 month, or incomplete response to at least 2 different NSAIDs over 2 months. PP: Chronic plaque psoriasis (at least 1 year) in adults who are candidates for systemic therapy or phototherapy, & when other systemic therapies are less appropriate. Items (1) & (2) must be met: 1) Patient has documented severe disease greater than 10% BSA affected OR b) less than 10% BSA affected w/involvement of sensitive areas that significantly involved impact quality of life (palms of hands, soles of feet, head/neck, genitalia), OR c) overlapping confirmed diagnosis of psoriatic arthritis AND (2) Patient has documented therapeutic failure of 3 months' trial, or inability to use, at least 2 preferred non-biologic therapies: MTX, cyclosproin, acitretin (Soriatane, TAR required), phototherapy w/methoxsalen (Oxsoralen, TAR required). For renewal: submit clinical documentation that supports a decrease or stabilization in percent of body surface area involvement when compared to baseline. PA: Diagnosis of active psoriatic arthritis in adults with documentation of trial and failure of, or contraindication to, a minimum of a 3 month trial of methotrexate or other oral DMARD if patient is unable to take methotrexate. RA: Limited to established RA (great than/equal to 6 months duration) with clinical documentation of active disease despite having a minimum of a 3 month trial to combination conventional oral DMARD therapy (double or triple therapy which would include MTX). HS: Confirmed moderate to severe hidradenitis suppurativa with documentation of Hurley Stage II or III disease. Documentation of a minimum of a 3 month trial to conventional therapy (oral antibiotics with or without antiandrogenic agents). CD, UC: Diagnosis of active, moderate to severe, CD or UC, w/ inadequate response to conventional therapy. Documentation of previous trial/failure, or contraindication to, at least 2 therapies such as corticosteroids, 5-aminosalicylates, immunomodulators (6-MP, azathioprine, MTX, cyclosporin), or

PA Criteria	Criteria Details
	other biologic agent. Special consideration for patients dependent on steroids w/documented inability to be weaned off of steroids or patients w/Crohns related fistulas or previous bowel resections. Uveitis: Documentation of non-infectious intermediate, posterior, & pan-uveitis that is chronic, recurrent, treatment refractory or vision threatening disease. Documentation of inadequate response to conventional therapies (e.g., systemic glucocorticoids, immunosuppressive drugs). Renewals: 12 months w/documentation of improvement in symptoms. Subsequent annual approvals with updated specialist notes documenting continued benefit.

Requirements for Hydroxyprogesterone Caproate (Makena)

Products Affected

- Makena
- Makena (PF)

PA Criteria	Criteria Details
Covered Uses	To reduce the risk of preterm birth in women with a singleton pregnancy (single fetus) who have a history of singleton spontaneous preterm birth.
Exclusion Criteria	Per FDA package labeling, Makena® is not intended for use in women with multiple gestations or other risk factors for preterm birth.
Required Medical Information	Documented history of prior singleton spontaneous preterm birth (delivery at less than 37 weeks' gestation). Treatment start date, treatment end date and the corresponding gestational week numbers.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Exact duration is dependent on start date. Will be extended up to & including gestational week 36.
Other Criteria	Member with a single fetus and documented history of spontaneous preterm delivery of singleton fetus. Treatment to start between 16 wks, 0 days and 20 weeks, 6 days, and continuing treatment through day 6 of week 36 or delivery, whichever occurs first. Requests to start treatment at 21 weeks or greater will require clinical data studies supporting efficacy with late treatment initiation. Note that brand Makena® is PHC's preferred product. Requests for generic hydroxyprogesterone caproate must include reasons why brand cannot be used, such as vials being necessary and yet brand not available, or the subcutaneous autoinjector is not indicated or is unavailable.

Continued on next page

Requirements for Golimumab IV vials (Simponi Aria)

Products Affected

- Simponi ARIA

PA Criteria	Criteria Details
Covered Uses	1)Active Ankylosing Spondylitis (AS). 2)Active Polyarticular Juvenile Idiopathic Arthritis (PJIA). 3)Active Psoriatic Arthritis (PsA). 4)Moderate to severely active Rheumatoid Arthritis (RA).
Exclusion Criteria	(1) Demyelinating disease (e.g., MS, optic neuritis). (2) Moderate to severe heart failure (NYHA Class III/IV). (3) Malignancy. (4) Active, serious infection, or latent (untreated) tuberculosis. (5) Combination with another monoclonal antibody/biologic therapy.

Continued on next page

PA Criteria	Criteria Details
Required Medical Information	For all indications: 1)Specialist's clinic notes documenting disease course (activity, progression, severity)with evidence of active disease &/or inflammation as appropriate by diagnosis(imaging, labs, or other findings as indicated). 2)Treatment plan. 3)Disease Activity Score. 4)Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg,Quanti FERON-TB Gold test). Active AS: 1)Adequate trial of at least two prescription-strength NSAIDs or COX-2 inhibitors, and 2)Documentation of trial and failure of subcutaneous golimumab (Simponi) or reasonswhy member cannot use the less invasive, self-administered Simponi pen or prefilled syringe, and 3)Documented therapeutic failure with at least one other preferred TNFi: adalimumab(Humira), etanercept (Enbrel), or certolizumab (Cimzia). Active PsA: 1)Documentation of evaluation from a rheumatologist to confirm diagnosis of psoriaticarthritis and one of a, b, or c: a.Severe psoriatic arthritis with erosive disease and functional limitation, or b.Moderate to severe axial involvement, or c.Documentation of trial and failure of, or contraindication to, a minimum of a3-month trial of methotrexate, or other oral DMARD (disease-modifying antirheumatic drug) if member is unable to take methotrexate (MTX) AND 4)Documentation of trial and failure of subcutaneous golimumab (Simponi) or reasonswhy member cannot use the less invasive & self-administered Simponi pen or prefilled syringe, and 5)Documented therapeutic failure with at least one other preferred TNFi: adalimumab(Humira), etanercept (Enbrel), or certolizumab (Cimzia). Active PJIA and Moderate to severely active RA: See "Other Criteria" for detail
Age Restrictions	PJIA & PsA: 2 years and older. All other indications: 18 years and older
Prescriber Restrictions	1)AS, PJIA, RA: Rheumatologist. 2)PsA: Rheumatologist (prescribed or recommend by), dermatologist may continue treatment that was initiated based on a rheumatologist's recommendation.
Coverage Duration	Initial: 6 months. Renewal: 12 months thereafter, with documentation of efficacy

Continued on next page

Requirements for Lifitegrast (Xiidra)

Products Affected

- Xiidra

PA Criteria	Criteria Details
Covered Uses	Treatment of chronic dry eye syndrome (i.e. keratoconjunctivitis sicca, dry eye disease, Sjorgrens).
Exclusion Criteria	Concurrent use of ophthalmic cyclosporin and lifitegrast, as there are no data to support concomitant use.
Required Medical Information	Clinical documentation supporting chronic dry eye syndrome (i.e. keratoconjunctivitis sicca, dry eye disease.
Age Restrictions	18 and older.
Prescriber Restrictions	None
Coverage Duration	Initial: 3 months Renewal: up to 12 months.
Other Criteria	Must have documented trial and inadequate response to at least 2 different formulary OTC artificial tears /eye lubricants for a minimum of 30 days each at routine scheduled dosing, one of which must be a formulary PRESERVATIVE-FREE product (e.g. Refresh Classic/Celluvisc/Plus, Refresh Optive Sensitive/Advanced, Bion Tears, Systane, or Systane Ultra). Renewal requests will require submission of documentation supporting a positive clinical response.

Requirements for Pegfilgrastim-jmdb (Fulphila) and Pegfilgrastim-cbqv (Udenyca)

Products Affected

- Udenyca

PA Criteria	Criteria Details
Covered Uses	Prevention of chemotherapy-induced neutropenia.
Exclusion Criteria	Use for mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. Dosed more frequently than every 14 days for prevention of chemotherapy-induced neutropenia.
Required Medical Information	Clinic notes documenting diagnosis, specific chemotherapy regimen with dose and frequency, current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable), and any member-specific risk factors for developing neutropenia. For chemotherapy regimens not identified as having high risk (greater than 20%) or intermediate risk (10-20%) of febrile neutropenia (FN) in the absence of any associated patient risk factor, clinical literature supporting intermediate to high risk of FN may be required.
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	TBD based on chemotherapy regimen, up to a maximum of 6 months per authorization.

Continued on next page

PA Criteria	Criteria Details
Other Criteria	For prevention of chemotherapy-induced neutropenia, must meet ONE of the following: (1) Primary prophylaxis of febrile neutropenia in patients receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20% (high risk) or at least 10-20% (intermediate risk) if patient has at least one risk factor for developing neutropenia as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. (2) Secondary prophylaxis of febrile neutropenia in patients who experienced neutropenic complication from prior chemotherapy and did not receive primary prophylaxis with a myeloid growth factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome. NOTE: Request for off-label use will be reviewed on a case-by-case basis.

Requirements for Rasagiline (Azilect)

Products Affected

- rasagiline

PA Criteria	Criteria Details
Covered Uses	For the treatment of Parkinson Disease (Monotherapy or adjunctive)
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years and older
Prescriber Restrictions	Neurologist
Coverage Duration	12 months
Other Criteria	Trial and failure of levodopa/carbidopa therapy and failure of formulary CODE-1 selegiline (Eldepryl). Quantity is limited to one per day.

Requirements for Testosterone Gel (Testim, Vogelxo) and Testosterone Cypionate Intramuscular Oil

Products Affected

- testosterone cypionate intramuscular oil 100 mg/mL, 200 mg/mL
- testosterone enanthate

PA Criteria	Criteria Details
Covered Uses	Treatment for male members with confirmed diagnosis of primary or secondary hypogonadism. Delayed puberty. Transgender hormonal therapy.
Exclusion Criteria	Males with prostate or breast cancer. Palpable prostate nodule or PSA level greater than 4 ng/ml. Hematocrit greater than 48%. Untreated severe obstructive sleep apnea. Severe lower urinary track symptoms. Uncontrolled HF, MI or stroke within the last 6 months. Thrombophilia.

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PA Criteria	Criteria Details
Required Medical Information	Primary or secondary hypogonadism- New to therapy: Lab reports documenting two total testosterone levels drawn prior to 9 am (fasting preferred) on separate days. In men with conditions which alter sex hormone-binding globulin (SHBG), or if initial total testosterone levels are at or near the lower limit of normal, additional laboratory levels may be required (free testosterone levels utilizing equilibrium dialysis, total testosterone, SHBG, albumin).Transgender hormonal therapy- New to therapy: Evaluation by a mental health professional or other health care professionals who have the appropriate experience and training. Confirmation of the following: well-documented gender dysphoria/gender incongruence, ability to make a well-informed decision, and stability of relevant medical and mental health. Testosterone levels will not be required for initiation of therapy.Renewal: Testosterone levels may be required if testosterone doses exceed the recommended dosing range. Levels should be drawn at the midpoint between injections, with a goal of maintaining serum concentrations approximately 400 to 800 ng/dL. For patients on testosterone injections, trough levels should be towards the lower end of this range, while peak levels should not exceed 1000 ng/dL. Routine monitoring schedule as recommended by the Endocrine Society: Evaluate the patient every three months in the first year corresponding to dose adjustment and then one to two times per year thereafter.
Age Restrictions	12 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Primary or secondary hypogonadism-New to therapy: Confirmation of diagnosis with documentation of symptoms consistent with testosterone deficiency AND two pretreatment total testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (fasting preferred). The levels should be taken on separate days before 9 am, within 90 days of the request.Continuation of care from another plan: Pharmacy records or clinic notes documenting prior use of testosterone within the past 180 days.Renewal: Testosterone levels may be required and should be in the mid-normal range between 450 to 600 ng/dL, drawn at the midpoint between injections.Limited to 30 day supply per fill.

Requirements for Testosterone Patch (Androderm) and Testosterone Gel (Androderm, Vogelxo)

Products Affected

- testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)

PA Criteria	Criteria Details
Covered Uses	Treatment for male members with confirmed diagnosis of primary or secondary hypogonadism. Transgender hormonal therapy.
Exclusion Criteria	Males with prostate or breast cancer. Palpable prostate nodule or PSA level greater than 4 ng/ml. Hematocrit greater than 48%. Untreated severe obstructive sleep apnea. Severe lower urinary track symptoms. Uncontrolled HF, MI or stroke within the last 6 months. Thrombophilia.
Required Medical Information	Primary or secondary hypogonadism and Transgender hormonal therapy - Testosterone levels confirming therapeutic failure to preferred testosterone products following appropriate dosage adjustments.
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months

Continued on next page

PA Criteria	Criteria Details
Other Criteria	Primary or secondary hypogonadism- New to therapy or continuation of care from another plan: Prior trial and failure or intolerance to preferred formulary intramuscular testosterone cypionate or intramuscular testosterone enanthate. Confirmation of diagnosis with documentation of symptoms consistent with testosterone deficiency and two pretreatment total testosterone levels (fasting preferred) below the lower limit of the normal testosterone reference range of the individual laboratory used. Renewal: Testosterone levels may be required and should be in the mid-normal range between 450 to 600 ng/dL, drawn as per manufacture recommendations. Transgender hormonal therapy- New to therapy: Confirmation of diagnosis with evaluation from appropriate provider. Prior trial and failure or intolerance to preferred formulary intramuscular testosterone cypionate or intramuscular testosterone enanthate. Testosterone levels will be required if TAR for topical testosterone states levels cannot be maintained on injection. Renewal: Testosterone levels may be required and should be drawn as per manufacture recommendation with a goal of maintaining serum concentrations approximately 400 to 800 ng/dL. Routine monitoring schedule as recommended by the Endocrine Society: Evaluate the patient every three months in the first year corresponding to dose adjustment and then one to two times per year thereafter.

Requirements for Tobramycin Nebulizer (Tobi & Kitabis Pak)

Products Affected

- tobramycin in 0.225 % NaCl
- tobramycin with nebulizer

PA Criteria	Criteria Details
Covered Uses	Tobramycin inhalation solution, Kitabis - Treatement of Cystic Fibrosis with positive culture for P. aeruginosa sensitive to tobramycin.
Exclusion Criteria	None
Required Medical Information	Include with TAR submission - 1) Requested (not required): Identify treatment as being for eradication vs chronic infection. 2) Off-label use: Submit clinic notes and culture & sensitivity (C & S) report.
Age Restrictions	CCS eligible condition for ages 0-21.
Prescriber Restrictions	Prescribed or recommended by a pulmonologist.
Coverage Duration	Eradication: 3 fills over 6 months. Chronic: 6 fills over 12 months
Other Criteria	Criteria applies to new start requests: 1) Diagnosis of cystic fibrosis with either new or chronic P. aeruginosa. 2) Eradication: Limited to a single 28 day fill. Retreatment for eradication requires a new C & S report showing recurrence of P. aeruginosa. 3) Chronic: Limited to BID dosing, dosed 28 days on, 28 days off. LDD requirement applies only to the brand name.

Requirements for Tofacitinib (Xeljanz, Xeljanz XR)

Products Affected

- Xeljanz oral tablet
- Xeljanz XR

PA Criteria	Criteria Details
Covered Uses	Psoriatic Arthritis (PsA), Rheumatoid Arthritis (RA), Moderately to severely active Ulcerative Colitis (UC)
Exclusion Criteria	The use of Tofacitinib in combination with biologic DMARDs or with potent immunosuppressants (eg, azathioprine, cyclosporine) is not recommended. Not indicated for patients with early symptomatic RA (less than 6 months).
Required Medical Information	Specialist clinic notes documenting disease course, previous therapies tried and responses, current evaluation (lab and imaging reports as appropriate), treatment plan, and disease activity score.
Age Restrictions	18 years and older
Prescriber Restrictions	RA: Rheumatologist, PsA: Rheumatologist, Dermatologist, UC: Gastroenterologist
Coverage Duration	See "Other Criteria" for full details.for each indication.

Continued on next page

PA Criteria	Criteria Details
Other Criteria	RA: Limited to established RA (6 months or greater in duration) with clinical documentation disease activity despite having a minimum of a 3-month trial to combination conventional oral DMARD therapy (double or triple therapy which would include MTX). Add: "Indicated for patients with moderately to severely active UC who have previously failed anti-TNF therapy. UC: Indicated for patients with moderately to severely active UC who have previously failed anti-TNF therapy. PHC's preferred anti-TNF therapy: Humira. PsA: Limited to patients with diagnosis of active psoriatic arthritis in adults with documentation of trial and failure of, or contraindication to, a minimum of a 3-month trial of methotrexate or other OSM drug (oral, small molecule) if patient is unable to take methotrexate. OSM: MTX, SSZ, CSA or APR (apremilast). Coverage Duration: For RA: 12 months, For UC: 10mg for up to 16 weeks for UC, discontinue therapy if inadequate response achieved after 16 weeks using 10 mg twice daily, For PsA: 12 months

Requirements for Vigabatrin (Sabril) tablet, packet

Products Affected

- vigabatrin

PA Criteria	Criteria Details
Covered Uses	Treatment of infantile spasms and refractory complex partial seizures
Exclusion Criteria	None
Required Medical Information	Initial: Neurology notes with confirmed diagnosis of infantile spasm OR refractory complex seizures along with documentation of current and prior therapies.Renewal: Follow-up clinic notes with evaluation of treatment response.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a Neurologist
Coverage Duration	Initial: 3 months. Renewal: 12 months, see "Other Criteria" for full details
Other Criteria	Infantile spasms: documentation confirming diagnosis of infantile spasm Refractory complex partial seizures: Documentation of trial and failure to at least four (4) formulary antiepileptic drugs. For renewal request: 12 months based on documentation of efficacy for refractory complex partial seizures. Limited to dispensing by AllianceRx/Walgreen's.

Index

TAR* Criteria for *Non*-Formulary Drugs

*Treatment Authorization Request

Other terms that mean the same thing as "TAR" include:

- **Prior Authorization**
- **Prior Auth**
- **PA**
- **Pre-Approval**
- **Pre-Authorization**

Prior Authorization Criteria (TAR Criteria) for ***non-formulary*** drugs are not included in the PHC Formulary Guide PDF document.

Please refer to the separate TAR (PA) Criteria document on the PHC website called TAR Criteria Table or to the Formulary Navigator(TM) Search Tool.

TARs may be submitted to the plan using the form on the following page, or through Partnership's pharmacy "eTAR" system called Partnership HealthPlan PAS. TAR forms require information that must be supplied directly to the plan by the member's providers (both pharmacy and prescribing providers).
Members may also request that the TAR process be started for them through the member portal.

If links don't seem to be working, copy and paste the needed web address into your browser:

- TAR Criteria Table web address: http://www.partnershiphp.org/Providers/Pharmacy/Documents/Pharmacy%202019%20documents/PA%20Criteria%20Table%202020.pdf
- Formulary Search Tool web address: https://client.formularynavigator.com/Search.aspx?siteCode=9588242881
- Member Portal: https://member.partnershiphp.org/

PARTNERSHIP HEALTHPLAN of CALIFORNIA

PHC PHARMACY SERVICES

Treatment Authorization Request (TAR)

for PHC Medi-Cal Members

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Dr.
Fairfield, CA 94534
(707) 863-4414 or (800) 863-4155
(707) 419-7900 FAX

IF NOT TYPED, PLEASE MAKE SURE HANDWRITTING IS NEAT & EASY TO READ

PROVIDER NPI: _____

PLEASE ENTER YOUR NAME, ADDRESS, PHONE & FAX

- NAME: _____
- ADDRESS: _____
- PHONE: _____
- FAX: _____

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.) _____ IDENTIFICATION NO. _____

STREET ADDRESS _____ SEX _____ AGE _____ DATE OF BIRTH (M M D D Y Y)

CITY, STATE, ZIP CODE _____ ☐ HOME ☐ BOARD & CARE

PHONE NUMBER: AREA ( ) _____ ☐ FOSTER CARE ☐ ACUTE, AWAITING DISCHARGE

☐ SNF/LTC, ADMIT DATE: _____

DIAGNOSIS DESCRIPTION (ICD-10 OPTIONAL):

MEDICAL JUSTIFICATION:

CHECK ALL THAT APPLY:

- ☐ MEDICALLY URGENT
- ☐ Continuing Care from another plan (Include records showing fill history)
- ☐ EMERGENCY ROOM Rx
- ☐ HOSPITAL DISCHARGE Rx
- ☐ COMPOUND Rx
- ☐ PART D EXCLUDED PER CMS
- ☐ MEDICARE B 20% COPAY
- ☐ PHC TAR RENEWAL
- ☐ eCOB (Copay > $50; additional form required)
- ☐ **RETROACTIVE REQUEST** (Include reason for RETRO in Medical Justification section)

SPECIFY RETROACTIVE DATE(S) BELOW:

PRESCRIPTION INFORMATION

PRODUCT NAME, STRENGTH & DOSAGE FORM _____ NDC: _____

DIRECTIONS (HOW MUCH, WHAT ROUTE, HOW OFTEN & FOR HOW LONG): _____ QUANTITY PER FILL _____

PRESCRIBER INFORMATION & AUTHOR ATTESTATION

NAME _____ CIRCLE ONE: MD DO PA DDS/DMD DPM OD FNP

ADDRESS _____ DEA or NPI: _____

PHONE _____ FAX _____ SPECIALTY: _____

To the best of my knowledge, the above information is (1) TRUE, ACCURATE & COMPLETE, and (2) the requested services are medically indicated and necessary to the health of the patient.

Signed: _____ TITLE _____ DATE _____ PRINT NAME OF CONTACT PERSON _____

NOTE: Approval does not guarantee payment. Payment is subject to Eligibility, SOC & Careve-Out status. Start dates are determined by PHC review, unless Retro is specified above. SRH01-MC_01012013TAR