ALAMEDA Alliance FOR HEALTH

Full Medi-Cal Wrap Formulary

September 2021

Alameda Alliance for Health

Medi-Cal Wrap FORMULARY

Last updated

September 1, 2021

The **Drug Formulary** is a complete list of covered and preferred outpatient prescription drugs for members. The Alliance reviews the list at least four times a year (formulary updates can be found on the Alliance website) and makes updates as needed. This printable list may not reflect the latest updates. Members can search the current list online at www.alamedaalliance.org or simply call the Alliance Customer Service Department (number listed below) to confirm if a drug is covered. The formulary is subject to change and all previous versions of the formulary are no longer in effect. This printable formulary can also be found on our website: https://alamedaalliance.org/members/pharmacy-and-medication-benefits/medication-formulary/

Members please call Member Services at (877) 932-2738. Open Monday to Friday from 8am – 5pm PST (Pacific Standard Time).

HOW TO USE THE DRUG FORMULARY

To find a drug on the list, search first for what the drug will treat. All drugs are then listed by their generic and brand names in their therapeutic category, class and in alphabetical order. Any drug not found in this Formulary by looking up the therapeutic category and class, brand or generic names then list is a Non-Formulary drug. If a generic equivalent for a brand name drug is not available or is not covered, the drug will not be separately listed by its generic name. This Drug Formulary applies only to outpatient drugs prescribed to members. It does not apply to drugs used in inpatient settings.

DEFINITIONS

ENROLLEE

An enrollee is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

PRESCRIPTION

A prescription is an oral, written or electronic order by a prescribing provider for a specific enrollee (and requires prescription under applicable law) that contains the name of the prescription drug, the quantity, the route of administration, directions for use, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed. Other requirements may apply depending on the drug requested. Please note that the presence of a prescription drug on the formulary does not guarantee the enrollee will be prescribed that prescription drug by his or her prescribing provider for a particular medication condition.

PRESCRIPTION DRUG

A prescription drug is a drug that is prescribed by the enrollee's prescribing provider and requires a prescription under applicable law.

PRESCRIBING PROVIDER

A prescribing provider is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

SUBSCRIBER

A subscriber is the person who is responsible for payment to the plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

CO-INSURANCE

Co-insurance is a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

OUT-OF-POCKET COST

Out-of-pocket costs are copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

COPAYMENT

A copayment is a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

DEDUCTIBLE

A deductible is the amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit

under the terms of the policy.

DRUG TIER

A drug tier is a group of prescription drugs that correspond to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost of the drug.

EXCEPTION REQUEST

An exception request is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

PRIOR AUTHORIZATION

Health plan's requirement that the enrollee or the enrollee's prescribing provider obtain the health plan's authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

EXIGENT CIRCUMSTANCES

An exigent circumstance is when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

GENERIC DRUG

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

INTRAVENOUS SOLUTIONS OF UNLISTED ANTIBIOTICS ml

Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital, when I.V. therapy with the same antibiotic was started before discharge. There is a maximum of a 10 day 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. See the Compound Drug Pharmacy Claim Form {30-4} Completion section for more information.

INTRAVENOUS SOLUTIONS OF OTHER UNLISTED DRUGS ml

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 a 10 day 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. See the Compound Drug Pharmacy Claim Form {30-4} Completion section for more information.

EXCEPTION REQUEST

An exception request is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing health care provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

Drug Coverage Requirements or Limits

A health plan may request an omission, deviation or substitution of the stated definitions to the Director for review and approval. There are some processes and limits that may apply to drugs in the formulary. Some are marked with a code on the list. The explanation for code is below:

Code	Meaning	Definition
QL	Quantity Limit	Coverage may be limited to specific quantities per prescription and/or time period
ST	Step Therapy	Coverage may depend on previous use of another drug
PA	Prior Authorization	Requires specific request process

Quantity Limits: For certain drugs, the Alliance has a limit on the number of pills that will be covered. In general, a 30-day supply is covered. However, if a member requires a drug in excess of the limit, a doctor can submit a Prior Authorization Form.

Step Therapy: In some cases, the Alliance requires members to first try certain drugs to treat a medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, we may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, we will then cover Drug B. Doctors can request an exception by submitting a Prior Authorization Form.

Generic Substitutions: The Alliance has a mandatory generic program. This program promotes the use of ***generic drugs*** over brand when medically appropriate. A doctor may write a prescription for a brand name drug and not a generic due to medical need. In these cases the doctor must submit a Prior Authorization Form.

Brand Name Drugs: A BRAND NAME DRUG is a drug that is marketed under a proprietary, trademark protected name.

Prior Authorization Process: To prescribe drugs that are not in our Drug Formulary or that exceed the plan quantity limits, a doctor can submit a Prior Authorization Form. The Alliance reviews these requests and asks for more details

if needed. We will inform the doctor of our decision within 24 hours to 72 hours for all requests.

Therapeutic Interchange: The Alliance may, with a doctor's approval, change the drug that the doctor prescribed to a drug on the formulary that is the same in effectiveness and safety.

NON-FORMULARY MEDICATIONS

A non-formulary drug is a drug not listed on the health plan's formulary. These medications are reserved for members who have used (or cannot/should not use) up to three formulary alternatives that are used to treat the documented diagnosis OR meet off-label criteria OR has tried and failed or is unable to use separate components (or therapeutic equivalents) of a combination medication or is unable to use a consolidated dose form. Each request can be reviewed via a prior authorization request within 24 to 72 hours from the time received. Non-formulary drugs will also be covered when determined to be medically necessary (e.g. once reviewed with a prior authorization request). The enrollee may file a grievance or complaint for a denial of coverage, along with information on appeal rights and procedures.

Authorization and Billing Instructions

Providers can supply in-office injectable drugs to Alliance members by purchasing directly from suppliers/manufacturers (commonly known as buy and bill) or Diplomat Specialty Pharmacy (Diplomat). The authorization and billing processes differ based on the method of obtaining the drug and the member's delegate:

<table>
<tr><th>Method of Procurement</th><th>Delegate</th><th>Requires Authorization</th><th>Where to Submit Authorization</th><th>Whom to Bill</th></tr>
<tr><td>Diplomat (Pharmacy Benefit)</td><td>All</td><td>Yes</td><td>PerformRx</td><td>Not necessary (Pharmacy bills Alliance directly)</td></tr>
<tr><td rowspan="4">Buy and Bill (Medical Benefit)</td><td>Alliance</td><td rowspan="4">Refer to list below for Alliance delegate or check with member's delegate</td><td>Alliance</td><td rowspan="4">Alliance</td></tr>
<tr><td>Children First Medical Group</td><td>Children First Medical Group</td></tr>
<tr><td>Community Health Center Network</td><td>Community Health Center Network</td></tr>
<tr><td></td><td>Hill Physician Medical Group</td></tr>
</table>

Please use the corresponding authorization form for the type of request:

- **Medical Benefit:** *Alliance Authorization Request* form
- Pharmacy Benefit :
  - *PerformRx Medication Request Form* (for Medi-Cal and Alliance Group Care)
  - *Request for Medicare Prescription Drug Coverage Determination* (Medicare)

Filling your Prescription at a Network Pharmacy

In most cases, you can fill prescriptions at any network retail pharmacy, except for prescriptions for a specialty drug. To find a network retail pharmacy, you can look in the Alliance Provider Directory, visit our website (www.alamedaalliance.org), or call Member Services at 510-747-4567 or toll-free 1-877-932-2738 (CRS/TTY 711 or 1-800-735-2929) from Monday to Friday, 8 a.m. to 5 p.m.

Process for Obtaining Specialty Drugs from Diplomat

Diplomat is the Alliance's specialty pharmacy for Alliance Medi-Cal and Alliance Group Care members. Retail pharmacies may not dispense these drugs for Medi-Cal or Alliance Group Care members. Specialty drug orders for Alliance CompleteCare members can be filled by Diplomat or any other Alliance contracted pharmacy.

Refer to the attached list of available drugs from Diplomat.

Certain drugs are only available from specific distributors and not Diplomat. The clinic can purchase these drugs directly from the distributors and bill the Alliance or have the distributor bill the Alliance. These drugs, along with the name and contact of the alternate distributors, are listed on the Limited Distribution Drug List.

Prior authorization is required for new specialty drug orders and for renewals (usually annually). The same review process is used for specialty drug orders as is used for other retail drugs that require prior authorization.

Authorization process for Diplomat Drugs:

- Fax the appropriate pharmacy request form to PerformRX (see above)
- Requests are processed (and notification of the decision sent to your office and Diplomat) within 72 hours for urgent requests or 14 days for routine requests.
- Upon PerformRx approval, **Diplomat** will call your office to obtain the prescription and dispense the drug by mail.

Contacts for Additional Information:

- Call Diplomat toll-free at **1-855-347-4783** for:
  - A complete list of specialty drugs provided by Diplomat
  - Questions related to dispensing of the drugs
- Call PerformRx toll-free at **1-855-508-1713** for questions related to prior authorizations
- Call Alliance Pharmacy Services at **510-747-4541** for questions related to specialty drugs from Diplomat

632_2002_Alameda Wrap34242508/18/2021

Alameda WRAP Medi-Medi Formulary

CURRENT AS OF 8/18/2021

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihistamine Drugs - Drugs For Allergy		
Ethanolamine Derivatives - Drugs For Allergy		
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL CAPSULE 25 MG (***diphenhydramine hcl***)	T1	
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL TABLET 25 MG (***diphenhydramine hcl***)	T1	
DIPHEDRYL ORAL LIQUID 12.5 MG/5 ML (***diphenhydramine hcl***)	T1	
DIPHENHIST ORAL TABLET 50 MG (***diphenhydramine hcl***)	T1	
diphenhydramine hcl oral capsule 50 mg	T1	
diphenhydramine hcl oral tablet 25 mg	T1	
Q-DRYL ORAL LIQUID 12.5 MG/5 ML (***diphenhydramine hcl***)	T1	
First Generation Antihistamines - Drugs For Allergy		
ALLERGY (CHLORPHENIRAMINE) ORAL TABLET 4 MG (***chlorpheniramine maleate***)	T1	
ALLERGY RELIEF(CHLORPHENIRAMN) ORAL TABLET EXTENDED RELEASE 12 MG (***chlorpheniramine maleate***)	T2	PA
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL CAPSULE 25 MG (***diphenhydramine hcl***)	T1	
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL TABLET 25 MG (***diphenhydramine hcl***)	T1	
DIPHEDRYL ORAL LIQUID 12.5 MG/5 ML (***diphenhydramine hcl***)	T1	
DIPHENHIST ORAL TABLET 50 MG (***diphenhydramine hcl***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
diphenhydramine hcl oral capsule 50 mg	T1	
diphenhydramine hcl oral tablet 25 mg	T1	
Q-DRYL ORAL LIQUID 12.5 MG/5 ML (***diphenhydramine hcl***)	T1	
Phenothiazine Derivatives - Drugs For Allergy		
promethazine oral syrup 6.25 mg/5 ml	T1	
promethazine-dm oral syrup 6.25-15 mg/5 ml	T1	QL (240 ML per 30 days); AL (Min 4 Years)
Propylamine Derivatives - Drugs For Allergy		
ALLERGY (CHLORPHENIRAMINE) ORAL TABLET 4 MG (***chlorpheniramine maleate***)	T1	
ALLERGY RELIEF(CHLORPHENIRAMN) ORAL TABLET EXTENDED RELEASE 12 MG (***chlorpheniramine maleate***)	T2	PA
AMBI 60PSE-4CPM ORAL TABLET 4-60 MG (***chlorpheniramine maleate/pseudoephedrine hcl***)	T1	
Second Generation Antihistamines - Drugs For Allergy		
ALLERCLEAR D-24HR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG (***loratadine/pseudoephedrine sulfate***)	T1	QL (60 EA per 30 days)
ALLERGY RELIEF (LORATADINE) ORAL TABLET,DISINTEGRATING 10 MG (***loratadine***)	T1	QL (30 EA per 30 days)
cetirizine oral tablet 10 mg	T1	
fexofenadine oral tablet 180 mg	T2	PA
fexofenadine oral tablet 60 mg	T2	
loratadine oral tablet 10 mg	T1	
LORATADINE-D ORAL TABLET EXTENDED RELEASE 12 HR 5-120 MG (***loratadine/pseudoephedrine sulfate***)	T1	QL (60 EA per 30 days)
Autonomic Drugs - Drugs For The Nervous System		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alpha- And Beta-Adrenergic Agonists - Drugs For Heart And Lungs		
ALLERCLEAR D-24HR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG (***loratadine/pseudoephedrine sulfate***)	T1	QL (60 EA per 30 days)
AMBI 60PSE-4CPM ORAL TABLET 4-60 MG (***chlorpheniramine maleate/pseudoephedrine hcl***)	T1	
LORATADINE-D ORAL TABLET EXTENDED RELEASE 12 HR 5-120 MG (***loratadine/pseudoephedrine sulfate***)	T1	QL (60 EA per 30 days)
NASAL DECONGESTANT (PSEUDOEPH) ORAL TABLET 30 MG (***pseudoephedrine hcl***)	T1	
pseudoephedrine hcl oral tablet 60 mg	T1	
SUDAFED 12 HOUR ORAL TABLET EXTENDED RELEASE 120 MG (***pseudoephedrine hcl***)	T1	
Alpha-Adrenergic Agonists - Drugs For Heart And Lungs		
TUSSIN CF COUGH-COLD ORAL LIQUID 5-10-100 MG/5 ML (***guaifenesin/dextromethorphan hbr/phenylephrine***)	T1	
Antimuscarinics/Antispasmodics - Drugs For Parkinson		
hyoscyamine sulfate oral tablet 0.125 mg	T2	
hyoscyamine sulfate sublingual tablet 0.125 mg	T2	
Autonomic Drugs, Miscellaneous - Drugs For The Nervous System		
NICODERM CQ TRANSDERMAL PATCH 24 HOUR 14 MG/24 HR, 21 MG/24 HR, 7 MG/24 HR (***nicotine***)	T1	QL (84 EA per 365 days)
nicotine (polacrilex) buccal gum 2 mg, 4 mg	T1	QL (360 EA per 30 days)
nicotine (polacrilex) buccal lozenge 2 mg, 4 mg	T1	QL (360 EA per 30 days)
nicotine transdermal patch 24 hour 14 mg/24 hr, 21 mg/24 hr, 7 mg/24 hr	T1	QL (84 EA per 365 days)
Blood Formation, Coagulation, Thrombosis - Drugs For The Blood		
Iron Preparations - Vitamins And Minerals		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CERTA PLUS ORAL TABLET 18-0.4-250 MG-MG-MCG (***folic acid/multivit with iron, minerals/lutein***)	T1	
COMPLETE MULTIVITAMIN ORAL TABLET (***multivitamin,therapeutic with iron and minerals***)	T1	
ferrous gluconate oral tablet 324 mg (38 mg iron)	T1	
ferrous sulfate oral solution 220 mg (44 mg iron)/5 ml	T1	
ferrous sulfate oral tablet 325 mg (65 mg iron)	T1	
ferrous sulfate oral tablet,delayed release (dr/ec) 324 mg (65 mg iron)	T1	
ferrous sulfate oral tablet,delayed release (dr/ec) 325 mg (65 mg iron)	T1	
MULTI-VIT WITH FLUORIDE-IRON ORAL DROPS 0.25MG FLUORIDE -10 MG IRON/ML (***pediatric multivitamin no.45/sodium fluoride/ferrous sulfate***)	T1	AL (Max 5 Years)
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG (***prenatal vitamin with calcium no.76/iron,carbonyl/folic acid***)	T1	AL (Max 50 Years)
PRENATAL 19 ORAL TABLET,CHEWABLE 29 MG IRON-1 MG (***prenatal vits with calcium no.115/iron fumarate/folic acid***)	T1	AL (Max 50 Years)
RIGHT STEP PRENATAL VITAMINS ORAL TABLET 27 MG IRON- 0.8 MG (***prenatal vitamins with calcium/ferrous fumarate/folic acid***)	T1	AL (Max 50 Years)
THERA-M ORAL TABLET (***multivitamin,therapeutic with iron and minerals***)	T1	
THERA-M ORAL TABLET 9 MG IRON-400 MCG (***multivits with calcium and minerals/iron fumarate/folic acid***)	T1	
Platelet-Aggregation Inhibitors - Drugs To Prevent Blood Clots		
aspirin oral tablet,chewable 81 mg	T1	
aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg	T1	
LITE COAT ASPIRIN ORAL TABLET 325 MG (***aspirin***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIGRAINE FORMULA ORAL TABLET 250-250-65 MG (***aspirin/acetaminophen/caffeine***)	T1	
Thrombolytic Agents - Drugs To Prevent Blood Clots		
aspirin oral tablet,chewable 81 mg	T1	
aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg	T1	
LITE COAT ASPIRIN ORAL TABLET 325 MG (***aspirin***)	T1	
MIGRAINE FORMULA ORAL TABLET 250-250-65 MG (***aspirin/acetaminophen/caffeine***)	T1	
Cardiovascular Drugs - Drugs For The Heart		
Antilipemic Agents, Miscellaneous - Drugs For Cholesterol		
FISH OIL ORAL CAPSULE 340-1,000 MG, 360-1,200 MG (***omega-3 fatty acids/fish oil***)	T1	QL (160 EA per 30 days)
niacin oral capsule, extended release 500 mg	T1	
niacin oral tablet 100 mg, 500 mg	T1	
niacin oral tablet 250 mg	T1	
niacin oral tablet extended release 1,000 mg	T1	
niacin oral tablet extended release 250 mg, 500 mg	T1	
omega 3-dha-epa-fish oil oral capsule 1,000 mg (120 mg-180 mg)	T2	QL (160 QY per 30 DYs)
Central Nervous System Agents - Drugs For The Nervous System		
Amphetamine Derivatives - Drugs For The Nervous System		
phentermine oral capsule 15 mg, 30 mg	T2	PA
phentermine oral tablet 37.5 mg	T2	PA
Analgesics And Antipyretics, Misc. - Drugs For Pain		
8 HOUR PAIN RELIEVER ORAL TABLET EXTENDED RELEASE 650 MG (***acetaminophen***)	T1	
ACEPHEN RECTAL SUPPOSITORY 325 MG (***acetaminophen***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
acetaminophen oral elixir 160 mg/5 ml	T1	
acetaminophen oral liquid 160 mg/5 ml	T1	
MIGRAINE FORMULA ORAL TABLET 250-250-65 MG (***aspirin/acetaminophen/caffeine***)	T1	
PAIN RELIEF (ACETAMINOPHEN) ORAL TABLET 500 MG (***acetaminophen***)	T1	
PAIN RELIEF (ACETAMINOPHEN) ORAL TABLET EXTENDED RELEASE 650 MG (***acetaminophen***)	T1	
PAIN RELIEVER (ACETAMINOPHEN) ORAL TABLET 325 MG (***acetaminophen***)	T1	
Anorexigenic Agents, Miscellaneous - Drugs For The Nervous System		
QSYMIA ORAL CAPSULE, ER MULTIPHASE 24 HR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (***phentermine hcl/topiramate***)	T2	PA
Antimigraine Agents, Miscellaneous - Migraine Treatment		
aspirin oral tablet,chewable 81 mg	T1	
aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg	T1	
LITE COAT ASPIRIN ORAL TABLET 325 MG (***aspirin***)	T1	
MIGRAINE FORMULA ORAL TABLET 250-250-65 MG (***aspirin/acetaminophen/caffeine***)	T1	
Anxiolytics,Sedatives,And Hypnotics,Misc - Drugs For Anxiety & Sleep Disorder		
promethazine oral syrup 6.25 mg/5 ml	T1	
Opiate Agonists - Drugs For Pain		
codeine-guaifenesin oral liquid 10-100 mg/5 ml	T1	QL (480 ML per 30 days); AL (Min 12 Years)
promethazine-codeine oral syrup 6.25-10 mg/5 ml	T1	QL (240 QY per 30 DYs); AL (Min 12 Years)
Other Nonsteroidal Anti-Inflam. Agents - Drugs For Pain		
ibuprofen oral tablet 200 mg	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Respiratory And Cns Stimulants - Drugs For The Nervous System		
MIGRAINE FORMULA ORAL TABLET 250-250-65 MG (***aspirin/acetaminophen/caffeine***)	T1	
Salicylates - Drugs For Pain		
aspirin oral tablet,chewable 81 mg	T1	
aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg	T1	
LITE COAT ASPIRIN ORAL TABLET 325 MG (***aspirin***)	T1	
MIGRAINE FORMULA ORAL TABLET 250-250-65 MG (***aspirin/acetaminophen/caffeine***)	T1	
Devices - Medical Supplies And Durable Medical Equipment		
Devices - Medical Supplies And Durable Medical Equipment		
MICROCHAMBER SPACER (***inhaler, assist devices***)	T1	QL (2 per per 365 days)
PROCHAMBER SPACER (***inhaler, assist devices***)	T1	QL (2 per per 365 days)
VORTEX FROG MASK-CHILD DEVICE (***inhaler, assist devices, accessories***)	T1	QL (2 per per 365 days)
VORTEX HOLDING CHAMBER CHILD SPACER (***inhaler,assist device with medium mask***)	T1	QL (2 EA per 365 days)
VORTEX HOLDING CHAMBER SPACER (***inhaler, assist devices***)	T1	QL (2 QY per 365 DYs)
VORTEX HOLDING CHAMBER TODDLER SPACER (***inhaler,assist device with small mask***)	T1	QL (2 EA per 365 days)
VORTEX LADYBUG MASK-TODDLER DEVICE (***inhaler, assist devices, accessories***)	T1	QL (2 per per 365 days)
VORTEX VHC FROG MASK-CHILD SPACER (***inhaler,assist device with medium mask***)	T1	QL (2 EA per 365 days)
VORTEX VHC LADYBUG MASK-TODDLR SPACER (***inhaler,assist device with small mask***)	T1	QL (2 EA per 365 days)
Diagnostic Agents		
Ketones		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KETONE CARE STRIP (***urine acetone test,strips***)	T1	QL (100 EA per 30 days)
Sugar		
DIASTIX STRIP (***urine glucose test strip***)	T1	
Electrolytic, Caloric, And Water Balance		
Caloric Agents - Drugs For Nutrition		
BOOST GLUCOSE CONTROL ORAL LIQUID 0.06-1.1 GRAM-KCAL/ML (***nutritional tx. glucose intolerance,lactose-free,soy/fiber***)	T2	PA
CAMINO PRO 15 PKU ORAL SUSPENSION 0.11-1.06 GRAM-KCAL/ML (***nutritional therapy for phenylketonuria(pku) with iron no.26***)	T2	PA
CAMINO PRO RESTORE LITE ORAL LIQUID 2 GRAM-14 KCAL/100 ML (***nutritional therapy for phenylketonuria (pku), no.49***)	T2	PA
CAMINO-PRO RESTORE ORAL LIQUID 2 GRAM-34 KCAL/100 ML (***nutritional therapy for phenylketonuria (pku), no.49***)	T2	PA
CAMINO-PRO RESTORE ORAL LIQUID 2 GRAM-36.4 KCAL/100 ML (***nut. tx for pku, #46***)	T2	PA
COMPLEAT PEDIATRIC ORAL LIQUID (***milk based formula***)	T2	PA
CRUCIAL ORAL LIQUID (***nut.tx.comp. immune systm,soy***)	T2	PA
GLUCERNA 1.2 CAL ORAL LIQUID 0.06-1.2 GRAM-KCAL/ML (***nutritional tx. glucose intolerance,lactose-free,soy/fiber***)	T2	PA
GLYTACTIN 15 PE BETTERMILK ORAL POWDER IN PACKET 31 GRAM-327 KCAL/100 GRAM (***nutritional therapy for pku no.64***)	T2	PA
NUTREN JUNIOR ORAL LIQUID 0.03-1 GRAM-KCAL/ML (***nutritional supplement***)	T2	PA

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEPTAMEN AF ORAL SUSPENSION 0.0756-1.2 GRAM-KCAL/ML (***nutritional supplement no.1/fructooligosaccharides/inulin***)	T2	PA
PERATIVE ORAL LIQUID 0.067-1.30 GRAM-KCAL/ML (***nut.tx. metabolic disorder,soy***)	T2	PA
PHENYLADE RTD PKU 10 ORAL LIQUID 10-60 GRAM-KCAL/75 ML (***nutritional therapy for phenylketonuria(pku) with iron no.50***)	T2	PA
PKU COOLER 10 ORAL SUSPENSION 0.12-0.71 G-KCAL/ML (***nutritional therapy for phenylketonuria(pku) with iron no.4***)	T2	PA
PKU LOPHLEX ORAL LIQUID IN PACKET 20-115 GRAM-KCAL/125ML (***nutritional therapy for phenylketonuria(pku) with iron no.42***)	T2	PA
PKU LOPHLEX ORAL LIQUID IN PACKET 20-116 GRAM-KCAL (***nutritional therapy for phenylketonuria(pku) with iron no.40***)	T2	PA
PULMOCARE ORAL LIQUID (***nutritional therapy, pulmonary disorder,soy,lactose-free***)	T2	PA
Replacement Preparations		
ANTACID EXTRA-STRENGTH ORAL TABLET,CHEWABLE 200 MG CALCIUM (500 MG) (***calcium carbonate***)	T1	
CALCIO DEL MAR ORAL TABLET 500 MG (***calcium***)	T1	
CALCIUM 500 + D ORAL TABLET 500 MG(1,250MG) -200 UNIT (***calcium carbonate/cholecalciferol (vitamin d3)***)	T1	
CALCIUM 500 WITH D ORAL TABLET 500 MG(1,250MG) -400 UNIT (***calcium carbonate/cholecalciferol (vitamin d3)***)	T1	
CALCIUM 600 + D(3) ORAL TABLET 600 MG(1,500MG) -200 UNIT, 600 MG(1,500MG) -400 UNIT (***calcium carbonate/cholecalciferol (vitamin d3)***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM 600 ORAL TABLET 600 MG CALCIUM (1,500 MG) (***calcium carbonate***)	T1	
calcium carbonate oral suspension 500 mg/5 ml (1,250 mg/5 ml)	T1	
calcium carbonate oral tablet 260 mg calcium (648 mg)	T1	
calcium carbonate oral tablet 500 mg calcium (1,250 mg)	T1	
calcium carbonate-vitamin d3 oral tablet,chewable 500-100 mg-unit	T1	
calcium citrate-vitamin d3 oral tablet 315 mg-6.25 mcg (250 unit)	T1	
calcium gluconate oral tablet 45 mg (500 mg), 60 mg (648 mg)	T1	
OYSTER SHELL CALCIUM-VIT D3 ORAL TABLET 250-125 MG-UNIT, 500 MG(1,250MG) -200 UNIT (***calcium carbonate/cholecalciferol (vitamin d3)***)	T1	
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG (***prenatal vitamin with calcium no.76/iron,carbonyl/folic acid***)	T1	AL (Max 50 Years)
RIGHT STEP PRENATAL VITAMINS ORAL TABLET 27 MG IRON- 0.8 MG (***prenatal vitamins with calcium/ferrous fumarate/folic acid***)	T1	AL (Max 50 Years)
RISACAL-D ORAL TABLET 100 MG CALCIUM- 3 MCG (***calcium phosphate, dibasic/cholecalciferol (vitamin d3)***)	T1	
THERA-M ORAL TABLET 9 MG IRON-400 MCG (***multivits with calcium and minerals/iron fumarate/folic acid***)	T1	
Eye, Ear, Nose And Throat (Eent) Preps.		
Eent Drugs, Miscellaneous		
ALTACHLORE OPHTHALMIC (EYE) DROPS 5 % (***sodium chloride***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALTACHLORE OPHTHALMIC (EYE) OINTMENT 5 % (***sodium chloride***)	T1	
ARTIFICIAL TEARS (POLYVIN ALC) OPHTHALMIC (EYE) DROPS 1.4 % (***polyvinyl alcohol***)	T1	
BABY AYR SALINE NASAL DROPS 0.65 % (***sodium chloride***)	T1	
SALINE MIST NASAL AEROSOL,SPRAY 0.65 % (***sodium chloride***)	T1	
Vasoconstrictors		
EYE ALLERGY RELIEF OPHTHALMIC (EYE) DROPS 0.025-0.3 %, 0.02675-0.315 % (***naphazoline hcl/pheniramine maleate***)	T1	
Gastrointestinal Drugs		
Antacids And Adsorbents		
ADVANCED ANTACID-ANTIGAS ORAL SUSPENSION 200-200-20 MG/5 ML (***magnesium hydroxide/aluminum hydroxide/simethicone***)	T1	
ANTACID EXTRA-STRENGTH ORAL TABLET,CHEWABLE 200 MG CALCIUM (500 MG) (***calcium carbonate***)	T1	
calcium carbonate oral tablet 260 mg calcium (648 mg)	T1	
GELUSIL ANTACID AND ANTI-GAS ORAL TABLET,CHEWABLE 200-200-25 MG (***magnesium hydroxide/aluminum hydroxide/simethicone***)	T1	
GERI-MOX ANTACID-ANTIGAS ORAL SUSPENSION 200-200-20 MG/5 ML (***magnesium hydroxide/aluminum hydroxide/simethicone***)	T1	
magnesium oxide oral tablet 400 mg (241.3 mg magnesium)	T1	
PINK BISMUTH ORAL TABLET 262 MG (***bismuth subsalicylate***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PINK BISMUTH ORAL TABLET,CHEWABLE 262 MG (***bismuth subsalicylate***)	T1	
sodium bicarbonate oral tablet 650 mg	T1	
SOOTHE REGULAR STRENGTH ORAL SUSPENSION 262 MG/15 ML (***bismuth subsalicylate***)	T1	
STOMACH RELIEF MAX STRENGTH ORAL SUSPENSION 525 MG/15 ML (***bismuth subsalicylate***)	T1	
Gastrointestinal Drugs - Drugs For The Stomach		
Antidiarrhea Agents - Drugs For Diarrhea		
ANTI-DIARRHEAL (LOPERAMIDE) ORAL TABLET 2 MG (***loperamide hcl***)	T1	
loperamide oral capsule 2 mg	T1	
PINK BISMUTH ORAL TABLET 262 MG (***bismuth subsalicylate***)	T1	
PINK BISMUTH ORAL TABLET,CHEWABLE 262 MG (***bismuth subsalicylate***)	T1	
SOOTHE REGULAR STRENGTH ORAL SUSPENSION 262 MG/15 ML (***bismuth subsalicylate***)	T1	
STOMACH RELIEF MAX STRENGTH ORAL SUSPENSION 525 MG/15 ML (***bismuth subsalicylate***)	T1	
Antiflatulents - Drugs For Gas		
ADVANCED ANTACID-ANTIGAS ORAL SUSPENSION 200-200-20 MG/5 ML (***magnesium hydroxide/aluminum hydroxide/simethicone***)	T1	
GAS RELIEF (SIMETHICONE) ORAL CAPSULE 125 MG (***simethicone***)	T1	
GELUSIL ANTACID AND ANTI-GAS ORAL TABLET,CHEWABLE 200-200-25 MG (***magnesium hydroxide/aluminum hydroxide/simethicone***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GERI-MOX ANTACID-ANTIGAS ORAL SUSPENSION 200-200-20 MG/5 ML (***magnesium hydroxide/aluminum hydroxide/simethicone***)	T1	
Cathartics And Laxatives - Drugs For Constipation		
BISA-LAX (BISACODYL) ORAL TABLET,DELAYED RELEASE (DR/EC) 5 MG (***bisacodyl***)	T1	
COLACE ORAL CAPSULE 50 MG (***docusate sodium***)	T1	
docusate sodium oral capsule 100 mg	T1	
ENEMA DISPOSABLE RECTAL ENEMA 19-7 GRAM/118 ML (***sodium phosphate,monobasic/sodium phosphate,dibasic***)	T1	
FIBER SMOOTH ORAL POWDER (***psyllium seed***)	T1	
KONSYL SUGAR-FREE ORAL POWDER IN PACKET 6 GRAM (***psyllium husk***)	T1	
LAXATIVE (BISACODYL) RECTAL SUPPOSITORY 10 MG (***bisacodyl***)	T1	
magnesium citrate oral solution	T1	
METAMUCIL (WITH SUGAR) ORAL POWDER IN PACKET 3.4 GRAM (***psyllium husk (with sugar)***)	T1	
MILK OF MAGNESIA ORAL SUSPENSION 400 MG/5 ML (***magnesium hydroxide***)	T1	
SANI-SUPP (ADULT) RECTAL SUPPOSITORY (***glycerin***)	T1	
SENNA LAX ORAL TABLET 8.6 MG (***sennosides***)	T1	
SENNA ORAL SYRUP 8.8 MG/5 ML (***sennosides***)	T1	
sorbitol solution 70 %	T1	
STOOL SOFTENER ORAL CAPSULE 250 MG (***docusate sodium***)	T1	
STOOL SOFTENER ORAL LIQUID 50 MG/5 ML (***docusate sodium***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STOOL SOFTENER ORAL SYRUP 60 MG/15 ML (***docusate sodium***)	T1	
Gi Drugs, Miscellaneous - Drugs For The Stomach		
ALLI ORAL CAPSULE 60 MG (***orlistat***)	T2	PA
XENICAL ORAL CAPSULE 120 MG (***orlistat***)	T2	PA
Histamine H2-Antagonists - Drugs For Ulcers And Stomach Acid		
famotidine oral tablet 10 mg, 20 mg	T1	
Miscellaneous Therapeutic Agents		
Cariostatic Agents - Vitamins And Fluoride		
MULTI-VIT WITH FLUORIDE-IRON ORAL DROPS 0.25MG FLUORIDE -10 MG IRON/ML (***pediatric multivitamin no.45/sodium fluoride/ferrous sulfate***)	T1	AL (Max 5 Years)
MULTI-VITAMIN WITH FLUORIDE ORAL DROPS 0.25 MG/ML, 0.5 MG/ML (***pediatric multivitamin no.2/sodium fluoride***)	T1	AL (Max 5 Years)
Other Miscellaneous Therapeutic Agents		
ICAPS AREDS ORAL TABLET,DELAYED RELEASE (DR/EC) 7,160-113-100 UNIT-MG-UNIT (***beta-carotene/ascorbic acid/vite ac/zinc oxide/cupric oxide***)	T1	
Nonhormonal Contraceptives - Drugs For Women		
Nonhormonal Contraceptives - Drugs For Women		
CONDOMS-PREM LUBRICATED DEVICE (***condoms, latex, lubricated***)	T1	
DUREX AVANTI BARE REAL FEEL (***condoms, non-latex, lubricated***)	T1	
FC2 FEMALE CONDOM (***condoms, female***)	T1	
GYNOL II VAGINAL GEL 3 % (***nonoxynol 9***)	T1	
VAGINAL CONTRACEPTIVE FOAM VAGINAL FOAM 12.5 % (***nonoxynol 9***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Respiratory Tract Agents - Drugs For The Lungs		
Alpha And Beta Adrenergic Agonist(Respr) - Drugs For Asthma/Copd		
ALLERCLEAR D-24HR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG (***loratadine/pseudoephedrine sulfate***)	T1	QL (60 EA per 30 days)
AMBI 60PSE-4CPM ORAL TABLET 4-60 MG (***chlorpheniramine maleate/pseudoephedrine hcl***)	T1	
LORATADINE-D ORAL TABLET EXTENDED RELEASE 12 HR 5-120 MG (***loratadine/pseudoephedrine sulfate***)	T1	QL (60 EA per 30 days)
NASAL DECONGESTANT (PSEUDOEPH) ORAL TABLET 30 MG (***pseudoephedrine hcl***)	T1	
pseudoephedrine hcl oral tablet 60 mg	T1	
SUDAFED 12 HOUR ORAL TABLET EXTENDED RELEASE 120 MG (***pseudoephedrine hcl***)	T1	
Antitussives - Drugs For Cough And Cold		
benzonatate oral capsule 100 mg, 200 mg	T1	QL (90 EA per 30 days)
codeine-guaifenesin oral liquid 10-100 mg/5 ml	T1	QL (480 ML per 30 days); AL (Min 12 Years)
dextromethorphan-guaifenesin oral syrup 10-100 mg/5 ml	T1	
promethazine-codeine oral syrup 6.25-10 mg/5 ml	T1	QL (240 QY per 30 DYs); AL (Min 12 Years)
promethazine-dm oral syrup 6.25-15 mg/5 ml	T1	QL (240 ML per 30 days); AL (Min 4 Years)
TUSSIN CF COUGH-COLD ORAL LIQUID 5-10-100 MG/5 ML (***guaifenesin/dextromethorphan hbr/phenylephrine***)	T1	
TUSSIN COUGH (DM ONLY) ORAL LIQUID 15 MG/5 ML (***dextromethorphan hbr***)	T1	
TUSSIN DM MAX ORAL LIQUID 10-200 MG/5 ML (***guaifenesin/dextromethorphan hbr***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TUSSIN DM ORAL LIQUID 10-100 MG/5 ML (***guaifenesin/dextromethorphan hbr***)	T1	
TUSSIN DM ORAL SYRUP 10-100 MG/5 ML (***guaifenesin/dextromethorphan hbr***)	T1	
Expectorants - Drugs For The Lungs		
ADULT TUSSIN CHEST CONGESTION ORAL LIQUID 100 MG/5 ML (***guaifenesin***)	T1	
codeine-guaifenesin oral liquid 10-100 mg/5 ml	T1	QL (480 ML per 30 days); AL (Min 12 Years)
dextromethorphan-guaifenesin oral syrup 10-100 mg/5 ml	T1	
guaifenesin oral liquid 100 mg/5 ml	T1	
guaifenesin oral tablet 200 mg, 400 mg	T1	
TUSSIN CF COUGH-COLD ORAL LIQUID 5-10-100 MG/5 ML (***guaifenesin/dextromethorphan hbr/phenylephrine***)	T1	
TUSSIN DM MAX ORAL LIQUID 10-200 MG/5 ML (***guaifenesin/dextromethorphan hbr***)	T1	
TUSSIN DM ORAL LIQUID 10-100 MG/5 ML (***guaifenesin/dextromethorphan hbr***)	T1	
TUSSIN DM ORAL SYRUP 10-100 MG/5 ML (***guaifenesin/dextromethorphan hbr***)	T1	
First Generation Antihist.(Respir Tract) - Drugs For Allergy		
ALLERGY (CHLORPHENIRAMINE) ORAL TABLET 4 MG (***chlorpheniramine maleate***)	T1	
ALLERGY RELIEF(CHLORPHENIRAMN) ORAL TABLET EXTENDED RELEASE 12 MG (***chlorpheniramine maleate***)	T2	PA
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL CAPSULE 25 MG (***diphenhydramine hcl***)	T1	
ALLERGY RELIEF(DIPHENHYDRAMIN) ORAL TABLET 25 MG (***diphenhydramine hcl***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMBI 60PSE-4CPM ORAL TABLET 4-60 MG (***chlorpheniramine maleate/pseudoephedrine hcl***)	T1	
DIPHEDRYL ORAL LIQUID 12.5 MG/5 ML (***diphenhydramine hcl***)	T1	
DIPHENHIST ORAL TABLET 50 MG (***diphenhydramine hcl***)	T1	
diphenhydramine hcl oral capsule 50 mg	T1	
diphenhydramine hcl oral tablet 25 mg	T1	
promethazine oral syrup 6.25 mg/5 ml	T1	
promethazine-codeine oral syrup 6.25-10 mg/5 ml	T1	QL (240 QY per 30 DYs); AL (Min 12 Years)
promethazine-dm oral syrup 6.25-15 mg/5 ml	T1	QL (240 ML per 30 days); AL (Min 4 Years)
Q-DRYL ORAL LIQUID 12.5 MG/5 ML (***diphenhydramine hcl***)	T1	
Second Generation Antihist(Respir Tract) - Drugs For Allergy		
ALLERCLEAR D-24HR ORAL TABLET EXTENDED RELEASE 24 HR 10-240 MG (***loratadine/pseudoephedrine sulfate***)	T1	QL (60 EA per 30 days)
ALLERGY RELIEF (LORATADINE) ORAL TABLET,DISINTEGRATING 10 MG (***loratadine***)	T1	QL (30 EA per 30 days)
cetirizine oral tablet 10 mg	T1	
fexofenadine oral tablet 180 mg	T2	PA
fexofenadine oral tablet 60 mg	T2	
loratadine oral tablet 10 mg	T1	
LORATADINE-D ORAL TABLET EXTENDED RELEASE 12 HR 5-120 MG (***loratadine/pseudoephedrine sulfate***)	T1	QL (60 EA per 30 days)
Skin And Mucous Membrane Agents - Drugs For The Skin		
Antibacterials (Skin, Mucous Membrane) - Drugs For The Skin		
bacitracin topical ointment 500 unit/gram	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
bacitracin topical packet 500 unit/gram	T1	
bacitracin zinc topical ointment 500 unit/gram	T1	
bacitracin zinc topical ointment in packet 500 unit/gram	T1	
bacitracin-polymyxin b topical packet 500-10,000 unit/gram	T1	
DOUBLE ANTIBIOTIC (B.TRACN ZN) TOPICAL OINTMENT 500-10,000 UNIT/GRAM (***bacitracin zinc/polymyxin b sulfate***)	T1	
POLY BACITRACIN TOPICAL OINTMENT 500-10,000 UNIT/GRAM (***bacitracin/polymyxin b sulfate***)	T1	
Antipruritics And Local Anesthetics - Drugs For The Skin		
ANTI-ITCH(DIPHENHYD) WITH ZINC TOPICAL CREAM 2-0.1 % (***diphenhydramine hcl/zinc acetate***)	T1	
Azoles (Skin And Mucous Membrane) - Drugs For The Skin		
ANTIFUNGAL CREAM (MICONAZOLE) TOPICAL CREAM 2 % (***miconazole nitrate***)	T1	
clotrimazole vaginal cream 1 %	T1	
CLOTRIMAZOLE-3 VAGINAL CREAM 2 % (***clotrimazole***)	T1	
miconazole nitrate vaginal cream 2 %	T1	
miconazole nitrate vaginal kit 1,200-2 mg-%	T1	
miconazole nitrate vaginal suppository 100 mg	T1	
MICONAZORB AF TOPICAL POWDER 2 % (***miconazole nitrate***)	T1	
Basic Lotions And Liniments - Drugs For The Skin		
calamine topical lotion	T1	
Basic Ointments And Protectants - Drugs For The Skin		
zinc oxide topical ointment 20 %	T1	
Corticosteroids (Skin, Mucous Membrane) - Drugs For The Skin		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANUCORT-HC RECTAL SUPPOSITORY 25 MG (***hydrocortisone acetate***)	T1	
AQUANIL HC TOPICAL LOTION 1 % (***hydrocortisone***)	T1	
CORTISONE (HYDROCORTISONE) TOPICAL LOTION 1 % (***hydrocortisone***)	T1	
hydrocortisone acetate topical cream 0.5 %	T1	QL (60 GM per 30 days)
hydrocortisone acetate topical ointment 1 %	T1	
hydrocortisone topical cream 0.5 %, 1 %	T1	
hydrocortisone topical cream with perineal applicator 2.5 %	T1	QL (60 GM per 30 days)
hydrocortisone topical lotion 1 %	T1	
hydrocortisone topical ointment 0.5 %, 1 %	T1	
Keratolytic Agents - Drugs For The Skin		
benzoyl peroxide topical cleanser 10 %, 5 %	T1	
benzoyl peroxide topical gel 10 %, 2.5 %	T1	
TARGETED ACNE SPOT TREATMENT TOPICAL CREAM 2.5 % (***benzoyl peroxide***)	T1	
Keratoplastic Agents - Drugs For The Skin		
CUTAR TOPICAL EMULSION 7.5 % (***coal tar***)	T1	
Local Anti-Infectives, Miscellaneous - Drugs For The Skin		
INSTACLEAN SOLUTION (***isopropyl alcohol***)	T1	
Scabicides And Pediculicides - Drugs For The Skin		
LICE TREATMENT TOPICAL LIQUID 1 % (***permethrin***)	T1	
Thiocarbamates(Skin And Mucous Membrane) - Drugs For The Skin		
MEDI-FIRST ANTI-FUNGAL TOPICAL PACKET 1 % (***tolnaftate***)	T1	
tolnaftate topical cream 1 %	T1	
Vitamins		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Multivitamin Preparations		
CERTA PLUS ORAL TABLET 18-0.4-250 MG-MG-MCG (***folic acid/multivit with iron, minerals/lutein***)	T1	
COMPLETE MULTIVITAMIN ORAL TABLET (***multivitamin,therapeutic with iron and minerals***)	T1	
DAILY MULTI-VITAMIN ORAL TABLET (***multivitamin***)	T1	
MULTI-VIT WITH FLUORIDE-IRON ORAL DROPS 0.25MG FLUORIDE -10 MG IRON/ML (***pediatric multivitamin no.45/sodium fluoride/ferrous sulfate***)	T1	AL (Max 5 Years)
MULTI-VITAMIN WITH FLUORIDE ORAL DROPS 0.25 MG/ML, 0.5 MG/ML (***pediatric multivitamin no.2/sodium fluoride***)	T1	AL (Max 5 Years)
POLY-VITAMIN ORAL DROPS 1,500-35-400 UNIT-MG-UNIT/ML (***pediatric multivitamin no.20***)	T1	
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG (***prenatal vitamin with calcium no.76/iron,carbonyl/folic acid***)	T1	AL (Max 50 Years)
PRENATAL 19 ORAL TABLET,CHEWABLE 29 MG IRON-1 MG (***prenatal vits with calcium no.115/iron fumarate/folic acid***)	T1	AL (Max 50 Years)
RIGHT STEP PRENATAL VITAMINS ORAL TABLET 27 MG IRON- 0.8 MG (***prenatal vitamins with calcium/ferrous fumarate/folic acid***)	T1	AL (Max 50 Years)
SUPER THERA VITE M ORAL TABLET (***multivitamin,therapeutic with minerals***)	T1	
THERA ORAL TABLET (***multivitamin,therapeutic***)	T1	
THERA-M ORAL TABLET (***multivitamin,therapeutic with iron and minerals***)	T1	
THERA-M ORAL TABLET 9 MG IRON-400 MCG (***multivits with calcium and minerals/iron fumarate/folic acid***)	T1	
THERAPEUTIC LIQUID ORAL LIQUID (***multivitamin,therapeutic***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMINS AND MINERALS ORAL TABLET (***multivitamin,therapeutic with minerals***)	T1	
Vitamin B Complex		
CERTA PLUS ORAL TABLET 18-0.4-250 MG-MG-MCG (***folic acid/multivit with iron, minerals/lutein***)	T1	
cyanocobalamin (vitamin b-12) injection solution 1,000 mcg/ml	T1	
DIALYVITE 800 ORAL TABLET 0.8 MG (***folic acid/vitamin b complex and vitamin c***)	T1	
DIALYVITE ORAL TABLET 100-1 MG (***folic acid/vitamin b complex and vitamin c***)	T1	
folic acid oral tablet 1 mg	T2	
NEPHRO-VITE RX ORAL TABLET 1-60-300 MG-MG-MCG (***vitamin b complex no.3/folic acid/ascorbic acid(vitc)/biotin***)	T1	
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG (***prenatal vitamin with calcium no.76/iron,carbonyl/folic acid***)	T1	AL (Max 50 Years)
PRENATAL 19 ORAL TABLET,CHEWABLE 29 MG IRON-1 MG (***prenatal vits with calcium no.115/iron fumarate/folic acid***)	T1	AL (Max 50 Years)
pyridoxine (vitamin b6) oral tablet 25 mg	T1	
RIGHT STEP PRENATAL VITAMINS ORAL TABLET 27 MG IRON- 0.8 MG (***prenatal vitamins with calcium/ferrous fumarate/folic acid***)	T1	AL (Max 50 Years)
THERA-M ORAL TABLET 9 MG IRON-400 MCG (***multivits with calcium and minerals/iron fumarate/folic acid***)	T1	
VITAMIN B-1 ORAL TABLET 100 MG (***thiamine hcl***)	T1	
VITAMIN B-6 ORAL TABLET 100 MG, 50 MG (***pyridoxine hcl (vitamin b6)***)	T1	
Vitamin C		

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIALYVITE 800 ORAL TABLET 0.8 MG (***folic acid/vitamin b complex and vitamin c***)	T1	
DIALYVITE ORAL TABLET 100-1 MG (***folic acid/vitamin b complex and vitamin c***)	T1	
NEPHRO-VITE RX ORAL TABLET 1-60-300 MG-MG-MCG (***vitamin b complex no.3/folic acid/ascorbic acid(vitc)/biotin***)	T1	
Vitamin D		
CALCIUM 500 + D ORAL TABLET 500 MG(1,250MG) -200 UNIT (***calcium carbonate/cholecalciferol (vitamin d3)***)	T1	
CALCIUM 500 WITH D ORAL TABLET 500 MG(1,250MG) -400 UNIT (***calcium carbonate/cholecalciferol (vitamin d3)***)	T1	
CALCIUM 600 + D(3) ORAL TABLET 600 MG(1,500MG) -200 UNIT, 600 MG(1,500MG) -400 UNIT (***calcium carbonate/cholecalciferol (vitamin d3)***)	T1	
calcium carbonate-vitamin d3 oral tablet,chewable 500-100 mg-unit	T1	
calcium citrate-vitamin d3 oral tablet 315 mg-6.25 mcg (250 unit)	T1	
cholecalciferol (vitamin d3) oral capsule 1,250 mcg (50,000 unit), 125 mcg (5,000 unit)	T1	
cholecalciferol (vitamin d3) oral tablet 25 mcg (1,000 unit)	T1	
ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)	T2	
ergocalciferol (vitamin d2) oral drops 200 mcg/ml (8,000 unit/ml)	T1	
OYSTER SHELL CALCIUM-VIT D3 ORAL TABLET 250-125 MG-UNIT, 500 MG(1,250MG) -200 UNIT (***calcium carbonate/cholecalciferol (vitamin d3)***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

lowercase bold italics = Generic drugs **UPPERCASE** = Brand name drugs	**Drug Tier** **NF** = Non-formulary **T1** = Formulary **T2** = Formulary Prior Authorization Required	**Coverage Requirements and Limits** **AL** = Age Limit Applies **PA** = PA Applies **QL** = Quantity Limit **ST** = ST Applies

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RISACAL-D ORAL TABLET 100 MG CALCIUM- 3 MCG (***calcium phosphate, dibasic/cholecalciferol (vitamin d3)***)	T1	
VITAMIN D3 ORAL CAPSULE 50 MCG (2,000 UNIT) (***cholecalciferol (vitamin d3)***)	T1	
VITAMIN D3 ORAL TABLET 10 MCG (400 UNIT) (***cholecalciferol (vitamin d3)***)	T1	

PA = Prior Authorization; ST = Step Therapy; QL = Quantity Limits; AL = Age Limits; T1 = Formulary; T2 = Formulary, Prior Authorization Required; QY = Quantity; DY = Day; EA = Each; GM = Gram; ML = Milliliter; MIN = Minimum; MAX = Maximum

Index