2026

Формуляр (список покрываемых лекарственных препаратов)

ElderServe MAP (HMO D-SNP)

ОБРАТИТЕ ВНИМАНИЕ: В ЭТОМ ДОКУМЕНТЕ СОДЕРЖИТСЯ ИНФОРМАЦИЯ О ЛЕКАРСТВАХ, КОТОРЫЕ МЫ ОПЛАЧИВАЕМ В РАМКАХ ДАННОГО СТРАХОВОГО ПЛАНА

HPMS Approved Formulary File Submission ID 00026056, Version: 14

Данный формуляр был обновлен 08/19/2026. Для получения более актуальной информации или ответов на другие вопросы обращайтесь в отдел обслуживания участников ElderServe Health Plan по номеру 1-800-362-2266 (для пользователей TTY/TDD: 711), в любой день недели с 8 a.m. до 8 p.m. Либо же посетите веб-сайт www.ElderServeHealth.org.

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Содержание

Формуляр препаратов, покрываемых по Части D, 2026 г.

Примечание для действующих участников. Содержание данного формуляра изменилось по сравнению с прошлым годом. Ознакомьтесь с настоящим документом, чтобы убедиться, что в нем все еще содержатся принимаемые вами препараты.

Местоимения «мы», «нас», «нам» и «наш», используемые в этом списке препаратов (формуляре), относятся к плану ElderServe MAP (HMO D-SNP). Термины «план» и «наш план» означают план ElderServe MAP (HMO D-SNP)

Этот документ включает «Список препаратов» (формуляр) для нашей программы, актуальный на 08/19/2026. Свяжитесь с нами, чтобы получить обновленную версию «Списка препаратов» (формуляра). Наша контактная информация, а также дата последнего обновления «Списка препаратов» (формуляра) указаны на лицевой и задней стороне обложки.

Как правило, вы должны обращаться в сетевые аптеки для получения рецептурных препаратов в рамках ваших льгот. Доступные льготы, содержание формуляра, сеть аптек и/или размер доплат/сострахования могут измениться 1 января 2026 года и иногда в течение года.

Что такое формуляр ElderServe MAP (HMO D-SNP)?

В настоящем документе термины «Список препаратов» и «формуляр» означают одно и то же. Формуляр — это список покрываемых лекарственных препаратов, составленный организацией ElderServe MAP (HMO D-SNP) совместно с группой поставщиков медицинских услуг и включающий лекарственные средства, которые считаются необходимой частью программы качественного медицинского обслуживания. Как правило, стоимость препаратов, перечисленных в формуляре, покрывается ElderServe MAP (HMO D-SNP), если препарат необходим с медицинской точки зрения и для его получения участник обращается в сетевую аптеку ElderServe MAP (HMO D-SNP), а также если соблюдаются остальные правила плана. Для получения дополнительной информации о выдаче препаратов по рецепту см. «Подтверждение страхового покрытия».

Может ли измениться формуляр?

Большинство изменений в покрытии препаратов начинают действовать с 1 января, но сотрудники плана ElderServe MAP (HMO D-SNP) могут дополнять формуляр или исключать из него лекарства, а также изменять для них уровень разделения затрат либо вносить новые ограничения в течение всего года. Мы должны следовать правилам Medicare при внесении таких изменений. Обновления формуляра публикуются ежемесячно на нашем веб-сайте: https://elderservemap.org/members/member-materials/.

Изменения, которые могут затронуть вас в этом году, представлены далее. В нижеуказанных случаях изменения в покрытии препаратов затронут вас в течение года.

- **Немедленная замена некоторых новых версий брендовых препаратов и оригинальных биологических продуктов.** Мы можем немедленно удалить препарат из нашего формуляра, если заменяем его определенной новой версией этого препарата, которая будет иметь такие же ограничения или меньшее их количество. Когда мы добавляем новую версию препарата в формуляр, мы можем оставить брендовый препарат или оригинальный биологический продукт в формуляре, но сразу добавить новые ограничения.

Мы можем вносить такие немедленные изменения только в случае, если мы добавляем новую дженерическую версию брендового препарата или добавляем определённые новые биосимиляры оригинального биологического продукта, которые уже были в формуляре (например, добавление взаимозаменяемого биосимиляра, который может быть заменен в аптеке на оригинальный биологический продукт без нового рецепта).

Если вы в настоящее время принимаете брендовый препарат или оригинальный биологический продукт, мы можем не уведомить вас заранее о немедленном изменении, но позже предоставим вам информацию о конкретных изменениях, которые были внесены.

Если мы вносим такое изменение, вы или ваш лечащий врач можете попросить нас сделать исключение и продолжить покрытие препарата, который подвергся изменению. Для получения дополнительной информации см. раздел ниже «Как запросить исключение из Формуляра ElderServe MAP (HMO D-SNP)?»

Некоторые из этих типов препаратов могут быть для вас новыми. Для получения дополнительной информации см. раздел ниже «Что такое оригинальные биопрепараты и как они связаны с биосимилярами?»

- **Препараты, выведенные из обращения.** Если препарат изымается с продажи производителем или Управление по санитарному надзору за качеством пищевых продуктов и медикаментов (Food and Drug Administration, FDA) по причинам безопасности либо эффективности, мы можем немедленно удалить препарат из нашего формуляра и позже уведомить членов плана, которые его принимают.

- **Прочие изменения.** Мы можем вносить и другие изменения, которые затрагивают участников, в настоящее время принимающих определенный препарат. Например, мы можем добавить новый дженерик для замены брендового препарата, который уже находится в формуляре, или добавить новый биосимиляр для замены оригинального биологического продукта, который уже есть в формуляре, либо добавить новые ограничения, либо и то, и другое после добавления соответствующего препарата. Мы также можем применять новые ограничения к брендовым препаратам или оригинальным биологическим продуктам, либо к обоим. Мы можем вносить изменения на основе новых клинических рекомендаций. Если мы исключаем препараты из формуляра, добавляем требования предварительного одобрения, ограничения по количеству и/или пошаговую терапию для препарата, мы обязаны уведомить затронутых членов как минимум за 30 дней до вступления изменений в силу. В качестве альтернативы, когда участник запрашивает повторный рецепт на препарат, он может получить 30-дневный запас препарата и уведомление о внесенных изменениях.

  Если мы вносим такие изменения, вы или специалист, выписавший вам рецепт, можете попросить нас сделать для вас исключение и продолжить покрытие препарата, который вы принимаете. Уведомление, которое мы вам предоставим, также будет содержать информацию о том, как подать запрос на исключение. Дополнительную информацию можно найти в разделе ниже «Как запросить исключение из Формуляра ElderServe MAP (HMO D-SNP)?».

Изменения, которые не затронут вас, если в настоящее время вы принимаете определенный препарат. Как правило, если вы принимаете покрываемый препарат, входивший в наш формуляр на начало 2026 страхового года, мы не станем отменять или сокращать покрытие такого препарата в течение 2026 страхового года, за исключением вышеописанных случаев. Это означает, что такие препараты останутся доступными в рамках той же схемы разделения затрат и без новых ограничений для тех участников, которые принимают их в течение оставшегося до конца года срока. В течение года вы не будете получать уведомления об изменениях, которые вас не затрагивают. Однако начиная с 1 января следующего года такие изменения вас коснутся, и поэтому важно ознакомиться с формуляром на следующий год и проверить его на предмет каких-либо изменений, касающихся препаратов.

Прилагаемый формуляр актуален на 08/19/2026. Чтобы получить актуальную информацию о препаратах, покрываемых планом ElderServe MAP (HMO D-SNP), свяжитесь с нами. Наша контактная информация указана на лицевой и задней стороне обложки.

Как использовать формуляр?

Поиск вашего препарата в формуляре можно произвести двумя способами:

По заболеванию

Формуляр начинается со страницы 2. Препараты в этом формуляре сгруппированы по категориям в зависимости от заболеваний, для лечения которых они предназначены. Например, лекарства, используемые для лечения сердечно-сосудистых заболеваний, указаны в категории «ПРЕПАРАТЫ ДЛЯ СЕРДЕЧНО-СОСУДИСТОЙ СИСТЕМЫ / ОТ ГИПЕРТОНИИ / ДЛЯ КОНТРОЛЯ ЛИПИДОВ». Если вы знаете, для чего назначается ваш препарат, найдите соответствующую категорию в списке, который начинается со страницы 2. Затем найдите свой препарат в соответствующей категории.

По алфавиту

Если вы не знаете, в какой категории следует искать препарат, обратитесь к указателю, который начинается на странице 89. Указатель представляет собой алфавитный список всех препаратов, включенных в настоящий документ. В указателе приводятся фирменные препараты и дженерики. Выполните поиск по указателю, чтобы найти свой препарат. Рядом со своим препаратом вы увидите номер страницы, на которой размещается информация о покрытии. Откройте страницу, обозначенную в указателе, и найдите название своего препарата в первом столбце списка.

Что такое дженерики?

План ElderServe MAP (HMO D-SNP) покрывает как фирменные препараты, так и дженерики. Дженерик — это одобренный FDA препарат, содержащий такое же действующее вещество, как и фирменный. Как правило, дженерики работают так же хорошо и обычно стоят дешевле, чем фирменные препараты. Для многих фирменных лекарственных препаратов есть замещающие их дженерики. Дженерики обычно можно заменить фирменным препаратом в аптеке без необходимости получения нового рецепта, в зависимости от законов штата.

Что такое оригинальные биопрепараты и как они связаны с биосимилярами?

В нашем формуляре, термин «препарат» может означать как лекарственный, так и биологический препарат. Биологические препараты — это препараты, которые сложнее обычных лекарств. Поскольку биологические препараты более сложны, чем обычные лекарства, у них нет прямого дженерического аналога; вместо этого существуют альтернативы, называемые биосимилярами. Как правило, биосимиляры работают так же хорошо, как и оригинальный биологический препарат, и могут стоить дешевле. Для некоторых оригинальных биологических препаратов существуют биосимиляры. Некоторые биосимиляры являются взаимозаменяемыми и, в зависимости от законодательства штата, могут заменять оригинальный биологический препарат в аптеке без необходимости нового рецепта, так же, как дженерические препараты могут заменять брендовые.

Подробнее о типах препаратов см. в документе «Подтверждение страхового покрытия», глава *5*, раздел 3.1, «В «Списке препаратов» указано, какие препараты по Части D покрываются».

Есть ли какие-либо ограничения в отношении моего покрытия?

В отношении некоторых препаратов, покрываемых страховым планом, могут действовать дополнительные требования или ограничения. Такие требования и ограничения могут включать:

- **Предварительное разрешение:** план ElderServe MAP (HMO D-SNP) требует, чтобы вы или специалист, выписавший вам рецепт, получили предварительное разрешение на определенные препараты. Это значит, что вам потребуется разрешение ElderServe MAP (HMO D-SNP), чтобы получить эти препараты по рецепту. Если вы не получите одобрение, ElderServe MAP (HMO D-SNP) может не покрыть ваш препарат.
- **Количественные ограничения:** Для некоторых препаратов ElderServe MAP (HMO D-SNP) ограничивает количество препарата, которое будет покрыто ElderServe MAP (HMO D-SNP). Например, программа ElderServe MAP (HMO D-SNP) предоставляет 60 таблеток на 30 дней по рецепту для препарата СТРЕПТОМИЦИН. Это может быть в дополнение к стандартному месячному или трехмесячному запасу. Это может быть в дополнение к стандартному месячному или трехмесячному запасу.
- **Поэтапная терапия:** В некоторых случаях ElderServe MAP (HMO D-SNP) требует, чтобы вы сначала попробовали определенные препараты для лечения вашего заболевания. Только после этого в покрытие будет внесен другой препарат для лечения этого заболевания. Например, если для лечения вашего заболевания используются препарат A и препарат B, то ElderServe MAP (HMO D-SNP) может включить в покрытие препарат B только после того, как вы вначале попробуете принимать препарат A. Если препарат A вам не подойдет, ElderServe MAP (HMO D-SNP) включит в покрытие препарат B.

Чтобы узнать о наличии дополнительных требований или ограничений в отношении вашего препарата, ознакомьтесь с формуляром, который начинается на странице 1. Вы также можете получить дополнительную информацию об ограничениях, действующих в отношении некоторых покрываемых препаратов, ознакомившись с нашим веб-сайтом. На веб-сайте размещены документы, разъясняющие процедуру получения предварительного разрешения и требования в отношении поэтапной терапии.

Вы также можете обратиться к нам за бумажной копией соответствующих документов. Наша контактная информация, а также дата последнего обновления формуляра указаны на лицевой и задней стороне обложки.

Вы можете обратиться в ElderServe MAP (HMO D-SNP) с просьбой в порядке исключения снять указанные ограничения либо предоставить список альтернативных препаратов, используемых для лечения вашего заболевания. См. раздел «Как запросить исключение из Формуляра ElderServe MAP (HMO D-SNP)?» на странице V, где указана соответствующая информация.

Что делать, если мой препарат не внесен в формуляр?

Если ваш препарат не включен в формуляр (перечень покрываемых препаратов), в первую очередь вам необходимо обратиться в отдел обслуживания участников и уточнить, входит ли препарат в покрытие.

Если вы выясните, что план ElderServe MAP (HMO D-SNP) не покрывает ваш препарат, у вас есть два варианта:

- Вы можете обратиться в Службу поддержки участников за списком аналогичных препаратов, покрываемых программой ElderServe MAP (HMO D-SNP). Когда вы получите этот список, покажите его своему врачу и попросите его выписать аналогичный препарат, который покрывается программой ElderServe MAP (HMO D-SNP).
- Вы можете обратиться в ElderServe MAP (HMO D-SNP) с просьбой в порядке исключения внести ваш препарат в покрытие. См. информацию ниже о том, как попросить об исключении.

Как запросить исключение из формуляра ElderServe MAP (HMO D-SNP)?

Вы можете запросить у ElderServe MAP (HMO D-SNP) исключение из правил страхового покрытия. Есть несколько видов исключений, о которых вы можете просить у представителей плана.

- Вы можете обратиться к нам с запросом о предоставлении покрытия для лекарства, даже если оно не внесено в наш формуляр. При получении одобрения препарат будет оплачиваться на определенных условиях разделения затрат, и у вас не будет возможности требовать предоставления препарата по меньшей стоимости.
- Вы можете попросить нас отменить ограничение на покрытие препарата, включая требования предварительного одобрения, пошаговой терапии или ограничения по количеству. Например, иногда план ElderServe MAP (HMO D-SNP) ограничивает количество покрываемого препарата. Если в отношении вашего препарата действуют количественные ограничения, вы можете обратиться с просьбой отменить эти ограничения и увеличить количество покрываемого препарата.

В целом, администрация ElderServe MAP (HMO D-SNP) одобрит ваш запрос на исключение только в том случае, если альтернативные препараты, включенные в формуляр плана, или применение ограничения не будут для вас столь же эффективными и/или могут вызвать у вас побочные эффекты.

Вы или специалист, выписавший вам рецепт, должны связаться с нами, чтобы запросить исключение из формуляра, включая исключение из ограничения на покрытие. ***Когда вы запрашиваете исключение, специалист, выписавший вам рецепт, должен будет объяснить медицинские причины, по которым вам нужно это исключение.*** Как правило, мы выносим решение в течение 72 часов с момента получения нами заявления специалиста, выписавшего вам рецепт и поддерживающего ваш запрос. Вы можете

попросить об ускоренном (быстром) решении, если считаете, что ваше здоровье может серьезно пострадать из-за ожидания решения до 72 часов, и мы согласны с этим. Если мы согласны или если специалист, выписавший вам рецепт, просит ускоренное рассмотрение, мы обязаны принять решение не позднее чем через 24 часа после получения подтверждающего заявления от вашего специалиста.

Что делать, если мой препарат не указан в формуляре или на него наложено ограничение?

Будучи новым или действующим участником нашей программы, вы можете принимать препараты, которые не включены в наш формуляр. Или вы можете принимать препарат, который включен в формуляр, но на него наложено ограничение на покрытие, например требование предварительного разрешения. Вы должны обсудить со своим специалистом, выписавшим рецепт, возможность запроса решения о покрытии, чтобы показать, что вы соответствуете критериям для одобрения, перехода на альтернативный препарат, который мы покрываем, или запроса исключения из формуляра, чтобы мы покрывали препарат, который вы принимаете. Пока вы и ваш специалист определяете подходящее решение, мы можем покрывать ваш препарат в определенных случаях в течение первых <*не менее 90 дней*> вашего участия в программе.

Для каждого препарата, которого нет в формуляре или на который наложено ограничение, мы предоставим временный запас на 30 дней. Если ваш рецепт выписан на меньший срок, мы разрешим повторные выдачи, чтобы обеспечить максимальный 30-дневный запас препарата. Если покрытие не будет одобрено, после первого 30-дневного запаса мы не будем оплачивать эти препараты, даже если вы состоите в программе меньше 90 дней.

Если вы проживаете в учреждении долгосрочного ухода и вам требуется препарат, не внесенный в наш формуляр, или препарат, в отношении которого действуют ограничения, и при этом истекли первые 90 дней вашего участия в нашем плане, мы оплатим экстренный 31-дневный запас препарата, пока вы будете подавать запрос на предоставление исключения из правил формуляра.

Дополнительная информация

Для получения дополнительной информации о покрытии рецептурных препаратов в рамках плана ElderServe MAP (HMO D-SNP) см. «Подтверждение страхового покрытия» и прочие материалы плана.

С вопросами об особенностях страхового плана ElderServe MAP (HMO D-SNP) обращайтесь к нам. Наша контактная информация, а также дата последнего обновления формуляра указаны на лицевой и задней стороне обложки.

Если у вас есть вопросы общего характера касательно покрытия рецептурных препаратов Medicare, обращайтесь в Medicare по номеру 1-800-MEDICARE (1-800-633-4227) в любое время суток и в любой день недели. Пользователям TTY следует звонить по номеру 1-877-486-2048. Или посетите веб-сайт http://www.medicare.gov.

Формуляр ElderServe MAP (HMO D-SNP)

Ниже приведен формуляр с информацией о покрытии препаратов планом ElderServe MAP (HMO D-SNP). Если вам трудно найти свой препарат в списке, обратитесь к указателю, который начинается на странице 89.

В первом столбце таблицы приведены названия препаратов. Фирменній препараты пишутся заглавными буквами (например, DIFICID ORAL TABLET), а дженерики — строчными буквами курсивом (например, эритромицин этилсукцинат, таблетки для приема внутрь).

Ниже приведен список сокращений, которые могут встречаться в данном документе в столбце «Требования/ограничения», содержащем информацию о наличии особых требований к покрытию препарата.

Список сокращений

B/D PA. Этот рецептурный препарат может быть покрыт в рамках Части B или Части D Medicare, в зависимости от обстоятельств. Возможно, потребуется предоставить информацию о применении и условиях использования препарата для принятия решения.

LA. Ограниченная доступность. Этот рецептурный препарат может быть доступен только в определенных аптеках. Для получения дополнительной информации позвоните в отдел обслуживания клиентов.

MO. Препарат, доставляемый по почте. Этот рецептурный препарат можно приобрести через нашу службу доставки по почте, а также в аптеках нашей розничной сети. Рассмотрите возможность заказа по почте препаратов длительного пользования (поддерживающих; например, препаратов для лечения высокого давления). Розничные аптеки могут быть более подходящими для краткосрочных рецептов (например, антибиотиков).

PA. Предварительное разрешение. План требует, чтобы вы или специалист, выписывающий вам рецепты, получали предварительное разрешение на определенные препараты. Это значит, что вам требуется разрешение для получения рецептурных препаратов. Если вы не получите разрешение, мы можем не включить препарат в покрытие.

QL. Ограничение по количеству. Для некоторых препаратов план ограничивает покрываемое количество.

ST. Поэтапная терапия. В некоторых случаях план требует сначала попробовать определенные препараты для лечения вашего заболевания, прежде чем мы покроем другой препарат для этого состояния. Например, если препарат A и препарат B оба используются для лечения вашего заболевания, мы можем не покрывать препарат B, пока вы не попробуете препарат A. Если препарат A вам не подойдет, мы включим в покрытие препарат B.

V. Эта вакцина предоставляется взрослым бесплатно, если используется в соответствии с рекомендациями Консультативного комитета по иммунизации (Advisory Committee on Immunization Practices, ACIP) Центров по контролю и профилактике заболеваний (Centers for Disease Control and Prevention, CDC).

Below is a list of abbreviations that may appear on the following pages in the Requirements/Limits column that tells you if there are any special requirements for coverage of your drug.

List of Abbreviations

B/D PA: This prescription drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

LA: Limited Availability. This prescription may be available only at certain pharmacies. For more information, please call Customer Service.

MO: Mail-Order Drug. This prescription drug is available through our mail-order service, as well as through our retail network pharmacies. Consider using mail order for your long-term (maintenance) medications (such as high blood pressure medications). Retail network pharmacies may be more appropriate for short-term prescriptions (such as antibiotics).

PA: Prior Authorization. The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.

QL: Quantity Limit. For certain drugs, the Plan limits the amount of the drug that we will cover.

ST: Step Therapy. In some cases, the Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

V: This vaccine is provided to adults at no cost when used based on recommendations by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).

Drug Name	Drug Tier	Requirements /Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
amphotericin b	1	B/D PA
amphotericin b liposome	1	B/D PA
caspofungin	1	
clotrimazole mucous membrane	1	MO
CRESEMBA ORAL	1	PA
fluconazole	1	MO
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml	1	PA; MO
fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml	1	PA
flucytosine	1	MO
griseofulvin microsize	1	MO
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	1	MO
itraconazole oral capsule	1	MO; QL (120 per 30 days)
itraconazole oral solution	1	MO
ketoconazole oral	1	MO
micafungin	1	MO
nystatin oral suspension	1	MO
nystatin oral tablet	1	MO
posaconazole oral tablet,delayed release (dr/ec)	1	PA; MO; QL (96 per 30 days)
terbinafine hcl oral	1	MO
voriconazole intravenous recon soln	1	PA
voriconazole oral suspension for reconstitution	1	PA; MO
voriconazole oral tablet	1	PA; MO
voriconazole-hpbcd	1	PA
ANTIVIRALS		
abacavir	1	MO
abacavir-lamivudine	1	MO
acyclovir oral capsule	1	MO
acyclovir oral suspension 200 mg/5 ml	1	MO
acyclovir oral suspension 200 mg/5 ml (5 ml)	1	
acyclovir oral tablet	1	MO
acyclovir sodium intravenous solution	1	B/D PA; MO
adefovir	1	MO
amantadine hcl	1	MO
APTIVUS	1	MO
atazanavir	1	MO
BARACLUDE ORAL SOLUTION	1	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
BIKTARVY	1	MO
CABENUVA	1	MO
cidofovir	1	
CIMDUO	1	MO
darunavir oral tablet 600 mg	1	MO
darunavir oral tablet 800 mg	1	MO
DELSTRIGO	1	MO
DESCOVY	1	MO
DOVATO	1	MO
EDURANT	1	MO
EDURANT PED	1	MO
efavirenz oral tablet	1	MO
efavirenz-emtricitabin-tenofov	1	MO
efavirenz-lamivu-tenofov disop	1	MO
emtricitabine	1	MO
emtricitabine-tenofovir (tdf)	1	MO
emtricita-rilpivirine-tenof df	1	MO
EMTRIVA ORAL SOLUTION	1	MO
entecavir	1	MO
etravirine	1	MO
EVOTAZ	1	MO
famciclovir	1	MO
fosamprenavir	1	MO
ganciclovir sodium intravenous recon soln	1	B/D PA; MO
ganciclovir sodium intravenous solution	1	B/D PA
GENVOYA	1	MO
IDVYNSO	1	MO
INTELENCE ORAL TABLET 25 MG	1	MO
ISENTRESS HD	1	MO
ISENTRESS ORAL POWDER IN PACKET	1	MO
ISENTRESS ORAL TABLET	1	MO
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	1	MO
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	1	MO
JULUCA	1	MO
KALETRA ORAL SOLUTION	1	MO
LAGEVRIO (EUA)	1	QL (40 per 30 days)
lamivudine	1	MO
lamivudine-zidovudine	1	MO
LEDIPASVIR-SOFOSBUVIR	1	PA; MO; QL (28 per 28 days)
LIVTENCITY	1	PA; LA; QL (120 per 30 days)
lopinavir-ritonavir oral tablet	1	MO
maraviroc	1	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
MAVYRET ORAL PELLETS IN PACKET	1	PA; MO; QL (168 per 28 days)
MAVYRET ORAL TABLET	1	PA; MO; QL (84 per 28 days)
nevirapine oral suspension	1	MO
nevirapine oral tablet	1	MO
nevirapine oral tablet extended release 24 hr	1	MO
NORVIR ORAL POWDER IN PACKET	1	MO
ODEFSEY	1	MO
oseltamivir	1	MO
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)- 100 MG (10)	1	QL (20 per 30 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (6)-100 MG (5)	1	QL (11 per 30 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	1	QL (30 per 30 days)
PIFELTRO	1	MO
PREVYMIS INTRAVENOUS	1	PA
PREVYMIS ORAL TABLET 240 MG	1	PA; MO; QL (56 per 28 days)
PREVYMIS ORAL TABLET 480 MG	1	PA; MO; QL (28 per 28 days)
PREZCOBIX	1	MO
PREZISTA ORAL SUSPENSION	1	MO
PREZISTA ORAL TABLET 150 MG, 75 MG	1	MO
RELENZA DISKHALER	1	MO
RETROVIR INTRAVENOUS	1	MO
REYATAZ ORAL POWDER IN PACKET	1	MO
ribavirin oral capsule	1	MO
ribavirin oral tablet 200 mg	1	MO
rilpivirine hcl	1	MO
rimantadine	1	MO
ritonavir	1	MO
RUKOBIA	1	MO
SELZENTRY ORAL SOLUTION	1	MO
SOFOSBUVIR-VELPATASVIR	1	PA; MO; QL (28 per 28 days)
STRIBILD	1	MO
SUNLENCA	1	
SYMTUZA	1	MO
tenofovir disoproxil fumarate	1	MO
TIVICAY ORAL TABLET 50 MG	1	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
TIVICAY PD	1	MO
TRIUMEQ	1	MO
TRIUMEQ PD	1	MO
TROGARZO	1	MO; LA
valacyclovir oral tablet 1 gram	1	MO; QL (120 per 30 days)
valacyclovir oral tablet 500 mg	1	MO; QL (60 per 30 days)
valganciclovir oral recon soln	1	MO
valganciclovir oral tablet	1	MO
VEMLIDY	1	MO
VIRACEPT ORAL TABLET	1	MO
VIREAD ORAL POWDER	1	MO
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	1	MO
VOSEVI	1	PA; MO; QL (28 per 28 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	1	MO
zidovudine oral capsule	1	MO
zidovudine oral syrup	1	MO
zidovudine oral tablet	1	MO
CEPHALOSPORINS		
cefaclor oral capsule	1	MO
cefaclor oral suspension for reconstitution 250 mg/5 ml	1	
cefadroxil oral capsule	1	MO
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	1	MO
cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml, 2 gram/50 ml	1	MO
cefazolin injection recon soln 1 gram, 500 mg	1	MO
cefazolin injection recon soln 100 gram, 300 gram	1	
cefazolin intravenous recon soln 1 gram, 10 gram	1	
cefdinir oral capsule	1	MO
cefdinir oral suspension for reconstitution	1	MO
cefepime in dextrose,iso-osm	1	
cefepime injection	1	MO
cefixime oral capsule	1	MO
cefixime oral suspension for reconstitution	1	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
cefoxitin in dextrose, iso-osm	1	PA
cefoxitin intravenous recon soln 1 gram, 2 gram	1	PA; MO
cefoxitin intravenous recon soln 10 gram	1	PA
cefpodoxime	1	MO
cefprozil	1	MO
ceftaroline fosamil	1	PA
ceftazidime injection recon soln 1 gram, 2 gram	1	PA; MO
ceftazidime injection recon soln 6 gram	1	PA
ceftriaxone in dextrose,iso-os	1	MO
ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg	1	MO
ceftriaxone injection recon soln 10 gram	1	
ceftriaxone intravenous	1	MO
cefuroxime axetil oral tablet	1	MO
cefuroxime sodium injection recon soln 750 mg	1	PA; MO
cefuroxime sodium intravenous recon soln 1.5 gram	1	PA; MO
cefuroxime sodium intravenous recon soln 7.5 gram	1	PA
cephalexin oral capsule 250 mg, 500 mg	1	MO
cephalexin oral suspension for reconstitution	1	MO
tazicef injection	1	PA; MO
TEFLARO	1	PA; MO
ERYTHROMYCINS / OTHER MACROLIDES		
azithromycin intravenous	1	PA; MO
azithromycin oral suspension for reconstitution	1	MO
azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	MO
clarithromycin	1	MO
DIFICID ORAL TABLET	1	QL (20 per 10 days)
ery-tab oral tablet,delayed release (dr/ec) 250 mg, 333 mg	1	MO
erythromycin ethylsuccinate oral tablet	1	
erythromycin oral capsule,delayed release(dr/ec)	1	
erythromycin oral tablet	1	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
erythromycin oral tablet,delayed release (dr/ec)	1	MO
fidaxomicin	1	QL (20 per 10 days)
MISCELLANEOUS ANTIINFECTIVES		
albendazole	1	MO
amikacin injection solution 1,000 mg/4 ml, 500 mg/2 ml	1	PA; MO
ARIKAYCE	1	PA; LA
atovaquone	1	MO
atovaquone-proguanil	1	MO
aztreonam	1	PA; MO
CAYSTON	1	PA; MO; LA; QL (84 per 56 days)
chloramphenicol sod succinate	1	
chloroquine phosphate	1	MO
clindamycin hcl	1	MO
clindamycin in 5 % dextrose	1	PA; MO
clindamycin phosphate injection	1	PA; MO
COARTEM	1	MO
colistin (colistimethate na)	1	PA; MO; QL (30 per 10 days)
dapsone oral	1	MO
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	1	MO
daptomycin intravenous recon soln 500 mg	1	MO
EMVERM	1	MO
ertapenem	1	PA; MO; QL (14 per 14 days)
ethambutol	1	MO
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	1	PA; MO
gentamicin injection	1	PA; MO
gentamicin sulfate (ped) (pf)	1	PA
hydroxychloroquine oral tablet 200 mg	1	MO
imipenem-cilastatin	1	PA; MO
IMPAVIDO	1	PA; MO
isoniazid injection	1	
isoniazid oral	1	MO
ivermectin oral tablet 3 mg	1	PA; QL (20 per 30 days)
ivermectin oral tablet 6 mg	1	PA; QL (8 per 30 days)
lincomycin	1	PA
linezolid in dextrose 5%	1	PA; MO
linezolid oral suspension for reconstitution	1	MO
linezolid oral tablet	1	MO
mefloquine	1	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
meropenem intravenous recon soln 1 gram, 2 gram	1	PA; QL (30 per 10 days)
meropenem intravenous recon soln 500 mg	1	PA; QL (10 per 10 days)
metro i.v.	1	PA; MO
metronidazole in nacl (iso-os)	1	PA; MO
metronidazole oral tablet 250 mg, 500 mg	1	MO
neomycin	1	MO
nitazoxanide	1	MO; QL (12 per 30 days)
pentamidine inhalation	1	B/D PA; MO; QL (1 per 28 days)
pentamidine injection	1	
praziquantel	1	MO
PRIFTIN	1	MO
PRIMAQUINE	1	MO
pyrazinamide	1	MO
pyrimethamine	1	PA; MO
quinine sulfate	1	MO
rifabutin	1	MO
rifampin intravenous	1	MO
rifampin oral	1	MO
SIRTURO	1	PA; LA
STREPTOMYCIN	1	PA; MO; QL (60 per 30 days)
tigecycline	1	PA; MO
tinidazole	1	MO
TOBI PODHALER	1	MO; QL (224 per 56 days)
tobramycin in 0.225 % nacl	1	PA; MO; QL (280 per 28 days)
tobramycin inhalation	1	PA; MO; QL (224 per 28 days)
tobramycin sulfate injection recon soln	1	PA; QL (9 per 14 days)
tobramycin sulfate injection solution 10 mg/ml	1	PA
tobramycin sulfate injection solution 40 mg/ml	1	PA; MO
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 1 GRAM/200 ML	1	QL (4000 per 10 days)
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 500 MG/100 ML	1	QL (1000 per 10 days)
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 750 MG/150 ML	1	QL (4050 per 10 days)
vancomycin intravenous recon soln 1,000 mg	1	MO; QL (20 per 10 days)
vancomycin intravenous recon soln 10 gram	1	QL (2 per 10 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
vancomycin intravenous recon soln 5 gram	1	QL (4 per 10 days)
vancomycin intravenous recon soln 500 mg	1	MO; QL (10 per 10 days)
vancomycin intravenous recon soln 750 mg	1	QL (27 per 10 days)
vancomycin oral capsule 125 mg	1	PA; MO; QL (40 per 10 days)
vancomycin oral capsule 250 mg	1	PA; MO; QL (80 per 10 days)
VIBATIV INTRAVENOUS RECON SOLN 750 MG	1	PA
XIFAXAN ORAL TABLET 200 MG	1	PA; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	1	PA; MO; QL (90 per 30 days)
PENICILLINS		
amoxicillin oral capsule	1	MO
amoxicillin oral suspension for reconstitution	1	MO
amoxicillin oral tablet	1	MO
amoxicillin oral tablet,chewable 125 mg, 250 mg	1	MO
amoxicillin-pot clavulanate oral suspension for reconstitution	1	MO
amoxicillin-pot clavulanate oral tablet	1	MO
amoxicillin-pot clavulanate oral tablet extended release 12 hr	1	MO
ampicillin oral capsule 500 mg	1	MO
ampicillin sodium injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	1	PA; MO
ampicillin sodium intravenous	1	PA
ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram	1	PA; MO
ampicillin-sulbactam injection recon soln 15 gram	1	PA
ampicillin-sulbactam intravenous recon soln 1.5 gram	1	PA
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	1	MO
BICILLIN L-A	1	PA
dicloxacillin	1	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
nafcillin in dextrose iso-osm intravenous piggyback 2 gram/100 ml	1	PA
nafcillin injection recon soln 1 gram, 2 gram	1	PA; MO
nafcillin injection recon soln 10 gram	1	PA
oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml	1	PA
oxacillin injection recon soln 1 gram, 10 gram	1	PA
oxacillin injection recon soln 2 gram	1	PA; MO
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML	1	PA
penicillin g potassium	1	PA; MO
penicillin g sodium	1	PA; MO
penicillin v potassium	1	MO
pfizerpen-g	1	PA
piperacillin-tazobactam intravenous recon soln 13.5 gram, 40.5 gram	1	
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram	1	MO
QUINOLONES		
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	MO
ciprofloxacin in 5 % dextrose	1	PA; MO
ciprofloxacin oral suspension,microcapsule recon 500 mg/5 ml	1	
levofloxacin in d5w intravenous piggyback 250 mg/50 ml	1	PA
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	1	PA; MO
levofloxacin oral solution	1	MO
levofloxacin oral tablet	1	MO
moxifloxacin oral	1	MO
moxifloxacin-sod.chloride(iso)	1	PA; MO
SULFA'S / RELATED AGENTS		
sulfadiazine	1	MO
sulfamethoxazole-trimethoprim intravenous	1	PA; MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
sulfamethoxazole-trimethoprim oral suspension	1	MO
sulfamethoxazole-trimethoprim oral tablet	1	MO
TETRACYCLINES		
demeclocycline	1	MO
doxy-100	1	PA; MO
doxycycline hyclate intravenous	1	PA
doxycycline hyclate oral capsule 100 mg, 50 mg	1	MO
doxycycline hyclate oral tablet 100 mg, 20 mg, 50 mg	1	MO
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	MO
doxycycline monohydrate oral suspension for reconstitution	1	MO
doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg	1	MO
minocycline oral capsule	1	MO
minocycline oral tablet	1	MO
mondoxyne nl oral capsule 100 mg	1	
tetracycline oral capsule	1	MO

Drug Name	Drug Tier	Requirements /Limits
URINARY TRACT AGENTS		
fosfomycin tromethamine	1	MO
methenamine hippurate	1	MO
methenamine mandelate oral tablet	1	MO
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	1	MO
nitrofurantoin monohyd/m-cryst	1	MO
trimethoprim	1	MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
BOMYNTRA	1	B/D PA; MO
dexrazoxane hcl	1	B/D PA; MO
ELITEK	1	MO
KHAPZORY	1	B/D PA
leucovorin calcium oral	1	MO
levoleucovorin calcium intravenous solution	1	B/D PA
mesna intravenous	1	B/D PA; MO
mesna oral	1	MO
WYOST	1	B/D PA; MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
abiraterone oral tablet 250 mg	1	PA; MO; QL (120 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
abiraterone oral tablet 500 mg	1	PA; MO; QL (60 per 30 days)
abirtega	1	PA; QL (120 per 30 days)
ADCETRIS	1	B/D PA; MO
ADSTILADRIN	1	PA
AKEEGA	1	PA; LA; QL (60 per 30 days)
ALECENSA	1	PA; MO; QL (240 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	1	PA; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	1	PA; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	1	PA; QL (30 per 180 days)
anastrozole	1	MO
ANKTIVA	1	PA; MO
arsenic trioxide intravenous solution 1 mg/ml	1	B/D PA
arsenic trioxide intravenous solution 2 mg/ml	1	B/D PA; MO
ASPARLAS	1	PA
AUGTYRO ORAL CAPSULE 160 MG	1	PA; QL (60 per 30 days)
AUGTYRO ORAL CAPSULE 40 MG	1	PA; QL (240 per 30 days)
AVMAPKI-FAKZYNJA	1	PA; QL (66 per 28 days)
AYVAKIT	1	PA; LA; QL (30 per 30 days)
azacitidine	1	B/D PA; MO
azathioprine oral tablet 50 mg	1	B/D PA; MO
azathioprine sodium	1	B/D PA
BALVERSA	1	PA; LA
BAVENCIO	1	B/D PA; LA
BEIZRAY-ALBUMIN	1	B/D PA
BELEODAQ	1	B/D PA
bendamustine intravenous recon soln	1	B/D PA; MO
BENDEKA	1	B/D PA; MO
BESPONSA	1	B/D PA; MO; LA
bexarotene	1	PA; MO
bicalutamide	1	MO
BIZENGRI	1	PA
BLENREP	1	PA
bleomycin	1	B/D PA; MO
BLINCYTO INTRAVENOUS KIT	1	B/D PA
BORTEZOMIB INJECTION RECON SOLN 1 MG, 2.5 MG	1	B/D PA
bortezomib injection recon soln 3.5 mg	1	B/D PA; MO
BOSULIF ORAL CAPSULE 100 MG	1	PA; MO; QL (180 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
BOSULIF ORAL CAPSULE 50 MG	1	PA; MO; QL (330 per 30 days)
BOSULIF ORAL TABLET 100 MG	1	PA; MO; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	1	PA; MO; QL (30 per 30 days)
bosutinib oral tablet 100 mg	1	PA; QL (90 per 30 days)
bosutinib oral tablet 400 mg, 500 mg	1	PA; QL (30 per 30 days)
BRAFTOVI	1	PA; MO; LA; QL (180 per 30 days)
BRUKINSA ORAL TABLET	1	PA; LA; QL (60 per 30 days)
busulfan	1	B/D PA
CABOMETYX	1	PA; MO; LA; QL (30 per 30 days)
CALQUENCE (ACALABRUTINIB MAL)	1	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	1	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	1	PA; LA; QL (30 per 30 days)
carboplatin intravenous solution	1	B/D PA; MO
carmustine intravenous recon soln 100 mg	1	B/D PA; MO
cisplatin intravenous solution	1	B/D PA; MO
cladribine	1	B/D PA; MO
clofarabine	1	B/D PA
COLUMVI	1	PA; MO
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	1	PA; MO; QL (56 per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	1	PA; MO; QL (112 per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	1	PA; MO; QL (84 per 28 days)
COPIKTRA	1	PA; LA; QL (56 per 28 days)
COTELLIC	1	PA; MO; LA; QL (63 per 28 days)
cyclophosphamide intravenous recon soln	1	B/D PA; MO
cyclophosphamide oral capsule	1	B/D PA; MO
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	1	B/D PA; MO
cyclosporine modified	1	B/D PA; MO
cyclosporine oral capsule	1	B/D PA; MO
CYRAMZA	1	B/D PA; MO
cytarabine	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
cytarabine (pf) injection solution 100 mg/5 ml (20 mg/ml), 2 gram/20 ml (100 mg/ml)	1	B/D PA; MO
cytarabine (pf) injection solution 20 mg/ml	1	B/D PA
dacarbazine	1	B/D PA; MO
dactinomycin	1	B/D PA; MO
DANYELZA	1	B/D PA
DANZITEN	1	PA; QL (112 per 28 days)
DARZALEX	1	B/D PA; MO; LA
DARZALEX FASPRO	1	B/D PA; MO
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 80 mg	1	PA; MO; QL (30 per 30 days)
dasatinib oral tablet 20 mg	1	PA; MO; QL (90 per 30 days)
dasatinib oral tablet 70 mg	1	PA; MO; QL (60 per 30 days)
DATROWAY	1	PA; MO
daunorubicin	1	B/D PA
DAURISMO ORAL TABLET 100 MG	1	PA; MO; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	1	PA; MO; QL (60 per 30 days)
decitabine	1	B/D PA; MO
docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 80 mg/8 ml (10 mg/ml)	1	B/D PA
docetaxel intravenous solution 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml)	1	B/D PA; MO
doxorubicin intravenous recon soln	1	B/D PA; MO
doxorubicin intravenous solution 10 mg/5 ml, 20 mg/10 ml, 50 mg/25 ml	1	B/D PA; MO
doxorubicin intravenous solution 2 mg/ml	1	B/D PA
doxorubicin, peg-liposomal	1	B/D PA; MO
DROXIA	1	MO
ELAHERE	1	PA; LA
ELIGARD	1	PA; MO
ELIGARD (3 MONTH)	1	PA; MO
ELIGARD (4 MONTH)	1	PA; MO
ELIGARD (6 MONTH)	1	PA; MO
ELREXFIO	1	PA
ELZONRIS	1	B/D PA; LA
EMPLICITI	1	B/D PA; MO
EMRELIS	1	PA

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Drug Name	Drug Tier	Requirements /Limits
ENSACOVE	1	PA; LA; QL (60 per 30 days)
ENVARSUS XR	1	B/D PA; MO
EPKINLY	1	PA
ERBITUX	1	B/D PA; MO
eribulin	1	B/D PA
ERIVEDGE	1	PA; MO; QL (30 per 30 days)
ERLEADA ORAL TABLET 240 MG	1	PA; MO; QL (30 per 30 days)
ERLEADA ORAL TABLET 60 MG	1	PA; MO; QL (120 per 30 days)
erlotinib oral tablet 100 mg, 150 mg	1	PA; MO; QL (30 per 30 days)
erlotinib oral tablet 25 mg	1	PA; MO; QL (60 per 30 days)
ETOPOPHOS	1	B/D PA; MO
etoposide intravenous	1	B/D PA; MO
EULEXIN	1	
everolimus (antineoplastic) oral tablet	1	PA; MO; QL (30 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg	1	PA; MO; QL (150 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	1	PA; MO; QL (90 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 5 mg	1	PA; MO; QL (60 per 30 days)
everolimus (immunosuppressive) oral tablet 0.25 mg	1	B/D PA; MO
everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg	1	B/D PA; MO
exemestane	1	MO
FAVLYXA	1	B/D PA
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	1	PA; MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	1	PA; MO
floxuridine	1	B/D PA
fludarabine intravenous recon soln	1	B/D PA; MO
fludarabine intravenous solution	1	B/D PA
fluorouracil intravenous solution 1 gram/20 ml, 500 mg/10 ml	1	B/D PA; MO
fluorouracil intravenous solution 2.5 gram/50 ml, 5 gram/100 ml	1	B/D PA

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Drug Name	Drug Tier	Requirements /Limits
FOTIVDA	1	PA; LA; QL (21 per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	1	PA; QL (84 per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	1	PA; QL (21 per 28 days)
fulvestrant	1	B/D PA; MO
FYARRO	1	PA
GAVRETO	1	PA; LA; QL (120 per 30 days)
GAZYVA	1	B/D PA; MO
gefitinib	1	PA; MO; QL (30 per 30 days)
gemcitabine intravenous recon soln 1 gram, 200 mg	1	B/D PA; MO
gemcitabine intravenous recon soln 2 gram	1	B/D PA
gemcitabine intravenous solution 1 gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml (38 mg/ml), 200 mg/5.26 ml (38 mg/ml)	1	B/D PA; MO
GEMCITABINE INTRAVENOUS SOLUTION 100 MG/ML	1	B/D PA
gengraf oral capsule	1	B/D PA; MO
GILOTRIF	1	PA; MO; QL (30 per 30 days)
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	1	
GLEOSTINE ORAL CAPSULE 100 MG	1	
GOMEKLI ORAL CAPSULE 1 MG	1	PA; QL (126 per 28 days)
GOMEKLI ORAL CAPSULE 2 MG	1	PA; QL (84 per 28 days)
GOMEKLI ORAL TABLET FOR SUSPENSION	1	PA; QL (168 per 28 days)
GRAFAPEX	1	B/D PA
HERNEXEOS	1	PA; MO; QL (90 per 30 days)
hydroxyurea	1	MO
HYRNUO	1	PA; QL (120 per 30 days)
IBRANCE ORAL CAPSULE 125 MG	1	PA; MO; QL (21 per 28 days)
IBRANCE ORAL TABLET	1	PA; MO; QL (21 per 28 days)
IBTROZI	1	PA; QL (90 per 30 days)
ICLUSIG	1	PA; QL (30 per 30 days)
idarubicin	1	B/D PA; MO
IDHIFA	1	PA; MO; LA; QL (30 per 30 days)
ifosfamide intravenous recon soln	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
ifosfamide intravenous solution 1 gram/20 ml	1	B/D PA; MO
ifosfamide intravenous solution 3 gram/60 ml	1	B/D PA
imatinib oral tablet 100 mg	1	PA; MO; QL (180 per 30 days)
imatinib oral tablet 400 mg	1	PA; MO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	1	PA; QL (90 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	1	PA; QL (28 per 28 days)
IMBRUVICA ORAL SUSPENSION	1	PA; QL (324 per 30 days)
IMBRUVICA ORAL TABLET	1	PA; QL (28 per 28 days)
IMDELLTRA	1	PA; MO
IMFINZI	1	B/D PA; MO; LA
IMJUDO	1	PA; MO
IMKELDI	1	PA; MO; QL (280 per 28 days)
INLEXZO	1	PA; MO; LA
INLURIYO	1	PA
INLYTA ORAL TABLET 1 MG	1	PA; MO; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	1	PA; MO; QL (120 per 30 days)
INQOVI	1	PA; MO; QL (5 per 28 days)
INREBIC	1	PA; MO; LA; QL (120 per 30 days)
irinotecan intravenous solution 100 mg/5 ml	1	B/D PA; MO
irinotecan intravenous solution 300 mg/15 ml, 500 mg/25 ml	1	B/D PA
irinotecan intravenous solution 40 mg/2 ml	1	B/D PA; MO
ISTODAX	1	B/D PA; MO
ITOVEBI ORAL TABLET 3 MG	1	PA; MO; QL (60 per 30 days)
ITOVEBI ORAL TABLET 9 MG	1	PA; MO; QL (30 per 30 days)
IWILFIN	1	PA; LA; QL (240 per 30 days)
IXEMPRA	1	B/D PA; MO
JAKAFI	1	PA; MO; QL (60 per 30 days)
JAKAFI XR	1	PA; MO; QL (30 per 30 days)
JAYPIRCA ORAL TABLET 100 MG	1	PA; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 50 MG	1	PA; QL (30 per 30 days)
JEMPERLI	1	PA; MO
JEVTANA	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
JYLAMVO	1	B/D PA; MO
KADCYLA	1	PA; MO
KEYTRUDA	1	PA; MO
KEYTRUDA QLEX	1	PA; MO
KIMMTRAK	1	B/D PA
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	1	PA; MO; QL (21 per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	1	PA; MO; QL (42 per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	1	PA; MO; QL (63 per 28 days)
KOMZIFTI	1	PA; QL (90 per 30 days)
KOSELUGO	1	PA
KRAZATI	1	PA; QL (180 per 30 days)
KYPROLIS	1	B/D PA; MO
lanreotide subcutaneous syringe 120 mg/0.5 ml	1	PA; MO
lapatinib	1	PA; MO; QL (180 per 30 days)
LAZCLUZE ORAL TABLET 240 MG	1	PA; LA; QL (30 per 30 days)
LAZCLUZE ORAL TABLET 80 MG	1	PA; LA; QL (60 per 30 days)
lenalidomide	1	PA; MO; QL (28 per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	1	PA; MO; QL (30 per 30 days)
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)	1	PA; MO; QL (90 per 30 days)
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)	1	PA; MO; QL (60 per 30 days)
letrozole	1	MO
LEUKERAN	1	MO
leuprolide subcutaneous kit	1	PA; MO
LIBTAYO	1	PA; LA
LIFYORLI ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 125 MG/DAY(100 MG X1-25MG X3), 125 MG/DAY(100 MG X1-25MG X9)	1	PA; LA; QL (18 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
LIFYORLI ORAL CAPSULE 150 MG/DAY(100 MG X1-25MG X2), 150 MG/DAY(100 MG X1-25MG X3), 150 MG/DAY(100 MG X1-25MG X9)	1	PA; LA; QL (27 per 28 days)
lomustine oral capsule 10 mg	1	
lomustine oral capsule 100 mg, 40 mg	1	
LONSURF	1	PA; MO
LOQTORZI	1	PA; MO
LORBRENA ORAL TABLET 100 MG	1	PA; MO; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	1	PA; MO; QL (90 per 30 days)
LUMAKRAS ORAL TABLET 120 MG	1	PA; MO; QL (240 per 30 days)
LUMAKRAS ORAL TABLET 240 MG	1	PA; MO; QL (120 per 30 days)
LUMAKRAS ORAL TABLET 320 MG	1	PA; MO; QL (90 per 30 days)
LUNSUMIO	1	PA; MO
LUNSUMIO VELO	1	PA; MO
LUPRON DEPOT	1	PA; MO
LYNOZYFIC	1	PA
LYNPARZA	1	PA; MO; QL (120 per 30 days)
LYSODREN	1	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	1	PA; LA; QL (84 per 28 days)
LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	1	PA; LA; QL (112 per 28 days)
LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	1	PA; LA; QL (140 per 28 days)
MATULANE	1	
megestrol oral suspension 400 mg/10 ml (10 ml)	1	PA
megestrol oral suspension 400 mg/10 ml (40 mg/ml)	1	PA; MO
megestrol oral suspension 625 mg/5 ml (125 mg/ml)	1	PA; MO
megestrol oral tablet	1	PA; MO
MEKINIST ORAL RECON SOLN	1	PA; MO; QL (1260 per 30 days)
MEKINIST ORAL TABLET 0.5 MG	1	PA; MO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	1	PA; MO; QL (30 per 30 days)
MEKTOVI	1	PA; MO; LA; QL (180 per 30 days)
melphalan hcl	1	B/D PA
mercaptopurine oral suspension	1	MO

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Drug Name	Drug Tier	Requirements /Limits
mercaptopurine oral tablet	1	MO
methotrexate sodium	1	B/D PA; MO
methotrexate sodium (pf) injection recon soln	1	B/D PA
methotrexate sodium (pf) injection solution	1	B/D PA; MO
mitomycin intravenous recon soln 20 mg, 5 mg	1	B/D PA; MO
mitomycin intravenous recon soln 40 mg	1	B/D PA; MO
mitoxantrone	1	B/D PA; MO
MODEYSO	1	PA; QL (20 per 28 days)
MONJUVI	1	PA; LA
mycophenolate mofetil (hcl)	1	B/D PA; MO
mycophenolate mofetil oral capsule	1	B/D PA; MO
mycophenolate mofetil oral suspension for reconstitution	1	B/D PA; MO
mycophenolate mofetil oral tablet	1	B/D PA; MO
mycophenolate sodium	1	B/D PA; MO
MYHIBBIN	1	B/D PA; MO
MYLOTARG	1	B/D PA; MO; LA
NELARABINE	1	B/D PA; MO
NEMLUVIO	1	PA; MO; QL (2 per 28 days)
NERLYNX	1	PA; MO; LA
nilotinib hcl oral capsule 150 mg, 200 mg	1	PA; MO; QL (112 per 28 days)
nilotinib hcl oral capsule 50 mg	1	PA; MO; QL (120 per 30 days)
nilutamide	1	PA; MO
NINLARO	1	PA; MO; QL (3 per 28 days)
NUBEQA	1	PA; MO; LA; QL (120 per 30 days)
NULOJIX	1	B/D PA; MO
octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml	1	PA; MO
octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml	1	PA; MO
octreotide acetate injection syringe	1	PA; MO
octreotide,microspheres	1	PA
ODOMZO	1	PA; MO; LA; QL (30 per 30 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	1	PA; QL (56 per 28 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	1	PA; QL (96 per 28 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	1	PA; QL (16 per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	1	PA; QL (20 per 28 days)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	1	PA; QL (24 per 28 days)
OJJAARA	1	PA; QL (30 per 30 days)
ONCASPAR	1	B/D PA
ONIVYDE	1	B/D PA
ONUREG	1	PA; MO; QL (14 per 28 days)
OPDIVO	1	PA; MO
OPDIVO QVANTIG	1	PA; MO
OPDUALAG	1	PA; MO
ORGOVYX	1	PA; LA; QL (30 per 28 days)
ORSERDU ORAL TABLET 345 MG	1	PA; QL (30 per 30 days)
ORSERDU ORAL TABLET 86 MG	1	PA; QL (90 per 30 days)
oxaliplatin intravenous recon soln 100 mg	1	B/D PA
oxaliplatin intravenous recon soln 50 mg	1	B/D PA; MO
oxaliplatin intravenous solution 100 mg/20 ml, 50 mg/10 ml (5 mg/ml)	1	B/D PA; MO
oxaliplatin intravenous solution 200 mg/40 ml	1	B/D PA
paclitaxel	1	B/D PA; MO
paclitaxel protein-bound	1	B/D PA; MO
PADCEV	1	PA; MO
pazopanib oral tablet 200 mg	1	PA; MO; QL (120 per 30 days)
PAZOPANIB ORAL TABLET 400 MG	1	PA; MO; QL (120 per 30 days)
PEMAZYRE	1	PA; LA; QL (28 per 28 days)
pemetrexed disodium intravenous recon soln 1,000 mg, 500 mg	1	B/D PA; MO
pemetrexed disodium intravenous recon soln 100 mg	1	B/D PA; MO
pemetrexed disodium intravenous recon soln 750 mg	1	B/D PA
PERJETA	1	B/D PA; MO
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	1	PA; QL (28 per 28 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	1	PA; QL (56 per 28 days)
POLIVY	1	PA; MO
pomalidomide	1	PA; MO; QL (21 per 28 days)
POTELIGEO	1	PA
pralatrexate intravenous solution 20 mg/ml (1 ml)	1	B/D PA; MO
PRALATREXATE INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)	1	B/D PA; MO
PROGRAF INTRAVENOUS	1	B/D PA
PROGRAF ORAL GRANULES IN PACKET	1	B/D PA; MO
QINLOCK	1	PA; LA; QL (90 per 30 days)
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	1	PA; MO; LA; QL (60 per 30 days)
RETEVMO ORAL TABLET 40 MG	1	PA; MO; LA; QL (90 per 30 days)
REVUFORJ ORAL TABLET 110 MG	1	PA; QL (120 per 30 days)
REVUFORJ ORAL TABLET 160 MG	1	PA; QL (60 per 30 days)
REVUFORJ ORAL TABLET 25 MG	1	PA; QL (240 per 30 days)
REZLIDHIA	1	PA; QL (60 per 30 days)
REZUROCK	1	PA; LA; QL (30 per 30 days)
romidepsin intravenous recon soln	1	B/D PA
romidepsin intravenous solution	1	B/D PA; MO
ROMVIMZA	1	PA; LA; QL (8 per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	1	PA; MO; QL (150 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	1	PA; MO; QL (90 per 30 days)
ROZLYTREK ORAL PELLETS IN PACKET	1	PA; MO; QL (336 per 28 days)
RUBRACA	1	PA; MO; LA; QL (120 per 30 days)
RUXIENCE	1	PA; MO
RYBREVANT	1	PA; MO
RYBREVANT FASPRO	1	PA; MO
RYDAPT	1	PA; MO; QL (224 per 28 days)
RYLAZE	1	B/D PA
RYTELO	1	PA

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 10 MG	1	PA; MO
SARCLISA	1	PA; LA
SCEMBLIX ORAL TABLET 100 MG	1	PA; QL (120 per 30 days)
SCEMBLIX ORAL TABLET 20 MG	1	PA; QL (60 per 30 days)
SCEMBLIX ORAL TABLET 40 MG	1	PA; QL (300 per 30 days)
SIGNIFOR	1	PA
SIMULECT	1	B/D PA
sirolimus	1	B/D PA; MO
SOLTAMOX	1	MO
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML, 90 MG/0.3 ML	1	PA; MO
sorafenib	1	PA; MO; QL (120 per 30 days)
STIVARGA	1	PA; MO; QL (84 per 28 days)
sunitinib malate	1	PA; MO; QL (28 per 28 days)
SYLVANT	1	B/D PA; MO
TABLOID	1	MO
TABRECTA	1	PA; MO
tacrolimus oral capsule	1	B/D PA; MO
TAFINLAR ORAL CAPSULE	1	PA; MO; QL (120 per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	1	PA; MO; QL (840 per 28 days)
TAGRISSO	1	PA; MO; LA; QL (30 per 30 days)
TALVEY	1	PA
TALZENNA	1	PA; MO; QL (30 per 30 days)
tamoxifen	1	MO
TECENTRIQ	1	B/D PA; MO; LA
TECENTRIQ HYBREZA	1	B/D PA; MO; LA
TECVAYLI	1	PA
TEMODAR	1	B/D PA; MO
temsirolimus	1	B/D PA; MO
TEPMETKO	1	PA; LA
TEVIMBRA	1	PA
THALOMID ORAL CAPSULE 100 MG	1	PA; MO; QL (112 per 28 days)
THALOMID ORAL CAPSULE 50 MG	1	PA; MO; QL (28 per 28 days)
thiotepa injection recon soln 100 mg	1	B/D PA
thiotepa injection recon soln 15 mg	1	B/D PA; MO
TIBSOVO	1	PA

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Drug Name	Drug Tier	Requirements /Limits
TIVDAK	1	PA; MO
topotecan	1	B/D PA; MO
toremifene	1	MO
torpenz	1	PA; QL (30 per 30 days)
TRAZIMERA	1	B/D PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	1	PA; MO
tretinoin (antineoplastic)	1	MO
TRODELVY	1	PA; LA
TRUQAP	1	PA; QL (64 per 28 days)
TUKYSA ORAL TABLET 150 MG	1	PA; LA; QL (120 per 30 days)
TUKYSA ORAL TABLET 50 MG	1	PA; LA; QL (300 per 30 days)
TURALIO	1	PA; LA; QL (120 per 30 days)
UNITUXIN	1	B/D PA
UNLOXCYT	1	PA
valrubicin	1	B/D PA; MO
VANFLYTA	1	PA; QL (56 per 28 days)
VECTIBIX	1	B/D PA; MO
VENCLEXTA ORAL TABLET 10 MG	1	PA; LA; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG	1	PA; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 50 MG	1	PA; LA; QL (30 per 30 days)
VENCLEXTA STARTING PACK	1	PA; LA; QL (42 per 180 days)
VERZENIO	1	PA; MO; LA; QL (56 per 28 days)
vinblastine	1	B/D PA; MO
vincristine	1	B/D PA; MO
vinorelbine	1	B/D PA; MO
VITRAKVI ORAL CAPSULE 100 MG	1	PA; MO; LA; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	1	PA; MO; LA; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION	1	PA; MO; LA; QL (300 per 30 days)
VONJO	1	PA; QL (120 per 30 days)
VORANIGO ORAL TABLET 10 MG	1	PA; QL (60 per 30 days)
VORANIGO ORAL TABLET 40 MG	1	PA; QL (30 per 30 days)
VYLOY	1	PA; LA
VYXEOS	1	B/D PA
WELIREG	1	PA; LA
XALKORI ORAL CAPSULE	1	PA; MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
XALKORI ORAL PELLET 150 MG	1	PA; MO; QL (180 per 30 days)
XALKORI ORAL PELLET 20 MG, 50 MG	1	PA; MO; QL (120 per 30 days)
XERMELO	1	PA; LA; QL (84 per 28 days)
XOSPATA	1	PA; LA; QL (90 per 30 days)
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80 MG/WEEK (80 MG X 1), 80MG TWICE WEEK (160 MG/WEEK)	1	PA; LA
XTANDI ORAL CAPSULE	1	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 40 MG	1	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 80 MG	1	PA; MO; QL (60 per 30 days)
YERVOY	1	B/D PA; MO
YONDELIS	1	B/D PA
yulithira	1	PA; QL (30 per 30 days)
ZALTRAP	1	B/D PA; MO
ZEJULA	1	PA; MO; LA; QL (30 per 30 days)
ZELBORAF	1	PA; MO; QL (224 per 28 days)
ZEPZELCA	1	PA
ZIIHERA	1	PA
ZIRABEV	1	B/D PA; MO
ZOLADEX	1	PA; MO
ZOLINZA	1	PA; MO; QL (120 per 30 days)
ZYDELIG	1	PA; MO; QL (60 per 30 days)
ZYKADIA	1	PA; MO; QL (90 per 30 days)
ZYNLONTA	1	PA; LA
ZYNYZ	1	PA; MO
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
brivaracetam intravenous	1	MO; QL (600 per 30 days)
brivaracetam oral solution	1	MO; QL (600 per 30 days)
brivaracetam oral tablet	1	MO; QL (60 per 30 days)
BRIVIACT INTRAVENOUS	1	MO; QL (600 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
BRIVIACT ORAL SOLUTION	1	MO; QL (600 per 30 days)
BRIVIACT ORAL TABLET	1	MO; QL (60 per 30 days)
carbamazepine oral capsule, er multiphase 12 hr	1	MO
carbamazepine oral suspension 100 mg/5 ml	1	MO
carbamazepine oral suspension 100 mg/5 ml (5 ml), 200 mg/10 ml	1	
carbamazepine oral tablet	1	MO
carbamazepine oral tablet extended release 12 hr	1	MO
carbamazepine oral tablet,chewable 100 mg	1	MO
clobazam oral suspension	1	PA; MO; QL (480 per 30 days)
clobazam oral tablet	1	PA; MO; QL (60 per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	1	MO; QL (90 per 30 days)
clonazepam oral tablet 2 mg	1	MO; QL (300 per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	1	MO; QL (90 per 30 days)
clonazepam oral tablet,disintegrating 2 mg	1	MO; QL (300 per 30 days)
DIACOMIT	1	PA; LA
diazepam rectal	1	MO
DILANTIN 30 MG	1	MO
divalproex	1	MO
EPIDIOLEX	1	PA; MO; LA
eslicarbazepine oral tablet 200 mg	1	MO; QL (180 per 30 days)
eslicarbazepine oral tablet 400 mg	1	MO; QL (90 per 30 days)
eslicarbazepine oral tablet 600 mg, 800 mg	1	MO; QL (60 per 30 days)
ethosuximide	1	MO
felbamate	1	MO
FINTEPLA	1	PA; LA; QL (360 per 30 days)
fosphenytoin	1	
FYCOMPA ORAL SUSPENSION	1	MO; QL (720 per 30 days)
gabapentin oral capsule 100 mg, 400 mg	1	MO; QL (270 per 30 days)
gabapentin oral capsule 200 mg	1	QL (540 per 30 days)
gabapentin oral capsule 300 mg	1	MO; QL (360 per 30 days)
gabapentin oral solution 250 mg/5 ml	1	MO; QL (2160 per 30 days)
gabapentin oral solution 250 mg/5 ml (5 ml), 300 mg/6 ml (6 ml)	1	QL (2160 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
gabapentin oral tablet 600 mg	1	MO; QL (180 per 30 days)
gabapentin oral tablet 800 mg	1	MO; QL (120 per 30 days)
gabapentin oral tablet extended release 24 hr 300 mg	1	PA; MO; QL (30 per 30 days)
gabapentin oral tablet extended release 24 hr 450 mg, 750 mg, 900 mg	1	PA; MO; QL (60 per 30 days)
gabapentin oral tablet extended release 24 hr 600 mg	1	PA; MO; QL (90 per 30 days)
lacosamide intravenous	1	MO; QL (1200 per 30 days)
lacosamide oral solution	1	MO; QL (1200 per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg	1	MO; QL (60 per 30 days)
lacosamide oral tablet 50 mg	1	MO; QL (120 per 30 days)
lamotrigine oral tablet	1	MO
lamotrigine oral tablet, chewable dispersible	1	MO
lamotrigine oral tablet,disintegrating	1	MO
levetiracetam in nacl (iso-os) intravenous piggyback 1,000 mg/100 ml, 500 mg/100 ml	1	MO
levetiracetam in nacl (iso-os) intravenous piggyback 1,500 mg/100 ml	1	
levetiracetam intravenous	1	MO
levetiracetam oral solution 100 mg/ml	1	MO
levetiracetam oral solution 500 mg/5 ml (5 ml)	1	
levetiracetam oral tablet	1	MO
levetiracetam oral tablet extended release 24 hr	1	MO
LEVETIRACETAM ORAL TABLET FOR SUSPENSION	1	MO
methsuximide	1	MO
NAYZILAM	1	PA; MO; QL (10 per 30 days)
oxcarbazepine oral suspension	1	MO
oxcarbazepine oral tablet	1	MO
perampanel oral suspension	1	MO; QL (720 per 30 days)
perampanel oral tablet 10 mg, 12 mg, 8 mg	1	MO; QL (30 per 30 days)
perampanel oral tablet 2 mg	1	MO; QL (60 per 30 days)
perampanel oral tablet 4 mg, 6 mg	1	MO; QL (60 per 30 days)
phenobarbital oral elixir	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg	1	PA
phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg	1	PA; MO
phenobarbital sodium injection solution 130 mg/ml	1	MO
phenobarbital sodium injection solution 65 mg/ml	1	
phenytoin oral suspension 125 mg/5 ml	1	MO
phenytoin oral tablet,chewable	1	MO
phenytoin sodium extended oral capsule 100 mg	1	MO
phenytoin sodium extended oral capsule 200 mg, 300 mg	1	
phenytoin sodium intravenous solution	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	1	MO; QL (90 per 30 days)
pregabalin oral capsule 225 mg, 300 mg	1	MO; QL (60 per 30 days)
pregabalin oral solution	1	MO; QL (900 per 30 days)
PRIMIDONE ORAL TABLET 125 MG	1	MO
primidone oral tablet 250 mg, 50 mg	1	MO
relgaabi oral capsule 300 mg	1	QL (360 per 30 days)
relgaabi oral capsule 400 mg	1	QL (270 per 30 days)
roweepra	1	MO
rufinamide oral suspension	1	PA; MO
rufinamide oral tablet	1	PA; MO
SPRITAM	1	
SUBVENITE ORAL SUSPENSION	1	MO
subvenite oral tablet	1	MO
SYMPAZAN ORAL FILM 10 MG, 20 MG	1	PA; MO; QL (60 per 30 days)
SYMPAZAN ORAL FILM 5 MG	1	PA; MO; QL (60 per 30 days)
tiagabine	1	MO
topiramate oral capsule, sprinkle 15 mg, 25 mg	1	PA; MO
topiramate oral solution	1	PA; MO
topiramate oral tablet	1	PA; MO
valproate sodium	1	MO
valproic acid	1	MO
valproic acid (as sodium salt) oral solution 250 mg/5 ml	1	MO

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Drug Name	Drug Tier	Requirements /Limits
valproic acid (as sodium salt) oral solution 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)	1	
VALTOCO	1	PA; MO; QL (10 per 30 days)
vigabatrin	1	PA; MO; LA
vigadrone	1	PA; LA
XCOPRI MAINTENANCE PACK	1	MO; QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG	1	MO; QL (30 per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	1	MO; QL (60 per 30 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	1	MO; QL (28 per 180 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	1	MO; QL (28 per 180 days)
ZONISADE	1	PA; MO
zonisamide	1	PA; MO
ZTALMY	1	PA; LA; QL (1100 per 30 days)
ANTIPARKINSONISM AGENTS		
benztropine injection	1	
benztropine oral	1	PA; MO
bromocriptine oral capsule	1	
bromocriptine oral tablet	1	MO
carbidopa	1	MO
carbidopa-levodopa oral tablet	1	MO
carbidopa-levodopa oral tablet extended release	1	MO
carbidopa-levodopa oral tablet,disintegrating	1	MO
carbidopa-levodopa-entacapone	1	MO
entacapone	1	MO
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	1	PA; QL (300 per 30 days)
NEUPRO	1	MO
pramipexole oral tablet	1	MO
rasagiline	1	MO
ropinirole oral tablet	1	MO
ropinirole oral tablet extended release 24 hr	1	MO
selegiline hcl	1	MO
trihexyphenidyl oral tablet	1	MO
MIGRAINE / CLUSTER HEADACHE THERAPY		

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Drug Name	Drug Tier	Requirements /Limits
AIMOVIG AUTOINJECTOR	1	PA; MO; QL (1 per 30 days)
dihydroergotamine injection	1	
dihydroergotamine nasal	1	QL (8 per 28 days)
EMGALITY PEN	1	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML	1	PA; MO; QL (2 per 30 days)
ergotamine-caffeine	1	MO
naratriptan	1	MO; QL (18 per 28 days)
NURTEC ODT	1	PA; QL (16 per 30 days)
QULIPTA	1	PA; MO; QL (30 per 30 days)
rizatriptan oral tablet	1	MO; QL (24 per 28 days)
rizatriptan oral tablet,disintegrating	1	MO; QL (24 per 28 days)
sumatriptan nasal	1	MO; QL (18 per 28 days)
sumatriptan succinate oral	1	MO; QL (18 per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	1	MO; QL (8 per 28 days)
sumatriptan succinate subcutaneous solution	1	MO; QL (8 per 28 days)
UBRELVY	1	PA; QL (20 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
MISCELLANEOUS NEUROLOGICAL THERAPY		
AUSTEDO ORAL TABLET 12 MG, 9 MG	1	PA; MO; QL (120 per 30 days)
AUSTEDO ORAL TABLET 6 MG	1	PA; MO; QL (60 per 30 days)
AUSTEDO XR	1	PA; MO; QL (30 per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG	1	PA; MO; QL (28 per 180 days)
BRIUMVI	1	PA; MO; QL (24 per 180 days)
dalfampridine	1	PA; MO; QL (60 per 30 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg	1	PA; MO; QL (56 per 28 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	1	PA; MO; QL (120 per 180 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg	1	PA; MO; QL (60 per 30 days)
donepezil oral tablet 10 mg, 5 mg	1	MO

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Drug Name	Drug Tier	Requirements /Limits
donepezil oral tablet 23 mg	1	MO
donepezil oral tablet,disintegrating	1	MO
fingolimod	1	PA; MO; QL (30 per 30 days)
galantamine oral capsule,ext rel. pellets 24 hr	1	MO
galantamine oral solution	1	MO
galantamine oral tablet	1	MO
glatiramer subcutaneous syringe 20 mg/ml	1	PA; MO; QL (30 per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	1	PA; MO; QL (12 per 28 days)
glatopa subcutaneous syringe 20 mg/ml	1	PA; MO; QL (30 per 30 days)
glatopa subcutaneous syringe 40 mg/ml	1	PA; MO; QL (12 per 28 days)
INGREZZA	1	PA; LA; QL (30 per 30 days)
INGREZZA INITIATION PK(TARDIV)	1	PA; LA; QL (28 per 180 days)
INGREZZA SPRINKLE	1	PA; LA; QL (30 per 30 days)
KESIMPTA PEN	1	PA; MO; QL (1.6 per 28 days)
memantine oral capsule,sprinkle,er 24hr	1	PA; MO
memantine oral solution	1	PA; MO
memantine oral tablet	1	PA; MO
memantine-donepezil	1	PA; MO
NUEDEXTA	1	PA; MO
RADICAVA ORS	1	PA; MO
RADICAVA ORS STARTER KIT SUSP	1	PA; MO
rivastigmine	1	MO
rivastigmine tartrate	1	MO
teriflunomide	1	PA; MO; QL (30 per 30 days)
tetrabenazine oral tablet 12.5 mg	1	PA; MO; QL (240 per 30 days)
tetrabenazine oral tablet 25 mg	1	PA; MO; QL (120 per 30 days)
VUMERITY	1	PA; MO; QL (120 per 30 days)
ZEPOSIA	1	PA; MO; QL (30 per 30 days)
ZEPOSIA STARTER KIT (28-DAY)	1	PA; MO; QL (28 per 180 days)
ZEPOSIA STARTER PACK (7-DAY)	1	PA; MO; QL (7 per 180 days)

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Drug Name	Drug Tier	Requirements /Limits
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
baclofen oral tablet	1	MO
cyclobenzaprine oral tablet 10 mg, 5 mg	1	PA; MO
dantrolene intravenous	1	
dantrolene oral	1	MO
LIORESAL	1	B/D PA
pyridostigmine bromide oral tablet 60 mg	1	MO
pyridostigmine bromide oral tablet extended release 180 mg	1	MO
revonto	1	
tizanidine oral tablet	1	MO
VYVGART	1	PA; MO; LA
VYVGART HYTRULO	1	PA; MO; LA
NARCOTIC ANALGESICS		
acetaminophen-codeine oral solution 120-12 mg/5 ml	1	MO; QL (4500 per 30 days)
acetaminophen-codeine oral solution 300 mg-30 mg /12.5 ml	1	QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg	1	MO; QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	1	MO; QL (180 per 30 days)
BELBUCA	1	PA; MO; QL (60 per 30 days)
buprenorphine hcl injection syringe	1	
buprenorphine hcl sublingual	1	MO
buprenorphine transdermal patch	1	PA; MO; QL (4 per 28 days)
endocet	1	QL (360 per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	1	PA; QL (10 per 30 days)
hydrocodone-acetaminophen oral solution 10-325 mg/15 ml, 7.5-325 mg/15 ml	1	QL (5550 per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	QL (360 per 30 days)
hydrocodone-ibuprofen oral tablet 7.5-200 mg	1	QL (50 per 30 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml, 2 mg/ml	1	
hydromorphone injection solution 2 mg/ml	1	

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Drug Name	Drug Tier	Requirements /Limits
hydromorphone injection syringe 1 mg/ml, 2 mg/ml, 4 mg/ml	1	
hydromorphone oral liquid	1	QL (2400 per 30 days)
hydromorphone oral tablet	1	QL (180 per 30 days)
hydromorphone oral tablet extended release 24 hr	1	PA; QL (60 per 30 days)
methadone injection solution	1	
methadone intensol	1	PA; QL (90 per 30 days)
methadone oral concentrate	1	PA; QL (90 per 30 days)
methadone oral solution 10 mg/5 ml	1	PA; QL (600 per 30 days)
methadone oral solution 5 mg/5 ml	1	PA; QL (1200 per 30 days)
methadone oral tablet 10 mg	1	PA; QL (120 per 30 days)
methadone oral tablet 5 mg	1	PA; QL (240 per 30 days)
methadose oral concentrate	1	PA; QL (90 per 30 days)
morphine (pf) injection solution 0.5 mg/ml, 1 mg/ml	1	
morphine concentrate oral solution	1	QL (900 per 30 days)
morphine injection syringe 4 mg/ml	1	
morphine intravenous solution 10 mg/ml, 4 mg/ml	1	
morphine intravenous syringe 2 mg/ml, 4 mg/ml	1	
morphine oral solution	1	QL (900 per 30 days)
morphine oral tablet	1	QL (180 per 30 days)
morphine oral tablet extended release	1	PA; QL (120 per 30 days)
oxycodone oral capsule	1	QL (360 per 30 days)
oxycodone oral concentrate	1	QL (180 per 30 days)
oxycodone oral solution	1	QL (1200 per 30 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg	1	QL (180 per 30 days)
oxycodone oral tablet 5 mg	1	QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	QL (360 per 30 days)
SUBLOCADE	1	MO
NON-NARCOTIC ANALGESICS		
buprenorphine-naloxone sublingual film	1	MO
buprenorphine-naloxone sublingual tablet	1	MO
butorphanol injection	1	MO
butorphanol nasal	1	MO; QL (10 per 28 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
celecoxib	1	MO
clonidine (pf) epidural solution 5,000 mcg/10 ml	1	
diclofenac potassium oral tablet 50 mg	1	MO
diclofenac sodium oral	1	MO
diclofenac sodium topical drops	1	MO; QL (300 per 28 days)
diclofenac sodium topical solution in metered-dose pump	1	MO; QL (224 per 28 days)
diclofenac-misoprostol	1	MO
diflunisal	1	MO
etodolac oral capsule	1	MO
etodolac oral tablet	1	MO
etodolac oral tablet extended release 24 hr	1	MO
flurbiprofen oral tablet 100 mg	1	MO
ibu	1	MO
ibuprofen oral suspension	1	MO
ibuprofen oral tablet 400 mg, 800 mg	1	MO
ibuprofen oral tablet 600 mg	1	
JOURNAVX	1	MO; QL (30 per 90 days)
KLOXXADO	1	MO
lurbiro	1	
meloxicam oral tablet	1	MO; QL (30 per 30 days)
nabumetone	1	MO
nalbuphine	1	
naloxone injection solution	1	
naloxone injection syringe	1	
naltrexone	1	MO
naproxen oral tablet	1	MO
naproxen oral tablet,delayed release (dr/ec)	1	MO
naproxen sodium oral tablet 275 mg, 550 mg	1	MO
oxaprozin oral tablet	1	MO
piroxicam	1	MO
salsalate	1	MO
sulindac	1	MO
tramadol oral tablet 50 mg	1	MO; QL (240 per 30 days)
tramadol-acetaminophen	1	MO; QL (240 per 30 days)
VIVITROL	1	MO
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	1	MO; QL (2.4 per 56 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	1	MO; QL (3.2 per 56 days)
ABILIFY MAINTENA	1	MO; QL (1 per 28 days)
amitriptyline	1	MO
amoxapine	1	MO
amphetamine	1	MO
aripiprazole oral solution	1	MO
aripiprazole oral tablet	1	MO; QL (30 per 30 days)
aripiprazole oral tablet,disintegrating	1	MO; QL (60 per 30 days)
ARISTADA INITIO	1	MO; QL (4.8 per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	1	MO; QL (3.9 per 56 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	1	MO; QL (1.6 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	1	MO; QL (2.4 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	1	MO; QL (3.2 per 28 days)
armodafinil	1	PA; MO; QL (30 per 30 days)
asenapine maleate	1	MO; QL (60 per 30 days)
atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg	1	MO; QL (60 per 30 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	1	MO; QL (30 per 30 days)
AUVELITY ORAL TABLET, IR AND ER, BIPHASIC	1	ST; QL (60 per 30 days)
AUVELITY ORAL TABLET,IR ER BIPHASIC,DOSEPACK	1	ST; QL (51 per 180 days)
BELSOMRA	1	PA; QL (30 per 30 days)
bupropion hcl oral tablet	1	MO
bupropion hcl oral tablet extended release 24 hr 150 mg	1	MO; QL (90 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
bupropion hcl oral tablet extended release 24 hr 300 mg	1	MO; QL (30 per 30 days)
bupropion hcl oral tablet sustained-release 12 hr	1	MO; QL (60 per 30 days)
buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	MO
BYSANTI	1	ST; QL (60 per 30 days)
BYSANTI TITRATION PACK A	1	ST; QL (8 per 180 days)
BYSANTI TITRATION PACK B	1	ST; QL (12 per 180 days)
BYSANTI TITRATION PACK C	1	ST; QL (8 per 180 days)
CAPLYTA	1	MO; QL (30 per 30 days)
chlorpromazine injection	1	
chlorpromazine oral	1	MO
citalopram oral solution	1	MO
citalopram oral tablet	1	MO; QL (30 per 30 days)
clomipramine	1	MO
clonidine hcl oral tablet extended release 12 hr	1	MO
clorazepate dipotassium oral tablet 15 mg	1	PA; MO; QL (180 per 30 days)
clorazepate dipotassium oral tablet 3.75 mg	1	PA; MO; QL (90 per 30 days)
clorazepate dipotassium oral tablet 7.5 mg	1	PA; MO; QL (360 per 30 days)
clozapine oral tablet	1	
clozapine oral tablet,disintegrating	1	
COBENFY	1	MO; QL (60 per 30 days)
COBENFY STARTER PACK	1	MO; QL (56 per 180 days)
desipramine	1	MO
desvenlafaxine succinate	1	MO; QL (30 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr	1	MO
dextroamphetamine-amphetamine oral tablet	1	MO
diazepam injection	1	PA
diazepam intensol	1	PA; MO; QL (240 per 30 days)
diazepam oral concentrate	1	PA; QL (240 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	1	PA; MO; QL (1200 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml, 5 ml)	1	PA; QL (1200 per 30 days)
diazepam oral tablet	1	PA; MO; QL (120 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
doxepin oral capsule	1	MO
doxepin oral concentrate	1	MO
doxepin oral tablet	1	MO; QL (30 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	1	MO; QL (60 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	1	MO; QL (30 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	1	MO; QL (60 per 30 days)
EMSAM	1	MO
escitalopram oxalate oral solution	1	MO
escitalopram oxalate oral tablet	1	MO; QL (30 per 30 days)
eszopiclone	1	MO; QL (30 per 30 days)
EXXUA ORAL TABLET EXTENDED RELEASE 24 HR 18.2 MG	1	ST; QL (30 per 30 days)
EXXUA ORAL TABLET EXTENDED RELEASE 24 HR 36.3 MG, 54.5 MG, 72.6 MG	1	ST; MO; QL (30 per 30 days)
EXXUA ORAL TABLET, EXT REL 24HR DOSE PACK	1	ST; MO; QL (32 per 180 days)
FANAPT	1	ST; MO; QL (60 per 30 days)
FANAPT TITRATION PACK A	1	ST; MO; QL (8 per 180 days)
FANAPT TITRATION PACK B	1	ST; QL (12 per 180 days)
FANAPT TITRATION PACK C	1	ST; QL (8 per 180 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)-40 MG (26)	1	QL (28 per 180 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	1	QL (30 per 30 days)
flumazenil	1	
fluoxetine oral capsule 10 mg	1	MO; QL (30 per 30 days)
fluoxetine oral capsule 20 mg	1	MO; QL (120 per 30 days)
fluoxetine oral capsule 40 mg	1	MO; QL (60 per 30 days)
fluoxetine oral solution	1	MO
fluphenazine decanoate	1	MO
fluphenazine hcl injection	1	
fluphenazine hcl oral	1	MO
fluvoxamine oral tablet 100 mg	1	MO; QL (90 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
fluvoxamine oral tablet 25 mg	1	MO; QL (30 per 30 days)
fluvoxamine oral tablet 50 mg	1	MO; QL (60 per 30 days)
haloperidol	1	MO
haloperidol decanoate intramuscular solution 100 mg/ml (1 ml), 50 mg/ml(1ml)	1	
haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml	1	MO
haloperidol lactate injection	1	
haloperidol lactate oral	1	MO
imipramine hcl	1	MO
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	1	MO; QL (3.5 per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	1	MO; QL (5 per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	1	MO; QL (0.75 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	1	MO; QL (1 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	1	MO; QL (1.5 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	1	MO; QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	1	MO; QL (0.5 per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	1	MO; QL (0.88 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	1	MO; QL (1.32 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	1	MO; QL (1.75 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	1	MO; QL (2.63 per 90 days)
lithium carbonate	1	MO
lithium citrate	1	MO
lorazepam injection	1	PA

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Drug Name	Drug Tier	Requirements /Limits
lorazepam intensol	1	PA; QL (150 per 30 days)
lorazepam oral concentrate	1	PA; MO; QL (150 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	1	PA; MO; QL (90 per 30 days)
lorazepam oral tablet 2 mg	1	PA; MO; QL (150 per 30 days)
loxapine succinate	1	MO
lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg	1	MO; QL (30 per 30 days)
lurasidone oral tablet 80 mg	1	MO; QL (60 per 30 days)
LYBALVI	1	MO; QL (30 per 30 days)
MARPLAN	1	MO
methylphenidate hcl oral capsule,er biphasic 50-50	1	MO
methylphenidate hcl oral solution	1	MO
methylphenidate hcl oral tablet	1	MO
methylphenidate hcl oral tablet extended release	1	MO
methylphenidate hcl oral tablet,chewable	1	MO
mirtazapine oral tablet	1	MO
mirtazapine oral tablet,disintegrating	1	MO

Drug Name	Drug Tier	Requirements /Limits
modafinil oral tablet 100 mg	1	PA; MO; QL (30 per 30 days)
modafinil oral tablet 200 mg	1	PA; MO; QL (60 per 30 days)
molindone oral tablet 10 mg, 25 mg	1	
molindone oral tablet 5 mg	1	MO
nefazodone	1	MO
nortriptyline oral capsule	1	MO
nortriptyline oral solution	1	MO
NUPLAZID	1	PA; MO; QL (30 per 30 days)
olanzapine intramuscular	1	
olanzapine oral tablet	1	MO; QL (30 per 30 days)
olanzapine oral tablet,disintegrating	1	MO; QL (30 per 30 days)
OPIPZA ORAL FILM 10 MG	1	MO; QL (90 per 30 days)
OPIPZA ORAL FILM 2 MG	1	MO; QL (30 per 30 days)
OPIPZA ORAL FILM 5 MG	1	MO; QL (180 per 30 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	1	MO; QL (30 per 30 days)
paliperidone oral tablet extended release 24hr 6 mg	1	MO; QL (60 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
paroxetine hcl oral suspension	1	MO
paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg	1	MO; QL (30 per 30 days)
paroxetine hcl oral tablet 30 mg	1	MO; QL (60 per 30 days)
paroxetine hcl oral tablet extended release 24 hr	1	MO; QL (60 per 30 days)
pentobarbital sodium injection solution	1	
perphenazine	1	MO
phenelzine	1	MO
pimozide	1	MO
protriptyline	1	MO
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	MO; QL (90 per 30 days)
quetiapine oral tablet 300 mg, 400 mg	1	MO; QL (60 per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	1	MO; QL (30 per 30 days)
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	1	MO; QL (60 per 30 days)
RALDESY	1	ST; MO
ramelteon	1	MO; QL (30 per 30 days)
REXULTI ORAL TABLET	1	MO; QL (30 per 30 days)
risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml	1	QL (2 per 28 days)
risperidone microspheres intramuscular suspension,extended rel recon 37.5 mg/2 ml, 50 mg/2 ml	1	MO; QL (2 per 28 days)
risperidone oral solution	1	MO
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	MO; QL (60 per 30 days)
risperidone oral tablet 4 mg	1	MO; QL (120 per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	MO; QL (60 per 30 days)
risperidone oral tablet,disintegrating 4 mg	1	MO; QL (120 per 30 days)
SECUADO	1	MO; QL (30 per 30 days)
sertraline oral concentrate	1	MO
sertraline oral tablet 100 mg, 50 mg	1	MO; QL (60 per 30 days)
sertraline oral tablet 25 mg	1	MO; QL (30 per 30 days)
sodium oxybate	1	PA; MO; LA; QL (540 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
SPRAVATO NASAL SPRAY,NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)	1	PA; MO
thioridazine	1	MO
thiothixene	1	MO
tranylcypromine	1	MO
trazodone	1	MO
trifluoperazine	1	MO
trimipramine	1	MO
TRINTELLIX	1	QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	1	MO; QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 75 mg	1	MO; QL (90 per 30 days)
venlafaxine oral tablet	1	MO; QL (90 per 30 days)
VERSACLOZ	1	
vilazodone	1	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE	1	MO; QL (30 per 30 days)
zaleplon oral capsule 10 mg	1	MO; QL (60 per 30 days)
zaleplon oral capsule 5 mg	1	MO; QL (30 per 30 days)
ziprasidone hcl	1	MO; QL (60 per 30 days)
ziprasidone mesylate	1	
zolpidem oral tablet	1	MO; QL (30 per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	1	PA; MO; QL (28 per 365 days)
ZURZUVAE ORAL CAPSULE 30 MG	1	PA; MO; QL (14 per 365 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	1	QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG	1	QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 405 MG	1	QL (1 per 28 days)
CARDIOVASCULAR, HYPERTENSION / LIPIDS		
ANTIARRHYTHMIC AGENTS		
adenosine	1	
amiodarone intravenous solution	1	
amiodarone oral	1	MO
dofetilide	1	MO
flecainide	1	MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
ibutilide fumarate	1	
lidocaine (pf) intravenous	1	
lidocaine in 5 % dextrose (pf) intravenous parenteral solution 4 mg/ml (0.4 %), 8 mg/ml (0.8 %)	1	
mexiletine	1	MO
MULTAQ	1	MO
pacerone oral tablet 100 mg, 200 mg	1	
procainamide injection	1	
propafenone oral capsule,extended release 12 hr	1	MO
propafenone oral tablet	1	MO
quinidine sulfate oral tablet	1	MO
sotalol af	1	
sotalol oral	1	MO
ANTIHYPERTENSIVE THERAPY		
acebutolol	1	MO
aliskiren	1	MO
amiloride	1	MO
amiloride-hydrochlorothiazide	1	MO
amlodipine	1	MO
amlodipine-benazepril	1	MO
amlodipine-olmesartan	1	MO
amlodipine-valsartan	1	MO
amlodipine-valsartan-hcthiazid	1	MO
atenolol	1	MO
atenolol-chlorthalidone	1	MO
azilsartan medoxomil	1	MO
benazepril	1	MO
benazepril-hydrochlorothiazide	1	MO
betaxolol oral	1	MO
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	MO
bisoprolol-hydrochlorothiazide	1	MO
bumetanide injection	1	
bumetanide oral	1	MO
candesartan	1	MO
candesartan-hydrochlorothiazid	1	MO
captopril	1	MO
captopril-hydrochlorothiazide	1	
cartia xt	1	MO
carvedilol	1	MO
chlorothiazide sodium	1	
chlorthalidone oral tablet 25 mg, 50 mg	1	MO
clonidine transdermal patch	1	MO; QL (4 per 28 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
clonidine (pf) epidural solution 1,000 mcg/10 ml (100 mcg/ml)	1	
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	MO
diltiazem hcl intravenous	1	
diltiazem hcl oral capsule,ext.rel 24h degradable	1	MO
diltiazem hcl oral capsule,extended release 12 hr	1	MO
diltiazem hcl oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	
diltiazem hcl oral capsule,extended release 24 hr 420 mg	1	MO
diltiazem hcl oral capsule,extended release 24hr	1	MO
diltiazem hcl oral tablet	1	MO
diltiazem hcl oral tablet extended release 24 hr 120 mg, 240 mg, 300 mg	1	MO
diltiazem hcl oral tablet extended release 24 hr 180 mg, 360 mg, 420 mg	1	
dilt-xr	1	MO
doxazosin oral tablet 1 mg, 2 mg, 4 mg	1	MO; QL (30 per 30 days)
doxazosin oral tablet 8 mg	1	MO; QL (60 per 30 days)
EDARBI	1	MO
EDARBYCLOR	1	MO
enalapril maleate oral tablet	1	MO
enalaprilat intravenous solution	1	
enalapril-hydrochlorothiazide	1	MO
eplerenone	1	MO
esmolol intravenous solution	1	
ethacrynate sodium	1	
felodipine	1	MO
fosinopril	1	MO
fosinopril-hydrochlorothiazide	1	MO
furosemide injection	1	
furosemide oral solution	1	MO
furosemide oral tablet	1	MO
hydralazine injection	1	
hydralazine oral	1	MO
hydrochlorothiazide	1	MO
indapamide	1	MO
irbesartan	1	MO
irbesartan-hydrochlorothiazide	1	MO
isosorbide-hydralazine	1	MO; QL (180 per 30 days)
isradipine	1	

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Drug Name	Drug Tier	Requirements /Limits
KERENDIA	1	PA; QL (30 per 30 days)
labetalol intravenous solution	1	
labetalol intravenous syringe 20 mg/4 ml (5 mg/ml)	1	
labetalol oral tablet 100 mg, 200 mg, 300 mg	1	MO
lisinopril	1	MO
lisinopril-hydrochlorothiazide	1	MO
losartan	1	MO
losartan-hydrochlorothiazide	1	MO
mannitol 20 %	1	
mannitol 25 % intravenous solution	1	
matzim la	1	MO
metolazone	1	MO
metoprolol succinate	1	MO
metoprolol ta-hydrochlorothiaz	1	MO
metoprolol tartrate intravenous	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	MO
metyrosine	1	PA; MO
minoxidil oral	1	MO
moexipril	1	MO
nadolol	1	MO
nebivolol	1	MO
nicardipine intravenous solution	1	
nicardipine oral	1	MO
nifedipine oral tablet extended release	1	MO
nifedipine oral tablet extended release 24hr	1	MO
nimodipine oral capsule	1	MO
olmesartan	1	MO
olmesartan-amlodipin-hcthiazid	1	MO
olmesartan-hydrochlorothiazide	1	MO
osmitrol 20 %	1	
perindopril erbumine	1	MO
phentolamine	1	
pindolol	1	MO
prazosin	1	MO
propranolol intravenous	1	
propranolol oral capsule,extended release 24 hr	1	MO
propranolol oral solution	1	MO
propranolol oral tablet	1	MO
quinapril	1	MO
quinapril-hydrochlorothiazide	1	MO
ramipril	1	MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
spironolactone oral tablet	1	MO
spironolacton-hydrochlorothiaz	1	MO
telmisartan	1	MO
telmisartan-amlodipine	1	
telmisartan-hydrochlorothiazid	1	MO
terazosin oral capsule 1 mg, 2 mg, 5 mg	1	MO; QL (30 per 30 days)
terazosin oral capsule 10 mg	1	MO; QL (60 per 30 days)
tiadylt er	1	MO
timolol maleate oral tablet 10 mg	1	
timolol maleate oral tablet 20 mg, 5 mg	1	MO
torsemide oral	1	MO
trandolapril	1	MO
trandolapril-verapamil	1	MO
treprostinil sodium	1	PA; MO; LA
triamterene-hydrochlorothiazid	1	MO
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	1	PA; MO; LA; QL (60 per 30 days)
UPTRAVI ORAL TABLETS,DOSE PACK	1	PA; MO; LA; QL (200 per 180 days)
valsartan oral tablet	1	MO
valsartan-hydrochlorothiazide	1	MO
veletri	1	B/D PA; MO
verapamil intravenous solution	1	
verapamil oral capsule, 24 hr er pellet ct	1	MO
verapamil oral capsule,ext rel. pellets 24 hr	1	MO
verapamil oral tablet	1	MO
verapamil oral tablet extended release	1	MO
COAGULATION THERAPY		
aminocaproic acid intravenous	1	MO
aminocaproic acid oral	1	MO
aspirin-dipyridamole	1	MO
CABLIVI INJECTION KIT	1	PA; LA
CEPROTIN (BLUE BAR)	1	PA; MO
CEPROTIN (GREEN BAR)	1	PA; MO
cilostazol	1	MO
clopidogrel oral tablet 300 mg	1	
clopidogrel oral tablet 75 mg	1	MO; QL (30 per 30 days)
dabigatran etexilate	1	MO; QL (60 per 30 days)
dipyridamole intravenous	1	
dipyridamole oral	1	MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
DOPTELET (10 TAB PACK)	1	PA; MO; LA
DOPTELET (15 TAB PACK)	1	PA; MO; LA
DOPTELET (30 TAB PACK)	1	PA; MO; LA
DOPTELET SPRINKLE	1	PA; MO; LA
ELIQUIS DVT-PE TREAT 30D START	1	MO; QL (74 per 180 days)
ELIQUIS ORAL TABLET	1	MO; QL (60 per 30 days)
ELIQUIS ORAL TABLET FOR SUSPENSION 0.5 MG	1	MO; QL (140 per 28 days)
ELIQUIS ORAL TABLET FOR SUSPENSION 1.5 MG (0.5 MG X 3)	1	MO; QL (420 per 28 days)
ELIQUIS ORAL TABLET FOR SUSPENSION 2 MG (0.5 MG X 4)	1	MO; QL (560 per 28 days)
ELIQUIS SPRINKLE	1	QL (70 per 28 days)
eltrombopag olamine	1	PA; MO
enoxaparin subcutaneous solution	1	MO; QL (30 per 30 days)
enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml	1	MO; QL (56 per 28 days)
enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml	1	MO; QL (44.8 per 28 days)
enoxaparin subcutaneous syringe 30 mg/0.3 ml	1	MO; QL (16.8 per 28 days)
enoxaparin subcutaneous syringe 40 mg/0.4 ml	1	MO; QL (22.4 per 28 days)
enoxaparin subcutaneous syringe 60 mg/0.6 ml	1	MO; QL (33.6 per 28 days)
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	1	MO
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	1	MO
heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml)	1	
heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)	1	MO
heparin (porcine) in nacl (pf) intravenous parenteral solution 1,000 unit/500 ml	1	MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
heparin (porcine) in nacl (pf) intravenous parenteral solution 2,000 unit/1,000 ml	1	
heparin (porcine) injection solution	1	MO
heparin (porcine) injection syringe 5,000 unit/ml	1	
HEPARIN(PORCINE) IN 0.45% NACL INTRAVENOUS PARENTERAL SOLUTION 12,500 UNIT/250 ML	1	
heparin(porcine) in 0.45% nacl intravenous parenteral solution 25,000 unit/250 ml, 25,000 unit/500 ml	1	MO
heparin, porcine (pf) injection solution 1,000 unit/ml	1	
heparin, porcine (pf) injection solution 5,000 unit/0.5 ml	1	MO
HEPARIN, PORCINE (PF) INJECTION SYRINGE	1	MO
jantoven	1	
pentoxifylline	1	MO
prasugrel hcl	1	MO
protamine	1	
rivaroxaban oral suspension for reconstitution	1	MO; QL (775 per 28 days)
rivaroxaban oral tablet	1	MO; QL (60 per 30 days)
ticagrelor	1	MO
warfarin	1	MO
XARELTO DVT-PE TREAT 30D START	1	MO; QL (51 per 180 days)
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG	1	MO; QL (30 per 30 days)
XARELTO ORAL TABLET 2.5 MG	1	MO; QL (60 per 30 days)
LIPID/CHOLESTEROL LOWERING AGENTS		
amlodipine-atorvastatin	1	MO; QL (30 per 30 days)
atorvastatin	1	MO; QL (30 per 30 days)
cholestyramine (with sugar)	1	MO
cholestyramine light	1	MO
colesevelam	1	MO
colestipol oral granules	1	MO
colestipol oral packet	1	
colestipol oral tablet	1	MO
ezetimibe	1	MO
ezetimibe-simvastatin	1	MO; QL (30 per 30 days)
fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg	1	MO
fenofibrate nanocrystallized	1	MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
fenofibrate oral tablet 160 mg, 54 mg	1	MO
fenofibric acid	1	
fenofibric acid (choline)	1	MO
fluvastatin oral capsule 20 mg	1	MO; QL (30 per 30 days)
fluvastatin oral capsule 40 mg	1	MO; QL (60 per 30 days)
gemfibrozil	1	MO
icosapent ethyl	1	MO
lovastatin oral tablet 10 mg	1	MO; QL (30 per 30 days)
lovastatin oral tablet 20 mg, 40 mg	1	MO; QL (60 per 30 days)
NEXLETOL	1	PA; MO
NEXLIZET	1	PA; MO
niacin oral tablet 500 mg	1	MO
niacin oral tablet extended release 24 hr	1	MO
omega-3 acid ethyl esters	1	MO
pitavastatin calcium	1	MO; QL (30 per 30 days)
pravastatin	1	MO; QL (30 per 30 days)
prevalite	1	MO
REPATHA	1	PA; QL (6 per 28 days)
REPATHA SURECLICK	1	PA; QL (6 per 28 days)
rosuvastatin	1	MO; QL (30 per 30 days)
simvastatin	1	MO; QL (30 per 30 days)
MISCELLANEOUS CARDIOVASCULAR AGENTS		
CAMZYOS	1	PA; MO; QL (30 per 30 days)
digoxin oral solution	1	MO
digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	1	MO
dobutamine	1	B/D PA
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	B/D PA
dopamine in 5 % dextrose intravenous solution 200 mg/250 ml (800 mcg/ml), 400 mg/250 ml (1,600 mcg/ml), 400 mg/500 ml (800 mcg/ml), 800 mg/500 ml (1,600 mcg/ml)	1	B/D PA
dopamine in 5 % dextrose intravenous solution 800 mg/250 ml (3,200 mcg/ml)	1	B/D PA; MO
dopamine intravenous solution 200 mg/5 ml (40 mg/ml)	1	B/D PA

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
dopamine intravenous solution 400 mg/10 ml (40 mg/ml)	1	B/D PA; MO
ENTRESTO SPRINKLE	1	QL (240 per 30 days)
ivabradine	1	MO; QL (60 per 30 days)
milrinone	1	B/D PA
milrinone in 5 % dextrose	1	B/D PA
norepinephrine bitartrate	1	
ranolazine	1	MO
sacubitril-valsartan	1	MO; QL (60 per 30 days)
VERQUVO	1	MO; QL (30 per 30 days)
VYNDAMAX	1	PA; MO
VYNDAQEL	1	PA
NITRATES		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	MO
isosorbide mononitrate	1	MO
nitro-bid	1	MO
nitroglycerin sublingual	1	MO
nitroglycerin transdermal ointment	1	
nitroglycerin transdermal patch 24 hour	1	MO
nitroglycerin translingual	1	MO
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
acitretin	1	MO
calcipotriene scalp	1	MO; QL (120 per 30 days)
calcipotriene topical cream	1	MO; QL (120 per 30 days)
calcipotriene topical ointment	1	MO; QL (120 per 30 days)
COSENTYX (2 SYRINGES)	1	PA; MO; QL (10 per 28 days)
COSENTYX INTRAVENOUS	1	PA; QL (20 per 28 days)
COSENTYX PEN	1	PA; MO; QL (5 per 28 days)
COSENTYX PEN (2 PENS)	1	PA; MO; QL (10 per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 150 MG/ML	1	PA; MO; QL (5 per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	1	PA; MO; QL (2.5 per 28 days)
COSENTYX UNOREADY PEN	1	PA; MO; QL (10 per 28 days)
OTULFI INTRAVENOUS	1	PA; MO; QL (104 per 180 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
OTULFI SUBCUTANEOUS SOLUTION	1	PA; MO; QL (0.5 per 28 days)
OTULFI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
OTULFI SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; MO; QL (1 per 28 days)
PYZCHIVA (ONLY NDCS STARTING WITH 61314) INTRAVENOUS SOLUTION 130 MG/26 ML	1	PA; MO; QL (104 per 180 days)
PYZCHIVA (ONLY NDCS STARTING WITH 61314) SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
PYZCHIVA (ONLY NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
PYZCHIVA (ONLY NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; MO; QL (1 per 28 days)
SELARSDI INTRAVENOUS	1	PA; MO; QL (104 per 180 days)
SELARSDI SUBCUTANEOUS SOLUTION	1	PA; MO; QL (0.5 per 28 days)
SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
SELARSDI SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; QL (1 per 28 days)
selenium sulfide topical lotion	1	MO
SKYRIZI SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (2 per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	1	PA; MO; QL (2 per 84 days)
STELARA INTRAVENOUS	1	PA; MO; QL (104 per 180 days)
STELARA SUBCUTANEOUS SOLUTION	1	PA; MO; QL (0.5 per 28 days)
TREMFYA INTRAVENOUS	1	PA; MO; QL (20 per 28 days)
TREMFYA ONE-PRESS	1	PA; MO; QL (2 per 28 days)
TREMFYA PEN	1	PA; MO; QL (2 per 28 days)
TREMFYA PEN INDUCTION PK(2PEN)	1	PA; MO; QL (12 per 180 days)
TREMFYA SUBCUTANEOUS SYRINGE	1	PA; MO; QL (2 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
USTEKINUMAB INTRAVENOUS	1	PA; MO; QL (104 per 180 days)
USTEKINUMAB SUBCUTANEOUS SOLUTION	1	PA; MO; QL (0.5 per 28 days)
USTEKINUMAB-AEKN SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
USTEKINUMAB-AEKN SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; MO; QL (1 per 28 days)
YESINTEK INTRAVENOUS	1	PA; MO; QL (104 per 180 days)
YESINTEK SUBCUTANEOUS SOLUTION	1	PA; MO; QL (0.5 per 28 days)
YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; MO; QL (1 per 28 days)
MISCELLANEOUS DERMATOLOGICALS		
ADBRY	1	PA; MO; QL (6 per 28 days)
ammonium lactate	1	MO
chloroprocaine (pf)	1	
dermacinrx lidocan	1	PA; QL (90 per 30 days)
diclofenac sodium topical gel 3 %	1	PA; MO; QL (100 per 28 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	1	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	1	PA; MO; QL (8 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	1	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML	1	PA; MO; QL (8 per 28 days)
EUCRISA	1	PA; MO; QL (120 per 30 days)
fluorouracil topical cream 5 %	1	MO
fluorouracil topical solution	1	MO
glydo	1	MO; QL (60 per 30 days)
imiquimod topical cream in packet 5 %	1	MO
lidocaine (pf) injection solution	1	
lidocaine hcl injection solution	1	
lidocaine hcl mucous membrane jelly	1	MO; QL (60 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
lidocaine hcl mucous membrane jelly in applicator	1	MO; QL (60 per 30 days)
lidocaine hcl mucous membrane solution 2 %	1	MO
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	1	MO
lidocaine topical adhesive patch,medicated 5 %	1	PA; MO; QL (90 per 30 days)
lidocaine topical ointment	1	MO; QL (50 per 30 days)
lidocaine-epinephrine	1	
lidocaine-epinephrine (pf) injection solution 1.5 %-1:200,000, 2 %-1:200,000	1	
lidocaine-prilocaine topical cream	1	MO; QL (30 per 30 days)
lidocan iii	1	PA; QL (90 per 30 days)
lidocan iv	1	PA; QL (90 per 30 days)
lidocan v	1	PA; QL (90 per 30 days)
methoxsalen	1	MO
PANRETIN	1	PA; MO
pimecrolimus	1	PA; MO; QL (100 per 30 days)
podofilox topical solution	1	MO
polocaine injection solution 1 % (10 mg/ml)	1	
polocaine-mpf	1	
SANTYL	1	MO; QL (180 per 30 days)
silver sulfadiazine	1	MO
ssd	1	MO
tacrolimus topical	1	PA; MO; QL (100 per 30 days)
VALCHLOR	1	PA; MO
THERAPY FOR ACNE		
accutane	1	
amnesteem	1	
azelaic acid	1	MO
claravis	1	
clindamycin phosphate topical gel	1	MO; QL (120 per 30 days)
clindamycin phosphate topical gel, once daily	1	MO; QL (150 per 30 days)
clindamycin phosphate topical lotion	1	MO; QL (120 per 30 days)
clindamycin phosphate topical solution	1	MO; QL (120 per 30 days)
ery pads	1	MO
erythromycin with ethanol topical solution	1	MO
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
metronidazole topical	1	MO
tazarotene topical cream	1	PA; MO
tazarotene topical gel	1	PA; MO
tretinoin topical cream 0.025 %, 0.05 %, 0.1 %	1	PA; MO
tretinoin topical gel 0.01 %, 0.025 %, 0.05 %	1	PA; MO
zenatane	1	
TOPICAL ANTIBACTERIALS		
gentamicin topical	1	MO; QL (60 per 30 days)
mupirocin	1	MO; QL (44 per 30 days)
sulfacetamide sodium (acne)	1	MO
TOPICAL ANTIFUNGALS		
ciclodan topical solution	1	QL (6.6 per 28 days)
ciclopirox topical cream	1	MO; QL (90 per 28 days)
ciclopirox topical gel	1	MO; QL (100 per 28 days)
ciclopirox topical shampoo	1	MO; QL (120 per 28 days)
ciclopirox topical solution	1	MO; QL (6.6 per 28 days)
ciclopirox topical suspension	1	MO; QL (60 per 28 days)
clotrimazole topical cream	1	MO; QL (45 per 28 days)
clotrimazole topical solution	1	MO; QL (30 per 28 days)
clotrimazole-betamethasone topical cream	1	MO; QL (45 per 28 days)
clotrimazole-betamethasone topical lotion	1	MO; QL (60 per 28 days)
econazole nitrate topical cream	1	MO; QL (85 per 28 days)
ketoconazole topical cream	1	MO; QL (60 per 28 days)
ketoconazole topical shampoo	1	MO; QL (120 per 28 days)
klayesta	1	MO; QL (180 per 30 days)
naftifine topical gel	1	MO; QL (60 per 28 days)
nyamyc	1	QL (180 per 30 days)
nystatin topical cream	1	MO; QL (30 per 28 days)
nystatin topical ointment	1	MO; QL (30 per 28 days)
nystatin topical powder	1	MO; QL (180 per 30 days)
nystatin-triamcinolone	1	MO; QL (60 per 28 days)
nystop	1	MO; QL (180 per 30 days)
TOPICAL ANTIVIRALS		
acyclovir topical ointment	1	PA; MO; QL (30 per 30 days)
penciclovir	1	MO; QL (5 per 30 days)
TOPICAL CORTICOSTEROIDS		

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
ala-cort topical cream	1	MO
alclometasone	1	MO
betamethasone dipropionate	1	MO
betamethasone valerate topical cream	1	MO
betamethasone valerate topical lotion	1	MO
betamethasone valerate topical ointment	1	MO
betamethasone, augmented topical cream	1	MO
betamethasone, augmented topical gel	1	MO
betamethasone, augmented topical lotion	1	MO
betamethasone, augmented topical ointment	1	MO
clobetasol scalp	1	MO; QL (100 per 28 days)
clobetasol topical cream 0.05 %	1	MO; QL (120 per 28 days)
clobetasol topical foam	1	MO; QL (100 per 28 days)
clobetasol topical gel	1	MO; QL (120 per 28 days)
clobetasol topical lotion	1	MO; QL (118 per 28 days)
clobetasol topical ointment	1	MO; QL (120 per 28 days)
clobetasol topical shampoo	1	MO; QL (236 per 28 days)
clobetasol-emollient topical cream	1	MO; QL (120 per 28 days)
desonide topical cream	1	MO
desonide topical ointment	1	MO
fluocinolone	1	MO
fluocinolone and shower cap	1	MO
fluocinonide topical cream 0.05 %	1	MO; QL (120 per 30 days)
fluocinonide topical gel	1	MO; QL (120 per 30 days)
fluocinonide topical ointment	1	MO; QL (120 per 30 days)
fluocinonide topical solution	1	MO; QL (120 per 30 days)
fluocinonide-emollient	1	MO; QL (120 per 30 days)
fluticasone propionate topical cream	1	MO
fluticasone propionate topical ointment	1	MO
halobetasol propionate topical cream	1	MO
halobetasol propionate topical ointment	1	MO
hydrocortisone topical cream 1 %, 2.5 %	1	MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
hydrocortisone topical lotion 2.5 %	1	MO
hydrocortisone topical ointment 1 %, 2.5 %	1	MO
mometasone topical	1	MO
triamcinolone acetonide topical cream	1	MO
triamcinolone acetonide topical lotion	1	MO
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	1	MO
triderm topical cream 0.5 %	1	
TOPICAL SCABICIDES / PEDICULICIDES		
malathion	1	MO
permethrin	1	MO; QL (60 per 30 days)
DIAGNOSTICS / MISCELLANEOUS AGENTS		
ANTIDOTES		
acetylcysteine intravenous	1	
IRRIGATING SOLUTIONS		
lactated ringers irrigation	1	
neomycin-polymyxin b gu	1	
ringer's irrigation	1	MO
MISCELLANEOUS AGENTS		
acamprosate	1	MO
acetic acid irrigation	1	MO
anagrelide	1	MO
caffeine citrate intravenous	1	
caffeine citrate oral	1	MO
carglumic acid	1	PA; MO
cevimeline	1	MO
CHEMET	1	PA
CLINIMIX 4.25%/D5W SULFIT FREE	1	B/D PA
d10 %-0.45 % sodium chloride	1	
d2.5 %-0.45 % sodium chloride	1	
d5 % and 0.9 % sodium chloride	1	MO
d5 %-0.45 % sodium chloride	1	MO
deferasirox oral granules in packet	1	PA; MO
deferasirox oral tablet	1	PA; MO
deferasirox oral tablet, dispersible 125 mg	1	PA; MO
deferasirox oral tablet, dispersible 250 mg, 500 mg	1	PA; MO
deferiprone	1	PA; MO
deferoxamine	1	B/D PA; MO
dextrose 10 % and 0.2 % nacl	1	
dextrose 10 % in water (d10w)	1	

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
dextrose 25 % in water (d25w)	1	
dextrose 5 % in water (d5w)	1	MO
dextrose 5 %-lactated ringers	1	MO
dextrose 5%-0.2 % sod chloride	1	
dextrose 5%-0.3 % sod.chloride	1	
dextrose 50 % in water (d50w)	1	
dextrose 70 % in water (d70w)	1	
disulfiram oral tablet 250 mg	1	MO
disulfiram oral tablet 500 mg	1	
droxidopa oral capsule 100 mg	1	PA; MO
droxidopa oral capsule 200 mg, 300 mg	1	PA; MO
glutamine (sickle cell)	1	PA; MO
INCRELEX	1	LA
kionex oral suspension	1	
levocarnitine (with sugar)	1	MO
levocarnitine oral solution 100 mg/ml	1	MO
levocarnitine oral tablet	1	MO
LOKELMA	1	MO
midodrine	1	MO
nitisinone	1	PA; MO
pilocarpine hcl oral	1	MO
PROLASTIN-C INTRAVENOUS SOLUTION	1	PA; MO; LA
REVCOVI	1	PA; LA
REZDIFFRA	1	PA; MO; QL (30 per 30 days)
riluzole	1	PA; MO
risedronate oral tablet 30 mg	1	MO; QL (30 per 30 days)
sevelamer carbonate oral tablet	1	PA; MO
sodium benzoate-sod phenylacet	1	
sodium chloride 0.9 % intravenous	1	MO
sodium chloride irrigation	1	MO
sodium phenylbutyrate oral powder	1	PA
sodium phenylbutyrate oral tablet	1	PA; MO
sodium polystyrene sulfonate oral powder	1	MO
sodium polystyrene sulfonate oral suspension	1	
sps (with sorbitol) oral	1	MO
sps (with sorbitol) rectal	1	

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
trientine oral capsule 250 mg	1	PA; MO
VELTASSA ORAL POWDER IN PACKET 1 GRAM, 16.8 GRAM, 8.4 GRAM	1	MO
VELTASSA ORAL POWDER IN PACKET 25.2 GRAM	1	
water for irrigation, sterile	1	MO
XIAFLEX	1	PA
zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml	1	PA; MO
SMOKING DETERRENTS		
bupropion hcl (smoking deter)	1	MO
NICOTROL NS	1	MO
varenicline tartrate oral tablet 0.5 mg, 1 mg	1	MO
varenicline tartrate oral tablet 1 mg (56 pack)	1	
varenicline tartrate oral tablets,dose pack	1	MO
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
azelastine nasal spray,non-aerosol 137 mcg (0.1 %)	1	MO; QL (60 per 30 days)
chlorhexidine gluconate mucous membrane	1	MO
denta 5000 plus	1	MO
dentagel	1	MO
fluoride (sodium) dental cream	1	
fluoride (sodium) dental gel	1	
fluoride (sodium) dental paste	1	MO
ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)	1	MO; QL (30 per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	1	MO; QL (30 per 20 days)
kourzeq	1	MO
periogard	1	MO
sf	1	MO
sf 5000 plus	1	MO
sodium fluoride 5000 dry mouth	1	MO
sodium fluoride 5000 plus	1	
sodium fluoride-pot nitrate	1	MO
triamcinolone acetonide dental	1	MO
MISCELLANEOUS OTIC PREPARATIONS		
acetic acid otic (ear)	1	MO
ciprofloxacin hcl otic (ear)	1	MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
flac otic oil	1	
fluocinolone acetonide oil	1	MO
hydrocortisone-acetic acid	1	MO
ofloxacin otic (ear)	1	MO
OTIC STEROID / ANTIBIOTIC		
ciprofloxacin-dexamethasone	1	MO; QL (7.5 per 7 days)
neomycin-polymyxin-hc otic (ear)	1	MO
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
cortisone	1	
dexamethasone intensol	1	MO
dexamethasone oral elixir	1	MO
dexamethasone oral solution	1	MO
dexamethasone oral tablet	1	MO
dexamethasone sodium phos (pf) injection solution 10 mg/ml	1	MO
dexamethasone sodium phosphate injection solution	1	MO
dexamethasone sodium phosphate injection syringe	1	
fludrocortisone	1	MO
hydrocortisone oral	1	MO
methylprednisolone acetate	1	MO
methylprednisolone oral tablet	1	B/D PA; MO
methylprednisolone oral tablets,dose pack	1	MO
methylprednisolone sodium succ injection recon soln 125 mg, 40 mg	1	MO
methylprednisolone sodium succ intravenous	1	MO
prednisolone oral solution	1	MO
prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	1	MO
prednisone intensol	1	MO
prednisone oral solution	1	MO
prednisone oral tablet	1	MO
prednisone oral tablets,dose pack 10 mg (48 pack), 5 mg (48 pack)	1	
prednisone oral tablets,dose pack 10 mg, 5 mg	1	MO
triamcinolone acetonide injection suspension 10 mg/ml	1	

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Drug Name	Drug Tier	Requirements /Limits
triamcinolone acetonide injection suspension 40 mg/ml	1	MO
ANTITHYROID AGENTS		
methimazole oral tablet 10 mg, 5 mg	1	MO
propylthiouracil	1	MO
DIABETES THERAPY		
acarbose oral tablet 100 mg	1	MO; QL (90 per 30 days)
acarbose oral tablet 25 mg	1	MO; QL (360 per 30 days)
acarbose oral tablet 50 mg	1	MO; QL (180 per 30 days)
ACCU-CHEK GUIDE TEST STRIPS	1	MO
alcohol pads	1	PA; MO
BAQSIMI	1	MO
dapagliflozin	1	MO; QL (30 per 30 days)
dapagliflozin-metformin oral tablet, ir - er, biphasic 24hr 10-1,000 mg, 10-500 mg	1	MO; QL (30 per 30 days)
dapagliflozin-metformin oral tablet, ir - er, biphasic 24hr 5-1,000 mg, 5-500 mg	1	MO; QL (60 per 30 days)
diazoxide	1	MO
DROPSAFE ALCOHOL PREP PADS	1	PA
FIASP FLEXTOUCH U-100 INSULIN	1	MO
FIASP PENFILL U-100 INSULIN	1	MO
FIASP U-100 INSULIN	1	MO
FREESTYLE INSULINX STRIP	1	MO
FREESTYLE INSULINX TEST STRIPS	1	MO
FREESTYLE LITE STRIPS	1	MO
FREESTYLE PRECISION NEO STRIPS	1	MO
FREESTYLE TEST	1	MO
glimepiride oral tablet 1 mg	1	MO; QL (240 per 30 days)
glimepiride oral tablet 2 mg	1	MO; QL (120 per 30 days)
glimepiride oral tablet 4 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet 10 mg	1	MO; QL (120 per 30 days)
glipizide oral tablet 5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 5 mg	1	MO; QL (120 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
glipizide-metformin oral tablet 2.5-250 mg	1	MO; QL (240 per 30 days)
glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg	1	MO; QL (120 per 30 days)
GLYXAMBI	1	MO; QL (30 per 30 days)
GVOKE	1	MO
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML	1	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 1 MG/0.2 ML	1	MO
GVOKE HYPOPEN 2-PACK	1	MO
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	MO
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	MO
HUMALOG JUNIOR KWIKPEN U-100	1	MO
HUMALOG KWIKPEN INSULIN	1	MO
HUMALOG MIX 50-50 KWIKPEN	1	MO
HUMALOG MIX 75-25 KWIKPEN	1	MO
HUMALOG MIX 75-25(U-100)INSULN	1	MO
HUMALOG U-100 INSULIN	1	MO
HUMULIN 70/30 U-100 INSULIN	1	MO
HUMULIN 70/30 U-100 KWIKPEN	1	MO
HUMULIN N NPH INSULIN KWIKPEN	1	MO
HUMULIN N NPH U-100 INSULIN	1	MO
HUMULIN R REGULAR U-100 INSULN	1	MO
HUMULIN R U-500 (CONC) INSULIN	1	
HUMULIN R U-500 (CONC) KWIKPEN	1	MO
INPEFA	1	PA; MO; QL (30 per 30 days)
INSULIN LISPRO	1	MO
INSULIN LISPRO PROTAMIN-LISPRO	1	MO
JANUMET	1	MO; QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	1	MO; QL (60 per 30 days)
JANUVIA	1	MO; QL (30 per 30 days)
JARDIANCE	1	MO; QL (30 per 30 days)
JENTADUETO	1	MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	1	MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	1	MO; QL (30 per 30 days)
KIRSTY	1	
KIRSTY PEN	1	
LANTUS SOLOSTAR U-100 INSULIN	1	
LANTUS U-100 INSULIN	1	MO
liraglutide	1	PA; QL (9 per 30 days)
LYUMJEV KWIKPEN U-100 INSULIN	1	MO
LYUMJEV KWIKPEN U-200 INSULIN	1	MO
LYUMJEV U-100 INSULIN	1	MO
metformin oral tablet 1,000 mg	1	MO; QL (75 per 30 days)
metformin oral tablet 500 mg	1	MO; QL (150 per 30 days)
metformin oral tablet 850 mg	1	MO; QL (90 per 30 days)
metformin oral tablet extended release 24 hr 500 mg	1	MO; QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	MO; QL (60 per 30 days)
MOUNJARO	1	PA; QL (2 per 28 days)
nateglinide oral tablet 120 mg	1	MO; QL (90 per 30 days)
nateglinide oral tablet 60 mg	1	MO; QL (180 per 30 days)
NOVOLIN 70/30 U-100 INSULIN	1	MO
NOVOLIN 70-30 FLEXPEN U-100	1	MO
NOVOLIN N FLEXPEN	1	MO
NOVOLIN N NPH U-100 INSULIN	1	MO
NOVOLIN R FLEXPEN	1	MO
NOVOLIN R REGULAR U100 INSULIN	1	MO
NOVOLOG MIX 70-30 U-100 INSULN	1	MO
NOVOLOG MIX 70-30FLEXPEN U-100	1	MO
NOVOLOG PENFILL U-100 INSULIN	1	MO

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Drug Name	Drug Tier	Requirements /Limits
OZEMPIC ORAL	1	PA; QL (30 per 30 days)
OZEMPIC SUBCUTANEOUS	1	PA; QL (3 per 28 days)
pioglitazone	1	MO; QL (30 per 30 days)
PRECISION XTRA TEST	1	MO
repaglinide oral tablet 0.5 mg	1	MO; QL (960 per 30 days)
repaglinide oral tablet 1 mg	1	MO; QL (480 per 30 days)
repaglinide oral tablet 2 mg	1	MO; QL (240 per 30 days)
RYBELSUS	1	PA; QL (30 per 30 days)
saxagliptin	1	MO; QL (30 per 30 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg	1	MO; QL (60 per 30 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg	1	MO; QL (30 per 30 days)
sitagliptin phos-metformin oral tablet	1	MO; QL (60 per 30 days)
sitagliptin phosphate	1	MO; QL (30 per 30 days)
SOLIQUA 100/33	1	QL (15 per 25 days)
SYNJARDY	1	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	1	MO; QL (30 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	1	MO; QL (60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR	1	MO
TOUJEO SOLOSTAR U-300 INSULIN	1	MO
TRADJENTA	1	MO; QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	1	MO; QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	1	MO; QL (60 per 30 days)
TRULICITY	1	PA; QL (2 per 28 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG	1	MO; QL (30 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG	1	MO; QL (60 per 30 days)
MISCELLANEOUS HORMONES		

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Drug Name	Drug Tier	Requirements /Limits
ALDURAZYME	1	PA; MO
cabergoline	1	MO
calcitonin (salmon) injection	1	MO
calcitonin (salmon) nasal	1	MO
calcitriol oral capsule	1	MO
calcitriol oral solution	1	
cinacalcet	1	PA; MO
clomid	1	PA; MO
clomiphene citrate	1	PA; MO
CRYSVITA	1	PA; MO; LA
danazol	1	MO
desmopressin injection	1	
desmopressin nasal spray with pump	1	MO
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	1	
desmopressin oral	1	MO
doxercalciferol intravenous	1	MO
doxercalciferol oral	1	MO
ELAPRASE	1	PA; MO
FABRAZYME	1	PA; MO
KANUMA	1	PA; MO
LUMIZYME	1	PA; MO
MEPSEVII	1	PA; MO
mifepristone oral tablet 300 mg	1	PA; MO
milophene	1	PA; MO
NAGLAZYME	1	PA; MO; LA
pamidronate intravenous solution	1	MO
paricalcitol intravenous	1	
paricalcitol oral	1	MO
sapropterin	1	PA; MO
SOMAVERT	1	PA; MO
STRENSIQ	1	PA; LA
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml	1	PA; MO
testosterone cypionate intramuscular oil 200 mg/ml (1 ml)	1	PA
testosterone enanthate	1	PA; MO
testosterone transdermal gel	1	PA; MO; QL (300 per 30 days)
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)	1	PA; MO; QL (300 per 30 days)
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	1	PA; MO; QL (150 per 30 days)

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	1	PA; MO; QL (300 per 30 days)
testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)	1	PA; MO; QL (37.5 per 30 days)
testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)	1	PA; MO; QL (150 per 30 days)
testosterone transdermal solution in metered pump w/app	1	PA; MO; QL (180 per 30 days)
tolvaptan	1	PA; MO
tolvaptan (polycys kidney dis)	1	PA; MO
VIMIZIM	1	PA; MO; LA
zoledronic acid intravenous solution	1	B/D PA; MO
THYROID HORMONES		
levothyroxine intravenous recon soln	1	
levothyroxine oral tablet	1	MO
levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	1	MO
liomny	1	
liothyronine intravenous	1	
liothyronine oral	1	MO
unithroid	1	MO
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
dicyclomine intramuscular	1	MO
dicyclomine oral capsule	1	MO
dicyclomine oral solution	1	MO
dicyclomine oral tablet 20 mg	1	MO
diphenoxylate-atropine oral liquid	1	MO
diphenoxylate-atropine oral tablet	1	MO
glycopyrrolate (pf) in water intravenous syringe 0.4 mg/2 ml (0.2 mg/ml)	1	
glycopyrrolate (pf) injection syringe 0.4 mg/2 ml (0.2 mg/ml)	1	MO
glycopyrrolate injection	1	MO
glycopyrrolate oral tablet 1 mg, 2 mg	1	MO
loperamide oral capsule	1	MO
opium tincture	1	
MISCELLANEOUS GASTROINTESTINAL AGENTS		
alosetron oral tablet 0.5 mg	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
alosetron oral tablet 1 mg	1	PA; MO
aprepitant	1	B/D PA; MO
balsalazide	1	MO
betaine	1	MO
budesonide oral capsule,delayed,extend.release	1	MO
budesonide oral tablet,delayed and ext.release	1	MO
CIMZIA POWDER FOR RECONST	1	PA; MO; QL (2 per 28 days)
CIMZIA STARTER KIT	1	PA; MO; QL (3 per 180 days)
CIMZIA SUBCUTANEOUS SYRINGE KIT 200 MG/ML	1	PA; QL (4 per 28 days)
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	1	PA; MO; QL (2 per 28 days)
CINVANTI	1	MO
compro	1	MO
constulose	1	MO
CORTIFOAM	1	MO
CREON	1	MO
cromolyn oral	1	MO
dimenhydrinate injection solution	1	MO
dronabinol oral capsule	1	PA; MO
droperidol injection solution	1	
enulose	1	MO
fosaprepitant	1	MO
GATTEX 30-VIAL	1	PA; MO
GATTEX ONE-VIAL	1	PA; MO
gavilyte-c	1	MO
gavilyte-g	1	MO
gavilyte-n	1	MO
generlac	1	MO
granisetron (pf) intravenous solution 1 mg/ml (1 ml)	1	MO
granisetron hcl intravenous solution 1 mg/ml	1	MO
granisetron hcl intravenous solution 1 mg/ml (1 ml)	1	
granisetron hcl oral	1	B/D PA; MO
hydrocortisone rectal	1	MO
hydrocortisone topical cream with perineal applicator 1 %	1	MO
hydrocortisone topical cream with perineal applicator 2.5 %	1	
INFLIXIMAB	1	PA; QL (20 per 28 days)
lactulose oral solution	1	MO

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Drug Name	Drug Tier	Requirements /Limits
LINZESS	1	MO; QL (30 per 30 days)
LIVDELZI	1	PA; QL (30 per 30 days)
lubiprostone	1	MO; QL (60 per 30 days)
meclizine oral tablet 12.5 mg, 25 mg	1	MO
mesalamine oral capsule (with del rel tablets)	1	MO
mesalamine oral capsule, extended release 250 mg	1	
mesalamine oral capsule, extended release 500 mg	1	MO
mesalamine oral capsule,extended release 24hr	1	MO
mesalamine oral tablet,delayed release (dr/ec)	1	MO
mesalamine rectal	1	MO
mesalamine with cleansing wipe	1	MO
metoclopramide hcl injection	1	
metoclopramide hcl oral solution	1	MO
metoclopramide hcl oral tablet	1	MO
nitroglycerin rectal	1	MO
ondansetron hcl (pf) injection solution	1	MO
ondansetron hcl (pf) injection syringe	1	
ondansetron hcl intravenous	1	MO
ondansetron hcl oral solution	1	B/D PA; MO
ondansetron hcl oral tablet 4 mg, 8 mg	1	B/D PA; MO
ondansetron oral tablet,disintegrating 4 mg, 8 mg	1	B/D PA; MO
palonosetron intravenous solution 0.25 mg/5 ml	1	MO
palonosetron intravenous syringe	1	
peg 3350-electrolytes	1	
peg-electrolyte	1	MO
prochlorperazine	1	MO
prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)	1	MO
prochlorperazine maleate oral	1	MO
procto-med hc	1	MO
proctosol hc topical	1	MO
proctozone-hc	1	
RELISTOR SUBCUTANEOUS SOLUTION	1	ST; MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	1	ST; MO; QL (18 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	1	ST; MO; QL (12 per 30 days)
REMICADE	1	PA; MO; QL (20 per 28 days)
scopolamine base	1	MO
SKYRIZI INTRAVENOUS	1	PA; MO; QL (30 per 180 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	1	PA; MO; QL (1.2 per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	1	PA; MO; QL (2.4 per 56 days)
sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram	1	MO
sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram 2 pack (480ml)	1	
SUCRAID	1	PA
sulfasalazine	1	MO
SYMPROIC	1	MO; QL (30 per 30 days)
TRULANCE	1	QL (30 per 30 days)
ursodiol oral capsule 300 mg	1	MO
ursodiol oral tablet	1	MO
VARUBI	1	B/D PA
VIBERZI	1	MO; QL (60 per 30 days)
VOWST	1	PA; LA
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, 60,000-189,600-252,600 UNIT	1	MO
ZYMFENTRA	1	PA; MO; QL (2 per 28 days)
ULCER THERAPY		
esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg	1	MO; QL (30 per 30 days)
esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg	1	MO; QL (60 per 30 days)
esomeprazole sodium	1	MO

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Drug Name	Drug Tier	Requirements /Limits
famotidine (pf) intravenous solution 20 mg/2 ml	1	MO
famotidine (pf)-nacl (iso-os)	1	MO
famotidine intravenous solution 10 mg/ml	1	MO
famotidine oral tablet 20 mg, 40 mg	1	MO
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	1	MO; QL (30 per 30 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	1	MO; QL (60 per 30 days)
misoprostol	1	MO
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg	1	MO; QL (30 per 30 days)
omeprazole oral capsule,delayed release(dr/ec) 40 mg	1	MO; QL (60 per 30 days)
pantoprazole intravenous	1	MO
pantoprazole oral tablet,delayed release (dr/ec) 20 mg	1	MO; QL (30 per 30 days)
pantoprazole oral tablet,delayed release (dr/ec) 40 mg	1	MO; QL (60 per 30 days)
sucralfate oral suspension	1	MO
sucralfate oral tablet	1	MO

Drug Name	Drug Tier	Requirements /Limits
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ACTIMMUNE	1	PA; MO
ARCALYST	1	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	1	PA; MO; QL (1 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	1	PA; MO; QL (1 per 28 days)
BESREMI	1	PA; LA
BETASERON SUBCUTANEOUS KIT	1	PA; MO; QL (14 per 28 days)
FULPHILA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	1	PA; MO
ILARIS (PF)	1	PA; MO; LA; QL (2 per 28 days)
NIVESTYM	1	PA; MO
NYVEPRIA	1	PA; MO
OMNITROPE	1	PA; MO
PEGASYS SUBCUTANEOUS SOLUTION	1	MO; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	1	MO; QL (2 per 28 days)
PLEGRIDY INTRAMUSCULAR	1	PA; MO; QL (1 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	1	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	1	PA; MO; QL (1 per 180 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	1	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	1	PA; MO; QL (1 per 180 days)
plerixafor	1	B/D PA; MO
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	1	PA; MO
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	1	PA; MO
RELEUKO SUBCUTANEOUS	1	PA; MO
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	1	PA; MO
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	1	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ABRYSVO (PF)	1	V
ACTHIB (PF)	1	
ADACEL(TDAP ADOLESN/ADULT)(PF)	1	V
AREXVY (PF)	1	V
BCG VACCINE, LIVE (PF)	1	V
BEXSERO	1	V
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE	1	V
DAPTACEL (DTAP PEDIATRIC) (PF)	1	
DENGVAXIA (PF)	1	
ENGERIX-B (PF)	1	B/D PA; V
ENGERIX-B PEDIATRIC (PF)	1	B/D PA; V
fomepizole	1	
GAMASTAN	1	MO
GAMUNEX-C	1	PA; MO
GARDASIL 9 (PF)	1	V

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Drug Name	Drug Tier	Requirements /Limits
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	1	V
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	1	
HEPLISAV-B (PF)	1	B/D PA; V
HIBERIX (PF)	1	
HYPERHEP B	1	
HYPERHEP B NEONATAL	1	
IMOVAX RABIES VACCINE (PF)	1	B/D PA; V
INFANRIX (DTAP) (PF)	1	
IPOL	1	V
IXIARO (PF)	1	V
JYNNEOS (PF)	1	B/D PA; V
KINRIX (PF)	1	
MENQUADFI (PF)	1	V
MENVEO A-C-Y-W-135-DIP (PF)	1	V
M-M-R II (PF)	1	V
MRESVIA (PF)	1	V
PEDIARIX (PF)	1	
PEDVAX HIB (PF)	1	
PENBRAYA (PF)	1	V
PENMENVY MEN A-B-C-W-Y (PF)	1	V
PENTACEL (PF)	1	
PRIORIX (PF)	1	V
PROQUAD (PF)	1	
QUADRACEL (PF)	1	
RABAVERT (PF)	1	B/D PA; V
RECOMBIVAX HB (PF)	1	B/D PA; V
ROTARIX ORAL SUSPENSION	1	
ROTATEQ VACCINE	1	
SHINGRIX (PF)	1	V; QL (2 per 720 days)
TENIVAC (PF)	1	V
TICE BCG	1	B/D PA
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML	1	
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	1	V
TRUMENBA	1	V
TWINRIX (PF)	1	V
TYPHIM VI	1	V
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	1	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML	1	V
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML	1	

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML	1	V
VARIVAX (PF)	1	V
VARIZIG	1	
VAXCHORA VACCINE	1	V
VIMKUNYA (PF)	1	V
VIVOTIF	1	MO; V
XEMBIFY	1	B/D PA; MO; LA
YF-VAX (PF)	1	V
MISCELLANEOUS SUPPLIES		
MISCELLANEOUS SUPPLIES		
ACCU-CHEK GUIDE GLUCOSE METER	1	MO
ACCU-CHEK GUIDE ME GLUCOSE MTR	1	MO
NOVO PEN NEEDLE	1	PA; MO
CEQUR SIMPLICITY DEVICE 2 UNIT (200 UNIT)	1	MO
CEQUR SIMPLICITY INSERTER	1	MO
DEXCOM G6 RECEIVER	1	MO
DEXCOM G6 SENSOR	1	MO
DEXCOM G6 TRANSMITTER	1	MO
DEXCOM G7 RECEIVER	1	MO
DEXCOM G7 SENSOR	1	MO
FREESTYLE FREEDOM LITE	1	MO
FREESTYLE INSULINX	1	
FREESTYLE LIBRE 14 DAY READER	1	
FREESTYLE LIBRE 14 DAY SENSOR	1	
FREESTYLE LIBRE 2 PLUS SENSOR	1	MO
FREESTYLE LIBRE 2 READER	1	MO
FREESTYLE LIBRE 2 SENSOR	1	
FREESTYLE LIBRE 3 PLUS SENSOR	1	MO
FREESTYLE LIBRE 3 READER	1	MO
FREESTYLE LIBRE 3 SENSOR	1	
FREESTYLE LITE METER	1	MO
GAUZE PADS 2 X 2	1	PA; MO
EMBECTA INSULIN SYRINGE	1	PA; MO
BD PEN NEEDLE	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
OMNIPOD 5 (LIBRE 2/3 PLUS)	1	MO
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	1	MO; QL (1 per 720 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	1	MO
OMNIPOD 5 INTRO (LIBRE2/3PLUS)	1	MO; QL (1 per 720 days)
OMNIPOD DASH INTRO KIT (GEN 4)	1	QL (1 per 720 days)
OMNIPOD DASH PODS (GEN 4)	1	MO
EMBECTA PEN NEEDLE	1	PA; MO
PIVOT INSULIN PUMP STARTER KIT	1	QL (1 per 720 days)
PIVOT SUPPLY KIT	1	
PRECISION XTRA MONITOR	1	MO
TWIIST REFILL KT(CSST-NDL-SYR)	1	
TWIIST RFL(INFUS-CSST-NDL-SYR)	1	
TWIIST STARTER KIT	1	QL (1 per 720 days)
BD INSULIN SYRINGE	1	PA; MO
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
allopurinol oral tablet 100 mg, 300 mg	1	MO
allopurinol sodium	1	
aloprim	1	
colchicine oral tablet	1	MO
febuxostat	1	MO
probenecid	1	MO
probenecid-colchicine	1	MO
OSTEOPOROSIS THERAPY		
alendronate oral solution	1	MO; QL (300 per 28 days)
alendronate oral tablet 10 mg	1	MO; QL (30 per 30 days)
alendronate oral tablet 35 mg, 70 mg	1	MO; QL (4 per 28 days)
BONSITY	1	PA; MO; QL (2.48 per 28 days)
CONEXXENCE	1	MO; QL (1 per 180 days)
ibandronate intravenous solution	1	PA
ibandronate intravenous syringe	1	PA; MO
ibandronate oral	1	MO; QL (1 per 30 days)
JUBBONTI	1	MO; QL (1 per 180 days)
PROLIA	1	MO; QL (1 per 180 days)
raloxifene	1	MO
risedronate oral tablet 150 mg	1	MO; QL (1 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)	1	MO; QL (4 per 28 days)
risedronate oral tablet 5 mg	1	MO; QL (30 per 30 days)
risedronate oral tablet,delayed release (dr/ec)	1	MO; QL (4 per 28 days)
teriparatide (only ndcs starting with 47781)	1	PA; MO; QL (2.48 per 28 days)
TYMLOS	1	PA; MO; QL (1.56 per 30 days)
OTHER RHEUMATOLOGICALS		
ACTEMRA ACTPEN	1	PA; MO; QL (3.6 per 28 days)
ACTEMRA INTRAVENOUS	1	PA; MO; QL (160 per 28 days)
ACTEMRA SUBCUTANEOUS	1	PA; MO; QL (3.6 per 28 days)
BENLYSTA	1	PA; MO
ENBREL MINI	1	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	1	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	1	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK	1	PA; MO; QL (8 per 28 days)
HADLIMA	1	PA; MO; QL (4.8 per 28 days)
HADLIMA PUSHTOUCH	1	PA; MO; QL (4.8 per 28 days)
HADLIMA(CF)	1	PA; MO; QL (2.4 per 28 days)
HADLIMA(CF) PUSHTOUCH	1	PA; MO; QL (2.4 per 28 days)
KINERET	1	PA; QL (18.76 per 28 days)
leflunomide	1	MO; QL (30 per 30 days)
milnacipran oral tablet	1	MO; QL (60 per 30 days)
milnacipran oral tablets,dose pack	1	MO; QL (55 per 180 days)
OTEZLA	1	PA; MO; QL (60 per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)	1	PA; MO; QL (55 per 180 days)
OTEZLA XR	1	PA; MO; QL (30 per 30 days)
OTEZLA XR INITIATION	1	PA; MO; QL (41 per 180 days)
penicillamine oral tablet	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
RINVOQ LQ	1	PA; MO; QL (360 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	1	PA; MO; QL (30 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	1	PA; MO; QL (84 per 180 days)
SAVELLA ORAL TABLET	1	QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK	1	QL (55 per 180 days)
SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	1	PA; MO; QL (4 per 28 days)
SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	1	PA; MO; QL (3 per 28 days)
SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML	1	PA; MO; QL (2 per 28 days)
SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; MO; QL (4 per 28 days)
tofacitinib oral solution	1	PA; MO; QL (480 per 24 days)
tofacitinib oral tablet	1	PA; MO; QL (60 per 30 days)
tofacitinib oral tablet extended release 24 hr	1	PA; MO; QL (30 per 30 days)
TYENNE AUTOINJECTOR	1	PA; MO; QL (3.6 per 28 days)
TYENNE INTRAVENOUS	1	PA; MO; QL (160 per 28 days)
TYENNE SUBCUTANEOUS	1	PA; MO; QL (3.6 per 28 days)
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
abigale	1	MO
abigale lo	1	MO
camila	1	MO
conjugated estrogens	1	MO
deblitane	1	MO
DEPO-SUBQ PROVERA 104	1	MO
dotti transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr	1	QL (8 per 28 days)
dotti transdermal patch semiweekly 0.1 mg/24 hr	1	MO; QL (8 per 28 days)
DUAVEE	1	MO
emzahh	1	MO
errin	1	MO

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Drug Name	Drug Tier	Requirements /Limits
estradiol oral	1	MO
estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr	1	QL (8 per 28 days)
estradiol transdermal patch semiweekly 0.1 mg/24 hr	1	MO; QL (8 per 28 days)
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	1	MO; QL (4 per 28 days)
estradiol transdermal patch weekly 0.0375 mg/24 hr, 0.05 mg/24 hr	1	QL (4 per 28 days)
estradiol vaginal	1	MO
estradiol valerate	1	MO
estradiol-norethindrone acet	1	MO
fyavolv	1	MO
gallifrey	1	MO
heather	1	MO
IMVEXXY MAINTENANCE PACK	1	MO
IMVEXXY STARTER PACK	1	MO
incassia	1	MO
jencycla	1	MO
jinteli	1	MO
lyleq	1	MO
lyllana transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr	1	QL (8 per 28 days)
lyllana transdermal patch semiweekly 0.1 mg/24 hr	1	MO; QL (8 per 28 days)
lyza	1	
medroxyprogesterone	1	MO
meleya	1	MO
mimvey	1	MO
nora-be	1	MO
norethindrone (contraceptive)	1	
norethindrone acetate	1	MO
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	MO
orquidea	1	MO
PREMARIN ORAL	1	MO
PREMARIN VAGINAL	1	
PREMPHASE	1	MO
PREMPRO	1	MO
progesterone	1	MO
progesterone micronized oral	1	MO
sharobel	1	MO
yuvafem	1	

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Drug Name	Drug Tier	Requirements /Limits
MISCELLANEOUS OB/GYN		
clindamycin phosphate vaginal	1	MO
eluryng	1	MO
etonogestrel-ethinyl estradiol	1	
LILETTA	1	MO
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	1	MO
mifepristone oral tablet 200 mg	1	LA
MYFEMBREE	1	PA; MO
NEXPLANON	1	
norelgestromin-ethin.estradiol	1	MO
terconazole	1	MO
tranexamic acid oral	1	MO
xulane	1	
zafemy	1	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
afirmelle	1	
altavera (28)	1	MO
alyacen 1/35 (28)	1	MO
alyacen 7/7/7 (28)	1	
amethyst (28)	1	
apri	1	MO
aranelle (28)	1	MO
aubra eq	1	MO
aviane	1	MO
azurette (28)	1	MO
camrese	1	MO
cryselle (28)	1	MO
cyred eq	1	MO
dasetta 1/35 (28)	1	MO
dasetta 7/7/7 (28)	1	MO
daysee	1	MO
desog-e.estradiol/e.estradiol	1	
drospirenone-e.estradiol-lm.fa oral tablet 3-0.03-0.451 mg (21) (7)	1	MO
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg	1	MO
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg	1	
elinest	1	MO
enskyce	1	MO
estarylla	1	MO
falmina (28)	1	MO
introvale	1	MO
isibloom	1	MO
jasmiel (28)	1	MO
jolessa	1	MO
juleber	1	MO
kalliga	1	
kariva (28)	1	
kelnor 1/35 (28)	1	MO
kurvelo (28)	1	MO

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Drug Name	Drug Tier	Requirements /Limits
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)	1	
larin 1.5/30 (21)	1	MO
larin 1/20 (21)	1	MO
larin 24 fe	1	MO
larin fe 1.5/30 (28)	1	MO
larin fe 1/20 (28)	1	MO
lessina	1	MO
levonest (28)	1	MO
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg	1	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	1	
levonorg-eth estrad triphasic	1	MO
loryna (28)	1	MO
low-ogestrel (28)	1	
lo-zumandimine (28)	1	MO
lutera (28)	1	
marlissa (28)	1	MO
microgestin 1.5/30 (21)	1	MO
microgestin 1/20 (21)	1	MO
microgestin fe 1.5/30 (28)	1	MO
microgestin fe 1/20 (28)	1	MO
mili	1	MO
mono-linyah	1	MO
nikki (28)	1	MO
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	1	MO
norgestimate-ethinyl estradiol	1	
nortrel 0.5/35 (28)	1	MO
nortrel 1/35 (21)	1	MO
nortrel 1/35 (28)	1	MO
nortrel 7/7/7 (28)	1	MO
philith	1	MO
pimtrea (28)	1	MO
portia 28	1	MO
reclipsen (28)	1	MO
setlakin	1	MO
sprintec (28)	1	MO
syeda	1	MO
tarina fe 1-20 eq (28)	1	MO
tilia fe	1	MO
tri-estarylla	1	MO
tri-legest fe	1	MO
tri-linyah	1	MO
tri-lo-estarylla	1	MO
tri-lo-marzia	1	MO
tri-lo-sprintec	1	
tri-sprintec (28)	1	MO
turqoz (28)	1	MO
valtya	1	MO

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Drug Name	Drug Tier	Requirements /Limits
velivet triphasic regimen (28)	1	MO
vestura (28)	1	MO
vienva	1	MO
viorele (28)	1	MO
wera (28)	1	MO
zovia 1-35 (28)	1	MO
zumandimine (28)	1	MO
OXYTOCICS		
methylergonovine oral	1	PA
OPHTHALMOLOGY		
ANTIBIOTICS		
bacitracin ophthalmic (eye)	1	
bacitracin-polymyxin b	1	MO
ciprofloxacin hcl ophthalmic (eye)	1	MO
erythromycin ophthalmic (eye)	1	MO; QL (3.5 per 14 days)
gatifloxacin	1	MO
gentamicin ophthalmic (eye) drops	1	MO; QL (70 per 30 days)
levofloxacin ophthalmic (eye) drops 0.5 %	1	MO
levofloxacin ophthalmic (eye) drops 1.5 %	1	
moxifloxacin ophthalmic (eye) drops	1	MO
moxifloxacin ophthalmic (eye) drops, viscous	1	
NATACYN	1	
neomycin-bacitracin-polymyxin	1	MO
neomycin-polymyxin-gramicidin	1	MO
ofloxacin ophthalmic (eye)	1	MO
polymyxin b sulf-trimethoprim	1	MO
tobramycin ophthalmic (eye)	1	MO; QL (10 per 14 days)
ANTIVIRALS		
trifluridine	1	MO
ZIRGAN	1	MO
BETA-BLOCKERS		
betaxolol ophthalmic (eye)	1	MO
carteolol	1	MO
levobunolol ophthalmic (eye) drops 0.5 %	1	MO
timolol maleate ophthalmic (eye) drops (not single use)	1	MO
timolol maleate ophthalmic (eye) gel forming solution	1	MO
MISCELLANEOUS OPHTHALMOLOGICS		
atropine ophthalmic (eye) drops 1 %	1	MO

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Drug Name	Drug Tier	Requirements /Limits
azelastine ophthalmic (eye)	1	MO
BYOOVIZ	1	PA
cromolyn ophthalmic (eye)	1	MO
cyclosporine ophthalmic (eye)	1	MO; QL (60 per 30 days)
CYSTARAN	1	PA
epinastine	1	MO
MIEBO (PF)	1	MO; QL (3 per 30 days)
OXERVATE	1	PA; MO
PAVBLU	1	PA; MO
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	1	MO
sulfacetamide sodium ophthalmic (eye) drops	1	MO
sulfacetamide-prednisolone	1	MO
XDEMVY	1	PA; QL (10 per 42 days)
XIIDRA	1	MO; QL (60 per 30 days)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
bromfenac	1	MO
diclofenac sodium ophthalmic (eye)	1	MO
flurbiprofen sodium	1	MO
ketorolac ophthalmic (eye)	1	MO
ORAL DRUGS FOR GLAUCOMA		
acetazolamide	1	MO
acetazolamide sodium	1	MO
methazolamide	1	MO
OTHER GLAUCOMA DRUGS		
bimatoprost ophthalmic (eye)	1	MO
dorzolamide	1	MO
dorzolamide-timolol	1	MO
latanoprost	1	MO
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	1	MO
miostat	1	
RHOPRESSA	1	
ROCKLATAN	1	
SIMBRINZA	1	MO
travoprost	1	MO
STEROID-ANTIBIOTIC COMBINATIONS		
neomycin-bacitracin-poly-hc	1	MO
neomycin-polymyxin b-dexameth	1	MO
neomycin-polymyxin-hc ophthalmic (eye)	1	MO
TOBRADEX OPHTHALMIC (EYE) OINTMENT	1	MO; QL (3.5 per 14 days)
tobramycin-dexamethasone	1	MO; QL (10 per 14 days)
STEROIDS		
dexamethasone sodium phosphate ophthalmic (eye)	1	MO

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Drug Name	Drug Tier	Requirements /Limits
fluorometholone	1	MO
INVELTYS	1	MO
loteprednol etabonate	1	MO
OZURDEX	1	MO
prednisolone acetate	1	MO
prednisolone sodium phosphate ophthalmic (eye)	1	MO
SYMPATHOMIMETICS		
apraclonidine	1	MO
brimonidine ophthalmic (eye) drops 0.1 %, 0.15 %	1	MO
brimonidine ophthalmic (eye) drops 0.2 %	1	MO
RESPIRATORY AND ALLERGY		
ANTIHISTAMINE / ANTIALLERGENIC AGENTS		
adrenalin injection solution 1 mg/ml	1	
adrenalin injection solution 1 mg/ml (1 ml)	1	MO
cetirizine oral solution 1 mg/ml	1	MO
diphenhydramine hcl injection solution 50 mg/ml	1	MO
diphenhydramine hcl injection syringe	1	
epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)	1	MO; QL (4 per 30 days)
epinephrine injection solution	1	
hydroxyzine hcl oral tablet	1	PA; MO
levocetirizine oral solution	1	MO
levocetirizine oral tablet	1	MO; QL (30 per 30 days)
promethazine injection solution	1	MO
promethazine oral	1	PA; MO
PULMONARY AGENTS		
acetylcysteine	1	B/D PA; MO
ADEMPAS	1	PA; MO; LA; QL (90 per 30 days)
ADVAIR HFA	1	MO; QL (12 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	1	MO; QL (17 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation package size 6.7 gm	1	QL (13.4 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml	1	B/D PA; MO
albuterol sulfate oral syrup	1	MO
albuterol sulfate oral tablet	1	MO
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION	1	MO; QL (12.2 per 30 days)
ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION	1	MO; QL (6.1 per 30 days)
alyq	1	PA; MO; QL (60 per 30 days)
ambrisentan	1	PA; MO; LA; QL (30 per 30 days)
arformoterol	1	B/D PA; MO; QL (120 per 30 days)
ASMANEX HFA	1	MO; QL (13 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	1	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	1	MO; QL (2 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (14)	1	QL (2 per 28 days)
ATROVENT HFA	1	MO; QL (25.8 per 30 days)
BEVESPI AEROSPHERE	1	MO; QL (10.7 per 30 days)
bosentan oral tablet	1	PA; MO; LA; QL (60 per 30 days)
BREO ELLIPTA	1	MO; QL (60 per 30 days)
breyna	1	MO; QL (10.3 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
BREZTRI AEROSPHERE	1	MO; QL (10.7 per 30 days)
budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml	1	B/D PA; MO; QL (120 per 30 days)
budesonide inhalation suspension for nebulization 1 mg/2 ml	1	B/D PA; MO; QL (60 per 30 days)
budesonide-formoterol	1	QL (10.2 per 30 days)
CINRYZE	1	PA; MO
COMBIVENT RESPIMAT	1	QL (8 per 30 days)
cromolyn inhalation	1	B/D PA; MO
DULERA	1	MO; QL (13 per 30 days)
FASENRA PEN	1	PA; MO; QL (1 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	1	PA; MO; QL (1 per 28 days)
flunisolide	1	MO; QL (50 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	1	ST; MO; QL (12 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	1	ST; MO; QL (24 per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation	1	MO; QL (10.6 per 30 days)
fluticasone propionate nasal	1	MO; QL (16 per 30 days)
fluticasone propion-salmeterol inhalation blister with device	1	MO; QL (60 per 30 days)
formoterol fumarate	1	B/D PA; MO; QL (120 per 30 days)
icatibant	1	PA; MO
ipratropium bromide inhalation hfa aerosol inhaler	1	MO; QL (25.8 per 30 days)
ipratropium bromide inhalation solution	1	B/D PA; MO
ipratropium-albuterol	1	B/D PA; MO
KALYDECO	1	PA; MO; QL (56 per 28 days)
macitentan	1	PA; MO; QL (30 per 30 days)
mometasone nasal	1	MO; QL (34 per 30 days)
montelukast oral granules in packet	1	MO

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This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
montelukast oral tablet	1	MO
montelukast oral tablet,chewable	1	MO
nintedanib	1	PA; MO; QL (60 per 30 days)
NUCALA SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	1	PA; MO; LA; QL (0.4 per 28 days)
OPSYNVI	1	PA; MO; QL (30 per 30 days)
ORKAMBI ORAL GRANULES IN PACKET	1	PA; MO; QL (56 per 28 days)
ORKAMBI ORAL TABLET	1	PA; MO; QL (112 per 28 days)
pirfenidone oral capsule	1	PA; MO; QL (270 per 30 days)
pirfenidone oral tablet 267 mg	1	PA; MO; QL (270 per 30 days)
pirfenidone oral tablet 801 mg	1	PA; MO; QL (90 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	1	MO; QL (2 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	1	MO; QL (1 per 30 days)
PULMOZYME	1	B/D PA; MO
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	1	QL (10.6 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	1	QL (21.2 per 30 days)
roflumilast	1	PA; MO; QL (30 per 30 days)
sajazir	1	PA; MO
sildenafil (pulmonary arterial hypertension) intravenous solution 10 mg/12.5 ml	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/19/2026.

Drug Name	Drug Tier	Requirements /Limits
sildenafil (pulmonary arterial hypertension) oral tablet 20 mg	1	PA; MO; QL (90 per 30 days)
SPIRIVA RESPIMAT	1	MO; QL (4 per 30 days)
STIOLTO RESPIMAT	1	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	1	MO; QL (4 per 30 days)
SYMDEKO	1	PA; MO; QL (56 per 28 days)
tadalafil (pulmonary arterial hypertension) oral tablet 20 mg	1	PA; QL (60 per 30 days)
terbutaline oral	1	MO
terbutaline subcutaneous	1	
TEZSPIRE	1	PA; MO; QL (1.91 per 30 days)
theophylline oral elixir	1	MO
theophylline oral solution	1	
theophylline oral tablet extended release 12 hr 100 mg, 200 mg	1	
theophylline oral tablet extended release 12 hr 300 mg, 450 mg	1	MO
theophylline oral tablet extended release 24 hr	1	MO
tiotropium bromide	1	QL (90 per 90 days)
TRELEGY ELLIPTA	1	MO; QL (60 per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	1	PA; MO; QL (56 per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	1	PA; MO; QL (84 per 28 days)
TYVASO	1	B/D PA; MO; QL (81.2 per 28 days)
TYVASO INSTITUTIONAL START KIT	1	B/D PA; QL (11.6 per 180 days)
TYVASO REFILL KIT	1	B/D PA; MO; QL (81.2 per 28 days)
TYVASO STARTER KIT	1	B/D PA; MO; QL (81.2 per 180 days)
WINREVAIR	1	PA; MO; QL (1 per 21 days)
wixela inhub	1	QL (60 per 30 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	1	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	1	PA; MO; LA; QL (1 per 28 days)
XOLAIR SUBCUTANEOUS RECON SOLN	1	PA; MO; LA; QL (8 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML	1	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	1	PA; MO; LA; QL (1 per 28 days)
zafirlukast	1	MO
UROLOGICALS		
ANTICHOLINERGICS / ANTISPASMODICS		
GEMTESA	1	MO
mirabegron oral tablet extended release 24 hr	1	MO
oxybutynin chloride oral syrup	1	MO
oxybutynin chloride oral tablet 5 mg	1	MO
oxybutynin chloride oral tablet extended release 24hr	1	MO
solifenacin	1	MO
tolterodine	1	MO
trospium oral tablet	1	MO
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
alfuzosin	1	MO
dutasteride	1	MO
dutasteride-tamsulosin	1	MO
finasteride oral tablet 5 mg	1	MO
tamsulosin	1	MO

Drug Name	Drug Tier	Requirements /Limits
MISCELLANEOUS UROLOGICALS		
alprostadil	1	
bethanechol chloride	1	MO
CYSTAGON	1	PA; LA
ELMIRON	1	MO
glycine urologic solution	1	
K-PHOS NO 2	1	MO
K-PHOS ORIGINAL	1	MO
potassium citrate oral tablet extended release	1	MO
RENACIDIN	1	MO
tadalafil oral tablet 2.5 mg	1	PA; MO; QL (60 per 30 days)
tadalafil oral tablet 5 mg	1	PA; MO; QL (30 per 30 days)
VITAMINS, HEMATINICS / ELECTROLYTES		
BLOOD DERIVATIVES		
albumin, human 25 %	1	
alburx (human) 25 %	1	
alburx (human) 5 %	1	
albutein 25 %	1	
albutein 5 %	1	
ELECTROLYTES		
calcium acetate(phosphat bind)	1	PA; MO
calcium chloride	1	

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Drug Name	Drug Tier	Requirements /Limits
calcium gluconate intravenous	1	
effer-k oral tablet, effervescent 25 meq	1	MO
klor-con 10	1	MO
klor-con 8	1	MO
klor-con m10	1	MO
klor-con m15	1	
klor-con m20	1	MO
klor-con oral packet 20	1	MO
lactated ringers intravenous	1	MO
magnesium chloride injection	1	
MAGNESIUM SULFATE IN D5W INTRAVENOUS PIGGYBACK 1 GRAM/100 ML	1	
magnesium sulfate in water intravenous parenteral solution	1	
magnesium sulfate in water intravenous piggyback 2 gram/50 ml (4 %), 4 gram/100 ml (4 %), 4 gram/50 ml (8 %)	1	
magnesium sulfate injection	1	
potassium acetate	1	
potassium chlorid-d5-0.45%nacl	1	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	1	
potassium chloride in 5 % dex	1	
potassium chloride in lr-d5	1	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 10 meq/50 ml, 20 meq/100 ml, 20 meq/50 ml, 40 meq/100 ml	1	
potassium chloride intravenous	1	
potassium chloride oral capsule, extended release	1	MO
potassium chloride oral liquid	1	MO
potassium chloride oral packet 20 meq	1	MO
potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq	1	MO
potassium chloride oral tablet,er particles/crystals 10 meq, 20 meq	1	MO
potassium chloride oral tablet,er particles/crystals 15 meq	1	

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Drug Name	Drug Tier	Requirements /Limits
potassium chloride-0.45 % nacl	1	
potassium chloride-d5-0.2%nacl	1	
potassium chloride-d5-0.9%nacl	1	
potassium phosphate m-/d-basic intravenous solution 3 mmol/ml	1	
ringer's intravenous	1	
sodium acetate	1	
sodium bicarbonate intravenous solution	1	
sodium bicarbonate intravenous syringe 50 meq/50 ml (8.4 %)	1	
sodium chloride 0.45 % intravenous	1	MO
sodium chloride 3 % hypertonic	1	
sodium chloride 5 % hypertonic	1	MO
sodium chloride intravenous	1	
sodium phosphate	1	MO
MISCELLANEOUS NUTRITION PRODUCTS		
CLINIMIX 5%/D15W SULFITE FREE	1	B/D PA
CLINIMIX 4.25%/D10W SULF FREE	1	B/D PA
CLINIMIX 5%-D20W(SULFITE-FREE)	1	B/D PA
CLINIMIX 6%-D5W (SULFITE-FREE)	1	B/D PA
CLINIMIX 8%-D10W(SULFITE-FREE)	1	B/D PA
CLINIMIX 8%-D14W(SULFITE-FREE)	1	B/D PA
electrolyte-148	1	
electrolyte-48 in d5w	1	
electrolyte-a	1	
intralipid intravenous emulsion 20 %	1	B/D PA
ISOLYTE S PH 7.4	1	
ISOLYTE-P IN 5 % DEXTROSE	1	
ISOLYTE-S	1	
PLENAMINE	1	B/D PA
premasol 10 %	1	B/D PA
travasol 10 %	1	B/D PA
TROPHAMINE 10 %	1	B/D PA
VITAMINS / HEMATINICS		
fluoride (sodium) oral tablet	1	MO
fluoride (sodium) oral tablet,chewable 1 mg (2.2 mg sod. fluoride)	1	MO
prenatal vitamin oral tablet	1	MO
wescap-pn dha	1	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **800-362-2266** (TTY: **711**; or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **800-362-2266**(TTY: **711**) o hable con su proveedor.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-362-2266（文本电话： 711）或咨询您的服务提供商。

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **800-362-2266**(TTY: **711**) или обратитесь к своему поставщику услуг.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **800-362-2266**(TTY: **711**) oswa pale avèk founisè w la.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **800-362-2266**(TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **800-362-2266** (TTY: **711**) o parla con il tuo fornitore.

Yiddish(**יידי ש** נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי .

צונעמען_אידס און בַאדינונגס אל_אר·צר ֵאווידינג אינאלאר_מ_אציע אין צוטריטלעך אלאר_מ_אטירונגען זענען אויך בנימצא רופן פריי.

. אדער רעדן מיט דיין טרעגער **711**ָ (TTY: **800-362-2266**(

Вы можете найти информацию о том, что означают символы и аббревиатуры в этой таблице, перейдя к началу.

(Bengali) ইংরেজিরে মরNোরhোগ: আপনN hনি অNয ভোষো বলরে পোরেN, োোহরল নবNোমূরলয ভোষো সহোয়ো পনেরষবো আপNোে িNয উপলব্ধ। অযোরেসরhোগয ফমযোরে েথ্য প্রিোরNে িNয উপhুক্ত সহোয়ক সহোয়ো এবং পনেরষবোগুনলও নবNোমূরলয পোওয়ো hোয়। 800-362-2266 (TTY: 711; অথ্বো আপNোে প্রিোNকোেীে সোরথ্ কথ্ো বলুN।

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **800-362-2266**(TTY: **711**) lub porozmawiaj ze swoim dostawcą.

)**Arabic**(العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **800-362-2266**)**711** (أو تحدث إلى مقدم الخدمة .

Français (French) ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour

fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **800-362-2266**(TTY: **711**) ou parlez à votre fournisseur.

(**Urdu**)اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔)**711 800-362-2266**:TTY) پر کال کریں یا

اپنے فراہم کنندہ سے بات کریں۔

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **800-362-2266**(TTY: **711**) o makipag-usap sa iyong provider.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **800-362-2266**(TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

Hindi ह ि◌ंदी ध्यान दें: यदि आप द5ि◌ंि◌ी बोलते 5ै◌ं, तो आपके दलए दनिः शुल्क भाषा स5ायता सेवाएि उपलब्ध 5ोती 5ै◌ं। सुलभ प्रारूपोि◌ं में जानकारी प्रिान करने के दलए उपयुक्त स5ायक साधन और सेवाएँ भी दनिः शुल्क उपलब्ध 5ै◌ं। **800-362-2266 (TTY:** 711**)** पर कॉल करें या अपने प्रिाता से बात करें।.

Вы можете найти информацию о том, что означают символы и аббревиатуры в этой таблице, перейдя к началу.

Уведомление о недопущении дискриминации ElderServe MAP (HMO D-SNP)

План ElderServe MAP (HMO D-SNP) соблюдает действующее федеральное законодательство о гражданских правах и не осуществляет дискриминацию по признаку расы, цвета кожи, национального происхождения (включая ограниченное владение английским языком и основной язык), возраста, инвалидности или пола в соответствии с федеральными правилами о запрете дискриминации по признаку пола (45 CFR § 92.101(a)(2)). ElderServe MAP (HMO D-SNP) не исключает людей и не относится к ним менее благоприятно по признаку расы, цвета кожи, национального происхождения, возраста, инвалидности или пола.

ElderServe MAP (HMO D-SNP):

- Предоставляет людям с инвалидностью разумные изменения и бесплатные соответствующие вспомогательные средства и услуги для эффективного общения с нами, включая:
    - Услуги квалифицированных сурдопереводчиков
    - Письменные материалы в других форматах (напечатанные крупным шрифтом, в виде аудиозаписи, в электронном и иных форматах)
- Предоставляет бесплатные услуги перевода лицам, для которых английский не является родным языком, в том числе:
    - Услуги квалифицированных устных переводчиков
    - Информацию на других языках

Если вам нужны разумные изменения, соответствующие вспомогательные средства и услуги, или языковая помощь, свяжитесь с координатором по вопросам гражданских прав. Если вы считаете, что компания ElderServe MAP (HMO D-SNP) не предоставила эти услуги или совершила дискриминацию по признаку расы, цвета кожи, национального происхождения, возраста, инвалидности или пола, то можете подать жалобу:

ElderServe Health

ATTN: Civil Rights Coordinator

80 West 225th Street

Bronx, NY, 10463

Телефон: 1-347-842-3660, TTY 711

Факс: 1-888-341-5009

Вы можете подать жалобу лично или по почте, телефону или факсу. Если вам нужна помощь с подачей жалобы, координатор по вопросам гражданских прав может вам помочь.

Вы можете найти информацию о том, что означают символы и аббревиатуры в этой таблице, перейдя к началу.

Вы также можете подать жалобу о нарушении гражданских прав в Управление по гражданским правам Министерства здравоохранения и социальных служб США в электронном виде на портале для подачи жалоб Управления по гражданским правам по адресу https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, по почте или по телефону:

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

Бланки для подачи жалоб доступны по адресу http://www.hhs.gov/ocr/office/file/index.html

Вы можете найти информацию о том, что означают символы и аббревиатуры в этой таблице, перейдя к началу.

ElderServe Health

Данный формуляр был обновлен 08/19/2026. Для получения более актуальной информации или ответов на другие вопросы обращайтесь в отдел обслуживания участников ElderServe Health Plan по номеру 1-800-362-2266 (для пользователей TTY/TDD: 711), в любой день недели с 8 a.m. до 8 p.m. Либо же посетите веб-сайт www.ElderServeHealth.org.