2025 SCAN Health Plan Formulary

List of Covered Drugs or “Drug List”

Formulario de SCAN Health Plan

Lista de medicamentos cubiertos o “Lista de medicamentos”

This formulary was updated on 4/1/2025. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-855-650-7226 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.

Este formulario se actualizó el 4/1/2025. Para obtener información más reciente o si tiene pregunta, comuníquese con Servicios para Miembros de SCAN Health Plan al 1-855-650-7226 (los usuarios de TTY deben llamar al 711), de 8:00 a. m. a 8:00 p. m., los 7 días de la semana, desde el 1 de octubre hasta el 31 de marzo. Desde el 1 de abril hasta el 30 de septiembre, el horario es de 8:00 a. m. a 8:00 p. m., de lunes a viernes (los mensajes recibidos en días festivos y fuera del horario de atención se responderán en el plazo de un día hábil). También puede visitar www.scanhealthplan.com.

25C-AZFOR900

SCAN Health Plan
2025 Formulary (List of Covered Drugs or “Drug List”)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

25409, 20

This formulary was updated on 04/01/2025. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-855-650-7226 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.

Note to existing members: This Formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this Drug List (Formulary) refers to “we,” “us”, or “our,” it means SCAN Health Plan. When it refers to “plan” or “our plan,” it means SCAN Classic (HMO), SCAN MyChoice (HMO), SCAN Venture (HMO), SCAN Balance (HMO C-SNP), SCAN Embrace (HMO POS I-SNP) and SCAN Strive (HMO C-SNP).

This document includes a Drug List (formulary) for our plan which is current as of April 2025. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2026, and from time to time during the year. You will receive notice when necessary.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Express Scripts Pharmacy℠ is our Preferred mail order pharmacy. While you can fill your prescription medications at any of our network mail order pharmacies, you may pay less at the Preferred mail order pharmacy. Typically, you should expect to receive your prescription drugs within 14 days from the time that Express Scripts mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact SCAN Health Plan’s Member Services. For your mail order prescriptions, you have the option to sign up for an automatic refill program by contacting Express Scripts Pharmacy at 1-866-553-4125, 24 hours a day, 7 days a week. TTY users should call 711. You may opt out of automatic deliveries at any time.

SCAN Health Plan is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

Y0057_SCAN_21327_2025_C

Date of last formulary update 4/1/2025

Table of Contents

What is the SCAN Health Plan formulary? 3

Can the formulary change? 3

How do I use the Formulary? 4

What are generic drugs? 5

What are original biological products and how are they related to biosimilars? 5

Are there any restrictions on my coverage? 5

What if my drug is not on the Formulary? 6

How do I request an exception to the SCAN Health Plan's Formulary? 6

What can I do if my drug is not on the formulary or has a restriction? 6

For more information 7

SCAN Health Plan's Formulary 12

Formulary Drugs Arranged by Therapeutic Class 26

Formulary Drugs with Quantity Limits 64

Index 69

Date of last formulary update 4/1/2025

What is the SCAN Health Plan formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by SCAN Health Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. SCAN Health Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a SCAN Health Plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the formulary change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: https://www.scanhealthplan.com/scan-resources/plan-materials/formulary.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **Immediate substitutions of certain new versions of brand-name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand-name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

  We can make these immediate changes only if we are adding a new generic version of a brand-name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

  If you are currently taking the brand-name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

  If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the SCAN Health Plan’s Formulary?”

  Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”
- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand-name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand-name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines.If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

  If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the SCAN Health Plan's Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of April 2025. To get updated information about the drugs covered by SCAN Health Plan, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 26. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents". If you know what your drug is used for, look for the category name in the list that begins on page number 26. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 69. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

SCAN Health Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs work just as well as and usually cost less than brand-name drugs. There are generic drug substitutes available for many brand-name drugs. Generic drugs usually can be substituted for the brand-name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand-name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5 Section 3.1, "The 'Drug List' tells which Part D drugs are covered."

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** SCAN Health Plan requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from SCAN Health Plan before you fill your prescriptions. If you don't get approval, SCAN Health Plan may not cover the drug.

- **Quantity Limits:** For certain drugs, SCAN Health Plan limits the amount of the drug that SCAN Health Plan will cover. For example, SCAN Health Plan provides 30 tablets per prescription for ramelteon. This may be in addition to a standard one-month or three-month supply.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 26. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explain our prior authorization restriction. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask SCAN Health Plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the SCAN Health Plan's formulary?" on page 6 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that SCAN Health Plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by SCAN Health Plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by SCAN Health Plan.

- You can ask SCAN Health Plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the SCAN Health Plan's Formulary?

You can ask SCAN Health Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, SCAN Health Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

- You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

Generally, SCAN Health Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or, formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary

exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary 30-day supply if you are not in a long-term care facility or a 31-day supply if you are a resident of a long-term care facility. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication if you are not in a long-term care facility or a 31-day supply of medication if you are a resident of a long-term care facility. If coverage is not approved, after your first 30-day supply if you are not in a long-term care facility or a 31-day supply if you are a resident of a long-term care facility, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you are a current member transitioning to a different level of care, you may be prescribed medications not on our formulary or your ability to get your drugs may be limited. In these instances, you need to talk with your doctor about the appropriate alternative therapies available on our formulary. If there are no appropriate alternative therapies on our formulary, you or your doctor can request an exception and ask the plan to cover the drug or remove restrictions from the drug. While you are talking with your doctor to determine the course of action, you are eligible to receive a 30-day transition supply of the drug if you are moving from a long-term care facility or a hospital stay to home or a 31-day transition supply of the drug if you are moving from home or a hospital stay to a long-term care facility.

For more information

For more detailed information about your SCAN Health Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about SCAN Health Plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit http://www.medicare.gov.

The charts below list what you will pay as your share of the costs for covered prescription drugs at our network pharmacies when you are in the Initial Coverage Stage.

Preferred cost-sharing is lower cost-sharing that may be available to you for certain covered Part D drugs at certain network pharmacies. For more information, please visit our online searchable Pharmacy Directory at www.scanhealthplan.com or call Member Services. Our contact information appears on the front and back cover pages.

Please refer to your Evidence of Coverage for information about the costs at Long-Term Care (LTC) pharmacies and out-of-network pharmacies.

If you receive “Extra Help,” your share of the cost for covered prescription drugs may vary based on the level of “Extra Help” you receive. For more information about your drug costs, look at the "LIS Rider".

You won’t pay more than $35 for a one-month supply and no more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on, even if you haven’t paid your deductible.

Most adult Part D vaccines are covered by our plan at no cost to you, even if you haven’t paid your deductible.

SCAN Classic (HMO): Maricopa, Pima and Pinal Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		$0	$0	$7	$14
2	Generic		$0	$0	$15	$30
3	Preferred Brand	Insulin	$35	$85	$35	$85
		Other Drugs	$42	$126	$47	$141
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

Date of last formulary update 4/1/2025

SCAN Balance (HMO C-SNP): Maricopa, Pima and Pinal Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		$0	$0	$5	$10
2	Generic		$0	$0	$9	$18
3	Preferred Brand	Insulin	$0	$0	$0	$0
		Other Drugs	$42	$126	$47	$141
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

SCAN MyChoice (HMO): Maricopa, Pima and Pinal Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		$0	$0	$0	$0
2	Generic		$0	$0	$0	$0
3	Preferred Brand	Insulin	$35	$85	$35	$85
		Other Drugs	$42	$126	$43	$129
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

Date of last formulary update 4/1/2025

SCAN Venture (HMO): Maricopa, Pima and Pinal Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		$0	$0	$10	$20
2	Generic		$0	$0	$20	$40
3	Preferred Brand	Insulin	$35	$85	$35	$85
		Other Drugs	$42	$126	$47	$141
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

SCAN Embrace (HMO POS I-SNP): Maricopa and Pima Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		$0	$0	$0	$0
2	Generic		$0	$0	$0	$0
3	Preferred Brand	Insulin	$0	$0	$0	$0
		Other Drugs	$42	$126	$43	$129
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

Date of last formulary update 4/1/2025

SCAN Strive (HMO C-SNP): Maricopa and Pima Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		$0	$0	$0	$0
2	Generic		$0	$0	$0	$0
3	Preferred Brand	Insulin	$35	$105	$35	$105
		Other Drugs	24%	24%	25%	25%
4	Non-Preferred Drug		45%	45%	45%	45%
5	Specialty Tier		25%	N/A	25%	N/A

Date of last formulary update 4/1/2025

SCAN Health Plan's Formulary

The formulary that begins on page 26 provides coverage information about the drugs covered by SCAN Health Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 69.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., JANUVIA) and generic drugs are listed in lower-case italics (e.g., *metformin*).

The information in the Requirements/Limits column tells you if SCAN Health Plan has any special requirements for coverage of your drug.

- The symbol [PA] indicates that prior authorization applies.
- The symbol [B vs D] indicates that this drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- The symbol [QL] indicates that quantities dispensed are limited. To see the quantity limit amount for the formulary drugs with quantity limits, turn to the page 64.
- The symbol [LD] indicates that limited distribution applies. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 1-855-650-7226 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.
- The symbol [EDS] indicates that this drug is available for an extended day supply (e.g., greater than a 30-day supply) at mail-order and many retail pharmacies.

SCAN Health Plan
Formulario de 2025 (Lista de medicamentos cubiertos o "Lista de medicamentos")

LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

25409, 20

Este formulario se actualizó el 04/01/2025. Para obtener información más reciente o si tiene preguntas, comuníquese con Servicios para Miembros de SCAN Health Plan al 1-855-650-7226 (los usuarios de TTY deben llamar al 711), de 8:00 a. m. a 8:00 p. m., los 7 días de la semana, del 1 de octubre al 31 de marzo. Del 1 de abril al 30 de septiembre, el horario es de 8:00 a. m. a 8:00 p. m., de lunes a viernes (los mensajes recibidos en días feriados y fuera del horario de atención se responderán en el plazo de un día hábil). También puede visitar www.scanhealthplan.com.

Nota para miembros actuales: Este Formulario ha cambiado desde el año pasado. Revise este documento para asegurarse que todavía se incluyen los medicamentos que toma.

Cuando esta Lista de medicamentos (Formulario) hace referencia a "nosotros" o "nuestro", quiere decir SCAN Health Plan. Cuando se hace referencia al "plan" o a "nuestro plan", quiere decir SCAN Classic (HMO), SCAN MyChoice (HMO), SCAN Venture (HMO), SCAN Balance (HMO C-SNP), SCAN Embrace (HMO POS I-SNP) y SCAN Strive (HMO C-SNP).

Este documento incluye una Lista de medicamentos (formulario) para nuestro plan que está vigente desde abril de 2025. Para obtener una Lista de medicamentos (formulario) actualizada, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la Lista de medicamentos (formulario), aparece en las páginas de portada y contraportada.

Por lo general, debe acudir a las farmacias de la red para usar el beneficio de medicamentos con receta. Los beneficios, el formulario, la red de farmacias, o los copagos/coseguros pueden cambiar el 1 de enero de 2026 y de vez en cuando durante el año. Recibirá un aviso cuando sea necesario.

Puede solicitar que se le envíen los medicamentos con receta a su hogar a través de nuestro programa de entrega de pedido por correo de la red. Express Scripts Pharmacy℠ es nuestra farmacia de pedido por correo preferida. Si bien puede surtir sus medicamentos con receta en cualquiera de las farmacias de pedido por correo de nuestra red, posiblemente pague menos en la farmacia de pedido por correo preferida. Por lo general, debería recibir sus medicamentos con receta dentro de los 14 días a partir del momento en que la farmacia de pedido por correo Express Scripts reciba el pedido. Si no recibe su(s) medicamento(s) con receta dentro de ese plazo, comuníquese con Servicios para Miembros de SCAN Health Plan. Para las recetas de pedido por correo, tiene la opción de inscribirse en un programa de resurtido automático comunicándose con Express Scripts Pharmacy al 1-866-553-4125, las 24 horas, los 7 días de la semana. Los usuarios de TTY deben llamar al 711. Puede desinscribirse de los envíos automáticos en cualquier momento.

SCAN Health Plan es un plan HMO con un contrato de Medicare. La inscripción en SCAN Health Plan depende de la renovación del contrato.

Y0057_SCAN_21327_2025_C

Date of last formulary update 4/1/2025

Tabla de contenidos

¿Qué es el formulario de SCAN Health Plan? 15

¿Puede cambiar el formulario? 15

¿Cómo uso el Formulario? 17

¿Qué son los medicamentos genéricos? 17

¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares? 17

¿Existe alguna restricción en mi cobertura? 18

¿Qué sucede si el medicamento que necesito no se incluye en el Formulario? 18

¿Cómo solicito una excepción para el Formulario de SCAN Health Plan? 18

¿Qué puedo hacer si mi medicamento no está en el formulario o tiene una restricción? 19

Para obtener más información 20

Formulario de SCAN Health Plan 25

Medicamentos del Formulario organizados por clase terapéutica 26

Medicamentos del Formulario con límites de cantidad 64

Índice 69

¿Qué es el formulario de SCAN Health Plan?

En este documento, usamos los términos Lista de medicamentos y formulario para hacer referencia a lo mismo. Un formulario es una lista de medicamentos cubiertos elegidos por SCAN Health Plan con el asesoramiento de un equipo de proveedores de atención médica, que representa las terapias con medicamentos con receta que se consideran una parte necesaria de un programa de tratamiento de calidad. Por lo general, SCAN Health Plan cubre los medicamentos que aparecen en nuestro formulario siempre y cuando el medicamento sea médicamente necesario, la receta se surta en una farmacia de la red de SCAN Health Plan y se respeten las demás normas del plan. Para obtener más información acerca de cómo surtir las recetas, revise la Evidencia de cobertura.

¿Puede cambiar el formulario?

La mayoría de los cambios en la cobertura de medicamentos se realizan el 1 de enero, pero podemos añadir o retirar medicamentos del formulario durante el año, pasarlos a diferentes niveles de gastos compartidos o añadir nuevas restricciones. Debemos seguir las normas de Medicare a la hora de hacer estos cambios. Las actualizaciones del formulario se publican mensualmente en nuestro sitio web aquí: https://www.scanhealthplan.com/scan-resources/plan-materials/formulary.

Los cambios que pueden afectarle este año: En los siguientes casos, los cambios de cobertura le afectarán durante el año:

- **Sustitución inmediata de ciertas versiones nuevas de medicamentos de marca y productos biológicos originales.** Podemos retirar inmediatamente un medicamento de nuestro formulario si lo reemplazamos con una determinada versión nueva de ese medicamento que aparecerá en el mismo nivel de gasto compartido o en uno menor y con las mismas restricciones o menos. Cuando agregamos una nueva versión de un medicamento a nuestro formulario, podemos decidir mantener el medicamento de marca o el producto biológico original en nuestro formulario, pero cambiarlo inmediatamente a un nivel de gastos compartidos diferente o agregar nuevas restricciones.

  Podemos hacer estos cambios inmediatos solo si agregamos una nueva versión genérica de un medicamento de marca, o si agregamos ciertas versiones biosimilares nuevas de un producto biológico original, que ya estaba en el formulario (por ejemplo, al agregar un biosimilar intercambiable que puede ser sustituido por un producto biológico original en una farmacia sin una nueva receta).

  Si actualmente toma el medicamento de marca o el producto biológico original, es posible que no le informemos por adelantado antes de hacer un cambio inmediato, pero luego le brindaremos información sobre los cambios específicos que hemos hecho.

  Si implementamos dicho cambio, usted u otra persona autorizada a dar recetas pueden solicitarnos que hagamos una excepción y sigamos cubriendo para usted el medicamento que se está cambiando. Para obtener más información, consulte la sección a continuación titulada "¿Cómo solicito una excepción para el Formulario de SCAN Health Plan?"

  Algunos de estos tipos de medicamentos pueden ser nuevos para usted. Para obtener más información, consulte la sección a continuación titulada "¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?"

- **Medicamentos retirados del mercado.** Si un medicamento es retirado de la venta por el fabricante, o la Administración de Alimentos y Medicamentos (FDA) determina su retiro por motivos de seguridad o eficacia, podemos retirar inmediatamente el medicamento de nuestro formulario y luego notificar a los miembros que lo toman.

- **Otros cambios.** Podemos realizar otros cambios que afecten a los miembros que toman actualmente un medicamento. Por ejemplo, podemos retirar un medicamento de marca del formulario al agregar un equivalente genérico o retirar un producto biológico original al agregar un biosimilar. También podemos aplicar nuevas restricciones al medicamento de marca o al producto biológico original, o moverlo a un nivel de gastos compartidos diferente, o ambas opciones. Podemos realizar cambios según nuevas pautas clínicas. Si retiramos medicamentos de nuestro formulario, agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada a un medicamento, o si movemos un medicamento a un nivel de gastos compartidos más alto, debemos notificar a los miembros afectados sobre el cambio, al menos 30 días antes de que el cambio esté vigente. O bien, cuando un miembro solicita un resurtido del medicamento, puede recibir un suministro del medicamento para 30 días y un aviso del cambio.

  Si implementamos estos cambios, usted u otra persona autorizada a dar recetas pueden solicitarle que hagamos una excepción para usted y que sigamos cubriendo el medicamento que ha estado tomando. El aviso que le proporcionaremos también incluye información sobre cómo solicitar una excepción y, además, puede encontrar información en la sección a continuación, "¿Cómo solicito una excepción para el Formulario de SCAN Health Plan?"

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si toma un medicamento que se encuentra en nuestro formulario de 2025 que estaba cubierto al comienzo del año, no descontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2025, excepto en los casos que se describieron anteriormente. Esto significa que estos medicamentos permanecerán disponibles con los mismos gastos compartidos y sin nuevas restricciones para aquellos miembros que los tomen durante el resto del año de cobertura. No recibirá un aviso directo sobre los cambios que no le afecten este año. Sin embargo, dichos cambios podrían afectarle a partir del 1 de enero del año siguiente, y es importante que revise el formulario del nuevo año de beneficios para ver los cambios en los medicamentos.

El formulario adjunto está vigente desde abril de 2025. Para obtener información actualizada acerca de los medicamentos cubiertos por SCAN Health Plan, póngase en contacto con nosotros. Nuestra información de contacto aparece en las páginas de la cubierta del frente y del dorso.

¿Cómo uso el Formulario?

Existen dos maneras de buscar un medicamento dentro del formulario:

Afección médica

El formulario comienza en la página 26. En este formulario, los medicamentos se dividen en categorías según el tipo de afección médica que tratan. Por ejemplo, los medicamentos usados para tratar una afección cardíaca se indican en la categoría “Agentes cardiovasculares”. Si usted sabe para qué se usa su medicamento, busque el nombre de la categoría en la lista que comienza en la página número 26. Luego busque el nombre del medicamento debajo del nombre de la categoría.

Orden alfabético

Si no sabe en qué categoría buscar, debe buscar el medicamento en el Índice que comienza en la página 69. El Índice le proporciona una lista en orden alfabético de todos los medicamentos incluidos en este documento. Tantos los medicamentos de marca como los medicamentos genéricos figuran en el Índice. Consulte el Índice y busque su medicamento. Al lado de medicamento, verá el número de página en donde puede encontrar la información de cobertura. Vaya a la página que figura en el Índice y busque el nombre del medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

SCAN Health Plan cubre tanto medicamentos de marca como genéricos. La Administración de Alimentos y Medicamentos (FDA) aprueba un medicamento genérico cuando considera que contiene el mismo ingrediente activo que el medicamento de marca. Por lo general, los medicamentos genéricos funcionan igual de bien que los medicamentos de marca y, en general, cuestan menos. Hay sustitutos genéricos disponibles para muchos medicamentos de marca. Por lo general, los medicamentos genéricos pueden sustituir al medicamento de marca en la farmacia sin necesidad de una nueva receta, según las leyes estatales.

¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?

En el formulario, cuando hablamos de medicamentos, podríamos hacer referencia a un medicamento o un producto biológico. Los productos biológicos son medicamentos que son más complejos que los medicamentos típicos. Dado que los productos biológicos son más complejos que los medicamentos típicos, en lugar de tener una forma genérica, tienen alternativas que se llaman biosimilares. En general, los biosimilares funcionan tan bien como el producto biológico original y pueden costar menos. Existen alternativas biosimilares para algunos productos biológicos originales. Algunos biosimilares son biosimilares intercambiables y, según las leyes estatales, pueden ser sustituidos por el producto biológico original en la farmacia sin necesidad de una nueva receta, al igual que los medicamentos genéricos pueden ser sustituidos por medicamentos de marca.

- Para obtener información sobre los tipos de medicamentos, consulte la Evidencia de cobertura, Sección 3.1 del Capítulo 5, “La 'Lista de medicamentos' indica qué medicamentos de la Parte D están cubiertos”.

¿Existe alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos o límites adicionales en la cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** SCAN Health Plan requiere que usted o su prescriptor/a obtengan una autorización previa para determinados medicamentos. Esto significa que deberá obtener la aprobación de SCAN Health Plan antes de surtir sus recetas. Si no obtiene la aprobación, es posible que SCAN Health Plan no cubra el medicamento.

- **Límites de cantidad:** Para determinados medicamentos, SCAN Health Plan limita la cantidad del medicamento que cubrirá SCAN Health Plan. Por ejemplo, SCAN Health Plan proporciona 30 comprimidos por receta para ramelteon. Esto puede ser un surtido adicional al suministro estándar de un mes o de tres meses.

Puede averiguar si su medicamento tiene algún requisito o límite adicional buscando en el formulario que comienza en la página 26. También puede obtener más información sobre las restricciones que se aplican a los medicamentos cubiertos específicos en nuestro sitio web. Hemos publicado un documento donde se explica nuestra restricción de autorización previa. Además, puede solicitarnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Puede solicitar a SCAN Health Plan que realice una excepción para estas restricciones o estos límites o para una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección, “¿Cómo solicito una excepción para el formulario de SCAN Health Plan?” en la página 19 para obtener información sobre cómo solicitar una excepción.

¿Qué sucede si el medicamento que necesito no se incluye en el Formulario?

Si el medicamento que necesita no está incluido en este formulario (lista de medicamentos cubiertos), primero debe comunicarse con Servicios para Miembros y preguntar si su medicamento está cubierto.

Si le informan que SCAN Health Plan no cubre su medicamento, tiene dos opciones:

- Puede solicitar a Servicios para Miembros una lista de medicamentos similares que estén cubiertos por SCAN Health Plan. Cuando reciba la lista, muéstresela a su médico/a y pídale que le recete un medicamento similar que esté cubierto por SCAN Health Plan.

- Puede solicitar a SCAN Health Plan que realice una excepción y cubra su medicamento. Consulte a continuación para obtener más información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción para el Formulario de SCAN Health Plan?

Puede solicitar a SCAN Health Plan que realice una excepción en nuestras normas de cobertura. Existen diferentes tipos de excepciones que puede pedirnos que hagamos.

- Puede pedirnos que cubramos un medicamento incluso si no figura en nuestro formulario. Si se aprueba, este medicamento estará cubierto a un nivel de compartición de costo predeterminado y no podrá pedirnos que proporcionemos el medicamento a un nivel de gastos compartidos inferior.

- Puede pedirnos que no apliquemos una restricción de cobertura que incluya una autorización previa, un tratamiento escalonado o un límite de cantidad para su medicamento. Por ejemplo, para ciertos medicamentos, SCAN Health Plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que no apliquemos el límite y que cubramos un monto mayor.

- Puede pedirnos que cubramos un medicamento del formulario a un nivel de gastos compartidos más bajo, a menos que el medicamento se encuentre entre los medicamentos de especialidad. Si se aprueba, esto disminuiría el monto que debe pagar por su medicamento.

Por lo general, SCAN Health Plan solo aprobará su solicitud de una excepción si los medicamentos alternativos incluidos en el formulario del plan, el medicamento con menor gasto compartido o la aplicación de la restricción no resultaran tan eficaces para usted ni provocaran efectos adversos.

Usted o la persona autorizada a dar recetas deben comunicarse con nosotros para solicitar una excepción de nivel o formulario, incluida una excepción a una restricción de cobertura. **Cuando solicite una excepción, la persona autorizada a dar recetas deberá explicarle los motivos médicos por los que necesita la excepción.** Por lo general, debemos tomar una decisión en un plazo de 72 horas después de recibir la declaración de apoyo de la persona autorizada a dar recetas. Puede solicitar una decisión acelerada (rápida) si cree, y estamos de acuerdo, que su salud podría verse gravemente perjudicada si espera hasta 72 horas por una decisión. Si estamos de acuerdo, o si la persona autorizada a dar recetas solicita una decisión rápida, debemos comunicarle una decisión en un plazo máximo de 24 horas después de recibir la declaración de apoyo de la persona autorizada a dar recetas.

¿Qué puedo hacer si mi medicamento no está en el formulario o tiene una restricción?

Como miembro nuevo o actual de nuestro plan, es posible que esté tomando medicamentos que no estén en nuestro formulario. O bien, puede estar tomando un medicamento que está en nuestro formulario, pero que tiene una restricción de cobertura, como una autorización previa. Debe hablar con la persona autorizada a dar recetas sobre solicitar una decisión de cobertura para demostrar que cumple con los criterios de aprobación, cambiar a un medicamento alternativo que cubramos o solicitar una excepción al formulario para que cubramos el medicamento que toma. Mientras usted y su médico/a determinan el curso de acción correcto para usted, podemos cubrir el medicamento en ciertos casos durante los primeros 90 días tras convertirse en miembro de nuestro plan.

Para cada uno de sus medicamentos que no estén en nuestro formulario o que tengan una restricción de cobertura, cubriremos un suministro temporal de 30 días si no se encuentra en un centro de atención médica a largo plazo, o un suministro de 31 días si es residente de un centro de atención médica a largo plazo. Si su receta está escrita por menos días, permitiremos resurtidos para proporcionar un suministro máximo de medicamentos para 30 días si no se encuentra en un centro de atención médica a largo plazo o un suministro de medicamentos para 31 días si es residente de un centro de atención médica a largo plazo. Si no se aprueba la cobertura, después primer suministro para 30 días, si no se encuentra en un centro de atención médica a largo plazo, o un suministro para 31 días si es residente de un centro de atención médica a largo plazo, no pagaremos por estos medicamentos, incluso si ha sido miembro del plan por menos de 90 días.

Si es residente de un centro de atención médica a largo plazo y necesita un medicamento que no está en nuestro formulario, o si su capacidad para obtener sus medicamentos es limitada pero pasó los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia de ese medicamento para 31 días mientras solicita una excepción del formulario.

Si es un miembro actual que se está cambiando a un nivel de atención diferente, es probable que le receten medicamentos que no están en nuestro formulario o que su capacidad para obtener los medicamentos sea limitada. En estos casos, tiene que hablar con su médico/a sobre los tratamientos alternativos adecuados que se encuentran disponibles en nuestro formulario. Si no hay tratamientos alternativos adecuados en nuestro formulario, usted o su médico/a pueden solicitar una excepción y pedirle al plan que cubra el medicamento o quite las restricciones del medicamento. Mientras habla con su médico/a para determinar el curso de acción, es elegible para recibir un suministro del medicamento para 30 días, si está pasando de un centro de atención médica a largo plazo o de una hospitalización a su hogar, o un suministro de transición del medicamento para 31 días, si está pasando de una hospitalización o de su hogar a un centro de atención médica a largo plazo.

Para obtener más información

Para obtener información más detallada sobre su cobertura para medicamentos con receta de SCAN Health Plan, revise su Evidencia de cobertura y el resto de los materiales del plan.

Si tiene preguntas sobre SCAN Health Plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Si tiene preguntas generales sobre su cobertura de Medicare para medicamentos con receta, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), disponible las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. O visite http://www.medicare.gov.

Las tablas a continuación enumeran lo que pagará por compartir los costos de los medicamentos con receta cubiertos en las farmacias de nuestra red cuando se encuentre en la etapa de cobertura inicial.

El gasto compartido preferido es más bajo que el gasto compartido que pueda tener disponible para ciertos medicamentos cubiertos de la Parte D en determinadas farmacias de la red. Para obtener más información, visite nuestro directorio de farmacias en línea donde se pueden realizar búsquedas en www.scanhealthplan.com o llame a Servicios para Miembros. Nuestra información de contacto aparece en las páginas de la cubierta del frente y del dorso.

Consulte la Evidencia de cobertura para obtener información sobre los costos en farmacias para cuidado a largo plazo (LTC) y farmacias fuera de la red.

Si recibe "Ayuda adicional", su parte del costo para medicamentos con receta cubiertos puede variar según el nivel de "Ayuda adicional" que reciba. Para obtener más información sobre los costos de los medicamentos, consulte la "Cláusula adicional LIS".

No pagará más de $35 por un suministro para un mes, ni más de $105 por un suministro para tres meses, de cada producto de insulina cubierto por nuestro plan, sin importar en qué nivel de gasto compartido se encuentre, incluso si no ha pagado el deducible.

La mayoría de las vacunas para adultos de la Parte D están cubiertas por nuestro plan sin costo alguno para usted, incluso si no ha pagado el deducible.

SCAN Classic (HMO): Condados de Maricopa, Pima y Pinal

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		$0	$0	$7	$14
2	Medicamentos genéricos		$0	$0	$15	$30
3	Medicamentos de marca preferidos	Insulina	$35	$85	$35	$85
		Otros medicamentos	$42	$126	$47	$141
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN Balance (HMO C-SNP): Condados de Maricopa, Pima y Pinal

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		$0	$0	$5	$10
2	Medicamentos genéricos		$0	$0	$9	$18
3	Medicamentos de marca preferidos	Insulina	$0	$0	$0	$0
		Otros medicamentos	$42	$126	$47	$141
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN MyChoice (HMO): Condados de Maricopa, Pima y Pinal

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		$0	$0	$0	$0
2	Medicamentos genéricos		$0	$0	$0	$0
3	Medicamen-tos de marca preferidos	Insulina	$35	$85	$35	$85
		Otros medicamentos	$42	$126	$43	$129
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN Venture (HMO): Condados de Maricopa, Pima y Pinal

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		$0	$0	$10	$20
2	Medicamentos genéricos		$0	$0	$20	$40
3	Medicamentos de marca preferidos	Insulina	$35	$85	$35	$85
		Otros medicamentos	$42	$126	$47	$141
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN Embrace (HMO POS I-SNP): Condados de Maricopa y Pima

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		$0	$0	$0	$0
2	Medicamentos genéricos		$0	$0	$0	$0
3	Medicamentos de marca preferidos	Insulina	$0	$0	$0	$0
		Otros medicamentos	$42	$126	$43	$129
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN Strive (HMO C-SNP): Condados de Maricopa y Pima

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		$0	$0	$0	$0
2	Medicamentos genéricos		$0	$0	$0	$0
3	Medicamentos de marca preferidos	Insulina	$35	$105	$35	$105
		Otros medicamentos	24%	24%	25%	25%
4	Medicamentos no preferidos		45%	45%	45%	45%
5	Medicamentos de especialidad		25%	N/C	25%	N/C

Formulario de SCAN Health Plan

El formulario que comienza en la página 26 proporciona información sobre la cobertura de los medicamentos cubiertos por SCAN Health Plan. Si no encuentra el medicamento en la lista, vaya al Índice que comienza en la página 69.

En la primera columna de la tabla aparece el nombre del medicamento. Los medicamentos de marca están en mayúscula (p. ej., JANUVIA) y los medicamentos genéricos aparecen en minúscula y cursiva (p. ej., *metformina*).

La información en la columna de Requisitos/Limitaciones indica si SCAN Health Plan tiene algún requisito especial para la cobertura de su medicamento.

- El símbolo [PA] indica que aplica una autorización previa.
- El símbolo [B vs D] indica que este medicamento puede estar cubierto por la Parte B o la Parte D de Medicare según las circunstancias. Es posible que tenga que enviar información describiendo el uso y entorno del medicamento para realizar la determinación.
- El símbolo [QL] indica que las cantidades suministradas son limitadas. Para ver el límite de cantidad para los medicamentos del formulario con límites de cantidad, vaya a la página 64.
- El símbolo [LD] indica que aplica una distribución limitada. Es posible que este medicamento con receta esté disponible solo en ciertas farmacias. Para obtener más información, consulte el Directorio de farmacias o llame a Servicios para Miembros al 1-855-650-7226 (los usuarios de TTY deben llamar al 711), de 8:00 a. m. a 8:00 p. m., los 7 días de la semana, del 1 de octubre al 31 de marzo. Del 1 de abril al 30 de septiembre, el horario es de 8:00 a. m. a 8:00 p. m., de lunes a viernes (los mensajes recibidos en días feriados y fuera del horario de atención se responderán en el plazo de un día hábil). También puede visitar www.scanhealthplan.com.
- El símbolo [EDS] indica que este medicamento está disponible para un suministro extendido (p. ej., un suministro para más de 30 días) con el servicio de pedido por correo y en muchas farmacias minoristas.

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
ANALGESICS		
Nonsteroidal Anti-inflammatory Drugs		
celecoxib	2	[EDS]
diclofenac potassium tab 50mg	1	[EDS]
diclofenac sodium dr	1	[EDS]
diclofenac sodium er	1	[EDS]
diclofenac sodium soln 1.5%	4	[QL] [EDS]
diclofenac sodium soln 2%	4	[QL] [EDS]
diflunisal	2	[EDS]
ec-naproxen	1	[EDS]
etodolac	2	[EDS]
etodolac er	2	[EDS]
ibu	1	[EDS]
ibuprofen	1	[EDS]
indomethacin er	2	[EDS]
indomethacin ir caps	2	[EDS]
ketorolac oral tabs	2	[EDS]
LODINE TABS	2	[EDS]
meloxicam tabs	1	[EDS]
nabumetone	2	[EDS]
naproxen tabs 250mg, 375mg & 500mg	1	[EDS]
naproxen sodium ir tabs	1	[EDS]
piroxicam	2	[EDS]
sulindac	2	[EDS]
Opioid Analgesics, Long-acting		
fentanyl patches 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr & 100mcg/hr	3	[QL] [EDS]
methadone oral	2	[EDS]
morphine sulfate er tabs	3	[QL] [EDS]
tramadol er tabs	3	[QL] [EDS]
Opioid Analgesics, Short-acting		
acetaminophen & codeine	2	[QL] [EDS]
butorphanol tartrate nasal	2	[QL] [EDS]
codeine sulfate	2	[EDS]
endocet	3	[QL] [EDS]
hydrocodone & acetaminophen soln 7.5-325mg/15ml	2	[QL] [EDS]
hydrocodone & acetaminophen soln 10-325mg/15ml	3	[QL] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
hydrocodone & acetaminophen tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg	2	[QL] [EDS]
hydrocodone & ibuprofen tabs 7.5-200mg	2	[QL] [EDS]
hydromorphone immediate-release oral soln & tabs	2	[EDS]
morphine sulfate oral	2	[EDS]
oxycodone immediate-release	2	[EDS]
oxycodone oral soln	2	[EDS]
oxycodone & acetaminophen 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg	3	[QL] [EDS]
tramadol tab 50mg	2	[EDS]
tramadol ir tab 100mg	2	[QL] [EDS]
tramadol & acetaminophen	2	[QL] [EDS]
ANESTHETICS		
Local Anesthetics		
lidocaine ointment	4	[QL] [EDS]
lidocaine patch	3	[PA] [EDS]
lidocaine topical soln	2	[QL] [EDS]
lidocaine & prilocaine cream	3	[QL] [EDS]
lidocan III	3	[PA] [EDS]
tridacaine ii patch	3	[PA] [EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
Alcohol Deterrents/Anti-Craving		
acamprosate calcium dr	2	[EDS]
disulfiram	2	[EDS]
naltrexone	1	[EDS]
Opioid Dependence		
buprenorphine sublingual tabs	1	[EDS]
buprenorphine & naloxone sublingual film	2	[EDS]
buprenorphine & naloxone sublingual tabs	2	[EDS]
Opioid Reversal Agents		
KLOXXADO	3	[EDS]
naloxone inj	2	[EDS]
OPVEE	4	[EDS]
Smoking Cessation Agents		
bupropion sr 150mg	2	[EDS]
NICOTROL NASAL	4	[EDS]
varenicline starting month box	4	[EDS]
varenicline tartrate	4	[EDS]
ANTIBACTERIALS		
Aminoglycosides		
amikacin inj	2	[EDS]
ARIKAYCE	5	[PA]
gentamicin cream 0.1% & oint 0.1%	2	[EDS]
gentamicin inj 40mg/ml	2	[EDS]
neomycin sulfate oral	2	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
streptomycin inj	4	[EDS]
tobramycin sulfate inj	2	[EDS]
Antibacterials, Other		
aztreonam inj	4	[EDS]
CLEOCIN VAGINAL SUPP	3	[EDS]
clindamycin oral	2	[EDS]
clindamycin phosphate inj	2	[EDS]
clindamycin phosphate/dextrose inj	2	[EDS]
clindamycin swab	2	[EDS]
clindamycin vaginal cream	2	[EDS]
colistimethate inj	4	[EDS]
daptomycin inj	5	
fosfomycin pack	4	[EDS]
linezolid inj	4	[EDS]
linezolid oral susp and tabs	4	[EDS]
methenamine hippurate	2	[EDS]
metronidazole inj	2	[EDS]
metronidazole oral	2	[EDS]
metronidazole vaginal gel	2	[EDS]
nitrofurantoin caps	2	[EDS]
SIVEXTRO TABS & INJ	5	
tigecycline inj	5	
tinidazole tabs	3	[EDS]
trimethoprim	2	[EDS]
vancomycin caps	4	[EDS]
vancomycin inj 500mg, 750mg, 1gm & 10gm	3	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
vancomycin oral soln 250mg/5ml	4	[EDS]
vandazole	2	[EDS]
Beta-lactam, Cephalosporins		
cefaclor	2	[EDS]
cefaclor er	2	[EDS]
cefadroxil caps & tabs	2	[EDS]
cefazolin inj	2	[EDS]
cefdinir	2	[EDS]
cefepime inj	2	[EDS]
cefixime caps	3	[EDS]
cefixime susp	4	[EDS]
cefoxitin sodium	2	[EDS]
cefpodoxime tabs	2	[EDS]
cefprozil	2	[EDS]
ceftazidime inj	2	[EDS]
ceftriaxone inj	2	[EDS]
cefuroxime oral	2	[EDS]
cefuroxime inj	2	[EDS]
cephalexin caps 250mg & 500mg	1	[EDS]
cephalexin oral susp	1	[EDS]
tazicef inj	2	[EDS]
TEFLARO INJ	5	
Beta-lactam, Penicillins		
amoxicillin	1	[EDS]
amoxicillin & clavulanate potassium chew tabs 400-57mg	2	[EDS]
amoxicillin & clavulanate potassium er	2	[EDS]
amoxicillin & clavulanate potassium oral susp & tabs	2	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
ampicillin inj	2	[EDS]
ampicillin oral	2	[EDS]
ampicillin & sulbactam inj 10-5gm, 2-1gm & 1-0.5gm	2	[EDS]
BICILLIN L-A INJ	4	[EDS]
dicloxacillin sodium	2	[EDS]
nafcillin sodium inj	4	[EDS]
penicillin g inj 5 million units & 20 million units	2	[EDS]
penicillin v potassium	2	[EDS]
piperacillin/tazobactam inj	3	[EDS]
ZOSYN INJ	4	[EDS]
Carbapenems		
cilastatin/imipenem inj	2	[EDS]
ertapenem inj	4	[EDS]
meropenem inj	3	[EDS]
Macrolides		
azithromycin tabs & oral susp bottle	2	[EDS]
azithromycin inj	2	[EDS]
clarithromycin	2	[EDS]
clarithromycin er	2	[EDS]
DIFICID	5	
ERYTHROCIN LACTOBIONATE INJ	4	[EDS]
erythromycin caps & tabs	4	[EDS]
erythromycin dr	4	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Quinolones		
ciprofloxacin in d5w inj	2	[EDS]
ciprofloxacin tabs immediate-release 250mg, 500mg & 750mg	1	[EDS]
levofloxacin in d5w inj	2	[EDS]
levofloxacin oral soln	2	[EDS]
levofloxacin tabs	1	[EDS]
moxifloxacin inj	4	[EDS]
moxifloxacin oral	2	[EDS]
ofloxacin oral	2	[EDS]
Sulfonamides		
sulfacetamide sodium topical lotion 10%	2	[EDS]
sulfadiazine tabs	4	[EDS]
sulfamethoxazole & trimethoprim tabs	1	[EDS]
sulfamethoxazole & trimethoprim ds tabs	1	[EDS]
sulfamethoxazole & trimethoprim oral susp	2	[EDS]
Tetracyclines		
demeclocycline	4	[EDS]
doxy 100 inj	2	[EDS]
doxycycline hyclate immediate-release caps 50mg & 100mg	2	[EDS]
doxycycline hyclate immediate-release tabs 100mg	2	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
doxycycline monohydrate immediate-release tabs, caps & oral susp	2	[EDS]
minocycline ir	2	[EDS]
tetracycline	3	[EDS]
ANTICONVULSANTS		
Anticonvulsants, Other		
BRIVIACT ORAL SOLN	4	[PA] [EDS]
BRIVIACT TABS	5	[PA]
EPIDIOLEX	5	[PA] [LD]
felbamate tabs 400mg	2	[EDS]
felbamate tabs 600mg	4	[EDS]
felbamate oral susp 600mg/5ml	5	
FINTEPLA	5	[PA]
FYCOMPA	4	[PA] [EDS]
levetiracetam er	2	[EDS]
levetiracetam oral tabs & soln	2	[EDS]
levetiracetam tabs for oral susp	4	[EDS]
NAYZILAM	4	[PA] [EDS]
roweepra 500mg	2	[EDS]
SPRITAM	4	[EDS]
valproic acid oral caps & soln	2	[EDS]
Calcium Channel Modifying Agents		
ethosuximide	2	[EDS]
methsuximide	4	[EDS]
Gamma-aminobutyric Acid (GABA) Modulating Agents		
clobazam	4	[PA] [EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
clonazepam	3	[EDS]
clonazepam odt	4	[EDS]
DIACOMIT	5	[PA]
DIAZEPAM RECTAL GEL	4	[EDS]
divalproex sodium dr	2	[EDS]
divalproex sodium er	2	[EDS]
gabapentin caps, ir tabs & oral soln	2	[EDS]
LIBERVANT	4	[PA] [EDS]
phenobarbital elixir & tabs	2	[EDS]
pregabalin	2	[EDS]
primidone tabs 50mg & 250mg	2	[EDS]
PRIMIDONE TABS 125MG	3	[EDS]
SYMPAZAN 5MG	4	[PA] [EDS]
SYMPAZAN 10MG & 20MG	5	[PA]
tiagabine	4	[EDS]
VALTOCO	4	[PA] [EDS]
vigabatrin	5	[LD]
vigadrone	5	[LD]
VIGAFYDE	5	
vigpoder	5	[LD]
ZTALMY SUSP	5	[LD]
Sodium Channel Agents		
APTIOM	5	[PA]
carbamazepine chewable tabs 100mg	2	[EDS]
carbamazepine chewable tabs 200mg	3	[EDS]
carbamazepine tabs & oral susp	2	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
carbamazepine er tabs & caps	3	[EDS]
DILANTIN CAPS	3	[EDS]
DILANTIN INFATABS	3	[EDS]
DILANTIN SUSP	3	[EDS]
epitol	2	[EDS]
lacosamide oral	4	[EDS]
oxcarbazepine tabs	2	[EDS]
oxcarbazepine susp	4	[EDS]
phenytek	2	[EDS]
phenytoin oral susp & chewable tabs	2	[EDS]
phenytoin er	2	[EDS]
rufinamide	4	[PA] [EDS]
TEGRETOL	3	[EDS]
TEGRETOL XR	3	[EDS]
TRILEPTAL	4	[EDS]
XCOPRI TABS	5	[PA]
XCOPRI MAINTENANCE PACK	5	[PA]
XCOPRI TITRATION PACK 12.5-25MG	4	[PA] [EDS]
XCOPRI TITRATION PACK 50-100MG, & 150-200MG	5	[PA]
ZONISADE	4	[EDS]
zonisamide	2	[EDS]
ANTIDEMENTIA AGENTS		
Antidementia Agents, Other		
Cholinesterase Inhibitors		
donepezil tabs 5mg & 10mg	2	[EDS]
donepezil odt	2	[EDS]
galantamine tabs	2	[QL] [EDS]
galantamine er caps	2	[QL] [EDS]
galantamine soln	4	[QL] [EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
rivastigmine caps	3	[QL] [EDS]
rivastigmine patches	4	[QL] [EDS]
N-methyl-D-aspartate (NMDA) Receptor Antagonists		
memantine hcl immediate release	2	[EDS]
memantine hcl soln	4	[EDS]
memantine hcl titration pack	4	[EDS]
ANTIDEPRESSANTS		
Antidepressants, Other		
AUVELITY	5	
bupropion hcl tabs	2	[EDS]
bupropion sr	2	[EDS]
bupropion xl 150mg & 300mg	2	[EDS]
bupropion xl 450mg	3	[EDS]
mirtazapine	1	[EDS]
mirtazapine odt	1	[EDS]
perphenazine & amitriptyline	4	[PA] [EDS]
ZURZUVAE	5	[PA]
Monoamine Oxidase Inhibitors		
EMSAM	5	
MARPLAN	4	[EDS]
phenelzine	2	[EDS]
tranylcypromine	4	[EDS]
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin & Norepinephrine Reuptake Inhibitors)		
citalopram tabs	1	[EDS]
citalopram oral soln	2	[EDS]
DESVENLAFAXINE ER	4	[EDS]
desvenlafaxine succinate er	3	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
DRIZALMA SPRINKLE	4	[EDS]
escitalopram	2	[EDS]
FETZIMA	4	[EDS]
FETZIMA TITRATION PACK	4	[EDS]
fluoxetine hcl caps 10mg, 20mg & 40mg	2	[EDS]
fluoxetine hcl tabs 10mg & 20mg	2	[EDS]
fluoxetine hcl oral soln	2	[EDS]
fluvoxamine	2	[EDS]
nefazodone	2	[EDS]
paroxetine hcl ir tabs	1	[EDS]
paroxetine hcl er	4	[EDS]
paroxetine hcl susp	4	[EDS]
pmdd fluoxetine hcl tabs 10mg & 20mg	2	[EDS]
sertraline tabs	1	[EDS]
sertraline oral soln	2	[EDS]
trazodone	1	[EDS]
TRINTELLIX	4	[EDS]
venlafaxine ir tabs	2	[EDS]
venlafaxine hcl er caps	2	[EDS]
vilazodone	3	[EDS]
Tricyclics		
amitriptyline	4	[PA] [EDS]
amoxapine	3	[EDS]
clomipramine	4	[PA] [EDS]
desipramine	4	[PA] [EDS]
doxepin caps	4	[PA] [EDS]
doxepin oral soln	4	[PA] [EDS]
imipramine hcl tabs	4	[PA] [EDS]
nortriptyline	4	[EDS]
protriptyline	3	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
trimipramine maleate	2	[EDS]
ANTIEMETICS		
Antiemetics, Other		
compro	4	[EDS]
meclizine	2	[EDS]
prochlorperazine oral	2	[EDS]
prochlorperazine supp	4	[EDS]
promethazine supp	3	[EDS]
promethazine syrup	2	[EDS]
promethazine tabs	2	[EDS]
promethegan supp	4	[EDS]
scopolamine patch	3	[EDS]
Emetogenic Therapy Adjuncts		
aprepitant caps 80mg & 125mg	4	[PA] [EDS]
aprepitant pack	4	[PA] [EDS]
dronabinol	4	[PA] [EDS]
granisetron oral	2	[PA] [B vs D] [EDS]
ondansetron odt	2	[PA] [B vs D] [EDS]
ondansetron oral soln	2	[PA] [B vs D] [EDS]
ondansetron tabs 4mg & 8mg	2	[PA] [B vs D] [EDS]
ANTIFUNGALS		
Antifungals		
ABELCET INJ	4	[PA] [B vs D] [EDS]
AMBISOME INJ	5	[PA] [B vs D]
amphotericin b inj	2	[PA] [B vs D] [EDS]
amphotericin b liposome inj	5	[PA] [B vs D]
caspofungin inj	4	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
clotrimazole cream 1%	2	[EDS]
clotrimazole topical soln 1%	2	[EDS]
clotrimazole troche	2	[EDS]
econazole nitrate	4	[EDS]
fluconazole in sodium chloride inj	2	[EDS]
fluconazole oral	2	[EDS]
flucytosine	5	
griseofulvin microsize	4	[EDS]
itraconazole	4	[EDS]
ketoconazole cream, shampoo & tabs	2	[EDS]
nyamyc	2	[EDS]
nystatin	2	[EDS]
nystop	2	[EDS]
posaconazole dr tabs	5	[PA]
posaconazole suspension	4	[PA] [EDS]
terbinafine	2	[EDS]
terconazole	2	[EDS]
voriconazole inj	5	[PA]
voriconazole oral suspension	5	
voriconazole tabs	4	[EDS]
ANTIGOUT AGENTS		
Antigout Agents		
allopurinol tabs 100mg & 300mg	1	[EDS]
colchicine tabs	3	[QL] [EDS]
febuxostat	3	[EDS]
probenecid	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
probenecid & colchicine	2	[EDS]
ANTIMIGRAINE AGENTS		
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists		
AIMOVIG INJ	3	[PA] [EDS]
EMGALITY INJ	3	[PA] [EDS]
NURTEC ODT	3	[PA] [EDS]
UBRELVY	3	[PA] [EDS]
Ergot Alkaloids		
caffeine-ergotamine	3	[EDS]
dihydroergotamine mesylate nasal	5	[PA] [QL]
Prophylactic		
EPRONTIA	4	[EDS]
timolol oral	1	[EDS]
topiramate immediate-release tabs	2	[EDS]
topiramate immediate-release caps 15mg & 25mg	2	[EDS]
topiramate immediate-release caps 50mg	4	[EDS]
Serotonin (5-HT) Receptor Agonist		
naratriptan	2	[QL] [EDS]
rizatriptan	2	[EDS]
rizatriptan odt	2	[EDS]
sumatriptan nasal	4	[EDS]
sumatriptan succinate inj	4	[EDS]
sumatriptan succinate tabs	2	[EDS]
zolmitriptan tabs	3	[QL] [EDS]
zolmitriptan odt	3	[QL] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
ANTIMYASTHENIC AGENTS		
Parasympathomimetics		
pyridostigmine soln	4	[EDS]
pyridostigmine tabs 60mg	3	[EDS]
pyridostigmine er tabs 180mg	4	[EDS]
ANTIMYCOBACTERIALS		
Antimycobacterials, Other		
dapsone tabs	3	[EDS]
rifabutin	4	[EDS]
Antituberculars		
ethambutol	2	[EDS]
isoniazid	2	[EDS]
PRIFTIN	4	[EDS]
pyrazinamide	4	[EDS]
rifampin oral and inj	2	[EDS]
SIRTURO	5	
TRECATOR	4	[EDS]
ANTINEOPLASTICS		
Alkylating Agents		
cyclophosphamide	3	[PA] [B vs D] [EDS]
GLEOSTINE	4	[EDS]
MATULANE	5	
VALCHLOR	5	[PA]
Antiandrogens		
abiraterone acetate	5	[PA]
bicalutamide	2	[EDS]
ERLEADA	5	[PA]
nilutamide	5	
NUBEQA	5	[PA] [LD]
XTANDI	5	[PA]
YONSA	5	[PA]
Antiangiogenic Agents		
lenalidomide	5	[PA] [LD]
POMALYST	5	[PA] [LD]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
REVLIMID	5	[PA] [LD]
THALOMID	5	[PA]
Antiestrogens/Modifiers		
ORSERDU TABS	5	[PA]
SOLTAMOX	5	
tamoxifen	2	[EDS]
toremifene citrate	5	
Antimetabolites		
hydroxyurea	2	[EDS]
mercaptopurine	2	[EDS]
PURIXAN	5	
Antineoplastics, Other		
AKEEGA	5	[PA] [LD]
INREBIC	5	[PA] [LD]
ITOVEBI	5	[PA]
IWILFIN	5	[PA] [LD]
LONSURF	5	[PA]
LAZCLUZE	5	[PA] [LD]
LYSODREN	5	
OGSIVEO	5	[PA]
ONUREG	5	[PA]
REVUFORJ	5	[PA]
VONJO	5	[PA]
Aromatase Inhibitors, 3rd Generation		
anastrozole	2	[EDS]
exemestane	3	[EDS]
letrozole	2	[EDS]
Molecular Target Inhibitors		
ALECENSA	5	[PA]
ALUNBRIG	5	[PA]
ALUNBRIG INITIATION PACK	5	[PA]
AUGTYRO	5	[PA]
AYVAKIT	5	[PA] [LD]
BALVERSA	5	[PA]
BOSULIF	5	[PA]
BRAFTOVI	5	[PA] [LD]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	**Nivel**	**Requisitos/ Límites**
BRUKINSA	5	[PA] [LD]
CABOMETYX	5	[PA]
CALQUENCE	5	[PA] [LD]
CAPRELSA	5	[PA]
COMETRIQ	5	[PA]
COPIKTRA	5	[PA] [LD]
COTELLIC	5	[PA]
DANZITEN	5	[PA]
dasatinib	5	[PA]
DAURISMO	5	[PA]
ERIVEDGE	5	[PA]
erlotinib	5	[PA]
everolimus tabs 2.5mg, 5mg, 7.5mg & 10mg	5	[PA]
everolimus tabs for suspension 2mg, 3mg & 5mg	5	[PA]
FOTIVDA	5	[PA] [LD]
FRUZAQLA	5	[PA]
GAVRETO	5	[PA] [LD]
gefitinib	5	[PA]
GILOTRIF	5	[PA]
IBRANCE	5	[PA]
ICLUSIG	5	[PA]
IDHIFA	5	[PA] [LD]
imatinib	5	[PA]
IMBRUVICA	5	[PA]
IMKELDI	5	[PA]
INLYTA	5	[PA]
INQOVI	5	[PA]
JAKAFI	5	[PA]
JAYPIRCA TABS	5	[PA]
KISQALI	5	[PA]
KISQALI FEMARA CO-PACK	5	[PA]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	**Nivel**	**Requisitos/ Límites**
KOSELUGO	5	[PA]
KRAZATI	5	[PA]
lapatinib	5	[PA]
LENVIMA	5	[PA]
LORBRENA	5	[PA]
LUMAKRAS	5	[PA]
LYNPARZA	5	[PA]
LYTGOBI TABS	5	[PA] [LD]
MEKINIST	5	[PA]
MEKTOVI	5	[PA] [LD]
NERLYNX	5	[PA] [LD]
NINLARO	5	[PA]
ODOMZO	5	[PA]
OJEMDA	5	[PA]
OJJAARA	5	[PA]
pazopanib	5	[PA]
PEMAZYRE	5	[PA] [LD]
PIQRAY	5	[PA]
QINLOCK	5	[PA] [LD]
RETEVMO	5	[PA] [LD]
REZLIDHIA CAPS	5	[PA]
ROZLYTREK	5	[PA]
RUBRACA	5	[PA] [LD]
RYDAPT	5	[PA]
SCEMBLIX	5	[PA]
sorafenib	5	[PA]
SPRYCEL	5	[PA]
STIVARGA	5	[PA]
sunitinib malate	5	[PA]
TABRECTA	5	[PA]
TAFINLAR	5	[PA]
TAGRISSO	5	[PA]
TALZENNA	5	[PA]
TASIGNA	5	[PA]
TAZVERIK	5	[PA] [LD]
TEPMETKO	5	[PA] [LD]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
TIBSOVO	5	[PA]
torpenz	5	[PA]
TRUQAP	5	[PA]
TUKYSA	5	[PA] [LD]
TURALIO	5	[PA] [LD]
VANFLYTA	5	[PA]
VENCLEXTA TABS 10MG & 50MG	3	[PA] [EDS]
VENCLEXTA TABS 100MG	5	[PA]
VENCLEXTA STARTING PACK	5	[PA]
VERZENIO	5	[PA] [LD]
VITRAKVI	5	[PA] [LD]
VIZIMPRO	5	[PA]
XALKORI	5	[PA]
XOSPATA	5	[PA] [LD]
XPOVIO	5	[PA] [LD]
ZEJULA TABS	5	[PA] [LD]
ZELBORAF	5	[PA]
ZOLINZA	5	[PA]
ZYDELIG	5	[PA]
ZYKADIA TABS	5	[PA]
Retinoids		
bexarotene	5	[PA]
PANRETIN	5	
tretinoin caps	5	
Treatment Adjuncts		
leucovorin oral	2	[EDS]
mesna	4	[EDS]
MESNEX TABS	4	[EDS]
VORANIGO	5	[PA]
ANTIPARASITICS		
Anthelmintics		
albendazole	4	[EDS]
ivermectin tabs	2	[EDS]
praziquantel tabs	4	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Antiprotozoals		
atovaquone susp	4	[EDS]
atovaquone/proguanil	2	[EDS]
chloroquine	2	[EDS]
COARTEM	3	[EDS]
hydroxychloroquine tab 200mg	2	[EDS]
mefloquine	2	[EDS]
NEBUPENT NEBULIZER	4	[PA] [B vs D] [EDS]
nitazoxanide	5	
pentamidine inhalation soln	3	[PA] [B vs D] [EDS]
pentamidine inj	4	[EDS]
PRIMAQUINE	3	[EDS]
pyrimethamine	5	[PA]
quinine sulfate caps	3	[PA] [EDS]
ANTIPARKINSON AGENTS		
Anticholinergics		
benztropine tabs	4	[PA] [EDS]
trihexyphenidyl elixir & tabs	3	[EDS]
Antiparkinson Agents, Other		
carbidopa & levodopa & entacapone	4	[EDS]
entacapone	4	[EDS]
Dopamine Agonists		
apomorphine hydrochloride inj	5	[PA]
bromocriptine	2	[EDS]
NEUPRO PATCH	4	[QL] [EDS]
pramipexole ir	2	[EDS]
ropinirole ir	2	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa	4	[EDS]
carbidopa & levodopa ir, er, odt	2	[EDS]
Monoamine Oxidase B (MAO-B) Inhibitors		
rasagiline	4	[EDS]
selegiline	2	[EDS]
ANTIPSYCHOTICS		
1st Generation/Typical		
chlorpromazine oral	4	[PA] [EDS]
fluphenazine oral	4	[EDS]
fluphenazine decanoate inj	4	[EDS]
fluphenazine inj	4	[EDS]
haloperidol oral	2	[EDS]
haloperidol decanoate inj	2	[EDS]
haloperidol lactate inj	2	[EDS]
loxapine	2	[EDS]
molindone	2	[EDS]
perphenazine	4	[EDS]
pimozide	2	[EDS]
thioridazine	2	[EDS]
thiothixene	2	[EDS]
trifluoperazine	2	[EDS]
2nd Generation/Atypical		
ABILIFY ASIMTUFII INJ	5	
ABILIFY MAINTENA INJ	5	
aripiprazole odt 10mg	5	
aripiprazole odt 15mg	4	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
aripiprazole soln	3	[EDS]
aripiprazole tabs	3	[EDS]
ARISTADA INJ	5	
ARISTADA INITIO INJ	4	[EDS]
asenapine maleate sublinqual	4	[EDS]
CAPLYTA	5	[PA]
FANAPT	4	[PA] [EDS]
FANAPT TITRATION PACK	4	[PA] [EDS]
INVEGA HAFYERA INJ	5	
INVEGA SUSTENNA INJ 39MG	4	[EDS]
INVEGA SUSTENNA INJ 78MG, 117MG, 156MG & 234MG	5	
INVEGA TRINZA INJ	5	
lurasidone hcl tabs	4	[EDS]
NUPLAZID	5	[PA]
olanzapine inj & tabs	2	[EDS]
olanzapine odt	4	[EDS]
paliperidone er tabs	4	[EDS]
quetiapine fumarate 25mg, 50mg, 100mg, 200mg, 300mg & 400mg tabs	2	[EDS]
quetiapine er tabs	3	[EDS]
REXULTI	5	
risperidone	2	[EDS]
risperidone er inj 12.5mg & 25mg	4	[EDS]
risperidone er inj 37.5mg & 50mg	5	
risperidone odt	2	[EDS]
SECUADO	5	[PA]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
UZEDY INJ	5	
VRAYLAR	4	[EDS]
ziprasidone inj	3	[EDS]
ziprasidone oral	2	[EDS]
Treatment-Resistant		
clozapine	3	[EDS]
clozapine odt	4	[EDS]
VERSACLOZ	5	
ANTISPASTICITY AGENTS		
Antispasticity Agents		
baclofen tabs	2	[EDS]
tizanidine caps	3	[EDS]
tizanidine tabs	2	[EDS]
ANTIVIRALS		
Anti-cytomegalovirus (CMV) Agents		
LIVTENCITY	5	[PA] [QL] [LD]
PREVYMIS	5	[PA] [QL]
valganciclovir oral soln	4	[EDS]
valganciclovir tabs	3	[EDS]
Anti-hepatitis B (HBV) Agents		
adefovir dipivoxil	4	[EDS]
BARACLUDE ORAL SOLN 0.05MG/ML	4	[EDS]
entecavir tabs	4	[EDS]
lamivudine tabs 100mg	3	[EDS]
VEMLIDY	5	
Anti-hepatitis C (HCV) Agents		
EPCLUSA	5	[PA]
HARVONI	5	[PA]
LEDIPASVIR/ SOFOSBUVIR	5	[PA]
ribavirin	3	[EDS]
SOFOSBUVIR/ VELPATASVIR	5	[PA]
VOSEVI	5	[PA]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Antiherpetic Agents		
acyclovir caps & tabs	2	[EDS]
acyclovir inj	2	[PA] [B vs D] [EDS]
acyclovir oral susp	4	[EDS]
famciclovir	2	[EDS]
valacyclovir	2	[EDS]
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
BIKTARVY	5	
DOVATO	5	
GENVOYA	5	
ISENTRESS CHEW TABS 25MG	3	[EDS]
ISENTRESS 100MG CHEW TABS	5	
ISENTRESS ORAL POWDER	5	
ISENTRESS TABS	5	
ISENTRESS HD TABS	5	
JULUCA	5	
STRIBILD	5	
TIVICAY TABS 50MG	5	
TIVICAY PD	4	[EDS]
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
COMPLERA	5	
DELSTRIGO	5	
EDURANT	5	
efavirenz tabs	4	[EDS]
efavirenz & emtricitabine & tenofovir disoproxil fumarate tabs	5	

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
efavirenz & lamivudine & tenofovir disoproxil fumarate tabs	5	
etravirine tabs 100mg	4	[EDS]
etravirine tabs 200mg	5	
INTELENCE TAB 25MG	4	[EDS]
nevirapine er & susp	4	[EDS]
nevirapine tabs	2	[EDS]
PIFELTRO	5	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
abacavir soln & tabs	4	[EDS]
abacavir & lamivudine	4	[EDS]
CIMDUO	5	
DESCOVY	5	
emtricitabine caps 200mg	4	[EDS]
emtricitabine & tenofovir disoproxil fumarate tabs 200mg-300mg	4	[EDS]
emtricitabine & tenofovir disoproxil fumarate tabs 100mg-150mg, 133mcg-200mg & 167mg-250mg	5	
EMTRIVA SOLN	4	[EDS]
lamivudine tabs 150mg & 300mg	3	[EDS]
lamivudine soln	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
lamivudine & zidovudine	3	[EDS]
ODEFSEY	5	
tenofovir disoproxil fumarate	4	[EDS]
TRIUMEQ	5	
TRIUMEQ PD	4	[EDS]
VIREAD TABS 150MG, 200MG & 250MG	5	
VIREAD POWDER	4	[EDS]
zidovudine	2	[EDS]
Anti-HIV Agents, Other		
FUZEON INJ	4	[EDS]
maraviroc	5	
RUKOBIA	5	
SELZENTRY SOLN	3	[EDS]
SUNLENCA	5	
TYBOST	3	[EDS]
Anti-HIV Agents, Protease Inhibitors (PI)		
APTIVUS CAPS	5	
atazanavir sulfate caps	4	[EDS]
darunavir tab 600mg	4	[EDS]
darunavir tab 800mg	5	
EVOTAZ	5	
fosamprenavir tabs	5	
lopinavir & ritonavir	4	[EDS]
NORVIR POWDER	3	[EDS]
PREZCOBIX	5	
PREZISTA SUSP 100MG/ML	4	[EDS]
PREZISTA TABS 75MG & 150MG	4	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
REYATAZ ORAL POWDER	5	
ritonavir tabs	3	[EDS]
SYMTUZA	5	
VIRACEPT	5	
Anti-influenza Agents		
amantadine	2	[EDS]
oseltamivir caps	2	[EDS]
oseltamivir susp	3	[EDS]
RELENZA DISKHALER	3	[EDS]
rimantadine	2	[EDS]
XOFLUZA	4	[EDS]
Antiviral, Coronavirus Agents		
PAXLOVID	3	[EDS]
ANXIOLYTICS		
Anxiolytics, Other		
buspirone	2	[EDS]
meprobamate	4	[EDS]
Benzodiazepines		
alprazolam ir tabs	2	[QL] [EDS]
clorazepate	4	[EDS]
diazepam soln	4	[PA] [EDS]
diazepam tabs	3	[PA] [EDS]
lorazepam soln	3	[EDS]
lorazepam tabs	2	[EDS]
BIPOLAR AGENTS		
Mood Stabilizers		
lamotrigine odt	4	[EDS]
lamotrigine chewable tabs	2	[EDS]
lamotrigine immediate-release tabs	2	[EDS]
lithium carbonate	2	[EDS]
lithium carbonate er	2	[EDS]
lithium oral soln	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
subvenite tabs	2	[EDS]
BLOOD GLUCOSE REGULATORS		
Antidiabetic Agents		
acarbose	2	[EDS]
glimepiride	1	[EDS]
glimepiride & pioglitazone	2	[QL] [EDS]
glipizide er	1	[EDS]
glipizide tabs 5mg & 10mg	1	[EDS]
glipizide & metformin tabs	1	[EDS]
GLYXAMBI	3	[QL] [EDS]
JANUMET	3	[QL] [EDS]
JANUMET XR	3	[QL] [EDS]
JANUVIA	3	[QL] [EDS]
JENTADUETO	3	[QL] [EDS]
JENTADUETO XR	3	[QL] [EDS]
metformin tabs	1	[EDS]
metformin er uncoated tabs 500mg & 750mg	1	[EDS]
MOUNJARO INJ	3	[PA] [QL] [EDS]
nateglinide	2	[EDS]
OZEMPIC INJ	3	[PA] [QL] [EDS]
pioglitazone	1	[EDS]
pioglitazone & metformin	2	[EDS]
repaglinide	2	[EDS]
RYBELSUS	3	[PA] [QL] [EDS]
SOLIQUA INJ	3	[EDS]
SYMLINPEN INJ	5	
SYNJARDY	3	[QL] [EDS]
SYNJARDY XR	3	[QL] [EDS]
TRADJENTA	3	[QL] [EDS]
TRIJARDY XR	3	[QL] [EDS]
TRULICITY INJ	3	[PA] [QL] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
XIGDUO XR	3	[QL] [EDS]
Glycemic Agents		
diazoxide	5	
GLUCAGON EMERGENCY KIT INJ	3	[EDS]
GVOKE INJ	3	[EDS]
ZEGALOGUE INJ	3	[EDS]
Insulins		
HUMALOG CARTRIDGE INJ	3	[EDS]
HUMALOG JUNIOR KWIKPEN INJ	3	[EDS]
HUMALOG KWIKPEN INJ	3	[EDS]
HUMALOG MIX 50/50 KWIKPEN INJ	3	[EDS]
HUMALOG MIX 75/25 KWIKPEN INJ	3	[EDS]
HUMALOG MIX 75/25 VIAL INJ	3	[EDS]
HUMALOG VIAL INJ	3	[EDS]
HUMULIN 70/30 KWIKPEN INJ	3	[EDS]
HUMULIN 70/30 VIAL INJ	3	[EDS]
HUMULIN N KWIKPEN INJ	3	[EDS]
HUMULIN N VIAL INJ	3	[EDS]
HUMULIN R U-500 (CONCENTRATED) KWIKPEN INJ	3	[EDS]
HUMULIN R U-500 (CONCENTRATED) VIAL INJ	3	[EDS]
HUMULIN R VIAL INJ	3	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
INSULIN LISPRO VIAL INJ	3	[EDS]
LANTUS SOLOSTAR PEN INJ	3	[EDS]
LANTUS VIAL INJ	3	[EDS]
LYUMJEV VIAL INJ	3	[EDS]
LYUMJEV KWIKPEN INJ	3	[EDS]
TOUJEO SOLOSTAR INJ	3	[EDS]
TOUJEO MAX SOLOSTAR INJ	3	[EDS]
TRESIBA VIAL INJ	3	[EDS]
TRESIBA FLEXTOUCH INJ	3	[EDS]
BLOOD PRODUCTS AND MODIFIERS		
Anticoagulants		
dabigatran etexilate	4	[QL] [EDS]
ELIQUIS STARTER PACK & TABS	3	[QL] [EDS]
enoxaparin inj syringe	4	[EDS]
fondaparinux inj 2.5mg/0.5ml & 5mg/0.4ml	4	[EDS]
fondaparinux inj 7.5mg/0.6ml & 10mg/0.8ml	5	
heparin inj vials 1000u/ml, 5000u/ml, 10000u/ml & 20000u/ml	2	[PA] [B vs D] [EDS]
jantoven	1	[EDS]
warfarin	1	[EDS]
XARELTO ORAL SUSP & TABS	3	[QL] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
XARELTO STARTER PACK	3	[QL] [EDS]
Blood Products and Modifiers, Other		
anagrelide	2	[EDS]
NIVESTYM INJ	5	[PA]
PROCRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML & 10000UNIT/ML	3	[PA] [EDS]
PROCRIT INJ 20000UNIT/ML & 40000UNIT/ML	5	[PA]
PROMACTA	5	[PA] [QL] [LD]
RELEUKO INJ	4	[PA]
RETACRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML,10000 UNIT/ML, 20000UNIT/2ML & 20000UNIT/ML	3	[PA] [EDS]
RETACRIT INJ 40000UNIT/ML	5	[PA]
UDENYCA INJ	5	[PA]
Hemostasis Agents		
tranexamic acid tabs	3	[EDS]
Platelet Modifying Agents		
BRILINTA	3	[EDS]
cilostazol	2	[EDS]
clopidogrel tabs 75mg	1	[EDS]
dipyridamole er & aspirin	4	[EDS]
dipyridamole oral	2	[EDS]
prasugrel	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
CARDIOVASCULAR AGENTS		
Alpha-adrenergic Agonists		
clonidine patches	4	[EDS]
clonidine tabs immediate-release	1	[EDS]
droxidopa	5	[PA]
guanfacine ir	2	[EDS]
midodrine tabs	3	[EDS]
Angiotensin-converting Enzyme (ACE) Inhibitors		
benazepril	1	[EDS]
captopril	1	[EDS]
enalapril tabs	1	[EDS]
fosinopril	1	[EDS]
lisinopril	1	[EDS]
moexipril	1	[EDS]
perindopril	1	[EDS]
quinapril	1	[EDS]
ramipril	1	[EDS]
trandolapril	1	[EDS]
Angiotensin II Receptor Antagonists		
candesartan	2	[EDS]
irbesartan	1	[EDS]
losartan	1	[EDS]
olmesartan	2	[EDS]
telmisartan	2	[EDS]
valsartan tabs	1	[EDS]
Antiarrhythmics		
amiodarone tabs	2	[EDS]
digoxin oral soln	2	[EDS]
digoxin tabs 125mcg & 250mcg	2	[EDS]
disopyramide phosphate	4	[EDS]
dofetilide	4	[EDS]
flecainide acetate	2	[EDS]
LANOXIN ORAL	3	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
mexiletine	2	[EDS]
MULTAQ	3	[EDS]
pacerone tabs	2	[EDS]
propafenone tabs	2	[EDS]
quinidine gluconate cr	4	[EDS]
quinidine sulfate	2	[EDS]
sotalol tabs	2	[EDS]
Beta-adrenergic Blocking Agents		
acebutolol	2	[EDS]
atenolol	1	[EDS]
bisoprolol	2	[EDS]
carvedilol	1	[EDS]
labetalol oral	2	[EDS]
metoprolol succinate er	2	[EDS]
metoprolol tartrate tabs 25mg, 50mg & 100mg	1	[EDS]
nadolol	2	[EDS]
nebivolol hcl	2	[EDS]
pindolol	2	[EDS]
propranolol ir tabs	1	[EDS]
propranolol er caps	2	[EDS]
propranolol oral soln	2	[EDS]
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine	1	[EDS]
felodipine er	2	[EDS]
isradipine	2	[EDS]
nicardipine caps	2	[EDS]
nifedipine caps	2	[EDS]
nifedipine er	2	[EDS]
nimodipine	4	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Calcium Channel Blocking Agents, Nondihydropyridines		
cartia xt	2	[EDS]
diltiazem tabs	2	[EDS]
diltiazem er caps	2	[EDS]
dilt-xr	2	[EDS]
tiadylt er	2	[EDS]
verapamil ir	1	[EDS]
verapamil er	2	[EDS]
verapamil sr	2	[EDS]
Cardiovascular Agents, Other		
aliskiren	3	[EDS]
amiloride & hydrochlorothiazide	1	[EDS]
amlodipine & atorvastatin	2	[EDS]
amlodipine & benazepril	1	[EDS]
amlodipine & valsartan & hydrochlorothiazide tabs	2	[EDS]
atenolol & chlorthalidone	1	[EDS]
benazepril & hydrochlorothiazide	1	[EDS]
bisoprolol & hydrochlorothiazide	2	[EDS]
CORLANOR TABS	4	[PA] [EDS]
enalapril & hydrochlorothiazide	1	[EDS]
ENTRESTO TABS	3	[QL] [EDS]
fosinopril & hydrochlorothiazide	1	[EDS]
irbesartan hct	1	[EDS]
ivabradine	4	[PA] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
lisinopril & hydrochlorothiazide	1	[EDS]
losartan hct	1	[EDS]
metoprolol & hydrochlorothiazide	2	[EDS]
metyrosine caps	5	[PA]
olmesartan & amlodipine	2	[EDS]
olmesartan hct	2	[EDS]
olmesartan medoxomil & amlodipine & hydrochlorothiazide tabs	2	[EDS]
pentoxifylline er	2	[EDS]
quinapril & hydrochlorothiazide	1	[EDS]
ranolazine er	3	[EDS]
spironolactone & hydrochlorothiazide	1	[EDS]
triamterene & hydrochlorothiazide	1	[EDS]
valsartan & amlodipine	1	[EDS]
valsartan hct	1	[EDS]
Diuretics, Loop		
bumetanide inj	2	[EDS]
bumetanide tabs	2	[EDS]
furosemide oral	1	[EDS]
furosemide inj	2	[EDS]
torsemide	2	[EDS]
Diuretics, Potassium-sparing		
amiloride	2	[EDS]
Diuretics, Thiazide		
chlorthalidone	1	[EDS]
hydrochlorothiazide	1	[EDS]
indapamide	1	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
metolazone	2	[EDS]
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate caps 43mg & 130mg	2	[EDS]
fenofibrate micronized caps 67mg, 134mg & 200mg	2	[EDS]
fenofibrate tabs 48mg, 54mg, 145mg & 160mg	2	[EDS]
fenofibric acid dr caps	3	[EDS]
gemfibrozil	2	[EDS]
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin	1	[EDS]
lovastatin	1	[EDS]
pravastatin	1	[EDS]
rosuvastatin	1	[EDS]
simvastatin	1	[EDS]
Dyslipidemics, Other		
cholestyramine	2	[EDS]
cholestyramine light	2	[EDS]
colesevelam	4	[EDS]
colestipol pack	2	[EDS]
colestipol tabs	2	[EDS]
ezetimibe	2	[EDS]
ezetimibe & simvastatin	3	[EDS]
icosapent ethyl	4	[EDS]
niacin er tabs	3	[QL] [EDS]
omega-3-acid ethyl esters	2	[EDS]
prevalite	2	[EDS]
REPATHA INJ	3	[PA] [EDS]
VASCEPA CAPS	4	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Mineralocorticoid Receptor Antagonists		
eplerenone	3	[EDS]
KERENDIA	3	[PA] [EDS]
spironolactone tabs	1	[EDS]
Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)		
FARXIGA	3	[QL] [EDS]
JARDIANCE	3	[QL] [EDS]
Vasodilators, Direct-acting Arterial		
hydralazine oral	2	[EDS]
minoxidil	2	[EDS]
Vasodilators, Direct-acting Arterial/Venous		
isosorbide dinitrate tabs 5mg, 10mg, 20mg & 30mg	2	[EDS]
isosorbide mononitrate er	2	[EDS]
nitro-bid oint	2	[EDS]
nitroglycerin lingual	2	[EDS]
nitroglycerin patches	2	[EDS]
nitroglycerin sublingual	2	[EDS]
VERQUVO	4	[PA] [EDS]
CENTRAL NERVOUS SYSTEM AGENTS		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine & dextroamphetamine tabs	2	[QL] [EDS]
dextroamphetamine sulfate tabs 5mg & 10mg	3	[QL] [EDS]
dextroamphetamine sulfate er	4	[QL] [EDS]
zenzedi tabs 5mg & 10mg	3	[QL] [EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
atomoxetine	3	[EDS]
clonidine er 0.1mg	2	[EDS]
dexmethylphenidate ir tabs	2	[EDS]
methylphenidate er tabs 10mg & 20mg	3	[EDS]
methylphenidate ir tabs 5mg, 10mg & 20mg	2	[EDS]
Central Nervous System, Other		
AUSTEDO	5	[PA] [QL] [LD]
AUSTEDO XR 6MG, 12MG & 24MG	5	[PA] [QL] [LD]
AUSTEDO XR 18MG, 30MG, 36MG, 42MG & 48MG	5	[PA] [QL]
AUSTEDO XR PATIENT TITRATION KIT	5	[PA] [QL]
COBENFY	4	[EDS]
NUEDEXTA	5	[PA]
riluzole	3	[EDS]
tetrabenazine	5	[PA] [QL]
Fibromyalgia Agents		
duloxetine hcl	2	[EDS]
SAVELLA	3	[EDS]
SAVELLA TITRATION PACK	3	[EDS]
Multiple Sclerosis Agents		
AVONEX INJ	5	[PA]
AVONEX PEN INJ	5	[PA]
BETASERON INJ	5	[PA]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
COPAXONE INJ 40MG/ML	5	[PA]
dalfampridine er	3	[PA] [EDS]
dimethyl fumarate caps	5	[PA]
dimethyl fumarate starter pack	5	[PA]
fingolimod hcl	5	[PA]
glatiramer acetate inj	5	[PA]
glatopa inj	5	[PA]
teriflunomide tabs	5	[PA]
VUMERITY	5	[PA]
DENTAL AND ORAL AGENTS		
Dental and Oral Agents		
cevimeline	3	[EDS]
chlorhexidine gluconate	2	[EDS]
doxycycline hyclate immediate-release tabs 20mg	2	[EDS]
kourzeq	2	[EDS]
lidocaine viscous soln	2	[EDS]
periogard	2	[EDS]
pilocarpine tabs	3	[EDS]
triamcinolone dental paste	2	[EDS]
DERMATOLOGICAL AGENTS		
Acne and Rosacea Agents		
acitretin	4	[PA] [EDS]
accutane	4	[EDS]
adapalene cream 0.1%	4	[EDS]
adapalene gel 0.3%	4	[EDS]
ALTRENO	3	[PA] [EDS]
amnesteem caps	4	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
claravis	4	[EDS]
isotretinoin caps 10mg, 20mg, 30mg & 40mg	4	[EDS]
metronidazole topical	3	[EDS]
tazarotene cream	4	[EDS]
tazarotene gel	4	[QL] [EDS]
tretinoin cream	3	[PA] [EDS]
tretinoin gel 0.01%, 0.025% & 0.05%	3	[PA] [EDS]
zenatane	4	[EDS]
Dermatitis and Pruritus Agents		
alclometasone dipropionate	2	[EDS]
ammonium lactate	2	[EDS]
betamethasone dipropionate	2	[EDS]
betamethasone dipropionate augmented	2	[EDS]
betamethasone valerate cream, oint & lotion	2	[EDS]
clobetasol propionate cream, foam, gel, oint & soln	4	[EDS]
clobetasol propionate emollient	4	[EDS]
desonide lotion, oint & cream	3	[QL] [EDS]
desoximetasone topical cream, gel & oint 0.05%	4	[QL] [EDS]
desoximetasone topical cream & oint 0.25%	3	[QL] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
fluocinolone acetonide cream, oint, soln	3	[EDS]
fluocinolone acetonide scalp oil	3	[EDS]
fluocinonide cream 0.05%, gel & oint	2	[QL] [EDS]
fluocinonide emulsified base cream	2	[QL] [EDS]
fluocinonide soln	2	[EDS]
fluticasone propionate cream & oint	2	[EDS]
halobetasol propionate cream & ointment	2	[EDS]
hydrocortisone lotion & oint 2.5%	2	[EDS]
hydrocortisone butyrate cream & soln	2	[EDS]
hydrocortisone valerate	2	[EDS]
mometasone cream, oint & soln	2	[EDS]
pimecrolimus	4	[QL] [EDS]
selenium sulfide lotion	2	[EDS]
tacrolimus oint	4	[QL] [EDS]
triamcinolone acetonide topical cream & lotion	2	[EDS]
triamcinolone acetonide topical oint 0.025%, 0.1% & 0.5%	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Dermatological Agents, Other		
calcipotriene cream & oint	4	[QL] [EDS]
calcipotriene soln	3	[EDS]
clotrimazole & betamethasone	2	[EDS]
diclofenac sodium gel 3%	4	[PA] [EDS]
fluorouracil topical 2% and 5%	3	[EDS]
imiquimod cream 5%	3	[EDS]
methoxsalen	5	
nystatin & triamcinolone	3	[EDS]
OTEZLA	5	[PA] [QL]
podofilox soln	2	[EDS]
silver sulfadiazine	2	[EDS]
REGRANEX	5	[PA] [QL]
SANTYL	3	[QL] [EDS]
ssd	2	[EDS]
Pediculicides/Scabicides		
malathion	4	[EDS]
permethrin cream	2	[EDS]
Topical Anti-infectives		
acyclovir cream & oint 5%	4	[QL] [EDS]
ciclopirox cream, gel, nail soln, shampoo & susp	2	[EDS]
clindamycin gel 1%	3	[EDS]
clindamycin lotion & soln	2	[EDS]
erythromycin topical gel & soln	2	[EDS]
mupirocin ointment	2	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
mupirocin cream	4	[QL] [EDS]
ELECTROLYTES/MINERALS/METALS/ VITAMINS		
Electrolyte/Mineral/Metal Modifiers		
deferasirox granule pack, tabs & tabs for soln	3	[PA] [EDS]
deferiprone	5	[PA]
penicillamine tabs	5	
trientine cap 250mg	5	
Electrolyte/Mineral Replacement		
carglumic acid	5	[PA]
CLINISOL SF INJ	4	[PA] [B vs D] [EDS]
dextrose inj	2	[EDS]
dextrose (10%, 5% or 2.5%) & sodium chloride inj	2	[EDS]
klor-con pack	4	[EDS]
klor-con tabs	2	[EDS]
magnesium sulfate inj	2	[EDS]
plenamine inj	2	[PA] [B vs D] [EDS]
potassium chloride oral soln	4	[EDS]
potassium chloride inj	2	[EDS]
potassium chloride pack 20meq	4	[EDS]
potassium chloride er & cr	2	[EDS]
potassium chloride & dextrose 20mEq/5% inj	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
potassium chloride & dextrose & lactated ringers inj	2	[EDS]
potassium chloride & dextrose & sodium chloride inj 10mEq/5%/0.45%, 20mEq/5%/0.2%, 20mEq/5%/0.45%, 20mEq/5%/0.9%, 30mEq/5%/0.45% 40mEq/5%/0.9% & 40mEq/5%/0.45%	2	[EDS]
potassium citrate er	2	[EDS]
PROSOL INJ	4	[PA] [B vs D] [EDS]
sodium chloride inj	2	[EDS]
TPN ELECTROLYTES INJ	3	[EDS]
TRAVASOL INJ	4	[PA] [B vs D] [EDS]
Potassium Binders		
kionex susp	2	[EDS]
LOKELMA	3	[EDS]
sodium polystyrene sulfonate powder	2	[EDS]
sps suspension	2	[EDS]
VELTASSA	3	[EDS]
Vitamins		
prenatal multi-vitamin	2	[EDS]
GASTROINTESTINAL AGENTS		
Anti-Constipation Agents		
constulose soln	2	[EDS]
enulose	*2*	*[EDS]*
generlac	2	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
lactulose soln 10g/15ml	2	[EDS]
LINZESS	3	[EDS]
lubiprostone	3	[EDS]
MOVANTIK	3	[EDS]
RELISTOR INJ	5	[PA]
RELISTOR TABS	5	[PA]
Anti-Diarrheal Agents		
alosetron hcl tab 0.5mg	4	[PA] [EDS]
alosetron hcl tab 1mg	5	[PA]
diphenoxylate & atropine oral soln	4	[EDS]
diphenoxylate & atropine tabs	4	[EDS]
loperamide caps 2mg	2	[EDS]
XERMELO	5	[PA]
Antispasmodics, Gastrointestinal		
dicyclomine	4	[PA] [EDS]
glycopyrrolate tabs 1mg & 2mg	2	[EDS]
Gastrointestinal Agents, Other		
gavilyte-c	2	[EDS]
gavilyte-g	2	[EDS]
gavilyte-n	2	[EDS]
metoclopramide oral tablets & soln	2	[EDS]
nitroglycerin rectal oint	4	[EDS]
peg 3350 & electrolytes	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
peg 3350 & sodium chloride & sodium bicarbonate & potassium chloride	2	[EDS]
peg 3350 & sodium sulfate & sodium chloride & potassium chloride & sodium ascorbate & ascorbic	3	[EDS]
PLENVU	3	[EDS]
sodium sulfate, potassium sulfate and magnesium sulfate	3	[EDS]
ursodiol cap 300mg & tabs 250mg & 500mg	3	[EDS]
VOWST	5	[PA] [LD]
XIFAXAN TABS 200MG	3	[PA] [EDS]
XIFAXAN TABS 550MG	5	[PA]
Histamine2 (H2) Receptor Antagonists		
cimetidine tabs	2	[EDS]
famotidine tabs	1	[EDS]
Protectants		
misoprostol	2	[EDS]
sucralfate tabs	2	[EDS]
Proton Pump Inhibitors		
esomeprazole magnesium dr caps	3	[EDS]
lansoprazole dr caps	2	[EDS]
omeprazole caps	1	[EDS]
pantoprazole tabs	1	[EDS]
rabeprazole sodium	3	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
betaine anhydrous	5	
CERDELGA	5	[PA]
CREON DR	3	[EDS]
cromolyn sodium oral	4	[EDS]
CYSTAGON	3	[EDS]
ENDARI	5	[PA]
l-glutamine	5	[PA]
miglustat	5	[PA] [LD]
nitisinone	5	[PA]
PROLASTIN C INJ	5	[PA] [LD]
sapropterin	5	
sodium phenylbutyrate powder & tabs	5	
WELIREG	5	[PA] [LD]
YARGESA	5	[PA] [LD]
GENITOURINARY AGENTS		
Antispasmodics, Urinary		
fesoterodine fumarate er	3	[EDS]
GEMTESA	4	[EDS]
MYRBETRIQ	3	[EDS]
oxybutynin ir	2	[EDS]
oxybutynin er	2	[EDS]
solifenacin succinate	3	[EDS]
tolterodine tartrate er	4	[QL] [EDS]
trospium ir	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er	2	[EDS]
doxazosin	2	[EDS]
dutasteride	3	[EDS]
dutasteride & tamsulosin	3	[EDS]
finasteride tabs 5mg	1	[EDS]
prazosin	2	[EDS]
tadalafil 2.5mg & 5mg	4	[PA] [QL] [EDS]
tamsulosin	1	[EDS]
terazosin	1	[EDS]
Genitourinary Agents, Other		
bethanechol	2	[EDS]
ELMIRON	4	[EDS]
tiopronin	5	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
dexamethasone dose pack	2	[EDS]
dexamethasone elixir	2	[EDS]
dexamethasone tabs	2	[EDS]
fludrocortisone acetate	2	[EDS]
HEMADY	4	[EDS]
hydrocortisone oral	2	[EDS]
MEDROL TABS	4	[PA] [B vs D] [EDS]
methylprednisolone dose pack	2	[EDS]
methylprednisolone oral	2	[PA] [B vs D] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
ORAPRED ODT	4	[PA] [B vs D] [EDS]
prednisolone oral soln	2	[PA] [B vs D] [EDS]
prednisolone odt	4	[PA] [B vs D] [EDS]
prednisolone tablet 5mg	4	[PA] [B vs D] [EDS]
PREDNISONE INTENSOL	4	[PA] [B vs D] [EDS]
prednisone oral soln	2	[PA] [B vs D] [EDS]
prednisone tabs	1	[PA] [B vs D] [EDS]
prednisone tab pack	1	[EDS]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
desmopressin acetate nasal	4	[EDS]
desmopressin acetate oral	2	[EDS]
GENOTROPIN INJ	5	[PA]
GENOTROPIN MINIQUICK INJ 0.2MG, 0.4MG, 0.6MG & 0.8MG	4	[PA] [EDS]
GENOTROPIN MINIQUICK INJ 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG & 2MG	5	[PA]
HUMATROPE INJ CARTRIDGE 6MG	4	[PA] [EDS]
HUMATROPE INJ CARTRIDGE 12MG & 24MG	5	[PA]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
INCRELEX INJ	5	[PA]
LUPRON DEPOT-PED (6-MONTH) INJ	5	[PA]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
Androgens		
danazol	4	[EDS]
testosterone cypionate inj	2	[EDS]
testosterone enanthate inj	2	[EDS]
testosterone gel 1% & 1.62%	3	[EDS]
testosterone gel 25mg/2.5g, 20.25mg/1.25g, 40.5mg/2.5g & 50mg/5g	3	[EDS]
Estrogens		
altavera	2	[EDS]
alyacen 1/35	2	[EDS]
apri	2	[EDS]
aranelle	2	[EDS]
aubra eq	2	[EDS]
aviane	2	[EDS]
azurette	2	[EDS]
blisovi fe 1.5/30	2	[EDS]
briellyn	2	[EDS]
cyred eq	2	[EDS]
desogestrel & ethinyl estradiol	2	[EDS]
dotti	2	[EDS]
drospirenone & ethinyl estradiol 3mg/0.02mg	2	[EDS]
eluryng	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	**Nivel**	**Requisitos/ Límites**
enilloring	3	[EDS]
enpresse-28	2	[EDS]
enskyce	2	[EDS]
estarylla	2	[EDS]
estradiol oral	2	[EDS]
estradiol patches	2	[EDS]
estradiol vaginal cream	2	[EDS]
estradiol vaginal tabs	2	[EDS]
estradiol & norethindrone acetate 0.5mg/0.1mg & 1mg/0.5mg	2	[EDS]
ESTRING	3	[EDS]
ethinyl estradiol & ethynodiol	2	[EDS]
ethinyl estradiol & norethindrone acetate 5mcg/1mg & 2.5mcg-0.5mg	2	[EDS]
etonogestrel & ethinyl estradiol ring	3	[EDS]
falmina	2	[EDS]
fyavolv	2	[EDS]
haloette	3	[EDS]
IMVEXXY PACK	3	[EDS]
introvale	2	[EDS]
isibloom	2	[EDS]
jasmiel	2	[EDS]
jinteli	2	[EDS]
juleber	2	[EDS]
junel 21 day	2	[EDS]
junel fe 1/20	2	[EDS]
kariva	2	[EDS]
kelnor 1/35 & 1/50	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	**Nivel**	**Requisitos/ Límites**
kurvelo	2	[EDS]
larin	2	[EDS]
larin fe	2	[EDS]
leena	2	[EDS]
levonest	2	[EDS]
levonorgestrel & ethinyl estradiol 0.1-0.02mg & 0.15-0.03mg & triphasic packs	2	[EDS]
levonorgestrel & ethinyl estradiol and ethinyl estradiol 0.1/0.02mg-0.01mg packs	2	[EDS]
levora	2	[EDS]
loryna	2	[EDS]
low-ogestrel	2	[EDS]
lyllana	2	[EDS]
marlissa 28 day	2	[EDS]
microgestin 1/20 & 1.5/30	2	[EDS]
microgestin fe 1/20 & 1.5/30	2	[EDS]
mili	2	[EDS]
mimvey	2	[EDS]
necon	2	[EDS]
nikki	2	[EDS]
norelgestromin/ethinyl estradiol patch	3	[EDS]
norethindrone, ethinyl estradiol, ferrous fumarate 0.4mg/0.035mg	2	[EDS]
norethindrone, ethinyl estradiol, ferrous fumarate 20mcg/75mg/1mg	2	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
norgestimate-ethinyl estradiol	2	[EDS]
nylia 7/7/7 & 1/35	2	[EDS]
pimtrea	2	[EDS]
PREMARIN ORAL	3	[EDS]
PREMARIN VAGINAL CREAM	3	[EDS]
PREMPHASE	3	[EDS]
PREMPRO	3	[EDS]
reclipsen	2	[EDS]
setlakin	2	[EDS]
tarina fe 1/20 eq	2	[EDS]
tri-estarylla	2	[EDS]
tri-lo-estarylla	2	[EDS]
tri-lo-sprintec	2	[EDS]
tri-mili	2	[EDS]
tri-sprintec	2	[EDS]
tri-vylibra	2	[EDS]
tri-vylibra lo	2	[EDS]
trivora-28	2	[EDS]
turqoz	2	[EDS]
velivet	2	[EDS]
vestura	2	[EDS]
vienva	2	[EDS]
vyfemla	2	[EDS]
vylibra	2	[EDS]
wymzya fe	2	[EDS]
xulane	3	[EDS]
yuvafem	2	[EDS]
zafemy	3	[EDS]
zovia	2	[EDS]
Progestins		
deblitane	2	[EDS]
DEPO-SUBQ PROVERA 104 INJ	3	[EDS]
gallifrey	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
heather tabs	2	[EDS]
incassia	2	[EDS]
LILETTA	3	[EDS]
lyleq	2	[EDS]
lyza	2	[EDS]
medroxyprogesterone acetate inj	2	[EDS]
medroxyprogesterone acetate tabs	2	[EDS]
megestrol acetate oral susp 40mg/ml	2	[EDS]
megestrol tabs	2	[EDS]
NEXPLANON	3	[EDS]
norethindrone	2	[EDS]
progesterone caps	2	[EDS]
sharobel	2	[EDS]
Selective Estrogen Receptor Modifying Agents		
DUAVEE	3	[EDS]
raloxifene hcl	3	[EDS]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
CYTOMEL	3	[EDS]
levothyroxine tabs	1	[EDS]
levoxyl	1	[EDS]
liothyronine tabs	2	[EDS]
SYNTHROID	3	[EDS]
unithroid	1	[EDS]
HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)		
Hormonal Agents, Suppressant (Adrenal or Pituitary)		
cabergoline	2	[EDS]
ELIGARD INJ	4	[PA] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
leuprolide acetate inj kit 1mg/0.2ml	4	[PA] [EDS]
LUPRON DEPOT INJ	5	[PA]
LUPRON DEPOT-PED (1-MONTH & 3-MONTH) INJ	5	[PA]
mifepristone tabs 300mg	5	[PA]
octreotide inj 50mcg/ml, 100mcg/ml, 200mcg/ml & 500mcg/ml	4	[PA] [EDS]
octreotide inj 1000mcg/ml	5	[PA]
ORGOVYX	5	[PA] [LD]
SIGNIFOR INJ	5	[PA]
SOMAVERT INJ	5	[PA]
SYNAREL	4	[EDS]
TRELSTAR MIXJECT INJ	4	[PA] [EDS]
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
Antithyroid Agents		
methimazole	2	[EDS]
propylthiouracil	2	[EDS]
IMMUNOLOGICAL AGENTS		
Angioedema Agents		
CINRYZE INJ	5	[PA]
icatibant inj	5	[PA] [QL]
sajazir inj	5	[PA]
Immunoglobulins		
GAMMAGARD INJ	5	[PA] [B vs D]
GAMUNEX-C INJ	5	[PA] [B vs D]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Immunological Agents, Other		
ARCALYST INJ	5	[PA]
BENLYSTA INJ	5	[PA]
COSENTYX INJ	5	[PA] [QL]
COSENTYX SENSOREADY PEN INJ	5	[PA] [QL]
COSENTYX UNOREADY PEN INJ	5	[PA] [QL]
DUPIXENT INJ	5	[PA] [QL]
ORENCIA INJ	5	[PA] [QL]
OTEZLA STARTER	5	[PA] [QL]
RIDAURA	5	
RINVOQ	5	[PA] [QL]
RINVOQ LQ	5	[PA] [QL]
SKYRIZI INJ	5	[PA] [QL]
STELARA INJ	5	[PA] [QL]
TREMFYA INJ	5	[PA] [QL]
XELJANZ	5	[PA] [QL]
XELJANZ XR	5	[PA] [QL]
XOLAIR INJ	5	[PA] [QL] [LD]
Immunostimulants		
ACTIMMUNE INJ	5	[PA]
BESREMI INJ	5	[PA] [LD]
PEGASYS VIAL INJ	5	[PA]
Immunosuppressants		
ASTAGRAF XL	4	[PA] [B vs D] [EDS]
AZASAN	4	[PA] [B vs D] [EDS]
azathioprine tabs 50mg	2	[PA] [B vs D] [EDS]
azathioprine tabs 75mg & 100mg	4	[PA] [B vs D] [EDS]
CELLCEPT CAPS	4	[PA] [B vs D] [EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
CELLCEPT ORAL SUSPENSION & TABS	5	[PA] [B vs D]
cyclosporine caps	3	[PA] [B vs D] [EDS]
cyclosporine modified	2	[PA] [B vs D] [EDS]
ENBREL INJ	5	[PA] [QL]
ENBREL MINI INJ	5	[PA] [QL]
ENBREL SURECLICK INJ	5	[PA] [QL]
ENVARSUS XR	4	[PA] [B vs D] [EDS]
everolimus 0.25mg	4	[PA] [B vs D] [EDS]
everolimus 0.5mg, 0.75mg & 1mg	5	[PA] [B vs D]
gengraf	2	[PA] [B vs D] [EDS]
HUMIRA INJ	5	[PA] [QL]
HUMIRA PEN-CD/UC/HS STARTER INJ	5	[PA] [QL]
HUMIRA PEN-PS/UV STARTER INJ	5	[PA] [QL]
HUMIRA PEN INJ	5	[PA] [QL]
IMURAN TABS	4	[PA] [B vs D] [EDS]
JYLAMVO SOLN	4	[EDS]
leflunomide	2	[QL] [EDS]
methotrexate inj 50mg/2ml	2	[EDS]
methotrexate oral	2	[EDS]
mycophenolate mofetil caps & tabs	2	[PA] [B vs D] [EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
mycophenolate mofetil oral susp	5	[PA] [B vs D]
mycophenolic acid dr	4	[PA] [B vs D] [EDS]
MYFORTIC	4	[PA] [B vs D] [EDS]
MYHIBBIN	4	[PA] [B vs D] [EDS]
NEORAL	4	[PA] [B vs D] [EDS]
PEGASYS SYRINGE INJ	5	[PA]
PROGRAF CAPS	4	[PA] [B vs D] [EDS]
PROGRAF PACK	4	[PA] [B vs D] [EDS]
RAPAMUNE TABS	4	[PA] [B vs D] [EDS]
SANDIMMUNE CAPS 25MG & 100MG	4	[PA] [B vs D] [EDS]
sirolimus soln	5	[PA] [B vs D]
sirolimus tabs	4	[PA] [B vs D] [EDS]
tacrolimus caps 0.5mg & 1mg	3	[PA] [B vs D] [EDS]
tacrolimus caps 5mg	4	[PA] [B vs D] [EDS]
Vaccines		
ABRYSVO INJ	3	[EDS]
ACTHIB INJ	3	[EDS]
ADACEL INJ	3	[EDS]
AREXVY INJ	3	[EDS]
BCG INJ	3	[EDS]
BEXSERO INJ	3	[EDS]
BOOSTRIX INJ	3	[EDS]
DAPTACEL INJ	3	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
ENGERIX-B INJ	3	[PA] [B vs D] [EDS]
GARDASIL 9 INJ	4	[EDS]
HAVRIX INJ	3	[EDS]
HEPLISAV-B INJ	3	[PA] [B vs D] [EDS]
HIBERIX INJ	3	[EDS]
IMOVAX RABIES INJ	3	[EDS]
INFANRIX INJ	3	[EDS]
IPOL INACTIVATED IPV INJ	3	[EDS]
IXCHIQ INJ	3	[EDS]
IXIARO INJ	4	[EDS]
JYNNEOS INJ	3	[PA] [B vs D] [EDS]
KINRIX INJ	3	[EDS]
MENACTRA INJ	3	[EDS]
MENQUADFI INJ	3	[EDS]
MENVEO-A/C/Y/W-135 INJ	3	[EDS]
MRESVIA INJ	3	[EDS]
M-M-R II INJ	3	[EDS]
PEDIARIX INJ	3	[EDS]
PEDVAX HIB INJ	3	[EDS]
PENBRAYA INJ	3	[EDS]
PENTACEL INJ	3	[EDS]
PRIORIX INJ	3	[EDS]
PROQUAD INJ	3	[EDS]
QUADRACEL INJ	3	[EDS]
RABAVERT INJ	3	[EDS]
RECOMBIVAX HB INJ	3	[PA] [B vs D] [EDS]
ROTARIX	3	[EDS]
ROTATEQ	3	[EDS]
SHINGRIX INJ	3	[EDS]
TENIVAC INJ	3	[EDS]
TICOVAC INJ	4	[EDS]
TRUMENBA INJ	3	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
TWINRIX INJ	3	[EDS]
TYPHIM VI INJ	3	[EDS]
VAQTA INJ	3	[EDS]
VARIVAX INJ	3	[EDS]
VAXCHORA INJ	3	[EDS]
YF-VAX INJ	3	[EDS]
INFLAMMATORY BOWEL DISEASE AGENTS		
Aminosalicylates		
balsalazide	3	[EDS]
mesalamine dr	4	[EDS]
mesalamine enema	4	[EDS]
mesalamine er caps	4	[QL] [EDS]
mesalamine rectal suppository	4	[EDS]
sulfasalazine	2	[EDS]
Glucocorticoids		
budesonide ec caps	4	[PA] [EDS]
budesonide er tabs 9mg	5	[PA]
hydrocortisone cream 2.5%	2	[EDS]
hydrocortisone enema	2	[EDS]
procto-med hc	2	[EDS]
proctosol hc	2	[EDS]
proctozone-hc	2	[EDS]
METABOLIC BONE DISEASE AGENTS		
Metabolic Bone Disease Agents		
alendronate tabs	1	[EDS]
calcitonin-salmon nasal	2	[EDS]
calcitriol caps	2	[PA] [B vs D] [EDS]
cinacalcet tab 30mg & 60mg	4	[PA] [B vs D] [EDS]
cinacalcet tab 90mg	5	[PA] [B vs D]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
doxercalciferol oral	4	[PA] [B vs D] [EDS]
ibandronate oral	2	[EDS]
paricalcitol caps	3	[PA] [B vs D] [EDS]
PROLIA INJ	4	[PA] [EDS]
RAYALDEE	5	
risedronate sodium	3	[EDS]
risedronate sodium dr	3	[EDS]
TERIPARATIDE INJ	5	[PA]
TYMLOS INJ	5	[PA]
XGEVA INJ	5	[PA]
MISCELLANEOUS THERAPEUTIC AGENTS		
Miscellaneous Therapeutic Agents		
alcohol pads	2	[PA] [EDS]
bd insulin syringe ultrafine	2	[PA] [EDS]
bd insulin syringe safetyglide	2	[PA] [EDS]
bd pen needle ultrafine	2	[PA] [EDS]
gauze pads 2"x2"	2	[PA] [EDS]
INTRALIPID INJ	4	[PA] [B vs D] [EDS]
levocarnitine oral	2	[PA] [B vs D] [EDS]
sodium chloride irrigation soln	2	[EDS]
OPHTHALMIC AGENTS		
Ophthalmic Agents, Other		
atropine sulfate soln	2	[EDS]
bacitracin & polymyxin b ointment	2	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
brimonidine & timolol maleate	4	[EDS]
cyclosporine emulsion 0.05%	3	[EDS]
CYSTARAN	5	
dorzolamide & timolol maleate	2	[EDS]
neomycin & polymyxin & bacitracin	2	[EDS]
neomycin & polymyxin & bacitracin & hydrocortisone	2	[EDS]
neomycin & polymyxin & dexamethasone	2	[EDS]
neomycin & polymyxin & gramicidin ophthalmic	2	[EDS]
neomycin & polymyxin & hydrocortisone	2	[EDS]
neo-polycin ophthalmic ointment	2	[EDS]
neo-polycin hc ophthalmic ointment	2	[EDS]
polycin ophthalmic ointment	2	[EDS]
polymyxin b sulfate & trimethoprim sulfate ophthalmic soln	2	[EDS]
ROCKLATAN	3	[EDS]
SIMBRINZA	4	[EDS]

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Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
sulfacetamide sodium & prednisolone sodium phosphate ophthalmic	2	[EDS]
TOBRADEX OINT	3	[EDS]
tobramycin & dexamethasone ophthalmic suspension	2	[EDS]
XIIDRA	3	[EDS]
Ophthalmic Anti-allergy Agents		
azelastine 0.05%	2	[EDS]
cromolyn sodium ophthalmic soln	2	[EDS]
Ophthalmic Anti-infectives		
AZASITE	3	[EDS]
bacitracin ophthalmic ointment	2	[EDS]
ciprofloxacin ophthalmic soln 0.3%	2	[EDS]
erythromycin ophthalmic oint	2	[EDS]
gentamicin ophthalmic soln 0.3%	2	[EDS]
moxifloxacin hcl ophthalmic	2	[EDS]
ofloxacin ophthalmic	2	[EDS]
sulfacetamide sodium ophthalmic oint & soln 10%	2	[EDS]
tobramycin ophthalmic solution	2	[EDS]
trifluridine	2	[EDS]
XDEMVY	5	[PA] [QL]
ZIRGAN	4	[EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Ophthalmic Anti-inflammatories		
bromfenac ophthalmic soln 0.07% & 0.075%	4	[EDS]
bromfenac ophthalmic soln 0.09%	3	[EDS]
dexamethasone ophthalmic soln	2	[EDS]
diclofenac sodium ophthalmic soln 0.1%	2	[EDS]
difluprednate	3	[EDS]
fluorometholone	2	[EDS]
ketorolac soln	2	[EDS]
LOTEMAX OINT	4	[EDS]
LOTEMAX SM GEL 0.38%	4	[EDS]
PRED MILD	3	[EDS]
prednisolone acetate	2	[EDS]
prednisolone sodium phosphate	2	[EDS]
Ophthalmic Beta-Adrenergic Blocking Agents		
betaxolol soln	2	[EDS]
carteolol	1	[EDS]
levobunolol	2	[EDS]
timolol hemihydrate	4	[EDS]
timolol ophthalmic gel forming	2	[EDS]
timolol ophth soln 12 hours 0.25% & 0.5% multi-use bottles	1	[EDS]
Ophthalmic Intraocular Pressure Lowering Agents, Other		
acetazolamide tabs	2	[EDS]
acetazolamide er caps	2	[EDS]

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brimonidine tartrate soln 0.15% & 0.1%	4	[EDS]
brimonidine tartrate soln 0.2%	2	[EDS]
dorzolamide	2	[EDS]
methazolamide	4	[EDS]
pilocarpine soln	2	[EDS]
RHOPRESSA	3	[EDS]
Ophthalmic Prostaglandin and Prostamide Analogs		
latanoprost	1	[EDS]
LUMIGAN	3	[EDS]
travoprost	3	[EDS]
VYZULTA	4	[EDS]
OTIC AGENTS		
Otic Agents		
acetic acid & hydrocortisone	2	[EDS]
CIPRO HC	4	[EDS]
ciprofloxacin & dexamethasone otic susp	4	[EDS]
fluocinolone acetonide otic soln	3	[EDS]
neomycin & polymyxin & hydrocortisone	2	[EDS]
ofloxacin otic	2	[EDS]
RESPIRATORY TRACT/PULMONARY AGENTS		
Antihistamines		
azelastine nasal 0.1%	2	[EDS]
cyproheptadine	4	[EDS]
desloratadine tabs	2	[EDS]
hydroxyzine hcl tabs	4	[PA] [EDS]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
hydroxyzine pamoate caps	4	[PA] [EDS]
levocetirizine	2	[EDS]
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA	3	[EDS]
ASMANEX HFA	3	[EDS]
ASMANEX TWISTHALER	3	[EDS]
budesonide nebulizer	4	[PA] [B vs D] [EDS]
flunisolide nasal	2	[QL] [EDS]
fluticasone propionate nasal	2	[QL] [EDS]
mometasone furoate nasal	3	[QL] [EDS]
PULMICORT NEBULIZER	4	[PA] [B vs D] [EDS]
QVAR REDIHALER	3	[EDS]
Antileukotrienes		
montelukast	2	[EDS]
zafirlukast	2	[QL] [EDS]
Bronchodilators, Anticholinergic		
ATROVENT HFA	3	[QL] [EDS]
ipratropium bromide nasal	2	[QL] [EDS]
ipratropium bromide nebulizer	2	[PA] [B vs D] [EDS]
SPIRIVA RESPIMAT	3	[QL] [EDS]
YUPELRI	5	[PA] [B vs D]
Bronchodilators, Sympathomimetic		
albuterol sulfate hfa 6.7gm inhaler	2	[QL] [EDS]
albuterol sulfate hfa 8.5gm inhaler	2	[QL] [EDS]
albuterol sulfate nebulizer	2	[PA] [B vs D] [EDS]

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[LD] = Limited Distribution [EDS] = Extended Day Supply
You can find information on what the symbols and abbreviations on this table mean by going to page 12
[PA] = Autorización Previa [B vs D] = B versus D [QL] = Límite de Cantidad
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Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla en la página 25

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
albuterol sulfate syrup	2	[EDS]
albuterol sulfate tabs	4	[EDS]
arformoterol tartrate nebulizer	4	[PA] [B vs D] [EDS]
BROVANA NEBULIZER	4	[PA] [B vs D] [EDS]
EPINEPHRINE AUTO-INJECTOR 0.15MG/0.3ML & 0.3MG/0.3ML	3	[EDS]
formoterol fumarate nebulizer	4	[PA] [B vs D] [EDS]
levalbuterol nebulizer	2	[PA] [B vs D] [EDS]
LEVALBUTEROL TARTRATE HFA	4	[EDS]
PERFOROMIST NEBULIZER	5	[PA] [B vs D]
PROAIR RESPICLICK	3	[EDS]
SEREVENT DISKUS	3	[EDS]
STRIVERDI RESPIMAT	3	[EDS]
terbutaline sulfate oral	4	[EDS]
Cystic Fibrosis Agents		
BETHKIS	5	[PA] [B vs D]
CAYSTON	5	[PA] [LD]
KALYDECO	5	[PA]
KITABIS NEBULIZER	5	[PA] [B vs D]
ORKAMBI	5	[PA]
PULMOZYME	5	[PA] [B vs D]
TOBI SOLN	5	[PA] [B vs D]
TOBI PODHALER	5	
tobramycin nebulizer	5	[PA] [B vs D]

Drug Name Nombre del Medicamento	Drug Tier Nivel	Requirements/ Limits Requisitos/ Límites
Mast Cell Stabilizers		
cromolyn sodium nebulizer soln	3	[PA] [B vs D] [EDS]
Phosphodiesterase Inhibitors, Airways Disease		
OHTUVAYRE NEBULIZER	5	[PA] [B vs D]
roflumilast tabs	3	[EDS]
theophylline er tabs	4	[EDS]
Pulmonary Antihypertensives		
ADEMPAS	5	[PA] [LD]
alyq	5	[PA]
ambrisentan	5	[PA] [LD]
bosentan tabs 62.5mg & 125mg	5	[PA] [LD]
OPSUMIT	5	[PA] [LD]
sildenafil tab 20mg	3	[PA] [EDS]
tadalafil tab 20mg	5	[PA]
TRACLEER 32MG	5	[PA] [LD]
UPTRAVI	5	[PA]
Pulmonary Fibrosis Agents		
OFEV	5	[PA] [QL]
pirfenidone	5	[PA] [QL]
Respiratory Tract Agents, Other		
acetylcysteine nebulizer soln	2	[PA] [B vs D] [EDS]
ADVAIR HFA	3	[EDS]
ANORO ELLIPTA	3	[EDS]
BEVESPI AEROSPHERE	3	[EDS]
BREO ELLIPTA	3	[EDS]
breyna	4	[QL] [EDS]
BREZTRI AEROSPHERE	3	[QL] [EDS]
budesonide-formoterol fumarate dihydrate	4	[QL] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	**Nivel**	**Requisitos/ Límites**
COMBIVENT RESPIMAT	3	[QL] [EDS]
DULERA	3	[EDS]
FASENRA INJ	5	[PA] [QL]
fluticasone propionate/salmeterol diskus 100mcg-50mcg, 250mcg-50mcg & 500mcg-50mcg	3	[QL] [EDS]
ipratropium bromide & albuterol sulfate nebulizer	2	[PA] [B vs D] [EDS]
STIOLTO RESPIMAT	3	[EDS]
TRELEGY ELLIPTA	3	[QL] [EDS]
wixela inhub	3	[QL] [EDS]
SKELETAL MUSCLE RELAXANTS		
Skeletal Muscle Relaxants		
carisoprodol tabs 350mg	2	[EDS]
chlorzoxazone tabs 500mg	2	[EDS]
cyclobenzaprine hcl ir	2	[PA] [EDS]
methocarbamol tabs 500mg & 750mg	2	[EDS]
SLEEP DISORDER AGENTS		
Sleep Promoting Agents		
ramelteon	3	[QL] [EDS]
tasimelteon caps	5	[PA]
temazepam caps	4	[PA] [EDS]
zolpidem ir tabs 5mg & 10mg	2	[EDS]
Wakefulness Promoting Agents		
armodafinil	3	[PA] [EDS]
modafinil	3	[PA] [EDS]
XYWAV	5	[PA] [LD]

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Additional Covered Drugs

Your plan has additional coverage for the prescription drugs listed below if you are enrolled in one of these plans:

- **SCAN Classic (HMO):** Maricopa, Pima, Pinal Counties
- **SCAN Venture (HMO):** Maricopa, Pima, Pinal Counties
- **SCAN MyChoice (HMO):** Maricopa, Pima, Pinal Counties

These prescription drugs are not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your out of pocket drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs.

Drug Name	Drug Tier	Requirements/Limits
Nombre del medicamento	**Nivel**	**Requisitos/limitaciones**
ERECTILE DYSFUNCTION		
sildenafil tabs 25mg, 50mg, 100mg (generic for Viagra)	1	[QL] (4 tablets per 30-day supply with a maximum of 49 tablets per year)
PRESCRIPTION VITAMINS		
cyanocobalamin inj 1000 mcg/ml (vitamin B12)	1	
ergocalciferol caps 1.25mg (50,000 units) (vitamin D2)	1	
folic acid tabs 1 mg (vitamin B9)	1	

Medicamentos adicionales cubiertos

Su plan tiene cobertura adicional para los medicamentos con receta que se enumeran a continuación si está inscrito/a en uno de estos planes:

- **SCAN Classic (HMO):** Condados de Maricopa, Pima y Pinal
- **SCAN Venture (HMO):** Condados de Maricopa, Pima y Pinal
- **SCAN MyChoice (HMO):** Condados de Maricopa, Pima y Pinal

Estos medicamentos con receta normalmente no están cubiertos en un plan de medicamentos con receta de Medicare. El monto que paga cuando surte una receta para estos medicamentos no cuenta para el costo de sus medicamentos que paga de bolsillo (es decir, el monto que paga no le ayuda a calificar para la cobertura catastrófica). Además de esto, si recibe ayuda adicional para pagar sus medicamentos con receta, no recibirá ayuda adicional para pagar estos medicamentos.

Nombre del medicamento	Nivel del medicamento	Requisitos/limitaciones
DISFUNCIÓN ERÉCTIL		
sildenafilo, comprimidos de 25 mg, 50 mg, 100 mg (genérico de Viagra)	1	[QL] (4 comprimidos por suministro para 30 días con un máximo de 49 comprimidos por año)
VITAMINAS CON RECETA		
cianocobalamina, inyectable de 1000 mcg/ml (vitamina B12)	1	
ergocalciferol, cápsulas de 1.25 mg (50,000 unidades) (vitamina D2)	1	
ácido fólico, comprimidos de 1 mg (vitamina B9)	1	

Drugs with Quantity Limits Medicamentos con Límites de Cantidad	
Drug Name Nombre del Medicamento	**Quantity Limits Límites de Cantidad**
acetaminophen & codeine #2 & #3 tabs	360 tabs per 30 days
acetaminophen & codeine #4 tabs	180 tabs per 30 days
acetaminophen & codeine elixir	5000ml per 30 days
acyclovir cream	5gm per 30 days
acyclovir ointment	30gm per 30 days
albuterol sulfate hfa 6.7gm inhaler	13.4gm per 30 days
albuterol sulfate hfa 8.5gm inhaler	17gm per 30 days
alprazolam ir tabs	0.25mg, 0.5mg & 1mg: 120 tabs per 30 days; 2mg: 150 tabs per 30 days
amphetamine & dextroamphetamine	60 tabs per 30 days
ATROVENT HFA	2 inhalers per 30 days
AUSTEDO	6mg: 60 tabs per 30 days; 9mg & 12mg: 120 tabs per 30 days
AUSTEDO XR 18MG, 30MG, 36MG, 42MG & 48MG	18mg: 60 tabs per 30 days; 30mg, 36mg, 42mg & 48mg: 30 tabs per 30 days
AUSTEDO XR 6MG, 12MG & 24MG	6mg & 12mg: 90 tabs per 30 days; 24mg: 60 tabs per 30 days
AUSTEDO XR PATIENT TITRATION KIT	1 pack per 28 days
breyna	10.3gm per 30 days
BREZTRI AEROSPHERE	10.7gm per 30 days
budesonide-formoterol fumarate dihydrate	10.20gm per 30 days
butorphanol tartrate nasal	4 bottles per 30 days
calcipotriene cream	60gm: 2 tubes per 30 days; 120gm: 1 tube per 30 days
calcipotriene oint	60gm: 2 tubes per 30 days
colchicine tabs	120 tabs per 30 days
COMBIVENT RESPIMAT	8gm per 30 days
COSENTYX INJ	150mg/mL: 10mL per 28 days; 75mg/0.5mL: 2.5mL per 28 days
COSENTYX SENSOREADY PEN INJ	10mL per 28 days
COSENTYX UNOREADY PEN INJ	10mL per 28 days
dabigatran etexilate	60 caps per 30 days
desonide lotion, oint & cream	cream & oint: 120gm per 30 days lotion: 118ml per 30 days
desoximetasone topical cream & oint 0.25%	120gm per 30 days
desoximetasone topical cream, gel & oint 0.05%	120gm per 30 days

Drugs with Quantity Limits Medicamentos con Límites de Cantidad	
Drug Name Nombre del Medicamento	**Quantity Limits Límites de Cantidad**
dextroamphetamine sulfate	5mg: 120 tabs per 30 days; 10mg: 180 tabs per 30 days
dextroamphetamine sulfate er	5mg: 30 caps per 30 days; 10mg & 15mg: 120 caps per 30 days
diclofenac sodium soln 1.5%	450mL per 28 days
diclofenac sodium soln 2%	224gm per 28 days
dihydroergotamine mesylate nasal	8mL per 30 days
DUPIXENT INJ	100mg/0.67mL: 1.34mL per 28 days; 200mg/1.14mL: 3.42mL per 28 days; 300mg/2mL pen: 8mL per 28 days; 300mg/2mL syringe: 8mL per 28 days
ELIQUIS STARTER PACK & TABS	Starter pack: 74 tabs per 180 days; tabs: 60 tabs per 30 days
ENBREL INJ	8 mL per 28 days
ENBREL MINI INJ	8 mL per 28 days
ENBREL SURECLICK INJ	8 mL per 28 days
endocet tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg	2.5-325mg & 5-325mg: 360 tabs per 30 days; 7.5-325mg: 240 tabs per 30 days; 10-325mg: 180 tabs per 30 days
ENTRESTO TABS	60 tabs per 30 days
FARXIGA	30 tabs per 30 days
FASENRA INJ	30mg/mL: 1mL per 28 days; 10mg/0.5mL: 1.50mL per 28 days
fentanyl patches	15 patches per 30 days
flunisolide nasal	2 bottles per 30 days
fluocinonide cream, gel & ointment	15gm: 4 tubes per 30 days; 30gm: 2 tubes per 30 days; 60g: 1 tube per 30 days
fluticasone propionate nasal	2 bottles per 30 days
fluticasone propionate/salmeterol diskus 100mcg-50mcg, 250mcg-50mcg & 500mcg-50mcg	60 blisters per 30 days
galantamine er caps	30 caps per 30 days
galantamine soln	200mL per 30 days
galantamine tabs	60 tabs per 30 days
glimepiride & pioglitazone	30 tabs per 30 days
GLYXAMBI	30 tabs per 30 days

Drugs with Quantity Limits Medicamentos con Límites de Cantidad	
Drug Name Nombre del Medicamento	**Quantity Limits Límites de Cantidad**
HUMIRA INJ	40mg/0.4mL & 40mg/0.8mL: 4 inj per 28 days; 10mg/0.1mL & 20mg/0.2mL: 2 inj per 28 days
HUMIRA PEN INJ	40mg/0.4mL & 40mg/0.8mL: 4 pens per 28 days; 80mg/0.8mL: 2 pens per 28 days
HUMIRA PEN-CD/UC/HS STARTER INJ	3 pens per 180 days
HUMIRA PEN-PS/UV STARTER INJ	3 pens per 180 days
hydrocodone & acetaminophen soln 7.5-325mg/15ml	5500ml per 30 days
hydrocodone &acetaminophen soln 10-325mg/15ml	5500ml per 30 days
hydrocodone & acetaminophen tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg	2.5-325mg & 5-325mg: 360 tabs per 30 days; 7.5-325mg & 10-325mg: 180 tabs per 30 days
hydrocodone & ibuprofen tabs 7.5-200mg	150 tabs per 30 days
icatibant inj	18mL per 30 days
ipratropium bromide nasal	1 bottle per 30 days
JANUMET	60 tabs per 30 days
JANUMET XR	60 tabs per 30 days
JANUVIA	30 tabs per 30 days
JARDIANCE	30 tabs per 30 days
JENTADUETO	60 tabs per 30 days
JENTADUETO XR	2.5-1000mg: 60 tabs per 30 days; 5-1000mg: 30 tabs per 30 days
leflunomide	30 tabs per 30 days
lidocaine & prilocaine	30gm: 1 tube per 30 days
lidocaine ointment	1 tube per 30 days
lidocaine topical soln	1 bottle per 30 days
LIVTENCITY	120 tabs per 30 days
mesalamine er caps	375mg: 120 caps per 30 days; 500mg: 240 caps per 30 days
mometasone furoate nasal	3 bottles per 30 days
morphine sulfate er tabs	120 tabs per 30 days
MOUNJARO INJ	2mL per 30 days
mupirocin cream	30gm per 30 days
naratriptan	8 tabs per 30 days
NEUPRO PATCH	30 patches per 30 days
niacin er tabs	60 caps per 30 days
OFEV	60 caps per 30 days
ORENCIA INJ	125mg/mL: 4.00mL per 28 days; 50mg/0.4mL: 1.60mL per 28 days; 87.5mg/0.7mL: 2.80mL per 28 days
OTEZLA	60 tabs per 30 days

Drugs with Quantity Limits Medicamentos con Límites de Cantidad	
Drug Name Nombre del Medicamento	**Quantity Limits Límites de Cantidad**
OTEZLA STARTER	55 tabs per 180 days
oxycodone & acetaminophen tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg	2.5-325mg & 5-325mg: 360 tabs per 30 days; 7.5-325mg: 240 tabs per 30 days; 10-325mg: 180 tabs per 30 days
OZEMPIC INJ	3mL per 30 days
pimecrolimus	30gm: 3 tubes per 30 days
pirfenidone	267mg: 270 tabs/caps per 30 days; 534mg & 801mg: 90 tabs per 30 days
PREVYMIS	Tabs: 30 tabs per 30 days; Pellets: 120 packs per 30 days
PROMACTA	12.5mg & 25mg: 30 tabs per 30 days; 50mg & 75mg: 60 tabs per 30 days; oral susp: 180 packets per 30 days
ramelteon	30 tabs per 30 days
REGRANEX	2 tubes per 30 days
RINVOQ	15mg & 30mg: 30 tabs per 30 days; 45mg: 84 tabs per 180 days
RINVOQ LQ	360ml per 30 days
rivastigmine caps	60 caps per 30 days
rivastigmine patches	30 patches per 30 days
RYBELSUS	30 tabs per 30 days
SANTYL	90gm per 30 days
SKYRIZI INJ	150mg/mL: 2mL per 28 days; 360mg/2.4ml: 2.4mL per 56 days; 180mg/1.2ml: 1.20mL per 56 days
SPIRIVA RESPIMAT	4gm per 30 days
STELARA INJ	45mg/0.5mL: 0.50mL per 28 days; 90mg/mL: 1mL per 28 days
SYNJARDY	60 tabs per 30 days
SYNJARDY XR	5-1000mg & 12.5-1000mg: 60 tabs per 30 days; 10-1000mg & 25-1000mg: 30 tabs per 30 days
tacrolimus oint	100g per 30days
tadalafil 2.5mg & 5mg	2.5mg: 60 tabs per 30 days; 5mg: 30 tabs per 30 days
tazarotene gel	30gm: 3 tubes per 30 days; 100gm: 1 tube per 30 days
tetrabenazine	12.5mg: 240 tabs per 30 days; 25mg: 120 tabs per 30 days
tolterodine tartrate er	30 caps per 30 days
TRADJENTA	30 tabs per 30 days

Drugs with Quantity Limits Medicamentos con Límites de Cantidad	
Drug Name Nombre del Medicamento	**Quantity Limits Límites de Cantidad**
tramadol & acetaminophen tabs 37.5-325mg	240 tabs per 30 days
tramadol er tabs	30 tabs per 30 days
tramadol ir tab 100mg	120 tabs per 30 days
TRELEGY ELLIPTA	60 blisters per 30 days
TREMFYA INJ	2mL per 28 days
TRIJARDY XR	5-2.5-1000mg & 12.5-2.5-1000mg: 60 tabs per 30 days; 25-5-1000mg & 10-5-1000mg: 30 tabs per 30 days
TRULICITY INJ	2mL per 30 days
wixela inhub	60 blisters per 30 days
XARELTO ORAL SUSP & TABS	oral susp: 775mL per 30 days; 2.5mg: 60 tabs per 30 days; 10mg, 15mg & 20mg: 30 tabs per 30 days
XARELTO STARTER PACK	51 tabs per 180 days
XDEMVY	10mL per 42 days
XELJANZ	tabs: 60 tabs per 30 days; soln: 300mL per 30 days
XELJANZ XR	30 tabs per 30 days
XIGDUO XR	5-500mg, 5-1000mg & 2.5-1000mg: 60 tabs per 30 days; 10-500mg & 10-1000mg: 30 tabs per 30 days
XOLAIR INJ	150mg/mL & 300mg/2mL: 8mL per 28 days; 75mg/0.5mL: 1mL per 28 days
zafirlukast	60 tabs per 30 days
zenzedi	5mg: 120 tabs per 30 days 10mg: 180 tabs per 30 days
zolmitriptan	2.5mg: 12 tabs per 30 days 5mg: 6 tabs per 30 days

INDEX
ÍNDICE

abacavir & lamivudine, 39
abacavir soln & tabs, 39
ABELCET INJ, 32
ABILIFY ASIMTUFII INJ, 37
ABILIFY MAINTENA INJ, 37
abiraterone acetate, 34
ABRYSVO INJ, 55
acamprosate calcium dr, 27
acarbose, 40
accutane, 46
acebutolol, 43
acetaminophen & codeine, 26, 64
acetazolamide er caps, 58
acetazolamide tabs, 58
acetic acid & hydrocortisone, 59
acetylcysteine nebulizer soln, 60
acitretin, 46
ACTHIB INJ, 55
ACTIMMUNE INJ, 54
acyclovir caps & tabs, 38
acyclovir cream, 64
acyclovir cream & oint 5%, 47
acyclovir inj, 38
acyclovir ointment, 64
acyclovir oral susp, 38
ADACEL INJ, 55
adapalene cream 0.1%, 46
adapalene gel 0.3%, 46
adefovir dipivoxil, 38
ADEMPAS, 60
ADVAIR HFA, 60
AIMOVIG INJ, 33
AKEEGA, 34
albendazole, 36
albuterol sulfate hfa 6.7gm inhaler, 59, 64
albuterol sulfate hfa 8.5gm inhaler, 59, 64
albuterol sulfate nebulizer, 59
albuterol sulfate syrup, 60
albuterol sulfate tabs, 60
alclometasone dipropionate, 46
alcohol pads, 57
ALECENSA, 34
alendronate tabs, 56
alfuzosin hcl er, 50
aliskiren, 43
allopurinol tabs 100mg & 300mg, 33
alosetron hcl tab 0.5mg, 49
alosetron hcl tab 1mg, 49
alprazolam ir tabs, 40, 64
altavera, 51
ALTRENO, 46
ALUNBRIG, 34
ALUNBRIG INITIATION PACK, 34
alyacen 1/35, 51
alyq, 60
amantadine, 40
AMBISOME INJ, 32
ambrisentan, 60
amikacin inj, 27
amiloride, 44
amiloride & hydrochlorothiazide, 43
amiodarone tabs, 42
amitriptyline, 32
amlodipine, 43
amlodipine & valsartan & hydrochlorothiazide tabs, 43
amlodipine & atorvastatin, 43
amlodipine & benazepril, 43
ammonium lactate, 46
amnesteem caps, 46
amoxapine, 32
amoxicillin, 28

amoxicillin & clavulanate potassium chew tabs 400-57mg, 28
amoxicillin & clavulanate potassium er, 28
amoxicillin & clavulanate potassium oral susp & tabs, 28
amphetamine & dextroamphetamine, 64
amphetamine & dextroamphetamine tabs, 45
amphotericin b inj, 32
amphotericin b liposome inj, 32
ampicillin & sulbactam inj 10-5gm, 2-1gm & 1-0.5gm, 29
ampicillin inj, 29
ampicillin oral, 29
anagrelide, 42
anastrozole, 34
ANORO ELLIPTA, 60
apomorphine hydrochloride inj, 36
aprepitant caps 80mg & 125mg, 32
aprepitant pack, 32
apri, 51
APTIOM, 30
APTIVUS CAPS, 39
aranelle, 51
ARCALYST INJ, 54
AREXVY INJ, 55
arformoterol tartrate nebulizer, 60
ARIKAYCE, 27
aripiprazole odt 10mg, 37
aripiprazole odt 15mg, 37
aripiprazole soln, 37
aripiprazole tabs, 37
ARISTADA INITIO INJ, 37
ARISTADA INJ, 37
armodafinil, 61
ARNUITY ELLIPTA, 59
asenapine maleate sublinqual, 37
ASMANEX HFA, 59
ASMANEX TWISTHALER, 59
ASTAGRAF XL, 54
atazanavir sulfate caps, 39
atenolol, 43
atenolol & chlorthalidone, 43
atomoxetine, 45
atorvastatin, 44
atovaquone susp, 36
atovaquone/proguanil, 36
atropine sulfate soln, 57
ATROVENT HFA, 59, 64
aubra eq, 51
AUGTYRO, 34
AUSTEDO, 45, 64
AUSTEDO XR 18MG, 30MG, 36MG, 42MG & 48MG, 45, 64
AUSTEDO XR 6MG, 12MG & 24MG, 45, 64
AUSTEDO XR PATIENT TITRATION KIT, 45, 64
AUVELITY, 31
aviane, 51
AVONEX INJ, 45
AVONEX PEN INJ, 45
AYVAKIT, 34
AZASAN, 54
AZASITE, 58
azathioprine tabs 50mg, 54
azathioprine tabs 75mg & 100mg, 54
azelastine 0.05%, 58
azelastine nasal 0.1%, 59
azithromycin inj, 29
azithromycin tabs & oral susp bottle, 29
aztreonam inj, 28
azurette, 51
bacitracin & polymyxin b ointment, 57
bacitracin ophthalmic ointment, 58
baclofen tabs, 38
balsalazide, 56
BALVERSA, 34
BARACLUDE ORAL SOLN 0.05MG/ML, 38
BCG INJ, 55
bd insulin syringe safetyglide, 57
bd insulin syringe ultrafine, 57
bd pen needle ultrafine, 57
benazepril, 42
benazepril & hydrochlorothiazide, 43
BENLYSTA INJ, 54
benztropine tabs, 36

BESREMI INJ, 54
betaine anhydrous, 50
betamethasone dipropionate, 46
betamethasone dipropionate augmented, 46
betamethasone valerate cream, oint & lotion, 46
BETASERON INJ, 45
betaxolol soln, 58
bethanechol, 50
BETHKIS, 60
BEVESPI AEROSPHERE, 60
bexarotene, 36
BEXSERO INJ, 55
bicalutamide, 34
BICILLIN L-A INJ, 29
BIKTARVY, 38
bisoprolol, 43
bisoprolol & hydrochlorothiazide, 43
blisovi fe 1.5/30, 51
BOOSTRIX INJ, 55
bosentan tabs 62.5mg & 125mg, 60
BOSULIF, 34
BRAFTOVI, 34
BREO ELLIPTA, 60
breyna, 60, 64
BREZTRI AEROSPHERE, 60, 64
briellyn, 51
BRILINTA, 42
brimonidine & timolol maleate, 57
brimonidine tartrate soln 0.15% & 0.1%, 59
brimonidine tartrate soln 0.2%, 59
BRIVIACT ORAL SOLN, 30
BRIVIACT TABS, 30
bromfenac ophthalmic soln 0.07% & 0.075%, 58
bromfenac ophthalmic soln 0.09%, 58
bromocriptine, 36
BROVANA NEBULIZER, 60
BRUKINSA, 35
budesonide ec caps, 56
budesonide er tabs 9mg, 56
budesonide nebulizer, 59
budesonide-formoterol fumarate dihydrate, 60, 64
bumetanide inj, 44
bumetanide tabs, 44
buprenorphine & naloxone sublingual film, 27
buprenorphine & naloxone sublingual tabs, 27
buprenorphine sublingual tabs, 27
bupropion, 31
bupropion sr, 31
bupropion sr 150mg, 27
bupropion xl 150mg & 300mg, 31
bupropion xl 450mg, 31
buspirone, 40
butorphanol tartrate nasal, 26, 64
cabergoline, 53
CABOMETYX, 35
caffeine-ergotamine, 33
calcipotriene cream, 64
calcipotriene cream & oint, 47
calcipotriene oint, 64
calcipotriene soln, 47
calcitonin-salmon nasal, 56
calcitriol caps, 56
CALQUENCE, 35
candesartan, 42
CAPLYTA, 37
CAPRELSA, 35
captopril, 42
carbamazepine chewable tabs 100mg, 30
carbamazepine chewable tabs 200mg, 30
carbamazepine er tabs & caps, 31
carbamazepine tabs & oral susp, 30
carbidopa, 37
carbidopa & levodopa, 37
carbidopa & levodopa & entacapone, 36
carglumic acid, 48
carisoprodol tabs 350mg, 61

carteolol, 58
cartia xt, 43
carvedilol, 43
caspofungin inj, 32
CAYSTON, 60
cefaclor, 28
cefaclor er, 28
cefadroxil caps & tabs, 28
cefazolin inj, 28
cefdinir, 28
cefepime inj, 28
cefixime caps, 28
cefixime susp, 28
cefoxitin sodium, 28
cefpodoxime tabs, 28
cefprozil, 28
ceftazidime inj, 28
ceftriaxone inj, 28
cefuroxime inj, 28
cefuroxime oral, 28
celecoxib, 26
CELLCEPT CAPS, 54
CELLCEPT ORAL SUSPENSION & TABS, 55
cephalexin caps 250mg & 500mg, 28
cephalexin oral susp, 28
CERDELGA, 50
cevimeline, 46
chlorhexidine gluconate, 46
chloroquine, 36
chlorpromazine oral, 37
chlorthalidone, 44
chlorzoxazone tabs 500mg, 61
cholestyramine, 44
cholestyramine light, 44
ciclopirox cream, gel, nail soln, shampoo & susp, 47
cilastatin/imipenem inj, 29
cilostazol, 42
CIMDUO, 39
cimetidine tabs, 49
cinacalcet tab 30mg & 60mg, 56
cinacalcet tab 90mg, 56
CINRYZE INJ, 54
CIPRO HC, 59
ciprofloxacin & dexamethasone otic susp, 59
ciprofloxacin in d5w inj, 29
ciprofloxacin ophthalmic soln 0.3%, 58
ciprofloxacin tabs immediate-release 250mg, 500mg & 750mg, 29
citalopram oral soln, 31
citalopram tabs, 31
claravis, 46
clarithromycin, 29
clarithromycin er, 29
CLEOCIN VAGINAL SUPP, 28
clindamycin gel 1%, 47
clindamycin lotion & soln, 47
clindamycin oral, 28
clindamycin phosphate inj, 28
clindamycin phosphate/dextrose inj, 28
clindamycin swab, 28
clindamycin vaginal cream, 28
CLINISOL SF INJ, 48
clobazam, 30
clobetasol propionate cream, foam, gel, oint & soln, 46
clobetasol propionate emollient, 46
clomipramine, 32
clonazepam, 30
clonazepam odt, 30
clonidine er 0.1mg, 45
clonidine patches, 42
clonidine tabs immediate-release, 42
clopidogrel tabs 75mg, 42
clorazepate, 40
clotrimazole & betamethasone, 47
clotrimazole cream 1%, 33
clotrimazole topical soln 1%, 33
clotrimazole troche, 33
clozapine, 38
clozapine odt, 38
COARTEM, 36
COBENFY, 45
codeine sulfate, 26

colchicine tabs, 33, 64
colesevelam, 44
colestipol pack, 44
colestipol tabs, 44
colistimethate inj, 28
COMBIVENT RESPIMAT, 61, 64
COMETRIQ, 35
COMPLERA, 38
compro, 32
constulose soln, 48
COPAXONE INJ 40MG/ML, 46
COPIKTRA, 35
CORLANOR TABS, 43
COSENTYX INJ, 54, 64
COSENTYX SENSOREADY PEN INJ, 54, 64
COSENTYX UNOREADY PEN INJ, 54, 64
COTELLIC, 35
CREON DR, 50
cromolyn sodium nebulizer soln, 60
cromolyn sodium ophthalmic soln, 58
cromolyn sodium oral, 50
cyclobenzaprine hcl ir, 61
cyclophosphamide caps & tabs, 34
cyclosporine caps, 55
cyclosporine emulsion 0.05%, 57
cyclosporine modified, 55
cyproheptadine, 59
cyred eq, 51
CYSTAGON, 50
CYSTARAN, 57
CYTOMEL, 53
dabigatran etexilate, 41, 64
dalfampridine er, 46
danazol, 51
DANZITEN, 35
dapsone tabs, 34
DAPTACEL INJ, 55
daptomycin inj, 28
darunavir tab 600mg, 39
darunavir tab 800mg, 39
dasatinib, 35
DAURISMO, 35
deblitane, 53
deferasirox granule pack, tabs & tabs for soln, 48
deferiprone, 48
DELSTRIGO, 38
demeclocycline, 29
DEPO-SUBQ PROVERA 104 INJ, 53
DESCOVY, 39
desipramine, 32
desloratadine tabs, 59
desmopressin acetate nasal, 51
desmopressin acetate oral, 51
desogestrel & ethinyl estradiol, 51
desonide lotion, oint & cream, 46, 64
desoximetasone topical cream & oint 0.25%, 46, 64
desoximetasone topical cream, gel & oint 0.05%, 46, 64
DESVENLAFAXINE ER, 31
desvenlafaxine succinate er, 31
dexamethasone dose pack, 50
dexamethasone elixir, 50
dexamethasone ophthalmic soln, 58
dexamethasone tabs, 50
dexmethylphenidate ir tabs, 45
dextroamphetamine sulfate, 65
dextroamphetamine sulfate er, 45, 65
dextroamphetamine sulfate tabs 5mg & 10mg, 45
dextrose (10%, 5% or 2.5%) & sodium chloride inj, 48
dextrose inj, 48
DIACOMIT, 30
DIAZEPAM RECTAL GEL, 30
diazepam soln, 40
diazepam tabs, 40
diazoxide, 41
diclofenac potassium tab 50mg, 26

diclofenac sodium dr, 26
diclofenac sodium er, 26
diclofenac sodium gel 3%, 47
diclofenac sodium ophthalmic soln 0.1%, 58
diclofenac sodium soln 1.5%, 26, 65
diclofenac sodium soln 2%, 26, 65
dicloxacillin sodium, 29
dicyclomine, 49
DIFICID, 29
diflunisal, 26
difluprednate, 58
digoxin oral soln, 42
digoxin tabs 125mcg & 250mcg, 42
dihydroergotamine mesylate nasal, 33, 65
DILANTIN CAPS, 31
DILANTIN INFATABS, 31
DILANTIN SUSP, 31
diltiazem er caps, 43
diltiazem tabs, 43
dilt-xr, 43
dimethyl fumarate caps, 46
dimethyl fumarate starter pack, 46
diphenoxylate & atropine oral soln, 49
diphenoxylate & atropine tabs, 49
dipyridamole er & aspirin, 42
dipyridamole oral, 42
disopyramide phosphate, 42
disulfiram, 27
divalproex sodium dr, 30
divalproex sodium er, 30
dofetilide, 42
donepezil odt, 31
donepezil tabs 5mg & 10mg, 31
dorzolamide, 59
dorzolamide & timolol maleate, 57
dotti, 51
DOVATO, 38
doxazosin, 50
doxepin caps, 32
doxepin oral soln, 32
doxercalciferol oral, 57
doxy 100 inj, 29
doxycycline hyclate immediate-release caps 50mg & 100mg, 29
doxycycline hyclate immediate-release tabs 100mg, 29
doxycycline hyclate immediate-release tabs 20mg, 46
doxycycline monohydrate immediate-release tabs, caps & oral susp, 30
DRIZALMA SPRINKLE, 32
dronabinol, 32
drospirenone & ethinyl estradiol 3mg/0.02mg, 51
droxidopa, 42
DUAVEE, 53
DULERA, 61
duloxetine hcl, 45
DUPIXENT INJ, 54, 65
dutasteride, 50
dutasteride & tamsulosin, 50
ec-naproxen, 26
econazole nitrate, 33
EDURANT, 38
efavirenz & lamivudine & tenofovir disoproxil fumarate tabs, 39
efavirenz tabs, 38
efavirenz& emtricitabine&tenofovir disoproxil fumarate tabs, 38
ELIGARD INJ, 53
ELIQUIS STARTER PACK & TABS, 41, 65
ELMIRON, 50
eluryng, 51
EMGALITY INJ, 33
EMSAM, 31
emtricitabine & tenofovir disoproxil fumarate tabs 100mg-150mg, 133mcg-200mg & 167mg-250mg, 39
emtricitabine & tenofovir disoproxil fumarate tabs 200mg-300mg, 39
emtricitabine caps 200mg, 39
EMTRIVA SOLN, 39
enalapril & hydrochlorothiazide, 43
enalapril tabs, 42

ENBREL INJ, 55, 65
ENBREL MINI, 55, 65
ENBREL SURECLICK INJ, 55, 65
ENDARI, 50
endocet, 26
endocet tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg, 65
ENGERIX-B INJ, 56
enilloring, 52
enoxaparin inj syringe, 41
enpresse-28, 52
enskyce, 52
entacapone, 36
entecavir tabs, 38
ENTRESTO TABS, 43, 65
enulose, 48
ENVARSUS XR, 55
EPCLUSA, 38
EPIDIOLEX, 30
EPINEPHRINE AUTO-INJECTOR 0.15MG/0.3ML & 0.3MG/0.3ML, 60
epitol, 31
eplerenone, 45
EPRONTIA, 33
ERIVEDGE, 35
ERLEADA, 34
erlotinib, 35
ertapenem inj, 29
ERYTHROCIN LACTOBIONATE INJ, 29
erythromycin caps & tabs, 29
erythromycin dr, 29
erythromycin ophthalmic oint, 58
erythromycin topical gel & soln, 47
escitalopram, 32
esomeprazole magnesium dr caps, 49
estarylla, 52
estradiol & norethindrone acetate 0.5mg/0.1mg & 1mg/0.5mg, 52
estradiol oral, 52
estradiol patches, 52
estradiol vaginal cream, 52
estradiol vaginal tabs, 52
ESTRING, 52
ethambutol, 34
ethinyl estradiol & ethynodiol, 52
ethinyl estradiol & norethindrone acetate 5mcg/1mg & 2.5mcg-0.5mg, 52
ethosuximide, 30
etodolac, 26
etodolac er, 26
etonogestrel & ethinyl estradiol ring, 52
etravirine tabs 100mg, 39
etravirine tabs 200mg, 39
everolimus 0.25mg, 55
everolimus 0.5mg, 0.75mg, 1mg, 55
everolimus tabs 2.5mg, 5mg, 7.5mg & 10mg, 35
everolimus tabs for suspension 2mg, 3mg & 5mg, 35
EVOTAZ, 39
exemestane, 34
ezetimibe, 44
ezetimibe & simvastatin, 44
falmina, 52
famciclovir, 38
famotidine tabs, 49
FANAPT, 37
FANAPT TITRATION PACK, 37
FARXIGA, 45, 65
FASENRA INJ, 61, 65
febuxostat, 33
felbamate oral susp 600mg/5ml, 30
felbamate tabs 400mg, 30
felbamate tabs 600mg, 30
felodipine er, 43
fenofibrate caps 43mg & 130mg, 44
fenofibrate micronized caps 67mg, 134mg & 200mg, 44
fenofibrate tabs 48mg, 54mg, 145mg & 160mg, 44

fenofibric acid dr caps, 44
fentanyl patches, 65
fentanyl patches 12mcg/hr, 25mcg/hr, 50mcg/hr & 75mcg/hr, 100mcg/hr, 26
fesoterodine fumarate er, 50
FETZIMA, 32
FETZIMA TITRATION PACK, 32
finasteride tabs 5mg, 50
fingolimod hcl, 46
FINTEPLA, 30
flecainide acetate, 42
fluconazole in sodium chloride inj, 33
fluconazole oral, 33
flucytosine, 33
fludrocortisone acetate, 50
flunisolide nasal, 59, 65
fluocinolone acetonide cream, oint, soln, 47
fluocinolone acetonide otic soln, 59
fluocinolone acetonide scalp oil, 47
fluocinonide cream 0.05%, gel & oint, 47
fluocinonide cream, gel & ointment, 65
fluocinonide emulsified base cream, 47
fluocinonide soln, 47
fluorometholone, 58
fluorouracil topical 2% and 5%, 47
fluoxetine hcl caps 10mg, 20mg & 40mg, 32
fluoxetine hcl oral soln, 32
fluoxetine hcl tabs 10mg & 20mg, 32
fluphenazine decanoate inj, 37
fluphenazine inj, 37
fluphenazine oral, 37
fluticasone propionate cream & oint, 47
fluticasone propionate nasal, 59, 65
fluticasone propionate/salmeterol diskus 100mcg-50mcg, 250mcg-50mcg & 500mcg-50mcg, 61, 65
fluvoxamine, 32
fondaparinux inj 2.5mg/0.5ml & 5mg/0.4ml, 41
fondaparinux inj 7.5mg/0.6ml & 10mg/0.8ml, 41
formoterol fumarate nebulizer, 60
fosamprenavir tabs, 39
fosfomycin pack, 28
fosinopril, 42
fosinopril & hydrochlorothiazide, 43
FOTIVDA, 35
FRUZAQLA, 35
furosemide inj, 44
furosemide oral, 44
FUZEON INJ, 39
fyavolv, 52
FYCOMPA, 30
gabapentin caps, ir tabs & oral soln, 30
galantamine, 31, 65
galantamine er caps, 31, 65
galantamine soln, 31, 65
galantamine tabs, 31, 65
gallifrey, 53
GAMMAGARD INJ, 54
GAMUNEX-C INJ, 54
GARDASIL 9 INJ, 56
gauze pads 2, 57
gavilyte-c, 49
gavilyte-g, 49
gavilyte-n, 49
GAVRETO, 35
gefitinib, 35
gemfibrozil, 44
GEMTESA, 50
generlac, 48
gengraf, 55
GENOTROPIN INJ, 51
GENOTROPIN MINIQUICK INJ 0.2MG, 0.4MG, 0.6MG & 0.8MG, 51
GENOTROPIN MINIQUICK INJ 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG & 2MG, 51
gentamicin cream 0.1% & oint 0.1%, 27
gentamicin inj 40mg/ml, 27
gentamicin ophthalmic soln 0.3%, 58
GENVOYA, 38
GILOTRIF, 35
glatiramer acetate inj, 46
glatopa inj, 46

GLEOSTINE CAPS, 34
glimepiride, 40
glimepiride & pioglitazone, 40, 65
glipizide & metformin tabs, 40
glipizide er, 40
glipizide tabs 5mg & 10mg, 40
GLUCAGON EMERGENCY KIT INJ, 41
glycopyrrolate tabs 1mg & 2mg, 49
GLYXAMBI, 40, 65
granisetron oral, 32
griseofulvin microsize, 33
guanfacine ir, 42
GVOKE INJ, 41
halobetasol propionate cream & ointment, 47
haloette, 52
haloperidol decanoate inj, 37
haloperidol lactate inj, 37
haloperidol oral, 37
HARVONI, 38
HAVRIX INJ, 56
heather tabs, 53
HEMADY, 50
heparin inj vials 1000u/ml, 5000u/ml, 10000u/ml & 20000u/ml, 41
HEPLISAV-B INJ, 56
HIBERIX INJ, 56
HUMALOG CARTRIDGE INJ, 41
HUMALOG JUNIOR KWIKPEN INJ, 41
HUMALOG KWIKPEN INJ, 41
HUMALOG MIX 50/50 KWIKPEN INJ, 41
HUMALOG MIX 75/25 KWIKPEN INJ, 41
HUMALOG MIX 75/25 VIAL INJ, 41
HUMALOG VIAL INJ, 41
HUMATROPE INJ CARTRIDGE 12MG & 24MG, 51
HUMATROPE INJ CARTRIDGE 6MG, 51
HUMIRA INJ, 55, 66
HUMIRA PEN INJ, 55, 66
HUMIRA PEN-CD/UC/HS STARTER INJ, 55, 66
HUMIRA PEN-PS/UV STARTER INJ, 55, 66
HUMULIN 70/30 KWIKPEN INJ, 41
HUMULIN 70/30 VIAL INJ, 41
HUMULIN N KWIKPEN INJ, 41
HUMULIN N VIAL INJ, 41
HUMULIN R U-500 (CONCENTRATED) KWIKPEN INJ, 41
HUMULIN R U-500 (CONCENTRATED) VIAL INJ, 41
HUMULIN R VIAL INJ, 41
hydralazine oral, 45
hydrochlorothiazide, 44
hydrocodone, 27
hydrocodone & acetaminophen soln, 66
hydrocodone & acetaminophen soln 10-325mg/15ml, 26
hydrocodone & acetaminophen soln 7.5-325mg/15ml, 26
hydrocodone & acetaminophen tabs, 66
hydrocodone & ibuprofen tabs 7.5-200mg, 66
hydrocodone & ibuprofen tabs 7.5-200mg, 27
hydrocodone &acetaminophen soln 10-325mg/15ml, 66
hydrocortisone butyrate cream & soln, 47
hydrocortisone cream 2.5%, 56
hydrocortisone enema, 56
hydrocortisone lotion & oint 2.5%, 47
hydrocortisone oral, 50
hydrocortisone valerate, 47
hydromorphone immediate-release oral soln & tabs, 27
hydroxychloroquine tab 200mg, 36
hydroxyurea, 34
hydroxyzine hcl tabs, 59
hydroxyzine pamoate caps, 59
ibandronate oral, 57
IBRANCE, 35
ibu, 26

ibuprofen, 26
icatibant inj, 54, 66
ICLUSIG, 35
icosapent ethyl, 44
IDHIFA, 35
imatinib, 35
IMBRUVICA, 35
imipramine hcl tabs, 32
imiquimod cream 5%, 47
IMKELDI, 35
IMOVAX RABIES INJ, 56
IMURAN TABS, 55
IMVEXXY PACK, 52
incassia, 53
INCRELEX INJ, 51
indapamide, 44
indomethacin er, 26
indomethacin ir caps, 26
INFANRIX INJ, 56
INLYTA, 35
INQOVI, 35
INREBIC, 34
INSULIN LISPRO VIAL INJ, 41
INTELENCE TAB 25MG, 39
INTRALIPID INJ, 57
introvale, 52
INVEGA HAFYERA INJ, 37
INVEGA SUSTENNA INJ 39MG, 37
INVEGA SUSTENNA INJ 78MG, 117MG, 156MG & 234MG, 37
INVEGA TRINZA INJ, 37
IPOL INACTIVATED IPV INJ, 56
ipratropium bromide & albuterol sulfate nebulizer, 61
ipratropium bromide nasal, 59, 66
ipratropium bromide nebulizer, 59
irbesartan, 42
irbesartan hct, 43
ISENTRESS 100MG CHEW TABS, 38
ISENTRESS CHEW TABS 25MG, 38
ISENTRESS HD TABS, 38
ISENTRESS ORAL POWDER, 38
ISENTRESS TABS, 38
isibloom, 52
isoniazid, 34
isosorbide dinitrate tabs 5mg, 10mg, 20mg & 30mg, 45
isosorbide mononitrate er, 45
isotretinoin caps 10mg, 20mg, 30mg & 40mg, 46
isradipine, 43
ITOVEBI, 34
itraconazole, 33
ivabradine, 43
ivermectin tabs, 36
IWILFIN, 34
IXCHIQ INJ, 56
IXIARO INJ, 56
JAKAFI, 35
jantoven, 41
JANUMET, 40, 66
JANUMET XR, 40, 66
JANUVIA, 40, 66
JARDIANCE, 45, 66
jasmiel, 52
JAYPIRCA TABS, 35
JENTADUETO, 40, 66
JENTADUETO XR, 40, 66
jinteli, 52
juleber, 52
JULUCA, 38
junel 21 day, 52
junel fe 1/20, 52
JYLAMVO SOLN, 55
JYNNEOS INJ, 56
KALYDECO, 60
kariva, 52
kelnor 1/35, 1/50, 52
KERENDIA, 45
ketoconazole cream, shampoo & tabs, 33
ketorolac oral tabs, 26
ketorolac soln 0.4% & 0.5%, 58
KINRIX INJ, 56
kionex susp, 48

KISQALI, 35
KISQALI FEMARA CO-PACK, 35
KITABIS NEBULIZER, 60
klor-con pack, 48
klor-con tabs, 48
KLOXXADO, 27
KOSELUGO, 35
kourzeq, 46
KRAZATI, 35
kurvelo, 52
labetalol oral, 43
lacosamide oral, 31
lactulose soln 10g/15ml, 49
lamivudine & zidovudine, 39
lamivudine soln, 39
lamivudine tabs 100mg, 38
lamivudine tabs 150mg & 300mg, 39
lamotrigine chewable tabs, 40
lamotrigine immediate-release tabs, 40
lamotrigine odt, 40
LANOXIN ORAL, 42
lansoprazole dr caps, 49
LANTUS SOLOSTAR PEN INJ, 41
LANTUS VIAL INJ, 41
lapatinib, 35
larin, 52
larin fe, 52
latanoprost, 59
LAZCLUZE, 34
LEDIPASVIR/SOFOSBUVIR, 38
leena, 52
leflunomide, 55, 66
lenalidomide, 34
LENVIMA, 35
letrozole, 34
leucovorin oral, 36
leuprolide acetate inj kit 1mg/0.2ml, 54
levalbuterol nebulizer, 60
LEVALBUTEROL TARTRATE HFA, 60
levetiracetam er, 30
levetiracetam oral tabs & soln, 30
levetiracetam tabs for oral susp, 30
levobunolol, 58
levocarnitine oral, 57
levocetirizine, 59
levofloxacin in d5w inj, 29
levofloxacin oral soln, 29
levofloxacin tabs, 29
levonest, 52
levonorgestrel & ethinyl estradiol 0.1-0.02mg & 0.15-0.03mg & triphasic packs, 52
levonorgestrel & ethinyl estradiol and ethinyl estradiol 0.1/0.02mg-0.01mg packs, 52
levora, 52
levothyroxine tabs, 53
levoxyl, 53
l-glutamine, 50
LIBERVANT, 30
lidocaine & prilocaine, 66
lidocaine & prilocaine cream, 27
lidocaine ointment, 27, 66
lidocaine patch, 27
lidocaine topical soln, 27, 66
lidocaine viscous soln, 46
lidocan III, 27
LILETTA, 53
linezolid inj, 28
linezolid oral susp and tabs, 28
LINZESS, 49
liothyronine tabs, 53
lisinopril, 42
lisinopril & hydrochlorothiazide, 44
lithium carbonate, 40
lithium carbonate er, 40
lithium oral soln, 40
LIVTENCITY, 38, 66
LODINE TABS, 26
LOKELMA, 48
LONSURF, 34
loperamide caps 2mg, 49

lopinavir & ritonavir, 39
lorazepam soln & tabs, 40
LORBRENA, 35
loryna, 52
losartan, 42
losartan hct, 44
LOTEMAX OINT, 58
LOTEMAX SM GEL 0.38%, 58
lovastatin, 44
low-ogestrel, 52
loxapine, 37
lubiprostone, 49
LUMAKRAS, 35
LUMIGAN, 59
LUPRON DEPOT INJ, 54
LUPRON DEPOT-PED (1-MONTH & 3-MONTH) INJ, 54
LUPRON DEPOT-PED (6-MONTH) INJ, 51
lurasidone hcl tabs, 37
lyleq, 53
lyllana, 52
LYNPARZA, 35
LYSODREN, 34
LYTGOBI TABS, 35
LYUMJEV KWIKPEN INJ, 41
LYUMJEV VIAL INJ, 41
lyza, 53
magnesium sulfate inj, 48
malathion, 47
maraviroc, 39
marlissa 28 day, 52
MARPLAN, 31
MATULANE, 34
meclizine, 32
MEDROL TABS, 50
medroxyprogesterone acetate inj, 53
medroxyprogesterone acetate tabs, 53
mefloquine, 36
megestrol acetate oral susp 40mg/ml, 53
megestrol tabs, 53
MEKINIST, 35
MEKTOVI, 35
meloxicam tabs, 26
memantine hcl immediate release, 31
memantine hcl soln, 31
memantine hcl titration pack, 31
MENACTRA INJ, 56
MENQUADFI INJ, 56
MENVEO-A/C/Y/W-135 INJ, 56
meprobamate, 40
mercaptopurine, 34
meropenem inj, 29
mesalamine dr, 56
mesalamine enema, 56
mesalamine er caps, 56, 66
mesalamine rectal suppository, 56
mesna, 36
MESNEX TABS, 36
metformin er uncoated tabs 500mg & 750mg, 40
metformin tabs, 40
methadone oral, 26
methazolamide, 59
methenamine hippurate, 28
methimazole, 54
methocarbamol tabs 500mg & 750mg, 61
methotrexate inj 50mg/2ml, 55
methotrexate oral, 55
methoxsalen, 47
methsuximide, 30
methylphenidate er tabs 10mg & 20mg, 45
methylphenidate ir tabs 5mg, 10mg & 20mg, 45
methylprednisolone dose pack, 50
methylprednisolone oral, 50
metoclopramide oral tablets & soln, 49
metolazone, 44
metoprolol & hydrochlorothiazide, 44
metoprolol succinate er, 43
metoprolol tartrate tabs 25mg,50mg & 100mg, 43
metronidazole inj, 28
metronidazole oral, 28
metronidazole topical, 46

metronidazole vagina gel, 28
metyrosine caps, 44
mexiletine, 43
microgestin 1/20 & 1.5/30, 52
microgestin fe 1/20 & 1.5/30, 52
midodrine tabs, 42
mifepristone tabs 300mg, 54
miglustat, 50
mili, 52
mimvey, 52
minocycline ir, 30
minoxidil, 45
mirtazapine, 31
mirtazapine odt, 31
misoprostol, 49
M-M-R II INJ, 56
modafinil, 61
moexipril, 42
molindone, 37
mometasone cream, oint & soln, 47
mometasone furoate nasal, 59
mometasone furoate nasal, 66
montelukast, 59
morphine sulfate er tabs, 26, 66
morphine sulfate oral, 27
MOUNJARO INJ, 40, 66
MOVANTIK, 49
moxifloxacin hcl ophthalmic, 58
moxifloxacin inj, 29
moxifloxacin oral, 29
MRESVIA INJ, 56
MULTAQ, 43
mupirocin cream, 48, 66
mupirocin ointment, 47
mycophenolate mofetil caps & tabs, 55
mycophenolate mofetil oral susp, 55
mycophenolic acid dr, 55
MYFORTIC, 55
MYHIBBIN, 55
MYRBETRIQ, 50
nabumetone, 26
nadolol, 43
nafcillin sodium inj, 29
naloxone inj, 27
naltrexone, 27
naproxen sodium ir tabs, 26
naproxen tabs 250mg, 375mg & 500mg, 26
naratriptan, 33, 66
nateglinide, 40
NAYZILAM, 30
nebivolol hcl, 43
NEBUPENT NEBULIZER, 36
necon, 52
nefazodone, 32
neomycin & polymyxin & bacitracin, 57
neomycin & polymyxin & bacitracin & hydrocortisone, 57
neomycin & polymyxin & dexamethasone, 57
neomycin & polymyxin & gramicidin ophthalmic, 57
neomycin & polymyxin & hydrocortisone, 57, 59
neomycin sulfate oral, 27
neo-polycin hc ophthalmic ointment, 57
neo-polycin ophthalmic ointment, 57
NEORAL, 55
NERLYNX, 35
NEUPRO PATCH, 36, 66
nevirapine er & susp, 39
nevirapine tabs, 39
NEXPLANON, 53
niacin er tabs, 44, 66
nicardipine caps, 43
NICOTROL NASAL, 27
nifedipine caps, 43
nifedipine er, 43
nikki, 52
nilutamide, 34
nimodipine, 43
NINLARO, 35

nitazoxanide, 36
nitisinone, 50
nitro-bid oint, 45
nitrofurantoin caps, 28
nitroglycerin lingual, 45
nitroglycerin patches, 45
nitroglycerin rectal oint, 49
nitroglycerin sublingual, 45
NIVESTYM INJ, 42
norelgestromin/ethinyl estradiol patch, 52
norethindrone, 53
norethindrone, ethinyl estradiol, ferrous fumarate 0.4mg/0.035mg, 52
norethindrone, ethinyl estradiol, ferrous fumarate 20mcg/75mg/1mg, 52
norgestimate-ethinyl estradiol, 53
nortriptyline, 32
NORVIR POWDER, 39
NUBEQA, 34
NUEDEXTA, 45
NUPLAZID, 37
NURTEC ODT, 33
nyamyc, 33
nylia 7/7/7 & 1/35, 53
nystatin, 33
nystatin & triamcinolone, 47
nystop, 33
octreotide inj 1000mcg/ml, 54
octreotide inj 50mcg/ml, 100mcg/ml, 200mcg/ml & 500mcg/ml, 54
ODEFSEY, 39
ODOMZO, 35
OFEV, 60, 66
ofloxacin ophthalmic, 58
ofloxacin oral, 29
ofloxacin otic, 59
OGSIVEO, 34
OHTUVAYRE NEBULIZER, 60
OJEMDA, 35
OJJAARA, 35
olanzapine inj & tabs, 37
olanzapine odt, 37
olmesartan, 42
olmesartan & amlodipine, 44
olmesartan hct, 44
olmesartan medoxomil & amlodipine & hydrochlorothiazide tabs, 44
omega-3-acid ethyl esters, 44
omeprazole caps, 49
ondansetron odt, 32
ondansetron oral soln, 32
ondansetron tabs 4mg & 8mg, 32
ONUREG, 34
OPSUMIT, 60
OPVEE, 27
ORAPRED ODT, 51
ORENCIA INJ, 54, 66
ORGOVYX, 54
ORKAMBI, 60
ORSERDU TABS, 34
oseltamivir caps, 40
oseltamivir susp, 40
OTEZLA, 47, 66
OTEZLA STARTER, 54, 67
oxcarbazepine susp, 31
oxcarbazepine tabs, 31
oxybutynin er, 50
oxybutynin ir, 50
oxycodone & acetaminophen, 67
oxycodone & acetaminophen 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg, 27
oxycodone immediate-release, 27
oxycodone oral soln, 27
OZEMPIC INJ, 40, 67
pacerone tabs, 43
paliperidone er tabs, 37
PANRETIN, 36
pantoprazole tabs, 49
paricalcitol caps, 57
paroxetine hcl er, 32
paroxetine hcl ir tabs, 32
paroxetine hcl susp, 32
PAXLOVID, 40
pazopanib, 35

PEDIARIX INJ, 56
PEDVAX HIB INJ, 56
peg 3350 & electrolytes, 49
peg 3350 & sodium chloride & sodium bicarbonate & potassium chloride, 49
peg 3350 & sodium sulfate & sodium chloride & potassium chloride & sodium ascorbate & ascorbic, 49
PEGASYS SYRINGE INJ, 55
PEGASYS VIAL INJ, 54
PEMAZYRE, 35
PENBRAYA INJ, 56
penicillamine tabs, 48
penicillin g inj 5 million units & 20 million units, 29
penicillin v potassium, 29
pentamidine inhalation soln, 36
pentamidine inj, 36
pentoxifylline er, 44
PERFOROMIST NEBULIZER, 60
perindopril, 42
periogard, 46
permethrin cream, 47
perphenazine, 37
perphenazine & amitriptyline, 31
PETACEL INJ, 56
phenelzine, 31
phenobarbital elixir & tabs, 30
phenytek, 31
phenytoin er, 31
phenytoin oral susp & chewable tabs, 31
PIFELTRO, 39
pilocarpine soln, 59
pilocarpine tabs, 46
pimecrolimus, 47, 67
pimozide, 37
pimtrea, 53
pindolol, 43
pioglitazone, 40
pioglitazone & metformin, 40
piperacillin/tazobactam inj, 29
PIQRAY, 35
pirfenidone, 60, 67
piroxicam, 26
plenamine inj, 48
PLENVU, 49
pmdd fluoxetine hcl tabs 10mg & 20mg, 32
podofilox soln, 47
polycin ophthalmic ointment, 57
polymyxin b sulfate & trimethoprim sulfate ophthalmic soln, 57
POMALYST, 34
posaconazole dr tabs, 33
posaconazole suspension, 33
potassium chloride & dextrose & lactated ringers inj, 48
potassium chloride & dextrose & sodium chloride inj 10mEq/5%/0.45%, 20mEq/5%/0.2%, 20mEq/5%/0.45%, 20mEq/5%/0.9%, 30mEq/5%/0.45% 40mEq/5%/0.9% & 40mEq/5%/0.45%, 48
potassium chloride & dextrose 20mEq/5% inj, 48
potassium chloride er & cr, 48
potassium chloride inj, 48
potassium chloride oral soln, 48
potassium chloride pack 20meq, 48
potassium citrate er, 48
pramipexole ir, 36
prasugrel, 42
pravastatin, 44
praziquantel tabs, 36
prazosin, 50
PRED MILD, 58
prednisolone acetate, 58
prednisolone odt, 51
prednisolone oral soln, 51
prednisolone sodium phosphate, 58
prednisolone tablet 5mg, 51
PREDNISONE INTENSOL, 51

prednisone oral soln, 51
prednisone tab pack, 51
prednisone tabs, 51
pregabalin, 30
PREMARIN ORAL, 53
PREMARIN VAGINAL CREAM, 53
PREMPHASE, 53
PREMPRO, 53
prenatal multi-vitamin, 48
prevalite, 44
PREVYMIS, 38, 67
PREZCOBIX, 39
PREZISTA SUSP 100MG/ML, 39
PREZISTA TABS 75MG & 150MG, 39
PRIFTIN, 34
PRIMAQUINE, 36
PRIMIDONE TABS 125MG, 30
primidone tabs 50mg & 250mg, 30
PRIORIX INJ, 56
PROAIR RESPICLICK, 60
probenecid, 33
probenecid & colchicine, 33
prochlorperazine oral, 32
prochlorperazine supp, 32
PROCRIT INJ 20000UNIT/ML & 40000UNIT/ML, 42
PROCRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML & 10000UNIT/ML, 42
procto-med hc, 56
proctosol hc, 56
proctozone-hc, 56
progesterone caps, 53
PROGRAF CAPS, 55
PROGRAF PACK, 55
PROLASTIN C INJ, 50
PROLIA INJ, 57
PROMACTA, 42, 67
promethazine supp, 32
promethazine syrup, 32
promethazine tabs, 32
promethegan supp, 32
propafenone tabs, 43
propranolol er caps, 43
propranolol ir tabs, 43
propranolol oral soln, 43
propylthiouracil, 54
PROQUAD INJ, 56
PROSOL INJ, 48
protriptyline, 32
PULMICORT NEBULIZER, 59
PULMOZYME, 60
PURIXAN, 34
pyrazinamide, 34
pyridostigmine er tabs 180mg, 34
pyridostigmine soln, 34
pyridostigmine tabs 60mg, 34
pyrimethamine, 36
QINLOCK, 35
QUADRACEL INJ, 56
quetiapine er tabs, 37
quetiapine fumarate 25mg, 50mg, 100mg, 200mg, 300mg & 400mg tabs, 37
quinapril, 42
quinapril & hydrochlorothiazide, 44
quinidine gluconate cr, 43
quinidine sulfate, 43
quinine sulfate caps, 36
QVAR REDIHALER, 59
RABAVERT INJ, 56
rabeprazole sodium, 49
raloxifene hcl, 53
ramelteon, 61, 67
ramipril, 42
ranolazine er, 44
RAPAMUNE TABS, 55
rasagiline, 37
RAYALDEE, 57
reclipsen, 53
RECOMBIVAX HB INJ, 56
REGRANEX, 47, 67
RELENZA DISKHALER, 40
RELEUKO INJ, 42
RELISTOR INJ, 49
RELISTOR TABS, 49

repaglinide, 40
REPATHA INJ, 44
RETACRIT INJ 20000UNIT/ML & 40000UNIT/ML, 42
RETACRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML,10000UNIT/ML & 20000UNIT/2ML, 42
RETEVMO, 35
REVLIMID, 34
REVUFORJ, 34
REXULTI, 37
REYATAZ ORAL POWDER, 40
REZLIDHIA CAPS, 35
RHOPRESSA, 59
ribavirin, 38
RIDAURA, 54
rifabutin, 34
rifampin oral and inj, 34
riluzole, 45
rimantadine, 40
RINVOQ, 54, 67
RINVOQ LQ, 67
RINVOQ LQ, 54
risedronate sodium, 57
risedronate sodium dr, 57
risperidone, 37
risperidone er inj 12.5mg & 25mg, 37
risperidone er inj 37.5mg & 50mg, 37
risperidone odt, 37
ritonavir tabs, 40
rivastigmine caps, 31, 67
rivastigmine patches, 31, 67
rizatriptan, 33
rizatriptan odt, 33
ROCKLATAN, 57
roflumilast tabs, 60
ropinirole ir, 36
rosuvastatin, 44
ROTARIX, 56
ROTATEQ, 56
roweepra 500mg, 30
ROZLYTREK, 35
RUBRACA, 35
rufinamide, 31
RUKOBIA, 39
RYBELSUS, 40, 67
RYDAPT, 35
sajazir inj, 54
SANDIMMUNE CAPS 25MG & 100MG, 55
SANTYL, 47, 67
sapropterin, 50
SAVELLA, 45
SAVELLA TITRATION PACK, 45
SCEMBLIX, 35
scopolamine patch, 32
SECUADO, 37
selegiline, 37
selenium sulfide lotion, 47
SELZENTRY SOLN, 39
SEREVENT DISKUS, 60
sertraline oral soln, 32
sertraline tabs, 32
setlakin, 53
sharobel, 53
SHINGRIX INJ, 56
SIGNIFOR INJ, 54
sildenafil tab 20mg, 60
sildenafil tab 25mg, 50mg, 100mg, 62
sildenafilo, comprimidos de 25 mg, 50 mg, 100 mg, 63
silver sulfadiazine, 47
SIMBRINZA, 57
simvastatin, 44
sirolimus soln, 55
sirolimus tabs, 55
SIRTURO, 34
SIVEXTRO TABS & INJ, 28
SKYRIZI INJ, 54, 67
sodium chloride inj, 48
sodium chloride irrigation soln, 57

sodium phenylbutyrate powder & tabs, 50
sodium polystyrene sulfonate powder, 48
sodium sulfate, potassium sulfate and magnesium sulfate, 49
SOFOSBUVIR/VELPATASVIR, 38
solifenacin succinate, 50
SOLIQUA INJ, 40
SOLTAMOX, 34
SOMAVERT INJ, 54
sorafenib, 35
sotalol tabs, 43
SPIRIVA RESPIMAT, 59, 67
spironolactone & hydrochlorothiazide, 44
spironolactone tabs, 45
SPRITAM, 30
SPRYCEL, 35
sps suspension, 48
ssd, 47
STELARA INJ, 54, 67
STIOLTO RESPIMAT, 61
STIVARGA, 35
streptomycin inj, 28
STRIBILD, 38
STRIVERDI RESPIMAT, 60
subvenite tabs, 40
sucralfate tabs, 49
sulfacetamide sodium & prednisolone sodium phosphate ophthalmic, 58
sulfacetamide sodium ophthalmic oint & soln 10%, 58
sulfacetamide sodium topical lotion 10%, 29
sulfadiazine tabs, 29
sulfamethoxazole & trimethoprim ds tabs, 29
sulfamethoxazole & trimethoprim oral susp, 29
sulfamethoxazole & trimethoprim tabs, 29
sulfasalazine, 56
sulindac, 26
sumatriptan nasal, 33
sumatriptan succinate inj, 33
sumatriptan succinate tabs, 33
sunitinib malate, 35
SUNLENCA, 39
SYMLINPEN INJ, 40
SYMPAZAN 10MG & 20MG, 30
SYMPAZAN 5MG, 30
SYMTUZA, 40
SYNAREL, 54
SYNJARDY, 40, 67
SYNJARDY XR, 40, 67
SYNTHROID, 53
TABRECTA, 35
tacrolimus caps 0.5mg & 1mg, 55
tacrolimus caps 5mg, 55
tacrolimus oint, 47, 67
tadalafil 2.5mg & 5mg, 50, 67
tadalafil tab 20mg, 60
TAFINLAR, 35
TAGRISSO, 35
TALZENNA, 35
tamoxifen, 34
tamsulosin, 50
tarina fe 1/20 eq, 53
TASIGNA, 35
tasimelteon caps, 61
tazarotene cream, 46
tazarotene gel, 46, 67
tazicef inj, 28
TAZVERIK, 35
TEFLARO INJ, 28
TEGRETOL, 31
TEGRETOL XR, 31
telmisartan, 42
temazepam caps, 61
TENIVAC INJ, 56
tenofovir disoproxil fumarate, 39
TEPMETKO, 35
terazosin, 50
terbinafine, 33
terbutaline sulfate oral, 60
terconazole, 33
teriflunomide tabs, 46
TERIPARATIDE INJ, 57
testosterone cypionate inj, 51

testosterone enanthate inj, 51
testosterone gel 1% & 1.62%, 51
testosterone gel 25mg/2.5g, 20.25mg/1.25g, 40.5mg/2.5g & 50mg/5g, 51
tetrabenazine, 67
tetrabenazine, 45
tetracycline, 30
THALOMID, 34
theophylline er tabs, 60
thioridazine, 37
thiothixene, 37
tiadylt er, 43
tiagabine, 30
TIBSOVO, 36
TICOVAC INJ, 56
tigecycline inj, 28
timolol hemihydrate, 58
timolol ophth soln 12 hours 0.25% & 0.5% multi-use bottles, 58
timolol ophthalmic gel forming, 58
timolol oral, 33
tinidazole tabs, 28
tiopronin, 50
TIVICAY PD, 38
TIVICAY TABS 50MG, 38
tizanidine caps, 38
tizanidine tabs, 38
TOBI PODHALER, 60
TOBI SOLN, 60
TOBRADEX OINT, 58
tobramycin & dexamethasone ophthalmic suspension, 58
tobramycin nebulizer, 60
tobramycin ophthalmic solution, 58
tobramycin sulfate inj, 28
tolterodine tartrate er, 50, 67
topiramate immediate-release caps 15mg & 25mg, 33
topiramate immediate-release caps 50mg, 33
topiramate immediate-release tabs, 33
toremifene citrate, 34
torpenz, 36
torsemide, 44
TOUJEO MAX SOLOSTAR INJ, 41
TOUJEO SOLOSTAR INJ, 41
TPN ELECTROLYTES INJ, 48
TRACLEER 32MG, 60
TRADJENTA, 40, 67
tramadol & acetaminophen, 27, 68
tramadol er tabs, 26, 68
tramadol ir tab 100mg, 27, 68
tramadol tab 50mg, 27
trandolapril, 42
tranexamic acid tabs, 42
tranylcypromine, 31
TRAVASOL INJ, 48
travoprost, 59
trazodone, 32
TRECATOR, 34
TRELEGY ELLIPTA, 61, 68
TRELSTAR MIXJECT INJ, 54
TREMFYA INJ, 54, 68
TRESIBA FLEXTOUCH INJ, 41
TRESIBA VIAL INJ, 41
tretinoin caps, 36
tretinoin cream, 46
tretinoin gel 0.01%, 0.025% & 0.05%, 46
triamcinolone acetonide topical cream & lotion, 47
triamcinolone acetonide topical oint 0.025%, 0.1% & 0.5%, 47
triamcinolone dental paste, 46
triamterene & hydrochlorothiazide, 44
tridacaine ii patch, 27
trientine cap 250mg, 48
tri-estarylla, 53
trifluoperazine, 37
trifluridine, 58
trihexyphenidyl elixir & tabs, 36

TRIJARDY XR, 40, 68
TRILEPTAL, 31
tri-lo-estarylla, 53
tri-lo-sprintec, 53
trimethoprim, 28
tri-mili, 53
trimipramine maleate, 32
TRINTELLIX, 32
tri-sprintec, 53
TRIUMEQ, 39
TRIUMEQ PD, 39
trivora-28, 53
tri-vylibra, 53
tri-vylibra lo, 53
trospium ir, 50
TRULICITY INJ, 40, 68
TRUMENBA INJ, 56
TRUQAP, 36
TUKYSA, 36
TURALIO, 36
turqoz, 53
TWINRIX INJ, 56
TYBOST, 39
TYMLOS INJ, 57
TYPHIM VI INJ, 56
UBRELVY, 33
UDENYCA INJ, 42
unithroid, 53
UPTRAVI, 60
ursodiol cap 300mg & tabs 250mg & 500mg, 49
UZEDY INJ, 38
valacyclovir, 38
VALCHLOR, 34
valganciclovir oral soln, 38
valganciclovir tabs, 38
valproic acid oral caps & soln, 30
valsartan & amlodipine, 44
valsartan hct, 44
valsartan tabs, 42
VALTOCO, 30
vancomycin caps, 28
vancomycin inj 500mg, 750mg, 1gm & 10gm, 28
vancomycin oral soln 250mg/5ml, 28
vandazole, 28
VANFLYTA, 36
VAQTA INJ, 56
varenicline starting month box, 27
varenicline tartrate, 27
VARIVAX INJ, 56
VASCEPA CAPS, 44
VAXCHORA INJ, 56
velivet, 53
VELTASSA, 48
VEMLIDY, 38
VENCLEXTA STARTING PACK, 36
VENCLEXTA TABS 100MG, 36
VENCLEXTA TABS 10MG & 50MG, 36
venlafaxine hcl er caps, 32
venlafaxine ir tabs, 32
verapamil er, 43
verapamil ir, 43
verapamil sr, 43
VERQUVO, 45
VERSACLOZ, 38
VERZENIO, 36
vestura, 53
vienva, 53
vigabatrin, 30
vigadrone, 30
VIGAFYDE, 30
vigpoder, 30
vilazodone, 32
VIRACEPT, 40
VIREAD POWDER, 39
VIREAD TABS 150MG, 200MG & 250MG, 39
VITRAKVI, 36
VIZIMPRO, 36
VONJO, 34
VORANIGO, 36
voriconazole inj, 33
voriconazole oral suspension, 33
voriconazole tabs, 33

VOSEVI, 38
VOWST, 49
VRAYLAR, 38
VUMERITY, 46
vyfemla, 53
vylibra, 53
VYZULTA, 59
warfarin, 41
WELIREG, 50
wixela inhub, 61, 68
wymzya fe, 53
XALKORI, 36
XARELTO ORAL SUSP & TABS, 41, 68
XARELTO STARTER PACK, 42, 68
XCOPRI MAINTENANCE PACK, 31
XCOPRI TABS, 31
XCOPRI TITRATION PACK 50-100MG, & 150-200MG, 31
XCOPRI TITRATION PACK 12.5MG/25MG, 31
XDEMVY, 58, 68
XELJANZ, 54, 68
XELJANZ XR, 54, 68
XERMELO, 49
XGEVA INJ, 57
XIFAXAN TABS 200MG, 49
XIFAXAN TABS 550MG, 49
XIGDUO XR, 41, 68
XIIDRA, 58
XOFLUZA, 40
XOLAIR INJ, 54, 68
XOSPATA, 36
XPOVIO, 36
XTANDI, 34
xulane, 53
XYWAV, 61
YARGESA, 50
YF-VAX INJ, 56
YONSA, 34
YUPELRI, 59
yuvafem, 53
zafemy, 53
zafirlukast, 68
zafirlukast, 59
ZEGALOGUE INJ, 41
ZEJULA TABS, 36
ZELBORAF, 36
zenatane, 46
zenzedi, 68
zenzedi tabs 5mg & 10mg, 45
zidovudine, 39
ziprasidone inj, 38
ziprasidone oral, 38
ZIRGAN, 58
ZOLINZA, 36
zolmitriptan, 68
zolmitriptan odt, 33
zolmitriptan tabs, 33
zolpidem ir tabs 5mg & 10mg, 61
ZONISADE, 31
zonisamide, 31
ZOSYN INJ, 29
zovia, 53
ZTALMY SUSP, 30
ZURZUVAE, 31
ZYDELIG, 36
ZYKADIA TABS, 36

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SCAN Member Services
SCAN Health Plan - California - 1-800-559-3500
SCAN Health Plan - Arizona -1-855-650-7226
SCAN Health Plan - New Mexico - 1-855-826-7226
SCAN Health Plan - Nevada -1-855-827-7226
SCAN Health Plan - Texas -1-855-844-7226
TTY: 711
FAX: 1-562-989-0958

Attention: Grievance and Appeals Department
P.O. Box 22644, Long Beach, CA 90801-5644

Or by filling out the "File a Grievance" form on our website at:
https://www.scanhealthplan.com/contact-us/file-a-grievance
If you need help filing a grievance, SCAN Member Services is available to help you.

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

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

Complaint forms are available at www.hhs.gov/civil-rights/filing-a-complaint/index.html.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Services).
- In writing: Fill out a complaint form or send a letter to:
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  Complaint forms are available at
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
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SCAN Health Plan - Arizona -1-855-650-7226
SCAN Health Plan - New Mexico - 1-855-826-7226
SCAN Health Plan - Nevada -1-855-827-7226
SCAN Health Plan - Texas -1-855-844-7226
TTY: 711
FAX: 1-562-989-0958

Attention: Grievance and Appeals Department
P.O. Box 22644, Long Beach, CA 90801-5644

O puede completar el formulario “Presentar un reclamo” en nuestro sitio web: https://www.scanhealthplan.com/contact-us/file-a-grievance

Si necesita ayuda para presentar un reclamo, Servicios para Miembros de SCAN puede ayudarlo.

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de manera electrónica a través del portal de quejas de la Oficina de Derechos Civiles disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf o por correo o teléfono:

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

Puede encontrar los formularios de quejas en https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Puede presentar un reclamo de derechos civiles ante la Oficina de Derechos Civiles del Dpto. de Servicios de Atención Médica de California por teléfono, por escrito o de manera electrónica:

- Por teléfono: Llame al 1-916-440-7370. Si tiene dificultades para hablar u oír, llame al servicio de TTY: 711.
- Por escrito: Complete un formulario de reclamo o envíe una carta a la siguiente dirección:
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  Puede encontrar los formularios de quejas en http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- De manera electrónica: Envíe un correo electrónico a mailto:CivilRights@dhcs.ca.gov.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, llame al (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Traditional: 我們提供免費的口譯服務，以解答您對我們的健康或藥物計劃可能有的任何問題。如需獲得口譯服務，請致電 (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) 聯絡我們。我們有會說中文的工作人員可以為您提供幫助。這是一項免費服務。

Chinese Simplified: 我们提供免费的口译服务，以解答您对我们的健康或药物计划可能有的任何问题。如需获得口译服务，请致电 (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) 联系我们。我们有会说中文的工作人员可以为您提供帮助。这是一项免费服务。

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi quý vị có thể có về chương sức khỏe và chương trình thuốc men. Để được thông dịch, chỉ cần gọi theo số (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Người nói Tiếng Việt có thể trợ giúp quý vị. Đây là dịch vụ miễn phí.

Tagalog: Mayroon kaming mga libreng serbisyo ng interpreter upang masagot ang anumang katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng interpreter, tawagan lamang kami sa (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Armenian: Առողջության կամ դեղերի ծրագրի վերաբերյալ որևէ հարց առաջանալու դեպքում կարող եք օգտվել անվճար թարգմանչական ծառայությունից: Թարգմանչի ծառայությունից օգտվելու համար զանգահարե՛ք (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیست با شماره (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) تماس بگیرید. شخصی که به زبان فارسی صحبت می کند، می تواند به شما کمک کند. این یک سرویس رایگان است.

Russian: Если у вас возникнут вопросы относительно плана медицинского обслуживания или обеспечения лекарственными препаратами, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номеру (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Вам окажет помощь сотрудник, который говорит на русском языке. Данная услуга бесплатная.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするため に、無料の通訳サービスをご用意しています。通訳をご利用になるには、 (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) にお電話ください。日本語を話す人者が支援いたします。これは無料のサー ビスです。

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة لديك تتعلق بخطتنا الصحية أو جدول الدواء. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم(CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). سيقوم شخص ما يتحدث العربية بمساعدتك.هذه الخدمة المجانية.

Punjabi: ਸਾਡੀ ਸਿਹਤ ਜਾਂ ਦਵਾਈ ਯੋਜਨਾ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲਾਂ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫ਼ਤ ਸੇਵਾ ਹੈ।

Mon-Khmer, Cambodian:
យើងខ្ញុំមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាពឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) ។
មានគេដែលនិយាយភាសាខ្មែរអាចជួយលោកអ្នកបាន។ សេវាកម្មនេះមិនគិតថ្លៃទេ។

Hmong: Peb muaj cov kev pab cuam txhais lus los teb koj cov lus nug uas koj muaj txog ntawm peb lub phiaj xwm kho mob thiab tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu peb ntawm (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Muaj qee tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov no yog kev pab cuam pab dawb.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Thai: เรามีบริการล่ามฟรีเพื่อตอบข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226)
เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄຳຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (CA : 1-800-559-3500) (AZ : 1-855-650-7226)(NM : 1-855-826-7226)(NV : 1-855-827-7226) (TX : 1-855-844-7226). Quelqu'un parlant français pourra vous aider. Ce service est gratuit.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226) (TX: 1-855-844-7226). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per usufruire di un interprete, contattare il numero (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226) (NV: 1-855-827-7226)(TX: 1-855-844-7226). Un nostro incaricato che parla Italiano Le fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (CA: 1-800-559-3500)(AZ: 1-855-650-7226) (NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Irá encontrar alguém que fale português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan sante oswa medikaman nou yo. Pou w jwenn yon entèprèt, jis rele nou nan (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226) (TX: 1-855-844-7226). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226) (TX: 1-855-844-7226).
Ta usługa jest bezpłatna.

Hmong-Mien: Peb muaj kev pab cuam txhais lus pub dawb los teb cov lus nug uas koj muaj txog ntawm peb lub phiaj xwm kev noj qab haus huv los sis phiaj xwm tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu peb ntawm (CA: 1-800-559-3500) (AZ: 1-855-650-7226)(NM: 1-855-826-7226)(NV: 1-855-827-7226)(TX: 1-855-844-7226). Muaj tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov kev pab cuam no yog pab dawb xwb.

Ukrainian: Ми надаємо безкоштовні послуги усного перекладача, який відповість на будь-які ваші запитання щодо нашого плану медичного обслуговування або лікарського забезпечення. Щоб отримати послуги перекладача, просто зателефонуйте нам за номером (CA: 1-800-559-3500)(AZ: 1-855-650-7226)(NM: 1-855-826-7226) (NV: 1-855-827-7226)(TX: 1-855-844-7226). Вам може допомогти людина, яка володіє українською мовою. Ця послуга безкоштовна.

The formulary and pharmacy network may change at any time. You will receive notice when necessary.

This formulary was updated on 4/1/2025. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-855-650-7226 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.

El formulario y la red de farmacias pueden cambiar en cualquier momento. Usted recibirá un aviso cuando sea necesario.

Este formulario se actualizó el 4/1/2025. Para obtener información más reciente o si tiene preguntas, comuníquese con Servicios para Miembros de SCAN Health Plan al 1-855-650-7226 (los usuarios de TTY deben llamar al 711), de 8:00 a. m. a 8:00 p. m., los 7 días de la semana, desde el 1 de octubre hasta el 31 de marzo. Desde el 1 de abril hasta el 30 de septiembre, el horario es de 8:00 a. m. a 8:00 p. m., de lunes a viernes (los mensajes recibidos en días feriados y fuera del horario de atención se responderán en el plazo de un día hábil). También puede visitar www.scanhealthplan.com.

SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCAN Health Plan cumple con las leyes federales de derechos civiles vigentes y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad ni sexo. SCAN Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。