2021 Formulary / Formulario 2021

(List of covered drugs) / (Lista de medicamentos cubiertos)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN
POR FAVOR LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

Approved formulary ID 00021198 / ID de formulario aprobado 00021198

Florida:

- Devoted Health Core Miami-Dade HMO
- Devoted Health Core Broward HMO
- Devoted Health Core Palm Beach HMO
- Devoted Health Core Greater Tampa Bay HMO
- Devoted Health Core Greater Orlando HMO
- Devoted Health Prime Miami-Dade HMO
- Devoted Health Prime Broward HMO
- Devoted Health Prime Palm Beach HMO
- Devoted Health Prime Greater HMO Tampa Bay
- Devoted Health Prime Greater Orlando HMO
- Devoted Health Essentials Miami-Dade HMO
- Devoted Health Essentials Broward HMO
- Devoted Health Essentials Palm Beach HMO
- Devoted Health Essentials Greater Tampa Bay HMO
- Devoted Health Essentials Polk HMO
- Devoted Health Essentials Greater Orlando HMO
- Devoted Health Core Manatee HMO
- Devoted Health Prime Manatee HMO
- Devoted Health Core Greater Jacksonville HMO
- Devoted Health Prime Greater Jacksonville HMO
- Devoted Health Essentials Greater Jacksonville HMO
- Devoted Health Essentials Manatee HM
- Devoted Health Core HMO
- Devoted Health Prime HMO

Texas:

- Devoted Health Core San Antonio HMO
- Devoted Health Prime San Antonio HMO

Ohio:

- Devoted Health Core HMO
- Devoted Health Prime HMO
- Devoted Health Saver HMO

Arizona:

- Devoted Health Core HMO
- Devoted Health Select HMO
- Devoted Health Flex HMO

This formulary was updated on October 15, 2020. For more recent information or other questions, please contact Devoted Health Member Services at 1-800-338-6833 or, for TTY users, 711, Monday - Friday 8am - 8pm. (from Oct 1 - March 31, representatives are available 7 days a week, 8am - 8pm), or visit us at **www.devoted.com**.

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

Este formulario se actualizó el 15 de octubre de 2020. Para obtener información actualizada o si tiene otras preguntas, comuníquese con Devoted Health al 1-800-338-6833 o, para usuarios de TTY, al 711 de lunes a viernes de 8:00 a.m. a 8:00 p.m., (del 1 de octubre al 31 de marzo), representantes están disponibles los 7 días de la semana de 8:00 a.m. a 8:00 p.m. Los usuarios de TTY deben llamar al 711. O visite **www.devoted.com/es**.

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

Last updated October 15, 2020

H1290_21M1_C
H7993_21M10_C
H2697_21M1_C
H8173_21M1_C

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 Devoted Health. When it refers to "plan" or "our plan," it means Devoted Health Core HMO, Devoted Health Prime HMO, Devoted Health Essentials HMO, Devoted Health Saver HMO, Devoted Health Select HMO, or Devoted Health Flex HMO.

This document includes a list of the drugs (formulary) for our plan which is current as of October 15, 2020. For an updated formulary, please contact us. Our contact information, along with the date we last updated the 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, 2022, and from time to time during the year.

What is the Devoted Health Formulary?

A formulary is a list of covered drugs selected by Devoted Health 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. Devoted Health will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Devoted Health 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 (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that 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 the brand name drug for you. 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 Devoted Health Formulary?"
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and 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 add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or 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, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
    - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. 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 Devoted Health Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 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 Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of October 15, 2020. To get updated information about the drugs covered by Devoted Health, please contact us. Our contact information appears on the front and back cover pages. We will update the downloadable formularies each month and they will be available on **www.devoted.com**. In the event of a mid-year non-maintenance formulary change, you will be notified via an errata sheet.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 18. 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". If you know what your drug is used for, look for the category name in the list that begins on page number 16. 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 77. The Index provides an alphabetical list of all 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?

Devoted Health 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 cost less than brand name drugs.

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

- **Quantity Limits:** For certain drugs, Devoted Health limits the amount of the drug that Devoted Health will cover. For example, Devoted Health provides 30 capsules every 30 days for DEXILANT. This may be in addition to a standard one-month or three-month supply.

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 18. You can also get more information about the restrictions applied to specific covered drugs by visiting our Website. We have posted online documents that explain our prior authorization and step therapy restrictions. 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 Devoted Health 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 Devoted Health formulary?" on page 4 for information about how to request an exception.

What are over-the-counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. Devoted Health pays for certain OTC drugs through your OTC benefit. Devoted Health will provide these OTC drugs at no cost to you. The cost to Devoted Health of these OTC drugs will not count toward your total Part D drug costs (that is, the cost of the OTC drugs does not count for the coverage gap).

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 Devoted Health does not cover your drug, you have two options:

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

- You can ask Devoted Health 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 Devoted Health Formulary?

You can ask Devoted Health 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 cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Devoted Health 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.

Generally, Devoted Health will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

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 your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to 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 if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, 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 experience a change in your level of care, such as a move from a home to a long-term care setting, and need a drug that is not on our formulary (or if your ability to get your drugs is limited), we may cover a one- time temporary supply from a network pharmacy for up to 30 days unless you have a prescription for fewer days. You should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

For More Information

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

If you have questions about Devoted Health, 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.

Devoted Health's Formulary

The formulary below provides coverage information about the drugs covered by Devoted Health. If you have trouble finding your drug in the list, turn to the Index that begins on page 77.

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

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

ED: Excluded Drug

This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total 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 this drug.

B/D: Medicare Part B or D

These drugs require prior authorization to determine appropriate coverage under Medicare Part B or Part D. Some Part B drugs may require a 20% co-insurance for Devoted Health members. Please refer to your Evidence of Coverage (EOC) for more information about this coverage.

QL: Quantity Limit Applies

Because of potential safety and utilization concerns, Devoted Health has placed dispensing limitations on a small number of prescription drugs. This means that the pharmacy will only dispense a certain quantity of a drug within a given time period. These quantities are based on recognized standards of care, such as U.S. Food and Drug Administration recommendations for use. If your doctor believes you need a quantity greater than the program limitation, your doctor may ask Devoted Health to make an exception to our coverage rules. See the section, "How do I request an exception to the Devoted Health formulary?" on page 4 for information about how to request an exception.

LA: Limited Access Drug

This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Devoted Health at 1-800-338-6833, Monday-Friday 8:00 a.m. – 8:00 p.m. (From Oct. 1 – Mar. 31 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.). TTY users should call 711.

PA: Prior Authorization Required

The Prior Authorization process encourages rational prescribing of drug products with significant safety and/or financial concerns. A provider can submit a request for coverage based on a member's medical need for a particular drug. If approved, the member pays the designated tier co-payment. An appeal process exists for denied requests.

ST: Step Therapy Applies

Step Therapy is an automated form of Prior Authorization, which uses claims history for approval of a drug at the point of sale. Step Therapy Programs help encourage the clinically proven use of first-line therapies and are designed to ensure the utilization of the most therapeutically appropriate and cost-effective agents first, before other treatments may be covered.

Members who are currently on drugs that meet the initial Step Therapy criteria will automatically be able to fill their prescriptions for medications on the next Step. If the member does not meet the initial Step Therapy criteria, the prescription will deny at the point of sale with a message indicating that Prior Authorization (PA) is required. Physicians may submit Prior Authorization requests to Devoted Health for members who do not meet the Step Therapy criteria at the point of sale. See the section, "How do I request an exception to the Devoted Health formulary?" on page 4 for information about how to request an exception to Devoted Health's prior authorization and step therapy criteria.

HI: Home Infusion Drug

This prescription drug may be covered under your medical benefit. Some Part B drugs may require a 20% co-insurance.

GC: Gap Coverage

We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

NDS: Non-extended Day Supply Drug

In an effort to contain drug costs, certain high-cost drugs will be limited up to a 30-day supply per fill.

SSM: Senior Savings Model Insulin

Select insulins that are part of the Part D Senior Savings Model are covered with a fixed copay in the Deductible, Initial Coverage, and Coverage Gap phases of your Part D benefit. See your Evidence of Coverage (EOC) booklet for additional information.

About Drug Tiers

Tiers are just a way to group drugs based on how much they cost. Generally, the higher the tier, the more you'll have to pay out of your own pocket.

Tier	Description
1	Preferred Generic Drugs
2	Generic Drugs
3	Preferred Brand Drugs
4	Non-Preferred Drugs
5	Specialty Tier Drugs

lowercase italics = generic drug
ALL CAPS = brand-name drug

Last Updated October 15, 2020

Nota para miembros actuales: Este formulario ha cambiado desde el año pasado. Revise este documento para asegurarse de que lista aun contiene los medicamentos que usted toma.

Cuando esta lista de medicamentos (formulario) se refiere a "nosotros" o "nuestro", significa Devoted Health. Cuando se refiere a “plan” o “nuestro plan” significa Devoted Health Core HMO, Devoted Health Prime HMO, Devoted Health Essentials HMO, Devoted Health Saver HMO, Devoted Health Select HMO, o Devoted Health Flex HMO.

Este documento incluye una lista de medicamentos (formulario) para nuestro plan el cual está vigente al 15 de octubre de 2020. Contáctenos para obtener un formulario actualizado. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y contraportada.

En general, debe usar las farmacias de la red para usar su beneficio de medicamentos recetados. Los beneficios, el formulario, la red de farmacias, y/o copagos/coseguro pueden cambiar el 1 de enero de 2022, y cada cierto tiempo a lo largo del año.

¿Qué es el Formulario de Devoted Health?

Un formulario es una lista de medicamentos cubiertos seleccionados por Devoted Health en consulta con un equipo de proveedores de atención médica, que representa las terapias de medicamentos considerados como una parte necesaria en un programa de tratamiento de calidad. Devoted Health, por lo general, cubrirá los medicamentos que se indican en nuestro formulario siempre que el medicamento sea necesario por razones médicas. El medicamento es surtido en una farmacia de la red de Devoted Health, y se siguen otras reglas del plan. Para obtener más información sobre cómo surtir sus medicamentos, revise su Evidencia de Cobertura.

¿Puede cambiar el Formulario (lista de medicamentos)?

La mayoría de los cambios en la cobertura de medicamentos suceden el 1 de enero, pero podemos agregar o eliminar medicamentos de la Lista de medicamentos durante el año, moverlos a diferentes niveles de costos compartidos o agregar nuevas restricciones. Debimos cumplir las reglas de Medicare al realizar estos cambios.

Cambios que pudieran afectarle este año: En los casos a continuación, se verá afectado por los cambios de cobertura durante el año:

- **Nuevos medicamentos genéricos.** Podemos eliminar inmediatamente un medicamento de marca de nuestra Lista de medicamentos, si lo reemplazamos con un medicamento genérico nuevo que aparecerá en el mismo nivel de costo compartido o con un costo compartido menor y con las mismas o menos restricciones. También, cuando se agrega un medicamento genérico nuevo, podríamos decidir conservar el medicamento de marca en nuestra Lista de medicamentos, pero moverlo inmediatamente a un nivel de costo compartido diferente o agregar nuevas restricciones. Si en la actualidad usted está tomando ese medicamento de marca, pudiéramos no informarle por anticipado de ese cambio, pero más adelante le proporcionaremos información sobre el(los) cambio(s) específico(s) que hayamos hecho.
    - Si hacemos tal cambio, usted o el profesional que emite su receta puede solicitarnos una excepción y continuar la cobertura del medicamento de marca que usted toma. La notificación que le proporcionamos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al formulario de Devoted Health?"

- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos considera que un medicamento incluido en nuestro formulario es inseguro o si el fabricante del medicamento lo retira del mercado, nosotros inmediatamente retiraremos el medicamento de nuestro formulario y notificaremos a los miembros que toman el medicamento.

- **Otros cambios.** Podemos realizar otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podemos agregar un medicamento genérico que no sea nuevo en el mercado para reemplazar un medicamento de marca que esté actualmente incluido en el formulario, o agregar nuevas restricciones al medicamento de marca, o moverlo a un nivel de costo compartido diferente o ambas cosas. O podemos hacer cambios basados en nuevas directrices clínicas. Si eliminamos medicamentos de nuestro formulario, agregamos autorización previa, limites de cantidad y/o restricciones en la terapia por fases en un medicamento o movemos el medicamento a un nivel de costo compartido mayor, debemos notificar a los miembros afectados del cambio, al menos 30 días antes de que el cambio entre en vigencia, o en el momento en que el miembro solicite una repetición del medicamento, en cuyo caso, el miembro recibirá un suministro de 30 días del medicamento.

  - Si hacemos estos otros cambios, usted o el profesional que emite su receta puede solicitarnos una excepción y continuar la cobertura del medicamento de marca que usted toma. La notificación que le proporcionamos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al formulario de Devoted Health?"

Cambios que no le afectarán si actualmente está tomando el medicamento. En general, si usted está tomando un medicamento incluido en nuestro formulario del 2021 que tenía cobertura a principios del año, no descontinuaremos o reduciremos la cobertura del medicamento durante la cobertura del 2021, salvo lo indicado anteriormente. Esto significa que estos medicamentos permanecerán disponibles al mismo costo-compartido y sin nuevas restricciones para aquellos miembros que estarán tomándolos por el resto del año de la cobertura. No recibirá ningún aviso directo sobre cambios que no le afecten durante el año en curso. No obstante, el 1 de enero del año siguiente, tales cambios le afectarían y es importante consultar la Lista de medicamentos para el nuevo año de beneficios para cualquier cambio en los medicamentos.

El formulario adjunto está actualizado al 15 de octubre de 2020. Contáctenos para obtener información actualizada sobre los medicamentos cubiertos por Devoted Health. Nuestra información de contacto se encuentra en la portada y contraportada. Actualizaremos los formularios descargables cada mes y estos estarán disponibles en **www.devoted.com/es**. En el caso de que se produzca un cambio a mediados de año en el formulario que no sea de mantenimiento, se le notificará a través de una fe de erratas.

¿Cómo utilizo el Formulario?

Hay dos maneras de encontrar su medicamento en el formulario:

Condición médica

El formulario comienza en la página 18. Los medicamentos en este formulario están agrupados por categorías dependiendo del tipo de condición médica para los que se utilizan. Por ejemplo, los medicamentos utilizados para el tratamiento de condiciones cardíacas están indicados bajo la categoría "Cardiovascular". Si usted conoce el uso que tiene su medicamento, busque el nombre de la categoría en la lista que comienza en la página número 16. Luego busque su medicamento bajo el nombre de la categoría.

Lista alfabética

De no estar seguro en que categoría debe buscar, usted debería buscar su medicamento en el Índice que comienza en la página 77. El Índice proporciona una lista alfabética de todos los medicamentos incluidos en este documento. Ambos, los medicamentos de marca y los genéricos están indicados en el Índice. Busque en el Índice y encuentre su medicamento. Al lado de su medicamento, verá el número de la página en la que puede encontrar la información de la cobertura. Vaya a la página indicada en el índice y encuentre el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Devoted Health cubre tanto los medicamentos de marca como los medicamentos genéricos. Un medicamento genérico recibe la aprobación de la FDA por tener los mismos ingredientes activos que el medicamento de marca. En general, los medicamentos genéricos tienen un costo menor que los medicamentos de marca.

¿Mi cobertura tiene alguna restricción?

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

- **Autorización previa:** Devoted Health requiere que usted o su médico obtengan autorización previa para ciertos medicamentos. Esto significa que usted necesitará obtener la aprobación de Devoted Health para poder surtir sus recetas. Si no obtiene la aprobación, Devoted Health pudiera no cubrir el medicamento.

- **Límites de la cantidad:** Para ciertos medicamentos, Devoted Health aplica límites en la cantidad del medicamento que Devoted Health cubrirá. Por ejemplo, Devoted Health provee 30 capsulas cada 30 días de DEXILANT. Esto pudiera ser adicional al suministro mensual estándar de un mes o de tres meses.

- **Terapia por fases:** En algunos casos, Devoted Health requiere que usted primero pruebe ciertos medicamentos para el tratamiento de su condición médica antes de cubrir otros medicamentos para esa condición. Por ejemplo, si el medicamento A y el medicamento B ambos son para el tratamiento de su condición médica, Devoted Health pudiera no cubrir el medicamento B, a menos, que usted pruebe primero el medicamento A. Si el medicamento A no funciona para usted, entonces Devoted Health cubrirá el medicamento B.

Usted puede encontrar si su medicamento tiene algún requisito o límite adicional buscando en el formulario que comienza en la página 18. También puede obtener más información sobre las restricciones aplicadas a medicamentos cubiertos específicos visitando nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y terapia por fases. También puede pedir que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y contraportada.

Puede solicitar a Devoted Health hacer una excepción a dichas restricciones o límites; o solicitar una lista de otros medicamentos similares que pueden usarse para el tratamiento de su condición médica. Consulte la sección “¿Cómo solicito una excepción al formulario de Devoted Health?” en la página 11 para obtener información sobre cómo solicitar una excepción.

¿Qué son los medicamentos de venta sin receta (OTC, por sus siglas en inglés)?

Los medicamentos OTC son medicamentos que se venden sin receta que normalmente no están cubiertos por un plan de medicamentos con receta de Medicare. Devoted Health paga ciertos medicamentos OTC a través de su beneficio OTC. Devoted Health le proporcionará estos medicamentos OTC sin costo alguno para usted. El costo para Devoted Health de estos medicamentos OTC no contará para sus costos totales de medicamentos de la Parte D (es decir, el costo de los medicamentos OTC no cuenta para el Período sin cobertura).

¿Qué sucede si mi medicamento no está en el Formulario?

Si su medicamento no ha sido incluido en este formulario (lista de medicamentos cubiertos), usted primero debe comunicarse con Servicios para miembros y preguntar si su medicamento está cubierto.

Si se entera que Devoted Health no cubre su medicamento, tiene dos opciones:

- Puede pedirle a Servicios para miembros una lista de medicamentos similares cubiertos por Devoted Health. Cuando reciba la lista, muéstresela a su médico y pídale le recete un medicamento similar que esté cubierto por Devoted Health.
- Usted puede pedirle a Devoted Health que haga una excepción y que cubra su medicamento. Vea a continuación información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al formulario de Devoted Health?

Usted puede pedirle a Devoted Health que haga una excepción a nuestras reglas de cobertura. Hay varios tipos de excepciones que puede solicitarnos.

- Puede pedirnos que se cubra un medicamento aun cuando no esté en nuestro formulario. Si es aprobado, este medicamento será cubierto en un nivel de costo-compartido predeterminado, y no podrá solicitarnos que le proporcionemos el medicamento a un nivel de costo compartido más bajo.
- Usted puede pedirnos cubrir un medicamento del formulario a un nivel de costo compartido más bajo, si el medicamento no se encuentra en el nivel de especialidad. Si es aprobado esto reduciría la cantidad que debe pagar por su medicamento.
- Puede solicitarnos que eliminemos las restricciones o límites de cobertura de su medicamento. Por ejemplo, para ciertos medicamentos, Devoted Health limita la cantidad de medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, usted puede solicitarnos que eliminemos el límite y que cubramos una mayor cantidad.

Por lo general, Devoted Health solo aprobará su solicitud de una excepción si los medicamentos alternativos incluidos en el formulario del plan, el medicamento de costo-compartido más bajo o las restricciones de utilización adicionales no serían tan eficaces en el tratamiento de su condición y/o causaría que tenga efectos médicos adversos.

Debería contactarnos para solicitar una decisión sobre la cobertura inicial para un formulario o excepción de restricción de utilización. **Cuando solicita una excepción al formulario o restricción de utilización, debe enviar una declaración de su médico o profesional que emite su receta que respalde su solicitud.** En general, debemos tomar nuestras decisiones dentro de 72 horas después de haber recibido la declaración de respaldo del profesional que emite su receta. Usted puede solicitar una excepción acelerada (rápida), si usted o su médico consideraran que su salud podría verse seriamente perjudicada al esperar hasta 72 horas para que se tome una decisión. Si su solicitud de excepción acelerada se aprueba, debemos darle una decisión a más tardar 24 horas después de que recibamos una declaración de respaldo de su médico u otro profesional que emita su receta.

¿Qué hago antes de poder hablar con mi médico sobre un cambio de medicamentos o solicitar una excepción?

Como miembro nuevo o continuo de nuestro plan, es posible que esté tomando medicamentos que no están en nuestro formulario. O, pudiera estar tomando un medicamento que esté en nuestro formulario pero su capacidad para obtenerlo es limitada. Por ejemplo, usted puede necesitar una autorización previa de nosotros antes de surtir su receta. Consulte a su médico para decidir si debe cambiarse a un medicamento apropiado cubierto por nosotros o solicitar una excepción del formulario, de manera que podamos cubrir el medicamento que usted toma. Mientras usted habla con su médico para determinar el curso correcto de acción, pudiéramos cubrir sus medicamentos en ciertos casos durante los primeros 90 días de su afiliación a nuestro plan.

Para cada uno de sus medicamentos que no está en nuestro formulario o si su capacidad para obtener sus medicamentos es limitada, nosotros cubriremos un suministro temporal de 30 días. Si su receta está escrita por menos de días, permitiremos repeticiones de medicamentos para proporcionarle un suministro máximo de medicamento para 30 días. Después de su primer suministro de 30 días, no pagaremos por estos medicamentos, incluso si ha sido miembro del plan por menos de 90 días.

Si usted reside en un centro de cuidado a largo plazo y necesita un medicamento que no esté en nuestro formulario o si su capacidad para obtener sus medicamentos es limitada, pero han pasado los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia de 31 días de ese medicamento, mientras procesa su excepción al formulario.

Si usted experimenta un cambio en su nivel de atención, tal como una mudanza de su hogar a un centro de cuidado a largo plazo, y necesita de un medicamento que no está incluido en nuestro formulario (o si su capacidad para obtenerlo es limitada), pudiéramos cubrir un suministro único temporal de una farmacia de la red hasta por 30 días, a menos, que tenga una receta por menos días. Debe usar el proceso de excepción del plan si desea continuar con la cobertura del medicamento después de que finalice el suministro temporal.

Para obtener más información

Para información más detallada sobre su cobertura de medicamentos recetados con Devoted Health, revise su Evidencia de cobertura y otros documentos del plan.

Contáctenos si tiene preguntas sobre Devoted Health. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y contraportada.

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

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Formulario de Devoted Health

El siguiente formulario provee información sobre la covertura de los medicamentos que cubre Devoted Health. Si tiene problemas para encontrar su medicamento en la lista, vaya al Índice que empieza en la página 77.

La primera columna de la tabla muestra el nombre del medicamento. Los medicamentos de marca están en mayúsculas (por ejemplo, ENTRESTO) y los medicamentos genéricos se muestran en minúsculas y cursivas (por ejemplo, *omeprazole*).

La información en la columna de Requisitos/Límites le dice si Devoted Health tiene algún requisito especial para cubrir su medicamento.

ED: Medicamento excluido

Este medicamento recetado no está normalmente cubierto en un Plan de medicamentos recetados de Medicare. El monto que paga cuando surte una receta para este medicamento no cuenta para el costo total del medicamento (es decir, el monto que paga no lo ayuda a calificar para una cobertura catastrófica). Además, si está recibiendo ayuda adicional para pagar por sus medicamentos, usted no recibirá ninguna ayuda adicional para pagar por este medicamento.

B/D: Parte B o D de Medicare

Estos medicamentos requieren autorización previa para determinar la cobertura apropiada bajo la Parte B o la Parte D de Medicare. Algunos medicamentos de la Parte B requieren un coseguro del 20% para los miembros de Devoted Health. Para obtener más información sobre esta cobertura, consulte su Evidencia de Cobertura (EOC siglas en Inglés).

QL: Se aplican límites en la cantidad

Debido a preocupaciones potenciales de seguridad y utilización, Devoted Health ha colocado limitaciones de suministro en una pequeña cantidad de medicamentos con receta. Esto significa que la farmacia solo suministrará una cierta cantidad de un medicamento dentro de un período de tiempo determinado. Estas cantidades se basan en los estándares reconocidos de cuidados, tales como las recomendaciones de la Administración de Alimentos y Medicamentos de los Estados Unidos. Si su médico cree que usted necesita una cantidad mayor a la limitación establecida por el programa, su médico puede solicitar a Devoted Health hacer una excepción a nuestras reglas de cobertura. Consulte la sección “¿Cómo solicito una excepción al formulario de Devoted Health?” en la página 11 para obtener información sobre cómo solicitar una excepción.

LA: Medicamento con acceso limitado

Este medicamento recetado puede estar disponible solo en ciertas farmacias. Para obtener más información consulte su Directorio de farmacias o llame a Devoted Health al 1-800-338-6833, de lunes a viernes, de 8:00 a.m. a 8:00 p.m. (Del 1 de octubre al 31 de marzo, los representantes están disponibles los 7 días de la semana, de 8:00 a.m. a 8:00 p.m.). Los usuarios de TTY deben llamar al 711.

PA: Se requiere autorización previa

El proceso de Autorización previa fomenta recetar de manera racional medicamentos con importantes problemas de seguridad y/o financieros. Un proveedor puede presentar una solicitud de cobertura basado en la necesidad médica de un miembro por un medicamento en particular. Si es aprobado, el miembro paga el nivel designado de copago. Existe un proceso de apelación para las solicitudes rechazadas.

ST: Se aplica la Terapia por fases

La Terapia por fases es una forma automática de Autorización previa que utiliza el historial de reclamaciones para la aprobación de un medicamento en el punto de venta. Los Programas de terapia por fases ayudan a fomentar el uso clínicamente probado de terapias de primera línea y están diseñados para garantizar que se utilicen, primero, los agentes más terapéuticamente apropiados y económicos, antes de que se puedan cubrir otros tratamientos.

Los miembros que actualmente toman medicamentos y que cumplen con el criterio inicial de Terapia por fases, automáticamente podrán surtir sus recetas por medicamentos en la próxima Fase. Si el miembro no cumple con el criterio inicial de Terapia por fases, el medicamento con receta será rechazado en el punto de venta con un mensaje que indica que se requiere la Autorización previa (PA). Los médicos pueden presentar a Devoted Health solicitudes de Autorización previa para miembros que no cumplen con el criterio de Terapia por fases en el punto de venta. Consulte la sección “¿Cómo solicito una excepción al formulario de Devoted Health?” en la página 11 para obtener información sobre cómo solicitar una excepción a los criterios de autorización previa y terapia por fases de Devoted Health.

HI: Infusión en el hogar

Este medicamento con receta puede estar cubierto por su beneficio médico. Algunos medicamentos de la Parte B pueden requerir un coseguro del 20%.

GC: Vacío de cobertura

Proporcionamos cobertura adicional de este medicamento recetado en el período sin cobertura. Consulte nuestra Evidencia de Cobertura para obtener más información sobre esta cobertura.

NDS: Días de suministro de medicamento no extendido

En un esfuerzo por contener los costos de los medicamentos, algunos medicamentos de alto costo estarán limitados a un suministro de hasta 30 días por surtido.

SSM: Insulina modelo de ahorros para personas de la tercera edad

Ciertas insulinas que son parte del Modelo de ahorros para personas de la tercera edad de la Parte D están cubiertos con un copago fijo en las fases de Deducible, Cobertura inicial y Período sin cobertura de su beneficio de la Parte D. Consulte su folleto de Evidencia de cobertura (EOC, por sus siglas en inglés) para obtener información adicional.

Sobre niveles en los medicamentos

Los niveles son solo una forma de agrupar los medicamentos según el costo. Por lo general, cuanto más alto sea el nivel, más tendrá que pagar de su propio bolsillo.

Tier	Description
1	Medicamentos genéricos preferidos
2	Medicamentos genéricos
3	Medicamentos de marca preferidos
4	Medicamentos no preferidos
5	Medicamentos con nivel de especialidad

minúsculas y cursivas = medicamento genérico
TODAS MAYUSCULAS = medicamento de marca

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
ANALGESICS		
GOUT		
allopurinol TABS 100mg, 300mg	2	
colchicine TABS .6mg	4	QL (120 tabs / 30 days)
colchicine w/ probenecid tab 0.5-500 mg	3	
MITIGARE CAPS .6mg	3	QL (60 caps / 30 days)
probenecid TABS 500mg	3	
NSAIDS		
celecoxib CAPS 50mg	3	QL (240 caps / 30 days)
celecoxib CAPS 100mg	3	QL (120 caps / 30 days)
celecoxib CAPS 200mg	3	QL (60 caps / 30 days)
celecoxib CAPS 400mg	3	QL (30 caps / 30 days)
diclofenac potassium TABS 50mg	3	QL (120 tabs / 30 days)
diclofenac sodium TB24 100mg	3	
diclofenac sodium TBEC 25mg, 50mg, 75mg	2	
diflunisal TABS 500mg	3	
ec-naproxen TBEC 375mg, 500mg	2	
etodolac CAPS 200mg, 300mg; TABS 400mg, 500mg; TB24 400mg, 500mg, 600mg	3	
flurbiprofen TABS 100mg	3	
ibu TABS 600mg, 800mg	1	
ibuprofen SUSP 100mg/5ml	3	
ibuprofen TABS 400mg, 600mg, 800mg	1	
meloxicam TABS 7.5mg, 15mg	1	
nabumetone TABS 500mg, 750mg	2	
naproxen TABS 250mg, 375mg, 500mg	1	
naproxen dr TBEC 375mg, 500mg	2	
naproxen sodium TABS 275mg, 550mg	3	
piroxicam CAPS 10mg, 20mg	3	
sulindac TABS 150mg, 200mg	2	
OPIOID ANALGESICS, LONG-ACTING		
fentanyl PT72 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr	4	QL (10 patches / 30 days), PA
HYSINGLA ER T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	3	QL (30 tabs / 30 days), PA
methadone hcl SOLN 5mg/5ml, 10mg/5ml	3	QL (450 mL / 30 days), PA
methadone hcl TABS 5mg, 10mg	3	QL (90 tabs / 30 days), PA
methadone hcl intensol CONC 10mg/ml	3	QL (90 mL / 30 days), PA
morphine sulfate TBCR 15mg, 30mg, 60mg, 100mg, 200mg	3	QL (90 tabs / 30 days), PA
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen w/ codeine soln 120-12 mg/5ml	3	QL (2700 mL / 30 days)
acetaminophen w/ codeine tab 300-15 mg	3	QL (400 tabs / 30 days)
acetaminophen w/ codeine tab 300-30 mg	3	QL (360 tabs / 30 days)

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PA–Prior Authorization **QL**–Quantity Limits **ST**–Step Therapy **NM**–not available at mail-order **B/D**–Covered under Medicare B or D **LA**–Limited Access **ED**–Excluded Drug **HI**–Home Infusion **GC**–We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage **NDS**–Non-Extended Days Supply **SSM**–Senior Savings Model insulin

List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
acetaminophen w/ codeine tab 300-60 mg	3	QL (180 tabs / 30 days)
butorphanol tartrate SOLN 1mg/ml, 2mg/ml	4	
endocet tab 2.5-325mg	3	QL (360 tabs / 30 days)
endocet tab 5-325mg	3	QL (360 tabs / 30 days)
endocet tab 7.5-325mg	3	QL (240 tabs / 30 days)
endocet tab 10-325mg	3	QL (180 tabs / 30 days)
fentanyl citrate LPOP 200mcg, 600mcg, 800mcg, 1200mcg, 1600mcg	5	NDS, QL (120 lozenges / 30 days), PA
fentanyl citrate LPOP 400mcg	4	QL (120 lozenges / 30 days), PA
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	4	QL (2700 mL / 30 days)
hydrocodone-acetaminophen tab 5-325 mg	3	QL (240 tabs / 30 days)
hydrocodone-acetaminophen tab 7.5-325 mg	3	QL (180 tabs / 30 days)
hydrocodone-acetaminophen tab 10-325 mg	3	QL (180 tabs / 30 days)
hydrocodone-ibuprofen tab 7.5-200 mg	3	QL (150 tabs / 30 days)
hydromorphone hcl LIQD 1mg/ml	4	QL (600 mL / 30 days)
hydromorphone hcl TABS 2mg, 4mg, 8mg	3	QL (180 tabs / 30 days)
lorcet	3	QL (240 tabs / 30 days)
lorcet hd	3	QL (180 tabs / 30 days)
lorcet plus	3	QL (180 tabs / 30 days)
morphine sulfate SOLN 1mg/ml, 4mg/ml, 8mg/ml, 10mg/ml	4	B/D
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml	4	B/D
morphine sulfate SOLN 10mg/5ml	3	QL (900 mL / 30 days)
morphine sulfate SOLN 20mg/5ml	3	QL (900 mL / 30 days)
morphine sulfate SOLN 100mg/5ml	3	QL (180 mL / 30 days)
morphine sulfate TABS 15mg, 30mg	3	QL (180 tabs / 30 days)
nalbuphine hcl SOLN 10mg/ml, 20mg/ml	4	
oxycodone hcl CAPS 5mg	4	QL (180 caps / 30 days)
oxycodone hcl CONC 100mg/5ml	4	QL (180 mL / 30 days)
oxycodone hcl SOLN 5mg/5ml	4	QL (900 mL / 30 days)
oxycodone hcl TABS 5mg, 10mg, 15mg, 20mg, 30mg	3	QL (180 tabs / 30 days)
oxycodone w/ acetaminophen tab 2.5-325 mg	3	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen tab 5-325 mg	3	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen tab 7.5-325 mg	3	QL (240 tabs / 30 days)
oxycodone w/ acetaminophen tab 10-325 mg	3	QL (180 tabs / 30 days)
tramadol hcl TABS 50mg	2	QL (240 tabs / 30 days)
tramadol-acetaminophen tab 37.5-325 mg	3	QL (240 tabs / 30 days)
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.) SOLN .5%, 1%, 1.5%, 2%	3	B/D
ANTI-INFECTIVES		
ANTI-INFECTIVES - MISCELLANEOUS		
albendazole TABS 200mg	5	NDS

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PA–Previa Autorización **QL**–Límites de Cantidad **ST**–Terapia por Fases **NM**–No Disponible en Pedido por Correo **B/D**–Cobertura bajo Medicare B o D **LA**–Acceso Limitado **ED**–Medicamento Excluido **HI**–Infusión en el hogar **GC**–Proveemos cobertura de este medicamento con receta en el período sin cobertura. Consulte nuestra Evidencia de cobertura para obtener más información sobre esta cobertura. **NDS**–Días de Suministro no Extendido **SSM**–Insulina modelo de ahorros para personas de la tercera edad

List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
ALINIA SUSR 100mg/5ml	5	NDS, QL (180 mL / 30 days)
ALINIA TABS 500mg	5	NDS, QL (6 tabs / 30 days)
amikacin sulfate SOLN 1gm/4ml, 500mg/2ml	4	HI
atovaquone SUSP 750mg/5ml	5	NDS
aztreonam SOLR 1gm, 2gm	4	
CAYSTON SOLR 75mg	5	NDS, NM, LA, PA
clindamycin hcl CAPS 75mg, 150mg, 300mg	2	
clindamycin palmitate hydrochloride SOLR 75mg/5ml	4	
clindamycin phosphate SOLN 9gm/60ml, 300mg/2ml, 9000mg/60ml	3	HI
clindamycin phosphate SOLN 600mg/4ml, 900mg/6ml	3	
clindamycin phosphate in d5w iv soln 300 mg/50ml	4	HI
clindamycin phosphate in d5w iv soln 600 mg/50ml	4	HI
clindamycin phosphate in d5w iv soln 900 mg/50ml	4	HI
CLINDMYC/NAC INJ 300/50ML	4	
CLINDMYC/NAC INJ 600/50ML	4	
CLINDMYC/NAC INJ 900/50ML	4	
colistimethate sodium SOLR 150mg	4	HI
dapsone TABS 25mg, 100mg	3	
DAPTOMYCIN SOLR 350mg	5	NDS
daptomycin SOLR 350mg, 500mg	5	NDS
EMVERM CHEW 100mg	5	NDS, QL (12 tabs / 365 days)
ertapenem sodium SOLR 1gm	4	
gentamicin in saline inj 0.8 mg/ml	3	HI
gentamicin in saline inj 1 mg/ml	3	HI
gentamicin in saline inj 1.2 mg/ml	3	HI
gentamicin in saline inj 1.6 mg/ml	3	HI
gentamicin in saline inj 2 mg/ml	3	HI
gentamicin sulfate SOLN 10mg/ml, 40mg/ml	3	HI
imipenem-cilastatin intravenous for soln 250 mg	4	
imipenem-cilastatin intravenous for soln 500 mg	4	
ivermectin TABS 3mg	3	
linezolid SOLN 600mg/300ml	4	
linezolid SUSR 100mg/5ml	5	NDS, QL (1800 mL / 30 days)
linezolid TABS 600mg	4	QL (60 tabs / 30 days)
linezolid in sodium chloride iv soln 600 mg/300ml-0.9%	4	
meropenem SOLR 1gm, 500mg	4	HI
methenamine hippurate TABS 1gm	3	
metronidazole TABS 250mg, 500mg	2	
metronidazole in nacl 0.79% iv soln 500 mg/100ml	3	
neomycin sulfate TABS 500mg	2	
nitrofurantoin macrocrystal CAPS 50mg, 100mg	3	
nitrofurantoin monohyd macro CAPS 100mg	3	

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List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
paromomycin sulfate CAPS 250mg	4	
pentamidine isethionate inh SOLR 300mg	4	B/D
pentamidine isethionate inj SOLR 300mg	4	
praziquantel TABS 600mg	4	
SIVEXTRO SOLR 200mg; TABS 200mg	5	NDS
streptomycin sulfate SOLR 1gm	5	NDS
SULFADIAZINE TABS 500mg	4	
sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml	4	
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	3	
sulfamethoxazole-trimethoprim tab 400-80 mg	1	
sulfamethoxazole-trimethoprim tab 800-160 mg	1	
SYNERCID INJ 500MG	5	NDS
tobramycin NEBU 300mg/5ml	5	NDS, NM, PA
tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml	3	HI
trimethoprim TABS 100mg	2	
vancomycin hcl CAPS 125mg	4	QL (80 caps / 180 days)
vancomycin hcl CAPS 250mg	4	QL (160 caps / 180 days)
vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg	4	HI
VANCOMYCIN INJ 1 GM	4	
VANCOMYCIN INJ 500MG	4	
VANCOMYCIN INJ 750MG	4	
ANTIFUNGALS		
ABELCET SUSP 5mg/ml	4	B/D
AMBISOME SUSR 50mg	5	NDS, HI, B/D
amphotericin b SOLR 50mg	4	B/D
caspofungin acetate SOLR 50mg, 70mg	5	NDS
fluconazole SUSR 10mg/ml, 40mg/ml; TABS 50mg, 100mg, 200mg	3	
fluconazole TABS 150mg	2	
fluconazole in nacl 0.9% inj 200 mg/100ml	3	HI
fluconazole in nacl 0.9% inj 400 mg/200ml	3	HI
flucytosine CAPS 250mg, 500mg	5	NDS
griseofulvin microsize SUSP 125mg/5ml; TABS 500mg	4	
griseofulvin ultramicrosize TABS 125mg, 250mg	4	
itraconazole CAPS 100mg	4	PA
ketoconazole TABS 200mg	3	PA
micafungin sodium SOLR 50mg, 100mg	5	NDS, HI
NOXAFIL SUSP 40mg/ml	5	NDS, QL (630 mL / 30 days)
nystatin TABS 500000unit	3	
posaconazole TBEC 100mg	5	NDS, QL (93 tabs / 30 days)
terbinafine hcl TABS 250mg	1	QL (90 tabs / year)
voriconazole SOLR 200mg; SUSR 40mg/ml	5	NDS, PA
voriconazole TABS 50mg	4	QL (480 tabs / 30 days), PA

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PA–Previa Autorización **QL**–Límites de Cantidad **ST**–Terapia por Fases **NM**–No Disponible en Pedido por Correo **B/D**–Cobertura bajo Medicare B o D **LA**–Acceso Limitado **ED**–Medicamento Excluido **HI**–Infusión en el hogar **GC**–Proveemos cobertura de este medicamento con receta en el período sin cobertura. Consulte nuestra Evidencia de cobertura para obtener más información sobre esta cobertura. **NDS**–Días de Suministro no Extendido **SSM**–Insulina modelo de ahorros para personas de la tercera edad

List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
voriconazole TABS 200mg	4	QL (120 tabs / 30 days), PA
ANTIMALARIALS		
atovaquone-proguanil hcl tab 62.5-25 mg	4	
atovaquone-proguanil hcl tab 250-100 mg	4	
chloroquine phosphate TABS 250mg, 500mg	3	
COARTEM TAB 20-120MG	4	
mefloquine hcl TABS 250mg	3	
primaquine phosphate TABS 26.3mg	3	
PRIMAQUINE PHOSPHATE TABS 26.3mg	3	
quinine sulfate CAPS 324mg	4	PA
ANTIRETROVIRAL AGENTS		
abacavir sulfate SOLN 20mg/ml	4	NM
abacavir sulfate TABS 300mg	3	NM
APTIVUS CAPS 250mg; SOLN 100mg/ml	5	NDS, NM
atazanavir sulfate CAPS 150mg, 200mg, 300mg	4	NM
CRIXIVAN CAPS 200mg, 400mg	4	NM
didanosine CPDR 200mg, 250mg, 400mg	4	NM
EDURANT TABS 25mg	5	NDS, NM
efavirenz CAPS 50mg, 200mg; TABS 600mg	4	NM
emtricitabine CAPS 200mg	3	NM
EMTRIVA CAPS 200mg; SOLN 10mg/ml	3	NM
fosamprenavir calcium TABS 700mg	5	NDS, NM
FUZEON SOLR 90mg	5	NDS, NM
INTELENCE TABS 25mg	4	NM
INTELENCE TABS 100mg, 200mg	5	NDS, NM
INVIRASE TABS 500mg	5	NDS, NM
ISENTRESS CHEW 25mg; PACK 100mg	3	NM
ISENTRESS CHEW 100mg; TABS 400mg	5	NDS, NM
ISENTRESS HD TABS 600mg	5	NDS, NM
lamivudine SOLN 10mg/ml; TABS 150mg, 300mg	3	NM
LEXIVA SUSP 50mg/ml	4	NM
nevirapine SUSP 50mg/5ml; TB24 100mg, 400mg	4	NM
nevirapine TABS 200mg	3	NM
NORVIR PACK 100mg; SOLN 80mg/ml	4	NM
PIFELTRO TABS 100mg	5	NDS, NM
PREZISTA SUSP 100mg/ml	5	NDS, QL (400 mL / 30 days), NM
PREZISTA TABS 75mg	4	QL (480 tabs / 30 days), NM
PREZISTA TABS 150mg	5	NDS, QL (240 tabs / 30 days), NM
PREZISTA TABS 600mg	5	NDS, QL (60 tabs / 30 days), NM
PREZISTA TABS 800mg	5	NDS, QL (30 tabs / 30 days), NM
REYATAZ PACK 50mg	5	NDS, NM
ritonavir TABS 100mg	3	NM

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
RUKOBIA TB12 600mg	5	NDS, NM
SELZENTRY SOLN 20mg/ml; TABS 75mg, 150mg, 300mg	5	NDS, NM
SELZENTRY TABS 25mg	3	NM
stavudine CAPS 15mg, 20mg, 30mg, 40mg	4	NM
tenofovir disoproxil fumarate TABS 300mg	3	NM
TIVICAY TABS 10mg	3	NM
TIVICAY TABS 25mg, 50mg	5	NDS, NM
TIVICAY PD TBSO 5mg	3	NM
TROGARZO SOLN 200mg/1.33ml	5	NDS, NM, LA
TYBOST TABS 150mg	4	NM
VIRACEPT TABS 250mg, 625mg	5	NDS, NM
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	5	NDS, NM
zidovudine CAPS 100mg; SYRP 50mg/5ml	4	NM
zidovudine TABS 300mg	3	NM
ANTIRETROVIRAL COMBINATION AGENTS		
abacavir sulfate-lamivudine tab 600-300 mg	3	NM
abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg	5	NDS, NM
ATRIPLA TAB	5	NDS, NM
BIKTARVY TAB	5	NDS, NM
CIMDUO TAB 300-300	5	NDS, NM
COMPLERA TAB	5	NDS, NM
DELSTRIGO TAB	5	NDS, NM
DESCOVY TAB 200/25	5	NDS, NM
DOVATO TAB 50-300MG	5	NDS, NM
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	5	NDS, NM
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	5	NDS, NM
EVOTAZ TAB 300-150	5	NDS, NM
GENVOYA TAB	5	NDS, NM
JULUCA TAB 50-25MG	5	NDS, NM
KALETRA TAB 100-25MG	4	NM
KALETRA TAB 200-50MG	5	NDS, NM
lamivudine-zidovudine tab 150-300 mg	4	NM
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	4	NM
ODEFSEY TAB	5	NDS, NM
PREZCOBIX TAB 800-150	5	NDS, NM
STRIBILD TAB	5	NDS, NM
SYMFI LO TAB	5	NDS, NM
SYMFI TAB	5	NDS, NM
SYMTUZA TAB	5	NDS, NM
TEMIXYS TAB 300-300	5	NDS, NM
TRIUMEQ TAB	5	NDS, NM
TRUVADA TAB 100-150	5	NDS, QL (30 tabs / 30 days), NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
TRUVADA TAB 133-200	5	NDS, QL (30 tabs / 30 days), NM
TRUVADA TAB 167-250	5	NDS, QL (30 tabs / 30 days), NM
TRUVADA TAB 200-300	5	NDS, QL (30 tabs / 30 days), NM
ANTITUBERCULAR AGENTS		
cycloserine CAPS 250mg	5	NDS
ethambutol hcl TABS 100mg, 400mg	3	
isoniazid SYRP 50mg/5ml	4	
isoniazid TABS 100mg, 300mg	1	
PASER PACK 4gm	4	
PRIFTIN TABS 150mg	4	
pyrazinamide TABS 500mg	4	
rifabutin CAPS 150mg	4	
rifampin CAPS 150mg, 300mg	3	
rifampin SOLR 600mg	4	
SIRTURO TABS 20mg, 100mg	5	NDS, LA, PA
TRECATOR TABS 250mg	4	
ANTIVIRALS		
acyclovir CAPS 200mg; TABS 400mg, 800mg	2	
acyclovir SUSP 200mg/5ml	4	
acyclovir sodium SOLN 50mg/ml	4	HI, B/D
adefovir dipivoxil TABS 10mg	5	NDS, NM
BARACLUDE SOLN .05mg/ml	5	NDS, NM
entecavir TABS .5mg, 1mg	4	NM
EPCLUSA TAB 400-100	5	NDS, NM, PA
EPIVIR HBV SOLN 5mg/ml	4	NM
famciclovir TABS 125mg, 250mg, 500mg	3	
ganciclovir sodium SOLR 500mg	4	B/D
HARVONI PAK 33.75-150MG	5	NDS, NM, PA
HARVONI PAK 45-200MG	5	NDS, NM, PA
HARVONI TAB 45-200MG	5	NDS, NM, PA
HARVONI TAB 90-400MG	5	NDS, NM, PA
lamivudine (hbv) TABS 100mg	4	NM
MAVYRET TAB 100-40MG	5	NDS, NM, PA
oseltamivir phosphate CAPS 30mg	3	QL (168 caps / year)
oseltamivir phosphate CAPS 45mg, 75mg	3	QL (84 caps / year)
oseltamivir phosphate SUSR 6mg/ml	3	QL (1080 mL / year)
PEGASYS SOLN 180mcg/0.5ml, 180mcg/ml	5	NDS, NM, PA
PEGASYS PROCLICK SOLN 180mcg/0.5ml	5	NDS, NM, PA
RELENZA DISKHALER AEPB 5mg/blister	3	QL (6 inhalers / year)
ribavirin (hepatitis c) CAPS 200mg	3	NM
ribavirin (hepatitis c) TABS 200mg	4	NM
rimantadine hydrochloride TABS 100mg	4	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
valacyclovir hcl TABS 1gm, 500mg	3	
valganciclovir hcl SOLR 50mg/ml; TABS 450mg	3	
VEMLIDY TABS 25mg	5	NDS, NM, PA
VOSEVI TAB	5	NDS, NM, PA
CEPHALOSPORINS		
cefaclor CAPS 250mg, 500mg	3	
cefaclor SUSR 125mg/5ml, 250mg/5ml, 375mg/5ml	4	
CEFACLOR ER TB12 500mg	4	
cefadroxil CAPS 500mg	2	
cefadroxil SUSR 250mg/5ml, 500mg/5ml	3	
CEFAZOLIN INJ 1GM/50ML	4	
cefazolin sodium SOLR 1gm, 10gm, 500mg	3	HI
CEFAZOLIN SOLN 2GM/100ML-4%	4	
cefdinir CAPS 300mg	2	
cefdinir SUSR 125mg/5ml, 250mg/5ml	3	
cefepime hcl SOLR 1gm, 2gm	4	HI
cefixime SUSR 100mg/5ml, 200mg/5ml	4	
cefoxitin sodium SOLR 1gm, 2gm, 10gm	4	HI
cefpodoxime proxetil SUSR 50mg/5ml, 100mg/5ml	4	
cefpodoxime proxetil TABS 100mg, 200mg	3	
cefprozil SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	3	
ceftazidime SOLR 1gm, 2gm, 6gm	4	
CEFTAZIDIME/ SOL D5W 1GM	4	
CEFTAZIDIME/ SOL D5W 2GM	4	
ceftriaxone sodium SOLR 1gm, 2gm, 10gm, 250mg, 500mg	4	HI
cefuroxime axetil TABS 250mg, 500mg	3	
cefuroxime sodium SOLR 1.5gm, 7.5gm, 750mg	3	HI
cephalexin CAPS 250mg, 500mg	1	
cephalexin SUSR 125mg/5ml, 250mg/5ml	3	
tazicef SOLR 1gm, 2gm, 6gm	4	
TEFLARO SOLR 400mg, 600mg	5	NDS
ERYTHROMYCINS/MACROLIDES		
azithromycin PACK 1gm; SUSR 100mg/5ml, 200mg/5ml	3	
azithromycin SOLR 500mg	3	HI
azithromycin TABS 250mg, 500mg, 600mg	1	
clarithromycin SUSR 125mg/5ml, 250mg/5ml	4	
clarithromycin TABS 250mg, 500mg; TB24 500mg	3	
DIFICID TABS 200mg	5	NDS
ery-tab TBEC 250mg, 333mg, 500mg	4	
ERYTHROCIN LACTOBIONATE SOLR 500mg	4	HI
erythrocin stearate TABS 250mg	4	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
erythromycin base CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	4	
erythromycin ethylsuccinate TABS 400mg	4	
FLUOROQUINOLONES		
CIPRO SUSR 500mg/5ml	4	
ciprofloxacin 200 mg/100ml in d5w	3	HI
ciprofloxacin 400 mg/200ml in d5w	3	HI
ciprofloxacin hcl TABS 100mg	4	
ciprofloxacin hcl TABS 250mg, 500mg, 750mg	1	
levofloxacin SOLN 25mg/ml	4	
levofloxacin TABS 250mg, 500mg, 750mg	1	
levofloxacin in d5w iv soln 250 mg/50ml	3	
levofloxacin in d5w iv soln 500 mg/100ml	3	
levofloxacin in d5w iv soln 750 mg/150ml	3	
PENICILLINS		
amoxicillin CAPS 250mg, 500mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg, 875mg	1	
amoxicillin CHEW 125mg, 250mg	2	
amoxicillin & k clavulanate chew tab 200-28.5 mg	4	
amoxicillin & k clavulanate chew tab 400-57 mg	4	
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	3	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	4	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	3	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	3	
amoxicillin & k clavulanate tab 250-125 mg	4	
amoxicillin & k clavulanate tab 500-125 mg	2	
amoxicillin & k clavulanate tab 875-125 mg	2	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	4	
ampicillin CAPS 500mg	2	
ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm	4	HI
ampicillin & sulbactam sodium for inj 3 (2-1) gm	4	HI
ampicillin & sulbactam sodium for iv soln 15 (10-5) gm	4	HI
ampicillin sodium SOLR 1gm, 2gm, 10gm, 125mg, 250mg, 500mg	4	HI
BICILLIN L-A SUSP 600000unit/ml, 1200000unit/2ml, 2400000unit/4ml	4	HI
dicloxacillin sodium CAPS 250mg, 500mg	3	
nafcillin sodium SOLR 1gm, 2gm	4	
nafcillin sodium SOLR 10gm	5	NDS
NAFCILLIN SODIUM SOLR 10gm	5	NDS
oxacillin sodium SOLR 1gm, 2gm	4	HI
oxacillin sodium SOLR 10gm	5	NDS, HI
PEN GK/DEXTR INJ 40000/ML	4	HI
PEN GK/DEXTR INJ 60000/ML	4	HI

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PA–Prior Authorization **QL**–Quantity Limits **ST**–Step Therapy **NM**–not available at mail-order **B/D**–Covered under Medicare B or D **LA**–Limited Access **ED**–Excluded Drug **HI**–Home Infusion **GC**–We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage **NDS**–Non-Extended Days Supply **SSM**–Senior Savings Model insulin

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
penicillin g potassium SOLR 5000000unit, 20000000unit	4	HI
PENICILLIN G PROCAINE SUSP 600000unit/ml	4	HI
penicillin g sodium SOLR 5000000unit	4	HI
penicillin v potassium SOLR 125mg/5ml, 250mg/5ml	2	
penicillin v potassium TABS 250mg, 500mg	1	
pfizerpen SOLR 5000000unit, 20000000unit	4	
piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)	4	HI
piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)	4	HI
piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)	4	HI
piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)	4	HI
piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)	4	
TETRACYCLINES		
doxy 100 SOLR 100mg	4	
doxycycline (monohydrate) CAPS 50mg, 100mg	2	
doxycycline (monohydrate) TABS 50mg, 75mg, 100mg	3	
doxycycline hyclate CAPS 50mg, 100mg; TABS 20mg, 100mg	3	
doxycycline hyclate SOLR 100mg	4	
minocycline hcl CAPS 50mg, 75mg, 100mg	3	
mondoxyne nl CAPS 100mg	2	
tetracycline hcl CAPS 250mg, 500mg	4	PA
tigecycline SOLR 50mg	5	NDS
TIGECYCLINE SOLR 50mg	5	NDS
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
BENDEKA SOLN 100mg/4ml	5	NDS, B/D, NM
carboplatin SOLN 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	3	B/D
cisplatin SOLN 50mg/50ml, 100mg/100ml, 200mg/200ml	3	B/D
cyclophosphamide CAPS 25mg, 50mg	3	B/D
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml	5	NDS, B/D
cyclophosphamide SOLR 1gm, 2gm, 500mg	5	NDS, B/D
LEUKERAN TABS 2mg	5	NDS
oxaliplatin SOLN 50mg/10ml, 100mg/20ml	4	B/D
oxaliplatin SOLR 50mg, 100mg	5	NDS, B/D
ANTIBIOTICS		
adriamycin SOLN 2mg/ml	4	B/D
doxorubicin hcl SOLN 2mg/ml	4	B/D
doxorubicin hcl liposomal INJ 2mg/ml	5	NDS, B/D
epirubicin hcl SOLN 50mg/25ml, 200mg/100ml	4	B/D
ANTIMETABOLITES		
ALIMTA SOLR 100mg, 500mg	5	NDS, B/D
azacitidine SUSR 100mg	5	NDS, B/D, NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
cytarabine SOLN 20mg/ml	3	B/D
fluorouracil SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	3	B/D
gemcitabine hcl SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; SOLR 1gm, 2gm, 200mg	4	B/D
mercaptopurine TABS 50mg	3	
methotrexate sodium SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	3	HI, B/D
PURIXAN SUSP 2000mg/100ml	5	NDS, NM
TABLOID TABS 40mg	4	
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate TABS 250mg	5	NDS, NM, PA
anastrozole TABS 1mg	1	
bicalutamide TABS 50mg	2	
DEPO-PROVERA SUSP 400mg/ml	4	B/D
EMCYT CAPS 140mg	4	
ERLEADA TABS 60mg	5	NDS, NM, LA, PA
exemestane TABS 25mg	4	
flutamide CAPS 125mg	3	
fulvestrant SOLN 250mg/5ml	5	NDS, B/D
letrozole TABS 2.5mg	2	
leuprolide acetate KIT 1mg/0.2ml	4	NM, PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	5	NDS, HI, NM, PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	5	HI, NM, PA; extended day supply copay applies
LYSODREN TABS 500mg	5	NDS
megestrol acetate TABS 20mg, 40mg	3	
nilutamide TABS 150mg	5	NDS
NUBEQA TABS 300mg	5	NDS, NM, LA, PA
SOLTAMOX SOLN 10mg/5ml	5	NDS
tamoxifen citrate TABS 10mg, 20mg	2	
toremifene citrate TABS 60mg	5	NDS
TRELSTAR MIXJECT SUSR 3.75mg	5	NDS, HI, NM, PA
TRELSTAR MIXJECT SUSR 11.25mg	5	NM, PA; extended day supply copay applies
XTANDI CAPS 40mg	5	NDS, NM, LA, PA
ZYTIGA TABS 500mg	5	NDS, NM, LA, PA
IMMUNOMODULATORS		
POMALYST CAPS 1mg, 2mg	5	NDS, QL (21 caps / 21 days), NM, LA, PA
POMALYST CAPS 3mg, 4mg	5	NDS, QL (21 caps / 28 days), NM, LA, PA

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg, 20mg, 25mg	5	NDS, QL (28 caps / 28 days), NM, LA, PA
THALOMID CAPS 50mg, 100mg	5	NDS, QL (28 caps / 28 days), NM, PA
THALOMID CAPS 150mg, 200mg	5	NDS, QL (56 caps / 28 days), NM, PA
MISCELLANEOUS		
bexarotene CAPS 75mg	5	NDS, NM, PA
hydroxyurea CAPS 500mg	2	
INQOVI TAB 35-100MG	5	NDS, NM, LA, PA
irinotecan hcl SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	4	B/D
KISQALI 200 PAK FEMARA	5	NDS, NM, PA
KISQALI 400 PAK FEMARA	5	NDS, NM, PA
KISQALI 600 PAK FEMARA	5	NDS, NM, PA
LONSURF TAB 15-6.14	5	NDS, NM, PA
LONSURF TAB 20-8.19	5	NDS, NM, PA
MATULANE CAPS 50mg	5	NDS, LA
SYNRIBO SOLR 3.5mg	5	NDS, NM, PA
tretinoin (chemotherapy) CAPS 10mg	5	NDS
MITOTIC INHIBITORS		
ABRAXANE INJ 100MG	5	NDS, B/D
docetaxel CONC 20mg/ml	4	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml, 200mg/10ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	NDS, B/D
docetaxel CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	5	NDS, B/D
etoposide SOLN 100mg/5ml, 500mg/25ml	3	B/D
paclitaxel CONC 30mg/5ml, 100mg/16.7ml, 150mg/25ml, 300mg/50ml	4	B/D
toposar SOLN 1gm/50ml, 100mg/5ml	3	B/D
vincristine sulfate SOLN 1mg/ml	2	B/D
vinorelbine tartrate SOLN 10mg/ml, 50mg/5ml	4	B/D
MOLECULAR TARGET AGENTS		
AFINITOR TABS 10mg	5	NDS, QL (30 tabs / 30 days), NM, PA
AFINITOR DISPERZ TBSO 2mg	5	NDS, QL (150 tabs / 30 days), NM, PA
AFINITOR DISPERZ TBSO 3mg	5	NDS, QL (90 tabs / 30 days), NM, PA
AFINITOR DISPERZ TBSO 5mg	5	NDS, QL (60 tabs / 30 days), NM, PA
ALECENSA CAPS 150mg	5	NDS, NM, LA, PA
ALUNBRIG TABS 30mg, 90mg, 180mg	5	NDS, NM, LA, PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
ALUNBRIG PAK	5	NDS, NM, LA, PA
AVASTIN SOLN 100mg/4ml, 400mg/16ml	5	NDS, NM, LA, PA
AYVAKIT TABS 100mg, 200mg, 300mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
BALVERSA TABS 3mg, 4mg, 5mg	5	NDS, NM, LA, PA
BORTEZOMIB SOLR 3.5mg	5	NDS, NM, PA
BOSULIF TABS 100mg, 400mg, 500mg	5	NDS, NM, PA
BRAFTOVI CAPS 75mg	5	NDS, NM, LA, PA
BRUKINSA CAPS 80mg	5	NDS, NM, LA, PA
CABOMETYX TABS 20mg, 40mg, 60mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
CALQUENCE CAPS 100mg	5	NDS, NM, LA, PA
CAPRELSA TABS 100mg, 300mg	5	NDS, NM, LA, PA
COMETRIQ (60MG DOSE) KIT 20mg	5	NDS, NM, LA, PA
COMETRIQ KIT 100MG	5	NDS, NM, LA, PA
COMETRIQ KIT 140MG	5	NDS, NM, LA, PA
COPIKTRA CAPS 15mg, 25mg	5	NDS, NM, LA, PA
COTELLIC TABS 20mg	5	NDS, NM, LA, PA
DAURISMO TABS 25mg, 100mg	5	NDS, NM, LA, PA
ERIVEDGE CAPS 150mg	5	NDS, NM, LA, PA
erlotinib hcl TABS 25mg	5	NDS, QL (90 tabs / 30 days), NM, PA
erlotinib hcl TABS 100mg, 150mg	5	NDS, QL (30 tabs / 30 days), NM, PA
everolimus TABS 2.5mg, 5mg, 7.5mg	5	NDS, QL (30 tabs / 30 days), NM, PA
FARYDAK CAPS 10mg, 20mg	5	NDS, NM, LA, PA
GILOTRIF TABS 20mg, 30mg, 40mg	5	NDS, NM, LA, PA
HERCEP HYLEC SOL 60-10000	5	NDS, NM, PA
HERCEPTIN SOLR 150mg	5	NDS, NM, PA
HERZUMA SOLR 150mg, 420mg	5	NDS, NM, PA
IBRANCE CAPS 75mg, 100mg, 125mg	5	NDS, QL (21 caps / 28 days), NM, LA, PA
IBRANCE TABS 75mg, 100mg, 125mg	5	NDS, QL (21 tabs / 28 days), NM, LA, PA
ICLUSIG TABS 15mg	5	NDS, QL (60 tabs / 30 days), NM, LA, PA
ICLUSIG TABS 45mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
IDHIFA TABS 50mg, 100mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
imatinib mesylate TABS 100mg	5	NDS, QL (90 tabs / 30 days), NM, PA

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imatinib mesylate TABS 400mg	5	NDS, QL (60 tabs / 30 days), NM, PA
IMBRUVICA CAPS 70mg	5	NDS, QL (56 caps / 28 days), NM, LA, PA
IMBRUVICA CAPS 140mg	5	NDS, QL (120 caps / 30 days), NM, LA, PA
IMBRUVICA TABS 140mg	5	NDS, QL (112 tabs / 28 days), NM, LA, PA
IMBRUVICA TABS 280mg	5	NDS, QL (56 tabs / 28 days), NM, LA, PA
IMBRUVICA TABS 420mg, 560mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
INLYTA TABS 1mg	5	NDS, QL (180 tabs / 30 days), NM, LA, PA
INLYTA TABS 5mg	5	NDS, QL (120 tabs / 30 days), NM, LA, PA
INREBIC CAPS 100mg	5	NDS, NM, LA, PA
IRESSA TABS 250mg	5	NDS, NM, LA, PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg	5	NDS, QL (60 tabs / 30 days), NM, LA, PA
KADCYLA SOLR 100mg, 160mg	5	NDS, B/D, NM
KANJINTI SOLR 150mg, 420mg	5	NDS, NM, PA
KEYTRUDA SOLN 100mg/4ml	5	NDS, NM, PA
KISQALI TBPK 200mg	5	NDS, NM, PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg	5	NDS, NM, LA, PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg	5	NDS, NM, LA, PA
LENVIMA 10 MG DAILY DOSE CPPK 10mg	5	NDS, NM, LA, PA
LENVIMA 12MG DAILY DOSE CPPK 4mg	5	NDS, NM, LA, PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg	5	NDS, NM, LA, PA
LENVIMA CAP 14 MG	5	NDS, NM, LA, PA
LENVIMA CAP 18 MG	5	NDS, NM, LA, PA
LENVIMA CAP 24 MG	5	NDS, NM, LA, PA
LORBRENA TABS 25mg, 100mg	5	NDS, NM, LA, PA
LYNPARZA TABS 100mg, 150mg	5	NDS, QL (120 tabs / 30 days), NM, LA, PA
MEKINIST TABS .5mg, 2mg	5	NDS, NM, LA, PA
MEKTOVI TABS 15mg	5	NDS, NM, LA, PA
MVASI SOLN 100mg/4ml, 400mg/16ml	5	NDS, NM, LA, PA
NERLYNX TABS 40mg	5	NDS, NM, LA, PA
NEXAVAR TABS 200mg	5	NDS, NM, LA, PA
NINLARO CAPS 2.3mg, 3mg, 4mg	5	NDS, NM, PA
ODOMZO CAPS 200mg	5	NDS, NM, LA, PA

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OGIVRI SOLR 150mg	5	NDS, NM, PA
OGIVRI INJ 420MG	5	NDS, NM, PA
ONTRUZANT SOLR 150mg, 420mg	5	NDS, NM, PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg	5	NDS, NM, LA, PA
PHESGO SOL	5	NDS, NM, LA, PA
PIQRAY 200MG DAILY DOSE TBPK 200mg	5	NDS, NM, PA
PIQRAY 250MG TAB DOSE	5	NDS, NM, PA
PIQRAY 300MG DAILY DOSE TBPK 150mg	5	NDS, NM, PA
QINLOCK TABS 50mg	5	NDS, NM, LA, PA
RETEVMO CAPS 40mg, 80mg	5	NDS, NM, LA, PA
RITUXAN SOLN 100mg/10ml, 500mg/50ml	5	NDS, NM, LA, PA
RITUXAN INJ HYCELA	5	NDS, NM, LA, PA
ROZLYTREK CAPS 100mg, 200mg	5	NDS, NM, LA, PA
RUBRACA TABS 200mg, 250mg, 300mg	5	NDS, NM, LA, PA
RUXIENCE SOLN 100mg/10ml, 500mg/50ml	5	NDS, NM, PA
RYDAPT CAPS 25mg	5	NDS, NM, PA
SPRYCEL TABS 20mg, 50mg, 70mg, 80mg, 100mg, 140mg	5	NDS, NM, PA
STIVARGA TABS 40mg	5	NDS, NM, LA, PA
SUTENT CAPS 12.5mg, 25mg, 37.5mg, 50mg	5	NDS, QL (30 caps / 30 days), NM, PA
TABRECTA TABS 150mg, 200mg	5	NDS, NM, PA
TAFINLAR CAPS 50mg, 75mg	5	NDS, NM, LA, PA
TAGRISSO TABS 40mg, 80mg NM, LA, PA	5	NDS, QL (30 tabs / 30 days),
TALZENNA CAPS .25mg, 1mg	5	NDS, NM, LA, PA
TASIGNA CAPS 50mg, 150mg, 200mg	5	NDS, NM, PA
TAZVERIK TABS 200mg	5	NDS, NM, LA, PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	5	NDS, NM, LA, PA
TIBSOVO TABS 250mg	5	NDS, NM, LA, PA
TRAZIMERA SOLR 420mg	5	NDS, NM, PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	5	NDS, NM, PA
TUKYSA TABS 50mg, 150mg	5	NDS, NM, LA, PA
TURALIO CAPS 200mg	5	NDS, NM, LA, PA
TYKERB TABS 250mg	5	NDS, NM, LA, PA
VELCADE SOLR 3.5mg	5	NDS, NM, PA
VENCLEXTA TABS 10mg	4	QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 50mg	5	NDS, QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 100mg	5 NM, LA, PA	NDS, QL (180 tabs / 30 days),

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VENCLEXTA TAB START PK	5	NDS, QL (42 tabs / 28 days), NM, LA, PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg	5	NDS, NM, LA, PA
VITRAKVI CAPS 25mg, 100mg; SOLN 20mg/ml	5	NDS, NM, LA, PA
VIZIMPRO TABS 15mg, 30mg, 45mg	5	NDS, NM, LA, PA
VOTRIENT TABS 200mg	5	NDS, NM, LA, PA
XALKORI CAPS 200mg, 250mg	5	NDS, NM, LA, PA
XOSPATA TABS 40mg	5	NDS, NM, LA, PA
XPOVIO 40 MG ONCE WEEKLY TBPK 20mg	5	NDS, NM, LA, PA
XPOVIO 40 MG TWICE WEEKLY TBPK 20mg	5	NDS, NM, LA, PA
XPOVIO 60 MG ONCE WEEKLY TBPK 20mg	5	NDS, NM, LA, PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg	5	NDS, NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY TBPK 20mg	5	NDS, NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg	5	NDS, NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY TBPK 20mg	5	NDS, NM, LA, PA
ZEJULA CAPS 100mg	5	NDS, NM, LA, PA
ZELBORAF TABS 240mg	5	NDS, NM, LA, PA
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	5	NDS, NM, PA
ZOLINZA CAPS 100mg	5	NDS, NM, PA
ZYDELIG TABS 100mg, 150mg	5	NDS, NM, LA, PA
ZYKADIA TABS 150mg	5	NDS, NM, LA, PA
PROTECTIVE AGENTS		
leucovorin calcium SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	4	HI, B/D
leucovorin calcium TABS 5mg, 10mg	3	
leucovorin calcium TABS 15mg, 25mg	4	
MESNEX TABS 400mg	5	NDS
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
amlodipine besylate-benazepril hcl cap 2.5-10 mg	2	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 5-10 mg	2	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 5-20 mg	2	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 5-40 mg	2	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 10-20 mg	2	QL (30 caps / 30 days)
amlodipine besylate-benazepril hcl cap 10-40 mg	2	QL (30 caps / 30 days)
benazepril & hydrochlorothiazide tab 5-6.25 mg	3	
benazepril & hydrochlorothiazide tab 10-12.5 mg	3	
benazepril & hydrochlorothiazide tab 20-12.5 mg	3	
benazepril & hydrochlorothiazide tab 20-25 mg	3	
captopril & hydrochlorothiazide tab 25-15 mg	3	
captopril & hydrochlorothiazide tab 25-25 mg	3	
captopril & hydrochlorothiazide tab 50-15 mg	3	

PA–Previa Autorización **QL**–Límites de Cantidad **ST**–Terapia por Fases **NM**–No Disponible en Pedido por Correo **B/D**–Cobertura bajo Medicare B o D **LA**–Acceso Limitado **ED**–Medicamento Excluido **HI**–Infusión en el hogar **GC**–Proveemos cobertura de este medicamento con receta en el período sin cobertura. Consulte nuestra Evidencia de cobertura para obtener más información sobre esta cobertura. **NDS**–Días de Suministro no Extendido **SSM**–Insulina modelo de ahorros para personas de la tercera edad

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
captopril & hydrochlorothiazide tab 50-25 mg	3	
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	
enalapril maleate & hydrochlorothiazide tab 10-25 mg	1	
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	3	
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	3	
lisinopril & hydrochlorothiazide tab 10-12.5 mg	1	
lisinopril & hydrochlorothiazide tab 20-12.5 mg	1	
lisinopril & hydrochlorothiazide tab 20-25 mg	1	
quinapril-hydrochlorothiazide tab 10-12.5 mg	3	
quinapril-hydrochlorothiazide tab 20-12.5 mg	3	
quinapril-hydrochlorothiazide tab 20-25 mg	3	
ACE INHIBITORS		
benazepril hcl TABS 5mg, 10mg, 20mg, 40mg	1	
captopril TABS 12.5mg, 25mg, 50mg, 100mg	3	
enalapril maleate TABS 2.5mg, 5mg, 10mg, 20mg	1	
fosinopril sodium TABS 10mg, 20mg, 40mg	2	
lisinopril TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	
moexipril hcl TABS 7.5mg, 15mg	2	
perindopril erbumine TABS 2mg, 4mg, 8mg	2	
quinapril hcl TABS 5mg, 10mg, 20mg, 40mg	1	
ramipril CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	
trandolapril TABS 1mg, 2mg, 4mg	1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
eplerenone TABS 25mg, 50mg	3	
spironolactone TABS 25mg, 50mg, 100mg	1	
ALPHA BLOCKERS		
doxazosin mesylate TABS 1mg, 2mg, 4mg, 8mg	2	
prazosin hcl CAPS 1mg, 2mg, 5mg	3	
terazosin hcl CAPS 1mg, 2mg, 5mg	1	
terazosin hcl CAPS 10mg	2	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
amlodipine besylate-olmesartan medoxomil tab 5-20 mg	3	QL (30 tabs / 30 days)
amlodipine besylate-olmesartan medoxomil tab 5-40 mg	3	QL (30 tabs / 30 days)
amlodipine besylate-olmesartan medoxomil tab 10-20 mg	3	QL (30 tabs / 30 days)
amlodipine besylate-olmesartan medoxomil tab 10-40 mg	3	QL (30 tabs / 30 days)
amlodipine besylate-valsartan tab 5-160 mg	2	QL (30 tabs / 30 days)
amlodipine besylate-valsartan tab 5-320 mg	2	QL (30 tabs / 30 days)
amlodipine besylate-valsartan tab 10-160 mg	2	QL (30 tabs / 30 days)
amlodipine besylate-valsartan tab 10-320 mg	2	QL (30 tabs / 30 days)
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg	4	QL (30 tabs / 30 days)
amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	4	QL (30 tabs / 30 days)

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amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg	4	QL (30 tabs / 30 days)
amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg	4	QL (30 tabs / 30 days)
amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg	4	QL (30 tabs / 30 days)
ENTRESTO TAB 24-26MG	3	
ENTRESTO TAB 49-51MG	3	
ENTRESTO TAB 97-103MG	3	
irbesartan-hydrochlorothiazide tab 150-12.5 mg	1	QL (30 tabs / 30 days)
irbesartan-hydrochlorothiazide tab 300-12.5 mg	1	QL (30 tabs / 30 days)
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	1	
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	1	
losartan potassium & hydrochlorothiazide tab 100-25 mg	1	
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg	3	QL (30 tabs / 30 days)
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg	3	QL (30 tabs / 30 days)
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg	3	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg	4	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg	4	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg	4	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg	4	QL (30 tabs / 30 days)
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg	4	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 80-12.5 mg	2	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 160-12.5 mg	2	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 160-25 mg	2	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 320-12.5 mg	2	QL (30 tabs / 30 days)
valsartan-hydrochlorothiazide tab 320-25 mg	2	QL (30 tabs / 30 days)
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
irbesartan TABS 75mg, 150mg, 300mg	1	QL (30 tabs / 30 days)
losartan potassium TABS 25mg, 50mg, 100mg	1	
olmesartan medoxomil TABS 5mg	3	QL (60 tabs / 30 days)
olmesartan medoxomil TABS 20mg, 40mg	3	QL (30 tabs / 30 days)
telmisartan TABS 20mg, 40mg, 80mg	3	QL (30 tabs / 30 days)
valsartan TABS 40mg, 80mg, 160mg	1	QL (60 tabs / 30 days)
valsartan TABS 320mg	1	QL (30 tabs / 30 days)
ANTIARRHYTHMICS		
amiodarone hcl SOLN 50mg/ml, 900mg/18ml	2	
amiodarone hcl TABS 100mg, 400mg	4	
amiodarone hcl TABS 200mg	1	
disopyramide phosphate CAPS 100mg, 150mg	4	
dofetilide CAPS 125mcg, 250mcg, 500mcg	4	NM
flecainide acetate TABS 50mg, 100mg, 150mg	3	
MULTAQ TABS 400mg	4	
NORPACE CR CP12 100mg, 150mg	4	
pacerone TABS 100mg, 400mg	4	

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pacerone TABS 200mg	1	
propafenone hcl CP12 225mg, 325mg, 425mg	4	
propafenone hcl TABS 150mg, 225mg, 300mg	3	
quinidine sulfate TABS 200mg, 300mg	2	
sorine TABS 80mg, 120mg, 160mg, 240mg	2	
sotalol hcl TABS 80mg, 120mg, 160mg, 240mg	2	
sotalol hcl (afib/afl) TABS 80mg, 120mg, 160mg	2	
ANTILIPEMICS, FIBRATES		
fenofibrate TABS 48mg, 54mg, 145mg, 160mg	3	
fenofibrate micronized CAPS 67mg, 134mg, 200mg	3	
gemfibrozil TABS 600mg	1	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
atorvastatin calcium TABS 10mg, 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
lovastatin TABS 10mg, 20mg, 40mg	1	QL (60 tabs / 30 days)
pravastatin sodium TABS 10mg, 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
rosuvastatin calcium TABS 5mg, 10mg, 20mg, 40mg	2	QL (30 tabs / 30 days)
simvastatin TABS 5mg, 10mg, 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS		
cholestyramine PACK 4gm; POWD 4gm/dose	3	
cholestyramine light PACK 4gm; POWD 4gm/dose	3	
colesevelam hcl PACK 3.75gm; TABS 625mg	4	
colestipol hcl GRAN 5gm; PACK 5gm	4	
colestipol hcl TABS 1gm	3	
ezetimibe TABS 10mg	3	
JUXTAPID CAPS 5mg, 10mg, 20mg, 30mg, 40mg, 60mg	5	NDS, NM, LA, PA
niacin (antihyperlipidemic) TBCR 500mg, 750mg, 1000mg	3	QL (60 tabs / 30 days)
PRALUENT SOAJ 75mg/ml, 150mg/ml	3	NM, PA
prevalite PACK 4gm; POWD 4gm/dose	3	
VASCEPA CAPS .5gm, 1gm	4	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol & chlorthalidone tab 50-25 mg	2	
atenolol & chlorthalidone tab 100-25 mg	2	
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	2	
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	2	
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	2	
metoprolol & hydrochlorothiazide tab 50-25 mg	3	
metoprolol & hydrochlorothiazide tab 100-25 mg	3	
metoprolol & hydrochlorothiazide tab 100-50 mg	3	
propranolol & hydrochlorothiazide tab 40-25 mg	3	
propranolol & hydrochlorothiazide tab 80-25 mg	3	

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BETA-BLOCKERS		
acebutolol hcl CAPS 200mg, 400mg	2	
atenolol TABS 25mg, 50mg, 100mg	1	
bisoprolol fumarate TABS 5mg, 10mg	2	
BYSTOLIC TABS 2.5mg, 5mg, 10mg	4	QL (30 tabs / 30 days)
BYSTOLIC TABS 20mg	4	QL (60 tabs / 30 days)
carvedilol TABS 3.125mg, 6.25mg, 12.5mg, 25mg	1	
labetalol hcl TABS 100mg, 200mg, 300mg	3	
metoprolol succinate TB24 25mg, 50mg, 100mg, 200mg	2	
metoprolol tartrate SOCT 5mg/5ml; SOLN 5mg/5ml	3	
metoprolol tartrate TABS 25mg, 50mg, 100mg	1	
nadolol TABS 20mg, 40mg, 80mg	3	
pindolol TABS 5mg, 10mg	3	
propranolol hcl CP24 60mg, 80mg, 120mg, 160mg; SOLN 20mg/5ml, 40mg/5ml	3	
propranolol hcl TABS 10mg, 20mg, 40mg, 60mg, 80mg	2	
timolol maleate TABS 5mg, 10mg, 20mg	3	
CALCIUM CHANNEL BLOCKERS		
amlodipine besylate TABS 2.5mg, 5mg, 10mg	1	
cartia xt CP24 120mg, 180mg, 240mg, 300mg	2	
dilt-xr CP24 120mg, 180mg, 240mg	3	
diltiazem hcl CP12 60mg, 90mg, 120mg	4	
diltiazem hcl SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml	3	
diltiazem hcl TABS 30mg, 60mg, 90mg, 120mg	2	
diltiazem hcl coated beads CP24 120mg, 180mg, 240mg, 300mg	2	
diltiazem hcl coated beads CP24 360mg	4	
diltiazem hcl extended release beads CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	
felodipine TB24 2.5mg, 5mg, 10mg	2	
isradipine CAPS 2.5mg, 5mg	3	
nicardipine hcl CAPS 20mg, 30mg	4	
nifedipine TB24 30mg, 60mg, 90mg	2	
nimodipine CAPS 30mg	4	
NYMALIZE SOLN 6mg/ml	5	NDS
taztia xt CP24 120mg, 180mg, 240mg, 300mg, 360mg	2	
tiadylt er CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	2	
verapamil hcl CP24 100mg, 200mg, 300mg, 360mg; SOLN 2.5mg/ml	4	
verapamil hcl CP24 120mg, 180mg, 240mg	3	
verapamil hcl TABS 40mg, 80mg, 120mg	1	
verapamil hcl TBCR 120mg, 180mg, 240mg	2	
DIURETICS		
acetazolamide CP12 500mg; TABS 125mg, 250mg	4	

List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
amiloride & hydrochlorothiazide tab 5-50 mg	2	
amiloride hcl TABS 5mg	2	
bumetanide SOLN .25mg/ml; TABS .5mg, 1mg, 2mg	3	
chlorthalidone TABS 25mg, 50mg	2	
furosemide SOLN 8mg/ml, 10mg/ml	2	
furosemide TABS 20mg, 40mg, 80mg	1	
furosemide inj SOLN 10mg/ml	3	HI
hydrochlorothiazide CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	
indapamide TABS 1.25mg, 2.5mg	2	
methazolamide TABS 25mg, 50mg	4	
metolazone TABS 2.5mg, 5mg, 10mg	3	
spironolactone & hydrochlorothiazide tab 25-25 mg	3	
torsemide TABS 5mg, 10mg, 20mg, 100mg	2	
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	
triamterene & hydrochlorothiazide tab 37.5-25 mg	1	
triamterene & hydrochlorothiazide tab 75-50 mg	1	
MISCELLANEOUS		
aliskiren fumarate TABS 150mg, 300mg	4	
clonidine PTWK .1mg/24hr, .2mg/24hr, .3mg/24hr	4	
clonidine hcl TABS .1mg, .2mg, .3mg	1	
CORLANOR SOLN 5mg/5ml; TABS 5mg, 7.5mg	4	
DEMSER CAPS 250mg	5	NDS, PA
digitek TABS .125mg, .25mg	2	QL (30 tabs / 30 days)
digox TABS 125mcg, 250mcg	2	QL (30 tabs / 30 days)
digoxin SOLN .05mg/ml, .25mg/ml	4	
digoxin TABS 125mcg, 250mcg	2	QL (30 tabs / 30 days)
guanfacine hcl TABS 1mg, 2mg	3	PA; PA if 70 years and older
hydralazine hcl SOLN 20mg/ml	4	
hydralazine hcl TABS 10mg, 25mg, 50mg, 100mg	2	
methyldopa TABS 250mg, 500mg	2	PA; PA if 70 years and older
metyrosine CAPS 250mg	5	NDS, PA
midodrine hcl TABS 2.5mg, 5mg	3	
midodrine hcl TABS 10mg	4	
minoxidil TABS 2.5mg, 10mg	2	
NORTHERA CAPS 100mg	5	NDS, QL (90 caps / 30 days), NM, LA, PA
NORTHERA CAPS 200mg, 300mg	5	NDS, QL (180 caps / 30 days), NM, LA, PA
ranolazine TB12 500mg, 1000mg	4	
NITRATES		
isosorbide dinitrate TABS 5mg, 10mg, 20mg, 30mg	3	
isosorbide mononitrate TABS 10mg, 20mg	2	

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List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
isosorbide mononitrate TB24 30mg, 60mg, 120mg	1	
minitran PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr	3	
NITRO-BID OINT 2%	3	
NITRO-DUR PT24 .3mg/hr, .8mg/hr	4	
nitroglycerin PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; SUBL .3mg, .4mg, .6mg	3	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg	5	NDS, QL (90 tabs / 30 days), NM, LA, PA
ambrisentan TABS 5mg, 10mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
bosentan TABS 62.5mg	5	NDS, QL (120 tabs / 30 days), NM, LA, PA
bosentan TABS 125mg	5	NDS, QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT TABS 10mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
sildenafil citrate (pulmonary hypertension) TABS 20mg	3	QL (90 tabs / 30 days), NM, PA
treprostinil SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	5	NDS, NM, LA, PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	5	NDS, NM, PA
CENTRAL NERVOUS SYSTEM		
ANTIANXIETY		
alprazolam TABS .25mg, .5mg, 1mg, 2mg	2	QL (150 tabs / 30 days)
buspirone hcl TABS 5mg, 10mg, 15mg	1	
buspirone hcl TABS 7.5mg, 30mg	3	
fluvoxamine maleate TABS 25mg, 50mg, 100mg	3	
lorazepam SOLN 2mg/ml, 4mg/ml	2	
lorazepam TABS .5mg, 1mg, 2mg	2	QL (150 tabs / 30 days)
lorazepam intensol CONC 2mg/ml	3	QL (150 mL / 30 days)
ANTICONVULSANTS		
APTIOM TABS 200mg, 400mg, 600mg, 800mg	5	NDS, QL (60 tabs / 30 days)
BANZEL SUSP 40mg/ml; TABS 200mg, 400mg	5	NDS, PA
BRIVIACT SOLN 10mg/ml	5	NDS, QL (600 mL / 30 days), PA
BRIVIACT SOLN 50mg/5ml	4	PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg	5	NDS, QL (60 tabs / 30 days), PA
carbamazepine CHEW 100mg; TABS 200mg	3	
carbamazepine CP12 100mg, 200mg, 300mg; SUSP 100mg/5ml; TB12 100mg, 200mg, 400mg	4	
CELONTIN CAPS 300mg	4	
clobazam SUSP 2.5mg/ml	4	QL (480 mL / 30 days), PA
clobazam TABS 10mg, 20mg	4	QL (60 tabs / 30 days), PA
clonazepam TABS 2mg	2	QL (300 tabs / 30 days)
clonazepam TABS .5mg, 1mg	2	QL (90 tabs / 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
clonazepam TBDP 2mg	3	QL (300 tabs / 30 days)
clonazepam TBDP .125mg, .25mg, .5mg, 1mg	3	QL (90 tabs / 30 days)
clorazepate dipotassium TABS 3.75mg, 7.5mg, 15mg	4	QL (180 tabs / 30 days), PA; PA if 65 years and older
diazepam CONC 5mg/ml	3	QL (240 mL / 30 days), PA; PA if 65 years and older
diazepam SOLN 5mg/5ml	3	QL (1200 mL / 30 days), PA; PA if 65 years and older
diazepam TABS 2mg, 5mg, 10mg	2	QL (120 tabs / 30 days), PA; PA if 65 years and older
diazepam (anticonvulsant) GEL 2.5mg, 10mg, 20mg	4	
diazepam inj SOLN 5mg/ml	4	
DILANTIN CAPS 30mg, 100mg	4	
DILANTIN INFATABS CHEW 50mg	4	
DILANTIN-125 SUSP 125mg/5ml	4	
divalproex sodium CSDR 125mg	4	
divalproex sodium TB24 250mg, 500mg; TBEC 125mg, 250mg, 500mg	3	
EPIDIOLEX SOLN 100mg/ml NM, LA, PA	5	NDS, QL (600 mL / 30 days),
epitol TABS 200mg	3	
ethosuximide CAPS 250mg	4	
ethosuximide SOLN 250mg/5ml	3	
felbamate SUSP 600mg/5ml	5	NDS
felbamate TABS 400mg, 600mg	4	
FINTEPLA SOLN 2.2mg/ml NM, LA, PA	5	NDS, QL (360 mL / 30 days),
FYCOMPA SUSP .5mg/ml	5	NDS, QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	4	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg	5	NDS, QL (60 tabs / 30 days), PA
FYCOMPA TABS 8mg, 10mg, 12mg	5	NDS, QL (30 tabs / 30 days), PA
gabapentin CAPS 100mg	2	QL (1080 caps / 30 days)
gabapentin CAPS 300mg	2	QL (360 caps / 30 days)
gabapentin CAPS 400mg	2	QL (270 caps / 30 days)
gabapentin SOLN 250mg/5ml	3	QL (2160 mL / 30 days)
gabapentin TABS 600mg	2	QL (180 tabs / 30 days)
gabapentin TABS 800mg	2	QL (120 tabs / 30 days)
lamotrigine CHEW 5mg, 25mg	3	
lamotrigine TABS 25mg, 100mg, 150mg, 200mg	1	
lamotrigine TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	4	
levetiracetam SOLN 100mg/ml; TB24 500mg, 750mg	3	
levetiracetam SOLN 500mg/5ml	4	
levetiracetam TABS 250mg, 500mg, 750mg, 1000mg	2	

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List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
levetiracetam in sodium chloride iv soln 500 mg/100ml	4	
levetiracetam in sodium chloride iv soln 1000 mg/100ml	4	
levetiracetam in sodium chloride iv soln 1500 mg/100ml	4	
NAYZILAM SOLN 5mg/0.1ml	4	
oxcarbazepine SUSP 300mg/5ml	4	
oxcarbazepine TABS 150mg, 300mg, 600mg	3	
PEGANONE TABS 250mg	4	
phenobarbital ELIX 20mg/5ml	4	PA; PA if 70 years and older
phenobarbital TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	3	PA; PA if 70 years and older
phenobarbital sodium SOLN 65mg/ml, 130mg/ml	4	PA; PA if 70 years and older
PHENYTEK CAPS 200mg, 300mg	4	
phenytoin CHEW 50mg; SUSP 125mg/5ml	3	
phenytoin sodium SOLN 50mg/ml	3	
phenytoin sodium extended CAPS 100mg, 200mg, 300mg	3	
pregabalin CAPS 25mg, 50mg, 75mg, 100mg, 150mg	3	QL (120 caps / 30 days), PA
pregabalin CAPS 200mg	3	QL (90 caps / 30 days), PA
pregabalin CAPS 225mg, 300mg	3	QL (60 caps / 30 days), PA
pregabalin SOLN 20mg/ml	4	QL (900 mL / 30 days), PA
primidone TABS 50mg, 250mg	2	
roweepra TABS 500mg, 750mg, 1000mg	2	
roweepra xr TB24 500mg, 750mg	3	
SPRITAM TB3D 250mg, 500mg, 750mg, 1000mg	4	
subvenite TABS 25mg, 100mg, 150mg, 200mg	1	
SYMPAZAN FILM 5mg	4	QL (60 films / 30 days), PA
SYMPAZAN FILM 10mg, 20mg	5	NDS, QL (60 films / 30 days), PA
tiagabine hcl TABS 2mg, 4mg, 12mg, 16mg	4	
topiramate CPSP 15mg, 25mg	3	
topiramate TABS 25mg, 50mg, 100mg, 200mg	2	
valproate sodium SOLN 100mg/ml	4	
valproate sodium SOLN 250mg/5ml	3	
valproic acid CAPS 250mg	3	
VALTOCO LIQD 5mg/0.1ml, 10mg/0.1ml; LQPK 7.5mg/0.1ml, 10mg/0.1ml	4	NM
vigabatrin PACK 500mg	5	NDS, QL (180 packets / 30 days), NM, LA, PA
vigabatrin TABS 500mg	5	NDS, QL (180 tabs / 30 days), NM, LA, PA
vigadrone PACK 500mg	5	NDS, QL (180 packets / 30 days), NM, LA, PA
VIMPAT SOLN 10mg/ml	5	NDS, QL (1200 mL / 30 days)
VIMPAT SOLN 200mg/20ml	5	NDS
VIMPAT TABS 50mg	4	QL (120 tabs / 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
VIMPAT TABS 100mg, 150mg, 200mg	5	NDS, QL (60 tabs / 30 days)
XCOPRI TABS 50mg	5	NDS, QL (90 tabs / 30 days)
XCOPRI TABS 100mg, 150mg, 200mg	5	NDS, QL (60 tabs / 30 days)
XCOPRI PAK 12.5-25	4	QL (28 tabs / 28 days)
XCOPRI PAK 50-100MG	5	NDS, QL (28 tabs / 28 days)
XCOPRI PAK 150-200MG (MAINTENANCE)	5	NDS, QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (TITRATION)	5	NDS, QL (28 tabs / 28 days)
XCOPRI TAB 50-200MG	5	NDS, QL (56 tabs / 28 days)
zonisamide CAPS 25mg, 50mg, 100mg	2	
ANTIDEMENTIA		
donepezil hydrochloride TABS 5mg; TBDP 5mg	2	QL (30 tabs / 30 days)
donepezil hydrochloride TABS 10mg; TBDP 10mg	2	
galantamine hydrobromide CP24 8mg, 16mg, 24mg	3	QL (30 caps / 30 days)
galantamine hydrobromide SOLN 4mg/ml	4	
galantamine hydrobromide TABS 4mg, 8mg, 12mg	3	QL (60 tabs / 30 days)
memantine hcl CP24 7mg, 14mg, 21mg, 28mg; SOLN 2mg/ml	4	PA; PA if < 30 yrs
memantine hcl TABS 5mg, 10mg	3	PA; PA if < 30 yrs
NAMZARIC CAP 7-10MG	4	
NAMZARIC CAP 14-10MG	4	
NAMZARIC CAP 21-10MG	4	
NAMZARIC CAP 28-10MG	4	
NAMZARIC CAP PACK	4	
rivastigmine PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	4	QL (30 patches / 30 days)
rivastigmine tartrate CAPS 1.5mg, 3mg	4	QL (90 caps / 30 days)
rivastigmine tartrate CAPS 4.5mg, 6mg	4	QL (60 caps / 30 days)
ANTIDEPRESSANTS		
amitriptyline hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	3	
amoxapine TABS 25mg, 50mg, 100mg, 150mg	3	
bupropion hcl TABS 75mg, 100mg; TB24 150mg, 300mg	3	
bupropion hcl TB12 100mg, 150mg, 200mg	2	
citalopram hydrobromide SOLN 10mg/5ml	3	
citalopram hydrobromide TABS 10mg, 20mg, 40mg	1	
clomipramine hcl CAPS 25mg, 50mg, 75mg	4	PA
desipramine hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	4	
desvenlafaxine succinate TB24 25mg, 50mg, 100mg	4	QL (30 tabs / 30 days), PA
doxepin hcl CAPS 10mg, 25mg, 50mg, 75mg, 100mg; CONC 10mg/ml	3	
doxepin hcl CAPS 150mg	4	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg	4	QL (60 caps / 30 days), PA
duloxetine hcl CPEP 20mg, 30mg, 60mg	2	QL (60 caps / 30 days)
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr	5	NDS, QL (30 patches / 30 days), PA
escitalopram oxalate SOLN 5mg/5ml	4	
escitalopram oxalate TABS 5mg, 10mg, 20mg	1	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
FETZIMA CP24 20mg, 40mg	4	QL (60 caps / 30 days), PA
FETZIMA CP24 80mg, 120mg	4	QL (30 caps / 30 days), PA
FETZIMA CAP TITRATIO	4	PA
fluoxetine hcl CAPS 10mg, 20mg	1	
fluoxetine hcl CAPS 40mg	2	
fluoxetine hcl SOLN 20mg/5ml	3	
imipramine hcl TABS 10mg, 25mg, 50mg	2	
maprotiline hcl TABS 25mg, 50mg, 75mg	3	
MARPLAN TABS 10mg	4	QL (180 tabs / 30 days)
mirtazapine TABS 7.5mg; TBDP 15mg, 30mg, 45mg	3	
mirtazapine TABS 15mg, 30mg, 45mg	2	
nefazodone hcl TABS 50mg, 100mg, 150mg, 200mg, 250mg	4	
nortriptyline hcl CAPS 10mg, 25mg, 50mg, 75mg	2	
nortriptyline hcl SOLN 10mg/5ml	4	
paroxetine hcl TABS 10mg, 20mg, 30mg, 40mg	2	
PAXIL SUSP 10mg/5ml	4	QL (900 mL / 30 days)
phenelzine sulfate TABS 15mg	3	
protriptyline hcl TABS 5mg, 10mg	4	
sertraline hcl CONC 20mg/ml	3	
sertraline hcl TABS 25mg, 50mg, 100mg	1	
tranylcypromine sulfate TABS 10mg	4	
trazodone hcl TABS 50mg, 100mg, 150mg	1	
trimipramine maleate CAPS 25mg	4	QL (240 caps / 30 days)
trimipramine maleate CAPS 50mg	4	QL (120 caps / 30 days)
trimipramine maleate CAPS 100mg	4	QL (60 caps / 30 days)
TRINTELLIX TABS 5mg	4	QL (120 tabs / 30 days)
TRINTELLIX TABS 10mg	4	QL (60 tabs / 30 days)
TRINTELLIX TABS 20mg	4	QL (30 tabs / 30 days)
venlafaxine hcl CP24 37.5mg, 75mg, 150mg	2	
venlafaxine hcl TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	3	
VIIBRYD TABS 10mg, 20mg, 40mg	4	QL (30 tabs / 30 days)
VIIBRYD KIT STARTER	4	
ANTIPARKINSONIAN AGENTS		
amantadine hcl CAPS 100mg	3	QL (120 caps / 30 days)
amantadine hcl SYRP 50mg/5ml	2	
amantadine hcl TABS 100mg	3	
APOKYN SOCT 30mg/3ml days), NM, LA, PA	5	NDS, QL (20 cartridges / 30
benztropine mesylate SOLN 1mg/ml	4	
benztropine mesylate TABS .5mg, 1mg, 2mg	3	PA; PA if 70 years and older
bromocriptine mesylate CAPS 5mg; TABS 2.5mg	4	
carbidopa & levodopa orally disintegrating tab 10-100 mg	4	

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PA–Previa Autorización **QL**–Límites de Cantidad **ST**–Terapia por Fases **NM**–No Disponible en Pedido por Correo **B/D**–Cobertura bajo Medicare B o D **LA**–Acceso Limitado **ED**–Medicamento Excluido **HI**–Infusión en el hogar **GC**–Proveemos cobertura de este medicamento con receta en el período sin cobertura. Consulte nuestra Evidencia de cobertura para obtener más información sobre esta cobertura. **NDS**–Días de Suministro no Extendido **SSM**–Insulina modelo de ahorros para personas de la tercera edad

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
carbidopa & levodopa orally disintegrating tab 25-100 mg	4	
carbidopa & levodopa orally disintegrating tab 25-250 mg	4	
carbidopa & levodopa tab 10-100 mg	2	
carbidopa & levodopa tab 25-100 mg	2	
carbidopa & levodopa tab 25-250 mg	2	
carbidopa & levodopa tab er 25-100 mg	3	
carbidopa & levodopa tab er 50-200 mg	3	
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	4	
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	4	
carbidopa-levodopa-entacapone tabs 25-100-200 mg	4	
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	4	
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	4	
carbidopa-levodopa-entacapone tabs 50-200-200 mg	4	
entacapone TABS 200mg	4	
NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr	4	
pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg	1	
rasagiline mesylate TABS 1mg	4	QL (30 tabs / 30 days)
rasagiline mesylate TABS .5mg	4	QL (60 tabs / 30 days)
ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	2	
selegiline hcl CAPS 5mg	4	
selegiline hcl TABS 5mg	3	
trihexyphenidyl hcl SOLN .4mg/ml; TABS 2mg, 5mg	3	PA; PA if 70 years and older
ANTIPSYCHOTICS		
ABILIFY MAINTENA PRSY 300mg, 400mg; SRER 300mg, 400mg	5	NDS, QL (1 injection / 28 days)
aripiprazole SOLN 1mg/ml	5	NDS, QL (900 mL / 30 days)
aripiprazole TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg	4	QL (30 tabs / 30 days)
aripiprazole TBDP 10mg, 15mg	5	NDS, QL (60 tabs / 30 days)
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml	5	NDS, QL (1 injection / 28 days)
ARISTADA PRSY 882mg/3.2ml	5	QL (1 injection / 28 days)
ARISTADA PRSY 1064mg/3.9ml	5	QL (1 injection / 56 days)
ARISTADA INITIO PRSY 675mg/2.4ml	5	NDS
CAPLYTA CAPS 42mg	4	QL (30 caps / 30 days)
chlorpromazine hcl SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	4	
clozapine TABS 25mg, 50mg	3	
clozapine TABS 100mg	4	QL (270 tabs / 30 days)
clozapine TABS 200mg	4	QL (135 tabs / 30 days)
clozapine TBDP 12.5mg, 25mg	4	PA
clozapine TBDP 100mg	4	QL (270 tabs / 30 days), PA
clozapine TBDP 150mg	5	NDS, QL (180 tabs / 30 days), PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
clozapine TBDP 200mg	5	NDS, QL (135 tabs / 30 days), PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg	5	NDS, QL (60 tabs / 30 days), PA
FANAPT PAK	4	PA
fluphenazine decanoate SOLN 25mg/ml	4	HI
fluphenazine hcl CONC 5mg/ml; ELIX 2.5mg/5ml; TABS 1mg, 2.5mg, 5mg, 10mg	4	
fluphenazine hcl SOLN 2.5mg/ml	4	HI
haloperidol TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	3	
haloperidol decanoate SOLN 50mg/ml, 100mg/ml	3	
haloperidol lactate CONC 2mg/ml; SOLN 5mg/ml	3	
INVEGA SUSTENNA SUSY 39mg/0.25ml	4	QL (1 injection / 28 days)
INVEGA SUSTENNA SUSY 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml	5	NDS, QL (1 injection / 28 days)
INVEGA TRINZA SUSY 273mg/0.875ml, 410mg/1.315ml, 546mg/1.75ml, 819mg/2.625ml	5	QL (1 injection / 90 days); extended day supply copay applies
LATUDA TABS 20mg, 40mg, 60mg, 120mg	4	QL (30 tabs / 30 days)
LATUDA TABS 80mg	4	QL (60 tabs / 30 days)
loxapine succinate CAPS 5mg, 10mg, 25mg, 50mg	3	
molindone hcl TABS 5mg, 10mg, 25mg	4	
NUPLAZID CAPS 34mg	5	NDS, QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
olanzapine SOLR 10mg	4	QL (3 vials / 1 day)
olanzapine TABS 2.5mg, 5mg, 10mg	2	QL (60 tabs / 30 days)
olanzapine TABS 7.5mg, 15mg, 20mg	2	QL (30 tabs / 30 days)
olanzapine TBDP 5mg, 15mg, 20mg	4	QL (30 tabs / 30 days)
olanzapine TBDP 10mg	4	QL (60 tabs / 30 days)
paliperidone TB24 1.5mg, 3mg, 9mg	4	QL (30 tabs / 30 days)
paliperidone TB24 6mg	4	QL (60 tabs / 30 days)
perphenazine TABS 2mg, 4mg, 8mg, 16mg	3	
PERSERIS PRSY 90mg, 120mg	5	NDS, QL (1 injection / 30 days)
pimozide TABS 1mg, 2mg	4	
quetiapine fumarate TABS 25mg, 50mg, 100mg, 200mg, 300mg, 400mg	2	
quetiapine fumarate TB24 50mg, 300mg, 400mg	4	QL (60 tabs / 30 days), PA
quetiapine fumarate TB24 150mg, 200mg	4	QL (30 tabs / 30 days), PA
REXULTI TABS 3mg, 4mg	4	QL (30 tabs / 30 days)
REXULTI TABS .25mg, .5mg, 1mg, 2mg	4	QL (60 tabs / 30 days)
RISPERDAL CONSTA SRER 12.5mg, 25mg	4	QL (2 injections / 28 days)
RISPERDAL CONSTA SRER 37.5mg, 50mg	5	NDS, QL (2 injections / 28 days)

Last Updated October 15, 2020

PA–Previa Autorización **QL**–Límites de Cantidad **ST**–Terapia por Fases **NM**–No Disponible en Pedido por Correo **B/D**–Cobertura bajo Medicare B o D **LA**–Acceso Limitado **ED**–Medicamento Excluido **HI**–Infusión en el hogar **GC**–Proveemos cobertura de este medicamento con receta en el período sin cobertura. Consulte nuestra Evidencia de cobertura para obtener más información sobre esta cobertura. **NDS**–Días de Suministro no Extendido **SSM**–Insulina modelo de ahorros para personas de la tercera edad

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
risperidone SOLN 1mg/ml	3	QL (240 mL / 30 days)
risperidone TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	2	
risperidone TBDP 1mg, 2mg, 3mg, 4mg	4	QL (60 tabs / 30 days)
risperidone TBDP .25mg, .5mg	4	QL (90 tabs / 30 days)
SAPHRIS SUBL 2.5mg, 5mg, 10mg	4	QL (60 tabs / 30 days)
SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr	4	QL (30 patches / 30 days)
thioridazine hcl TABS 10mg, 25mg, 50mg, 100mg	3	
thiothixene CAPS 1mg, 2mg, 5mg, 10mg	4	
trifluoperazine hcl TABS 1mg, 2mg, 5mg, 10mg	3	
VERSACLOZ SUSP 50mg/ml	5	NDS, QL (600 mL / 30 days), PA
VRAYLAR CAPS 1.5mg	5	NDS, QL (60 caps / 30 days), PA
VRAYLAR CAPS 3mg, 4.5mg, 6mg	5	NDS, QL (30 caps / 30 days), PA
VRAYLAR CAP 1.5-3MG	4	PA
ziprasidone hcl CAPS 20mg, 40mg, 60mg, 80mg	4	QL (60 caps / 30 days)
ziprasidone mesylate SOLR 20mg	4	QL (6 injections / 3 days)
ZYPREXA RELPREVV SUSR 210mg	4	QL (2 vials / 28 days), PA
ZYPREXA RELPREVV SUSR 300mg	5	NDS, QL (2 vials / 28 days), PA
ZYPREXA RELPREVV SUSR 405mg	5	NDS, QL (1 vial / 28 days), PA
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
amphetamine-dextroamphetamine cap er 24hr 5 mg	4	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 10 mg	4	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 15 mg	4	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 20 mg	4	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 25 mg	4	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine cap er 24hr 30 mg	4	QL (30 caps / 30 days), PA
amphetamine-dextroamphetamine tab 5 mg	3	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 7.5 mg	3	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 10 mg	3	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 12.5 mg	3	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 15 mg	3	QL (60 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 20 mg	3	QL (90 tabs / 30 days), PA
amphetamine-dextroamphetamine tab 30 mg	3	QL (60 tabs / 30 days), PA
atomoxetine hcl CAPS 10mg, 18mg, 25mg	4	QL (120 caps / 30 days)
atomoxetine hcl CAPS 40mg	4	QL (60 caps / 30 days)
atomoxetine hcl CAPS 60mg, 80mg, 100mg	4	QL (30 caps / 30 days)
dexmethylphenidate hcl TABS 2.5mg, 5mg	3	QL (120 tabs / 30 days), PA
dexmethylphenidate hcl TABS 10mg	3	QL (60 tabs / 30 days), PA
guanfacine hcl (adhd) TB24 1mg, 2mg, 3mg, 4mg 70 years and older	3	QL (30 tabs / 30 days), PA; PA if
metadate er TBCR 20mg	4	QL (90 tabs / 30 days), PA
methylphenidate hcl SOLN 5mg/5ml	4	QL (1800 mL / 30 days), PA
methylphenidate hcl SOLN 10mg/5ml	4	QL (900 mL / 30 days), PA

List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
methylphenidate hcl TABS 5mg, 10mg	3	QL (180 tabs / 30 days), PA
methylphenidate hcl TABS 20mg	3	QL (90 tabs / 30 days), PA
methylphenidate hcl TBCR 10mg, 20mg	4	QL (90 tabs / 30 days), PA
HYPNOTICS		
BELSOMRA TABS 5mg, 10mg, 15mg, 20mg	4	QL (30 tabs / 30 days)
doxepin hcl (sleep) TABS 3mg, 6mg	3	QL (30 tabs / 30 days)
HETLIOZ CAPS 20mg	5	NDS, NM, LA, PA
temazepam CAPS 7.5mg	4	QL (30 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
temazepam CAPS 15mg calendar year	4	QL (60 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a
temazepam CAPS 30mg	4	QL (30 caps / 30 days), PA; PA if 65 years and older
zolpidem tartrate TABS 5mg, 10mg	2	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
MIGRAINE		
AIMOVIG SOAJ 70mg/ml, 140mg/ml	3	QL (1 pen / 30 days), NM, PA
dihydroergotamine mesylate SOLN 1mg/ml	5	NDS
dihydroergotamine mesylate SOLN 4mg/ml	5	NDS, QL (8 mL / 30 days), PA
ergotamine w/ caffeine tab 1-100 mg	3	
naratriptan hcl TABS 1mg, 2.5mg	3	QL (12 tabs / 30 days)
rizatriptan benzoate TABS 5mg, 10mg; TBDP 5mg, 10mg	3	QL (18 tabs / 30 days)
sumatriptan SOLN 5mg/act	4	QL (24 inhalers / 30 days)
sumatriptan SOLN 20mg/act	4	QL (12 inhalers / 30 days)
sumatriptan succinate SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml	4	QL (18 injections / 30 days)
sumatriptan succinate SOAJ 6mg/0.5ml; SOCT 6mg/0.5ml; SOLN 6mg/0.5ml; SOSY 6mg/0.5ml	4	QL (12 injections / 30 days)
sumatriptan succinate TABS 25mg, 50mg, 100mg	2	QL (12 tabs / 30 days)
zolmitriptan TABS 2.5mg, 5mg; TBDP 2.5mg, 5mg	4	QL (12 tabs / 30 days)
MISCELLANEOUS		
AUSTEDO TABS 6mg	5	NDS, QL (60 tabs / 30 days), NM, PA
AUSTEDO TABS 9mg, 12mg	5	NDS, QL (120 tabs / 30 days), NM, PA
INGREZZA CAPS 40mg, 80mg	5	NDS, QL (30 caps / 30 days), NM, PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
INGREZZA CAP 40-80MG	5	NDS, QL (28 caps / 28 days), NM, PA
LITHIUM SOLN 8meq/5ml	4	
lithium carbonate CAPS 150mg, 300mg, 600mg	1	
lithium carbonate TABS 300mg; TBCR 300mg, 450mg	2	
LYRICA CR TB24 82.5mg, 165mg, 330mg	3	QL (60 tabs / 30 days), PA
NUEDEXTA CAP 20-10MG	4	QL (60 caps / 30 days), PA
pyridostigmine bromide TABS 60mg	3	
riluzole TABS 50mg	4	
tetrabenazine TABS 12.5mg	5	NDS, QL (90 tabs / 30 days), NM, PA
tetrabenazine TABS 25mg	5	NDS, QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
BETASERON KIT .3mg	5	NDS, QL (14 syringes / 28 days), NM, PA
dalfampridine TB12 10mg	3	NM, PA
GILENYA CAPS .5mg	5	NDS, QL (28 caps / 28 days), NM, PA
glatiramer acetate SOSY 20mg/ml	5	NDS, QL (30 syringes / 30 days), NM, PA
glatiramer acetate SOSY 40mg/ml	5	NDS, QL (12 syringes / 28 days), NM, PA
glatopa SOSY 20mg/ml	5	NDS, QL (30 syringes / 30 days), NM, PA
glatopa SOSY 40mg/ml	5	NDS, QL (12 syringes / 28 days), NM, PA
MUSCULOSKELETAL THERAPY AGENTS		
baclofen TABS 10mg, 20mg	3	
cyclobenzaprine hcl TABS 5mg, 10mg	3	PA; PA if 70 years and older
dantrolene sodium CAPS 25mg, 50mg, 100mg	4	
tizanidine hcl TABS 2mg, 4mg	2	
NARCOLEPSY/CATAPLEXY		
armodafinil TABS 50mg	3	QL (90 tabs / 30 days), PA
armodafinil TABS 150mg, 200mg, 250mg	3	QL (30 tabs / 30 days), PA
XYREM SOLN 500mg/ml	5	NDS, QL (540 mL / 30 days), NM, LA, PA
PSYCHOTHERAPEUTIC-MISC		
acamprosate calcium TBEC 333mg	4	
buprenorphine hcl SUBL 2mg, 8mg	3	QL (90 tabs / 30 days), PA
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	4	QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	4	QL (90 films / 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	4	QL (90 films / 30 days)
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	4	QL (60 films / 30 days)
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	2	QL (90 tabs / 30 days)
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	2	QL (90 tabs / 30 days)
bupropion hcl (smoking deterrent) TB12 150mg	3	
CHANTIX TABS .5mg, 1mg	4	PA
CHANTIX CONTINUING MONTH TABS 1mg	4	PA
CHANTIX PAK 0.5& 1MG	4	PA
disulfiram TABS 250mg, 500mg	3	
naloxone hcl SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	2	
naltrexone hcl TABS 50mg	3	
NARCAN LIQD 4mg/0.1ml	3	
NICOTROL INHALER INHA 10mg	4	
NICOTROL NS SOLN 10mg/ml	4	
VIVITROL SUSR 380mg	5	NDS, NM
ENDOCRINE AND METABOLIC		
ANDROGENS		
ANADROL-50 TABS 50mg	5	NDS, PA
ANDRODERM PT24 2mg/24hr, 4mg/24hr	4	QL (30 patches / 30 days), PA
oxandrolone TABS 2.5mg	3	QL (120 tabs / 30 days), PA
oxandrolone TABS 10mg	4	QL (60 tabs / 30 days), PA
testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm	4	QL (300 gm / 30 days), PA
testosterone cypionate SOLN 100mg/ml, 200mg/ml	3	PA
testosterone enanthate SOLN 200mg/ml	3	HI, PA
ANTIDIABETICS		
acarbose TABS 25mg, 50mg, 100mg	3	
alogliptin benzoate TABS 6.25mg, 12.5mg, 25mg	2	QL (30 tabs / 30 days)
alogliptin-metformin hcl tab 12.5-500 mg	2	QL (60 tabs / 30 days)
alogliptin-metformin hcl tab 12.5-1000 mg	2	QL (60 tabs / 30 days)
BYDUREON BCISE AUIJ 2mg/0.85ml	3	QL (4 pens / 28 days)
BYDUREON PEN PEN 2mg	3	QL (4 pens / 28 days)
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml	4	QL (1 pen / 30 days)
FARXIGA TABS 5mg, 10mg	3	QL (30 tabs / 30 days)
glimepiride TABS 1mg, 2mg	1	QL (90 tabs / 30 days)
glimepiride TABS 4mg	1	QL (60 tabs / 30 days)
glipizide TABS 5mg	1	QL (240 tabs / 30 days)
glipizide TABS 10mg	1	QL (120 tabs / 30 days)
glipizide TB24 2.5mg, 5mg	1	QL (90 tabs / 30 days)
glipizide TB24 10mg	1	QL (60 tabs / 30 days)
glipizide xl TB24 2.5mg, 5mg	1	QL (90 tabs / 30 days)
glipizide xl TB24 10mg	1	QL (60 tabs / 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
glipizide-metformin hcl tab 2.5-250 mg	1	QL (240 tabs / 30 days)
glipizide-metformin hcl tab 2.5-500 mg	1	QL (120 tabs / 30 days)
glipizide-metformin hcl tab 5-500 mg	1	QL (120 tabs / 30 days)
GLYXAMBI TAB 10-5 MG	3	QL (30 tabs / 30 days)
GLYXAMBI TAB 25-5 MG	3	QL (30 tabs / 30 days)
JANUMET TAB 50-500MG	3	QL (60 tabs / 30 days)
JANUMET TAB 50-1000	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	3	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	3	QL (30 tabs / 30 days)
JANUVIA TABS 25mg, 50mg, 100mg	3	QL (30 tabs / 30 days)
JARDIANCE TABS 10mg	3	QL (60 tabs / 30 days)
JARDIANCE TABS 25mg	3	QL (30 tabs / 30 days)
JENTADUETO TAB 2.5-500	3	QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-850	3	QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-1000	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000MG	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000MG	3	QL (30 tabs / 30 days)
metformin hcl TABS 500mg	1	QL (150 tabs / 30 days)
metformin hcl TABS 850mg	1	QL (90 tabs / 30 days)
metformin hcl TABS 1000mg	1	QL (75 tabs / 30 days)
metformin hcl TB24 500mg	1	QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
metformin hcl TB24 750mg	1	QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
nateglinide TABS 60mg, 120mg	1	QL (90 tabs / 30 days)
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/1.5ml	3	QL (1 pen / 28 days)
OZEMPIC (1MG/DOSE) SOPN 2mg/1.5ml	3	QL (2 pens / 28 days)
pioglitazone hcl TABS 15mg, 30mg, 45mg	1	QL (30 tabs / 30 days)
repaglinide TABS 2mg	1	QL (240 tabs / 30 days)
repaglinide TABS .5mg, 1mg	1	QL (120 tabs / 30 days)
RYBELSUS TABS 3mg, 7mg, 14mg	3	QL (30 tabs / 30 days)
SYNJARDY TAB 5-500MG	3	QL (120 tabs / 30 days)
SYNJARDY TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000	3	QL (30 tabs / 30 days)
TRADJENTA TABS 5mg	3	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG	3	QL (60 tabs / 30 days)

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PA–Prior Authorization **QL**–Quantity Limits **ST**–Step Therapy **NM**–not available at mail-order **B/D**–Covered under Medicare B or D **LA**–Limited Access **ED**–Excluded Drug **HI**–Home Infusion **GC**–We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage **NDS**–Non-Extended Days Supply **SSM**–Senior Savings Model insulin

List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
TRIJARDY XR TAB ER 24HR 10-5-1000MG	3	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG	3	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 25-5-1000MG	3	QL (30 tabs / 30 days)
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml	3	QL (4 pens / 28 days)
VICTOZA SOPN 18mg/3ml	3	QL (3 pens / 30 days)
XIGDUO XR TAB 2.5-1000	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	3	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000	3	QL (30 tabs / 30 days)
ANTIDIABETICS, INSULINS		
BASAGLAR KWIKPEN SOPN 100unit/ml	3	SSM
BD ALCOHOL SWABS	1	
FIASP FLEX INJ TOUCH	3	SSM
FIASP INJ 100/ML	3	SSM
FIASP PENFIL INJ U-100	3	SSM
GAUZE PADS 2" X 2"	1	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml	5	NDS, B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	5	NDS
INSULIN SAFETY NEEDLES	1	
INSULIN SYRINGES: BD/ULTIMED/ALLISON/TRIVIDIA/MHC	1	
LEVEMIR SOLN 100unit/ml	3	SSM
LEVEMIR FLEXTOUCH SOPN 100unit/ml	3	SSM
NOVOLIN INJ 70/30	3	SSM (brand RELION not covered)
NOVOLIN INJ 70/30 FP	3	SSM (brand RELION not covered)
NOVOLIN N SUSP 100unit/ml	3	SSM (brand RELION not covered)
NOVOLIN N FLEXPEN SUPN 100unit/ml	3	SSM (brand RELION not covered)
NOVOLIN R SOLN 100unit/ml	3	SSM (brand RELION not covered)
NOVOLIN R FLEXPEN SOPN 100unit/ml	3	SSM (brand RELION not covered)
NOVOLOG SOLN 100unit/ml	3	SSM
NOVOLOG FLEXPEN SOPN 100unit/ml	3	SSM
NOVOLOG MIX INJ 70/30	3	SSM
NOVOLOG MIX INJ FLEXPEN	3	SSM
NOVOLOG PENFILL SOCT 100unit/ml	3	SSM
OMNIPOD KIT STARTER	4	QL (1 kit / year), PA
OMNIPOD MIS 5 PACK	4	QL (10 boxes / 30 days), PA
PEN NEEDLES: NOVO/BD/ULTIMED/OWEN/TRIVIDIA	1	
SOLIQUA INJ 100/33	3	QL (10 pens / 30 days); SSM
TRESIBA SOLN 100unit/ml	3	SSM
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	3	SSM
V-GO 20 KIT	4	QL (1 kit / 30 days), PA
V-GO 30 KIT	4	QL (1 kit / 30 days), PA

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PA–Previa Autorización **QL**–Límites de Cantidad **ST**–Terapia por Fases **NM**–No Disponible en Pedido por Correo **B/D**–Cobertura bajo Medicare B o D **LA**–Acceso Limitado **ED**–Medicamento Excluido **HI**–Infusión en el hogar **GC**–Proveemos cobertura de este medicamento con receta en el período sin cobertura. Consulte nuestra Evidencia de cobertura para obtener más información sobre esta cobertura. **NDS**–Días de Suministro no Extendido **SSM**–Insulina modelo de ahorros para personas de la tercera edad

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
V-GO 40 KIT	4	QL (1 kit / 30 days), PA
XULTOPHY INJ 100/3.6	3	QL (5 pens / 30 days); SSM
ANTIDIABETICS, TEST STRIPS		
FREESTYLE KIT SENSOR	PART B	
ONETOUCH TES ULTRA	PART B	QL (500 strips / 90 days)
ONETOUCH TES VERIO	PART B	QL (500 strips / 90 days)
CALCIUM REGULATORS		
alendronate sodium TABS 10mg, 35mg, 70mg	1	
calcitonin (salmon) SOLN 200unit/act	3	B/D
FORTEO SOPN 600mcg/2.4ml	5	NDS, NM, PA
ibandronate sodium TABS 150mg	3	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	5	NDS, NM, PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	3	B/D
pamidronate disodium SOLN 30mg/10ml, 90mg/10ml; SOLR 30mg, 90mg	3	B/D
PROLIA SOSY 60mg/ml	4	QL (1 injection / 180 days), NM; extended day supply copay applies
TYMLOS SOPN 3120mcg/1.56ml	5	NDS, NM, PA
XGEVA SOLN 120mg/1.7ml	5	NDS, NM, PA
zoledronic acid CONC 4mg/5ml; SOLN 4mg/100ml, 5mg/100ml	4	B/D, NM
CHELATING AGENTS		
CHEMET CAPS 100mg	4	
clovique CAPS 250mg	5	NDS, PA
deferasirox PACK 90mg, 180mg, 360mg; TABS 90mg, 180mg, 360mg	5	NDS, NM, PA
kionex SUSP 15gm/60ml	3	
LOKELMA PACK 5gm, 10gm	3	
penicillamine TABS 250mg	5	NDS
sodium polystyrene sulfonate SUSP 15gm/60ml	3	
sodium polystyrene sulfonate powder	3	
sps SUSP 15gm/60ml	3	
trientine hcl CAPS 250mg	5	NDS, PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	4	LA, PA
CONTRACEPTIVES		
afirmelle	2	
altavera	2	
alyacen 1/35	2	
alyacen 7/7/7	2	
apri	2	
aranelle	3	
aubra eq	2	
aurovela 1/20	3	
aurovela fe 1.5/30	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
aurovela fe 1/20	2	
aviane	2	
ayuna	2	
azurette	3	
balziva	3	
bekyree	3	
blisovi fe 1.5/30	2	
briellyn	3	
camila TABS .35mg	2	
caziant	3	
chateal	2	
cryselle-28	2	
cyclafem 1/35	2	
cyclafem 7/7/7	2	
cyred eq	2	
dasetta 1/35	2	
dasetta 7/7/7	2	
deblitane TABS .35mg	2	
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)	3	
drospirenone-ethinyl estradiol tab 3-0.02 mg	3	
drospirenone-ethinyl estradiol tab 3-0.03 mg	3	
elinest	2	
ELLA TABS 30mg	3	
eluryng	4	
emoquette	2	
enpresse-28	2	
enskyce	2	
errin TABS .35mg	2	
estarylla	2	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	3	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	3	
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr	4	
falmina	2	
femynor	2	
gianvi	3	
hailey 1.5/30	3	
heather TABS .35mg	2	
incassia TABS .35mg	2	
introvale	3	
isibloom	2	
jasmiel	3	
jolessa	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
juleber	2	
junel 1.5/30	3	
junel 1/20	3	
junel fe 1.5/30	2	
junel fe 1/20	2	
kariva	3	
kelnor 1/35	3	
kelnor 1/50	3	
kurvelo	2	
larin 1.5/30	3	
larin 1/20	3	
larin fe 1.5/30	2	
larin fe 1/20	2	
larissia	2	
leena	3	
lessina	2	
levonest	2	
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	3	
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	2	
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	2	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	2	
levora 0.15/30-28	2	
lillow	2	
loryna	3	
low-ogestrel	2	
lutera	2	
lyza TABS .35mg	2	
marlissa	2	
medroxyprogesterone acetate (contraceptive) SUSP 150mg/ml; SUSY 150mg/ml	3	
microgestin 1.5/30	3	
microgestin 1/20	3	
microgestin fe	2	
microgestin fe 1.5/30	2	
mili	2	
mono-linyah	2	
necon 0.5/35-28	3	
nikki	3	
nora-be TABS .35mg	2	
norethindrone (contraceptive) TABS .35mg	2	
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	3	
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg	3	

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norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg	2	
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	2	
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	3	
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	2	
norlyroc TABS .35mg	2	
nortrel 0.5/35 (28)	3	
nortrel 1/35 (21)	2	
nortrel 1/35 (28)	2	
nortrel 7/7/7	2	
ocella	3	
orsythia	2	
philith	3	
pimtrea	3	
pirmella 1/35	2	
portia-28	2	
previfem	2	
reclipsen	2	
setlakin	3	
sharobel TABS .35mg	2	
simliya	3	
sprintec 28	2	
sronyx	2	
syeda	3	
tarina fe 1/20 eq	2	
tilia fe	3	
tri-estarylla	2	
tri-legest fe	3	
tri-linyah	2	
tri-lo-estarylla	3	
tri-lo-marzia	3	
tri-lo-mili	3	
tri-lo-sprintec	3	
tri-mili	2	
tri-previfem	2	
tri-sprintec	2	
tri-vylibra	2	
tri-vylibra lo	3	
trivora-28	2	
tulana TABS .35mg	2	
velivet	3	
vienva	2	
viorele	3	

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vyfemla	3	
vylibra	2	
wera	3	
xulane	4	
zarah	3	
zovia 1/35e	3	
zumandimine	3	
ENDOMETRIOSIS		
danazol CAPS 50mg, 100mg, 200mg	4	
SYNAREL SOLN 2mg/ml	5	NDS
ESTROGENS		
amabelz	3	
DELESTROGEN OIL 10mg/ml	4	
dotti PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	3	
estradiol PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr	3	
estradiol TABS .5mg, 1mg, 2mg	2	
estradiol & norethindrone acetate tab 0.5-0.1 mg	3	
estradiol & norethindrone acetate tab 1-0.5 mg	3	
estradiol vaginal CREA .1mg/gm	3	
estradiol vaginal TABS 10mcg	4	
estradiol valerate OIL 20mg/ml, 40mg/ml	4	
fyavolv tab 0.5mg-2.5mcg	3	
fyavolv tab 1mg-5mcg	3	
jinteli	3	
lopreeza	3	
mimvey	3	
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	3	
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	3	
yuvafem TABS 10mcg	4	
GLUCOCORTICOIDS		
cortisone acetate TABS 25mg	4	
dexamethasone ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	3	
DEXAMETHASONE INTENSOL CONC 1mg/ml	4	
dexamethasone sodium phosphate SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	3	
fludrocortisone acetate TABS .1mg	2	
hydrocortisone TABS 5mg, 10mg, 20mg	3	
methylprednisolone TABS 4mg, 8mg, 16mg, 32mg	3	B/D

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methylprednisolone TBPK 4mg	2	
methylprednisolone acetate SUSP 40mg/ml, 80mg/ml	3	B/D
methylprednisolone sod succ SOLR 40mg, 125mg, 1000mg	3	B/D
prednisolone SOLN 15mg/5ml	2	B/D
prednisolone sodium phosphate SOLN 5mg/5ml, 25mg/5ml	3	B/D
prednisolone sodium phosphate SOLN 15mg/5ml	2	B/D
prednisone SOLN 5mg/5ml	4	B/D
prednisone TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	2	B/D
prednisone TBPK 5mg, 10mg	3	
PREDNISONE INTENSOL CONC 5mg/ml	4	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	4	
GLUCOSE ELEVATING AGENTS		
diazoxide SUSP 50mg/ml	5	NDS
GVOKE HYPOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	3	
GVOKE PFS SOSY .5mg/0.1ml, 1mg/0.2ml	3	
MISCELLANEOUS		
ALDURAZYME SOLN 2.9mg/5ml	5	NDS, NM, LA, PA
cabergoline TABS .5mg	3	
CARBAGLU TABS 200mg	5	NDS, NM, LA, PA
CERDELGA CAPS 84mg	5	NDS, NM, PA
CEREZYME SOLR 400unit	5	NDS, NM, LA, PA
cinacalcet hcl TABS 30mg	4	B/D, QL (120 tabs / 30 days), NM
cinacalcet hcl TABS 60mg days), NM	5	NDS, B/D, QL (60 tabs / 30
cinacalcet hcl TABS 90mg days), NM	5	NDS, B/D, QL (120 tabs / 30
CYSTADANE POW	5	NDS, NM, LA
CYSTAGON CAPS 50mg, 150mg	4	NM, LA, PA
desmopressin acetate SOLN 4mcg/ml	5	NDS
desmopressin acetate TABS .1mg, .2mg	3	
desmopressin acetate spray SOLN .01%	4	
desmopressin acetate spray refrigerated SOLN .01%	4	
FABRAZYME SOLR 5mg, 35mg	5	NDS, NM, LA, PA
GENOTROPIN SOLR 5mg, 12mg	5	NDS, NM, PA
GENOTROPIN MINIQUICK SOLR .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	5	NDS, NM, PA
INCRELEX SOLN 40mg/4ml	5	NDS, NM, LA, PA
KORLYM TABS 300mg	5	NDS, NM, LA, PA
KUVAN PACK 100mg, 500mg; TBSO 100mg	5	NDS, NM, LA, PA
levocarnitine (metabolic modifiers) SOLN 1gm/10ml; TABS 330mg	4	B/D
LUMIZYME SOLR 50mg	5	NDS, NM, LA, PA
LUPRON DEPOT-PED (1-MONTH) KIT 7.5mg, 11.25mg, 15mg	5	NDS, NM, PA

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LUPRON DEPOT-PED (3-MONTH) KIT 11.25mg, 30mg	5	NM, PA; extended day supply copay applies
miglustat CAPS 100mg	5	NDS, QL (90 caps / 30 days), NM, PA
NAGLAZYME SOLN 1mg/ml	5	NDS, NM, LA, PA
nitisinone CAPS 2mg, 5mg, 10mg	5	NDS, NM, PA
octreotide acetate SOLN 50mcg/ml, 100mcg/ml, 200mcg/ml	4	HI, NM, PA
octreotide acetate SOLN 500mcg/ml, 1000mcg/ml	5	NDS, HI, NM, PA
OSPHENA TABS 60mg	3	PA
raloxifene hcl TABS 60mg	3	
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	5	NDS, NM, LA, PA
sodium phenylbutyrate POWD 3gm/tsp; TABS 500mg	5	NDS, NM, PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	5	NDS, NM, PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	5	NDS, NM, LA, PA
STIMATE SOLN 1.5mg/ml	5	NDS, NM
PHOSPHATE BINDER AGENTS		
AURYXIA TABS 210mg	5	NDS, QL (360 tabs / 30 days), PA
calcium acetate (phosphate binder) CAPS 667mg	3	QL (360 caps / 30 days)
calcium acetate (phosphate binder) TABS 667mg	4	QL (360 tabs / 30 days)
sevelamer carbonate PACK 2.4gm	5	NDS, QL (180 packets / 30 days)
sevelamer carbonate PACK .8gm	5	NDS, QL (540 packets / 30 days)
sevelamer carbonate TABS 800mg	4	QL (540 tabs / 30 days)
PROGESTINS		
medroxyprogesterone acetate TABS 2.5mg, 5mg, 10mg	1	
megestrol acetate SUSP 40mg/ml	3	
megestrol acetate (appetite) SUSP 625mg/5ml	4	PA
norethindrone acetate TABS 5mg	3	
THYROID AGENTS		
euthyrox TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	2	
levo-t TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 1 12mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	
levothyroxine sodium TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	
levoxyl TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	2	
liothyronine sodium TABS 5mcg, 25mcg, 50mcg	3	
methimazole TABS 5mg, 10mg	1	
propylthiouracil TABS 50mg	3	
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	3	

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unithroid TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	2	
VITAMIN D ANALOGS		
calcitriol CAPS .25mcg, .5mcg	2	B/D
calcitriol SOLN 1mcg/ml	4	B/D
paricalcitol CAPS 1mcg, 2mcg, 4mcg	4	B/D
RAYALDEE CPCR 30mcg	5	NDS
GASTROINTESTINAL		
ANTIEMETICS		
aprepitant CAPS 40mg, 80mg, 125mg	4	B/D
aprepitant capsule therapy pack 80 & 125 mg	4	B/D
compro SUPP 25mg	4	
dronabinol CAPS 2.5mg, 5mg, 10mg	4	B/D, QL (60 caps / 30 days)
EMEND SUSR 125mg/5ml	4	B/D
granisetron hcl SOLN 1mg/ml, 4mg/4ml	3	
granisetron hcl TABS 1mg	4	B/D
meclizine hcl TABS 12.5mg, 25mg	2	
metoclopramide hcl SOLN 5mg/5ml, 5mg/ml	3	
metoclopramide hcl TABS 5mg, 10mg	1	
ondansetron TBDP 4mg, 8mg	3	B/D
ondansetron hcl SOLN 4mg/2ml, 40mg/20ml	3	
ondansetron hcl SOLN 4mg/5ml	4	B/D
ondansetron hcl TABS 4mg, 8mg, 24mg	3	B/D
prochlorperazine SUPP 25mg	4	
prochlorperazine edisylate SOLN 10mg/2ml	4	
prochlorperazine maleate TABS 5mg, 10mg	2	
promethazine hcl SOLN 25mg/ml, 50mg/ml; SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg	3	PA; PA if 70 years and older
scopolamine PT72 1mg/3days PA if 70 years and older	4	QL (10 patches / 30 days), PA;
ANTISPASMODICS		
dicyclomine hcl CAPS 10mg; TABS 20mg	3	
dicyclomine hcl SOLN 10mg/5ml	4	
glycopyrrolate TABS 1mg, 2mg	3	
H2-RECEPTOR ANTAGONISTS		
famotidine SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	3	
famotidine SUSR 40mg/5ml	4	QL (300 mL / 30 days)
famotidine TABS 20mg	1	QL (120 tabs / 30 days)
famotidine TABS 40mg	1	QL (60 tabs / 30 days)
famotidine in nacl 0.9% iv soln 20 mg/50ml	3	
nizatidine CAPS 150mg, 300mg	3	

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INFLAMMATORY BOWEL DISEASE		
balsalazide disodium CAPS 750mg	3	
budesonide CPEP 3mg	4	
budesonide TB24 9mg	5	NDS
hydrocortisone (intrarectal) ENEM 100mg/60ml	4	
mesalamine CP24 .375gm	4	QL (120 caps / 30 days)
mesalamine CPDR 400mg	4	QL (180 caps / 30 days)
mesalamine ENEM 4gm; SUPP 1000mg	4	
mesalamine TBEC 1.2gm	4	QL (120 tabs / 30 days)
mesalamine w/ cleanser KIT 4gm	4	
sulfasalazine TABS 500mg	2	
sulfasalazine TBEC 500mg	3	
LAXATIVES		
constulose SOLN 10gm/15ml	3	
enulose SOLN 10gm/15ml	3	
gavilyte-c	2	
gavilyte-g	2	
gavilyte-n/flavor pack	2	
generlac SOLN 10gm/15ml	3	
GOLYTELY SOL	3	
lactulose SOLN 10gm/15ml	3	
lactulose (encephalopathy) SOLN 10gm/15ml	3	
NULYTELY SOL FLAV PKS	3	
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	2	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	2	
PLENVU SOL	4	
SUPREP BOWEL SOL PREP KIT	4	
trilyte	2	
MISCELLANEOUS		
alosetron hcl TABS 1mg	5	NDS, QL (60 tabs / 30 days), PA
alosetron hcl TABS .5mg	4	QL (60 tabs / 30 days), PA
cromolyn sodium (mastocytosis) CONC 100mg/5ml	4	
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	4	
diphenoxylate w/ atropine tab 2.5-0.025 mg	3	
GATTEX KIT 5mg	5	NDS, NM, LA, PA
LINZESS CAPS 72mcg, 145mcg, 290mcg	4	QL (30 caps / 30 days)
loperamide hcl CAPS 2mg	3	
misoprostol TABS 100mcg, 200mcg	3	
MOVANTIK TABS 12.5mg	3	QL (60 tabs / 30 days)
MOVANTIK TABS 25mg	3	QL (30 tabs / 30 days)
RELISTOR SOLN 8mg/0.4ml, 12mg/0.6ml	5	NDS, PA
sucralfate TABS 1gm	3	

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TRULANCE TABS 3mg	4	QL (30 tabs / 30 days)
ursodiol CAPS 300mg	3	
ursodiol TABS 250mg, 500mg	4	
XIFAXAN TABS 550mg	5	NDS, PA
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	3	
CREON CAP 6000UNIT	3	
CREON CAP 12000UNT	3	
CREON CAP 24000UNT	3	
CREON CAP 36000UNT	3	
ZENPEP CAP 3000UNIT	4	
ZENPEP CAP 5000UNIT	4	
ZENPEP CAP 10000UNT	4	
ZENPEP CAP 15000UNT	4	
ZENPEP CAP 20000UNT	4	
ZENPEP CAP 25000	4	
ZENPEP CAP 40000	4	
PROTON PUMP INHIBITORS		
DEXILANT CPDR 30mg, 60mg	4	QL (30 caps / 30 days)
esomeprazole magnesium CPDR 20mg, 40mg	4	QL (30 caps / 30 days), ST
lansoprazole CPDR 15mg, 30mg	3	QL (60 caps / 30 days)
omeprazole CPDR 10mg, 20mg, 40mg	1	
pantoprazole sodium SOLR 40mg	4	
pantoprazole sodium TBEC 20mg, 40mg	1	
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
alfuzosin hcl TB24 10mg	2	QL (30 tabs / 30 days)
dutasteride CAPS .5mg	3	QL (30 caps / 30 days)
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	4	QL (30 caps / 30 days)
finasteride TABS 5mg	1	
tamsulosin hcl CAPS .4mg	2	
MISCELLANEOUS		
acetic acid SOLN .25%	2	
bethanechol chloride TABS 5mg, 10mg, 25mg, 50mg	3	
potassium citrate (alkalinizer) TBCR 15meq, 540mg, 1080mg	4	
URINARY ANTISPASMODICS		
MYRBETRIQ TB24 25mg, 50mg	4	QL (30 tabs / 30 days)
oxybutynin chloride SYRP 5mg/5ml; TABS 5mg	3	
oxybutynin chloride TB24 5mg	3	QL (30 tabs / 30 days)
oxybutynin chloride TB24 10mg, 15mg	3	QL (60 tabs / 30 days)
solifenacin succinate TABS 5mg, 10mg	3	QL (30 tabs / 30 days)

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tolterodine tartrate CP24 2mg, 4mg	4	QL (30 caps / 30 days), ST
tolterodine tartrate TABS 1mg, 2mg	4	QL (60 tabs / 30 days), ST
TOVIAZ TB24 4mg, 8mg	3	QL (30 tabs / 30 days)
trospium chloride TABS 20mg	3	QL (60 tabs / 30 days)
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal CREA 2%	3	
metronidazole vaginal GEL .75%	3	
terconazole vaginal CREA .4%, .8%; SUPP 80mg	3	
vandazole GEL .75%	3	
HEMATOLOGIC		
ANTICOAGULANTS		
ELIQUIS TABS 2.5mg	3	QL (60 tabs / 30 days)
ELIQUIS TABS 5mg	3	QL (74 tabs / 30 days)
ELIQUIS STARTER PACK TBPK 5mg	3	QL (74 tabs / 30 days)
enoxaparin sodium SOLN 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml, 300mg/3ml	4	
fondaparinux sodium SOLN 2.5mg/0.5ml	4	
fondaparinux sodium SOLN 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	5	NDS
HEP SOD/NACL INJ 25000UNT	3	
heparin sodium (porcine) SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	3	HI, B/D
heparin sodium (porcine) 100 unit/ml in d5w	3	
heparin sodium (porcine)-dextrose iv sol 20000 unit/500ml-5%	3	
heparin sodium (porcine)-dextrose iv sol 25000 unit/500ml-5%	3	
HEPARIN/NACL INJ 25000UNT	3	
jantoven TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	
PRADAXA CAPS 75mg, 110mg, 150mg	4	QL (60 caps / 30 days)
warfarin sodium TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	
XARELTO TABS 2.5mg	3	QL (60 tabs / 30 days)
XARELTO TABS 10mg, 15mg, 20mg	3	QL (30 tabs / 30 days)
XARELTO STAR TAB 15/20MG	3	QL (51 tabs / 30 days)
HEMATOPOIETIC GROWTH FACTORS		
PROCRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml	3	HI, NM, PA
PROCRIT SOLN 20000unit/ml, 40000unit/ml	5	NDS, HI, NM, PA
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	5	NDS, NM, PA
MISCELLANEOUS		
anagrelide hcl CAPS .5mg, 1mg	4	
BERINERT KIT 500unit	5	NDS, QL (24 boxes / 30 days), NM, LA, PA
cilostazol TABS 50mg, 100mg	2	
DROXIA CAPS 200mg, 300mg, 400mg	3	

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ENDARI PACK 5gm	5	NDS, NM, LA, PA
HAEGARDA SOLR 2000unit	5	NDS, QL (30 vials / 30 days), NM, LA, PA
HAEGARDA SOLR 3000unit	5	NDS, QL (20 vials / 30 days), NM, LA, PA
icatibant acetate SOLN 30mg/3ml	5	NDS, QL (9 syringes / 30 days), NM, PA
pentoxifylline TBCR 400mg	2	
PROMACTA PACK 12.5mg	5	NDS, QL (360 packets / 30 days), NM, LA, PA
PROMACTA PACK 25mg	5	NDS, QL (180 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg, 25mg	5	NDS, QL (30 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg, 75mg	5	NDS, QL (60 tabs / 30 days), NM, LA, PA
tranexamic acid SOLN 1000mg/10ml	4	
tranexamic acid TABS 650mg	3	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole cap er 12hr 25-200 mg	4	
BRILINTA TABS 60mg, 90mg	4	
clopidogrel bisulfate TABS 75mg	1	
dipyridamole TABS 25mg, 50mg, 75mg	3	PA; PA if 70 years and older
prasugrel hcl TABS 5mg, 10mg	3	
IMMUNOLOGIC AGENTS		
AUTOIMMUNE AGENTS		
ENBREL SOLN 25mg/0.5ml	5	NDS, QL (16 vials / 28 days), NM, PA
ENBREL SOLR 25mg	5 NM, PA	NDS, HI, QL (16 vials / 28 days),
ENBREL SOSY 25mg/0.5ml	5	NDS, HI, QL (16 syringes / 28 days), NM, PA
ENBREL SOSY 50mg/ml	5	NDS, HI, QL (8 syringes / 28 days), NM, PA
ENBREL MINI SOCT 50mg/ml	5	NDS, HI, QL (8 injections / 28 days), NM, PA
ENBREL SURECLICK SOAJ 50mg/ml	5	NDS, HI, QL (8 injections / 28 days), NM, PA
HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml	5	NDS, QL (2 injections / 28 days), NM, PA
HUMIRA PSKT 10mg/0.2ml, 20mg/0.4ml	5	NDS, QL (2 syringes / 28 days), NM, PA

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
HUMIRA PSKT 40mg/0.4ml	5	NDS, QL (6 injections / 28 days), NM, PA
HUMIRA PSKT 40mg/0.8ml	5	NDS, QL (6 syringes / 28 days), NM, PA
HUMIRA PEDIA INJ CROHNS	5	NDS, NM, PA
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml	5	NDS, NM, PA
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml	5	NDS, QL (6 pens / 28 days), NM, PA
HUMIRA PEN KIT PS/UV	5	NDS, NM, PA
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml, 80mg/0.8ml	5	NDS, NM, PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml	5	NDS, NM, PA
REMICADE SOLR 100mg	5	NDS, NM, PA
RENFLEXIS SOLR 100mg	5	NDS, NM, LA, PA
RINVOQ TB24 15mg	5	NDS, QL (30 tabs / 30 days), NM, PA
SKYRIZI PSKT 75mg/0.83ml	5	NDS, QL (7 kits / year), NM, PA
STELARA SOLN 45mg/0.5ml	5	NDS, QL (1 vial / 28 days), NM, LA, PA
STELARA SOSY 45mg/0.5ml, 90mg/ml	5	NDS, QL (1 syringe / 28 days), NM, PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml	5	NDS, QL (3 syringes / 28 days), NM, LA, PA
XELJANZ TABS 5mg, 10mg	5	NDS, QL (60 tabs / 30 days), NM, PA
XELJANZ XR TB24 11mg, 22mg	5	NDS, QL (30 tabs / 30 days), NM, PA
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
hydroxychloroquine sulfate TABS 200mg	3	
leflunomide TABS 10mg, 20mg	3	QL (30 tabs / 30 days)
methotrexate sodium TABS 2.5mg	3	
XATMEP SOLN 2.5mg/ml	4	B/D
IMMUNOGLOBULINS		
BIVIGAM SOLN 5gm/50ml	5	NDS, NM, PA
FLEBOGAMMA DIF SOLN 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	NDS, NM, PA
GAMASTAN INJ	4	B/D, NM
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	NDS, HI, NM, PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	5	NDS, HI, NM, PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	5	NDS, NM, PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	5	NDS, NM, PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	NDS, HI, NM, PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 25gm/500ml, 30gm/300ml	5	NDS, HI, NM, PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	5	NDS, NM, PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	5	NDS, NM, PA
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000unit/0.5ml	5	NDS, NM, LA, PA
ARCALYST SOLR 220mg	5	NDS, NM, PA
INTRON A SOLN 10mu/ml, 6000000unit/ml; SOLR 18mu, 50mu	5	NDS, B/D, NM
INTRON A SOLR 10mu	5	NDS, HI, B/D, NM
IMMUNOSUPPRESSANTS		
azathioprine TABS 50mg	3	B/D
BENLYSTA SOAJ 200mg/ml; SOLR 120mg, 400mg; SOSY 200mg/ml	5	NDS, NM, PA
cyclosporine CAPS 25mg, 100mg; SOLN 50mg/ml	4	B/D, NM
cyclosporine modified (for microemulsion) CAPS 25mg, 50mg, 100mg; SOLN 100mg/ml	4	B/D, NM
everolimus (immunosuppressant) TABS .5mg, .75mg	5	NDS, B/D, NM
everolimus (immunosuppressant) TABS .25mg	4	B/D, NM
gengraf CAPS 25mg, 100mg; SOLN 100mg/ml	4	B/D, NM
mycophenolate mofetil CAPS 250mg; TABS 500mg	3	B/D, NM
mycophenolate mofetil SUSR 200mg/ml	5	NDS, B/D, NM
mycophenolate sodium TBEC 180mg, 360mg	4	B/D, NM
NULOJIX SOLR 250mg	5	NDS, B/D, NM
PROGRAF PACK .2mg, 1mg	4	B/D, NM
SANDIMMUNE SOLN 100mg/ml	3	B/D, NM
sirolimus SOLN 1mg/ml; TABS 2mg	5	NDS, B/D, NM
sirolimus TABS .5mg, 1mg	4	B/D, NM
tacrolimus CAPS .5mg, 1mg, 5mg	4	B/D, NM
ZORTRESS TABS 1mg	5	NDS, B/D, NM
VACCINES		
ACTHIB INJ	3	
ADACEL INJ	3	
BCG VACCINE INJ	3	
BEXSERO INJ	3	
BOOSTRIX INJ	3	
DAPTACEL INJ	3	
DIP/TET PED INJ 25-5LFU	3	B/D
ENGERIX-B SUSP 10mcg/0.5ml, 20mcg/ml	3	B/D
GARDASIL 9 INJ	3	

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	3	
HIBERIX SOLR 10mcg	3	
IMOVAX RABIES (H.D.C.V.) INJ 2.5unit/ml	3	B/D
INFANRIX INJ	3	
IPOL INJ INACTIVE	3	
IXIARO INJ	3	
KINRIX INJ	3	
M-M-R II INJ	3	
MENACTRA INJ	3	
MENVEO INJ	3	
PEDIARIX INJ 0.5ML	3	
PEDVAX HIB SUSP 7.5mcg/0.5ml	3	
PENTACEL INJ	3	
PROQUAD INJ	3	
QUADRACEL INJ	3	
RABAVERT INJ	3	B/D
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml	3	B/D
ROTARIX SUS	3	
ROTATEQ SOL	3	
SHINGRIX SUSR 50mcg/0.5ml	3	QL (2 vials per lifetime)
TDVAX INJ 2-2 LF	3	B/D
TENIVAC INJ 5-2LF	3	B/D
TRUMENBA INJ	3	
TWINRIX INJ	3	
TYPHIM VI SOLN 25mcg/0.5ml	3	
VAQTA SUSP 25unit/0.5ml, 50unit/ml	3	
VARIVAX INJ 1350pfu/0.5ml	3	
YF-VAX INJ	3	
ZOSTAVAX SUSR 19400unt/0.65ml	3	QL (1 vial per lifetime)
NUTRITIONAL/SUPPLEMENTS		
ELECTROLYTES/MINERALS, INJECTABLE		
D5W/LYTES INJ #48	4	
D5W/NACL INJ 0.3%	3	
D10W/NACL INJ 0.2%	3	HI
dextrose 2.5% w/ sodium chloride 0.45%	3	HI
dextrose 5% in lactated ringers	3	
dextrose 5% w/ sodium chloride 0.2%	3	
dextrose 5% w/ sodium chloride 0.9%	3	HI
dextrose 5% w/ sodium chloride 0.45%	3	HI
dextrose 10% w/ sodium chloride 0.45%	3	HI
ISOLYTE-P INJ /D5W	4	
ISOLYTE-S INJ	4	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj	3	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj	3	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj	3	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj	3	
kcl 20 meq/l (0.15%) in nacl 0.9% inj	3	
kcl 20 meq/l (0.15%) in nacl 0.45% inj	3	
kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj	3	
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj	3	
kcl 40 meq/l (0.3%) in nacl 0.9% inj	3	
KCL/D5W/NACL INJ 0.3/0.9%	4	
KCL/D5W/NACL INJ 0.15/0.2	4	
lactated ringer's solution	3	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	3	
magnesium sulfate SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%	3	HI
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml	3	
MG SO4/D5W INJ 10MG/ML	3	
NORMOSOL -M INJ /D5W	4	
PLASMA-LYTE INJ -148	4	
PLASMA-LYTE INJ -A	4	
potassium chloride SOLN 2meq/ml	3	HI
POTASSIUM CHLORIDE SOLN 10meq/100ml, 10meq/50ml, 20meq/100ml, 20meq/50ml, 40meq/100ml	4	HI
potassium chloride 20 meq/l (0.15%) in dextrose 5% inj	3	
sodium chloride SOLN .45%, .9%, 2.5meq/ml, 3%, 5%	3	HI
TPN ELECTROL INJ	4	B/D
ELECTROLYTES/MINERALS/VITAMINS, ORAL		
klor-con PACK 20meq	4	
klor-con 8 TBCR 8meq	2	
klor-con 10 TBCR 10meq	2	
klor-con m10 TBCR 10meq	2	
klor-con m15 TBCR 15meq	2	
klor-con m20 TBCR 20meq	2	
klor-con sprinkle CPCR 8meq, 10meq	3	
M-NATAL PLUS TAB	3	
ONE VITE TAB 1MG PLUS	3	
PNV FOLIC AC TAB + IRON	3	
potassium chloride CPCR 8meq, 10meq	3	
potassium chloride PACK 20meq; SOLN 10%, 20%	4	
potassium chloride TBCR 8meq, 10meq, 20meq	2	
potassium chloride microencapsulated crystals er TBCR 10meq, 20meq	2	

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
PRENATAL TAB 27-1MG	3	
PRENATAL TAB PLUS	3	
PRENATAL VIT TAB LOW IRON	3	
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	2	
TRICARE TAB PRENATAL	3	
IV NUTRITION		
AMINOSYN-PF INJ 7%	4	B/D
CLINIMIX INJ 4.25/D5W	4	HI, B/D
CLINIMIX INJ 4.25/D10	4	HI, B/D
CLINIMIX INJ 5%/D15W	4	HI, B/D
CLINIMIX INJ 5%/D20W	4	HI, B/D
clinisol sf 15%	4	HI, B/D
CLINOLIPID EMU 20%	4	B/D
dextrose SOLN 5%, 10%	3	HI
dextrose SOLN 50%, 70%	3	B/D
FREAMINE HBC INJ 6.9%	4	B/D
FREAMINE III INJ 10%	4	B/D
hepatamine	4	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	4	HI, B/D
NEPHRAMINE INJ 5.4%	4	B/D
NUTRILIPID EMUL 20gm/100ml	4	B/D
plenamine	4	B/D
PREMASOL SOL 10%	4	B/D
PROCALAMINE INJ 3%	4	B/D
PROSOL INJ 20%	4	B/D
TRAVASOL INJ 10%	4	HI, B/D
TROPHAMINE INJ 10%	4	B/D
OPHTHALMIC		
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	3	
BLEPHAMIDE OIN S.O.P.	4	
neomycin-polymyxin-dexamethasone ophth oint 0.1%	2	
neomycin-polymyxin-dexamethasone ophth susp 0.1%	2	
neomycin-polymyxin-hc ophth susp	4	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	2	
TOBRADEX OIN 0.3-0.1%	3	
TOBRADEX ST SUS 0.3-0.05	3	
tobramycin-dexamethasone ophth susp 0.3-0.1%	4	
ZYLET SUS 0.5-0.3%	3	
ANTI-INFECTIVES		
bacitracin (ophthalmic) OINT 500unit/gm	3	

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bacitracin-polymyxin b ophth oint	2	
BESIVANCE SUSP .6%	3	
CILOXAN OINT .3%	3	
ciprofloxacin hcl (ophth) SOLN .3%	2	
erythromycin (ophth) OINT 5mg/gm	2	
gatifloxacin (ophth) SOLN .5%	3	
gentak OINT .3%	3	
gentamicin sulfate (ophth) SOLN .3%	2	
moxifloxacin hcl (ophth) SOLN .5%	3	
NATACYN SUSP 5%	4	
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	3	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	3	
ofloxacin (ophth) SOLN .3%	2	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	2	
sulfacetamide sodium (ophth) OINT 10%; SOLN 10%	3	
tobramycin (ophth) SOLN .3%	2	
trifluridine SOLN 1%	4	
ZIRGAN GEL .15%	4	
ANTI-INFLAMMATORIES		
ALREX SUSP .2%	3	
bromfenac sodium (ophth) SOLN .09%	4	
BROMSITE SOLN .075%	4	
dexamethasone sodium phosphate (ophth) SOLN .1%	3	
diclofenac sodium (ophth) SOLN .1%	2	
DUREZOL EMUL .05%	3	
FLAREX SUSP .1%	4	
fluorometholone (ophth) SUSP .1%	3	
flurbiprofen sodium SOLN .03%	3	
ILEVRO SUSP .3%	3	
ketorolac tromethamine (ophth) SOLN .4%	3	
ketorolac tromethamine (ophth) SOLN .5%	2	
LOTEMAX OINT .5%	3	
prednisolone acetate (ophth) SUSP 1%	3	
PREDNISOLONE SODIUM PHOSP SOLN 1%	3	
PROLENSA SOLN .07%	3	
ANTIALLERGICS		
azelastine hcl (ophth) SOLN .05%	3	
BEPREVE SOLN 1.5%	3	
cromolyn sodium (ophth) SOLN 4%	1	
LASTACAFT SOLN .25%	4	
olopatadine hcl SOLN .2%	3	
PAZEO SOLN .7%	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
ZERVIATE SOLN .24%	4	
ANTIGLAUCOMA		
ALPHAGAN P SOLN .1%	3	
AZOPT SUSP 1%	3	
betaxolol hcl (ophth) SOLN .5%	3	
BETOPTIC-S SUSP .25%	3	
brimonidine tartrate SOLN .2%	1	
brimonidine tartrate SOLN .15%	4	
carteolol hcl (ophth) SOLN 1%	2	
COMBIGAN SOL 0.2/0.5%	3	
dorzolamide hcl SOLN 2%	2	
dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml	2	
latanoprost SOLN .005%	2	
levobunolol hcl SOLN .5%	2	
LUMIGAN SOLN .01%	3	
PHOSPHOLINE IODIDE SOLR .125%	4	
pilocarpine hcl SOLN 1%, 2%, 4%	3	
RHOPRESSA SOLN .02%	3	
SIMBRINZA SUS 1-0.2%	3	
timolol maleate (ophth) SOLG .25%, .5%	4	
timolol maleate (ophth) SOLN .25%, .5%	1	
timolol maleate (ophth) once-daily SOLN .5%	4	
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1%	3	
CYSTARAN SOLN .44%	5	NDS, NM, LA, PA
proparacaine hcl SOLN .5%	3	
XIIDRA SOLN 5%	3	QL (60 single use vials / 30 days)
RESPIRATORY		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS		
ANORO ELLIPT AER 62.5-25	3	QL (60 blisters / 30 days)
BEVESPI AER 9-4.8MCG	3	QL (1 inhaler / 30 days)
COMBIVENT AER 20-100	4	QL (2 inhalers / 30 days)
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	3	B/D
TRELEGY AER ELLIPTA	3	QL (60 blisters / 30 days)
ANTICHOLINERGICS		
ATROVENT HFA AERS 17mcg/act	4	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA AEPB 62.5mcg/inh	3	QL (30 blisters / 30 days)
ipratropium bromide SOLN .02%	2	B/D
ipratropium bromide (nasal) SOLN .03%, .06%	3	
ANTIHISTAMINES		
azelastine hcl SOLN .1%, .15%	3	

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cetirizine hcl SOLN 1mg/ml	2	
cyproheptadine hcl SYRP 2mg/5ml; TABS 4mg	3	PA; PA if 70 years and older
diphenhydramine hcl SOLN 50mg/ml	3	
hydroxyzine hcl SOLN 25mg/ml, 50mg/ml	4	PA; PA if 70 years and older
hydroxyzine hcl SYRP 10mg/5ml	3	PA; PA if 70 years and older
hydroxyzine hcl TABS 10mg, 25mg, 50mg	2	PA; PA if 70 years and older
hydroxyzine pamoate CAPS 25mg, 50mg	2	PA; PA if 70 years and older
levocetirizine dihydrochloride SOLN 2.5mg/5ml	4	
levocetirizine dihydrochloride TABS 5mg	2	
BETA AGONISTS		
albuterol sulfate AERS 108mcg/act (generic of Proair HFA)	3	QL (2 inhalers / 30 days);
albuterol sulfate AERS 108mcg/act (generic of Ventolin HFA)	3	QL (2 inhalers / 30 days);
albuterol sulfate NEBU .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	3	B/D
albuterol sulfate NEBU .083%	2	B/D
albuterol sulfate SYRP 2mg/5ml	2	
albuterol sulfate TABS 2mg, 4mg	4	
albuterol sulfate TB12 4mg, 8mg	3	
levalbuterol hcl NEBU 1.25mg/0.5ml, 1.25mg/3ml	4	B/D
levalbuterol tartrate AERO 45mcg/act	3	QL (2 inhalers / 30 days)
SEREVENT DISKUS AEPB 50mcg/dose	3	QL (60 inhalations / 30 days)
terbutaline sulfate TABS 2.5mg, 5mg	4	
VENTOLIN HFA AERS 108mcg/act	3	QL (2 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
montelukast sodium CHEW 4mg, 5mg	2	
montelukast sodium PACK 4mg	4	
montelukast sodium TABS 10mg	1	
zafirlukast TABS 10mg, 20mg	3	
MISCELLANEOUS		
acetylcysteine SOLN 10%, 20%	3	B/D
ARALAST NP SOLR 500mg, 1000mg	5	NDS, NM, LA, PA
cromolyn sodium NEBU 20mg/2ml	3	B/D
DALIRESP TABS 250mcg, 500mcg	4	
epinephrine (anaphylaxis) SOAJ .15mg/0.3ml, .3mg/0.3ml	3	(generic of EpiPen)
epinephrine (anaphylaxis) SOAJ .15mg/0.15ml, .3mg/0.3ml	3	(generic of Adrenaclick)
ESBRIET CAPS 267mg	5	NDS, QL (270 caps / 30 days), NM, PA
ESBRIET TABS 267mg	5	NDS, QL (270 tabs / 30 days), NM, PA
ESBRIET TABS 801mg	5	NDS, QL (90 tabs / 30 days), NM, PA

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PA–Previa Autorización **QL**–Límites de Cantidad **ST**–Terapia por Fases **NM**–No Disponible en Pedido por Correo **B/D**–Cobertura bajo Medicare B o D **LA**–Acceso Limitado **ED**–Medicamento Excluido **HI**–Infusión en el hogar **GC**–Proveemos cobertura de este medicamento con receta en el período sin cobertura. Consulte nuestra Evidencia de cobertura para obtener más información sobre esta cobertura. **NDS**–Días de Suministro no Extendido **SSM**–Insulina modelo de ahorros para personas de la tercera edad

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
FASENRA SOSY 30mg/ml	5	NDS, NM, LA, PA
FASENRA PEN SOAJ 30mg/ml	5	NDS, NM, LA, PA
KALYDECO PACK 25mg, 50mg, 75mg	5	NDS, QL (56 packs / 28 days), NM, PA
KALYDECO TABS 150mg	5	NDS, QL (60 tabs / 30 days), NM, PA
OFEV CAPS 100mg, 150mg	5	NDS, QL (60 caps / 30 days), NM, PA
ORKAMBI GRA 100-125	5	NDS, QL (56 packs / 28 days), NM, PA
ORKAMBI GRA 150-188	5	NDS, QL (56 packs / 28 days), NM, PA
ORKAMBI TAB 100-125 NM, PA	5	NDS, QL (112 tabs / 28 days),
ORKAMBI TAB 200-125	5	NDS, QL (112 tabs / 28 days), NM, PA
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg	5	NDS, NM, LA, PA
PULMOZYME SOLN 1mg/ml	5	NDS, NM, PA
SYMDEKO TAB 50-75MG	5	NDS, QL (56 tabs / 28 days), NM, LA, PA
SYMDEKO TAB 100-150	5	NDS, QL (56 tabs / 28 days), NM, LA, PA
SYMJEPI SOSY .15mg/0.3ml, .3mg/0.3ml	4	
THEO-24 CP24 100mg, 200mg, 300mg, 400mg	4	
theophylline SOLN 80mg/15ml; TB12 300mg, 450mg	4	
theophylline TB24 400mg, 600mg	3	
TRIKAFTA TAB	5	NDS, QL (84 tabs / 28 days), NM, LA, PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	5	NDS, HI, NM, LA, PA
ZEMAIRA SOLR 1000mg	5	NDS, HI, NM, LA, PA
NASAL STEROIDS		
flunisolide (nasal) SOLN .025%	3	QL (3 bottles / 30 days)
fluticasone propionate (nasal) SUSP 50mcg/act	2	QL (1 bottle / 30 days)
STEROID INHALANTS		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act	3	QL (30 inhalations / 30 days)
budesonide (inhalation) SUSP .5mg/2ml	4	B/D, QL (60 respules / 30 days)
budesonide (inhalation) SUSP .25mg/2ml	4	B/D, QL (90 respules / 30 days)
FLOVENT DISKUS AEPB 50mcg/blist	3	QL (180 inhalations / 30 days)
FLOVENT DISKUS AEPB 100mcg/blist, 250mcg/blist	3	QL (240 inhalations / 30 days)
FLOVENT HFA AERO 44mcg/act, 110mcg/act, 220mcg/act	3	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER AEPB 90mcg/act	4	QL (3 inhalers / 30 days)
PULMICORT FLEXHALER AEPB 180mcg/act	4	QL (2 inhalers / 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
STEROID/BETA-AGONIST COMBINATIONS		
ADVAIR DISKU AER 100/50	3	QL (60 inhalations / 30 days)
ADVAIR DISKU AER 250/50	3	QL (60 inhalations / 30 days)
ADVAIR DISKU AER 500/50	3	QL (60 inhalations / 30 days)
ADVAIR HFA AER 45/21	3	QL (1 inhaler / 30 days)
ADVAIR HFA AER 115/21	3	QL (1 inhaler / 30 days)
ADVAIR HFA AER 230/21	3	QL (1 inhaler / 30 days)
BREO ELLIPTA INH 100-25	3	QL (60 blisters / 30 days)
BREO ELLIPTA INH 200-25	3	QL (60 blisters / 30 days)
SYMBICORT AER 80-4.5	3	QL (1 inhaler / 30 days)
SYMBICORT AER 160-4.5	3	QL (1 inhaler / 30 days)
Sexual Dysfunction Agents		
Sexual Dysfunction Agents		
sildenafil citrate TABS 25mg, 50mg, 100mg	2	ED, GC, QL (6 tabs / 30 days); CAP=72 TABS EVERY YEAR
TOPICAL		
DERMATOLOGY, ACNE		
amnesteem CAPS 10mg, 20mg, 40mg	4	PA
avita CREA .025%; GEL .025%	4	QL (45 gm / 30 days), PA
benzoyl peroxide-erythromycin gel 5-3%	4	
claravis CAPS 10mg, 20mg, 30mg, 40mg	4	PA
clindamycin phosphate (topical) GEL 1%	3	QL (75 gm / 30 days)
clindamycin phosphate (topical) LOTN 1%; SOLN 1%	3	QL (60 mL / 30 days)
ery PADS 2%	3	
erythromycin (acne aid) SOLN 2%	3	QL (60 mL / 30 days)
isotretinoin CAPS 10mg, 20mg, 30mg, 40mg	4	PA
myorisan CAPS 10mg, 20mg, 30mg, 40mg	4	PA
sulfacetamide sodium (acne) LOTN 10%	4	
tretinoin CREA .025%, .05%, .1%; GEL .01%, .025%	4	QL (45 gm / 30 days), PA
zenatane CAPS 10mg, 20mg, 30mg, 40mg	4	PA
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical) CREA .1%	4	QL (30 gm / 30 days)
gentamicin sulfate (topical) OINT .1%	3	
mupirocin OINT 2%	2	QL (220 gm / 30 days)
silver sulfadiazine CREA 1%	2	
ssd CREA 1%	2	
SULFAMYLON CREA 85mg/gm	4	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox olamine CREA .77%	3	QL (90 gm / 30 days)
ciclopirox olamine SUSP .77%	3	QL (60 mL / 30 days)
clotrimazole (topical) CREA 1%	3	QL (45 gm / 30 days)

Last Updated October 15, 2020

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
clotrimazole (topical) SOLN 1%	3	QL (30 mL / 30 days)
clotrimazole w/ betamethasone cream 1-0.05%	3	QL (45 gm / 30 days)
ketoconazole (topical) CREA 2%	3	QL (60 gm / 30 days)
nyamyc POWD 100000unit/gm	3	QL (60 gm / 30 days)
nystatin (topical) CREA 100000unit/gm; OINT 100000unit/gm	3	QL (30 gm / 30 days)
nystatin (topical) POWD 100000unit/gm	3	QL (60 gm / 30 days)
nystop POWD 100000unit/gm	3	QL (60 gm / 30 days)
DERMATOLOGY, ANTIPSORIATICS		
acitretin CAPS 10mg, 17.5mg, 25mg	4	PA
calcipotriene CREA .005%; OINT .005%	4	QL (120 gm / 30 days), PA
calcipotriene SOLN .005%	4	QL (120 mL / 30 days), PA
calcitrene OINT .005%	4	QL (120 gm / 30 days), PA
tazarotene CREA .1%	3	QL (60 gm / 30 days), PA
TAZORAC CREA .05%	4	QL (60 gm / 30 days), PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) SHAM 2%	2	QL (120 mL / 30 days)
selenium sulfide LOTN 2.5%	2	
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort CREA 1%	1	
ala-cort CREA 2.5%	2	
alclometasone dipropionate CREA .05%; OINT .05%	3	
betamethasone dipropionate (topical) CREA .05%; LOTN .05%	3	
betamethasone dipropionate (topical) OINT .05%	4	
betamethasone dipropionate augmented CREA .05%	3	
betamethasone dipropionate augmented GEL .05%; LOTN .05%; OINT .05%	4	
betamethasone valerate CREA .1%; LOTN .1%; OINT .1%	3	
clobetasol propionate CREA .05%; OINT .05%	3	QL (60 gm / 30 days)
clobetasol propionate GEL .05%	4	QL (60 gm / 30 days)
clobetasol propionate SOLN .05%	3	QL (50 mL / 30 days)
clobetasol propionate e CREA .05%	3	QL (60 gm / 30 days)
ENSTILAR AER	4	QL (120 gm / 30 days), PA
fluocinolone acetonide CREA .01%, .025%; OINT .025%	3	
fluocinolone acetonide OIL .01%	4	
fluocinolone acetonide SOLN .01%	4	QL (90 mL / 30 days)
fluocinonide CREA .05%	3	QL (120 gm / 30 days)
fluocinonide GEL .05%; OINT .05%	4	QL (60 gm / 30 days)
fluocinonide SOLN .05%	3	QL (60 mL / 30 days)
fluocinonide emulsified base CREA .05%	3	QL (120 gm / 30 days)
fluticasone propionate CREA .05%; OINT .005%	3	
halobetasol propionate CREA .05%; OINT .05%	4	QL (50 gm / 30 days)
hydrocortisone (topical) CREA 1%	1	
hydrocortisone (topical) CREA 2.5%; LOTN 2.5%; OINT 2.5%	2	

List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
mometasone furoate CREA .1%; OINT .1%; SOLN .1%	3	
triamcinolone acetonide (topical) CREA .1%	2	QL (454 gm / 30 days)
triamcinolone acetonide (topical) CREA .025%, .5%; OINT .025%, .1%, .5%	2	
triamcinolone acetonide (topical) LOTN .025%, .1%	3	
DERMATOLOGY, LOCAL ANESTHETICS		
glydo PRSY 2%	3	QL (30 mL / 30 days), PA
lidocaine OINT 5%	4	QL (50 gm / 30 days), PA
lidocaine PTCH 5%	4	QL (3 patches / 1 day), PA
lidocaine hcl GEL 2%	3	QL (30 mL / 30 days), PA
lidocaine hcl SOLN 4%	3	QL (50 mL / 30 days), PA
lidocaine-prilocaine cream 2.5-2.5%	3	QL (30 gm / 30 days), PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
diclofenac sodium (topical) GEL 1%	3	QL (1000 gm / 30 days), PA
fluorouracil (topical) CREA 5%	4	QL (40 gm / 30 days)
fluorouracil (topical) SOLN 2%, 5%	3	QL (10 mL / 30 days)
imiquimod CREA 5%	3	QL (24 packets / 30 days)
lactic acid (ammonium lactate) CREA 12%	2	
lactic acid (ammonium lactate) LOTN 12%	3	
metronidazole (topical) CREA .75%; LOTN .75%	4	
metronidazole (topical) GEL .75%	3	
PICATO GEL .05%	4	QL (2 tubes / 30 days)
PICATO GEL .015%	4	QL (3 tubes / 30 days)
podofilox SOLN .5%	3	
procto-med hc CREA 2.5%	3	
procto-pak CREA 1%	3	
proctosol hc CREA 2.5%	3	
proctozone-hc CREA 2.5%	3	
RECTIV OINT .4%	4	QL (30 gm / 30 days)
rosadan CREA .75%	4	
tacrolimus (topical) OINT .03%, .1%	4	QL (100 gm / 30 days)
TARGRETIN GEL 1%	5	NDS, QL (60 gm / 30 days), NM, PA
VALCHLOR GEL .016%	5	NDS, QL (60 gm / 30 days), NM, LA, PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
malathion LOTN .5%	4	
permethrin CREA 5%	3	
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01%	5	NDS, QL (30 gm / 30 days), PA
SANTYL OINT 250unit/gm	4	
sodium chloride (gu irrigant) SOLN .9%	3	

List of Covered Drugs / Lista de Medicamentos

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER/ NIVEL	REQUIREMENTS / LIMITS REQUISITOS/LIMITACIONES
water for irrigation, sterile irrigation soln	2	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl CAPS 30mg	4	
chlorhexidine gluconate (mouth-throat) SOLN .12%	1	
clotrimazole TROC 10mg	4	QL (150 lozenges / 30 days)
lidocaine hcl (mouth-throat) SOLN 2%	2	
nystatin (mouth-throat) SUSP 100000unit/ml	3	
paroex SOLN .12%	1	
periogard SOLN .12%	1	
pilocarpine hcl (oral) TABS 5mg, 7.5mg	4	
triamcinolone acetonide (mouth) PSTE .1%	3	
OTIC		
acetic acid (otic) SOLN 2%	3	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	3	
flac OIL .01%	4	
fluocinolone acetonide (otic) OIL .01%	4	
neomycin-polymyxin-hc otic soln 1%	3	
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Non-Discrimination Notice

Devoted Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Devoted Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Devoted Health

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other language

If you need these services, contact Devoted Health at 1-800-338-6833 (TTY 711).

If you believe that Devoted Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Dual HMO plans only:
Devoted Health – Appeals & Grievances
PO Box 21917
Eagan, MN 55121
1-800-338-6833 (TTY 711)

All other HMO plans:
Devoted Health – Appeals & Grievances
PO Box 21327
Eagan, MN 55121
1-800-338-6833 (TTY 711)

You can file a grievance in person, by mail and by phone. If you need help filing a grievance, call 1-800-338-6833 (TTY 711).

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, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Last Updated October 15, 2020

Aviso de no discriminación

Devoted Health cumple con las leyes aplicables de derechos civiles federales y no discrimina por motivos de raza, color de la piel, nacionalidad de origen, edad, discapacidad o sexo. Devoted Health no excluye a las personas ni las trata de manera diferente por motivos de raza, color de la piel, nacionalidad de origen, edad, discapacidad o sexo.

Devoted Health

Provee recursos y servicios gratuitos para personas con discapacidad para comunicarse efectivamente con nosotros, tales como:

- Intérpretes de lenguaje de señas acreditados
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

Provee servicios gratuitos de idiomas para personas cuyo idioma principal no es el inglés, tales como:

- Interpretes acreditados
- Información escrita en otros idiomas

Si necesita estos servicios, póngase en contacto con Devoted Health al 1-800-338-6833 (TTY 711).

Si usted cree que Devoted Health ha fallado en proveer estos servicios o le ha discriminado de otra forma por motivos de raza, color de la piel, nacionalidad de origen, edad, discapacidad o sexo, puede presentar una queja formal ante:

Solamente planes HMO Dual:
Devoted Health – Appeals & Grievances
PO Box 21917
Eagan, MN 55121
1-800-338-6833 (TTY 711)

Todos los demás planes HMO:
Devoted Health – Appeals & Grievances
PO Box 21327
Eagan, MN 55121
1-800-338-6833 (TTY 711)

Puede presentar una queja formal en persona, por correo y por teléfono. Si necesita ayuda para presentar una queja formal, llame al 1-800-338-6833 (TTY 711).

También puede presentar una queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos, Oficina de Derechos Civiles, por medios electrónicos 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 postal o por teléfono a:

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

Los formularios de quejas están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

Last Updated October 1, 2020

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-338-6833 (TTY 711).

العربيـــة **(Arabic):** ملحوظة: إذا كنـت تتحــدث اللغـــة الإنجليزيــــة، فإن خدمات المســاعدة اللغويـــة متوفـــرة لك مجاناً. اتصـــل بـــالرقم (1-800-338-6833) للصــم و البكــم: 711)

您講中文 **(Chinese):** 注意：如果您講英語，則可免費獲得語言幫助服務。請呼叫 1-800-338-6833 (TTY 711)。

فارسـی **(Farsi):**

توجه : اگر به زبان فارسی صحبت میکنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با این شماره تماس بگیرید:(TTY 711) 1-800-338-6833 .

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-338-6833 (ATS 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-338-6833 (TTY 711).

ગુજરાતી **(Gujarati):** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોવ તો ભાષા સહાય સેવાઓ (લેન્ગવેજ આસિસ્ટન્સ સર્વિસીસ) આપના માટે વિનામૂલ્યે ઉપલબ્ધ છે. 1-800-338-6833 (TTY 711) પર કૉલ કરો.

Kreyòl Ayisyen (Haitian Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-338-6833 (TTY 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, dei servizi di assistenza linguistica gratuiti sono disponibili. Chiamare 1-800-338-6833 (TTY 711).

日本語 **(Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-338-6833 (TTY 711) まで、お電話にてご連絡ください。

한국어 **(Korean):** 주의: 영어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-338-6833 (TTY 711). 번으로 전화해 주십시오.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-338-6833 (TTY 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-338-6833 (TTY 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-338-6833 (телетайп 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-338-6833 (TTY 711).

Tagalog (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-338-6833(TTY 711).

ไทย (Thai): โปรดทราบ: หากคุณสื่อสารด้วยภาษาไทย บริการช่วยเหลือด้านภาษา ไม่มีค่าใช้จ่าย พร้อมให้บริการคุณ ที่หมายเลขโทรศัพท์ 1-800-338-6833 (พิมพ์ TTY 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-338-6833 (TTY 711).

Last Updated October 15, 2020

NOTES / NOTAS

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This formulary was updated on October 15, 2020. For more recent information or other questions, please contact Devoted Health Member Services at 1-800-338-6833 or, for TTY users, 711, Monday - Friday 8am - 8pm.(from Oct 1 - March 31, representatives are available 7 days a week, 8am - 8pm), or visit us at www.devoted.com.

Este formulario fue actualizado el 15 de octubre de 2020. Para la información más reciente o si tiene preguntas, comuníquese con Servicios para Miembros de Devoted Health llamando al 1-800-338-6833 o los usuarios de TTY, marcar 711, de lunes a viernes de 8 am a 8 pm (del 1 de octubre al 31 de marzo, los representantes están disponibles los 7 días de la semana, de 8 am a 8 pm), o visítenos en www.devoted.com/es.

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