ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

AHCCCS

ACUTE - LONG TERM CARE DRUG LIST

- **Generic Drugs Are Preferred Over Brand Name Drugs Unless The Drug Is Specified As BRAND ONLY**
- **Federally Reimbursable Drugs Not Listed On The AHCCCS Drug List May Be Available Through Prior Authorization**

Effective Date: November 1, 2026

Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ADHD/ANTI-NARCOLEPSY							
AMPHETAMINES**							
AMPHETAMINE-DEXTROAMPHETAMINE CAPSULE ER 24 HR	ADDERALL XR		PREFERRED DRUG	PA REQUIRED for Ages < 6 years		90	90
AMPHETAMINE-DEXTROAMPHETAMINE TABLET	**ADDERALL**	**Brand and Generic**	**PREFERRED DRUG**	**PA REQUIRED for Ages < 6 years**		**180**	**90**
DEXTROAMPHETAMINE SULFATE TABLET	ZENZEDI		PREFERRED DRUG	PA REQUIRED for Ages < 6 years		180	90
LISDEXAMFETAMINE DIMESYLATE CAPSULE	**VYVANSE**		**PREFERRED DRUG**	**PA REQUIRED for Ages < 6 years**		**90**	**90**
LISDEXAMFETAMINE DIMESYLATE TABLET CHEWABLE	**VYVANSE**		**PREFERRED DRUG**	**PA REQUIRED for Ages < 6 years**		**90**	**90**
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS**							
ATOMOXETINE HCL CAPSULES	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
CLONIDINE HCL	CATAPRES			PA REQUIRED for Ages < 6 years of age			
CLONIDINE HCL TRANSDERMAL PATCH	CATAPRES PATCHES			PA REQUIRED for Ages < 6 years of age		4	28
CLONIDINE HCL (ADHD) TABLET 12-HOUR	CLONIDINE ER		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		120	30
GUANFACINE HCL (ADHD) TABLET 24-HOUR	GUANFACINE ER		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
GUANFACINE HCL TABLET	GUANFACINE HCL			PA REQUIRED for Ages < 6 years of age			
STIMULANTS - MISC.**							
ARMODAFINIL TABLET (50MG)	NUVIGIL	**Authorized Generic Only**	PREFERRED DRUG	PA REQUIRED for Ages < 18 years of age		180	90
ARMODAFINIL TABLET (150MG, 200MG, 250MG)	NUVIGIL	**Authorized Generic Only**	PREFERRED DRUG	PA REQUIRED for Ages < 18 years of age		90	90
DEXMETHYLPHENIDATE HCL CAPSULE 24-HOUR	FOCALIN XR		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
DEXMETHYLPHENIDATE HCL TABLETS	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
METHYLPHENIDATE HCL CAPSULE 24-HOUR	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
METHYLPHENIDATE HCL CAPSULE CONTROLLED RELEASE CD	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
METHYLPHENIDATE PATCH	**METHYLPHENIDATE PATCH**		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
METHYLPHENIDATE HCL SOLUTION	**METHYLIN**		**PREFERRED DRUG**	**PA REQUIRED for Ages < 6 years**		**900**	**90**
METHYLPHENIDATE HCL TABLETS	VARIOUS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		90	30
METHYLPHENIDATE HCL TABLET EXTENDED RELEASE	CONCERTA		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		60	30
MODAFINIL TABLET	PROVIGIL		PREFERRED DRUG	PA REQUIRED for Ages < 18 years of age		90	90
METHYLPHENIDATE HCL TABLET ER 24HR	METHYLPHENIDATE ER		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		90	90
AMINOGLYCOSIDES							
AMINOGLYCOSIDES							
NEOMYCIN SULFATE TABLETS	NEOMYCIN SULFATE						
INHALED ANTIBIOTICS							
PAROMOMYCIN SULFATE CAPSULE	HUMATIN			Not covered through AHCCCS. Please contact Waylis Pharmaceuticals for the patient assistance program. Toll Free Number: 1-800-689-0255			
TOBRAMYCIN NEBULIZED	**BETHKIS**	**BRAND ONLY**	**PREFERRED DRUG**	PA REQUIRED			
TOBRAMYCIN NEBULIZED	**KITABIS**	**BRAND ONLY**	**PREFERRED DRUG**	PA REQUIRED			
ANALGESICS - ANTI-INFLAMMATORY							
ANTIRHEUMATIC ANTIMETABOLITES							
METHOTREXATE SODIUM TABLETS	RHEUMATREX						
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)							
CELECOXIB CAPSULE	CELEBREX					180	90
CELECOXIB SUSPENSION	VYSCOXA			PA Required < 2 and > 10 Years of Age			
DICLOFENAC SODIUM TABLET ENTERIC COATED	DICLOFENAC SODIUM DR						
DICLOFENAC TABLET ENTERIC COATED	DICLOFENAC SODIUM EC						
ETODOLAC CAPSULE	ETODOLAC						
ETODOLAC TABLET	LODINE						
FLURBIPROFEN TABLET	FLURBIPROFEN						
IBUPROFEN CAPSULE	MOTRIN IB						
IBUPROFEN SUSPENSION (RX ONLY)	MEDI-PROFEN						
IBUPROFEN TABLET (Excluding 300mg)	ADVIL						
INDOMETHACIN CAPSULE	TIVORBEX						
KETOPROFEN CAPSULE	KETOPROFEN						
KETOROLAC TROMETHAMINE TABLET	KETOROLAC TROMETHAMINE					20	30
MELOXICAM TABLET	MOBIC						
NABUMETONE TABLET (Excluding 1000mg)	NABUMETONE						
NAPROXEN SODIUM TABLET	PAMPRIN ALL DAY MAXIMUM STRENGTH						
NAPROXEN TABLET	NAPROSYN						
PIROXICAM CAPSULE	FELDENE						
SULINDAC TABLET	SULINDAC						
PYRIMIDINE SYNTHESIS INHIBITORS							
LEFLUNOMIDE TABLETS	ARAVA						
SELECTIVE COSTIMULATION MODULATORS							
ABATACEPT CLICKJECT OR SYRINGE	**ORENCIA**		PREFERRED DRUG	PA REQUIRED			
CYTOKINE & CAM ANTAGONIST AGENTS							
ADALIMUMAB-BWWD SOLN AUTO-INJ	**HADLIMA PUSH**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			

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ADALIMUMAB-BWWD SOLN PREF SYR	**HADLIMA**	**Authorized Unbranded Biosimilar Only**	**PREFERRED DRUG**	**PA REQUIRED**			
ADALIMUMAB-FKJP AUTO-INJECTOR KIT	**HULIO**	**BIOSIMILAR BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
ADALIMUMAB-FKJP PREFILLED SYRINGE KIT	**HULIO**	**BIOSIMILAR BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
APREMILAST TABLET	**OTEZLA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
APREMILAST TABLET ER 24HR	**OTEZLA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
APREMILAST TAB THER PACK	**OTEZLA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
ETANERCEPT	**ENBREL**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
TOFACITINIB CITRATE	**XELJANZ IMMEDIATE RELEASE ONLY**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
TOFACITINIB CITRATE TABLET ER 24HR	**XELJANZ XR**	**BRAND ONLY**	**PREFERRED DRUG**	PA REQUIRED			
INTERLEUKIN - 6 RECEPTOR ANTAGONIST AGENTS							
TOCILIZUMAB-AAZG AUTOINJECTOR	**TYENNE**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
TOCILIZUMAB-AAZG SYRINGE	**TYENNE**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
TOCILIZUMAB-AAZG VIAL	**TYENNE**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
TOCILIZUMAB-BAVI SOLUTION	**TOFIDENCE**	**BIOSIMILAR BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
TOCILIZUMAB-ANOH SOLUTION	**AVTOZMA**	**BIOSIMILAR BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
TOCILIZUMAB-ANOH SOLN AUTO-INJ	**AVTOZMA**	**BIOSIMILAR BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
TOCILIZUMAB-ANOH SOLN PREF SYR	**AVTOZMA**	**BIOSIMILAR BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
ANALGESICS - NONNARCOTIC							
ANALGESIC COMBINATIONS							
BUTALBITAL-ACETAMINOPHEN-CAFFEINE TABLETS	VARIOUS					120	30
BUTALBITAL-ASPIRIN-CAFFEINE TABLETS	VARIOUS					120	30
ANALGESICS OTHER							
ACETAMINOPHEN CAPSULES	VARIOUS						
ACETAMINOPHEN CHEWABLE TABLETS	VARIOUS						
ACETAMINOPHEN ELIXIR	VARIOUS						
ACETAMINOPHEN LIQUID	VARIOUS						
ACETAMINOPHEN SUPPOSITORY	FEVERALL INFANTS						
ACETAMINOPHEN SUSPENSION	TYLENOL INFANTS						
SALICYLATES							
ASPIRIN CHEWABLE TABLETS	VARIOUS						
ASPIRIN SUPPOSITORY	VARIOUS						
ASPIRIN TABLETS	VARIOUS						
SALSALATE TABLETS	DISALCID						
ANALGESICS - OPIOID							
LONG-ACTING OPIOID AGONISTS							
FENTANYL PATCH 72-HOUR 12mcg, 25mcg, 50mcg, 75mcg & 100mcg	DURAGESIC 12mcg, 25mcg, 50mcg, 75mcg & 100mcg		PREFERRED DRUG	PA REQUIRED			
MORPHINE-NALTREXONE CAPSULE CONTROLLED RELEASE RELEASE	**EMBEDA**	**BRAND ONLY**	**PREFERRED DRUG**	PA REQUIRED			
MORPHINE SULFATE TABLET CONTROLLED RELEASE	VARIOUS		PREFERRED DRUG	PA REQUIRED			
OXYCODONE ER	**OXYCOTIN**	**BRAND ONLY**	**PREFERRED DRUG**	PA REQUIRED			
TRAMADOL HCL TABLETS ER	ULTRAM ER		PREFERRED DRUG	PA REQUIRED			
BUPRENORPHINE PATCH WEEKLY	**BUTRANS**		**PREFERRED DRUG**	**PA REQUIRED**			
SHORT-ACTING OPIOID AGONISTS							
HYDROMORPHONE HCL TABLETS	DILAUDID			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE SOLUTION	MORPHINE SULFATE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE TABLETS	MORPHINE SULFATE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
MORPHINE SULFATE TABLET ER	MS CONTIN		PREFERRED DRUG	PA REQUIRED			
OXYCODONE HCL SOLUTION	OXYCODONE HCL			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL TABLETS	ROXICODONE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE HCL TAB 12HR DETER	**OXYCONTIN**	**BRAND ONLY**		**PA REQUIRED**			
TRAMADOL HCL TABLETS 50MG	ULTRAM			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OPIOID COMBINATIONS							
ACETAMINOPHEN W/ CODEINE SOLUTION	ACETAMINOPHEN/CODEINE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
ACETAMINOPHEN W/ CODEINE TABLETS	ACETAMINOPHEN/CODEINE			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN CAPSULES	HYDROGESIC			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN SOLUTION	HYCET			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
HYDROCODONE-ACETAMINOPHEN TABLETS	VERDROCET			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			

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OXYCODONE W/ ACETAMINOPHEN CAPSULES	OXYCODONE/ACETAMINOPHEN			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE W/ ACETAMINOPHEN TABLETS	ENDOCET			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
OXYCODONE-IBUPROFEN TABLETS	OXYCODONE/IBUPROFEN			PA REQUIRED for > 2 Short Acting Opioid Medications in a 30-day time period.			
TRAMADOL-ACETAMINOPHEN TABLET	TRAMADOL/ACETAMINOPHEN						
ANTIDOTES							
OPIOID ANTAGONISTS							
NALOXONE HCL SOLUTION + SYRINGE	NALOXONE HCL + SYRINGE		PREFERRED DRUG				
NALOXONE HCL NASAL SPRAY	NARCAN NASAL SPRAY	OVER-THE-COUNTER & PRESCRIPTION ONLY	PREFERRED DRUG			2	1
NALOXONE HCL NASAL SPRAY 8mg	KLOXXADO NASAL SPRAY		PREFERRED DRUG			2	1
NALTREXONE HCL TABLETS	NALTREXONE HCL		PREFERRED DRUG				
NALTREXONE SUSPENSION	VIVITROL		PREFERRED DRUG				
OPIOID AGONISTS							
BUPRENORPHINE	VARIOUS			PA REQUIRED unless the member is pregnant or nursing. The prescriber must note the following ICD-10 codes on the prescription: 1. O09.91- Supervision of high risk pregnancy, 1st Trimester. 2. O09.92- Supervision of high risk pregnancy, 2nd Trimester. 3. O09.93- Supervision of high risk pregnancy, 3rd Trimester. 4. O09.91- Supervision of high risk pregnancy- use for Postpartum Nursing Mothers. The first digit of the diagnosis code is the Letter - O and the second is a Zero - 0			
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE FILM	**SUBOXONE FILM**	**BRAND ONLY**	**PREFERRED DRUG**				
BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE ORALLY DISINTEGRATING TABLETS	VARIOUS	GENERIC FORMULATIONS ONLY	PREFERRED DRUG				
BUPRENORPHINE EXTENDED RELEASE INJECTION	SUBLOCADE		PREFERRED DRUG	PA REQUIRED			
BUPRENORPHINE SOLN PREF SYR	BRIXADI		PREFERRED DRUG	PA REQUIRED			
METHADONE HCL TABLET	METHADONE			PA REQUIRED			
METHADONE HCL CONCENTRATE	METHADONE			PA REQUIRED			
METHADONE HCL SOLUTION	METHADONE			PA REQUIRED			
METHADONE HCL TABLET SOLUBLE	METHADONE			PA REQUIRED			
MISCELLANEOUS AGENTS							
ACAMPROSATE	VARIOUS						
DISULFIRAM	ANTABUSE						
ANDROGENS-ANABOLIC							
ANDROGENS							
DANAZOL CAPSULES	DANAZOL						
TESTOSTERONE CYPIONATE SOLUTION	DEPO-TESTOSTERONE			PA REQUIRED			
TESTOSTERONE ENANTHATE SOLUTION	TESTOSTERONE ENANTHATE			PA REQUIRED			
TESTOSTERONE GEL (1.62% - PUMP BOTTLE)	ANDROGEL/TESTOSTERONE (AG)	**AUTHORIZED GENERIC ONLY**	PREFERRED DRUG	PA REQUIRED			
TESTOSTERONE PATCH	ANDRODERM			PA REQUIRED			
ANORECTAL AGENTS							
INTRARECTAL STEROIDS							
HYDROCORTISONE (INTRARECTAL) ENEMA	COLOCORT						
HYDROCORTISONE ACETATE (INTRARECTAL) FOAM	CORTIFOAM						
RECTAL STEROIDS							
HYDROCORTISONE (RECTAL) CREAM	VARIOUS						
ANTHELMINTICS							
ANTHELMINTICS							
ALBENDAZOLE TABLETS	ALBENZA			PA REQUIRED			
IVERMECTIN TABLETS	STROMECTOL			PA REQUIRED			
PRAZIQUANTEL TABLETS	BILTRICIDE						
ANTIANGINAL AGENTS							
ANTIANGINALS-OTHER							
RANOLAZINE TABLET 12-HOUR	RANEXA			PA REQUIRED			
NITRATES							
ISOSORBIDE DINITRATE CAPSULE CONTROLLED RELEASE	DILATRATE SR						
ISOSORBIDE DINITRATE SUBLINGUAL	ISOSORBIDE DINITRATE						
ISOSORBIDE DINITRATE TABLETS	ISORDIL TITRADOSE						

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ISOSORBIDE DINITRATE TABLET CONTROLLED RELEASE	ISOSORBIDE DINITRATE ER						
ISOSORBIDE MONONITRATE TABLETS	ISOSORBIDE MONONITRATE						
ISOSORBIDE MONONITRATE TABLET 24-HOUR	IMDUR						
NITROGLYCERIN CAPSULE CONTROLLED RELEASE	NITRO-TIME						
NITROGLYCERIN OINTMENT	NITRO-BID						
NITROGLYCERIN PATCH 24-HOUR	NITRO-DUR						
NITROGLYCERIN SUBLINGUAL	NITROSTAT						
ANTIANXIETY AGENTS							
ANTIANXIETY AGENTS - MISC.							
BUSPIRONE HCL TAB 5 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 7.5 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 10 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 15 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
BUSPIRONE HCL TAB 30 MG	BUSPIRONE HCL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
HYDROXYZINE HCL SYRUP	HYDROXYZINE SYRUP					300	30
HYDROXYZINE HCL TABLETS	HYDROXYZINE TABLETS					240	30
HYDROXYZINE PAMOATE CAPSULES	VISTARIL					120	30
BENZODIAZEPINES							
ALPRAZOLAM CONC 1 MG/ML	ALPRAZOLAM INTENSOL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	15
ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.25 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM ORALLY DISINTEGRATING TAB 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM ORALLY DISINTEGRATING TAB 1 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM ORALLY DISINTEGRATING TAB 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
ALPRAZOLAM TAB 0.25 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 1 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
ALPRAZOLAM TAB 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
ALPRAZOLAM TAB SR 24HR 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 1 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		30	30
ALPRAZOLAM TAB SR 24HR 3 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		30	30

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CHLORDIAZEPOXIDE HCL CAP 10 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CHLORDIAZEPOXIDE HCL CAP 25 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CHLORDIAZEPOXIDE HCL CAP 5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLONAZEPAM 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM 1.0 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLONAZEPAM ODT 0.125MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ODT 0.25MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ODT 0.5 MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ODT 1MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ODT 2MG	VARIOUS			PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLORAZEPATE DIPOTASSIUM TAB 15 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLORAZEPATE DIPOTASSIUM TAB 3.75 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLORAZEPATE DIPOTASSIUM TAB 7.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM CONC 5 MG/ML	DIAZEPAM INTENSOL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
DIAZEPAM SOLN 1 MG/ML	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		300	30
DIAZEPAM TAB 10 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM TAB 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
DIAZEPAM TAB 5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM CONC 2 MG/ML	LORAZEPAM INTENSOL			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
LORAZEPAM TAB 0.5 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM TAB 1 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
LORAZEPAM TAB 2 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
OXAZEPAM CAP 10 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
OXAZEPAM CAP 15 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

AHCCCS

ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
OXAZEPAM CAP 30 MG	VARIOUS			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
ANTIARRHYTHMICS							
ANTIARRHYTHMICS TYPE I-A							
DISOPYRAMIDE PHOSPHATE CAPSULES	NORPACE						
DISOPYRAMIDE PHOSPHATE CAPSULE 12-HOUR	NORPACE CR						
QUINIDINE GLUCONATE TABLET CONTROLLED RELEASE	QUINIDINE GLUCONATE CR						
QUINIDINE SULFATE TABLETS	QUINIDINE SULFATE						
QUINIDINE SULFATE TABLET CONTROLLED RELEASE	QUINIDINE SULFATE ER						
ANTIARRHYTHMICS TYPE I-B							
MEXILETINE HCL CAPSULES	MEXILETINE HCL						
ANTIARRHYTHMICS TYPE I-C							
FLECAINIDE ACETATE TABLETS	TAMBOCOR						
PROPAFENONE HCL CAPSULE 12-HOUR	RYTHMOL SR						
PROPAFENONE HCL TABLETS	RYTHMOL						
ANTIARRHYTHMICS TYPE III							
AMIODARONE HCL TABLETS 100MG & 200MG	PACERONE						
DOFETILIDE CAPSULES	TIKOSYN			PA REQUIRED			
DRONEDARONE HCL TABLETS	MULTAQ			PA REQUIRED			
ANTIASTHMATIC AND BRONCHODILATOR AGENTS							
ANTIASTHMATIC - MONOCLONAL ANTIBODIES**							
BENRALIZUMAB SOLN AUTO-INJ	FASENRA		PREFERRED DRUG	PA REQUIRED			
BENRALIZUMAB SOLN PREF SYR	FASENRA		PREFERRED DRUG	PA REQUIRED			
OMALIZUMAB SOLUTION RECONSTITUTED	XOLAIR	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
OMALIZUMAB SOLN AUTO-INJ	XOLAIR	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
OMALIZUMAB SOLN PREF SYR	XOLAIR	BRAND ONLY	PREFERRED DRUG	PA REQUIRED			
ANTI-INFLAMMATORY AGENTS							
CROMOLYN SODIUM NEBULIZER	CROMOLYN SODIUM						
BRONCHODILATORS - ANTICHOLINERGICS							
IPRATROPIUM BROMIDE HFA AEROSOL	ATROVENT HFA	BRAND ONLY	PREFERRED DRUG				
IPRATROPIUM BROMIDE SOLUTION	IPRATROPIUM BROMIDE		PREFERRED DRUG				
TIOTROPIUM BROMIDE MONOHYDRATE AEROSOL SOLUTION	SPIRIVA RESPIMAT		PREFERRED DRUG				
TIOTROPIUM BROMIDE MONOHYDRATE CAPSULES	SPIRIVA HANDIHALER		PREFERRED DRUG				
UMECLIDINIUM BROMIDE ARSL PWDR-BREATH ACTIVATE	INCRUSE		PREFERRED DRUG				
LEUKOTRIENE MODULATORS							
MONTELUKAST SODIUM CHEWABLE TABLETS	SINGULAIR		PREFERRED DRUG			30	30
MONTELUKAST SODIUM GRANULES	SINGULAIR			PA IS NOT REQUIRED for < 4 Years of Age		30	30
MONTELUKAST SODIUM TABLETS	SINGULAIR		PREFERRED DRUG			30	30
STEROID INHALANTS							
BECLOMETHASONE DIPROPIONATE	**QVAR REDIHALER**	**BRAND ONLY**	**PREFERRED DRUG**				
BUDESONIDE (INHALATION) SUSPENSION 0.25MG, 0.50MG & 1.0MG	PULMICORT	VARIOUS	PREFERRED DRUG				
BUDESONIDE INHALATION POWDER	**PULMICORT FLEXHALER**	**BRAND ONLY**	**PREFERRED DRUG**				
FLUTICASONE FUROATE (INHALATION) ARSL PWDR-BREATH ACTIVATE	**ARNUITY**	**BRAND ONLY**	**PREFERRED DRUG**				
FLUTICASONE PROPIONATE HFA AERO	VARIOUS	AUTHORIZED GENERIC ONLY	PREFERRED DRUG				
FLUTICASONE PROPIONATE ORAL INHALATION	VARIOUS	AUTHORIZED GENERIC ONLY	PREFERRED DRUG				
MOMETASONE FUROATE HFA	**ASMANEX HFA**	**BRAND ONLY**	**PREFERRED DRUG**				
MOMETASONE FUROATE (INHALATION) AEPB	**ASMANEX TWISTHALER**	**BRAND ONLY**	**PREFERRED DRUG**				
SYMPATHOMIMETICS							
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (PROVENTIL) (AG) (INHALATION)	NDC 00254100752 NDC 00781729685	Preferred Albuterol NDCs				
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (PROVENTIL) (INHALATION)	NDC 00054074287 NDC 69097014260 NDC 72572001401 NDC 76282067942	Preferred Albuterol NDCs				
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (PROAIR) (AG) (INHALATION)	NDC 00093317431	Preferred Albuterol NDCs				
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (PROAIR) (INHALATION)	NDC 45802008801 NDC 68180096301	Preferred Albuterol NDCs				
ALBUTEROL SULFATE INHALER	ALBUTEROL HFA (VENTOLIN) (AG) (INHALATION)	NDC 66993001968	Preferred Albuterol NDCs				
ALBUTEROL SULFATE NEBULIZED	ALBUTEROL SULFATE		PREFERRED DRUG				
ALBUTEROL SULFATE SYRUP	ALBUTEROL SULFATE		PREFERRED DRUG				
BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE AEROSOL	SYMBICORT	**AUTHORIZED GENERIC ONLY**	PREFERRED DRUG			6	90

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
FLUTICASONE-SALMETEROL AEROSOL	AIRDUO RESPICLICK	AUTHORIZED GENERIC ONLY	PREFERRED DRUG			6	90
FLUTICASONE-SALMETEROL ARSL PWDR-BREATH ACTIVATE	**AIRDUO**		**PREFERRED DRUG**			6	90
FLUTICASONE-SALMETEROL AEROSOL	**ADVAIR HFA**	**BRAND ONLY**	**PREFERRED DRUG**			3	90
MOMETASONE FUROATE-FORMOTEROL FUMARATE DIHYDRATE AEROSOL	**DULERA**	**BRAND ONLY**	**PREFERRED DRUG**			6	90
IPRATROPIUM-ALBUTEROL AEROSOL	COMBIVENT RESPIMAT		PREFERRED DRUG				
IPRATROPIUM-ALBUTEROL SOLUTION	DUONEB		PREFERRED DRUG				
SALMETEROL XINAFOATE AEROSOL POWDER BREATH ACTIVATED	SEREVENT DISKUS		PREFERRED DRUG	PA REQUIRED			
SALMETEROL XINAFOATE AEROSOL POWDER BREATH ACTIVATED	SEREVENT DISKUS		PREFERRED DRUG	PA REQUIRED			
TIOTROPIUM BROMIDE-OLODATEROL HCL AEROSOL SOLUTION	STIOLTO RESPIMAT		PREFERRED DRUG	PA REQUIRED		1	30
UMECLIDINIUM-VILANTEROL AEROSOL POWDER	ANORO ELLIPTA		PREFERRED DRUG	PA REQUIRED		1	30
ANTICOAGULANTS							
COUMARIN ANTICOAGULANTS							
WARFARIN SODIUM TABLETS	VARIOUS		PREFERRED DRUG				
DIRECT FACTOR XA INHIBITORS							
APIXABAN CAPSULE SPRINKLE	**ELIQUIS**	**BRAND ONLY**	**PREFERRED DRUG**			222	90
APIXABAN TABLET	**ELIQUIS**	**BRAND ONLY**	**PREFERRED DRUG**			180	90
APIXABAN TAB THER PACK	**ELIQUIS STARTER PACK**	**BRAND ONLY**	**PREFERRED DRUG**			74	365
APIXABAN TABLET SOLUBLE	**ELIQUIS**	**BRAND ONLY**	**PREFERRED DRUG**			222	90
RIVAROXABAN TABLET	**XARELTO**	**BRAND ONLY**	**PREFERRED DRUG**			180	90
RIVAROXABAN TAB THER PACK	**XARELTO STARTER PACK**	**BRAND ONLY**	**PREFERRED DRUG**			51	30
HEPARINS AND HEPARINOID-LIKE AGENTS							
ENOXAPARIN SODIUM INJ 100 MG/ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 120 MG/0.8ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 150 MG/ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 30 MG/0.3ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 300 MG/3ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 40 MG/0.4ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 60 MG/0.6ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
ENOXAPARIN SODIUM INJ 80 MG/0.8ML	VARIOUS VIAL OR SYRINGE		PREFERRED DRUG			60	30
HEPARIN (PORCINE) IN SODIUM CHLORIDE SOLUTION	HEPARIN SODIUM/NACL 0.9%						
HEPARIN SOD (PORCINE) IN D5W SOLUTION	HEPARIN SODIUM/D5W						
HEPARIN SODIUM (PORCINE) LOCK FLUSH & NACL LOCK FLUSH KIT	HEPARIN SODIUM LOCK FLUSH						
HEPARIN SODIUM (PORCINE) LOCK FLUSH SOLUTION	HEPARIN LOCK FLUSH						
THROMBIN INHIBITORS							
DABIGATRAN ETEXILATE MESYLATE CAPSULES	**PRADAXA**	**BRAND ONLY**	**PREFERRED DRUG**			60	30
ANTICONVULSANTS							
AMPA GLUTAMATE RECEPTOR ANTAGONISTS**							
PERAMPANEL TABLET	FYCOMPA			PA REQUIRED			
PERAMPANEL SUSPENSION	FYCOMPA			PA REQUIRED			
ANTICONVULSANTS - BENZODIAZEPINES							
CLOBAZAM SUSPENSION	ONFI			PA REQUIRED			
CLOBAZAM TABLETS	ONFI			PA REQUIRED			
CLONAZEPAM TAB 0.5 MG	KLONOPIN			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM TAB 1 MG	KLONOPIN			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM TAB 2 MG	KLONOPIN			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.125 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.25 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 0.5 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30
CLONAZEPAM ORALLY DISINTEGRATING TAB 1 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		120	30

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CLONAZEPAM ORALLY DISINTEGRATING TAB 2 MG	CLONAZEPAM ODT			PA REQUIRED for Ages < 6 years. PA REQUIRED for > 1 Anxiolytic Medication in a 30-day time period.		60	30
DIAZEPAM (ANTICONVULSANT) GEL (10MG, 20MG)	VARIOUS	GENERIC ONLY				2	30
DIAZEPAM (ANTICONVULSANT) LIQUID	VALTOCO					2	30
DIAZEPAM (ANTICONVULSANT) LIQD THER PACK	VALTOCO					2	30
MIDAZOLAM (ANTICONVULSANT) SOLUTION	NAYZILAM					4	30
ANTICONVULSANTS - MISC.							
BRIVARACETAM TABLET	BRIVIACT	BRAND ONLY		PA REQUIRED			
BRIVARACETAM SOLUTION	BRIVIACT	BRAND ONLY		PA REQUIRED			
CANNABIDIOL SOLUTION	EPIDIOLEX			PA REQUIRED			
CARBAMAZEPINE TABLET CHEWABLE	CARBAMAZEPINE						
CARBAMAZEPINE CAPSULE ER 12 HR	CARBATROL						
CARBAMAZEPINE CAPSULE ER 12 HR	CARBATROL						
CARBAMAZEPINE SUSPENSION	TEGRETOL						
CARBAMAZEPINE TABLET	EPITOL						
CARBAMAZEPINE TABLET ER 12HR	TEGRETOL-XR						
GABAPENTIN CAPSULE	NEURONTIN						
GABAPENTIN SOLUTION	NEURONTIN						
GABAPENTIN TABLET	NEURONTIN						
LACOSAMIDE SOLUTION	VIMPAT			PA REQUIRED			
LACOSAMIDE TABLET	VIMPAT			PA REQUIRED			
LAMOTRIGINE TABLET CHEWABLE	LAMICTAL CHEWABLE DISPERSIBLE						
LAMOTRIGINE SUSPENSION	SUBVENITE			PA Required > 10 Years of Age			
LAMOTRIGINE TABLET ER 24HR	LAMICTAL XR						
LAMOTRIGINE TABLET DISINTEGRATING	LAMICTAL ODT						
LEVETIRACETAM SOLUTION	KEPPRA						
LEVETIRACETAM TABLET	ROWEEPRA						
LEVETIRACETAM TABLET ER 24HR	KEPPRA XR						
OXCARBAZEPINE SUSPENSION	TRILEPTAL						
OXCARBAZEPINE TABLET	TRILEPTAL						
PREGABALIN CAPSULE (25MG, 50MG, 75MG, 100MG, 150MG, 200MG)	LYRICA					90.00	30.00
PREGABALIN CAPSULE (225MG, 300MG)	LYRICA					60.00	30.00
PREGABALIN SOLUTION	LYRICA					900	30
PRIMIDONE TABLET (20MG, 250MG)	MYSOLINE						
RUFINAMIDE SUSPENSION	BANZEL			PA REQUIRED			
RUFINAMIDE TABLET	BANZEL			PA REQUIRED			
TOPIRAMATE CAPSULE ER 24 HR	**TROKENDI XR**	**BRAND ONLY**		PA REQUIRED			
TOPIRAMATE CAPSULE SPRINKLE (15MG, 25MG)	TOPAMAX SPRINKLE						
TOPIRAMATE CP24 SPRINKLE	QUDEXY XR			PA REQUIRED			
TOPIRAMATE TABLET	TOPAMAX						
ZONISAMIDE CAPSULE	ZONEGRAN						
ZONISAMIDE SUSPENSION	ZONISADE					180ml	30
CARBAMATES**							
CENOBAMATE TABLET	XCOPRI			PA REQUIRED			
CENOBAMATE TAB THER PACK	XCOPRI			PA REQUIRED			
FELBAMATE SUSPENSION	FELBATOL						
FELBAMATE TABLET	FELBATOL						
GABA MODULATORS**							
TIAGABINE HCL TABLET	GABITRIL			PA REQUIRED			
HYDANTOINS**							
PHENYTOIN TABLET CHEWABLE	DILANTIN CHEWABLES						
PHENYTOIN SODIUM EXTENDED CAPSULE	DILANTIN/PHENYTEK ER						
PHENYTOIN SUSPENSION	DILANTIN-125						
SUCCINIMIDES**							
ETHOSUXIMIDE CAPSULE	ZARONTIN						
ETHOSUXIMIDE SOLUTION	ZARONTIN						
METHSUXIMIDE CAPSULE	**CELONTIN**	**BRAND ONLY**					
VALPROIC ACID**							
DIVALPROEX SODIUM CAP DR SPRINKLE	DEPAKOTE SPRINKLES						
DIVALPROEX SODIUM TABLET ER 24HR	DEPAKOTE ER						
DIVALPROEX SODIUM TABLET ENTERIC COATED	DEPAKOTE						
VALPROATE SODIUM SOLUTION	VALPROATE SODIUM						
VALPROIC ACID CAPSULE	VALPROIC ACID						
ANTIDEPRESSANTS							
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)							
MIRTAZAPINE TABLETS	MIRTAZAPINE			PA REQUIRED for Ages < 6 years of age		30	30
MIRTAZAPINE ORALLY DISINTEGRATING TABLETS	REMERON SOLTAB			PA REQUIRED for Ages < 6 years of age		30	30

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID**							
ZURANOLONE CAPSULE	ZURZUVAE			PA REQUIRED			
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST							
ESKETAMINE HYDROCHLORIDE	SPRAVATO			PA REQUIRED			
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRIs)							
BUPROPION HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 6 years of age		120	30
BUPROPION HCL TABLET 12-HOUR	BUDEPRION SR			PA REQUIRED for Ages < 6 years of age		60	30
BUPROPION HCL TABLET 24-HOUR (150MG & 300MG)	VARIOUS			PA REQUIRED for Ages < 6 years of age		30	30
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)							
CITALOPRAM HYDROBROMIDE SOLUTION	CELEXA			PA REQUIRED for Ages < 6 years of age and greater than 12 years of age		600	30
CITALOPRAM HYDROBROMIDE TABLETS	CELEXA			PA REQUIRED for Ages < 6 years of age		10mg: 60 20mg: 30 40mg: 30	30 30 30
ESCITALOPRAM OXALATE TABLETS	LEXAPRO			PA REQUIRED for Ages < 6 years of age		5mg: 60 10mg: 30 20mg: 30	30 30 30
FLUOXETINE HCL CAPSULES ONLY	PROZAC			PA REQUIRED for Ages < 6 years of age		10mg: 60 20mg: 120 40mg: 60	30 30 30
FLUOXETINE HCL SOLUTION	PROZAC			PA REQUIRED for Ages < 6 years of age and greater than 12 years of age		600	30
FLUOXETINE HCL TABLETS - WEEKLY	PROZAC WEEKLY			PA REQUIRED			
FLUVOXAMINE MALEATE TABLETS	LUVOX			PA REQUIRED for Ages < 6 years of age		25mg: 60 50mg: 180 100mg: 90	30 30 30
PAROXETINE HCL TABLETS	PAXIL			PA REQUIRED for Ages < 6 years of age		10mg: 30 20mg: 30 30mg: 30 40mg: 45	30 30 30 30
SERTRALINE HCL CONCENTRATE	ZOLOFT			PA REQUIRED for Ages < 6 years of age and greater than 12 years of age		300	30
SERTRALINE HCL TABLETS	ZOLOFT			PA REQUIRED for Ages < 6 years of age		25mg: 90 50mg: 120 100mg: 60	30 30 30
SEROTONIN MODULATORS							
TRAZODONE HCL TABLETS	TRAZODONE HCL			PA REQUIRED for Ages < 6 years of age		50mg:90 100mg:120 150mg: 60 300mg 30	30 30 30 30
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)							
DESVENLAFAXINE SUCCINATE TABLET ER 24HR	PRISTIQ			**PA REQUIRED for Ages < 6 years**		90	90
DULOXETINE HCL CAPSULE DELAYED RELEASE 20MG, 30MG & 60MG	CYMBALTA 20MG, 30MG & 60MG			PA REQUIRED for Ages < 6 years of age		20mg: 120 30mg: 120 60mg: 60	30 30 30
VENLAFAXINE HCL CAPSULE CONTROLLED RELEASE	EFFEXOR XR			PA REQUIRED for Ages < 6 years of age		37.5mg: 90 75mg: 90 150mg: 30	30 30 30
VENLAFAXINE HCL TABLETS - IMMEDIATE RELEASE ONLY	VENLAFAXINE HCL			PA REQUIRED for Ages < 6 years of age		25mg: 120 37.5mg: 90 50mg: 90 75mg: 150 100mg: 90	30 30 30 30 30
TRICYCLIC AGENTS							
AMITRIPTYLINE HCL TABLETS	AMITRIPTYLINE HCL			PA REQUIRED for Ages < 6 years of age			
AMOXAPINE TABLETS	VARIOUS			PA REQUIRED for Ages < 6 years of age			
CLOMIPRAMINE HCL CAPSULES	ANAFRANIL			PA REQUIRED for Ages < 6 years of age			
DESIPRAMINE HCL TABLETS	NORPRAMIN			PA REQUIRED for Ages < 6 years of age			
DOXEPIN HCL CAPSULES	DOXEPIN HCL			PA REQUIRED for Ages < 6 years of age		90	30
DOXEPIN HCL CONCENTRATE	DOXEPIN HCL			PA REQUIRED for Ages < 6 years of age		180	30
IMIPRAMINE PAMOATE CAPSULES	TORFRANIL-PM			PA REQUIRED for Ages < 6 years of age		30	30
IMIPRAMINE HCL TABLETS	TOFRANIL			PA REQUIRED for Ages < 6 years of age			
MAPROTILINE HCL	VARIOUS			PA REQUIRED for Ages < 6 years of age			
NORTRIPTYLINE HCL CAPSULES	PAMELOR			PA REQUIRED for Ages < 6 years of age			
NORTRIPTYLINE HCL SOLUTION	NORTRIPTYLINE HCL			PA REQUIRED for Ages < 6 years of age			
PROTRIPTYLINE HCL TABLETS	VIVACTIL			PA REQUIRED for Ages < 6 years of age			
TRIMIPRAMINE MALEATE	SURMONTIL			PA REQUIRED for Ages < 6 years of age			

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ANTIDIABETICS							
ALPHA-GLUCOSIDASE INHIBITORS							
ACARBOSE TABLETS	PRECOSE						
ANTIDIABETIC - AMLYN ANALOGS							
PRAMLINTIDE ACETATE SOLUTION PEN INJECTION	SYMLINPEN 60		PREFERRED DRUG	PA REQUIRED			
ANTIDIABETIC COMBINATIONS							
ALOGLIPTIN-METFORMIN	VARIOUS		PREFERRED DRUG		STEP THROUGH METFORMIN		
ALOGLIPTIN-PIOGLITAZONE	VARIOUS		PREFERRED DRUG		STEP THROUGH METFORMIN		
DAPAGLIFLOZIN FREE BASE-METFORMIN HCL TABLET ER 24HR	**XIGDUO XR**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN	**TRIJARDY XR**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
EMPAGLIFLOZIN-METFORMIN HCL	**SYNJARDY**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
LINAGLIPTIN-METFORMIN HCL TABLETS	**JENTADUETO**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
PIOGLITAZONE HCL-METFORMIN HCL TABLETS	ACTOPLUS MET						
SITAGLIPTIN-METFORMIN HCL TABLETS	**JANUMET**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
SITAGLIPTIN-METFORMIN HCL TABLET 24-HOUR	**JANUMET XR**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
BIGUANIDES							
METFORMIN HCL TABLETS	GLUCOPHAGE						
METFORMIN HCL TABLET 24-HOUR (GENERIC OF GLUCOPHAGE XR ONLY- 500MG & 750MG)	VARIOUS			PA REQUIRED for Osmotic and Modified Release Products			
DIABETIC OTHER							
DASIGLUCAGON HCL SOLN AUTO-INJ	**ZEGALOGUE**	**BRAND ONLY**	**PREFERRED DRUG**			**1**	**30**
DASIGLUCAGON HCL SOLN PREF SYR	**ZEGALOGUE**	**BRAND ONLY**	**PREFERRED DRUG**			**2**	**30**
DIAZOXIDE SUSPENSION	**PROGLYCEM**	**BRAND ONLY**					
GLUCAGON POWDER	**BAQSIMI**	**BRAND ONLY**	**PREFERRED DRUG**			**2**	**30**
GLUCAGON SOLUTION RECONSTITUTED	**GLUCAGON EMERGENCY KIT**		**PREFERRED DRUG**			**2**	**30**
MIFEPRISTONE (HYPERGLYCEMIA) TABLET	KORLYM			PA REQUIRED			
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS							
ALOGLIPTIN BENZOATE TABLETS	NESINA		PREFERRED DRUG		STEP THROUGH METFORMIN		
LINAGLIPTIN TABLETS	**TRADJENTA**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
SITAGLIPTIN PHOSPHATE TABLETS	**JANUVIA**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)							
DULAGLUTIDE SOLUTION PEN-INJECTION	TRULICITY		PREFERRED DRUG	PA REQUIRED			
EXENATIDE SOLN PEN-INJ *Byetta will be Obsolete 2027-03-07	BYETTA	**BRAND ONLY**	PREFERRED DRUG	PA REQUIRED			
LIRAGLUTIDE SOLN PEN-INJ	VICTOZA	Brand & Generic	PREFERRED DRUG	PA Required			
TIRZEPATIDE SOLN AUTO-INJ	**MOUNJARO**			**PA REQUIRED**			
DIABETIC MISCELLANEOUS AGENT							
PRAMLINTIDE	SYMLIN PEN		PREFERRED DRUG	PA REQUIRED			
INSULIN SENSITIZING AGENTS							
INSULIN DEGLUDEC SOLUTION	**TRESIBA**	**BRAND ONLY**					
INSULIN DEGLUDEC SOLN PEN-INJ	**TRESIBA**	**BRAND ONLY**					
PIOGLITAZONE HCL TABLETS	ACTOS						
INSULIN							
INSULIN LISPRO (HUMAN) SOLUTION	HUMALOG	AUTHORIZED GENERIC ONLY	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION PEN INJECTION 100/ML	HUMALOG JUNIOR KWIKPEN	AUTHORIZED GENERIC ONLY	PREFERRED DRUG				
INSULIN LISPRO (HUMAN) SOLUTION PEN INJECTION 100/ML	HUMALOG KWIKPEN	AUTHORIZED GENERIC ONLY	PREFERRED DRUG				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	**HUMULIN 70/30**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	**HUMULIN 70/30 KWIKPEN**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN NPH (HUMAN) (ISOPHANE) SUSPENSION	**HUMULIN N**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN REGULAR (HUMAN) SOLUTION PEN INJECTION	**HUMULIN N KWIKPEN**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN REGULAR (HUMAN) SOLUTION	**HUMULIN R U-100**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN REGULAR (HUMAN) SOLUTION	**HUMULIN R U-500 (CONCENTRATED)**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
INSULIN REGULAR (HUMAN) SOLUTION PEN-INJECTION	**HUMULIN R U-500 KWIKPEN**	**BRAND ONLY**	**PREFERRED DRUG**	PA REQUIRED			
INSULIN GLARGINE SOLUTION	**LANTUS**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN GLARGINE SUSPENSION	**LANTUS SOLOSTAR**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN NPH ISOPHANE & REG (HUMAN) SUSPENSION	**NOVOLIN 70/30**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN NPH (HUMAN) (ISOPHANE) SUSPENSION	**NOVOLIN N**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN REGULAR (HUMAN) SOLUTION	**NOVOLIN R**	**BRAND ONLY**	**PREFERRED DRUG**				
INSULIN GLARGINE-YFGN SOLN PEN-INJ	SEMGLEE						
INSULIN ASPART SOLUTION	NOVOLOG		PREFERRED DRUG				
INSULIN ASPART SOLUTION PEN-INJECTION	NOVOLOG FLEXPEN		PREFERRED DRUG				

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
INSULIN ASPART PROTAMINE & ASPART (HUMAN) SUSPENSION (70/30)	NOVOLOG MIX 70/30		PREFERRED DRUG				
INSULIN ASPART PROTAMINE & ASPART (HUMAN) SUSPENSION PEN INJECTION (70/30)	NOVOLOG MIX 70/30 FLEXPEN		PREFERRED DRUG				
INSULIN ASPART SOLUTION CARTRIDGE	NOVOLOG PENFILL		PREFERRED DRUG				
MEGLITINIDE ANALOGUES							
NATEGLINIDE TABLETS	STARLIX						
REPAGLINIDE TABLETS	PRANDIN						
SGLT2S							
DAPAGLIFLOZIN TABLET	**FARXIGA**	**BRAND ONLY**	**PREFERRED DRUG**		STEP THROUGH METFORMIN		
EMPAGLIFLOZIN	JARDIANCE		**PREFERRED DRUG**		STEP THROUGH METFORMIN		
SULFONYLUREAS							
GLIMEPIRIDE TABLETS (1MG, 2MG, 4MG)	AMARYL						
GLIPIZIDE TABLET (EXCLUDING 15MG)	GLUCOTROL						
GLIPIZIDE TABLET 24-HOUR	GLUCATROL XL						
GLYBURIDE MICRONIZED TABLETS	GLYNASE						
GLYBURIDE TABLETS	DIABETA						
ANTIDIARRHEALS							
ANTIPERISTALTIC AGENTS							
DIPHENOXYLATE W/ ATROPINE LIQUID	DIPHENOXYLATE/ATROPINE						
DIPHENOXYLATE W/ ATROPINE TABLETS	LOMOTIL						
LOPERAMIDE HCL CAPSULES	LOPERAMIDE HCL						
LOPERAMIDE HCL CHEWABLE TABLETS	IMODIUM A-D						
LOPERAMIDE HCL LIQUID	LOPERAMIDE HCL						
LOPERAMIDE HCL SUSPENSION	IMODIUM A-D						
LOPERAMIDE HCL TABLETS	IMODIUM A-D						
ANTIDOTES							
OPIOID ANTAGONISTS							
NALOXONE HCL SOLUTION + SYRINGE	NALOXONE HCL + SYRINGE		PREFERRED DRUG				
NALOXONE	**KLOXXADO**	**BRAND ONLY**	**PREFERRED DRUG**				
NALOXONE HCL NASAL SPRAY	**NARCAN NASAL SPRAY/REXTOVY NASAL SPRAY**	**BRAND ONLY**	**PREFERRED DRUG**			2	1
ANTIEMETICS							
5-HT3 RECEPTOR ANTAGONISTS							
DOLASETRON MESYLATE TABLETS	ANZEMET			PA REQUIRED			
GRANISETRON HCL SOLUTION	VARIOUS			PA REQUIRED			
GRANISETRON HCL TABLETS	VARIOUS			PA REQUIRED			
ONDANSETRON SOLUTION	VARIOUS			PA REQUIRED for tablets > 8mg Per Dose		300	30
ONDANSETRON HCL ODT TABLETS	VARIOUS			PA REQUIRED for tablets > 8mg Per Dose		60	30
ONDANSETRON HCL TABLETS	VARIOUS			PA REQUIRED for tablets > 8mg per Dose		60	30
ANTIEMETICS MISC.							
PROCHLORPERAZINE MALEATE TABLETS	COMPAZINE						
PROCHLORPERAZINE SUPPOSITORY	COMPAZINE						
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONIST							
APREPITANT CAPSULES	EMEND					6	21
ANTIFUNGALS							
ANTIFUNGAL ORAL AGENTS							
CLOTRIMAZOLE TROCHE	VARIOUS						
GRISEOFULVIN SUSPENSION	VARIOUS						
GRISEOFULVIN MICROSIZE TABLETS	GRIFULVIN V						
NYSTATIN SUSPENSION	NYSTATIN						
NYSTATIN TABLETS	NYSTATIN						
TERBINAFINE HCL TABLETS	LAMISIL					90	365
IMIDAZOLE-RELATED ANTIFUNGALS							
FLUCONAZOLE SUSPENSION RECONSTITUTED (10MG/ML)	DIFLUCAN					600	30
FLUCONAZOLE SUSPENSION RECONSTITUTED (40MG/ML)	DIFLUCAN					300	30
FLUCONAZOLE TABLET (50MG, 100MG, 200MG)	DIFLUCAN					60	30
FLUCONAZOLE TABLET (150MG)	DIFLUCAN					3	30
POSACONAZOLE TABLET ENTERIC COATED	NOXAFIL	AUTHORIZED GENERIC & GENERIC FORMULATIONS		PA REQUIRED			
VORICONAZOLE TABLET	VFEND						
VORICONAZOLE SUSPENSION	VFEND	**BRAND ONLY**		PA REQUIRED			
ANTIHISTAMINES							
ANTIHISTAMINES - ALKYLAMINES							
BROMPHENIRAMINE MALEATE	J-TAN PD						
CHLORPHINERAMINE MALEATE	CHLORPHENIRAMINE MALEATE						
DEXCHLORPHENIRAMINE MALEATE SYRUP	DEXCHLORPHENIRAMINE MALEATE						
ANTIHISTAMINES - ETHANOLAMINES							

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CLEMASTINE FUMARATE TABLETS	CLEMASTINE FUMARATE						
DIPHENHYDRAMINE HCL CAPSULES	VARIOUS						
DIPHENHYDRAMINE HCL CHEWABLE TABLETS	VARIOUS						
DIPHENHYDRAMINE HCL ELIXIR	VARIOUS						
DIPHENHYDRAMINE HCL LIQUID	VARIOUS						
DIPHENHYDRAMINE HCL SOLUTION	VARIOUS						
DIPHENHYDRAMINE HCL SUSPENSION	VARIOUS						
DIPHENHYDRAMINE HCL SYRUP	VARIOUS						
DIPHENHYDRAMINE HCL TABLETS	VARIOUS						
ANTIHISTAMINES - NON-SEDATING							
CETIRIZINE HCL SOLUTION	VARIOUS					150	30
CETIRIZINE HCL TABLETS	VARIOUS					30	30
CETIRIZINE HCL ORALLY DISINTEGRATING TABLETS	ZYRTEC ALLERGY					30	30
FEXOFENADINE HCL TABLET DISINTEGRATING (60mg)	WAL-FEX ALLERGY 12 HOUR					60	30
FEXOFENADINE HCL TABLET DISINTEGRATING (180mg)	WAL-FEX ALLERGY 12 HOUR					30	30
FEXOFENADINE HCL TABLETS	ALLEGRA ALLERGY CHILDRENS					30	30
FEXOFENADINE HCL ORALLY DISINTEGRATING TABLETS	ALLEGRA ALLERGY CHILDRENS					30	30
LEVOCETIRIZINE DIHYDROCHLORIDE TABLET	LEVOCETIRIZINE					30	30
LORATADINE CHEWABLE TABLETS	CLARITIN					30	30
LORATADINE SYRUP	CLARITIN					150	30
LORATADINE TABLETS	ALAVERT					30	30
LORATADINE TABLET DISINTEGRATING (5MG)	CLARITIN REDITABS					30	30
ANTIHISTAMINES - PHENOTHIAZINES							
PROMETHAZINE HCL SUPPOSITORY	PHENERGAN						
PROMETHAZINE HCL TABLETS	PROMETHAZINE HCL						
ANTIHISTAMINES - PIPERIDINES							
CYPROHEPTADINE HCL SYRUP	CYPROHEPTADINE HCL						
CYPROHEPTADINE HCL TABLETS	CYPROHEPTADINE HCL						
ANTIHYPERLIPIDEMICS							
BILE ACID SEQUESTRANTS							
CHOLESTYRAMINE LIGHT PACKETS	PREVALITE						
CHOLESTYRAMINE LIGHT POWDER	PREVALITE						
CHOLESTYRAMINE PACKETS	QUESTRAN						
CHOLESTYRAMINE POWDER	QUESTRAN						
COLESTIPOL HCL TABLETS	COLESTID						
FIBRIC ACID DERIVATIVES							
FENOFIBRATE MICRONIZED CAPSULES 67MG, 134MG & 200MG	VARIOUS						
FENOFIBRATE TABLETS 48MG, 54MG, 145MG & 160MG	VARIOUS						
FENOFIBRIC ACID TABLETS	FIBRICOR						
GEMFIBROZIL TABLETS	LOPID						
HMG COA REDUCTASE INHIBITORS							
ATORVASTATIN CALCIUM TABLETS	LIPITOR		PREFERRED DRUG			30	30
LOVASTATIN TABLETS	MEVACOR		PREFERRED DRUG			30	30
PRAVASTATIN SODIUM TABLETS	PRAVACOL		PREFERRED DRUG			30	30
ROUVASTATIN TABLETS	CRESTOR		PREFERRED DRUG			30	30
SIMVASTATIN TABLETS	ZOCOR		PREFERRED DRUG			30	30
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS							
EZETIMIBE TABLETS	ZETIA		PREFERRED DRUG	PA REQUIRED			
NICOTINIC ACID DERIVATIVES							
NIACIN CAPSULE CONTROLLED RELEASE	VARIOUS						
NIACIN TABLET CONTROLLED RELEASE	VARIOUS						
MISC. NUTRITIONAL SUBSTANCES							
OMEGA-3 FATTY ACIDS CAPSULES	FISH OIL						
OMEGA-3 FATTY ACIDS CAPSULE DELAYED RELEASE	FISH OIL						
ANTIHYPERTENSIVES							
ACE INHIBITORS							
BENAZEPRIL HCL TABLETS	BENAZEPRIL HCL						
ENALAPRIL MALEATE SOLUTION	EPANED						
ENALAPRIL MALEATE TABLETS	VARIOUS						
LISINOPRIL TABLETS	ZESTRIL						
RAMIPRIL CAPSULES	ALTACE						
ANGIOTENSIN II RECEPTOR ANTAGONISTS							
IRBESARTAN TABLETS	AVAPRO						
LOSARTAN POTASSIUM TABLETS	COZAAR						
TELMISARTAN TABLET	MICARDIS						
VALSARTAN TABLETS	DIOVAN						

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ANTIADRENERGIC ANTIHYPERTENSIVES							
CLONIDINE HCL PATCH-WEEKLY	CATAPRES-TTS-1			PA REQUIRED for Ages < 6 years of age		4	28
CLONIDINE HCL TABLET (EXCLUDING 0.05MG)	CLONIDINE HYDROCHLORIDE			PA REQUIRED for Ages < 6 years			
CLONIDINE HCL (ADHD) TABLET 12-HOUR	CLONIDINE ER			PA REQUIRED for Ages < 6 years of age		120	30
DOXAZOSIN MESYLATE TABLETS	CARDURA						
GUANFACINE HCL TABLETS	TENEX						
GUANFACINE HCL (ADHD) TABLET 24-HOUR	GUANFACINE ER		PREFERRED DRUG	PA REQUIRED for Ages < 6 years of age		30	30
METHYLDOPA TABLETS	METHYLDOPA						
PRAZOSIN HCL CAPSULES	MINIPRESS						
TERAZOSIN HCL CAPSULES	TERAZOSIN HCL						
ANTIHYPERTENSIVE COMBINATIONS							
AMLODIPINE BESYLATE-BENAZEPRIL HCL CAPSULE	LOTREL						
AMLODIPINE BESYLATE-VALSARTAN TABLET	EXFORGE						
ATENOLOL & CHLORTHALIDONE TABLETS	VARIOUS						
BENAZEPRIL & HYDROCHLOROTHIAZIDE TABLET	LOTENSIN HCT						
BISOPROLOL & HYDROCHLOROTHIAZIDE TABLET	ZIAC						
CAPTOPRIL & HYDROCHLOROTHIAZIDE TABLET (25-15MG, 50-15MG)	CAPTOPRIL/HYDROCHLOROTHIAZIDE						
ENALAPRIL MALEATE & HYDROCHLOROTHIAZIDE TABLETS	ENALAPRIL MALEATE/ HYDROCHLOROTHIAZIDE						
IRBESARTAN-HYDROCHLOROTHIAZIDE TABLET	AVALIDE						
LISINOPRIL & HYDROCHLOROTHIAZIDE TABLETS	ZESTORETIC						
LOSARTAN POTASSIUM & HYDROCHLOROTHIAZIDE TABLETS	HYZAAR						
MOEXIPRIL - HYDROCHLOROTHIAZIDE TABLETS	UNIRETIC						
QUINAPRIL - HYDROCHLOROTHIAZIDE TABLETS	ACCURETIC						
VALSARTAN - HYDROCHLOROTHIAZIDE TABLETS	DIOVAN HCT						
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)							
EPLERENONE TABLETS	INSPRA			PA REQUIRED			
VASODILATORS							
HYDRALAZINE HCL TABLETS	HYDRALAZINE HCL						
MINOXIDIL TABLETS	MINOXIDIL						
ANTI-INFECTIVE AGENTS - MISC.							
ANTI-INFECTIVE AGENTS - MISC.							
METRONIDAZOLE TABLET (250MG, 500MG)	FLAGYL						
METRONIDAZOLE SUSPENSION	LIKMEZ			PA NOT REQUIRED FOR < 10 YEARS OF AGE			
TINIDAZOLE	VARIOUS						
TRIMETHOPRIM TABLETS	TRIMETHOPRIM						
VANCOMYCIN HCL CAPSULES	VANCOCIN HCL						
VANCOMYCIN HCL SOLUTION RECONSTITUTED	VARIOUS						
ANTI-INFECTIVE MISC. - COMBINATIONS							
ERYTHROMYCIN-SULFISOXAZOLE SUSPENSION	E.S.P.						
SULFAMETHOXAZOLE-TRIMETHOPRIM SUSPENSION	SULFATRIM PEDIATRIC						
SULFAMETHOXAZOLE-TRIMETHOPRIM TABLETS	BACTRIM						
LEPROSTATICS							
DAPSONE TABLETS	DAPSONE						
OXAZOLIDINONES							
LINEZOLID SUSPENSION	ZYVOX			PA REQUIRED			
LINEZOLID TABLET	ZYVOX						
ANTIMALARIALS							
ANTIMALARIAL COMBINATIONS							
ARTEMETHER-LUMEFANTRINE TABLETS	COARTEM						
ATOVAQUONE-PROGUANIL HCL TABLETS	MALARONE						
ANTIMALARIALS							
CHLOROQUINE PHOSPHATE TABLETS	CHLOROQUINE PHOSPHATE						
HYDROXYCHLOROQUINE SULFATE TABLETS	PLAQUENIL						
PRIMAQUINE PHOSPHATE TABLETS	PRIMAQUINE PHOSPHATE						
QUININE SULFATE CAPSULES	QUALAQUIN						
ANTIMYCOBACTERIAL AGENTS							
ETHAMBUTOL HCL TABLETS	MYAMBUTOL						
ISONIAZID SYRUP	ISONIAZID						
ISONIAZID TABLETS	ISONIAZID						
PYRAZINAMIDE TABLETS	PYRAZINAMIDE						
RIFAMPIN CAPSULES	RIFADIN						
ONCOLOGY -FEDERALLY REIMBURSABLE ANTINEOPLASTIC AGENTS, NOT LISTED BELOW, ARE AVAILABLE THROUGH PRIOR AUTHORIZATION							
ALKYLATING AGENTS							

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MELPHALAN TABLETS	ALKERAN			Not covered through AHCCCS. Please contact Waylis Pharmaceuticals for the patient assistance program. Toll Free Number: 1-800-689-0255			
ANTIMETABOLITES							
MERCAPTOPURINE TABLETS	PURINETHOL						
METHOTREXATE SODIUM TABLETS	METHOTREXATE						
ANTINEOPLASTIC - ANTIBODIES							
PEMBROLIZUMAB SOLUTION	KEYTRUDA			PA REQUIRED			
RITUXIMAB-ABBS	RIABNI			PA REQUIRED			
RITUXIMAB-PVVR	RUXIENCE			PA REQUIRED			
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS							
BEVACIZUMAB-AWWB INJECTION	MVASI			PA REQUIRED			
BEVACIZUMAB-BVZR INJECTION	ZIRABEV			PA REQUIRED			
ANTINEOPLASTIC - ANTI-HER2 AGENTS							
TRASTUZUMAB-ANNS SOLUTION	KANJINTI			PA REQUIRED			
TRASTUZUMAB-ANNS INJECTION	KANJINTI			PA REQUIRED			
TRASTUZUMAB-DKST INJECTION	OGIVRI			PA REQUIRED			
TRASTUZUMAB-PKRB INJECTION	HERZUMA			PA REQUIRED			
TRASTUZUMAB-QYYP INJECTION	TRAZIMERA			PA REQUIRED			
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS							
ANASTROZOLE TABLETS	ARIMIDEX			PA REQUIRED			
EXEMESTANE TABLETS	AROMASIN			PA REQUIRED			
FLUTAMIDE CAPSULE	EULEXIN			Not covered through AHCCCS. Please contact Waylis Pharmaceuticals for the patient assistance program. Toll Free Number: 1-800-689-0255			
LEUPROLIDE ACETATE KIT	LUPRON DEPOT			PA REQUIRED			
TAMOXIFEN CITRATE TABLETS	TAMOXIFEN CITRATE						
TOREMIFENE CITRATE TABLETS	FARESTON			PA REQUIRED			
ANTINEOPLASTIC ENZYME INHIBITORS							
AXITINIB TABLETS	INLYTA			PA REQUIRED			
CRIZOTINIB CAPSULES	XALKORI			PA REQUIRED			
CRIZOTINIB CAPSULE SPRINKLE	XALKORI			PA REQUIRED			
DASATINIB TABLETS	SPRYCEL			PA REQUIRED			
EVEROLIMUS TABLET	AFINITOR			PA REQUIRED			
ERLOTINIB HCL TABLETS	TARCEVA			PA REQUIRED			
EVEROLIMUS SOLUBLE TABLET	AFINITOR DISPERZ			PA REQUIRED			
GEFITINIB TABLETS	IRESSA			PA REQUIRED			
IBRUTINIB CAPSULES	IMBRUVICA			PA REQUIRED			
IBRUTINIB SUSPENSION	IMBRUVICA			PA REQUIRED			
IMATINIB MESYLATE TABLETS	GLEEVEC			PA REQUIRED			
LAPATINIB DITOSYLATE TABLETS	TYKERB			PA REQUIRED			
NILOTINIB HCL CAPSULES	TASIGNA			PA REQUIRED			
PONATINIB HCL TABLETS	ICLUSIG			PA REQUIRED			
RUXOLITINIB PHOSPHATE TABLETS	JAKAFI			PA REQUIRED			
RUXOLITINIB PHOSPHATE TABLET ER 24HR	JAKAFI XR			PA REQUIRED			
SORAFENIB TOSYLATE TABLETS	NEXAVAR			PA REQUIRED			
SUNITINIB MALATE CAPSULES	SUTENT			PA REQUIRED			
VANDETANIB TABLETS	CAPRELSA			PA REQUIRED			
VEMURAFENIB TABLETS	ZELBORAF			PA REQUIRED			
VORINOSTAT CAPSULES	ZOLINZA			PA REQUIRED			
ANTINEOPLASTICS - MISC.							
BEXAROTENE CAPSULES	VARIOUS			PA REQUIRED			
HYDROXYUREA CAPSULES	HYDREA						
INTERFERON ALFA-2B SOLUTION	INTRON A			PA REQUIRED			
INTERFERON ALFA-2B SOLUTION	INTRON A			PA REQUIRED			
INTERFERON ALFA-N3 SOLUTION	ALFERON N			PA REQUIRED			
INTERFERON GAMMA-1B SOLUTION	ACTIMMUNE			PA REQUIRED			
PEGINTERFERON ALFA-2B (ANTINEOPLASTIC) KIT	SYLATRON			PA REQUIRED			
PROCARBAZINE HCL CAPSULES	MATULANE						
TRETINOIN (CHEMOTHERAPY) CAPSULES	TRETINOIN			PA REQUIRED For > 26 Years of Age			
CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS							
LEUCOVORIN CALCIUM TABLETS	LEUCOVORIN CALCIUM			PA REQUIRED			
MITOTIC INHIBITORS							
ETOPOSIDE CAPSULES	ETOPOSIDE			PA REQUIRED			
ANTIPARKINSON AGENTS							
ANTIPARKINSON ANTICHOLINERGICS							
BENZTROPINE MESYLATE TABLETS	BENZTROPINE MESYLATE						
TRIHEXYPHENIDYL HCL ELIXIR	TRIHEXYPHENIDYL HCL						
TRIHEXYPHENIDYL HCL TABLETS	TRIHEXYPHENIDYL HCL						

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ANTIPARKINSON COMT INHIBITORS							
ENTACAPONE TABLETS	COMTAN						
ANTIPARKINSON DOPAMINERGICS							
AMANTADINE HCL CAPSULES	AMANTADINE HCL						
AMANTADINE HCL SYRUP	AMANTADINE HCL						
BROMOCRIPTINE MESYLATE CAPSULES	PARLODEL						
BROMOCRIPTINE MESYLATE TABLETS	PARLODEL						
CARBIDOPA-LEVODOPA TABLETS	SINEMET						
CARBIDOPA-LEVODOPA ER TABLETS	VARIOUS						
PRAMIPEXOLE DIHYDROCHLORIDE TABLETS	MIRAPEX						
ROPINIROLE HYDROCHLORIDE TABLETS	REQUIP						
ANTIPSYCHOTICS/ANTIMANIC AGENTS							
ANTIMANIC AGENTS							
LITHIUM CARBONATE CAPSULES	LITHIUM CARBONATE			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LITHIUM CARBONATE TABLETS	LITHIUM CARBONATE			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LITHIUM CARBONATE TABLET CONTROLLED RELEASE	LITHOBID			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LITHIUM SOLUTION	LITHIUM			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
ANTIPSYCHOTICS							
ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL ORAL AGENTS							
ARIPIPRAZOLE SOLUTION	ABILIFY		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		750	30
ARIPIPRAZOLE TABLETS	ABILIFY		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
CLOZAPINE ORALLY DISPERSABLE TABLET	FAZACLO		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		150	30
CLOZAPINE TABLETS	CLOZARIL		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		150	30
CARIPRAZINE HCL CAPSULE (0.5MG, 0.75MG, 4.5MG, 6MG)	**VRAYLAR**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**		**90**	**90**
CARIPRAZINE HCL CAPSULE (1.5MG, 3MG)	**VRAYLAR**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**		**180**	**90**
LURASIDONE HCL TABS	LATUDA		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
OLANZAPINE ORALLY DISPERSABLE TABLET	ZYPREXA ZYDIS		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		5MG: 60 10MG: 60 15MG: 30 20MG: 30	30 30 30 30

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ACUTE - LONG TERM CARE DRUG LIST

Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
OLANZAPINE TABLETS	ZYPREXA		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		30	30
QUETIAPINE FUMARATE TABLETS	SEROQUEL		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
QUETIAPINE FUMARATE TABLET ER 24HR	SEROQUEL XR		PREFERRED DRUG	PA REQUIRED for < 6 Years of Age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.		180	90
RISPERIDONE ORALLY DISPERSABLE TABLET	RISPERIDONE ODT		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
RISPERIDONE ORAL SOLUTION	RISPERDAL		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		240	30
RISPERIDONE TABLETS	RISPERDAL		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
ZIPRASIDONE HCL CAPSULES	GEODON		PREFERRED DRUG	PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		60	30
ANTIPSYCHOTICS - SECOND GENERATION - ATYPICAL LONG ACTING INJECTABLES							
ARIPIPRAZOLE LAUROXIL PREFILLED SYR (441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML)	**ARISTADA**		**PREFERRED DRUG**	**PA REQUIRED for Ages < 18 years Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**1**	**30**
ARIPIPRAZOLE LAUROXIL PREFILLED SYR (1064 MG/3.9ML)	**ARISTADA**		**PREFERRED DRUG**	**PA REQUIRED for Ages < 18 years Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**1**	**60**
ARIPIPRAZOLE LAUROXIL PREFILLED SYR (675 MG/2.4ML)	**ARISTADA INITIO**		**PREFERRED DRUG**	**PA REQUIRED for Ages < 18 years Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**2**	**365**
ARIPIPRAZOLE PREFILLED SYR (300MG)	**ABILIFY MAINTENA**		**PREFERRED DRUG**	**PA REQUIRED for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**1**	**30**
ARIPIPRAZOLE PREFILLED SYR (400MG)	**ABILIFY MAINTENA**		**PREFERRED DRUG**	**PA REQUIRED for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**2**	**30**
ARIPIPRAZOLE PREFILLED SYR	**ABILIFY ASIMTUFII**		**PREFERRED DRUG**	**PA REQUIRED for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**1**	**60**
ARIPIPRAZOLE SUSP RECONSTITUTED ER (300MG)	**ABILIFY MAINTENA**		**PREFERRED DRUG**	**PA REQUIRED for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**1**	**30**
ARIPIPRAZOLE SUSP RECONSTITUTED ER (400MG)	**ABILIFY MAINTENA**		**PREFERRED DRUG**	**PA REQUIRED for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**2**	**30**

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ARIPIPRAZOLE TABLET	**ABILIFY**		**PREFERRED DRUG**	**PA REQUIRED for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**90**	**90**
ARIPIPRAZOLE SOLUTION	**ABILIFY**		**PREFERRED DRUG**	**PA REQUIRED for < 6 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**2250**	**90**
PALIPERIDONE PALMITATE SUSPENSION	INVEGA HAFYERA		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	180
PALIPERIDONE PALMITATE SUSPENSION	INVEGA SUSTENNA		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 years and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	30
PALIPERIDONE PALMITATE SUSPENSION	INVEGA TRINZA		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 years and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		1	90
PALIPERIDONE TABLET ER 24HR (1.5MG, 3MG, 9MG)	**INVEGA**			**PA REQUIRED for < 12 Years of Age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**90**	**90**
PALIPERIDONE TABLET ER 24HR (6MG)	**INVEGA**			**PA REQUIRED for < 12 Years of Age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**180**	**90**
RISPERIDONE INJECTABLE SUSPENSION	UZEDY		PREFERRED DRUG	PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 years and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.		50MG: 1 75MG: 1 100MG: 1 125MG: 1 150MG: 1 200MG: 1 250MG: 1	30 30 30 30 60 60 60
RISPERIDONE MICROSPHERES SUSP RECONSTITUTED ER	**RISPERDAL CONSTA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED for < 18 years of age, Prior Authorization is not required when prescribed by a psychiatric clinician, a behavioral pediatrician or other prescribers as approved by the FFS Administration.**		**2**	**28**
ANTIPSYCHOTICS - FIRST GENERATION -TYPICAL ORAL AGENTS							
CHLORPROMAZINE HCL SOLUTION	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
CHLORPROMAZINE HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
FLUPHENAZINE HCL CONCENTRATE	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
FLUPHENAZINE HCL ELIXIR	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
FLUPHENAZINE HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 6 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
HALOPERIDOL LACTATE CONCENTRATE	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
HALOPERIDOL TABLETS	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
LOXAPINE SUCCINATE CAPSULES	LOXITANE			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
MOLINDONE	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
PERPHENAZINE TABLETS	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
PIMOZIDE	ORAP			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
THIORIDAZINE HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
THIOTHIXENE CAPSULES	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
TRIFLUOPERAZINE HCL TABLETS	VARIOUS			PA REQUIRED for Ages < 12 years Prior Authorization is not REQUIRED for ages 6 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
ANTIPSYCHOTICS - FIRST GENERATION -TYPICAL -LONG ACTING INJECTIONS							
FLUPHENAZINE DECANOATE SOLUTION	FLUPHENAZINE DECANOATE			PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
HALOPERIDOL DECANOATE SOLUTION	HALDOL DECANOATE 50			PA REQUIRED for Ages < 18 years Prior Authorization is not REQUIRED for ages 18 and greater when prescribed by a psychiatric clinician, a developmental pediatrician or other prescribers as approved by the MCO Contractors.			
ANTIVIRALS							
ANTIRETROVIRALS							
ABACAVIR SULFATE SOLUTION	ZIAGEN		PREFERRED DRUG				
ABACAVIR SULFATE TABLETS	ZIAGEN		PREFERRED DRUG				
ABACAVIR SULFATE-LAMIVUDINE TABLETS	EPZICOM		PREFERRED DRUG				
ABACAVIR SULFATE-LAMIVUDINE-ZIDOVUDINE TABLETS	TRIZIVIR		PREFERRED DRUG				
ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TABLETS	TRIUMEQ		PREFERRED DRUG			30	30
ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE SUSPENSION	TRIUMEQ PD		PREFERRED DRUG			180	30
ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE TABLETS	TRIUMEQ		PREFERRED DRUG				
ATAZANAVIR SULFATE CAPSULES	REYATAZ		PREFERRED DRUG				
ATAZANAVIR SULFATE POWDER PACK	REYATAZ		PREFERRED DRUG				
ATAZANAVIR SULFATE-COBICISTAT TABLETS	EVOTAZ		PREFERRED DRUG				

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
BICTEGRAVIR-EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	BIKTARVY		PREFERRED DRUG			30	30
COBICISTAT TABLETS	TYBOST		PREFERRED DRUG			30	30
DARUNAVIR ETHANOLATE SUSPENSION	**PREZISTA**	**BRAND ONLY**	**PREFERRED DRUG**				
DARUNAVIR ETHANOLATE TABLETS	**PREZISTA**	**BRAND ONLY**	**PREFERRED DRUG**				
DARUNAVIR-COBICISTAT TABLETS	PREZCOBIX		PREFERRED DRUG				
DARUNAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE TABLETS	SYMTUZA		PREFERRED DRUG				
DOLUTEGRAVIR SODIUM TABLETS	TIVICAY		PREFERRED DRUG				
DOLUTEGRAVIR SODIUM SOLUBLE TABLETS	TIVICAY PD		PREFERRED DRUG				
DOLUTEGRAVIR SODIUM-LAMIVUDINE TABLETS	DOVATO		PREFERRED DRUG				
DOLUTEGRAVIR SODIUM-RILPIVIRINE HCL TABLETS	JULUCA		PREFERRED DRUG				
DORAVIRINE-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	DELSTRIGO		PREFERRED DRUG				
DORAVIRINE TABLETS	PIFELTRO		PREFERRED DRUG				
EFAVIRENZ CAPSULES	SUSTIVA		PREFERRED DRUG				
EFAVIRENZ TABLETS	SUSTIVA		PREFERRED DRUG				
EFAVIRENZ-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE TABLET	**SYMFI LO**					**90**	**90**
ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR TABLETS	STRIBILD		PREFERRED DRUG				
ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE TABLETS	GENVOYA		PREFERRED DRUG			30	30
EMTRICITABINE CAPSULES	EMTRIVA		PREFERRED DRUG				
EMTRICITABINE SOLUTION	EMTRIVA		PREFERRED DRUG				
EMTRICITABINE-RILPIVIRINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	ODEFSEY		PREFERRED DRUG			30	30
EMTRICITABINE-RILPIVIRINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	**COMPLERA**	**BRAND ONLY**	**PREFERRED DRUG**				
EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE TABLETS	DESCOVY		PREFERRED DRUG			30	30
EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS	TRUVADA		PREFERRED DRUG				
ENFUVIRTIDE SOLUTION	FUZEON		PREFERRED DRUG	PA REQUIRED		1	30
FOSAMPRENAVIR CALCIUM SUSPENSION	LEXIVA		PREFERRED DRUG				
FOSAMPRENAVIR CALCIUM TABLETS	LEXIVA		PREFERRED DRUG				
LAMIVUDINE SOLUTION	EPIVIR		PREFERRED DRUG				
LAMIVUDINE TABLETS	EPIVIR		PREFERRED DRUG				
LAMIVUDINE-ZIDOVUDINE TABLETS	COMBIVIR		PREFERRED DRUG				
LOPINAVIR-RITONAVIR SOLUTION	KALETRA		PREFERRED DRUG				
LOPINAVIR-RITONAVIR TABLETS	KALETRA		PREFERRED DRUG				
MARAVIROC TABLETS	SELZENTRY		PREFERRED DRUG	PA REQUIRED			
NEVIRAPINE SUSPENSION	VIRAMUNE		PREFERRED DRUG				
NEVIRAPINE TABLETS	VIRAMUNE		PREFERRED DRUG				
NEVIRAPINE TABLET 24-HOUR	VIRAMUNE XR		PREFERRED DRUG				
RALTEGRAVIR POTASSIUM CHEWABLE TABLETS	ISENTRESS		PREFERRED DRUG				
RALTEGRAVIR POTASSIUM PACK	ISENTRESS		PREFERRED DRUG				
RALTEGRAVIR POTASSIUM TABLETS	ISENTRESS		PREFERRED DRUG				
RILPIVIRINE HCL TABLET	**EDURANT**	**BRAND ONLY**					
RILPIVIRINE HCL TABLET SOLUBLE	EDURANT PED						
RITONAVIR CAPSULES	NORVIR		PREFERRED DRUG				
RITONAVIR TABLETS	NORVIR		PREFERRED DRUG				
RITONAVIR PACKET	NORVIR		PREFERRED DRUG				
TENOFOVIR DISOPROXIL FUMARATE POWDER	VIREAD		PREFERRED DRUG				
ZIDOVUDINE CAPSULES	RETROVIR		PREFERRED DRUG				
ZIDOVUDINE SYRUP	RETROVIR		PREFERRED DRUG				
ZIDOVUDINE TABLETS	ZIDOVUDINE		PREFERRED DRUG				
CMV AGENTS							
CIDOFOVIR IV	VISTIDE			PA REQUIRED			
FOSCARENT SODIUM	FOSCAVIR			PA REQUIRED			
GANCICLOVIR SODIUM	CYTOVENE			PA REQUIRED			
MARIBAVIR TABLETS	LIVTENCITY			PA REQUIRED			
VALGANCICLOVIR HCL SOLUTION	VALCYTE			PA REQUIRED			
VALGANCICLOVIR HCL TABLETS	VALCYTE			PA REQUIRED			
HEPATITIS B AGENTS							
ADEFOVIR DIPIVOXIL TABLETS	HEPSERA			PA REQUIRED			
ENTECAVIR SOLUTION	BARACLUDE			PA REQUIRED			
ENTECAVIR TABLETS	BARACLUDE			PA REQUIRED			
LAMIVUDINE (HBV) SOLUTION	EPIVIR HBV						
LAMIVUDINE (HBV) TABLETS	EPIVIR HBV						

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
HEPATITIS C AGENTS							
GLECAPREVIR-PIBRENTASVIR TABLETS	MAVYRET		PREFERRED DRUG	PA Required if member has been treated previously with Direct-Acting Antiviral (DAA) Hep C Regimens in the past.		168	Lifetime
GLECAPREVIR-PIBRENTASVIR PACKETS	MAVYRET		PREFERRED DRUG	PA Required if member has been treated previously with Direct-Acting Antiviral (DAA) Hep C Regimens in the past.		280	Lifetime
PEGINTERFERON ALFA-2A SOLUTION	PEGASYS		PREFERRED DRUG	PA REQUIRED			
PEGINTERFERON ALFA-2B KIT	PEGINTRON		PREFERRED DRUG	PA REQUIRED			
RIBAVIRIN (HEPATITIS C) CAPSULES	VARIOUS		PREFERRED DRUG	PA REQUIRED			
RIBAVIRIN (HEPATITIS C) TABLETS	VARIOUS		PREFERRED DRUG	PA REQUIRED			
SOFOSBUVIR-VELPATASVIR TABLETS	EPCLUSA	AUTHORIZED GENERIC ONLY	PREFERRED DRUG	PA Required if member has been treated previously with Direct-Acting Antiviral (DAA) Hep C Regimens in the past.		168	Lifetime
HERPES AGENTS							
ACYCLOVIR SUSPENSION	VARIOUS						
ACYCLOVIR TABLETS	VARIOUS						
FAMCICLOVIR TABLETS	FAMVIR			PA REQUIRED			
VALACYCLOVIR HCL TABLETS	VALTREX			PA REQUIRED			
INFLUENZA AGENTS							
OSELTAMIVIR PHOSPHATE CAPSULES	TAMIFLU					20	270
OSELTAMIVIR PHOSPHATE SUSPENSION	TAMIFLU						
RIMANTADINE HYDROCHLORIDE TABLETS	FLUMADINE						
ZANAMIVIR AEROSOL POWDER BREATH ACTIVATED	RELENZA DISKHALER					40	270
MISC. ANTIVIRALS							
MOLNUPIRAVIR CAPSULES	LAGEVRIO			Minimum Patient Age of 18 Years		80	365
NIRMATRELVIR-RITONAVIR	PAXLOVID			Minimum Patient Age of 12 Years		60	365
REMDESIVIR SOLUTION	VEKLURY						
REMDESIVIR FOR SOLUTION	VEKLURY						
ASSORTED CLASSES							
BLOOD PRODUCTS - IMMUNE GLOBULINS							
IMMUNE GLOBULIN (HUMAN)-HIPP SOLUTION	**CUTAQUIG**	**BRAND ONLY**		**PA REQUIRED**			
IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLUTION	**GAMMAGARD/GAMMAKED/GAMUNEX-C**	**BRAND ONLY**		**PA REQUIRED**			
IMMUNE GLOBULIN (HUMAN) IV SOLUTION	**BIVIGAM/GAMMAPLEX/FLEBOGAMMA/OCTAGAM/PRIVIGEN**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
IMMUNE GLOBULIN (HUMAN) IV SOLUTION RECONSTITUTED	**GAMMAGARD S/D IGA LESS THAN 1MCG/ML**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
IMMUNE GLOBULIN (HUMAN) SUBCUTANEOUS SOLUTION	**HIZENTRA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
IMMUNE GLOBULIN (HUMAN) SUBCUTANEOUS SOLN PREF SYR	**HIZENTRA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
IMMUNE GLOBULIN (HUMAN)-KLHW SOLUTION	**XEMBIFY**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
CHELATING AGENTS							
PENICILLAMINE CAPSULES	CUPRIMINE						
IMMUNOMODULATORS							
LENALIDOMIDE CAPSULE	REVLIMID	BRAND ONLY		PA REQUIRED			
IMMUNOSUPPRESSIVE AGENTS							
AZATHIOPRINE TABLETS	IMURAN						
CYCLOSPORINE CAPSULES	SANDIMMUNE						
CYCLOSPORINE MODIFIED (FOR MICROEMULSION) CAPSULES	GENGRAF						
CYCLOSPORINE MODIFIED (FOR MICROEMULSION) SOLUTION	GENGRAF						
CYCLOSPORINE SOLUTION	SANDIMMUNE						
EVEROLIMUS (IMMUNOSUPRESSANT) TABLETS	ZORTRESS			PA REQUIRED			
MYCOPHENOLATE MOFETIL CAPSULES	CELLCEPT						
MYCOPHENOLATE MOFETIL SUSPENSION	CELLCEPT						
MYCOPHENOLATE MOFETIL TABLETS	CELLCEPT						
SIROLIMUS SOLUTION	RAPAMUNE						
SIROLIMUS TABLETS	RAPAMUNE						
TACROLIMUS CAPSULES	HECORIA						
TACROLIMUS CAPSULE CONTROLLED RELEASE	ASTAGRAF XL						
ROCK2 INHIBITORS							
BELUMOSUDIL MESYLATE	REZUROCK			PA REQUIRED			
POTASSIUM REMOVING RESINS							
SODIUM POLYSTYRENE SULFONATE POWDER	KAYEXALATE						
SODIUM POLYSTYRENE SULFONATE SUSPENSION	KIONEX						
BETA BLOCKERS							
ALPHA-BETA BLOCKERS							

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CARVEDILOL TABLETS	COREG		PREFERRED DRUG				
LABETALOL HCL TABLETS	TRANDATE		PREFERRED DRUG				
BETA BLOCKERS CARDIO-SELECTIVE							
ATENOLOL TABLETS	TENORMIN		PREFERRED DRUG				
ATENOLOL/CHLORTHALIDONE	VARIOUS		PREFERRED DRUG				
BISOPROLOL	VARIOUS		PREFERRED DRUG				
BISOPROLOL/HCTZ	VARIOUS		PREFERRED DRUG				
METOPROLOL TARTRATE TABLETS	VARIOUS		PREFERRED DRUG				
METOPROLOL SUCCINATE TABLET XL 24-HOUR	VARIOUS		PREFERRED DRUG				
METOPROLOL TARTRATE/HCTZ	VARIOUS		PREFERRED DRUG				
METOPROLOL TARTRATE SOLUTION	LOPRESSOR			PA Required > 10 Years of Age			
NEBIVOLOL HCL TABLET	BYSTOLIC						
BETA BLOCKERS NON-SELECTIVE							
NADOLOL	VARIOUS		PREFERRED DRUG	PA NOT REQUIRED FOR CHILDREN AND ADOLESCENTS UNDER 19 YEARS OF AGE			
PROPRANOLOL HCL CAPSULE ER CONTROLLED RELEASE	VARIOUS		PREFERRED DRUG				
PROPRANOLOL HCL SOLUTION	HEMANGEOL			PA Required > 10 Years of Age			
PROPRANOLOL HCL TABLETS	VARIOUS		PREFERRED DRUG				
PROPRANOLOL / HCTZ	VARIOUS		PREFERRED DRUG				
SOTALOL HCL TABLETS	BETAPACE		PREFERRED DRUG				
CALCIUM CHANNEL BLOCKERS							
CALCIUM CHANNEL BLOCKERS							
AMLODIPINE BESYLATE	VARIOUS		PREFERRED DRUG			30	30
AMLODIPINE BENZOATE SUSPENSION	KATERZIA		PREFERRED DRUG	PA Required for > 7 Years Old		300	30
DILTIAZEM CAPSULE ER	VARIOUS		PREFERRED DRUG				
DILTIAZEM TABLETS	VARIOUS		PREFERRED DRUG				
FELODIPINE TABLET ER 24-HOUR	VARIOUS		PREFERRED DRUG			30	30
NIFEDIPINE IR CAPSULES	VARIOUS		PREFERRED DRUG				
NIFEDIPINE TABLET ER 24-HOUR	VARIOUS		PREFERRED DRUG			30	30
VERAPAMIL HCL CAPSULE SR	VARIOUS		PREFERRED DRUG			30	30
VERAPAMIL HCL TABLETS	VARIOUS		PREFERRED DRUG				
VERAPAMIL HCL TABLET CONTROLLED RELEASE	VARIOUS		PREFERRED DRUG			30	30
CARDIOTONICS							
CARDIAC GLYCOSIDES							
DIGOXIN SOLUTION	DIGOXIN						
DIGOXIN TABLETS	LANOXIN						
CARDIOVASCULAR AGENTS - MISC.							
ANGIOTENSTIN RECEPTOR NEPRILYSIN INHIBITOR							
SACUBITRIL-VALSARTAN TABLET	ENTRESTO	GENERIC ONLY					
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAG							
AMBRISENTAN TABLETS	LETAIRIS		PREFERRED DRUG	PA REQUIRED			
BOSENTAN TABLETS SOLUBLE	TRACLEER		PREFERRED DRUG	PA REQUIRED			
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBIT		GENERIC ONLY					
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) SUSPENSION RECONSTITUTED	REVATIO		Preferred for Under the Age of 12	PA Required For > 12 Year of Age			
SILDENAFIL CITRATE (PULMONARY HYPERTENSION) TABLETS	VARIOUS			PA REQUIRED			
TADALAFIL (PULMONARY HYPERTENSION) TABLETS	VARIOUS			PA REQUIRED			
PROSTAGLANDIN VASODILATORS**							
TREPROSTINIL DIOLAMINE TABLET ER	**ORENITRAM**	**BRAND ONLY**		**PA REQUIRED**			
TREPROSTINIL DIOLAMINE TBER THER PACK	**ORENITRAM**	**BRAND ONLY**		**PA REQUIRED**			
TREPROSTINIL SODIUM CAPSULE	**YUTREPIA**	**BRAND ONLY**		**PA REQUIRED**			
CEPHALOSPORINS							
CEPHALOSPORINS - 1ST GENERATION							
CEFADROXIL CAPSULES	CEFADROXIL						
CEFADROXIL SUSPENSION	CEFADROXIL						
CEFADROXIL TABLETS	CEFADROXIL						
CEPHALEXIN CAPSULES	KEFLEX						
CEPHALEXIN SUSPENSION	CEPHALEXIN						
CEPHALEXIN TABLETS	CEPHALEXIN						
CEPHALOSPORINS - 2ND GENERATION							
CEFACLOR CAPSULES	CEFACLOR						
CEFACLOR SUSPENSION	CEFACLOR						
CEFPROZIL SUSPENSION	CEFPROZIL						
CEFPROZIL TABLETS	CEFPROZIL						
CEFUROXIME AXETIL SUSPENSION	CEFTIN						
CEFUROXIME AXETIL TABLETS	CEFTIN						

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
CEPHALOSPORINS - 3RD GENERATION							
CEFDINIR CAPSULES	CEFDINIR						
CEFDINIR SUSPENSION	CEFDINIR						
CEFIXIME CAPSULES	SUPRAX					1	30
CEFIXIME CHEWABLE TABLETS	SUPRAX					1	30
CEFIXIME SUSPENSION	SUPRAX					1	30
CEFIXIME TABLETS	SUPRAX					1	30
CEFPODOXIME PROXETIL SUSPENSION	CEFPODOXIME PROXETIL						
CEFPODOXIME PROXETIL TABLETS	CEFPODOXIME PROXETIL						
CONTRACEPTION							
COMBINATION CONTRACEPTIVES - ORAL							
DESOGESTREL & ETHINYL ESTRADIOL TABLET	RECLIPSEN					336	365
DESOGESTREL-ETHINYL ESTRADIOL (BIPHASIC) TABLET	KARIVA					336	365
DESOGESTREL-ETHINYL ESTRADIOL (TRIPHASIC) TABLET	VELIVET					336	365
DROSPIRENONE-ETHINYL ESTRADIOL TABLET	VESTURA					336	365
DROSPIRENONE-ETHINYL ESTRADIOL-LEVOMEFOLATE CALCIUM TABLET	BEYAZ/SAFYRAL					336	365
ETHYNODIOL DIACET & ETH ESTRAD TABLET (1/35)	KELNOR 1/35					336	365
LEVONORGESTREL & ETH ESTRADIOL TABLET CHEWABLE	TYBLUME					336	365
LEVONORGESTREL & ETH ESTRADIOL TABLET	ORSYTHIA					336	365
LEVONORGESTREL-ETH ESTRADIOL (TRIPHASIC) TABLET	ENPRESSE-28					336	365
LEVONORGESTREL-ETHINYL ESTRADIOL (91-DAY) TABLET	CAMRESE LO					364	365
NORETHIN ACET & ESTRAD-FE TABLET	**JUNEL FE**					336	365
NORETHINDRONE & ETH ESTRADIOL TABLET	BALZIVA					336	365
NORETHINDRONE & ETHINYL ESTRADIOL-FE TABLET CHEWABLE	KAITLIB FE					336	365
NORETHINDRONE ACET & ETH ESTRA TABLET	JUNEL					336	365
NORETHINDRONE ACETATE-ETHINYL ESTRADIOL-FE TABLET	TILIA FE					336	365
NORETHINDRONE-ETH ESTRADIOL (TRIPHASIC) TABLET (7/7/7)	NORTREL 7/7/7					336	365
NORGESTIMATE-ETHINYL ESTRADIOL (TRIPHASIC) TABLET	TRI-LO-SPRINTEC					336	365
NORGESTIMATE-ETHINYL ESTRADIOL TABLET	SPRINTEC 28					336	365
NORGESTREL & ETHINYL ESTRADIOL TABLET	CRYSELLE-28					336	365
COMBINATION CONTRACEPTIVES - VAGINAL							
ETONOGESTREL-ETHINYL ESTRADIOL RING	Generic Only						
COPPER CONTRACEPTIVES - IUD							
COPPER IUD	PARAGARD					1	999+
EMERGENCY CONTRACEPTIVES							
LEVONORGESTREL (EMERGENCY OC) TABLET	OPTION 2		PREFERRED DRUG				
ULIPRISTAL ACETATE TABLET	ELLA		PREFERRED DRUG			1	5
PROGESTINS							
MEDROXYPROGESTERONE ACETATE TABLETS	PROVERA		PREFERRED DRUG				
NORETHINDRONE ACETATE	AYGESTIN		PREFERRED DRUG				
PROGESTERONE MICRONIZED CAPSULES	PROMETRIUM		PREFERRED DRUG				
PROGESTIN CONTRACEPTIVES - IMPLANTS							
ETONOGESTREL IMPLANT	NEXPLANON					1	999+
PROGESTIN CONTRACEPTIVES - INJECTABLE							
MEDROXYPROGESTERONE ACETATE (CONTRACEPTIVE) SUSPENSION	DEPO-PROVERA CONTRACEPTIVE						
PROGESTIN CONTRACEPTIVES - IUD							
LEVONORGESTREL (IUD)	LILETTA					1	999+
LEVONORGESTREL (IUD)	SKYLA					1	730.00
LEVONORGESTREL (IUD)	MIRENA					1	999.00
LEVONORGESTREL (IUD)	KYLEENA					1	730.00
PROGESTIN CONTRACEPTIVES - ORAL							
NORETHINDRONE (CONTRACEPTIVE) TABLET	DEBLITANE					336	365
NORGESTREL TABLET	OPILL					336	365
PROGESTIN CONTRACEPTIVES - TRANSDERMAL							
NORELGESTROMIN-ETHINYL ESTRADIOL PATCH WEEKLY	ZAFEMY	BRAND ONLY					
CORTICOSTEROIDS							
GLUCOCORTICOSTEROIDS							
DEFLAZACORT TABLET	EMFLAZA						

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DEFLAZACORT SUSPENSION	EMFLAZA						
DEXAMETHASONE CONCENTRATE	DEXAMETHASONE INTENSOL						
DEXAMETHASONE ELIXIR	VARIOUS						
DEXAMETHASONE SOLUTION	DEXAMETHASONE						
DEXAMETHASONE TABLET (ALL STRENGTHS EXCEPT 0.25MG & 20MG)	DECADRON						
HYDROCORTISONE SOD SUCCINATE SOLUTION (INJECTABLE)	A-HYDROCORT			PA REQUIRED			
METHYLPREDNISOLONE ACETATE SUSPENSION (INJECTABLE)	DEPO-MEDROL			PA REQUIRED			
METHYLPREDNISOLONE SOD SUCC SOLUTION (INJECTABLE)	A-METHAPRED			PA REQUIRED			
METHYLPREDNISOLONE TABLETS	MEDROL						
PREDNISOLONE SODIUM PHOSPHATE SOLUTION	ORAPRED						
PREDNISOLONE SODIUM PHOSPHATE ORALLY DISINTEGRATING TABLETS	ORAPRED ODT						
PREDNISOLONE SYRUP	PRELONE						
PREDNISOLONE TABLETS	VARIOUS						
PREDNISONE CONCENTRATE	PREDNISONE INTENSOL						
PREDNISONE SOLUTION	PREDNISONE						
PREDNISONE TABLETS	PREDNISONE						
TRIAMCINOLONE ACETONIDE SUSPENSION (INJECTABLE)	KENALOG-10			PA REQUIRED			
TRIAMCINOLONE DIACETATE SUSPENSION (INJECTABLE)	TRIAMCINOLONE			PA REQUIRED			
TRIAMCINOLONE HEXACETONIDE SUSPENSION (INJECTABLE)	ARISTOSPAN INTRALESIONAL & INTRA-ARTICULAR			PA REQUIRED			
MINERALOCORTICOIDS							
FLUDROCORTISONE ACETATE TABLETS	FLORINEF						
NONSTEROIDAL MINERALOCORTICOID RECEPTOR ANTAGONIST							
FINERENONE TABLETS	KERENDIA			PA REQUIRED			
COUGH/COLD/ALLERGY							
ANTITUSSIVES							
BENZONATATE CAPSULES	TESSALON PERLES						
HYDROCODONE W/ HOMATROPINE SYRUP	VARIOUS			PA REQUIRED for < 18 years of age		240	12
HYDROCODONE W/ HOMATROPINE TABLETS	VARIOUS			PA REQUIRED for < 18 years of age			
COUGH/COLD/ALLERGY COMBINATIONS							
BROMPHENIRAMINE & PSEUDOEPHEDRINE LIQUID	VARIOUS						
BROMPHENIRAMINE &PSEUDOEPHEDRINE TABLET 12-HOUR	VARIOUS						
BROMPHENIRAMINE-DEXTROMETHORPHAN-PHENYLEPHRINE LIQUID/TABLETS	VARIOUS						
CHLORPHENIRAMINE &PSEUDOEPHEDRINE CHEWABLE TABLETS	VARIOUS						
CHLORPHENIRAMINE &PSEUDOEPHEDRINE LIQUID	VARIOUS					480	30
CHLORPHENIRAMINE &PSEUDOEPHEDRINE SOLUTION	VARIOUS					480	30
CHLORPHENIRAMINE &PSEUDOEPHEDRINE SYRUP	VARIOUS					480	30
CHLORPHENIRAMINE &PSEUDOEPHEDRINE TABLETS	VARIOUS						
DEXTROMETHORPHAN-GUAIFENESIN TABLET	VARIOUS						
DEXTROMETHORPHAN-GUAIFENESIN LIQUID	VARIOUS					480	30
DEXTROMETHORPHAN-GUAIFENESIN TABLET 12-HOUR	MUCINEX DM						
GUAIFENESIN-CODEINE SYRUP	ROBITUSSIN AC			PA REQUIRED for < 18 years of age		240	12
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN CAPSULES	VARIOUS						
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN LIQUID	ROBITUSSIN CHILDRENS COUGH & COLD CF					480	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN SYRUP	VARIOUS					480	30
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN TABLETS	VARIOUS						
PHENYLEPHRINE W/ DEXTROMETHORPHAN-GUAIFENESIN TABLET 12-HOUR	VARIOUS						
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN ELIXIR	VARIOUS					480	30
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN LIQUID	DIMETAPP DEXTROMETHORPHAN COLD & COUGH					480	30
PHENYLEPHRINE-BROMPHENIRAMINE-DEXTROMETHORPHAN SYRUP	VARIOUS					480	30

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PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN LIQUID	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN DROPS	VARIOUS			PA REQUIRED for < 6 years age			
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN SYRUP	VARIOUS					480	30
PHENYLEPHRINE-CHLORPHENIRAMINE-DEXTROMETHORPHAN TABLETS	VARIOUS						
PHENYLEPHRINE-GUAIFENESIN CAPSULES	VARIOUS						
PHENYLEPHRINE-GUAIFENESIN LIQUID	TRIAMINIC CHEST/NASAL CONGESTION					480	30
PHENYLEPHRINE-GUAIFENESIN SYRUP	TRIAMINIC CHEST & NASAL CONGESTION					480	30
PHENYLEPHRINE-GUAIFENESIN TABLETS	VARIOUS						
PROMETHAZINE & PHENYLEPHRINE SYRUP	PROMETHAZINE/ PHENYLEPHRINE					480	30
PROMETHAZINE W/CODEINE SYRUP	PROMETHAZINE/CODEINE			PA REQUIRED for < 18 years of age		240	12
PROMETHAZINE-DEXTROMETHORPHAN SYRUP	PROMETHAZINE/ DEXTROMETHORPHAN					480	30
PSEUDOEPHEDRINE W/ CODEINE-GUAIFENESIN SYRUP	VARIOUS			PA REQUIRED for < 18 years of age		240	12
EXPECTORANTS							
GUAIFENESIN LIQUID	VARIOUS					480	30
GUAIFENESIN SYRUP	VARIOUS					480	30
GUAIFENESIN TABLETS	VARIOUS						
GUAIFENESIN TABLET 12-HOUR	VARIOUS						
DERMATOLOGICALS							
ACNE PRODUCTS							
BENZOYL PEROXIDE WASH 5% & 10%	VARIOUS						
BENZOYL PEROXIDE CLEANSER 6%	NEUTROGENA ON-THE-SPOT ACNE TREATMENT						
BENZOYL PEROXIDE GEL	BENZOYL PEROXIDE						
BENZOYL PEROXIDE LIQUID	PANOXYL						
BENZOYL PEROXIDE LOTION	BP CLEANSING LOTION						
BENZOYL PEROXIDE-ERYTHROMYCIN PACK	BENZAMYCINPAK						
CLINDAMYCIN PHOSPHATE (TOPICAL) GEL	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) LOTION	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) SOLUTION	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE (TOPICAL) SWAB	CLEOCIN-T						
CLINDAMYCIN PHOSPHATE-BENZOYL PEROXIDE (REFRIGERATE)	CLINDAMY/BEN						
ERYTHROMYCIN ACNE GEL	VARIOIUS	NDCs: 45802096694, 45802096696, 63739005366, 63739005368					
ERYTHROMYCIN (ACNE AID) SOLUTION	ERYTHROMYCIN						
ISOTRETINOIN CAPSULES	ABSORICA			PA REQUIRED			
TRETINOIN CREAM	VARIOIUS			PA REQUIRED For > 26 Years of Age			
TRETINOIN GEL	VARIOIUS			PA REQUIRED For > 26 Years of Age			
ANTIBIOTICS - TOPICAL							
BACITRACIN OINTMENT	BACIGUENT						
BACITRACIN ZINC OINTMENT	BACITRACIN						
BACITRACIN-POLYMYXIN B OINTMENT	POLYSPORIN						
BACITRACIN-POLYMYXIN-NEOMYCIN HC OINTMENT	CORTISPORIN						
GENTAMICIN SULFATE CREAM	GENTAMICIN SULFATE						
GENTAMICIN SULFATE OINTMENT	GENTAMICIN SULFATE						
MUPIROCIN CALCIUM CREAM	BACTROBAN						
MUPIROCIN OINTMENT	BACTROBAN						
NEOMYCIN-BACITRACIN-POLYMYXIN OINTMENT	NEOSPORIN						
ANTIFUNGALS - TOPICAL							
BUTENAFINE	LOTRIMIN ULTRA						
CICLOPROX CREAM	VARIOUS		**PREFERRED DRUG**				
CICLOPROX SOLUTION	VARIOUS		**PREFERRED DRUG**				
CLOTRIMAZOLE CREAM (RX & OTC)	LOTRIMIN		**PREFERRED DRUG**				
CLOTRIMAZOLE OINTMENT	LOTRIMIN						
CLOTRIMAZOLE W/ BETAMETHASONE CREAM	LOTRISONE		**PREFERRED DRUG**				
KETOCONAZOLE CREAM	VARIOUS		**PREFERRED DRUG**				
KETOCONAZOLE SHAMPOO	VARIOUS		**PREFERRED DRUG**				
MICONAZOLE NITRATE CREAM	VARIOUS		**PREFERRED DRUG**				
MICONAZOLE NITRATE POWDER	VARIOUS		**PREFERRED DRUG**				
NYSTATIN CREAM	VARIOUS		**PREFERRED DRUG**				
NYSTATIN OINTMENT	VARIOUS		**PREFERRED DRUG**				
NYSTATIN POWDER	VARIOUS		**PREFERRED DRUG**				
TOLNAFTATE AERO POWDER	VARIOUS		**PREFERRED DRUG**				
TOLNAFTATE CREAM	VARIOUS		**PREFERRED DRUG**				
TOLNAFTATE POWDER	VARIOUS		**PREFERRED DRUG**				

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TERBINAFINE CREAM	VARIOUS		**PREFERRED DRUG**				
ANTIHISTAMINES-TOPICAL							
DIPHENHYDRAMINE HCL CREAM	ANTI-ITCH MAXIMUM STRENGTH						
DIPHENHYDRAMINE HCL GEL	BENADRYL ITCH STOPPING						
DIPHENHYDRAMINE HCL SOLUTION	BENADRYL MAXIMUM STRENGTH						
ANTI-INFLAMMATORY AGENTS - TOPICAL**							
DICLOFENAC SODIUM (TOPICAL) SOLUTION (1.5%)	DICLOFENAC SODIUM						
ANTISEBORRHEIC TOPICAL PRODUCTS							
SELENIUM SULFIDE LOTION	SELSUN SHAMPOO						
ANTIVIRALS - TOPICAL							
ACYCLOVIR TOPICAL CREAM (NON AG)	VARIOUS					15 GM	30
ACYCLOVIR TOPICAL OINTMENT	VARIOUS					15 GM	30
DOCOSANOL CREAM	ABREVA					2 GM	30
BURN PRODUCTS							
SILVER SULFADIAZINE CREAM	SILVADENE						
CORTICOSTEROIDS - TOPICAL LOW POTENCY							
FLUOCINOLONE ACETONIDE	**DERMA-SMOOTH FS**	**BRAND ONLY**	**PREFERRED DRUG**				
FLUOCINOLONE ACETONIDE SOLUTION	SYNALAR						
HYDROCORTISONE CREAM	VARIOUS		PREFERRED DRUG				
HYDROCORTISONE GEL	VARIOUS		PREFERRED DRUG				
HYDROCORTISONE LOTION	VARIOUS		PREFERRED DRUG				
HYDROCORTISONE OINTMENT	VARIOUS		PREFERRED DRUG				
FLUOCINOLONE 0.01% OIL	VARIOUS		PREFERRED DRUG				
CORTICOSTEROIDS - TOPICAL MEDIUM POTENCY							
FLUTICASONE PROPIONATE CREAM	VARIOUS		PREFERRED DRUG				
FLUTICASONE PROPIONATE OINTMENT	VARIOUS		PREFERRED DRUG				
MOMETASONE FUROATE CREAM	VARIOUS		PREFERRED DRUG				
MOMETASONE FUROATE OINTMENT	VARIOUS		PREFERRED DRUG				
MOMETASONE FUROATE SOLUTION	VARIOUS		PREFERRED DRUG				
CORTICOSTEROIDS - TOPICAL HIGH POTENCY							
BETAMETHASONE DIPROPIONATE LOTION	VARIOUS		PREFERRED DRUG				
BETAMETHASONE DIPROPIONATE CREAM	VARIOUS		PREFERRED DRUG				
BETAMETHASONE DIPROPIONATE/PROPYLENE GLYC. CREAM	VARIOUS		PREFERRED DRUG				
BETAMETHASONE DIPROPIONATE (TOPICAL) OINTMENT	VARIOIUS		PREFERRED DRUG				
BETAMETHASONE VALERATE CREAM	VARIOUS		PREFERRED DRUG				
BETAMETHASONE VALERATE LOTION	VARIOUS		PREFERRED DRUG				
BETAMETHASONE VALERATE SOLUTION	VARIOUS		PREFERRED DRUG				
FLUOCINONIDE CREAM	VARIOUS		PREFERRED DRUG				
FLUOCINONIDE OINTMENT	VARIOUS		PREFERRED DRUG				
FLUOCINONIDE SOLUTION	VARIOUS		PREFERRED DRUG				
TRIAMCINOLONE ACETONIDE CREAM	VARIOUS		PREFERRED DRUG				
TRIAMCINOLONE ACETONIDE LOTION	VARIOUS		PREFERRED DRUG				
TRIAMCINOLONE ACETONIDE OINTMENT	VARIOUS		PREFERRED DRUG				
CORTICOSTEROIDS - TOPICAL VERY HIGH POTENCY							
CLOBETASOL PROPIONATE CREAM	VARIOUS		PREFERRED DRUG			100	30
CLOBETASOL PROPIONATE EMOLLIENT	VARIOUS		PREFERRED DRUG			100	30
CLOBETASOL PROPIONATE GEL	VARIOUS		PREFERRED DRUG			118	30
CLOBETASOL PROPIONATE OINTMENT	VARIOUS		PREFERRED DRUG			100	30
CLOBETASOL PROPIONATE SHAMPOO	VARIOUS		PREFERRED DRUG			120	30
CLOBETASOL PROPIONATE SOLUTION	VARIOUS		PREFERRED DRUG			100	30
HALOBETASOL PROPIONATE CREAM	VARIOUS		PREFERRED DRUG			100	30
HALOBETASOL PROPIONATE OINTMENT	VARIOUS		PREFERRED DRUG			100	30
STEROIDS - MOUTH/THROAT/DENTAL**							
TRIAMCINOLONE ACETONIDE (MOUTH) PASTE	ORALONE DENTAL PASTE					10	30
ECZEMA AGENTS							
DUPILUMAB SOLN AUTO-INJ	DUPIXENT			PA REQUIRED			
DUPILUMAB SOLN PREF SYR	DUPIXENT			PA REQUIRED			
RUXOLITINIB PHOSPHATE (TOPICAL) CREAM	OPZELURA		PREFERRED DRUG	PA REQUIRED		60 GM	30
TAPINAROF CREAM	**VTAMA**	**BRAND ONLY**		**PA REQUIRED**		**60 GM**	**30**
TRALOKINUMAB-LDRM SOLN AUTO-INJ	ADBRY		PREFERRED DRUG	PA REQUIRED			
TRALOKINUMAB-LDRM SOLN PREF SYR	ADBRY		PREFERRED DRUG	PA REQUIRED			
ENZYMES - TOPICAL							
TACROLIMUS (TOPICAL) OINTMENT	PROTOPIC		PREFERRED DRUG	PA REQUIRED			
IMMUNOSUPPRESSIVE AGENTS - TOPICAL							
PIMECROLIMUS CREAM	VARIOUS			PA REQUIRED		60 GM	30
PIMECROLIMUS CREAM	VARIOUS		PREFERRED DRUG			60 GM	30
KERATOLYTIC/ANTIMITOTIC AGENTS							
SALICYLIC ACID CREAM	SALACYN						

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SALICYLIC ACID FOAM	SALVAX						
SALICYLIC ACID GEL	KERALYT						
SALICYLIC ACID LIQUID	VIRASAL						
SALICYLIC ACID LOTION	SALACYN						
SALICYLIC ACID SHAMPOO	SALEX						
SALICYLIC ACID SOLUTION	VARIOUS						
LOCAL ANESTHETICS - TOPICAL							
CAPSAICIN CREAM	ZOSTRIX NATURAL PAIN RELIEF						
LIDOCAINE HCL AEROSOL SOLUTION	BURN RELIEF						
LIDOCAINE HCL CREAM	ASPERCREME W/LIDOCAINE					267 GM	30
LIDOCAINE HCL GEL	LIDOMAX						
LIDOCAINE HCL LOTION	LIDO-SORB			PA REQUIRED (3% Only)			
LIDOCAINE HCL OINTMENT	ASPERFLEX LIDOCAINE						
LIDOCAINE HCL SOLUTION	MEDI-FIRST BURN SPRAY						
LIDOCAINE PATCH	ZTLIDO			PA REQUIRED (1.8% & 3.5% Only)		60	30
LIDOCAINE-PRILOCAINE CREAM	LIDOCAINE/PRILOCAINE					30 GM	30
TOPICAL - MISC.							
ALUMINUM CHLORIDE SOLUTION	DRYSOL						
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL							
CRISABOROLE OINTMENT	EUCRISA		**PREFERRED DRUG**	PA REQUIRED			
ROFLUMILAST (TOPICAL) CREAM	ZORYVE		PREFERRED DRUG	PA Required		60GM	30
ROSACEA TOPICAL AGENTS							
METRONIDAZOLE CREAM 0.75%	METROCREAM						
METRONIDAZOLE GEL 0.75%	METROGEL						
METRONIDAZOLE LOTION	METROLOTION						
SCABICIDES & PEDICULICIDES TOPICAl AGENTS+A1106							
CROTAMITON CREAM	EURAX						
CROTAMITON LOTION	EURAX						
IVERMECTIN LOTION	SKLICE			PA REQUIRED			
PERMETHRIN CREAM	ACTICIN						
PERMETHRIN 1%, 5%	NIX, ELIMITE						
PERMETHRIN LIQUID	NIX CREME RINSE						
PYRETHRINS-PIPERONYL BUTOXIDE GEL	A-200						
PYRETHRINS-PIPERONYL BUTOXIDE LIQUID	BARC						
PYRETHRINS-PIPERONYL BUTOXIDE SHAMPOO	LICIDE						
SPINOSAD SUSPENSION	NATROBA			PA REQUIRED			
DIAGNOSTIC PRODUCTS							
DIAGNOSTIC TESTS							
BLOOD GLUCOSE MONITORS & STRIPS	VARIOUS						
DIGESTIVE AIDS							
DIGESTIVE ENZYMES							
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE	**CREON**	**BRAND ONLY**	**PREFERRED DRUG**			500	30
LIPASE-PROTEASE-AMYLASE CAPSULE DELAYED RELEASE	**ZENPEP**	**BRAND ONLY**	**PREFERRED DRUG**			500	30
DIURETICS							
CARBONIC ANHYDRASE INHIBITORS							
ACETAZOLAMIDE CAPSULE 12-HOUR	DIAMOX						
ACETAZOLAMIDE TABLETS	ACETAZOLAMIDE						
METHAZOLAMIDE TABLETS	VARIOUS						
DIURETIC COMBINATIONS							
SPIRONOLACTONE & HYDROCHLOROTHIAZIDE TABLETS	ALDACTAZIDE						
TRIAMTERENE & HYDROCHLOROTHIAZIDE CAPSULES	DYAZIDE						
TRIAMTERENE & HYDROCHLOROTHIAZIDE TABLETS	MAXZIDE-25						
LOOP DIURETICS							
BUMETANIDE TABLETS	BUMETANIDE						
FUROSEMIDE SOLUTION	FUROSEMIDE						
FUROSEMIDE TABLETS	LASIX						
TORSEMIDE TABLETS	DEMADEX						
POTASSIUM SPARING DIURETICS							
SPIRONOLACTONE TABLETS	ALDACTONE						
THIAZIDES AND THIAZIDE-LIKE DIURETICS							
CHLOROTHIAZIDE SUSPENSION	DIURIL						
CHLOROTHIAZIDE TABLETS	CHLOROTHIAZIDE						
CHLORTHALIDONE TABLETS	CHLORTHALIDONE						
HYDROCHLOROTHIAZIDE CAPSULES 12.5MG	VARIOUS						
HYDROCHLOROTHIAZIDE TABLETS 25MG & 50MG	HYDROCHLOROTHIAZIDE						
INDAPAMIDE TABLETS	INDAPAMIDE						

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
METOLAZONE TABLETS	ZAROXOLYN						
ENDOCRINE AND METABOLIC AGENTS - MISC.							
BONE DENSITY REGULATORS							
ALENDRONATE SODIUM SOLUTION	ALENDRONATE SODIUM						
ALENDRONATE SODIUM TABLETS	ALENDRONATE SODIUM						
CALCITONIN (SALMON) SOLUTION	FORTICAL						
DENOSUMAB-NXXP SOLN PREF SYR	BILDYOS			PA REQUIRED			
IBANDRONATE SODIUM	BONIVA						
RALOXIFENE TABLETS	VARIOUS						
TERIPARATIDE (RECOMBINANT)	**FORTEO**	**BRAND ONLY**		PA REQUIRED			
GROWTH HORMONES							
SOMAPACITAN-BECO SOLN PEN-INJ	SOGROYA			PA REQUIRED			
SOMATROPIN CARTRIDGE	GENOTROPIN	**BRAND ONLY**	PREFERRED DRUG	PA Required			
SOMATROPIN SOLN PEN-INJ	NORDITROPIN FLEXPRO		**PREFERRED DRUG**	PA REQUIRED			
SOMATROPIN PREFILLED SYR	GENOTROPIN MINIQUICK	**BRAND ONLY**	**PREFERRED DRUG**	PA REQUIRED			
GNRH/LHRH ANTAGONISTS**							
ENDOCRINE AND METABOLIC AGENTS - MISC.*	ORILISSA			PA REQUIRED			
HORMONE RECEPTOR MODULATORS							
RALOXIFENE HCL TABLETS	EVISTA						
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)							
MECASERMIN SOLUTION	INCRELEX			PA REQUIRED			
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS							
LEUPROLIDE ACETATE (CPP) (6 MONTH) KIT	FENSOLVI			PA REQUIRED			
LEUPROLIDE ACETATE (3 MONTH) INJECTABLE	ELIGARD			PA REQUIRED			
LEUPROLIDE ACETATE (3 MONTH) KIT	LEUPROLIDE			PA REQUIRED			
LEUPROLIDE ACETATE (4 MONTH) KIT	ELIGARD			PA REQUIRED			
LEUPROLIDE ACETATE (6 MONTH) KIT	ELIGARD			PA REQUIRED			
LEUPROLIDE ACETATE (CPP) KIT	LUPRON DEPOT-PED (1-MONTH)			PA REQUIRED			
METABOLIC MODIFIERS							
TIVIDENOFUSP ALFA-EKNM SOLUTION RECONSTITUTED	AVLAYAH			PA REQUIRED			
CALCITRIOL CAPSULE	ROCALTROL						
CALCITRIOL SOLUTION	ROCALTROL						
CINACALCET HCL TABLET	SENSIPAR						
GLYCEROL PHENYLBUTYRATE LIQUID	RAVICTI	BRAND ONLY		PA REQUIRED			
IDURSULFASE SOLUTION	ELAPRASE			PA REQUIRED			
LEVOCARNITINE (METABOLIC MODIFIERS) SOLUTION	CARNITOR						
LEVOCARNITINE (METABOLIC MODIFIERS) TABLET	CARNITOR						
SODIUM PHENYLBUTYRATE TABLET	BUPHENYL			PA REQUIRED			
SODIUM PHENYLBUTYRATE POWDER	BUPHENYL			PA REQUIRED			
POSTERIOR PITUITARY HORMONES							
DESMOPRESSIN ACETATE REFRIGERATED SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SPRAY REFRIGERATED SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE SPRAY SOLUTION	VARIOUS						
DESMOPRESSIN ACETATE TABLETS	VARIOUS			PA REQUIRED			
ESTROGENS							
ESTROGEN COMBINATIONS							
CONJUGATED ESTROGENS-MEDROXYPROGESTERONE ACETATE TABLET	PREMPRO						
ELAGOLIX SODIUM-ESTRADIOL-NORETHINDRONE ACETATE CAP THER PACK	ORIAHNN			PA REQUIRED			
ESTERIFIED ESTROGENS & METHYLTESTOSTERONE TABLET	COVARYX HS						
ESTRADIOL & NORETHINDRONE ACETATE PATCH TWICE WEEKLY	COMBIPATCH						
ESTRADIOL & NORETHINDRONE ACETATE TABLET	AMABELZ						
ESTRADIOL-LEVONORGESTREL PATCH WEEKLY	CLIMARA PRO						
NORETHINDRONE ACETATE-ETHINYL ESTRADIOL TABLET	FYAVOLV						
RELUGOLIX-ESTRADIOL-NORETHINDRONE ACETATE TABLET	MYFEMBREE			PA REQUIRED			
ESTROGENS							
ESTERIFIED ESTROGENS TABLETS	MENEST						
ESTRADIOL PATCH-TWICE WEEKLY	ALORA						
ESTRADIOL PATCH-WEEKLY	MENOSTAR						
ESTRADIOL TABLETS	ESTRACE						
ESTROGENS, CONJUGATED SYNTHETIC A TABLETS	CENESTIN						

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Drug Class/Drug Name	Reference Brand Name	Brand Only/Generic Notes	Preferred Drug Status	PA Status	Step Therapy Requirements	Quantity Limit (QL)	QL Days
ESTROGENS, CONJUGATED TABLET	PREMARIN	BRAND ONLY					
ESTROPIPATE TABLETS	ORTHO-EST						
FLUOROQUINOLONES							
FLUOROQUINOLONES							
CIPROFLOXACIN HCL TABLETS	CIPROFLOXACIN HCL						
LEVOFLOXACIN SOLUTION	LEVAQUIN						
LEVOFLOXACIN TABLETS	LEVAQUIN						
OFLOXACIN TABLETS	OFLOXACIN						
GASTROINTMENTESTINAL AGENTS - MISC.							
5-HT4 RECEPTOR AGONISTS**							
PRUCALOPRIDE SUCCINATE TABLET	MOTEGRITY						
GALLSTONE SOLUBILIZING AGENTS							
URSODIOL CAPSULES	ACTIGALL						
URSODIOL TABLETS	URSO 250						
GASTROINTMENTESTINAL CHLORIDE CHANNEL ACTIVATORS							
LUBIPROSTONE CAPSULE	AMITIZA					180	90
GASTROINTMENTESTINAL STIMULANTS							
METOCLOPRAMIDE HCL SOLUTION	VARIOUS						
METOCLOPRAMIDE HCL TABLETS	VARIOUS						
METOCLOPRAMIDE HCL ORALLY DISINTEGRATING TABLETS	VARIOUS						
INFLAMMATORY BOWEL AGENTS							
INFLIXIMAB SOLUTION RECONSTITUTED	REMICADE (AG)	**JANSSEN PHARMACUETICALS' AUTHORIZED BIOSIMILIAR ONLY**	PREFERRED DRUG	PA REQUIRED			
MESALAMINE CAPSULE CONTROLLED RELEASE	**PENTASA**	**BRAND ONLY**	PREFERRED DRUG			270	30
MESALAMINE CAPSULE DELAYED RELEASE CAPSULE	**DELZICOL**	**BRAND ONLY**	PREFERRED DRUG			180	30
MESALAMINE CAPSULE 24-HOUR	VARIOUS		PREFERRED DRUG			120	30
MESALAMINE ENEMA	**SFROWASA**	**BRAND ONLY**	PREFERRED DRUG			30	30
MESALAMINE TABLET ENTERIC COATED	VARIOIUS		PREFERRED DRUG			120	30
SULFASALAZINE TABLETS	VARIOUS		PREFERRED DRUG			240	30
SULFASALAZINE TABLET ENTERIC COATED DELAYED RELEASE	AZULFIDINE EN-TABLETS	AUTHORIZED GENERIC ONLY	PREFERRED DRUG			240	30
USTEKINUMAB-HMNY SOLUTION	STARJEMZA			PA REQUIRED			
USTEKINUMAB-HMNY SOLN PREF SYR	STARJEMZA			PA REQUIRED			
IRRITABLE BOWEL SYNDROME (IBS) AGENTS							
LINACLOTIDE CAPSULES	LINZESS			PA REQUIRED			
PHOSPHATE BINDER AGENTS							
CALCIUM ACETATE (PHOSPHATE BINDER) CAPSULE	CALCIUM ACETATE		PREFERRED DRUG				
CALCIUM ACETATE (PHOSPHATE BINDER) TABLET	CALPHRON		PREFERRED DRUG				
FERRIC CITRATE TABLET	AURYXIA		PREFERRED DRUG	PA REQUIRED			
LANTHANUM CARBONATE TABLET CHEWABLE	FOSRENOL		PREFERRED DRUG				
SEVELAMER CARBONATE TABLETS	RENVELA	VARIOUS	PREFERRED DRUG				
GENITOURINARY AGENTS - MISC.							
INTERSTITIAL CYSTITIS AGENTS							
PENTOSAN POLYSULFATE SODIUM CAPSULES	ELMIRON			PA REQUIRED			
PROSTATIC HYPERTROPHY AGENTS							
ALFUZOSIN ER	VARIOUS		PREFERRED DRUG				
DOXAZOSIN MESYLATE	VARIOUS		PREFERRED DRUG				
DUTASTERIDE	VARIOUS		PREFERRED DRUG				
FINASTERIDE	PROSCAR		PREFERRED DRUG				
TAMSULOSIN HCL	FLOMAX		PREFERRED DRUG				
TERAZOSIN	VARIOUS		PREFERRED DRUG				
URINARY ANALGESICS							
PHENAZOPYRIDINE HCL TABLETS	PYRIDIUM						
GOUT AGENTS							
GOUT AGENTS							
ALLOPURINOL TABLETS	ZYLOPRIM						
COLCHICINE TABLETS	VARIOUS						
FEBUXOSTAT TABLETS	ULORIC			PA REQUIRED			
URICOSURICS							
PROBENECID TABLETS	PROBENECID						
HEMATOLOGICAL AGENTS - MISC.							
PLATELET AGGREGATION INHIBITORS							
CILOSTAZOL TABLETS	PLETAL						
CLOPIDOGREL BISULFATE TABLETS	PLAVIX						
DIPYRIDAMOLE TABLETS	PERSANTINE	**BRAND ONLY**					
TICAGRELOR TABLETS	**BRILINTA**	**BRAND ONLY**					
HEMATOPOIETIC AGENTS							
AGENTS FOR GAUCHER DISEASE							

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TALIGLUCERASE ALFA	**ELELYSO (IV)**	**BRAND ONLY**		PA REQUIRED			
MIGLUSTAT(AG) ORAL	MIGLUSTAT (ORAL)	AUTHORIZED GENERIC ONLY		PA REQUIRED			
HEMATOPOIETIC GROWTH FACTORS							
ELTROMBOPAG OLAMINE TABLET	VARIOUS		PREFERRED DRUG	PA REQUIRED			
ELTROMBOPAG OLAMINE TABLET	**PROMACTA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
EPOETIN ALFA SOLUTION	**EPOGEN**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
EPOETIN ALFA-EPBX SOLUTION	**RETACRIT**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
FILGRASTIM-AAFI SOLUTION	**NIVESTYM**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
FILGRASTIM-AAFI SOLN PREF SYR	**NIVESTYM**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
FILGRASTIM-AYOW	**RELEUKO**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
PEGFILGRASTIM-JMDB SOLN PREF SYR	**FULPHILA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
PEGFILGRASTIM-PBBK SOLN PREF SYR	**FYLNETRA**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
ROMIPLOSTIM SOLUTION RECONSTITUTED	**NPLATE**	**BRAND ONLY**	**PREFERRED DRUG**	**PA REQUIRED**			
AGENTS FOR SICKLE CELL DISEASE**							
HYDROXYUREA (SICKLE CELL DISEASE) SOLUTION	XROMI			PA Required > 10 Years of Age			
HEMOSTATICS							
HEMOSTATICS - SYSTEMIC							
AMINOCAPROIC ACID SYRUP	AMICAR						
AMINOCAPROIC ACID TABLETS	AMICAR						
HEREDITARY ANGIOEDEMA AGENTS							
ICATIBANT ACETATE SOLUTION	VARIOUS		PREFERRED DRUG	PA REQUIRED			
C1 ESTERASE INHIBITOR (HUMAN) SOLUTION	**BERINERT**	**BRAND ONLY**	**PREFERRED DRUG**	PA REQUIRED			
C1 ESTERASE INHIBITOR (HUMAN) SOLUTION RECONSTITUTED	**CINRYZE/HAEGARDA**	**BRAND ONLY**		**PA REQUIRED**			
ECALLANTIDE SOLUTION	KALBITOR		PREFERRED DRUG	PA REQUIRED			
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENT							
BARBITURATE HYPNOTICS							
PHENOBARBITAL SOLUTION	PHENOBARBITAL						
PHENOBARBITAL TABLETS	PHENOBARBITAL						
NON-BARBITURATE HYPNOTICS							
ESZOPICLONE	LUNESTA	VARIOUS	PREFERRED DRUG	PA REQUIRED for Ages <6 years PA REQUIRED for > 1 Hypnotic Drug		30	30
TEMAZEPAM CAPSULES 15MG & 30MG	RESTORIL		PREFERRED DRUG	PA REQUIRED for Ages <6 years PA REQUIRED for > 1 Hypnotic Drug		30	30
ZOLPIDEM TARTRATE TABLETS 5MG	AMBIEN		PREFERRED DRUG	PA REQUIRED for Ages <6 years PA REQUIRED for > 1 Hypnotic Drug		60	30
ZOLPIDEM TARTRATE TABLETS 10MG	AMBIEN		PREFERRED DRUG	PA REQUIRED for Ages <6 years PA REQUIRED for > 1 Hypnotic Drug		30	30
ZOLPIDEM TARTRATE TABLET ER	AMBIEN CR		PREFERRED DRUG	PA Required for Ages <6 years PA Required for > 1 Hypnotic Drug		30	30
SELECTIVE MELATONIN RECEPTOR AGONISTS							
RAMELTEON TABLET	ROZEREM				Patient must have tried two preferred agents (Temazepam, Zolpidem and Eszopiclone)	30	30
LAXATIVES							
LAXATIVE COMBINATIONS							
PEG 3350-KCL-SOD BICARB-SOD CHLORIDE-SOD SULFATE SOLUTION	COLYTE						
LAXATIVES - MISC.							
LACTULOSE SOLUTION	LACTULOSE						
MACROLIDES							
AZITHROMYCIN							
AZITHROMYCIN PACKETS	ZITHROMAX						
AZITHROMYCIN SUSPENSION	ZITHROMAX						
AZITHROMYCIN TABLETS	ZITHROMAX						
CLARITHROMYCIN							
CLARITHROMYCIN SUSPENSION	CLARITHROMYCIN						
CLARITHROMYCIN TABLETS	BIAXIN						
CLARITHROMYCIN TABLET 24-HOUR	BIAXIN XL						
FIDAXOMICIN**							
FIDAXOMICIN TABLET	**DIFICID**	**BRAND ONLY**		**PA Required**			
MEDICAL DEVICES							
CONTRACEPTIVES							
CONDOMS - FEMALE MISC.	FC FEMALE CONDOM						
CONDOMS - MALE MISC.	LIFESTYLES ASSORTED COLORS						
DIAPHRAGM ARC-SPRING DPRH	CAYA						
DIAPHRAGM COIL SPRING KIT	ORTHO DIAPHRAGM COIL SPRING KIT 50						
DIAPHRAGM FLAT SPRING KIT	ORTHO DIAPHRAGM FLAT SPRING KIT 55						
DIAPHRAGM WIDE SEAL DPRH	WIDE-SEAL SILICONE DIAPHRAGM KIT 60						
DIAPHRAGMS - OTHER+A1294	OMNIFLEX DIAPHRAGM						
DIABETIC SUPPLIES							

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BLOOD GLUCOSE MONITORING KIT W/ DEVICE	VARIOUS						
BLOOD GLUCOSE MONITORING DEVICES	VARIOUS						
LANCET DEVICES MISC.	VARIOUS						
LANCETS MISC.	VARIOUS						
DEVICES - MISC.							
ALCOHOL SWABS PADS	ALCOH-GLOVE CONTOURED WIPE						
RESPIRATORY THERAPY SUPPLIES							
SPACER/AEROSOL-HOLDING CHAMBER SUPPLIES - MASKS	MASK VORTEX/BABY WHIRL DUCKLING					2	365
SPACER/AEROSOL-HOLDING CHAMBERS DEVICE	AEROCHAMBER/MINI AEROCHAMBER					2	365
MIGRAINE PRODUCTS							
MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES							
DIHYDROERGOTAMINE MESYLATE SOLUTION	VARIOUS					2	30
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONIST							
DIHYDROERGOTAMINE MESYLATE SOLUTION	**MIGRANAL**						
ERENUMAB-AOOE SOLN AUTO-INJ	**AMOVIG**		**PREFERRED DRUG**	**PA REQUIRED**		**3**	**90**
FREMANEZUMAB-VFRM SOLN AUTO-INJ	**AJOVY**		**PREFERRED DRUG**	**PA REQUIRED**			
FREMANEZUMAB-VFRM SOLN PREF SYR	**AJOVY**		**PREFERRED DRUG**	**PA REQUIRED**			
GALCANEZUMAB-GNLM SOLN AUTO-INJ	**EMGALITY**		**PREFERRED DRUG**	**PA REQUIRED**			
GALCANEZUMAB-GNLM SOLN PREF SYR	**EMGALITY**		**PREFERRED DRUG**	**PA REQUIRED**			
UBROGEPANT TABLET	**UBRELVY**		**PREFERRED DRUG**	**PA REQUIRED**		**10**	**30**
MIGRAINE COMBINATIONS**							
ERGOTAMINE W/ CAFFEINE TABLET	CAFERGOT					40	30
SEROTONIN AGONISTS							
ELETRIPTAN HYDROBROMIDE TABLET	RELPAX					9	30
NARATRIPTAN HCL TABLETS	AMERGE		PREFERRED DRUG			9	30
RIZATRIPTAN BENZOATE ORALLY DISPERSABLE TABLET	MAXALT-MLT		PREFERRED DRUG			9	30
RIZATRIPTAN BENZOATE TABLETS	MAXALT		PREFERRED DRUG			9	30
SUMATRIPTAN NASAL SPRAY	VARIOIUS		PREFERRED DRUG			6	30
SUMATRIPTAN SUCCINATE SUBCUTANEOUS SOLUTION AUTO INJECTION	IMITREX		PREFERRED DRUG			2	30
SUMATRIPTAN SUCCINATE SUBCUTANEOUS SOLUTION CARTRIDGE	IMITREX		PREFERRED DRUG			2	30
SUMATRIPTAN SUCCINATE TABLETS	IMITREX		PREFERRED DRUG			9	30
ZOLMITRIPTAN ORALLY DISPERSABLE TABLET	ZOMIG ZMT		PREFERRED DRUG			9	30
ZOLMITRIPTAN TABLETS	ZOMIG		PREFERRED DRUG			9	30
MINERALS & ELECTROLYTES							
SODIUM FLUORIDE CHEWABLE TABLETS	LUDENT						
SODIUM FLUORIDE LOZG	LOZI-FLUR						
SODIUM FLUORIDE SOLUTION	FLUOR-A-DAY						
SODIUM FLUORIDE TABLETS	SODIUM FLUORIDE						
MOUTH/THROAT/DENTAL AGENTS							
ANTI-INFECTIVES - THROAT							
CLOTRIMAZOLE TROC	CLOTRIMAZOLE						
STEROIDS - MOUTH/THROAT							
TRIAMCINOLONE ACETONIDE ORAL PASTE	ORALONE						
MULTIVITAMINS							
PRENATAL VITAMINS							
PRENATAL MULTIVITAMINS WITH OR WITHOUT MINERALS W/ FOLATE	VARIOUS						
PRENATAL MULTIVITAMINES WITH MINERAL W/FE-FA	VARIOUS						
MUSCULOSKELETAL THERAPY AGENTS							
CENTRAL MUSCLE RELAXANTS							
BACLOFEN TABLET (5MG, 10MG, 20MG)	BACLOFEN						
CYCLOBENZAPRINE HCL TABLETS 5MG & 10MG	FLEXERIL			PA REQUIRED for dosages other than 5mg and 10mg tablets			
METHOCARBAMOL TABLETS	ROBAXIN						
TIZANIDINE HCL TABLETS - 2MG & 4MG ONLY	TIZANIDINE HCL						
DIRECT MUSCLE RELAXANTS							
DANTROLENE SODIUM CAPSULES	DANTRIUM						
NASAL AGENTS - SYSTEMIC AND TOPICAL							
NASAL ANTIALLERGY							
AZELASTINE HCL SOLUTION 0.10%	ASTELIN						
NASAL ANTICHOLINERGICS							
IPRATROPIUM BROMIDE SOLUTION	ATROVENT						
NASAL STEROIDS							
FLUTICASONE PROPIONATE SUSPENSION	FLONASE						
SYMPATHOMIMETIC DECONGESTANTS							
PSEUDOEPHEDRINE HCL LIQUID	SUDAFED CHILDRENS						

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PSEUDOEPHEDRINE HCL SYRUP	PSEUDOEPHEDRINE						
PSEUDOEPHEDRINE HCL TABLETS	SUDAFED						
PSEUDOEPHEDRINE HCL TABLET 12-HOUR	NASAL DECONGESTANT						
PSEUDOEPHEDRINE HCL TABLET 24-HOUR	SUDAFED 24 HOUR						
NEUROMUSCULAR AGENTS*							
FRIEDRICH'S ATAXIA AGENTS**							
OMAVELOXOLONE CAPSULE	SKYCLARYS			PA REQUIRED			
OPHTHALMIC AGENTS							
OPHTHALMIC - BETA-BLOCKERS							
DORZOLAMIDE HCL-TIMOLOL MALEATE SOLUTION (EXCLUDES PRESERVATIVE FREE)	COSOPT						
METIPRANOLOL SOLUTION	METIPRANOLOL						
TIMOLOL MALEATE SOLUTION	TIMOPTIC-XE						
TIMOLOL MALEATE (OPHTH) SOLUTION (EXCLUDES PRESERVATIVE FREE AND ONCE-DAILY)	TIMOPTIC						
OPHTHALMIC - CYCLOPLEGIC MYDRIATICS							
ATROPINE SULFATE OINTMENT	ATROPINE SULFATE						
ATROPINE SULFATE SOLUTION	ISOPTO ATROPINE						
CYCLOPENTOLATE HCL SOLUTION	CYCLOGYL						
HOMATROPINE HBR SOLUTION	ISOPTO HOMATROPINE						
OPHTHALMIC - MIOTICS							
PILOCARPINE HCL GEL	PILOPINE HS						
OPHTHALMIC ADRENERGIC AGENTS**							
BRIMONIDINE TARTRATE SOLUTION (0.025%, 0.2%)	LUMIFY						
OPHTHALMIC - ANTI-INFECTIVES							
BACITRACIN OINTMENT	BACITRACIN					3.5GM	7
BACITRACIN-POLYMYXIN B OINTMENT	POLYCIN						
CIPROFLOXACIN HCL OINTMENT	CILOXAN						
CIPROFLOXACIN HCL SOLUTION	CILOXAN						
ERYTHROMYCIN OINTMENT	ILOTYCIN						
GENTAMICIN SULFATE OINTMENT	GARAMYCIN						
GENTAMICIN SULFATE SOLUTION	GARAMYCIN						
MOXIFLOXACIN HCL SOLUTION	VIGAMOX						
NATAMYCIN SUSPENSION	NATACYN						
NEOMYCIN-BACITRACIN ZN-POLYMYXIN OINTMENT	NEO-POLYCIN						
NEOMYCIN-POLYMYXIN-GRAMICIDIN SOLUTION	NEOSPORIN						
OFLOXACIN SOLUTION	OCUFLOX						
POLYMYXIN B-TRIMETHOPRIM SOLUTION	POLYTRIM						
SULFACETAMIDE SODIUM OINTMENT	SULFACETAMIDE SODIUM						
SULFACETAMIDE SODIUM SOLUTION	BLEPH-10						
TOBRAMYCIN OINTMENT	TOBREX					3.5GM	7
TOBRAMYCIN SOLUTION	TOBREX						
TRIFLURIDINE SOLUTION	VIROPTIC						
OPHTHALMIC - DECONGESTANTS							
NAPHAZOLINE HCL SOLUTION	VASOCLEAR						
NAPHAZOLINE W/ PHENIRAMINE SOLUTION	NAPHCON-A						
OPHTHALMIC - IMMUNOMODULATORS							
CYCLOSPORINE EMULSION	RESTASIS						
OPHTHALMIC INTEGRIN ANTAGONISTS**							
LIFITEGRAST SOLUTION	XIIDRA			PA REQUIRED			
OPHTHALMIC - MISCELLANEOUS TOPICALS							
EYELID CLEANSERS FOAM	OCUSOFT						
EYELID CLEANSERS PAD	OCUSOFT						
TEA TREE OIL	VARIOUS						
OPHTHALMIC - STEROIDS							
BACITRACIN-POLY-NEOMYCIN-HC OINTMENT	NEO-POLYCIN HC						
DEXAMETHASONE SUSPENSION	MAXIDEX						
DEXAMETHASONE SODIUM PHOSPHATE SOLUTION	DEXAMETHASONE SODIUM PHOSPHATE						
FLUOROMETHOLONE OINTMENT	FML						
FLUOROMETHOLONE SUSPENSION	FML LIQUIFILM						
GENTAMICIN-PREDNISOLONE ACETATE OINTMENT	PRED-G S.O.P.						
GENTAMICIN-PREDNISOLONE ACETATE SUSPENSION	PRED-G						
NEOMYCIN-POLYMY-DEXAMETH OINTMENT	MAXITROL						
NEOMYCIN-POLYMY-DEXAMETH SUSPENSION	MAXITROL						
PREDNISOLONE ACETATE SUSPENSION	PRED MILD						
PREDNISOLONE SODIUM PHOSPHATE SOLUTION	PREDNISOLONE SODIUM PHOSPHATE						
SULFACETAMIDE SOD-PREDNISOLONE OINTMENT	BLEPHAMIDE S.O.P.						
SULFACETAMIDE SOD-PREDNISOLONE SOLUTION	SULFACETAMIDE SODIUM/PREDNISOLONE SODIUM PHOSPHATE						
SULFACETAMIDE SOD-PREDNISOLONE SUSPENSION	BLEPHAMIDE						

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TOBRAMYCIN-DEXAMETHASONE OINTMENT	TOBRADEX						
TOBRAMYCIN-DEXAMETHASONE SUSPENSION	TOBRADEX ST						
MIOTICS							
PILOCARPINE HCL SOLUTION	PILOCARPINE						
OPHTHALMICS - MISC.							
CROMOLYN SODIUM SOLUTION	CROMOLYN SODIUM						
DICLOFENAC SODIUM SOLUTION	DICLOFENAC SODIUM						
DORZOLAMIDE HCL SOLUTION	TRUSOPT						
FLURBIPROFEN SODIUM SOLUTION	OCUFEN						
KETOROLAC TROMETHAMINE SOLUTION	ACULAR LS						
KETOTIFEN FUMARATE SOLUTION	ALAWAY						
OPHTHALMIC - PROSTAGLANDINS							
BIMATOPROST SOLUTION (0.03%)	BIMATOPROST						
LATANOPROST SOLUTION (EXCLUDES PRESERVATIVE FREE)	XALATAN					8	90
TRAVOPROST SOLUTION	VARIOUS						
OTIC AGENTS							
OTIC AGENTS - MISCELLANEOUS							
ACETIC ACID SOLUTION	ACETIC ACID						
OTIC ANTI-INFECTIVES							
CIPROFLOXACIN HCL (OTIC) SOLUTION	**CETRAXAL**		**PREFERRED DRUG**				
OFLOXACIN (OTIC) SOLUTION	VARIOIUS						
OTIC COMBINATIONS							
CIPROFLOXACIN-HYDROCORTISONE SUSPENSION	CIPRO HC	BRAND ONLY	PREFERRED DRUG				
CIPROFLOXACIN-DEXAMETHASONE	VARIOIUS		PREFERRED DRUG				
NEOMYCIN-POLYMYXIN-HC SOLUTION	CORTISPORIN		PREFERRED DRUG				
NEOMYCIN-POLYMYXIN-HC SUSPENSION	NEO/POLYMYXIN/HC 5-10000-1		PREFERRED DRUG				
OTIC STEROIDS							
FLUOCINOLONE ACETONIDE (OTIC) OIL	VARIOUS						
HYDROCORTISONE W/ACETIC ACID SOLUTION	ACETASOL HC						
OXYTOCICS							
OXYTOCICS							
METHYLERGONOVINE MALEATE TABLETS	METHERGINE						
PASSIVE IMMUNIZING AGENTS							
MONOCLONAL ANTIBODIES							
PALIVIZUMAB SOLUTION	SYNAGIS			PA is not Required for children under the age of 2 years. Note: the prescriber must buy and bill a medical claim for the drug			
PENICILLINS							
AMINOPENICILLINS							
AMOXICILLIN CAPSULES	AMOXICILLIN						
AMOXICILLIN CHEWABLE TABLETS	AMOXICILLIN						
AMOXICILLIN SUSPENSION	AMOXICILLIN						
AMOXICILLIN TABLETS	AMOXICILLIN						
AMPICILLIN CAPSULES	AMPICILLIN						
AMPICILLIN SUSPENSION	AMPICILLIN						
NATURAL PENICILLINS							
PENICILLIN V POTASSIUM SOLUTION	PENICILLIN V POTASSIUM						
PENICILLIN V POTASSIUM TABLETS	PENICILLIN V POTASSIUM						
PENICILLIN COMBINATIONS							
AMOXICILLIN & POT CLAVULANATE CHEWABLE TABLETS	AUGMENTIN						
AMOXICILLIN & POT CLAVULANATE SUSPENSION	AUGMENTIN						
AMOXICILLIN & POT CLAVULANATE TABLET 12-HOUR	AUGMENTIN XR						
PENICILLINASE-RESISTANT PENICILLINS							
DICLOXACILLIN SODIUM CAPSULES	DICLOXACILLIN SODIUM						
PROGESTINS							
PROGESTINS							
MEDROXYPROGESTERONE ACETATE TABLETS	PROVERA						
PROGESTERONE MICRONIZED CAPSULES	PROMETRIUM						
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT							
ANTIDEMENTIA AGENTS							
DONEPEZIL HYDROCHLORIDE TABLETS	ARICEPT			PA REQUIRED			
DONEPEZIL HYDROCHLORIDE ORALLY DISINTEGRATING TABLETS	ARICEPT ODT			PA REQUIRED			
GALANTAMINE HYDROBROMIDE CAPSULE CONTROLLED RELEASE	RAZADYNE ER			PA REQUIRED			
GALANTAMINE HYDROBROMIDE SOLUTION	RAZADYNE			PA REQUIRED			
GALANTAMINE HYDROBROMIDE TABLETS	RAZADYNE			PA REQUIRED			
MEMANTINE HCL SOLUTION	NAMENDA			PA REQUIRED			

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ACUTE - LONG TERM CARE DRUG LIST

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MEMANTINE HCL TABLETS	NAMENDA			PA REQUIRED			
RIVASTIGMINE PATCH	EXELON			PA REQUIRED			
RIVASTIGMINE TARTRATE CAPSULES	EXELON			PA REQUIRED			
RIVASTIGMINE TARTRATE SOLUTION	EXELON			PA REQUIRED			
MOVEMENT DISORDERS							
DEUTETRABENAZINE TABLET	AUSTEDO			PA REQUIRED		60	30
DEUTETRABENAZINE TAB THERAPY PACK	AUSTEDO PATIENT TITRATION KIT			PA REQUIRED		1 kit	28
DEUTETRABENAZINE TABLET ER 24HR	AUSTEDO XR			PA REQUIRED		30	30
DEUTETRABENAZINE TBER THERAPY PACK	AUSTEDO XR PATIENT TITRATION KIT			PA REQUIRED		1 kit	28
TETRABENAZINE TABLET	XENAZINE			PA REQUIRED			
VALBENAZINE TOSYLATE CAPSULE	INGREZZA			PA REQUIRED		30	30
VALBENAZINE TOSYLATE CAPSULE SPRINKLE	INGREZZA			PA REQUIRED		30	30
VALBENAZINE TOSYLATE CAP THER PACK	INGREZZA			PA REQUIRED		1 kit	28
MULTIPLE SCLEROSIS AGENTS							
DIMETHYL FUMARATE CAPSULE DELAYED RELEASE	TECFIDERA			PA REQUIRED			
DALFAMPRIDINE TABLET ER 12HR	AMPYRA			PA REQUIRED			
FINGOLIMOD HCL CAPSULE	GILENYA			PA REQUIRED			
GLATIRAMER ACETATE SOLN PREF SYR	**COPAXONE**		**PREFERRED DRUG**	**PA REQUIRED**			
INTERFERON BETA-1A AUTO-INJECTOR KIT	AVONEX PEN			PA REQUIRED			
INTERFERON BETA-1A PREFILLED SYRINGE KIT	AVONEX			PA REQUIRED			
INTERFERON BETA-1A SOLN AUTO-INJ	REBIF REBIDOSE			PA REQUIRED			
INTERFERON BETA-1A SOLN PREF SYR	REBIF			PA REQUIRED			
NATALIZUMAB CONCENTRATE	TYSABRI			PA REQUIRED			
OFATUMUMAB (MS) SOLN AUTO-INJ	KESIMPTA		**PREFERRED DRUG**	PA REQUIRED			
TERIFLUNOMIDE TABLET	AUBAGIO			PA REQUIRED			
UBLITUXIMAB-XIIY SOLUTION	BRIUMVI			PA Required			
SMOKING DETERRENTS							
BUPROPION HCL (SMOKING DETERRENT) TABLET 12-HOUR	BUPROBAN					84-day supply	180
NICOTINE INHA	NICOTROL INHALER					84-day supply	180
NICOTINE POLACRILEX GUM	NICORETTE GUM					84-day supply	180
NICOTINE POLACRILEX LOZENGE	COMMIT					84-day supply	180
NICOTINE PATCH	NICODERM CQ					84-day supply	180
NICOTINE SOLUTION	NICOTROL NS					84-day supply	180
VARENICLINE TARTRATE TABLETS	CHANTIX					84-day supply	180
RESPIRATORY AGENTS - MISC.							
ALPHA-PROTEINASE INHIBITOR (HUMAN)							
ALPHA1-PROTEINASE INHIBITOR (HUMAN) SOLUTION	ARALAST NP			PA REQUIRED			
ALPHA1-PROTEINASE INHIBITOR (HUMAN) SOLUTION	PROLASTIN-C/GLASSIA			PA REQUIRED			
CYSTIC FIBROSIS AGENTS							
DORNASE ALFA SOLUTION	PULMOZYME			PA REQUIRED			
PULMONARY FIBROSIS AGENTS							
NINTEDANIB ESYLATE CAPSULE (Sandoz MFG Only)	**OFEV**			**PA REQUIRED**			
PIRFENIDONE CAPSULE	**ESBRIET**			**PA REQUIRED**			
SULFONAMIDES							
SULFONAMIDES							
SULFADIAZINE TABLETS	SULFADIAZINE						
TETRACYCLINES							
TETRACYCLINES							
DEMECLOCYCLINE HCL TABLETS	DEMECLOCYCLINE HCL			PA REQUIRED			
DOXYCYCLINE HYCLATE CAPSULES - 50MG AND 100MG CAPSULES ONLY	VARIOUS						
DOXYCYCLINE HYCLATE TABLETS - 20MG AND 100MG TABLETS ONLY	VARIOUS						
DOXYCYCLINE MONOHYDRATE - CAPSULES 50MG & 100MG ONLY	VARIOUS						
MINOCYCLINE HCL SOLUTION RECONSTITUTED	MINOCIN						
THYROID AGENTS							
ANTITHYROID AGENTS							
METHIMAZOLE TABLETS	TAPAZOLE						
PROPYLTHIOURACIL TABLETS	PROPYLTHIOURACIL						
THYROID HORMONES							
LEVOTHYROXINE SODIUM TABLETS	LEVO-T						
LIOTHYRONINE SODIUM TABLETS	CYTOMEL						
THYROID TABLETS	ARMOUR THYROID						
ULCER DRUGS							
ANTISPASMODICS							
DICYCLOMINE HCL CAPSULES	VARIOUS						
DICYCLOMINE HCL SOLUTION	VARIOUS						
DICYCLOMINE HCL TABLET 20mg ONLY	VARIOUS	20MG ONLY					

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GLYCOPYRROLATE SOLUTION	VARIOUS						
GLYCOPYRROLATE TABLETS	VARIOUS						
HYOSCYAMINE SULFATE ELIXIR	VARIOUS						
HYOSCYAMINE SULFATE SOLUTION	VARIOUS						
HYOSCYAMINE SULFATE SUBLINGUAL	VARIOUS						
HYOSCYAMINE SULFATE TABLETS	VARIOUS						
HYOSCYAMINE SULFATE TABLET 12-HOUR	VARIOUS						
HYOSCYAMINE SULFATE CONTROLLED RELEASE TABLET	VARIOUS						
HYOSCYAMINE SULFATE ORALLY DISINTEGRATING TABLETS	VARIOUS						
PROPANTHELINE BROMIDE TABLETS	VARIOUS						
H-2 ANTAGONISTS							
FAMOTIDINE CHEWABLE TABLETS	PEPCID AC						
FAMOTIDINE SUSPENSION	PEPCID						
FAMOTIDINE TABLETS	PEPCID AC						
RANITIDINE HCL CAPSULES	RANITIDINE HCL						
RANITIDINE HCL SUSPENSION	DEPRIZINE FUSEPAQ						
RANITIDINE HCL SYRUP	ZANTAC						
RANITIDINE HCL TABLETS	ZANTAC 75						
ANTI-ULCER - MISC.							
SUCRALFATE TABLETS	CARAFATE						
PROTON PUMP INHIBITORS							
ESOMEPRAZOLE MAGNESIUM CAPSULE DELAYED RELEASE	VARIOUS		PREFERRED DRUG			180	90
ESOMEPRAZOLE MAGNESIUM PACKETS	NEXIUM		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		30	30
LANSOPRAZOLE ORALLY DISPERSABLE TABLET (ODT)	PREVACID SOLUTAB		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		60	30
OMEPRAZOLE ORAL CAPSULES	VARIOUS		PREFERRED DRUG			60	30
PANTOPRAZOLE SODIUM PACKETS	PROTONIX		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		30	30
PANTOPRAZOLE TABLETS	PROTONIX		PREFERRED DRUG			30	30
URINARY ANTISPASMODICS							
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)**							
FESOTERODINE FUMARATE TABLET ER 24HR	TOVIAZ		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE SOLUTION	OXYBUTYNIN CHLORIDE		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE TABLET (5MG)	OXYBUTYNIN CHLORIDE		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE TABLET ER 24HR	DITROPAN XL		PREFERRED DRUG				
TOLTERODINE TARTRATE CAPSULE ER 24 HR	DETROL LA		PREFERRED DRUG				
TOLTERODINE TARTRATE TABLET	DETROL		PREFERRED DRUG				
SOLIFENACIN SUCCINATE TABLET	VESICARE						
VAGINAL PRODUCTS							
SPERMICIDES							
NONOXYNOL-9 FOAM	VCF VAGINAL CONTRACEPTIVE FOAM						
NONOXYNOL-9 GEL	SHUR-SEAL						
VAGINAL ANTI-INFECTIVES							
CLINDAMYCIN PHOSPHATE VAGINAL CREAM	CLEOCIN						
CLINDAMYCIN PHOSPHATE VAGINAL SUPPOSITORY	CLEOCIN						
CLOTRIMAZOLE VAGINAL CREAM	GYNE-LOTRIMIN						
METRONIDAZOLE VAGINAL GEL	METROGEL-VAGINAL						
MICONAZOLE NITRATE VAGINAL	MONISTAT 3 COMBINATION PACKETS						
MICONAZOLE NITRATE VAGINAL SUPPOSITORY	MICONAZOLE 3						
SULFANILAMIDE VAGINAL CREAM	AVC						
VAGINAL ESTROGENS							
ESTRADIOL ACETATE VAGINAL RING	FEMRING			PA REQUIRED			
ESTRADIOL VAGINAL RING	ESTRING						
ESTRADIOL VAGINAL TABLETS	VAGIFEM						
ESTRADIOL VAGINAL CREAM 0.01%	ESTRACE CREAM						
ESTROGENS, CONJUGATED VAGINAL CREAM	PREMARIN VAGINAL CREAM			PA REQUIRED			
VASOPRESSORS							
ANAPHYLAXIS THERAPY AGENTS							
EPINEPHRINE (ANAPHYLAXIS) SOLN AUTO-INJ	EPIPEN	VIATRIS SP - AUTHORIZED GENERIC ONLY	PREFERRED DRUG	PA REQUIRED for > 2 Per Month		2	30
RANITIDINE HCL CAPSULES	RANITIDINE HCL						
RANITIDINE HCL SUSPENSION	DEPRIZINE FUSEPAQ						
RANITIDINE HCL SYRUP	ZANTAC						
RANITIDINE HCL TABLETS	ZANTAC 75						
ANTI-ULCER - MISC.							
SUCRALFATE TABLETS	CARAFATE						
PROTON PUMP INHIBITORS							

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ESOMEPRAZOLE MAGNESIUM CAPSULE DELAYED RELEASE	VARIOUS		PREFERRED DRUG			180	90
ESOMEPRAZOLE MAGNESIUM PACKETS	NEXIUM		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		30	30
LANSOPRAZOLE ORALLY DISPERSABLE TABLET (ODT)	PREVACID SOLUTAB		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		60	30
OMEPRAZOLE ORAL CAPSULES	VARIOUS		PREFERRED DRUG			60	30
PANTOPRAZOLE SODIUM PACKETS	PROTONIX		PREFERRED DRUG	PA REQUIRED for > 18 Years of Age		30	30
PANTOPRAZOLE TABLETS	PROTONIX		PREFERRED DRUG			30	30
URINARY ANTISPASMODICS							
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLI)							
FESOTERODINE FUMARATE	**TOVIAZ**	**BRAND ONLY**	**PREFERRED DRUG**				
OXYBUTYNIN CHLORIDE SYRUP	VARIOUS		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE 5MG TABLETS	VARIOUS		PREFERRED DRUG				
OXYBUTYNIN CHLORIDE TABLET 24-HOUR	DITROPAN XL		PREFERRED DRUG				
TOLTERODINE TARTRATE CAPSULE CONTROLLED RELEASE	**DETROL LA**	**BRAND ONLY**	**PREFERRED DRUG**				
TOLTERODINE TARTRATE TABLETS	**DETROL**	**BRAND ONLY**	**PREFERRED DRUG**				
VAGINAL PRODUCTS							
SPERMICIDES							
NONOXYNOL-9 FOAM	VCF VAGINAL CONTRACEPTIVE FOAM						
NONOXYNOL-9 GEL	SHUR-SEAL						
VAGINAL ANTI-INFECTIVES							
CLINDAMYCIN PHOSPHATE VAGINAL CREAM	CLEOCIN						
CLINDAMYCIN PHOSPHATE VAGINAL SUPPOSITORY	CLEOCIN						
CLOTRIMAZOLE VAGINAL CREAM	GYNE-LOTRIMIN						
METRONIDAZOLE VAGINAL GEL	METROGEL-VAGINAL						
MICONAZOLE NITRATE VAGINAL	MONISTAT 3 COMBINATION PACKETS						
MICONAZOLE NITRATE VAGINAL SUPPOSITORY	MICONAZOLE 3						
SULFANILAMIDE VAGINAL CREAM	AVC						
VAGINAL ESTROGENS							
ESTRADIOL ACETATE VAGINAL RING	FEMRING			PA REQUIRED			
ESTRADIOL VAGINAL RING	ESTRING						
ESTRADIOL VAGINAL TABLETS	VAGIFEM						
ESTRADIOL VAGINAL CREAM 0.01%	ESTRACE CREAM						
ESTROGENS, CONJUGATED VAGINAL CREAM	PREMARIN VAGINAL CREAM			PA REQUIRED			
VASOPRESSORS							
ANAPHYLAXIS THERAPY AGENTS							
EPINEPHRINE (ANAPHYLAXIS) SOLN AUTO-INJ	EPIPEN	VIATRIS SP - AUTHORIZED GENERIC ONLY	PREFERRED DRUG	PA REQUIRED for > 2 Per Month		2	30
COVID AT-HOME TEST KITS		VARIOUS				2 TESTS	30