MC-Rx/Jai Medical Systems Managed Care Organization
2024 Therapeutic Formulary

This formulary describes the circumstances under which pharmacies participating in a particular medical benefit program will be reimbursed for medications dispensed to patients covered by the program. This formulary does not:

a) Require or prohibit the prescribing or dispensing of any medication.

b) Substitute for the independent professional judgment of the physician or pharmacist.

c) Relieve the physician or pharmacist of any obligation to the patient or others.

I. Non-Prescription Medication Policy

The only over-the-counter (OTC) medications that are covered by Jai Medical Systems are listed within the program formulary. All OTC medications, with the exception of OTC emergency contraception, can be reimbursed only if it is written on a valid prescription form by a licensed prescriber. OTC emergency contraception may be obtained without a written prescription; see page 6 of the formulary for limitations.

II. Unapproved Use of Formulary Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications, which are accepted as safe and effective by the balance of current medical opinion and available scientific evidence, may also be covered. The Pharmacy Benefits Manager (PBM), MC-Rx, utilizing the procedures outlined in Section IV, will make decisions about reimbursement for these other indications. Experimental, investigational drugs and drugs used for cosmetic purposes are not eligible for coverage.

III. Prior Authorization Procedure

To promote the most appropriate utilization of selected high risk and/or high-cost medication, a prior authorization procedure has been created. The criteria for this system have been established by the MC-Rx/Jai Medical Systems Managed Care Organization program, with input from pharmacists and physician practitioners and in consideration of the available medical literature. The Pharmacy and Therapeutics Committee will have final approval responsibility for this list. In order for a dispensed prior authorization medication to be reimbursed to the pharmacy, the patient's prescribing physician must apply for pre-authorization for a specific patient and drug. The physician may phone or fax the PBM to initiate a request for prior authorization:

MC-Rx
Prior Authorization Desk
1267 Professional Parkway
Gainesville, Georgia 30507
(800) 555-8513
(800) 583-6010 (fax)
(866) 999-7736 (alternate fax)

Please have patient information, including member ID number, complete diagnosis, medication history, and current medications readily available. Special request forms are required for Hepatitis C treatments and for opioids. All forms can be found online at www.jaimedicalsystems.com/providers/pharmacy/.

A completed, signed prior authorization form is needed in order for a request to be reviewed, but providers may call the MC-Rx Prior Authorization department to request forms and for help with the prior authorization request process. These phone lines are dedicated to physicians making requests for medications that require prior authorization and non-formulary items. Members cannot be assisted if they call the prior authorization toll-free number, but they may call the MC-Rx Customer Service Department at 800-213-5640 for help getting a prior authorization form faxed to their provider. For all requests for drugs requiring prior authorization, a decision will be provided within 24 hours of receiving the completed request. That decision will be to either approve, deny, or request more information. The requesting provider will receive a telecommunication response informing them of this decision. If the requested information is not received, this process could take up to 14 calendar days. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific patient to receive the requested drug. A prior authorization number will be issued to the prescribing physician and may be clearly written on the top of the prescription to inform the dispensing pharmacist of the approval. This number is for identification purposes only and does not need to be submitted for adjudication to occur. If the request is denied, information about the denial will be provided to the prescribing physician along with the patient and the patient's PCP, when appropriate.

Additionally, most injectables (except Depo-Provera, enoxaparin sodium, insulin, Glucagon Kit, and formulary epinephrine products) require prior approval. Questions about injectable drugs administered by home health or healthcare providers should be directed to MC-Rx at 800-555-8513. If the medication will be billed on a medical claim rather than through the pharmacy, the provider may contact the Provider Relations or Utilization Management Departments at 888-524-1999 with any questions.

Our prior authorization criteria can be found on our website, www.jaimedicalsystems.com, as well as in this formulary. Any updates made to our criteria will be posted on the website above within 30 days.

IV. Unique Patient Needs Non-Formulary Medication

This formulary attempts to provide appropriate and cost effective drug therapy to all enrollees of the Jai Medical Systems Managed Care Organization program. If a patient requires medication that is not covered by the formulary, a request can be made for payment of the non-covered item. It is anticipated that such exceptions will be rare, and that formulary medications will be appropriate to treat the vast majority of medical conditions. Requests for non-formulary medications should be made in writing (on the prior authorization form) and mailed or faxed to:

MC-Rx
Prior Authorization Desk
1267 Professional Parkway
Gainesville, Georgia 30507
(800) 555-8513
(800) 583-6010 (fax)
(866) 999-7736 (alternate fax)

Appropriate documentation must be provided to support the request. For all requests for drugs requiring prior authorization, a decision will be provided within 24 hours of receiving the request. That decision will be either to approve, deny, or request more information. The requesting provider will receive a telecommunication response informing them of this decision. If the requested information is not received, this process could take up to 14 calendar days. Approval of non-formulary items will be considered based upon Maryland Medicaid HealthChoice Benefit Coverage, availability and appropriateness of alternative medications on the formulary, and any applicable criteria sourced or developed by the Pharmacy and Therapeutics Committee of Jai Medical Systems Managed Care Organization, Inc. and the PBM, including the FDA-approved prescribing information for the medication and other information sources, such as UpToDate.

Physicians are expected to comply with this formulary when prescribing medication for those patients covered by Jai Medical Systems Managed Care Organization, Inc. If a pharmacist receives a prescription for a non-formulary medication, the pharmacist should attempt to contact the prescribing physician to request a change to a product included in this formulary guide.

The pharmacy will not be reimbursed for non-formulary medications unless they received prior approval from Jai Medical Systems Managed Care Organization, Inc.

In an emergency situation outside of the PBM's regular business hours where the physician cannot be contacted, the pharmacist is authorized to dispense a 72-hour emergency supply of a medication, unless the medication is classified as a DESI, LTE, or specifically excluded drug category (see Section VI) product or is one of the treatments for Hepatitis C, which should not be dispensed until the member has prior authorization to begin treatment.

The pharmacist should contact the PBM's Help Desk at (800) 213-5640 to arrange for reimbursement for the emergency supply.

V. Newly Marketed Products

Standard medications will be reviewed for coverage decisions within 180 calendar days of FDA approval. Priority medications will be reviewed for coverage decisions within 90 calendar days of FDA approval. Newly marketed drug products will not normally be placed on the formulary during their first year on the market. Exceptions to this rule will be made on a case-by-case basis using the medical necessity procedure.

VI. Specific Exclusions

The following drug categories are not part of the Jai Medical Systems Managed Care Organization formulary and are not covered by the 72-hour emergency supply reimbursement policy:

- Antiobesity products
- Blood and blood plasma
- Cosmetic drugs
- Cough and cold products (except those listed in the formulary)
- DESI drugs
- Diagnostic products (except those listed in the formulary)
- Erectile/sexual dysfunction agents

- Medical supplies and durable medical equipment (except certain diabetic supplies and specific Optichamber spacers)
- Most vitamins (except those listed in the formulary)
- Nutritional and dietary supplements
- Research drugs
- Most non-prescription medications, including topical minoxidil (except non-prescription medications listed in the formulary)
- Fertility treatment medications, such as ovulation stimulants (except when covered as part of a pre-approved fertility preservation service for members at risk of iatrogenic infertility due to upcoming cancer treatment or gender affirming care)

VII. Fee-for-Service Carve-outs

In addition to the above exclusions, the following are also excluded from the formulary and are covered by the Maryland Department of Health:

- Mental health drugs (refer to Section VIII). A list of Mental Health medications can be found online at: https://health.maryland.gov/mmcp/pap/pages/paphome.aspx under the Mental Health Formulary link
- Substance use disorder medications, including, but not limited to, buprenorphine, buprenorphine/naloxone, Campral®, Chantix®, Revia®, naloxone, Nicotrol®, nicotine patches, gum, and lozenges. (Refer to Section VIII). A list of substance use disorder medications is available online at: https://health.maryland.gov/mmcp/pap/pages/paphome.aspx under the Substance Use Disorder Medication Clinical Criteria Final link

VIII. Behavioral Health Medication Policy

Please refer to the Maryland Department of Health's Mental Health Formulary for a complete listing of behavioral health medications. Any behavioral health medications that are covered by Jai Medical Systems Managed Care Organization are listed in the prescription formulary.

- Kapvay – For recipients 6 -17 years old, extended-release clonidine (Kapvay) is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, extended-release clonidine continues to be a part of the MCO pharmacy benefit and would require prior authorization as a non-formulary medication.
- Intuniv – For recipients 6 -17 years old, extended-release guanfacine (Intuniv) is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, extended-release guanfacine continues to be a part of the MCO pharmacy benefit and would require prior authorization as a non-formulary medication.

IX. Mandatory Generic Substitution & Therapeutic Interchange

Generic substitution is mandatory when a generic equivalent is available, unless the brand is specified as the preferred medication on the formulary. All branded products that have 3 or more generic equivalents available will be reimbursed at the maximum allowable cost. No other therapeutic interchange is permitted.

X. Gender Affirming Care

Certain medications, including medications on the drug list with prior authorization requirements, such as Testosterone, Nafarelin, and Leuprolide and medications that are usually excluded like Clomiphene, may be covered for gender affirming care, in accordance with the Gender-Affirming Treatment Services Under the Maryland Medicaid Program document, available on our website at https://www.jaimedicalsystems.com/providers/pharmacy/ under Gender Affirming Care. Please ensure that all necessary documentation required under the criteria is included to show consent for treatment and medical necessity (documentation requirements may vary depending on patient age, type of treatment requested, and specialty of requesting provider).

XI. Specialty Medications

Specialty medications will be covered under the pharmacy benefit for Jai Medical Systems. All requests will undergo prior authorization review when available drug-specific prior authorization criteria will apply. When prior authorization criteria do not exist, the request will be reviewed for FDA approved indications according to Jai Medical Systems Managed Care Organization, Inc.'s approved medical necessity review process. All specialty drug requests should contain the following:

- Drug name, strength, dose, and quantity requested
- Diagnosis for use
- Any previous drug therapies tried and failed, or why medications on the drug list are not appropriate
- Any additional clinical information pertinent to the drug review

XII. High Cost, Low Utilization Medications

In accordance with the Maryland Department of Health's High Cost, Low Volume Drug Risk Mitigation Policy and the Social Security Act 1927 (d)(5), Jai Medical Systems **will not pay** for any of the aforementioned high-cost drugs that are not appropriately pre-authorized by Jai Medical Systems. The current list of NDCs and J-Codes Covered by High Cost Low Volume Risk Mitigation Policy can be found on our website at https://www.jaimedicalsystems.com/providers/pharmacy/ under the High Cost Low Volume Drugs heading and will be updated as Maryland Medicaid updates the list.

Our health plan will not conduct any retrospective review for these drugs; they must be pre-authorized and approved by our plan beforehand. **THERE WILL BE NO EXCEPTIONS TO THE REQUIREMENT FOR PRE-AUTHORIZATION**. Please be advised that this policy includes both Physician Administered Drugs and retail pharmacy drugs.

Please be advised that this list is subject to change. If you are unsure of whether or not a medication requires prior authorization and/or pre-certification, please contact our Utilization Management Department at 1-888-JAI-1999.

XIII. General Parameters

- Members must be enrolled in Jai Medical Systems Managed Care Organization, Inc. at the time the medication is dispensed.
- Valid DEA and NPI numbers are required.
- Prescribers must be appropriately registered and active with Maryland Medicaid's ePREP system. Jai Medical Systems reserves the right to review the current ePREP status of a prescriber, in accordance with Section 6401 of the Affordable Care Act and Code of Federal Regulations section 42 CFR §

455.410(b). Jai Medical Systems may deny a prior authorization request if the prescriber is not registered and in an active status with Maryland Medicaid's ePREP system.

- Refill too soon - 75% of the days supplied must elapse before the prescription can be refilled. For opioid medications, 85% of the days supplied must have elapsed before the prescription can be refilled.
- The standard maximum allowable quantity is a 30-day supply. The allowed quantity limit for formulary asthma controller medications and certain statins on the drug list (which cost less than $100 for a 90-day supply and when the member has already received a 30-day supply first) is a 90-day supply. The quantity limit on most medications is a 400-unit maximum limit per month. Most narcotics have individualized quantity and dosage form limitations, which are listed on page 14 of the formulary. If necessary, a healthcare provider may request a quantity override by contacting MC-Rx's Prior Authorization Department. Even with an override, the quantity may not exceed a 100-day supply, except for contraceptives as described below. Opioid prescriptions have separate days' supply limits as described below.
- If a member is new to opioid treatment (no pharmacy claims history of any opioid medication in the previous 90 days), their first fill is limited to no more than a 7-day supply. Effective November 1, 2021, after the initial fill, members are limited to 14-day supplies for their opioid medications unless their provider requests prior authorization, or unless they were already receiving greater than 14-day supplies when the change was implemented. If a member stops filling opioid medication for 90 days, they will be considered new to treatment and will lose their approval for greater than 14-day supplies and will need to follow the rules about initial fill limits. Opioid prescriptions cannot exceed a 30-day supply.
- Oral contraceptives will be available in up to 12-month supplies when ordered by a qualified practitioner.
- All generic oral contraceptives (including emergency contraceptives) and brand oral contraceptives that do not have a generic version available are formulary. Examples are listed on pages 6 and 7.
- Contraceptive implants and IUDs are covered under the medical benefit and should be billed for on a medical claim.
- Jai Medical Systems covers most common vaccines through the medical benefit and pharmacy benefit, including all COVID-19 vaccines, most flu vaccines, and most other standard age-appropriate vaccines (as determined by Maryland Medicaid.)
- A current listing of HIV medications covered by Jai Medical Systems are listed on page 3.
- Requests for some medications require special forms. All pharmacy prior authorization request forms can be found online at: http://www.jaimedicalsystems.com/providers/pharmacy/.
- Prior authorization is required for all extended-release opioid products as well as methadone prescribed for pain and any other opioids prescribed for quantities greater than 90 MMEs per day. A specialized form is required for these requests and can be found online at http://www.jaimedicalsystems.com/providers/pharmacy/.
- Prior authorization requests for medications for the treatment of Hepatitis C require a special prior authorization request form. While prior authorization is still required, Jai Medical Systems prefers Mavyret, generic Epclusa, generic Harvoni, and Zepatier, unless they are not medically appropriate. These forms and prior authorization criteria can be found at http://www.jaimedicalsystems.com/providers/pharmacy/.

- Vacation fill overrides may be requested by contacting Jai Medical Systems at 1-800-524-1999. Information from the prescribing doctor or primary care provider may be required before the request can be approved. Requests for vacation overrides for opioids are not generally available.
- Overrides for lost or stolen prescriptions may be requested by contacting Jai Medical Systems at 1-800-524-1999. Information from the prescribing doctor or primary care provider may be required before the request can be approved. Requests for override for lost or stolen opioids are not generally available.

XIII. Where to Call?

PHYSICIANS	
Formulary Questions: MC-Rx	(800) 555-8513
Medical Necessity: MC-Rx	(800) 555-8513
Prior Authorization: MC-Rx	(800) 555-8513
Provider Relations: Jai Medical Systems Managed Care Organization, Inc.	(888) JAI-1999
PHARMACISTS	
Provider Network Questions: MC-Rx	(800) 213-5640
Provider Relations: MC-Rx	(800) 213-5640

XIV. Abbreviations

Providers are encouraged to prescribe generically available drugs whenever possible and to prescribe first- line lower cost options when appropriate. Drugs are ranked by cost with the following abbreviations:

*	=	This product has a MAC price attached to some or all
$	=	Cost per Rx is <$20
$$	=	Cost per Rx is <$40
$$	=	Cost per Rx is $40 - $80
$$	=	Cost per Rx is $80 - $160
$$	=	Cost per Rx is >$160

XV. Reference

The formulary is available online at Formulary Navigator. This is updated monthly and will have the most up-to-date information. Formulary access is free and available at:
https://client.formularynavigator.com/Search.aspx?siteCode=9386334079

Links to all Maryland Medicaid Managed Care Organization Formulary Navigator pages can be found on the website listed below:
https://health.maryland.gov/mmcp/pap/pages/Weblinks-for-Providers.aspx

A link to a pdf copy of the Jai Medical Systems formulary and copies of our recent formulary change notices is also available in the Providers section of our homepage:
http://www.jaimedicalsystems.com/providers/pharmacy/

XVI. Copays

Beginning on May 1, 2024, HealthChoice MCOs are required to charge the following pharmacy copays:

Copayment Charge	New and Refill Drug Type
$3.00	Non-preferred and non-formulary brand name drugs
$1.00	All generic drugs (preferred and non-preferred)
$1.00	Preferred brand name drugs
$1.00	HIV/AIDS drugs

Individuals under the age of 21, pregnant individuals, individuals in long-term care facilities, and Native Americans are not required to pay copayments for prescription drugs in HealthChoice because of other federal and state statutory requirements. Copayments also do not apply to family planning drugs and adult vaccines and their administration, provided that the vaccine is approved by the FDA for use by adults and is administered in accordance with recommendations of the Advisory Committee on Immunization Practices (ACIP). COVID-19 prescription drugs and vaccinations temporarily have copayments waived until further federal guidance is issued. Additionally, in alignment with Medicaid fee-for-service regulations, pharmacy providers are not permitted to deny prescriptions to any Medicaid participant who is unable to pay the copayments.

XVII. Prior Authorization Auto-Renewal

Jai Medical Systems offers automatic prior authorization renewals for Advair, Symbicort, Wixela, and their generic equivalents. For members with a current approved prior authorization, claims will continue to process as long as the member has filled for that medication within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to therapy, or with no claim history of that medication within the last 4 months.

XVIII. Notice of Non-Discrimination

Jai Medical Systems Managed Care Organization, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of language, age, race, color, sex, sexual orientation, national origin, disability, medical condition, or religion against members, contracted providers, staff, and/or non-affiliated individuals. This includes women, individuals of minority and non-minority groups, individuals of the LGBT community, individuals with disabilities, and/or members with limited English proficiency. Jai Medical Systems Managed Care Organization, Inc. does not exclude people or treat them differently because of language, age, race, color, sex or sexual orientation, national origin, disability, medical condition, or religion.

To ensure effective communication for individuals with disabilities, Jai Medical Systems Managed Care Organization, Inc. shall:

- Provide equal access to auxiliary aids and services as necessary for individuals with disabilities, in accordance with applicable law.
- Include taglines for language accessibility in top 15 languages on the website, and in larger significant publications and significant communications.
- Include taglines for language accessibility in two popular languages in significant publications including Member Handbook, and significant communications.
- Provide free language assistance and interpretation services for members with limited English proficiency to communicate effectively.
- Provide free sign language interpretation for members with hearing disabilities.

- Provide free oral language assistance and written translation through Jai Medical Systems Managed Care Organization, Inc.'s multilingual staff, oral interpreters, and translators.

If you need these services, contact our Non-Discrimination Compliance Coordinator at <customerservice@jaimedical.com>. Additionally, information is made available in languages other than English upon request.

XIX. Equal Employment Opportunity Statement

Jai Medical Systems Managed Care Organization, Inc. provides equal employment opportunity for everyone regardless of language, age, sex, color, creed, national origin, pregnancy, ancestry, marital status, political belief, genetic information, and physical or mental disability that does not prohibit performance of essential job functions. In addition, Jai Medical Systems Managed Care Organization, Inc. complies with Section 1557 of the Affordable Care Act, all applicable federal, state, and local anti-discrimination laws. This policy is reflected in all of Jai Medical Systems Managed Care Organization, Inc.'s practices and policies regarding hiring, training, promotions, transfers, rates of pay, layoffs, and other forms of compensation. All matters relating to employment are based upon ability to perform the job, as well as dependability and reliability once hired.

If you believe that Jai Medical Systems Managed Care Organization, Inc. has failed to provide these services or discriminated on the basis of language, age, race, color, sex or sexual orientation, national origin, disability, medical condition, or religion, you can file a grievance with:

Non-Discrimination Compliance Coordinator Jai Medical
Systems Managed Care Organization, Inc.
301 International Circle, Hunt Valley, MD 21030
Phone: 410-433-2200|Fax: 410-433-4615|
Email: <customerservice@jaimedical.com>

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Non-Discrimination Compliance Coordinator is available to help you. Grievances must be submitted to the Coordinator within sixty days of the date you become aware of the alleged discrimination.

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

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

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

XX. Language Accessibility Statement

Interpreter Services are Available for Free
Help is available in your language:
1-888-524-1999 (TTY: 1-800-735-2258).
These services are available for free.

Español/Spanish
Hay ayuda disponible en su idioma: 1-888-524-1999 (TTY: 1-800-735-2258). Estos servicios están disponibles gratis.

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አገዛ በ ቋንቋዎ ማግኘት ይችላሉ፡-: 1-888-524-1999 (TTY: 1-800-735-2258)። እነዚህ አገልግሎቶች ያለክፍያ የሚገኙ ነጻናቸው·

ال عرب ية/Arabic
المساعدة متوفرة في لغتك: اتصل على الرقم 1-888-524-1999 (للمعاقين سمعيا: 1-800-735-2258
ذه خلـه مرت خم فـخه الـم ا ً

Français/French
Vous pouvez disposer d'une assistance dans votre langue : 1-888-524-1999 (TTY: 1-800-735-2258). Ces services sont disponibles pour gratuitement.

ગુજ રાતી/Gujarati
તમારી ભાષામાં મદદ ઉપલબ્ધ છે: 1-888-524-1999 (ટીટીવાય: 1-800-735-2258). સેવાઓ મફત ઉપલબ્ધ છે

kreyòl ayisyen/Haitian Creole
Gen èd ki disponib nan lang ou: 1-888-524-1999 (TTY: 1-800-735-2258). Sèvis sa yo disponib gratis.

Igbo
Enyemaka di na asusu gi: 1-888-524-1999 (TTY: 1-800-735-2258). Ọrụ ndị a dị na enweghi ugwo i ga akwu maka ya.

한국어/Korean
사용하시는 언어로 지원해드립니다: 1-888-524-1999 (TTY: 1-800-735-2258). 무료로 제공 됩니다

Português/Portuguese
A ajuda está disponível em seu idioma: 1-888-524-1999 (TTY: 1-800-735-2258). Estes serviços são oferecidos de graça.

Русский/Russian
Помощь доступна на вашем языке: 1-888-524-1999 (TTY: 1-800-735-2258). Эти услуги предоставляются бесплатно.

中文/Chinese
用您的语言为您提供帮助：1-888-524-1999 (TTY: 1-800-735-2258)。这些服务都是免费的

Farsi/فارسی
ماست خط) 1-800-735-2258 دیکـن یم تبصح ماش کـه یبـانز هبمکـک نتلـف خط 1-888-524-1999 (ناشـنوا افـراد

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Tagalog
Makakakuha kayo ng tulong sa iyong wika: 1-888-524-1999 (TTY: 1-800-735-2258). Ang mga serbisyong ito ay libre.

Urdu/اردو
آپ کی زبان میں مدد دستیاب ہے: 1-888-524-1999 (ٹی ٹی وائی): 1-800-735-2258

ریہ بہ ایتسد ےذلے کتفہ متامدخ

Tiếng Việt/Vietnamese
Hỗ trợ là có sẵn trong ngôn ngữ của quí vị 1-888-524-1999 (TTY: 1-800-735-2258). Những dịch vụ này có sẵn miễn phí.

Yorùbá/Yoruba
Ìrànlọ wọ wà ní àrọ wọ́tọ́ ní èdè rẹ: 1-888-524-1999 (TTY: 1-800-735-2258). Àwon ise yi wa fun o free.

Generic Name	Brand Name	Annotation
I. ANTI-INFECTIVE AGENTS		
PENICILLINS		
$ Amoxicillin*	AMOXIL	*no chewables*
$ Ampicillin*	AMPICILLIN	
$ Penicillin G Benzathine	BICILLIN	
$ Penicillin V Potassium*	PENICILLIN V POTASSIUM	
Penicillinase-resistant		
$ Dicloxacillin Sodium*	DICLOXACILLIN SODIUM	
$ Oxacillin*	OXACILLIN	
Penicillin Combinations		
$$$ Amox & K Clavulanate*	AUGMENTIN	*no chewables*
CEPHALOSPORINS		
Cephalosporins - 1st Generation		
$$ Cephalexin*	KEFLEX	*no tablets*
$$ Cephradine*	CEPHRADINE	
Cephalosporins - 2nd Generation		
$$ Cefaclor*	CEFACLOR	
$$$ Cefprozil*	CEFPROZIL	
$$$ Cefuroxime*	CEFTIN	*Oral tablets only*
$$$ Loracarbef	LORABID SUSPENSION	*AL under 12 yrs*
Cephalosporins - 3rd Generation		
$ Cefixime	SUPRAX	*QL = 1 tab*
$$$ Ceftriaxone*	ROCEPHIN	
$$$ Cefdinir*	CEFDINIR	
MACROLIDE ANTIBIOTICS		
Erythromycins		
$ Erythromycin Base*	ERY-TAB	
$ Erythromycin Estolate*	ERYTHROMYCIN ESTOLATE	
$ Erythromycin Ethylsuccinate*	E.E.S.	
$ Erythromycin Stearate*	ERYTHROCIN	
Lincomycins		
$$ Clindamycin*	CLEOCIN	
Misc. Macrolide Antibiotics		
$$ Azithromycin*	ZITHROMAX	
$$$ Azithromycin suspension*	ZITHROMAX	*QL = 1 single dose packet*
$$$ Clarithromycin*	BIAXIN	
Misc. Antibiotics		
$$$ Rifaximin	XIFAXAN	*550mg only*
Prior Authorization Required		
TETRACYCLINES		
$$$ Doxycycline*	VIBRAMYCIN	
$ Tetracycline*	SUMYCIN	*no tablets*
FLUOROQUINOLONES		
$$$ Ciprofloxacin*	CIPRO	
$$$$ Levofloxacin*	LEVAQUIN	
$$$$ Moxifloxacin*	AVELOX	*QL 14 per 30 days*
Prior Authorization Required		
ANTIMALARIAL		
$ Chloroquine*	ARALEN	*no 500mg tabs*
$ Hydroxychloroquine*	PLAQUENIL	
$$$$$ Pyrimethamine	DARAPRIM	

Generic Name	*Brand Name*	*Annotation*
ANTHELMINTIC		
$$ Albendazole	ALBENZA	
$$ Ivermectin*	STROMECTOL	*tablets only*
$$ Pyrantel Pamoate*	PIN - X	*OTC product*
AMINOGLYCOSIDES		
$ Gentamicin Sulfate*	GARAMYCIN	
$ Neomycin Sulfate*	NEOMYCIN	*tablets only*
SULFONAMIDES		
$ Erythromycin/Sulfisoxazole*	ERYTHROMYCIN/SULFISOXAZOLE	
$ Sulfadiazine*	SULFADIAZINE	
$ Sulfasalazine*	AZULFIDINE	*no EN tabs*
$ Sulfisoxazole*	SULFISOXAZOLE	
$ Trimethoprim/Sulfamethoxazole*	BACTRIM / DS	
ANTIMYCOBACTERIAL AGENTS		
$$$$ Cycloserine	SEROMYCIN	
$$$ Ethambutol*	MYAMBUTOL	
$$$ Ethionamide	TRECATOR	
$ Isoniazid*	ISONIAZID	
$$$ Pyrazinamide*	PYRAZINAMIDE	
$$$$$ Rifabutin*	MYCOBUTIN	
$$$$ Rifampin*	RIFADIN	
MISC. ANTIINFECTIVES		
$ Metronidazole*	FLAGYL	
$ Trimethoprim*	TRIMETHOPRIM	
$$ Chlorhexidine*	PERIOGARD	*0.12% oral rinse*
Leprostatics		
$ Dapsone*	DAPSONE	
ANTIFUNGALS		
$ Griseofulvin Microsize*	GRIFULVIN V	
$ Griseofulvin Ultramicrosize*	GRIS-PEG	
$ Nystatin*	NYSTATIN TAB	
Imidazole-Related Antifungals		
$ Ketoconazole*	NIZORAL	
$ Miconazole*	MONISTAT	*OTC product*
$$ Terbinafine*	LAMISIL	
$$ Itraconazole*	SPORANOX	
Prior Authorization Required		
Triazoles		
$ Fluconazole*	DIFLUCAN	*150mg x2 tablets/month is formulary. Authorization required for higher quantity or other strengths*
Prior Authorization Required		
ANTIVIRAL		
Neuraminidase Inhibitors		
$$ Oseltamivir Phosphate	TAMIFLU	*QL=1 course of treatment per calendar year*
$$ Zanamivir	RELENZA	*QL=1 course of treatment per calendar year*
CMV Agents		
$$$$ Ganciclovir*	CYTOVENE	

Generic Name	Brand Name	Annotation
Hepatic Agents		
$$$$$ Lamivudine HBV	EPIVIR	
$$$$$ Tenofovir Disoproxil Fumarate	VIREAD	*QL = 30 tabs / month*
$$$$$ ENTECAVIR	BARACLUDE	*QL = 30 tabs / month*
$$$$$ Elbasvir-Grazoprevir	ZEPATIER	*Preferred for types 1,4*
$$$$$ Glecaprevir-Pibrentasvir	MAVYRET	*Preferred all types*
$$$$$ Sofosbuvir-Velpatasvir*	GENERIC EPCLUSA	*Preferred all types*
$$$$$ Sofosbuvir-Velpatasvir-Voxilaprevir	VOSEVI	*Retreatment only*
$$$$$ Peginterferon	PEG-INTRON, PEGASYS	
$$$$$ Ribavirin*	REBETOL	
$$$$$ Ledipasvir-Sofosbuvir*	GENERIC HARVONI	*Preferred for 1,4,5,6*
****Special PA forms required. Please see www.jaimedicalsystems.com/providers/pharmacy for forms and full Maryland Medicaid prior authorization criteria.****		
Herpes Agents		
$$ Amantadine*	AMANTADINE	
$$$ Acyclovir*	ZOVIRAX	*PA for ointment & susp.*
HIV Agents		
$$$$$ Abacavir	ZIAGEN	*QL = 60 tabs / month*
$$$$$ Abacavir-Lamivudine	EPZICOM	*QL = 30 tabs / month*
$$$$$ Abacavir-Lamivudine-Zidovudine	TRIZIVIR	*QL = 60 tabs / month*
$$$$$ Atazanavir Sulfate	REYATAZ	*QL = 30 tabs / month*
$$$$$ Efavirenz / Emtricitabine / TDF	ATRIPLA GENERIC	*QL = 30 tabs / month*
$$$$$ Bictegravir / Emtricitabine / TAF	BIKTARVY	*QL = 30 tabs / month*
$$$$$ Emtricitabine / Rilpivirine / TDF	COMPLERA	*QL = 30 tabs / month*
$$$$$ Efavirenz	SUSTIVA	*QL = 60 tabs / month*
$$$$$ Atazanavir and Cobicistat	EVOTAZ	*QL = 30 tabs / month*
$$$$$ Elvitegravir / Cobicistat / FTC / TAF	GENVOYA	*QL = 30 tabs / month*
$$$$$ Etravirine	INTELENCE	*QL = 60 tabs / month*
$$$$$ Raltegravir	ISENTRESS	*QL = 60 tabs / month*
$$$$$ Dolutegravir / Rilpivirine	JULUCA	*QL = 30 tabs / month*
$$$$$ Lopinavir / Ritonavir	KALETRA	*QL = 120 tabs / month*
$$$$$ Lamivudine	EPIVIR	*QL = 30 tabs / month*
$$$$$ Lamivudine-Zidovudine	COMBIVIR	*QL = 60 tabs / month*
$$$$$ Emtricitabine / Rilpivirine / TAF	ODEFSEY	*QL = 30 tabs / month*
$$$$$ Darunavir and Cobicistat	PREZCOBIX	*QL = 30 tabs / month*
$$$$$ Darunavir Ethanolate	PREZISTA	*QL = 60 tabs / month*
$$$$$ Elvitegravir / Cobicistat / FTC / TDF	STRIBILD	*QL = 30 tabs / month*
$$$$$ Darunavir / Cobicistat / FTC / TAF	SYMTUZA	*QL = 30 tabs / month*
$$$$$ Emtricitabine / Tenofovir DF	TRUVADA GENERIC	*QL = 30 tabs / month*
$$$$$ Emtricitabine / Tenofovir Alafenamide	DESCOVY	*QL = 30 tabs / month*
$$$$$ Tenofovir Disoproxil Fumarate	VIREAD	*QL = 30 tabs / month*
$$$$$ Dolutegravir	TIVICAY	*QL = 30 tabs / month*
$$$$$ Dolutegravir / Abacavir / Lamivudine	TRIUMEQ	*QL = 30 tabs / month*
$$$$$ Zidovudine	RETROVIR	*QL = 60 tabs / month*
$$$$$ Fosamprenavir	LEXIVA	*QL = 60 tabs / month*
$$$$$ Ritonavir	NORVIR	*QL = 30 tabs / month*
$$$$ Nevirapine	VIRAMUNE	*QL = 60 tabs / month*
$$$$$ Stavudine	ZERIT	*QL = 60 tabs / month*
$$$$$ Dolutegravir/Lamivudine	DOVATO	*QL = 30 tabs / month*

II. ANTINEOPLASTICS

ANTINEOPLASTICS

Alkylating Agents	
$$$$$ Busulfan	MYLERAN
Nitrogen Mustards	
$$$$$ Chlorambucil	LEUKERAN
$$$$$ Cyclophosphamide*	CYTOXAN
$$$$$ Melphalan	ALKERAN

Generic Name	Brand Name	Annotation
Nitrosoureas		
$$$$$ Lomustine	LOMUSTINE	
Antimetabolites		
$$$$$ Capecitabine*	XELODA	
$$$$ Fluorouracil*	EFUDEX	*2% and 5% cream only*
$$$$$ Mercaptopurine*	PURINETHOL	
$$$$ Methotrexate*	RHEUMATREX	
$$$$$ Thioguanine	TABLOID	
Progestins-Antineoplastic		
$$$$ Megestrol*	MEGACE	*Tabs & Oral Susp*
Antiandrogens		
$$$$$ Flutamide*	FLUTAMIDE	
Aromatase Inhibitors		
$$$$$ Letrozole*	FEMARA	
$$$$$ Anastrozole*	ARIMIDEX	
$$$$ Exemestane*	AROMASIN	
Antineoplastic Hormones Misc.		
$$$$$ Bicalutamide*	CASODEX	
$$$$ Tamoxifen*	TAMOXIFEN	
$$$$$ Leuprolide	LUPRON	
Prior Authorization Required		
Mitotic Inhibitors		
$$$$ Etoposide*	ETOPOSIDE	
Antineoplastics Misc.		
$$$$$ Afatinib Dimaleate	GILOTRIF	
$$$$$ Erlotinib	TARCEVA	
$$$$ Hydroxyurea*	HYDREA	
$$$$$ Mitotane	LYSODREN	
$$$$$ Procarbazine	MATULANE	
$$$$$ Sorafenib	NEXAVAR	
$$$$$ Interferon Alfa-2A	ROFERON-A	
$$$$$ Interferon Alfa-2B	INTRON-A	
$$$$$ Interferon Alfa-n3	ALFERON N	
Prior Authorization Required		
Systemic Enzyme Inhibitor		
$$$$$ Imatinib Mesylate	GLEEVEC	*QL = 90 tabs / 30 days*

III. ENDOCRINE & METABOLIC DRUGS

CORTICOSTEROIDS

Glucocorticosteroids		
$ Cortisone*	CORTISONE	
$ Dexamethasone*	DEXAMETHASONE	*no dose paks*
$ Hydrocortisone*	CORTEF	
$ Methylprednisolone*	MEDROL	*tabs & dose packs*
$ Prednisone*	PREDNISONE	
$ Prednisolone*	PRELONE	
$$ Prednisolone Na Phosphate*	PEDIAPRED	
$$ Prednisolone Na Phosphate*	ORAPRED	
$ Prednisolone Acetate	FLO-PRED	
Mineralocorticoids		
$ Fludrocortisone*	FLUDROCORTISONE	

ANDROGEN-ANABOLIC

Androgens		
$$$ Methyltestosterone	ANDROID	
$$$ Danazol*	DANAZOL	
$$$ Testosterone Gel, Injection	ANDROGEL, TESTIM	
Prior Authorization Required		

Generic Name	***Brand Name***	***Annotation***
ESTROGENS		
$ Estradiol*	ESTRACE	
$$ Esterified Estrogens	MENEST	
$$ Estrogens, Conjugated	PREMARIN	
$$$ Estradiol TD Patch*	CLIMARA	
Estrogen Combinations		
$$ Conjugated Estrogens & Medroxyprogesterone	PREMPRO	
CONTRACEPTIVES		
All generic oral contraceptives are formulary		
Progestin		
$$$ Norethindrone*	NOR-QD, ORTHO MICRON	*Females only*
$$ Norethindrone*	LYLEQ	*Females only*
Combinations		
$$ Desogestrel & Ethinyl Estradiol*	DESOGEN, ORTHO-CEPT	*Females only*
$$ Drospirenone-Ethinyl Estradiol*	YASMIN, YAZ	*Females only*
$$ Drospirenone-Eth Estrad Levomefolate	SAFYRAL, BEYAZ	*Females only*
$$ Ethynodiol Diacet-Eth Estrad*	ZOVIA	*Females only*
$$$ Etonogestrel-Ethinyl Estradiol	NUVARING, ELURYNG	*QL= 1 ring / month, Females only*
$$ Levonorgestrel & Ethinyl Estradiol*	NORDETTE, AVIANE, ICLEVIA, DOLISHALE	*Females only*
$$ Norethindrone-Ethinyl Estradiol*	MODICON, BREVICON	*Females only*
$$ Norethindrone Ace-Ethinyl Estrad*	LOESTRIN	*Females only*
$$ Norgestrel-Ethinyl Estradiol*	CRYSELLE, OGESTREL	*Females only*
$$ Norgestimate-Ethinyl Estradiol*	ORTHO-CYCLEN	*Females only*
$$ Norethindrone & Ethinyl Estrad FE*	FEMCON FE	*Females only*
$$ Norethindrone Ace-Ethinyl Estrad FE*	LOESTRIN FE	*Females only*
$$$ Norelgestromin-Ethinyl Estradiol*	XULANE, ZAFEMY	*Females only*
Biphasic		
$$ Desogest-Eth Estrad & Eth Estrad	MIRCETTE	*Females only*
$$ Norethindrone-Mestranol	NORINYL, NECON	*Females only*
$$ Norethindrone-Ethinyl Estradiol FE	LO LOESTRIN FE	*Females only*
Triphasic		
$$ Desogest-Ethin Est*	CYCLESSA	*Females only*
$$ Levonorgestrel-Eth Estradiol*	TRIVORA	*Females only*
$$ Norethindrone-Ethinyl Estradiol*	ORTHO NOVUM 7/7/7	*Females only*
$$ Norgestimate-Ethinyl Estradiol*	ORTHO TRI-CYCLEN / LO	*Females only*
$$$ Norethindrone Ac-Ethinyl Estrad FE*	ESTROSTEP FE	*Females only*
$ Norethindrone-Ethinyl Estradiol*	NYLIA 7/7/7	*Females only*
$$ Norethindrone-Ethinyl Estradiol*	TRI-NYMYO	*Females only*
Four Phase		
$$ Estradiol Valerate-Dienogest	NATAZIA	*Females only*
Extended		
$$ Levonorgestrel-Ethinyl Estradiol*	SEASONIQUE, QUARTETTE, LOSEASONIQUE	*Females only*
Continuous		
$$ Levonorgestrel-Ethinyl Estradiol	AMETHYST	*Females only*
PROGESTINS		
$ Medroxyprogesterone*	PROVERA	*Tabs only / females only*
$$$ Medroxyprogesterone Acetate	DEPO-PROVERA, DEPO-SQ PROVERA 104	*Females only*
$ Norethindrone Acetate*	AYGESTIN	*Females only*
EMERGENCY CONTRACEPTIVE		
$$ Levonorgestrel*	PLAN B ONE STEP	*1 kit / month; 3 kits / yr*
	PLAN B	*Females only* *No prescription required for OTC formulation*

Generic Name	*Brand Name*	*Annotation*
ANTIDIABETIC		
Thiazolidinediones/Combination		
$$$$$ Pioglitazone*	ACTOS	*QL = 30 tabs / month*
$$$$$ Pioglitazone-Glimepiride*	DUETACT	*QL = 30 tabs / month*
$$$$ Pioglitazone-Metformin*	ACTOPLUS MET	*QL = 30 tabs / month*
$$$$$ Pioglitazone-Metformin SR	ACTOPLUS MET XR	*QL = 30 tabs / month*
Human Insulin		
$ Insulin Aspart	NOVOLOG, FIASP, NOVOLOG 50-50	
$ Insulin Isophane	HUMULIN N, NOVOLIN N	
$ Insulin Reg & Isophane	HUMULIN 50/50	
$ Insulin Reg & NPH	HUMULIN 70/30, NOVOLIN 70/30	
$ Insulin Regular	HUMULIN R, NOVOLIN R	
$ Insulin Lispro	HUMALOG, ADMELOG	
$ Insulin Glargine	TOUJEO, BASAGLAR	
$$ Insulin Glargine-aglr	REZVOGLAR	
$$$ Insulin Glargine-yfgn	INSULIN GLARGINE-YFGN	
Sulfonylureas		
$$ Glimepiride	AMARYL	
$$ Glipizide	GLUCOTROL/XL	
$$ Glyburide	DIABETA, GLYNASE	
Alpha-Glucosidase Inhibitors		
$$$$ Acarbose*	PRECOSE	*QL = 90 tabs / month*
Prior Authorization Required		
Dipeptidyl Peptidase-4 inhibitors		
$$$$$ Sitagliptin Phosphate	JANUVIA	Step Therapy
$$$$$ Alogliptin	NESINA	Step Therapy
Incretin Mimetic		
$$$$$ Exenatide	BYDUREON	
$$$$$ Liraglutide	VICTOZA	
$$$$$ Dulaglutide	TRULICITY	*Brand Only*
Prior Authorization Required		
Sodium-Glucose Cotransporter 2 Inhibitors		
$$$$$ Dapagliflozin	FARXIGA	
$$$$$$ Empagliflozin	JARDIANCE	
Prior Authorization Required		
Meglitinides		
$$$$$ Repaglinide	PRANDIN	
Prior Authorization Required		
Diabetic Other		
$ Metformin*	GLUCOPHAGE	
$ Metformin Extended Release	GLUCOPHAGE XR	
$$$$$ Glucagon	GLUCAGON EMERGENCY KIT	
$$$$$$ Empagliflozin/linagliptin	GLYXAMBI	
Prior Authorization Required		
THYROID		
Thyroid Hormones		
$ Levothyroxine*	LEVOXYL, SYNTHROID, THYQUIDITY	
$ Liothyronine*	CYTOMEL	
$ Thyroid*	THYROID	
Antithyroid Agents		
$ Methimazole*	TAPAZOLE	
$ Propylthiouracil*	PROPYLTHIOURACIL	
OXYTOCICS		
$ Methylergonovine*	METHERGINE	
MISC. ENDOCRINE		
Calcium Regulators		
$$$$ Calcitonin (Salmon)	MIACALCIN INJ	
$$$$ Calcitonin (Salmon)*	MIACALCIN NASAL	
Prior Authorization Required		

Generic Name	Brand Name	Annotation

Hormone Receptor Modulators

$$$$$ Raloxifene*	EVISTA	
Prior Authorization Required		

Gonadotropin Releasing Hormones

$$$$$ Nafarelin	SYNAREL	
Prior Authorization Required		

Growth Hormone

$$$$$ Somatropin	HUMATROPE ONLY	
Prior Authorization Required		

Posterior Pituitary

$$$ Alendronate*	FOSAMAX	
$$$$ Alendronate + Cholecalciferol	FOSAMAX PLUS D	
$$$$ Ibandronate*	BONIVA	
$$$$ Risedronate	ACTONEL	
$$$$ Desmopressin*	DDAVP	*(all dosage forms)*
Prior Authorization Required		

Parathyroid Hormone

$$$$$ Teriparatide	FORTEO	

IV.CARDIOVASCULAR AGENTS

CARDIOTONICS

Digitalis

$ Digoxin*	LANOXIN	*no caps*

PED Inhibitors

$$$$ Sildenafil Citrate	REVATIO	*20mg tablets and*
Prior Authorization Required		*10mg/mL liquid*

ANTIANGINAL AGENTS

Nitrates

$ Isosorbide Dinitrate*	ISORDIL, ISORDIL TEMBIDS	5mg, 10mg, 20mg, 30mg
$ Nitroglycerin (oral)*	NITROSTAT	
$$$ Nitroglycerin (topical)*	NITRODUR, NITROBID	
$$ Isosorbide Mononitrate*	IMDUR	

Antianginals-Other

$ Dipyridamole*	PERSANTINE	

BETA BLOCKERS

Beta Blockers Non-Selective

$ Propranolol*	INDERAL/LA	
$ Timolol*	TIMOLOL	
$ Betaxolol	BETAXOLOL	
$$$ Sotalol*	BETAPACE	
$$$ Carvedilol*	COREG	

Beta Blockers Cardio-Selective

$ Atenolol*	TENORMIN	
$ Metoprolol Tartrate*	LOPRESSOR	
$$$ Metoprolol Succinate*	TOPROL XL	

Alpha-Beta Blockers

$$$ Labetalol*	TRANDATE	

CALCIUM BLOCKERS

$$$ Amlodipine*	NORVASC	
$$$ Amlodipine & Benazepril*	LOTREL	
$$$ Diltiazem*	CARDIZEM/CD, DILACOR/XR	
$$ Felodipine*	FELODIPINE	
$$$ Nifedipine*	ADALAT CC, PROCARDIA XL	
$$ Verapamil*	CALAN, SR	

Generic Name	Brand Name	Annotation
ANTIARRHYTHMIC		
$$$ Amiodarone*	CORDARONE	
$ Disopyramide*	NORPACE, CR	
$$$ Flecainide*	TAMBOCOR	
$ Procainamide*	PROCAINAMIDE	
$ Quinidine Sulfate*	QUINIDINE SULFATE	
$$$$ Mexiletine*	MEXILETINE	
$$$$ Propafenone*	RYTHMOL	
ANTIHYPERTENSIVE		
ACE Inhibitors		
$ Captopril*	CAPTOPRIL	
$$ Benazepril*	LOTENSIN	
$$ Enalapril*	VASOTEC	
$$ Fosinopril*	FOSINOPRIL	
$$ Lisinopril*	ZESTRIL	
$$ Quinapril*	ACCUPRIL	
$$ Ramipril*	ALTACE	
ARBs		
$$$$ Irbesartan*	AVAPRO	*QL = 30 tabs / month*
$$$ Losartan potassium*	COZAAR	*QL = 30 tabs / month*
$$$$$ Valsartan	DIOVAN	*QL = 30 tabs / month*
Prior Authorization Required		
Adrenolytics - Central		
$ Clonidine*	CATAPRES	*AL = 18 years and over; No patches*
$ Guanfacine*	TENEX	*AL = 18 years and over*
Please note, extended release clonidine (Kapvay) and extended release guanfacine (Intuniv) for children ages 6-17 are covered under the mental health benefit; outside of that age range would require prior authorization as a non-formulary medication.		
$ Methyldopa*	METHYLDOPA	
Adrenolytics - Peripheral		
$ Reserpine*	RESERPINE	
Alpha Blockers		
$$ Doxazosin*	CARDURA	
$ Prazosin*	MINIPRESS	
$$$$ Tamsulosin*	FLOMAX	
$$$ Terazosin*	TERAZOSIN	
Vasodilators		
$ Hydralazine*	APRESOLINE	
$ Minoxidil*	MINOXIDIL	*Topical not covered*
$$$$$ Ambrisentan	LETAIRIS	
Prior Authorization Required		
Beta Blocker Combinations		
$ Atenolol & Chlorthalidone*	TENORETIC	
$$$ Metoprolol & HCTZ*	LOPRESSOR HCT	
$ Propranolol & HCTZ*	PROPRANOLOL & HCTZ	*no LA*
ACE and ACE II Inhibitors & Diazides		
$$$$ Irbesartan & HCTZ*	AVALIDE	*QL = 30 tabs / month*
$$ Lisinopril & HCTZ*	ZESTORETIC	
$$$ Losartan potassium/HCTZ*	HYZAAR	*QL = 30 tabs / month*
$$$$ Valsartan & HCTZ*	DIOVAN HCT	*QL = 30 tabs / month*
Prior Authorization Required		
Adrenolytics-Central & Thiazides		
$ Methyldopa & HCTZ*	METHYLDOPA & HCTZ	
$$ Clonidine & Chlorthalidone*	CLORPRES	
Vasodilators & Thiazides		
$ Hydralazine & HCTZ*	HYDRALAZINE & HCTZ	
DIURETICS		
Carbonic Anhydrase Inhibitors		
$ Acetazolamide*	DIAMOX	*no sequels*
$$$ Methazolamide*	METHAZOLAMIDE	

Generic Name	Brand Name	Annotation
Loop Diuretics		
$ Furosemide*	LASIX	
Potassium Sparing Diuretics		
$ Spironolactone*	ALDACTONE	
Thiazides		
$ Chlorothiazide*	DIURIL	
$ Chlorthalidone*	CHLORTHALIDONE	
$ Hydrochlorothiazide*	HYDROCHLOROTHIAZIDE	
$ Methyclothiazide*	METHYCLOTHIAZIDE	
$ Metolazone*	ZAROXOLYN	
$ Indapamide*	INDAPAMIDE	
Combination Diuretics		
$ Spironolactone & HCTZ*	ALDACTAZIDE	
$ Triamterene & HCTZ*	MAXZIDE	
Osmotic Diuretics		
$ Glycerin Supp*	GLYCERIN	*adult, infant, child*
PRESSORS		
Emergency Kits		
$$$$$ Epinephrine	EPI-PEN, EPI-PEN JR, ADRENACLICK	
ANTIHYPERLIPIDEMIC		
Bile Sequestrants		
$$$ Cholestyramine*	QUESTRAN, LIGHT	*cans only*
$$$ Colestipol*	COLESTID	*cans only*
Misc.		
$ Niacin*	NIACIN	*OTC (slow release)*
$ Niacin CR*	NIASPAN	
$$$$ Ezetimibe	ZETIA	*QL= 30/30 days*
$$$$ Fenofibric Acid	FIBRICOR	*35mg, 45mg, 105mg, 135mg; Step Therapy*
$$$ Fenofibrate tablets*	LOFIBRA	*54mg and 160mg*
$$$ Fenofibrate*	TRICOR	*48mg and 145mg*
$$$$ Fenofibrate	LIPOFEN, TRIGLIDE	*134mg and 200mg*
$$$$ Fenofibrate micronized	ANTARA	*134mg and 200mg*
$$$$ Fenofibric acid*	TRILIPIX, FIBRICOR	*Step Therapy; 35mg, 45mg, 105mg, 135mg*
$$ Gemfibrozil*	LOPID	
$$$$ Omega-3-acid ethyl esters*	LOVAZA	
HMG CoA Reductase Inhibitors		
$$$$$ Amlodipine & Atorvastatin*	CADUET	
$$$$ Atorvastatin*	LIPITOR	
$$$$ Fluvastatin*	LESCOL	
$$ Lovastatin*	MEVACOR	
$$$$ Niacin & Lovastatin	ADVICOR	
$ Pravastatin*	PRAVACHOL	
$$$$ Niacin-Simvastatin	SIMCOR	
$$$$ Rosuvastatin Calcium	CRESTOR	
$$$ Simvastatin*	ZOCOR	
$$$$$ Sacubitril & Valsartan	ENTRESTO	
$$$$ Simvastatin*	ZOCOR	*80mg only*
$$$$ Ezetimibe + Simvastatin	VYTORIN	
PCSK9 Inhibitors		
$$$$$ Evolocumab	REPATHA	*140mg/ml*
Prior Authorization Required		

V. RESPIRATORY AGENTS

ANTIHISTAMINES

Antihistamines - Ethanolamines		
$ Diphenhydramine*	BENADRYL	*OTC product*

Generic Name	Brand Name	Annotation
Antihistamines - Non-Sedating		
$ Clemastine*	TAVIST	*Pediatric formulation*
$$ Loratadine*	ALAVERT, CLARITIN	*OTC product*
$$ Loratadine / Pseudoephedrine*	CLARITIN-D 12hr, 24hr	*OTC product*
$$ Cetirizine*	ZYRTEC	*chew tabs/liquid AL ≤18*
$$ Cetirizine tabs*	ZYRTEC	
$$ Fexofenadine*	ALLEGRA OTC, ALLEGRA SUSP, ALLEGRA ODT	*30 or 60 per 30 days*
$$ Fexofenadine / Pseudoephedrine*	ALLEGRA-D OTC 12hr, 24hr	*30 or 60 per 30 days*
Antihistamines - Phenothiazines		
$ Promethazine*	PROMETHAZINE	*tabs/liquid* *tabs only AL ≥ 2 years*
SYSTEMIC AND TOPICAL NASAL PRODUCTS		
Nasal Antihistamines		
$$$$ Azelastine*	ASTELIN	
Prior Authorization Required		
Nasal Steroids		
$$ Flunisolide*	NASALIDE	
$$ Triamcinolone*	NASACORT AQ	
$$$ Fluticasone*	FLONASE	
$$$$ Mometasone furoate	NASONEX	
Mucolytics		
$$ Acetylcysteine*	MUCOMYST	
ANTIASTHMATIC		
Anticholinergics		
$$ Ipratropium*	ATROVENT NASAL	
$$$$ Ipratropium	ATROVENT HFA	
$$$$ Tiotropium	SPIRIVA	
$$$$$ Aclidinium Bromide	TUDORZA PRESSAIR	*QL = 1 inh / 30 days*
Prior Authorization Required		
Anti-Inflammatory Agents		
$$$ Cromolyn (inhalation)*	INTAL	
$ Cromolyn (nasal)*	NASALCROM	
$$$$$ Omalizumab	XOLAIR	
Prior Authorization Required		
Beta Adrenergics		
$$ Albuterol	PROVENTIL HFA, VENTOLIN HFA, PROAIR HFA	
$$ Albuterol*	ALBUTEROL NEBULIZER SOLUTION	*0.5% (5mg/mL) and 0.083% (2.5mg/3ml)*
$$$$$ Olodaterol	STRIVERDI	
$$$ Salmeterol	SEREVENT DISKUS	
Prior Authorization Required		
Adrenergic Combinations		
$$$$$ Ipratropium-Albuterol	COMBIVENT RESPIMAT	
$$$$ Albuterol-Ipratropium*	DUONEB	
$$$$$ Tiotropium-Olodaterol	STIOLTO	
$$ Umeclidinium-Vilanterol	ANORO ELLIPTA	
$$$$ Salmeterol-Fluticasone	ADVAIR, ADVAIR HFA	
$$$$ Budesonide-Formoterol	SYMBICORT	*AL ≥ 6 years*
$$$ Fluticasone-Umeclidinium-Vilanterol	TRELEGY	
Prior Authorization Required		
Steroid Inhalants		
$$$$ Fluticasone	FLOVENT HFA	
$$$$ Budesonide	PULMICORT FLEXHALER	
$$$$ Budesonide*	PULMICORT RESPULES	*AL ≤ 4 years; QL = 1 box / 30 days*
$$$$ Beclomethasone Dipropionate	QVAR	
Sympathomimetic Agents		
$ Pseudoephedrine HCL*	PSEUDOEPHEDRINE	*OTC product*
Mixed Adrenergics		
$$$$$ Epinephrine	EPI-PEN, EPI-PEN JR, ADRENACLICK	

Generic Name	Brand Name	Annotation
Xanthines		
$ Aminophylline*	AMINOPHYLLINE	
$$ Theophylline*	THEO-24, THEOCHRON	
Leukotriene Receptor Antagonists		
$$$ Montelukast Sodium*	SINGULAIR	
COUGH/COLD/ALLERGY		
Expectorants		
$ Guaifenesin*	GUAIFENESIN	*OTC product*
$ Guaifenesin/DM*	GUAIFENESIN DM	*OTC product*
Cough/Cold/Allergy Combinations		
$ Brompheniramine*	BROMPHENIRAMINE	*Pediatric formulation*
$ Brompheniramine / Pseudoephedrine*	BROMPHENIRAMINE / PSEUDOEPHEDRINE	
$ Chlorpheniramine*	CHLORPHENIRAMINE	*Pediatric formulation*
$ Phenylephrine*	SUDAFED	*Pediatric formulation*
$ Pseudoephedrine-Bromphen-DM*	PSEUDOEPHED-BROMPHEN DM	
$ Pseudoephedrine-Chlorphen-DM*	PEDIA RELIEF LIQ COUGH/COLD	
$ Pseudoephedrine-DM liquid*	TRIAMINIC AM LIQ CGH/DECON	
$ Pseudoephedrine-DM soln*	PSEUDOEPHEDRINE-DM SOLN	
$ GG/Codeine sol*	GUIATUSS AC	
$ Benzonatate*	TESSALON, TESSALON PERLES	
$$ Pseudoephedrine-GG*	PSEUDO-G / PSI	
$ Pseudoephedrine HCL*	PSEUDOEPHEDRINE	*OTC product*

VI. GASTROINTESTINAL AGENTS

LAXATIVES

Osmotic Laxatives		
$ Polyethylene Glycol powder*	MIRALAX	
Surfactant Laxatives		
$ Docusate Sodium*	COLACE	*OTC product*
Stimulant Laxatives		
$ Bisacodyl*	DULCOLAX	*OTC product / caps only*
$ Sennosides*	SENOKOT	*OTC product*
$ Sennosides/Docusate*	SENNA-S	*OTC product*
Bulk Laxatives		
$ Polycarbophil Calcium*	FIBERCON	*OTC product*
$ Psyllium*	METAMUCIL	*OTC product*
Miscellaneous Laxatives		
$ Glycerin*	GLYCERIN	*OTC product*
$ Lactulose	LACTULOSE	
$ Magnesium Citrate*	CITROMA	*OTC product*
$ PEG-Electrolyte*	GOLYTELY	
$$ PEG350/SodSul/Nacl/KcL/Asb/C*	MOVIPREP	
$$ PEG350/SodSul/Nacl/KcL/Asb/C	PLENVU	
$ PEG3350/SodSulf,Bicarb,Cl/Kcl	GAVILYTE - C, GAVILYTE - G	
$$ Sod Sulf/Pot Chloride/Mag Sulf	SUTAB	
$$$ Sodium/Potassium/Mag Sulfates*	SUPREP	
$$$$$ Lubiprostone	AMITIZA	
Prior Authorization Required		

ANTIDIARRHEALS

Antiperistaltic Agents		
$ Diphenoxylate w/ Atropine*	LOMOTIL	
$ Loperamide*	IMODIUM	*OTC product*
Misc Antidiarrheal Agents		
$ Bismuth Subsalicylate*	PEPTO-BISMOL	*no tabs, OTC*
$$$$ Octreotide Acetate*	SANDOSTATIN	
Prior Authorization Required		

ANTACIDS

Antacids - Aluminum Salts		
$ Aluminum Hydroxide Gel*	ALUMINUM HYDROXIDE	*OTC product*

Generic Name	Brand Name	Annotation
Antacids - Calcium Salts		
$ Calcium Carbonate*	OS-CAL	*OTC product*
Antacid Combinations		
$ Al Hydrox-Mag Carb*	MAALOX	*no tabs, OTC*
$ Aluminum & Magnesium Hydroxide*	MYLANTA	*no tabs, OTC*
ULCER DRUGS		
Belladonna Alkaloids		
$ Hyoscyamine Sulfate*	LEVSIN	*tablets or SL only*
Quaternary Anticholinergics		
$ Propantheline Bromide*	PROPANTHELINE BROMIDE	
Antispasmodics		
$ Dicyclomine*	BENTYL	
H-2 Antagonists		
$ Famotidine*	PEPCID	*tabs only*
$ Ranitidine*	ZANTAC	*no caps*
Proton Pump Inhibitors		
$ Esomeprazole Magnesium	NEXIUM 24 HR OTC	*OTC*
$$ Omeprazole*	PRILOSEC OTC	*OTC*
$$ Lansoprazole*	PREVACID	*OTC*
$$$$ Lansoprazole*	PREVACID	*RX*
$$$ Pantoprazole*	(Generic) PROTONIX	
$$$$ Lansoprazole*	PREVACID SOLU-TAB	
Prior Authorization Required		
Misc. Anti-Ulcer		
$$ Sucralfate*	CARAFATE TABLETS	
ANTIEMETICS		
Antiemetics - Anticholinergic		
$ Meclizine*	MECLIZINE	
$$ Prochlorperazine*	PROCHLORPERAZINE	*no SR*
5-HT3 Receptor Antagonists		
$$$$$ Ondansetron*	ZOFRAN TABLETS, ZOFRAN ODT	*QL = 10 tabs per fill*
$$$$$ Ondansetron Suspension*	ZOFRAN SUSPENSION	*QL = 50 mls per fill*
Neurokinin 1 Receptor		
$$$$$ Aprepitant	EMEND	
Prior Authorization Required		
Other		
Doxylamine Succinate/Pyridoxine HCL	DICLEGIS	QL= 40 / 10 days
DIGESTIVE AIDS		
Digestive Aids - Mixtures		
$$$$ Pancrelipase (Lip-Prot-Amyl) DR	CREON	
MISC. GI		
GI Stimulants		
$ Metoclopramide*	REGLAN	*no 5mg tabs*
Inflammatory Bowel Agents		
$$$$$ Mesalamine	PENTASA	
$$$$ Mesalamine*	ROWASA	
$ Sulfasalazine*	AZULFIDINE	*no EN tabs*

Generic Name	*Brand Name*	*Annotation*

VII. GENITOURINARY

URINARY ANTIINFECTIVES

$ Methenamine Mandelate*	MANDELAMINE	
$$$ Nitrofurantoin*	FURADANTIN	
$$ Nitrofurantoin Macrocrystals*	MACROBID	
$ Trimethoprim*	TRIMETHOPRIM	

URINARY ANTISPASMODICS

$ Bethanechol*	URECHOLINE	
$$$ Finasteride*	PROSCAR	
$$$ Flavoxate*	FLAVOXATE	
$ Hyoscyamine*	LEVSINEX	
$ Oxybutynin*	DITROPAN	
$ Oxybutynin ER*	DITROPAN XL	*QL = 30/30 days*
$$$$ Tolterodine Tartrate	DETROL	*Step Therapy*
$$$$$ Fesoterodine Fumarate	TOVIAZ	*Step Therapy*
$$$$ Trospium*	TROSPIUM	*Step Therapy*
$$$$$ Solifenacin	VESICARE	*Step Therapy*
$$$$$ Darifenacin Hydrobromide	ENABLEX	
$$$$$ Mirabergron	MYRBETRIQ	
Prior Authorization Required		

VAGINAL PRODUCTS

Vaginal Antiinfectives

$$ Clindamycin*	CLEOCIN	
$ Nystatin*	NYSTATIN	
$$ Sulfanilamide	AVC	
$$ Metronidazole*	METROGEL-VAGINAL	
Prior Authorization Required		

Imidazole-Related Antifungals

$ Butoconazole Nitrate*	GYNAZOLE-1	*OTC product*
$ Clotrimazole Vag*	MYCELEX	*OTC product*
$ Miconazole*	MONISTAT	*OTC product*

Vaginal Antiinfective Combinations

$ Triple Sulfas Vaginal*	TRIPLE SULFAS VAGINAL	

MISCELLANEOUS GENITOURINARY PRODUCTS

Citrates

$ Sodium Citrate & Citric Acid*	ORACIT	

Urinary Analgesics

$ Phenazopyridine*	PYRIDIUM	

VIII. CENTRAL NERVOUS SYSTEM DRUGS

ANTIPSYCHOTICS

Phenothiazines

$$ Prochlorperazine*	PROCHLORPERAZINE	*no SR*

HYPNOTICS

Barbiturate Hypnotics

$ Butabarbital	BUTISOL	
$ Mephobarbital	MEBARAL	
$ Phenobarbital*	PHENOBARBITAL	

Antihistamine Hypnotics

$ Diphenhydramine*	BENADRYL	*OTC product*

Generic Name	*Brand Name*	*Annotation*

IX.ANALGESICS & ANESTHETICS

ANALGESICS - NonNarcotic

Salicylates		
$ Aspirin zero order*	ZORPRIN	
$$ Salsalate*	DISALCID	
Salicylate Combinations		
$ Aspirin Enteric Coated*	ECOTRIN	*OTC product*
$ Aspirin with Buffers*	ASPIRIN BUFFERED	*OTC product*
$$ Choline & Mag Salicylate*	CHOLINE & MAG SALICYLATE	
Analgesics Other		
$ Acetaminophen*	TYLENOL	*OTC product*
Analgesics - Sedatives		
$ Butalbital/APAP/Caffeine *	FIORICET	*50/325/40 mg only*
$ Butalbital/Aspirin/Caffeine*	FIORINAL	*50/325/40 mg only*

ANALGESICS - Narcotic

QUANTITY LIMITS APPLY TO ALL NARCOTIC ANALGESICS. PLEASE SEE WEBSITE FOR FULL LIST OF QUANTITY LIMITS: jaimedicalsystems.com/providers/pharmacy.
The initial fill of an opioid (initial fill = no opioid fills in the last 90 days) is limited to no more than a 7-day supply. After that it is limited to no more than 14-day supplies unless PA is approved.
****PA required for methadone for pain and all extended-release opioid formulations and for quantities greater than 90 MME or to exceed quantity limits. Special PA forms are available at jaimedicalsystems.com/providers/pharmacy.****

Narcotic Agonists		
$ Codeine Phosphate*	CODEINE PHOSPHATE	
$ Codeine Sulfate*	CODEINE SULFATE	
$$$ Hydromorphone*	DILAUDID	
$ Meperidine*	DEMEROL	
$$$ Morphine Sulfate*	MORPHINE SULFATE	
$$$ Oxycodone*	OXYCODONE	*5mg caps*
$$$ Oxycodone*	ROXICODONE	*5mg, 10mg, 15mg, 30mg tabs and 20mg/mL oral soln*
$$$ Tramadol*	ULTRAM	
$$$$ Tramadol/APAP*	ULTRACET	
$ Methadone*	METHADONE	*Attestation PA only*
$$$$ Morphine Sulfate SR*	MS CONTIN	*Attestation PA only*
$$$$$ Tramadol ER*	ULTRAM ER	
$$$$$ Fentanyl*	DURAGESIC	
$$$$$ Oxycodone CR*	OXYCONTIN	
Prior Authorization Required		
Narcotic Combinations		
$ Oxycodone w/ Acetaminophen*	PERCOCET	*5/500 tabs and caps; 5/325 tabs and soln*
Codeine Combinations		
$ Acetaminophen w/ Codeine*	TYLENOL / CODEINE	
$ Acetaminophen w/ Codeine Sol*	ACETAMINOPHEN W / COD	*120-12 mg / 5ml*
Hydrocodone Combinations		
$$ Hydrocodone w/ Acetaminophen*	VICODIN, LORTAB, NORCO	*5/325, 7.5/325, 10/325*
$$ Hydrocodone w/ Acetaminophen*	XODOL	*5/300 mg tabs*

ANTI-RHEUMATIC

NSAID's		
$$ Diclofenac*	VOLTAREN	
$$ Etodolac*	ETODOLAC	
$$ Fenoprofen*	NALFON	
$$$ Flurbiprofen*	FLURBIPROFEN	
$ Ibuprofen*	MOTRIN	
$ Indomethacin*	INDOCIN	*no SR or supp.*
$ Meloxicam*	MOBIC	
$ Naproxen*	NAPROSYN	*no EC*
$ Naproxen Sodium*	ANAPROX	
$ Piroxicam*	FELDENE	
$$ Sulindac*	SULINDAC	

Generic Name	Brand Name	Annotation
COX-2 Inhibitor		
$$$$$ Celecoxib	CELEBREX	*QL = 60 caps / 30 days; Step Therapy*
Anti-Rheumatic Antimetabolite		
$$$$ Methotrexate*	RHEUMATREX	
GOUT		
$ Allopurinol*	ZYLOPRIM	
$$$$ Colchicine	COLCRYS	
Uricosurics		
$ Probenecid*	PROBENECID	
LOCAL ANESTHETICS		
$ Lidocaine*	LIDOCAINE	*2% soln, 3%, 5% cream*
Lidocaine/Prilocaine	EMLA	*2.5/2.5%*
$$$$$ Lidocaine*	LIDODERM PATCHES	*QL = 90 patches /30 days*
Prior Authorization Required		
MIGRAINE PRODUCTS		
$$$ Ergoloid mesylates*	HYDERGINE	
$$$$ Sumatriptan tablets*	IMITREX	*QL = 9 tabs/30 days*
$$$$ Sumatriptan injection*	IMITREX	*QL = 2 injections/30 days*
$$$$ Sumatriptan nasal*	IMITREX	*QL = 6 sprays/30 days*
$$$$$ Sumatriptan-naproxen	TREXIMET	*QL = 9 tabs/30 days*
$$$$$ Rizatriptan tablets*	MAXALT	*QL = 6 tabs/30 days*
$$$$ Zolmitriptan tablets*	ZOMIG	*QL = 6 tabs/30 days, tabs only*
Prior Authorization Required		

X. NEUROMUSCULAR AGENTS

ANTICONVULSANT		
Hydantoins		
$$ Phenytoin*	DILANTIN	
Succinimides		
$$ Ethosuximide*	ZARONTIN	
Miscellaneous Anticonvulsants		
$$$ Primidone*	MYSOLINE	
ANTIPARKINSONIAN		
COMT Inhibitors		
$$$ Entacapone*	COMTAN	
Prior Authorization Required		
Dopaminergic		
$ Amantadine*	AMANTADINE	
$$$ Bromocriptine*	PARLODEL	*no postpartum use*
$$ Ropinirole*	REQUIP	
Prior Authorization Required		
Levodopa Combinations		
$$$ Carbidopa-Levodopa*	SINEMET, CR	*no 100-25 CR*
Monoamine Oxidase Inhibitor		
$$$$ Selegiline*	ELDEPRYL	
MUSCULOSKELETAL THERAPY AGENTS		
Central Muscle Relaxants		
$$ Baclofen*	BACLOFEN	
$ Cyclobenzaprine*	CYCLOBENZAPRINE	
$ Methocarbamol*	ROBAXIN	
Direct Muscle Relaxants		
$$$$ Dantrolene*	DANTRIUM	
Prior Authorization Required		

Generic Name	Brand Name	Annotation
Fibromyalgia		
$$$$$ Milnacipran	SAVELLA	
Prior Authorization Required		
Muscle Relaxant Combinations		
$ Methocarbamol w/ Aspirin*	METHOCARBAMOL w/ASA	
ANTIMYASTHENIC AGENTS		
Antimyasthenic Agents		
$$$$ Pyridostigmine*	MESTINON	
Benzothiazoles		
$$$$$ Riluzole*	RILUTEK	
Prior Authorization Required		

XI. NUTRITIONAL PRODUCTS

VITAMINS

Water Soluble Vitamins		
$ Niacin*	NIACIN	
Oil Soluble Vitamins		
$ Vitamin A*	VITAMIN A	
Vitamin D		
$$ Calcitriol*	ROCALTROL	*Vitamin D3*
$$ Ergocalciferol*	DRISDOL	*Vitamin D2*
$$ Cholecalciferol*	VITAMIN D3	
Vitamin K		
$$ Phytonadione	VITAMIN K	*QL = 5 tabs / 30 days*

MULTIVITAMINS

$ Folic Acid & Vitamin B Complex*	NEPHROCAPS	
$ Multiple Vitamin*	ONE-A-DAY	*OTC product*
$ Multiple Vitamin w/ Minerals*	AP-ZEL, BACMIN, CENTRUM	
$ Pediatric Vitamins*	PEDIATRIC VITAMINS	*OTC product*
$ Pediatric Multivitamins*	POLY-VI-SOL	*up to 16 years only*
$ Pediatric Multivitamins w/Iron*	POLY-VI-SOL / IRON	*up to 16 years only*
$ Pediatric Multivitamins w/Fluoride*	TRI-VI-FLOR	*up to 16 years only*
$ Pediatric Multivitamins w/Fluoride and Iron*	TRI-VI-FLOR / IRON	*up to 16 years only*
$ Pediatric Vitamin ADC*	TRI-VI-SOL	*up to 16 years only*
$ Pediatric Vitamin ADC w/Iron*	TRI-VI-SOL / IRON	*up to 16 years only*
$ Prenatal MV & Min w/FE-FA*	PRENATAL-1	
$ Prenatal Vitamins*	PRENATABS RX	

CITRATES

$ Sodium Citrate & Citric Acid*	ORACIT	

MINERALS & ELECTROLYTES

Calcium		
$ Calcium Acetate*	PHOSLO	*caps only*
$ Calcium Carbonate*	OS-CAL	*OTC product*
Fluoride		
$ Sodium Fluoride*	LURIDE	
Potassium		
$ Potassium Chloride Capsule*	MICRO-K	
$ Potassium Chloride Liquid*	POTASSIUM CHLORIDE LIQUID	
$ Potassium Chloride Tablet*	KLOR-CON	
Electrolyte Mixtures		
$ Oral Electrolytes Packets*	CERALYTE, CERASPORT	
$ Oral Electrolytes*	PEDIALYTE	*OTC product*

Generic Name	*Brand Name*	*Annotation*

DIETARY PRODUCTS

$$ Infant Foods	ENFAMIL / SIMILAC	*OTC product*
$$ Phenyl-Free*	PHENYL-FREE	*OTC product*

MISCELLANEOUS NUTRITIONAL PRODUCTS

$$ Nutritional Supplements	ENSURE, PEDIASURE, BOOST, VIVONEX	
Prior Authorization Required		
For enteral access only. For members without enteral access, follow the DME process. (Nutritional Supplements are not limited to this list)		

XII. HEMATOLOGICAL AGENTS

HEMATOPOIETIC AGENTS

Cobalamines

$ Cyanocobalamin*	VITAMIN B-12	*1,000mcg tabs only*
$ Folic Acid*	FOLIC ACID	
$$$ Leucovorin Calcium*	LEUCOVORIN	
$ Thiamine	THIAMINE	
$ Cyanocobalamin*	VITAMIN B-12	*injection*
$ Hydroxocobalamin*	HYDROXOCOBALAMIN	
$$$$$ Pegfilgrastim-pbbk	FYLNETRA	*injection*
$$$$$ Filgastrim-Ayow	RELEUKO	*injection*
Prior Authorization Required		

Iron

$ Ferrous Gluconate*	FERGON	*OTC product*
$ Ferrous Sulfate*	FEOSOL	*OTC product*

Hematopoietic Growth Factors

$$$$$ Darbepoetin	ARANESP	*QL = 4 injections / month*
Prior Authorization Required		

Erythropoietins

$$$$$ Epoetin Alfa	EPOGEN	*2,000U, 3,000U, 4,000U, 10,000U - QL = 12 injections / month; 20,000U, 40,000U - QL = 4 injections / month*
Prior Authorization Required		

ANTICOAGULANTS

Coumarin Anticoagulants

$$ Warfarin Sodium*	COUMADIN

Heparin Agents

$$$$$ Enoxaparin*	LOVENOX
$$$$$ Apixaban	ELIQUIS
$$$$$ Rivaroxaban	XARELTO

Thrombin Inhibitors

$$$$$ Dabigatran	PRADAXA

HEMOSTATICS

Hemostatics - Topical

$$$$ Thrombin	THROMBIN	
Prior Authorization Required		

MISC. HEMATOLOGICAL

Antihemophilic Products

$$$$$ Antihemophilic Factor (Human)	KOATE-DVI, HP, HEMOFIL M	
$$$$$ Antihemophilic Factor (Recombinate)	RECOMBINATE	
$$$$$ Antiinhibitor Coagulant Complex	FEIBA VH	
$$$$$ Antithrombin III (Human)	THROMBATE III	
Prior Authorization Required		

Generic Name	Brand Name	Annotation
Platelet Aggregation Inhibitors		
$$$ Clopidogrel*	PLAVIX	
Phosphodiesterase III Inhibitors		
$$$$ Cilostazol	PLETAL	
Hematorheological		
$$ Pentoxifylline*	TRENTAL	
Prior Authorization Required		

XIII. BEHAVIORAL HEALTH AGENTS

MISCELLANEOUS

Reversible Acetylcholinesterase inhibitor		
$$$$ Donepezil*	ARICEPT	
$$$$ Galantamine*	RAZADYNE / RAZADYNE ER	
$$$$ Rivastigmine*	EXELON	
Prior Authorization Required		
Miscellaneous		
$$$$$ Clonidine Extended Release*	KAPVAY	*Please refer to Introduction page I-5*
$$$$$ Guanfacine Extended Release*	INTUNIV	*Please refer to Introduction page I-5*
$$$$ Memantine	NAMENDA	
Prior Authorization Required		

ANTICONVULSANT

Misc. Anticonvulsants		
$$$ Primidone*	MYSOLINE	

XIV. TOPICAL AGENTS

OPHTHALMIC

Antibiotics		
$$$ Bacitracin*	AK-TRACIN	
$$$ Ciprofloxacin*	CILOXAN	
$ Erythromycin*	ROMYCIN	
$ Gentamicin Sulfate*	GENTAK	
$$$ Moxifloxacin Hydrochloride	VIGAMOX	*AL ≤ 18 years*
$ Ofloxacin	OCUFLOX	
$ Polymyxin B-Trimethoprim*	POLYTRIM	
$$$ Gatifloxacin*	ZYMAXID	
Prior Authorization Required		
Anti Allergic		
$ Ketotifen Fumarate Ophth Soln*	ZADITOR	
$$ Lodoxamide Tromethamine	ALOMIDE	*QL = 10 mls / 30 days*
$$$ Olopatadine HCL Ophth soln 0.1%	PATANOL	*QL = 10 mls / 30 days*
$$$$ Olopatadine HCL Ophth soln 0.2%	PATADAY	*QL = 10 mls / 30 days*
$$$$ Azelastine 0.05% eye drops	(GENERIC) OPTIVAR	QL = 12 mls / 30 days
Sulfonamides		
$ Sodium Sulfacetamide*	BLEPH-10	
Antivirals		
$$$ Trifluridine*	VIROPTIC	
Antiinfective Combinations		
$ Bacitracin-Polymyxin B*	POLYSPORIN	
$ Neomycin-Bac Zn-Polymyxin*	NEOMYCIN-BAC ZN-POLYMIXIN	
$ Neomycin-Polymy-Gramicidin*	NEOSPORIN	
Beta-Blockers		
$$$$ Betaxolol*	BETOPTIC, BETOPTIC S	
$ Timolol*	BETIMOL, TIMOPTIC	*no XE*
$ Dorzolamide HCL-Timolol Maleate*	COSOPT	
Steroids		
$$ Dexamethasone*	DEXAMETHASONE	
$$ Prednisolone Acetate*	PRED FORTE, MILD	

Generic Name	Brand Name	Annotation
Immunomodulators		
$$$$ Cyclosporine	RESTASIS	
Prior Authorization Required		
Steroid Combinations		
$ Bacitracin-Polymyxin-Neomycin-HC*	BACITRACIN-POLYMIXIN-NEOMYCIN-HC	
$ Neomycin-Polymyxin-Dexamethasone*	MAXITROL	
$$ Tobramycin-Dexamethasone*	TOBRADEX	
$$$ Neomycin-Polymyxin-HC*	CORTISPORIN	
$$$ Sulfacetamide Sod-Prednisolone*	BLEPHAMIDE	
Cycloplegics		
$ Atropine Sulfate*	ISOPTO ATROPINE	
Decongestants		
$ Naphazoline*	NAPHAZOLINE	
$$ Phenylephrine*	MYDFRIN	
Ophthalmic NSAID's		
$ Diclofenac Sodium*	VOLTAREN	
$$ Flurbiprofen*	OCUFEN	
Miotics - Direct Acting		
$ Pilocarpine*	ISOPTO-CARPINE	*no Ocusert*
$$ Brimonidine Tartrate	ALPHAGAN 0.2%, ALPHAGAN P 0.15%	*QL = 10 mls / 30 days*
Prostaglandins		
$$$ Latanoprost*	XALATAN	
Carbonic Anhydrase Inhibitors		
$$ Dorzolamide*	TRUSOPT	
OTIC		
Steroids		
$ Hydrocortisone w/Acetic Acid*	ACETASOL HC	*QL = 20 mls / 30 days*
Antibiotics & Steroid-Antibiotic Combinations		
$ Neomycin-Polymyxin-HC*	CORTISPORIN	*QL = 20 mls / 30 days*
Antibiotics		
$$$ Ofloxacin*	OFLOXACIN	*QL = 20 mls / 30 days*
Anti Infective		
$ Carbamide Peroxide*	DEBROX	
Analgesic Combinations		
$ Benzocaine & Antipyrine*	A/B OTIC	
MOUTH & THROAT (Local)		
Antiinfectives - Throat		
$$$ Clotrimazole*	CLOTRIMAZOLE TROCHE	
$ Nystatin*	NYSTATIN	
ANORECTAL		
Rectal Steroids		
$ Hydrocortisone*	ANUSOL-HC	*2.5% cream*
$$ Hydrocortisone*	PROCTOCREAM	*2.5% cream*
DERMATOLOGICAL		
Antibiotics - Topical		
$$ Bacitracin*	BACITRACIN	*OTC product*
$ Gentamicin Sulfate*	GENTAMICIN	
$$$ Metronidazole*	METROGEL	
$$$ Mupirocin*	BACTROBAN	
$ Neomycin Sulfate*	NEOMYCIN	
Antibiotic Mixtures Topical		
$ Neomycin-Bacitracin-Polymyxin*	NEOSPORIN	*OTC product*
Antibiotic Steroid Combinations		
$$ Neomycin-Polymyxin-HC*	CORTISPORIN	

Generic Name	***Brand Name***	***Annotation***
Imidazole-Related Antifungals (Topical)		
$$ Clotrimazole Topical*	LOTRIMIN	*OTC product*
$ Miconazole*	MONISTAT	*OTC product*
Antifungals		
$ Nystatin*	NYSTATIN	*no powder*
Antifungals - Topical Combinations		
$$ Nystatin-Triamcinolone*	NYSTATIN-TRIAMCINOLONE	
Antipsoriatics		
$$$$ Calcipotriene*	DOVONEX	
$$$$$ Ixekizumab	TALTZ	
$$$$$ Risankizumab-Rzaa	SKYRIZI	
Prior Authorization Required		
Antiseborrheic Products		
$ Sulfacetamide Sodium*	SULFACETAMIDE SODIUM	
Burn Products		
$ Silver Sulfadiazine*	SILVADENE	
Tar Products		
$ Coal Tar*	COAL TAR SHAMPOO	*1% only*
Enzymes - Topical		
$$$ Collagenase	SANTYL	*QL = 90g*
Keratolytics/Antimitotics		
$$$$ Podofilox*	CONDYLOX	
$$$$$ Urea*	KERALAC, UMECTA	
$$$$$ Urea 45%*	URAMAXIN GEL 45%	
Local Anesthetics - Topical		
$ Lidocaine viscous*	LIDOCAINE VISCOUS	
$$ Diclofenac*	VOLTAREN	*1% gel*
Scabicides & Pediculocides		
$ Lindane*	LINDANE	
$$ Permethrin*	ELIMITE	
$$ Permethrin*	NIX	*OTC product*
Misc. Topical		
$$ Ammonium Lactate*	LAC-HYDRIN	*cream & lotion*
$$$ Fluorouracil*	EFUDEX	*2% and 5% cream only*
$$$ Tacrolimus oint*	PROTOPIC	
$$$ Pimecrolimus	ELIDEL	
$$$$$ Dupilumab	DUPIXENT	
Prior Authorization Required		
Antiviral Topical		
$$$$ Acyclovir	ZOVIRAX	*ointment & suspension*
Prior Authorization Required		
Corticosteroids - Topical		
$ Betamethasone Dipropionate*	BETAMETHASONE DIPROPIONATE	
$ Betamethasone Valerate*	BETAMETHASONE VALERATE	
$ Clobetasol Propionate*	TEMOVATE	
$ Desonide*	DESOWEN	
$ Fluocinonide*	FLUOCINONIDE	
$ Fluocinonide Acetonide*	SYNALAR	
$ Hydrocortisone*	HYDROCORTISONE	*OTC product*
$ Triamcinolone Acetonide*	KENALOG	*Topical and Injectable*
$ Triamcinolone Acetonide in Orabase*	TRIAM. ACET. IN ORABASE	
Acne Products		
$ Benzoyl Peroxide*	BENZAC W	
$$ Tretinoin*	RETIN-A	*AL ≤ 32; no Micro*
$$$ Adapalene*	DIFFERIN	*AL ≤ 21; only Gel or Cream*
Acne Antibiotics		
$$ Clindamycin Phosphate*	CLEOCIN	
$$ Erythromycin Gel*	ERYGEL	

Generic Name	*Brand Name*	*Annotation*

XV. MISCELLANEOUS PRODUCTS

ANTIDOTES

$ Ipecac*	IPECAC	*OTC product*
$ Charcoal Activated	CHARCOCAPS	*OTC product*

DIAGNOSTIC PRODUCTS

Diagnostic Reagents

$ Acetone Tablets	ACETEST	
$ Acetone Test*	KETOSTIX	
$ Glucose Urine Test*	CLINITEST	
$$ Glucose Blood*	GLUCOSE BLOOD	

MEDICAL DEVICES

Parenteral Therapy Supplies

$ Disposable Needles & Syringes*	B-D INSULIN SYRINGE	
$ Insulin Pen Needles	Insulin Pen Needles	

Diabetic Supplies

$$ Blood Glucose Monitoring Tests*	GLUCOMETER	*Contour, Contour Next, and Contour Next EZ*
$ Calibration Solution*	CALIBRATION SOLUTION	
$ Lancet Device	GLUCOLET / AUTOLET	
$ Lancets*	LANCETS	
$$$$ Blood Glucose Monitor Test	FREESTYLE LIBRE	

Prior Authorization Required

Misc. Devices

$ Alcohol Swabs*	ALCOHOL PADS	
Spacer	OPTICHAMBER	*QL = 1 / 180 days*

Only specific Optichamber devices covered under pharmacy benefit; Other brands may be available under DME benefit with PCP referral

CONTRACEPTIVES

$ Condoms		**prescription not required for latex condoms*

ASSORTED CLASSES

Chelating Agents

$$$$ Penicillamine	CUPRIMINE	
$$$$ Succimer	CHEMET	

Prior Authorization Required

Immunosuppressive Agents

$$$$$ Cyclosporine Microsize*	NEORAL	
$$$$$ Sirolimus*	RAPAMUNE	
$$$$$ Tacrolimus*	PROGRAF	

Inosine Monophosphate Dehydrogenase Inhibitors

$$$$$ Mycophenolate Mofetil*	CELLCEPT	
$$$$$ Mycophenolate Sodium*	MYFORTIC	

Mutiple Sclerosis – Adjuvants

$$$$$ Teriflunomide	AUBAGIO	*QL = 60 tabs / 30 days*
$$$$$ Dimethyl Fumarate	TECFIDERA	*QL = 60 tabs / 30 days*
$$$$$ Dalfampridine	AMPYRA	*QL = 60 tabs / 30 days*
$$$$$ Interferon Beta-1a	AVONEX	*QL = 60 tabs / 30 days*
$$$$$ Glatiramer Acetate	COPAXONE	*QL = 60 tabs / 30 days*
$$$$$ Interferon Beta-1a	REBIF	*QL = 60 tabs / 30 days*
$$$$$ Interferon Beta-1b	BETASERON	*QL = 60 tabs / 30 days*

Prior Authorization Required

Purine Analogs

$$$ Azathioprine*	IMURAN	

K Removing Resin

$$$$ Sodium Polystyrene Sulfonate*	KAYEXALATE	

Rheumatology Biologics

$$$$$ Adalimumab-adaz, -bwwd	HADLIMA, UNBRANDED HYRIMOZ
$$$$$ Etanercept	ENBREL
Prior Authorization Required	

Janus Kinase (JAK) Inhibitors

$$$$$ Upadacitinib	RINVOQ
Prior Authorization Required	

Prior Authorization Guidelines

GENERIC: ACARBOSE
BRAND: PRECOSE®

INDICATION:

(1) Type 2 diabetes mellitus

Criteria:

(a) Failure of maximal doses of *one* oral sulfonylurea (e.g., glyburide 20mg daily or equivalent). Failure is defined as Hemoglobin A1c> 7.0.

GENERIC: ACLIDINIUM BROMIDE AEROSOL POWDER
BRAND: TUDORZA PRESSAIR®

INDICATION:

(1) Long-term maintenance treatment of bronchospasm associated with COPD (including bronchitis and emphysema)

Criteria:

(a) Diagnosis of COPD **and**
(b) Must be greater than 18 years of age **and**
(c) Documented inadequate response or intolerance to Spiriva

GENERIC: ACYCLOVIR TOPICAL OINTMENT/SUSPENSION
BRAND: ZOVIRAX® 5%

INDICATIONS:

(1) Herpes genitalis
(2) Oral herpes infection

Criteria:

(a) Herpes genitalis – for initial episode only; **or**
(b) Oral herpes infection – for immunocompromised patients *only*.

Additional Criteria for Suspension:

(c) Patient is <17 years of age; **or**
(d) Unable to ingest solid dosage form (e.g. capsules) due to dysphagia

GENERIC: ADALIMUMAB-BWWD, ADALIMUMAB-ADAZ
BRAND: HADLIMA®, HYRIMOZ® (UNBRANDED)

INDICATIONS:

(1) Moderate to severely active rheumatoid arthritis (RA)
(2) Moderately to severely Active Polyarticular Juvenile Idiopathic Arthritis (JIA)
(3) Psoriatic arthritis (PsA)
(4) Ankylosing spondylitis (AS)
(5) Moderate to severely active Crohn's disease (CD)
(6) Moderately to Severely Active Ulcerative Colitis (UC)
(7) Moderately to Severely Active Plaque Psoriasis (Ps)
(8) Moderately to Severely Active Hidradenitis Suppurativa (HS)
(9) Uveitis

Criteria:

(a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to therapy; **and**
(b) The patient does not have a clinically important active infection

Additional Criteria for RA, JIA, and PsA:

(c) The patient has failed or is intolerant to one formulary NSAID **and**

(d) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for AS:

(c) Physician documents that patient failed treatment with at least two NSAIDS for at least three months, except if NSAIDs are contraindicated or if patient has presented toxicity or intolerance.

Additional Criteria for CD and UC:

(c) The patient has failed or is intolerant to infliximab; or
(d) The patient has failed or is intolerant to mesalamine or sulfasalazine; and
(e) The patient has failed or is intolerant to corticosteroids; and
(f) The patient has failed or is intolerant to an immunomodulator (e.g., methotrexate,6-mercaptopurine or azathioprine)

Additional Criteria for Ps

(c) Document that the patient has an incomplete response or intolerance or contraindicated to one appropriate systemic agent (ex: MTX, cyclosporine, acitretin) or phototherapy or biologic agents.

Additional Criteria for Hs

(c) Documentation of evidence failure with the previous treatment including antibiotics, hormonal therapies or oral retinoid at least for 90 days.

GENERIC: ALOGLIPTIN

Step Therapy Criteria:

Recent trial of metformin or sulfonylurea or thiazolidinedione - Cumulative days' supply for more than sixty (60) days within the last one-hundred and eighty (180) days with at least one (1) cumulative fill.

GENERIC: AMBRISENTAN

INDICATION:

(1) Indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1)

Criteria:

(a) Documentation of pulmonary arterial hypertension (PAH) (WHO Group 1)

GENERIC: ANTIHEMOPHILIC FACTORS
BRAND: KOATE-DVI®, FEIBA VH®, RECOMBINATE®, THROMBATE III®

INDICATION:

(2) Hemophilia A

Criteria:

(a) Diagnosis of Hemophilia A

GENERIC: APREPITANT
BRAND: EMEND®

INDICATION:

(1) Nausea and vomiting

Criteria:

(a) For the prevention of post-operative nausea and vomiting; **or**
(b) For the prevention of chemotherapy-induced nausea and vomiting

Prior Authorization Guidelines

GENERIC: AZELASTINE NASAL SPRAY
BRAND: ASTELIN®

INDICATIONS:
(1) Perennial allergic rhinitis
(2) Seasonal allergic rhinitis
Criteria:
(a) Patient is ≥ 5 years of age with one of the above diagnoses; **and**
(b) Failure of at least one formulary nasal steroid after a period of at least two months on the maximum dose appropriate and tolerated by the patient

GENERIC: BUDESONIDE/FORMOTEROL
BRAND: SYMBICORT®

INDICATION:
(1) Maintenance treatment of asthma in patients 6 years of age and older
(2) Maintenance Treatment of Chronic Obstructive Pulmonary Disease
Criteria:
Criteria for Asthma:
(a) Currently on, but not controlled by an inhaled corticosteroid for more than sixty (60) days; **and**
(b) The patient must be reevaluated after 6 months
Criteria for COPD:
(a) Currently on, but not controlled by a LAMA for more than sixty (60) days; **and**
(b) The patient must be reevaluated after 6 months

* *For members currently with an approved prior authorization for Symbicort, claims will process as long as the member has filled Symbicort within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Symbicort therapy or with no claims history of Symbicort within the last 4 months. Once approved, 90-day supplies are allowed.*

GENERIC: CALCITONIN-SALMON
BRAND: MIACALCIN®

INDICATIONS:
(1) Mild to moderate Paget's disease of bone
(2) Osteoporosis
Criteria:
(a) Failure, contraindication or intolerance to adequate trial of oral bisphosphonate; **and**
(b) One of the following:
(1) Bone density measurement ≥2.5 standard deviations below the mean for normal, young adults of same gender (T-score ≤ -2.5); **or**
(2) History of an osteoporotic vertebral fracture; **or**
(3) Postmenopausal woman with low bone mineral density defined by T-score between -2.0 and -2.5 AND one of the following risk factors for fracture:
(a) Thinness or low body mass index defined by weight <127 lb (57.7 kg) or BMI < 21 kg/m^2
(b) History of fragility fracture since menopause
(c) History of hip fracture in a parent
(4) Diagnosis of Paget's disease of bone
(c) Patients receiving glucocorticoids in daily dosages of >7.5mg prednisone daily (see table) AND who have bone density measurement > 1 standard deviations below the mean for normal, young adults of same gender (T-score < -1.0)

Glucocorticoid Potency Equivalencies			
Glucocorticoid	**Approximate equivalent dose (mg)**	**Relative anti-inflammatory (glucocorticoid) potency**	**Relative mineralocorticoid potency**
Short-acting			
Cortisone	25	0.8	2
Hydrocortisone	20	1	2
Intermediate-acting			
Prednisone	5	4	1
Prednisolone	5	4	1
Triamcinolone	4	5	0
Methylprednisolone	4	5	0
Long-acting			
Dexamethasone	0.75	20-30	0
Betamethasone	0.6-0.75	20-30	0

Table adapted from Facts and Comparisons® 1999:122

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

** If documentation of osteoporosis is available, please submit with PA request.*

GENERIC: CELECOXIB
BRAND: CELEBREX®

Step Therapy Criteria:
Single trial of at least 7 days of NSAIDs in the past 30 days

GENERIC: CYANOCOBALAMIN (HYDROXOCOBALAMIN)
BRAND: VITAMIN B-12®

INDICATION:
(1) Vitamin B-12 deficiency

Criteria:
(a) Patients who lack intrinsic factor; **or**
(b) Patients who are on long-term PPI therapy; **or**
(c) Patients with a partial or complete gastrectomy.

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: CYCLOSPORINE OPHTHALMIC EMULSION 0.05%
BRAND: RESTASIS

INDICATION:
(1) Increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca

Criteria:
(a) Failure of, intolerance to, contraindication, or previous use to artificial tears, or equivalent

GENERIC: DALFAMPRIDINE
BRAND: AMPYRA®

INDICATION:
(1) Improved walking speed in patients with multiple sclerosis
Criteria:
(a) Diagnosis of multiple sclerosis; **and**
(b) Prescribed by a neurologist; **and**

GENERIC: DANTROLENE
BRAND: DANTRIUM®

INDICATION:
(1) Spasticity resulting from upper motor neuron disorders
Criteria:
(a) Demonstrated failure of, or intolerance to, Baclofen (Lioresal®).

GENERIC: DAPAGLIFLOZIN
BRAND: FARXIGA®

INDICATION:
(1) Type 2 diabetes mellitus
(2) To reduce the risk of hospitalization and/or death for heart failure in adults with type 2 diabetes mellitus and either established cardiovascular disease or multiple cardiovascular risk factors or heart failure with reduced ejection fraction (NYHA class II-IV).
(3) To reduce the risk of sustained eGFR decline, end stage kidney disease, cardiovascular death and hospitalization for heart failure in adults with chronic kidney disease at risk of progression.
Criteria for Type 2 diabetes mellitus:
(a) Diagnosis of Type 2 diabetes mellitus
(b) Has not achieved adequate glycemic control on the following:
(1) Metformin (alone or in combination)
Criteria for heart failure:
(a) Diagnosis of heart failure with reduced ejection fraction.
(b) Has not achieved adequate symptom control with the following:
(1) ACE/ARB or ARNI, and
(2) Beta Blocker
Criteria for Chronic Kidney Disease:
(a) Diagnosis of Chronic Kidney Disease
(b) Has not achieved adequate symptom control with the following:
(1) ACE/ARB,
(c) NOT on dialysis

GENERIC: DARBEPOETIN ALFA
BRAND: ARANESP®

INDICATIONS:
(1) Anemia with cancer chemotherapy (nonmyeloid)
(2) Anemia due to chronic renal failure
Criteria:
(a) Ensure patient's iron stores are adequate (Ferritin ≥ 100 ng/mL and/or Transferrin saturation ≥ 20%) or patient is being treated with iron; **and**
(b) Adequate blood pressure control; **and**
Chronic kidney disease patients:
(a) Initiate treatment when hemoglobin is <10g/dL; **or**
Anemia due to chemotherapy in cancer:
(a) Initiate treatment only if hemoglobin is <10g/dL; **and**

(b) Anticipated duration of myelosuppressive chemotherapy is ≥ 2 months

For renewals:

(a) **Chronic kidney disease patients:**
  (1) With dialysis Hbg <11; **or**
  (2) Without dialysis Hbg <10

(b) **Anemia due to chemotherapy in cancer patients:**
  (1) Hbg <11

GENERIC: DARIFENACIN
BRAND: ENABLEX®

INDICATION:
(1) Overactive bladder

Criteria:
(a) Failure of Oxybutynin

GENERIC: DESMOPRESSIN
BRAND: DDAVP®

INDICATIONS:
(1) Central cranial diabetes insipidus (CCDI)
(2) Primary nocturnal enuresis

Criteria:
(a) Diagnosis of CCDI; **or**
(b) For the treatment of enuresis, age 6 to 18 years; **and**
(c) Failure of behavior modification for 6 months (e.g., alarms, no beverages after 5pm, special diapers, etc.)

** Renewals for the indication of nocturnal enuresis will require the documentation of a retrial of behavior modification.*

GENERIC: DIMETHYL FUMERATE
BRAND: TECFIDERA®

INDICATION:
(1) Diagnosis of a relapsing form of Multiple Sclerosis

Criteria:
(a) Prescribed by neurologist, and
(b) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Gilenya, Aubagio or Tecfidera.

GENERIC: DONEPEZIL
BRAND: ARICEPT®

INDICATION:
(1) Alzheimer's disease: for the treatment of dementia.

Criteria:
(a) Dementia must be confirmed by clinical evaluation

GENERIC: DULAGLUTIDE
BRAND: TRULICITY®

INDICATION:
(1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes mellitus

(2) To reduce the risk of major adverse cardiovascular events in adults with type II diabetes mellitus who have established cardiovascular disease or multiple cardiovascular risk factors

Criteria:

(a) Diagnosis of type II diabetes mellitus; **and**

(b) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications

GENERIC: DUPILUMAB
BRAND: DUPIXENT®

INDICATION:

(1) Treatment of pediatric patients 6 months and older, who have had an inadequate response or intolerance to topical drug products, with active atopic dermatitis (AD).

(2) Treatment of pediatric patients 6 years and older, characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma, with moderate-to-severe asthma.

(3) Treatment of adult patients, as an add-on maintenance treatment, chronic rhinosinusitis with nasal polyposis (CRSwNP).

(4) Treatment of pediatric patients 12 years and older with eosinophilic esophagitis (EoE).

(5) Treatment of adult patients with prurigo nodularis (PN).

Criteria:

(a) For pediatric patients 6 months and older with AD and PN
   i. Previous treatment, or intolerance of, with TCS for more than sixty (60) days; and
   ii. Previous treatment, or intolerance of, with TCI for more than sixty (60) days

(b) For pediatric and adult patients 6 years and older with asthma
   i. Previous treatment, or intolerance of, with Xolair for more than sixty (60) days; and
   ii. Patients must be reevaluated after 6 months

(c) For adult patients with CRSwNP
   i. Previous treatment, or intolerance of, with Xolair for more than sixty (60) days; and
   ii. Previous treatment, or intolerance of, with oral corticosteroid

(d) For pediatric patients 12 years and older with EoE
   i. Confirmed diagnosis with endoscopic esophageal biopsy showing the presence of eosinophils (≥15 eosinophils per high-power field); and
   ii. Previous treatment with proton-pump inhibitor (PPI) for more than sixty (60) days; and
   iii. Previous treatment with oral corticosteroid; and
   iv. Attestation of dietary modifications (e.g., avoidance of food allergen triggers)

GENERIC: ELBASVIR-GRAZOPREVIR
BRAND: ZEPATIER®

INDICATION:

(1) Chronic Hepatitis C

Criteria:

(a) Preferred for genotypes 1 and 4

(b) Must follow the clinical criteria as set by the Maryland Department of Health

(c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at http://www.jaimedicalsystems.com/providers/pharmacy/ or by contacting MC-Rx at 1-800-555-8513

GENERIC: EMPAGLIFLOZIN
BRAND: JARDIANCE®

INDICATION:
(1) Type II Diabetes Mellitus
(2) To reduce the risk of cardiovascular death and hospitalization for heart failure in adults with hearth failure
(3) To reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease

Criteria for Type 2 diabetes mellitus:
(a) Failure of metformin, a sulfonylurea, or pioglitazone

Criteria for heart failure:
(a) Diagnosis of heart failure
(b) Has not achieved adequate symptom control with the following:
(1) ACE/ARB or ARNI, and
(2) Beta Blocker

GENERIC: EMPAGLIFLOZIN-LINAGLIPTIN
BRAND: GLYXAMBI®

INDICATION:
(1) Type II Diabetes Mellitus

Criteria:
(a) For use when an SGLT2 and a DPP-4 Inhibitor is appropriate.

GENERIC: ENTACAPONE
BRAND: COMTAN®

INDICATION:
(1) As an adjunct to levodopa/carbidopa to treat patients with idiopathic Parkinson's disease

Criteria:
(a) Diagnosis of idiopathic Parkinson's disease; **and**
(b) Patient is receiving concomitant levodopa/carbidopa therapy.

GENERIC: EPOETIN ALFA
BRAND: EPOGEN®

INDICATIONS:
(1) Anemia with cancer chemotherapy (nonmyeloid)
(2) Anemia due to chronic renal failure
(3) Anemia of HIV infection associated with zidovudine
(4) Reduction of allogenic blood transfusion for elective, noncardiac, nonvascular surgery

Criteria:
(a) Patient's iron stores are adequate (Ferritin ≥100 mcg/mL and/or Transferrin saturation ≥20%) or patient is being treated with iron; **and**
(b) Adequate blood pressure control

Chronic kidney disease patients:
(c) Initiate treatment when hemoglobin is <10 g/dL (3-month approval)

Anemia due to chemotherapy in cancer patients:
(c) Initiate treatment only if hemoglobin <10 g/dL and anticipated duration of myelosuppressive chemotherapy is ≥2 months

Anemia due to zidovudine in HIV-infected patients:
(c) Initiate treatment when hemoglobin is <10 g/dL

Surgical procedure - Transfusion of blood product, Allogeneic;
Prophylaxis:
(c) Patient's pre-operative Hgb >10 to ≤13 g/dL (14-day approval)

For renewals:
Chronic kidney disease patients:
(a) With dialysis Hbg <11
(b) Without dialysis Hbg <10
Anemia due to chemotherapy in cancer patients:
(a) Hbg <11
Anemia due to zidovudine in HIV-infected patients:
(a) Hbg <11

GENERIC: ETANERCEPT
BRAND: ENBREL®
INDICATIONS:
(1) Moderate to severely active rheumatoid arthritis
(2) Moderate to severely active polyarticular juvenile rheumatoid arthritis
(3) Psoriatic spondylitis
(4) Ankylosing spondylitis
(5) Plaque psoriasis
Criteria:
(a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Enbrel therapy; **and**
(b) The patient does not have a clinically important active infection
Additional Criteria for RA:
(c) The patient has failed or is intolerant to one formulary NSAID **and**
(d) The patient has failed or is intolerant to one formulary DMARD
Additional Criteria for Plaque Psoriasis:
(c) Involvement of ≥ 10% body surface area (BSA)

GENERIC: EVOLOCUMAB
BRAND: REPATHA®
INDICATION:
(1) Primary hyperlipidemia
(2) High cholesterol in the blood
(3) Heterozygous familial hypercholesterolemia (HeFH)
(4) Reduce the risk of heart attack, stroke, and certain types of heart surgery in patients.
(5) Atherosclerotic cardiovascular disease (ASCVD)
(6) Homozygous familial hypercholesterolemia
Criteria:
(a) Documentation of positive clinical response
(b) Comprehensive counseling regarding diet
(c) Not used in combination with another type 9 (PCSK9) INHIBITOR

GENERIC: EXENATIDE
BRAND: BYDUREON®
INDICATION:
(1) Adjunctive therapy of type 2 diabetes mellitus
Criteria:
(a) Diagnosis of type 2 diabetes; **and**
(b) Failure or intolerance to sulfonylureas and/or metformin at optimal dosing. Failure defined as Hemoglobin A1c ≥ 7.0; **and**
(c) Patient ≥ 10 years of age

GENERIC: FENOFIBRIC ACID 35MG, 105MG, 45MG, AND 135 MG

Step Therapy Criteria:

Recent trial of formulary product generic Fenofibrate - Cumulative days supply for more than sixty (60) days within the last one-hundred and eighty (180) days with at least one (1) cumulative fill

GENERIC: FENTANYL TRANSDERMAL PATCH
BRAND: DURAGESIC®

INDICATION:

(1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time

Criteria:

(a) Diagnosis of persistent, moderate to severe chronic or cancer-related pain requiring continuous, around-the-clock opioid administration for an extended period of time; **and**
(b) Patient unable to take medications by mouth; **or**
(c) Failure of or intolerance/contraindication to a long-acting oral opiate (narcotic) medication (controlled-release morphine, oxycodone, or oxymorphone)
(d) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: FESOTERODINE FUMARATE

Step Therapy Criteria:

Recent trial of formulary product generic Oxybutynin - Cumulative days' supply for more than sixty (60) days within the last one-hundred and eighty (180) days with at least one (1) cumulative fill

GENERIC: FILGRASTIM-AYOW
BRAND: RELEUKO®

INDICATIONS:

(1) Prevention of neutropenia in patients receiving myelosuppressive chemotherapy for nonmyeloid malignancies
(2) Patients undergoing peripheral blood progenitor cell collection and therapy
(3) Patients with severe chronic neutropenia

Criteria:

(a) The patient is undergoing peripheral blood progenitor cell collection and therapy; or
(b) Diagnosis of severe chronic neutropenia with an absolute neutrophil count (ANC) < 1,000; or
(c) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given for prophylaxis for all future chemo cycles.

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

** Please indicate estimated duration of therapy*

GENERIC: FLASH GLUCOSE SENSOR
BRAND: FREESTYLE LIBRE®

INDICATIONS:

(1) Treatment of patients indicated for the management of diabetes in persons aged 4 years and older.

Criteria:

(a) Diagnosed with Type I or Type II Diabetes mellitus; and
(b) Actively seeing an Endocrinologist (at least one visit within past 6 months); and
(c) Blood glucose testing at least 4x/day for more than sixty (60) days; and

(d) Insulin injections at least 3x/day; and
(e) The member must have been assessed by the prescriber for ability to adhere to the CGM monitor regimen and any adherence/compliance issues must have been addressed and resolved by the prescriber; and
(f) Frequent adjustments to amount of injected insulin based on glucose testing results; and
(g) Wide variance in blood sugar levels OR unexplained or severe hypoglycemia OR hypoglycemic unawareness

GENERIC: FLUCONAZOLE
BRAND: DIFLUCAN®

(PA required after 150mg x2 tablet dispensed)

INDICATIONS:

(1) Vaginal candidiasis
(2) Cryptococcal meningitis
(3) Serious systemic Candida infections
(4) Oropharyngeal and esophageal candidiasis

Criteria:

(a) Any of the above diagnoses; **except**
(b) For the diagnosis of oropharyngeal candidiasis, failure of nystatin therapy; **and**
(c) For the diagnosis of vaginal candidiasis, patients who are immunocompromised and/or have recurrent or refractory infections.

GENERIC: FLUTICASONE/UMECLINDIUM/VILANTEROL
BRAND: TRELEGY®

INDICATION:

(1) Maintenance treatment of asthma in patients 18 years of age and older
(2) Maintenance treatment of patients with chronic obstructive pulmonary disease (COPD)

Criteria for Asthma:

(a) Currently on, but not adequately controlled by an two (2) or more inhaled medium to high dose LABA+ICS for more than sixty (60) days; and
(b) Patients must be reevaluated after 6 months

Criteria for COPD:

(a) Currently on, but not adequately controlled by an two (2) or more inhaled medium to high dose LABA+ICS for more than sixty (60) days; and
(b) Currently on, but not adequately controlled by an inhaled LAMA or LAMA+LABA for more than sixty (60) days
(c) Patients must be reevaluated after 6 months

GENERIC: GALANTAMINE HYDROBROMIDE
BRAND: RAZADYNE®, RAZADYNE ER®

INDICATION:

(1) Alzheimer's disease: for the treatment of dementia

Criteria:

(a) Confirmation by clinical evaluation

GENERIC: GATIFLOXACIN
BRAND: ZYMAXID®

INDICATION:

(1) Bacterial conjunctivitis

Criteria:

(a) Failure of, contraindication to, or intolerance to ciprofloxacin ophthalmic formulation.

GENERIC: GLATIRAMER ACETATE
BRAND: COPAXONE®

INDICATIONS:
(1) Relapsing-remitting Multiple Sclerosis
(2) To prevent or slow the development of clinically definite Multiple Sclerosis in patients who have experienced a first clinical episode and have MRI features consistent with Multiple Sclerosis

Criteria:
(a) Prescribed by neurologist; and
(b) Not requesting combination therapy of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

GENERIC: GLECAPREVIR-PIBRENTASVIR
BRAND: MAVYRET®

INDICATION:
(1) Chronic Hepatitis C

Criteria:
(a) Preferred for genotypes 1, 2, 3, 4, 5 and 6
(b) Must follow the clinical criteria as set by the Maryland Department of Health
(c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at http://www.jaimedicalsystems.com/providers/pharmacy/ or by contacting MC-Rx at 1-800-555-8513

GENERIC: HYDROXOCOBALAMIN

INDICATION:
(1) Vitamin B-12 deficiency

Criteria:
(a) Patients who lack intrinsic factor; **or**
(b) Patients who are on long-term PPI therapy; **or**
(c) Patients with a partial or complete gastrectomy.

GENERIC: INTERFERON ALFA
BRAND: ROFERON-A®, INTRON-A®, and ALFERON N®

INDICATIONS:
(1) Hairy cell leukemia
(2) AIDS-related Kaposi's sarcoma
(3) Chronic Hepatitis B or C
(4) Malignant melanoma

Criteria:
(a) Any of the above diagnoses.

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: INTERFERON BETA
BRAND: AVONEX®, BETASERON®, REBIF®

INDICATIONS:
(1) Diagnosis of a relapsing form of Multiple Sclerosis; **or**
(2) First clinical demyelinating event with MRI evidence consistent with Multiple Sclerosis

Criteria:
(a) Prescribed by neurologist; **and**
(b) If patient has a history of or is currently being treated for severe psychiatric disorders, suicidal ideation or severe depression, this condition is well controlled; **and**
(c) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: ITRACONAZOLE
BRAND: SPORANOX®

INDICATIONS:
(1) Histoplasmosis infections
(2) Aspergillosis infections
(3) Blastomycosis

Criteria:
(a) Any of the above diagnoses.

GENERIC: IXEKIZUMAB
BRAND: TALTZ®

INDICATIONS:
(1) Treatment of pediatric patients aged ≥ 6 years with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.
(2) Treatment of adult patients with active psoriatic arthritis
(3) Treatment of adults with active ankylosing spondylitis.
(4) Adults with active non-radiographic axial spondyloarthritis (nrAxSpA) with objective signs of inflammation.

Criteria:
1. First Prescription and every 12 months: The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to treatment.
2. For adult patients with plaque psoriasis, psoriatic arthritis, ankylosing spondylitis, and nrAxSpA
   a. Previous treatment, or intolerance of, with Enbrel for more than sixty (60) days; and
   b. Previous treatment, or intolerance of, with formulary Humira biosimilar for more than sixty (60) days

GENERIC: LANSOPRAZOLE
BRAND: PREVACID SOLU-TAB®

INDICATION:
(1) Gastroesophageal reflux disease (GERD), heartburn, gastric ulcer, and duodenal ulcer.

Criteria:
(a) Unable to ingest a solid dosage form (e.g. oral tablet or capsule) due to one of the following:
   (1) Age
   (2) Oral/motor difficulties
   (3) Dysphagia
   (4) Patient utilizes a feeding tube for medication administration

GENERIC: LEDIPASVIR-SOFOSBUVIR
BRAND: HARVONI®

INDICATION:
(1) Chronic Hepatitis C

Criteria:
(a) Generic tablet only
(b) Must follow the clinical criteria as set by the Maryland Department of Health
(c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at http://www.jaimedicalsystems.com/providers/pharmacy/ or by contacting MC-Rx at 1-800-555-8513

GENERIC: LEUPROLIDE
BRAND: LUPRON®

INDICATIONS:
(1) Advanced prostate cancer
(2) Central precocious puberty
(3) Endometriosis
(4) Uterine leiomyomata (fibroids)

Criteria:
(a) Diagnosis of advanced prostate cancer, precocious puberty or fibroids; **or**
(b) For the diagnosis of endometriosis, failure of NSAIDS **and** oral contraceptives **or** endometriosis diagnosed by laparoscopy.

Gender Affirming Treatment:
For all requests for gender affirming care, please refer to the Gender-Affirming Treatment Services Under the Maryland Medicaid Program document (for a copy of the criteria see our website at https://jaimedicalsystems.com/providers/pharmacy/.) Please ensure that all necessary documentation required under the criteria is included to show consent for treatment and medical necessity (documentation requirements may vary depending on patient age, type of treatment requested, and specialty of requesting provider).

** Note: This agent is ordinarily administered at the physician's office. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary*

GENERIC: LIDOCAINE PATCH 5%
BRAND: LIDODERM PATCH 5%®

INDICATION:
(1) Relief of pain associated with post-herpetic neuralgia.

Criteria:
(a) Skin application site is intact, and
(b) For the relief of pain associated with post-herpetic neuralgia;
and
(c) Failure, adverse reaction, or contraindication to two prescription analgesics, including formulary lidocaine topical cream or gel.

GENERIC: LIRAGLUTIDE
BRAND: VICTOZA®

INDICATION:
(1) Adjunct to diet and exercise to improve glycemic control in patients 10 years and older with type II diabetes mellitus
(2) To reduce the risk of major adverse cardiovascular events in adults with type II diabetes

(3) . mellitus and established cardiovascular disease.

Criteria:

(a) Diagnosis of type II diabetes mellitus; **and**

(b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by a diabetes educator; **and**

(c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione, or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications; **and**

(d) NO personal or family history of medullary thyroid carcinoma

GENERIC: LUBIPROSTONE
BRAND: AMITIZA®

INDICATION:

(1) Chronic idiopathic constipation

(2) Irritable bowel syndrome

(3) Opioid-induced constipation

Criteria:

(a) Must have a diagnosis of either chronic idiopathic constipation, irritable bowel syndrome, or opioid-induced constipation; and

(b) Failure of Miralax, Senna-S, and/or lactulose

GENERIC: MEMANTINE
BRAND: NAMENDA®

INDICATION:

(1) Alzheimer's disease: for treatment of moderate-to-severe cases of dementia

Criteria:

(a) Dementia must be confirmed by clinical evaluation; **and**

(b) Documented dementia is either moderate or severe

GENERIC: METHADONE
BRAND: METHADONE

INDICATION:

(1) Persistent, moderate to severe chronic pain that requires around-the-clock opioid (narcotic) administration for an extended period of time; not intended as an as-needed analgesic.

Criteria:

(a) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: METRONIDAZOLE 0.75% VAGINAL GEL
BRAND: METROGEL®

INDICATION:

(1) Bacterial vaginosis

Criteria:

(a) Pregnancy; **or**

(b) Intolerance to oral metronidazole

GENERIC: MILNACIPRAN
BRAND: SAVELLA®

INDICATION:

(1) Moderate to severe fibromyalgia

Criteria:

(a) Diagnosis of fibromyalgia; **and**

(b) Documented failure or contraindication to:

(1) Pain relievers (e.g. Tramadol); **or**

(2) Muscle Relaxants (e.g. cyclobenzaprine, Baclofen)

GENERIC: MIRABEGRON
BRAND: MYRBETRIQ®

INDICATION:

(1) Overactive bladder

(2) Neurogenic detrusor over-activity (NDO) in pediatric patients

Criteria:

(a) Failure of Oxybutynin

(b) Age 3 years and older and weighing 35kg or more (NDO)

GENERIC: MORPHINE SULFATE SUSTAINED-RELEASE
BRAND: MS CONTIN®

INDICATION:

(1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time; not intended as an as needed analgesic

Criteria:

(a) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: MOXIFLOXACIN
BRAND: AVELOX®

INDICATIONS:

(1) Acute bacterial sinusitis

(2) Acute bacterial exacerbations of chronic bronchitis

(3) Mild to moderate pelvic inflammatory disease

(4) Complicated/Uncomplicated skin and skin structure infections

(5) Community-acquired pneumonia

(6) Complicated intra-abdominal infections

Criteria:

In patients ≥18 years of age with any of the above listed indications when:

(a) Cultures show sensitivity to Avelox® only; **or**

(b) Patient discharged on Avelox® from the hospital and needs to complete regimen on an outpatient basis

GENERIC: NAFARELIN
BRAND: SYNAREL®

INDICATIONS:

(1) Central precocious puberty

(2) Endometriosis

Criteria:

(a) Diagnosis of central precocious puberty; **or**

(b) For the diagnosis of endometriosis in patients ≥ 18 years of age, failure of NSAIDs **and** oral contraceptives, **or** endometriosis diagnosed by laparoscopy.

Gender Affirming Treatment:

For all requests for gender affirming care, please refer to the Gender-Affirming Treatment Services Under the Maryland Medicaid Program document (for a copy of the criteria see our website at

https://jaimedicalsystems.com/providers/pharmacy/.) Please ensure that all necessary documentation required under the criteria is included to show consent for treatment and medical necessity (documentation requirements may vary depending on patient age, type of treatment requested, and specialty of requesting provider).

GENERIC: NUTRITIONAL SUPPLEMENTS
BRAND: ENSURE®, PEDIASURE®, BOOST®, VIVONEX®

INDICATION:
(1) Nutritional supplementation
Criteria:
(a) Patient must have enteral access via one of the following: nasogastric (NG) tube, nasoduodenal (ND) tube, nasojejunal (NJ) tube, percutaneous endoscopic gastrostomy (PEG) or percutaneous endoscopic jejunostomy (PEJ).

To obtain nutritional supplements (e.g., Ensure or Pediasure) for members without enteral access, please follow the DME process. For assistance accessing the DME process, please contact Customer Service at 1-888-524-1999.

GENERIC: OCTREOTIDE
BRAND: SANDOSTATIN®

INDICATIONS:
(1) Symptomatic treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumors
(2) Profuse, watery diarrhea associated with vasoactive intestinal peptide (VIP) secreting tumors
(3) To reduce the blood levels of growth hormone and IGF-I associated with acromegaly
Criteria:
(a) Any of the above diagnoses; **and**
(b) For the diagnosis of acromegaly, the patient has had an inadequate response to, or cannot be treated with surgical resection, pituitary irradiation **and** bromocriptine at maximally tolerated doses.

For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC: OLODATEROL HCL
BRAND: STRIVERDI®

INDCATION:
(1) Maintenance Treatment of Chronic Obstructive Pulmonary Disease
Criteria:
(a) Currently on, but not controlled by a LAMA for more than sixty (60) days; and
(b) The patient must be reevaluated after 6 months

GENERIC: OMALIZUMAB
BRAND: XOLAIR®

INDCATION:
(1) Treatment of moderate to severe persistent asthma in patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids.
(2) Treatment of adult patients, as an add-on maintenance treatment, chronic rhinosinusitis with nasal polyposis (CRSwNP).
(3) Treatment of adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment with chronic spontaneous urticaria (CSU).
Criteria:
(a) For pediatric patients 6 years and older with asthma

i. Documentation of baseline (pre-omalizumab treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL
ii. Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen
iii. Previous treatment, or intolerance of, with two (2) or more inhaled medium to high dose LABA+ICS for more than sixty (60) days; and
iv. Patients must be reevaluated after 6 months

(b) For adult patients with asthma
i. Documentation of baseline (pre-omalizumab treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL
ii. Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen
iii. Previous treatment, or intolerance of, with LAMA+LABA+ICS for more than sixty (60) days; and
iv. Patients must be reevaluated after 6 months

(c) For adult patients with CRSwNP
i. Previous treatment, or intolerance of, with two (2) or more intranasal corticosteroid for more than ninety (90) days; and
ii. Previous treatment, or intolerance of, with oral corticosteroid

(d) For pediatric patients 12 years and older with CSU
i. Previous treatment with two (2) H1-antihistamines for more than sixty (60) days within the past ninety (90) days

GENERIC: OXYCODONE, CONTROLLED-RELEASE
BRAND: OXYCONTIN®

INDICATION:

(1) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time; not intended as an as-needed analgesic.

Criteria:

(a) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires around-the-clock analgesia for an extended period of time; **and**
(b) For chronic pain, failure, intolerance, or contraindication to at least 2 short-acting formulary narcotic analgesics and controlled-release morphine (MS Contin, others). For cancer pain, failure intolerance, or contraindication to controlled-release morphine (MS Contin, others).
(c) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: PEGFILGRASTIM-PBBK
BRAND: FYLNETRA®

INDICATIONS:

(1) Prevention of neutropenia in patients receiving myelosuppressive chemotherapy for nonmyeloid malignancies
(2) Patients undergoing peripheral blood progenitor cell collection and therapy
(3) Patients with severe chronic neutropenia

Criteria:

(a) The patient is undergoing peripheral blood progenitor cell collection and therapy; or
(b) Diagnosis of severe chronic neutropenia with an absolute neutrophil count (ANC) < 1,000; or
(c) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given for prophylaxis for all future chemo cycles.

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

** Please indicate estimated duration of therapy*

GENERIC: PEGINTERFERON ALFA-2A
BRAND: PEGASYS®

INDICATIONS:

(1) Use in combination with ribavirin or ribavirin and other Direct-Acting Antivirals for the treatment of chronic Hepatitis C
(2) Treatment of chronic Hepatitis C in patients coinfected with HIV whose HIV is clinically stable.
(3) Treatment of patients with HBeAg positive and HBeAg negative chronic Hepatitis B

Criteria:

(In combination with ribavirin or ribavirin and other Direct-Acting Antivirals)

(a) Diagnosis as indicated above including any applicable labs and/or tests
(b) Clinically documented chronic Hepatitis C with detectable HCV RNA levels > 50 IU/mL
(c) Age ≥ 3 years
(d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
(e) Intolerant to Peg-Intron
(f) If HIV positive, patient is clinically stable.

(For chronic Hepatitis B)

(a) Documented HBeAg positive or negative chronic Hepatitis B
(b) Compensated liver disease
(c) Evidence of viral replication
(d) Evidence of liver inflammation
(e) Not contraindicated

GENERIC: PENTOXIFYLLINE
BRAND: TRENTAL®

INDICATION:

(1) Intermittent claudication

Criteria:

(a) Pain on walking or ABI < 0.8; **or**
(b) Diabetic foot ulcer; **or**
(c) Gangrene; or
(d) Risk of, or existing, amputation.

GENERIC: PIMECROLIMUS
BRAND: ELIDEL®

INDICATION:

(1) Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when treatments are not advisable.

Criteria:

(a) Documented failure of optimal dosing/adequate duration; **or**
(b) Intolerance or contraindication to at least one formulary topical corticosteroid; **and**
(c) Diagnosis of mild to moderate atopic dermatitis; **and**
(d) Using for short-term and non-continuous treatment.

GENERIC: RALOXIFENE
BRAND: EVISTA®

INDICATION:

(1) Treatment and prevention of osteoporosis in postmenopausal women

Criteria:

(a) Personal or family history of breast cancer; **or**
(b) Intolerable side effects to at least one formulary estrogen.

GENERIC: REPAGLINIDE
BRAND: PRANDIN

INDICATION:
(1) Type 2 diabetes mellitus

Criteria:
(a) Diagnosis of Type 2 diabetes mellitus
(b) Has not achieved adequate glycemic control on at least ONE of the following:
  (1) Metformin (alone or in combination)
  (2) A Sulfonylurea (alone or in combination)
  (3) A preferred DPP-4 inhibitor
(c) Contraindication to metformin, a sulfonylurea, OR a preferred DPP-4 Inhibitor

GENERIC: RIBAVIRIN
BRAND: REBETOL®

INDICATION:
(1) Indicated **only** in combination with a recombinant interferon alfa-2a or alfa-2b product or in combination with other Direct-Acting Antivirals for the treatment of chronic Hepatitis C.

Criteria:
(a) Diagnosis of chronic Hepatitis C; **and**
(b) Patient is receiving concomitant recombinant interferon alfa-2a or alfa-2b therapy or other Direct-Acting Antivirals.

GENERIC: RIFAXIMIN 550 MG
BRAND: XIFAXAN® 550 MG

INDICATION:
(1) Reduction in risk of overt hepatic encephalopathy (HE) recurrence in adults
(2) Treatment of irritable bowel syndrome with diarrhea (IBS-D) in adults

Criteria:
(a) Hepatic encephalopathy
- Failure of, intolerance to, contraindication, or previous use to lactulose at maximally tolerated doses

(b) IBS-D
- Failure of, intolerance to, contraindication, or previous use to loperamide
- For renewals: the patient has a ten (10) or more week treatment-free period

GENERIC: RILUZOLE
BRAND: RILUTEK®

INDICATION:
(1) Amyotrophic lateral sclerosis (ALS)

Criteria:
(a) Diagnosis of ALS.

GENERIC: RISANKIZUMAB
BRAND: SKYRIZI®

INDICATION:
(1) Treatment of adult patients with moderate-to-severe plaque psoriasis (Ps) who are candidates for systemic therapy or phototherapy.
(2) Treatment of adult patients with active psoriatic arthritis (PsA)
(3) Treatment of adults with moderately to severely active Crohn's disease (CD).

Criteria:

(a) First Prescription and every 12 months: The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to treatment.
(b) For adult patients with Ps and PsA - Previous treatment, or intolerance of, with Taltz for more than sixty (60) days
(c) For adult patients with CD - Previous treatment, or intolerance of, with formulary Humira biosimilar for more than sixty (60) days.

GENERIC: RIVASTIGMINE TARTRATE
BRAND: EXELON®

INDICATION:
(1) Alzheimer's disease: for the treatment of dementia
Criteria:
(a) Confirmation by clinical evaluation

GENERIC: RIZATRIPTAN
BRAND: MAXALT®

INDICATION:
(1) Acute treatment of migraine headache
Criteria:
(a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID's, ergotamine, or combination analgesic); **or**
(b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
(c) Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist.

GENERIC: ROPINIROLE
BRAND: REQUIP®

INDICATIONS:
(1) For the treatment of signs and symptoms of idiopathic Parkinson's disease.
(2) Moderate to severe primary Restless Leg Syndrome.
Criteria:
(a) Diagnosis of idiopathic Parkinson's disease; **or**
(b) Diagnosis of Restless Leg Syndrome and normal iron stores (serum ferritin and/or iron-binding saturation)

GENERIC: SALMETEROL / FLUTICASONE
BRAND: ADVAIR® / ADVAIR HFA®, WIXELA®, SALMETEROL / FLUTICASONE

INDICATION:
(1) Long-term, twice–daily maintenance treatment of asthma in patients 4 years of age and older.
(2) Maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease.
Criteria for Asthma:
(a) Currently on, but not controlled by an inhaled corticosteroid for more than sixty (60) days; and
(b) The patient must be reevaluated after 6 months
Criteria for COPD:
(a) Currently on, but not controlled by a LAMA for more than sixty (60) days; and
(b) The patient must be reevaluated after 6 months

** For members currently with an approved prior authorization for Advair, claims will process as long as the member has filled Advair within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Advair therapy, or with no claim history of Advair within the last 4 months. Once approved, 90-day supplies are allowed.*

GENERIC: SALMETEROL XINAFOATE
BRAND: SEREVENT DISKUS®

INDICATIONS:
(1) Maintenance treatment of asthma and prevention of bronchospasm in adults and children 4 years of age and older
(2) Prevention of exercise-induced bronchospasm in patients 4 years of age and older
(3) Serevent Diskus® is indicated for the maintenance treatment of bronchospasm associated with chronic obstructive pulmonary disease

Criteria for Asthma:
(a) Currently on, but not controlled by an inhaled corticosteroid for more than sixty (60) days; and
(b) Patients must be reevaluated after 6 months

Criteria for COPD:
(a) Currently on, but not controlled by a LAMA for more than sixty (60) days; and
(b) The patient must be reevaluated after 6 months

GENERIC: SILDENAFIL
BRAND: REVATIO®

INDICATION:
(1) Pulmonary Arterial Hypertension (PAH)

Criteria:
(a) For the treatment of PAH; **and**
(b) Current utilization of nitrates is contraindicated; **and**
(c) Age limit of 2 years and younger for the solution

GENERIC: SIMVASTATIN 80mg
BRAND: ZOCOR®

INDICATIONS:
(1) Heterozygous or homozygous familial hypercholesterolemia
(2) Familial type 3 hyperlipoproteinemia
(3) Hypertriglyceridemia
(4) Primary hypercholesterolemia, or mixed hyperlipidemia
(5) Decrease cardiovascular event risk in patients with high coronary event risk
(6) Cerebrovascular accident prophylaxis

Criteria:
(a) Age ≤ 65 years
(b) Male gender (female gender predisposed to myopathy including rhabdomyolysis)
(c) Controlled hypothyroidism
(d) Normal renal function
(e) Documentation of all cholesterol lowering agents tried and failed must be provided.

GENERIC: SITAGLIPTIN PHOSPHATE
BRAND: JANUVIA®

Step Therapy Criteria:
Recent trial of formulary product Alogliptin - Cumulative days' supply for more than sixty (60) days with at least one (1) fill within the last one-hundred and eighty (180) days.

GENERIC: SOFOSBUVIR-VELPATASVIR
BRAND: EPCLUSA®

INDICATION:
(1) Chronic Hepatitis C

Criteria:
(a) Generic tablets only
(b) Preferred for genotypes 1, 2, 3, 4, 5 and 6
(c) Must follow the clinical criteria as set by the Maryland Department of Health
(d) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at http://www.jaimedicalsystems.com/providers/pharmacy/ or by contacting MC-Rx at 1-800-555-8513

GENERIC: SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR
BRAND: VOSEVI®

INDICATION:
(1) Chronic Hepatitis C

Criteria:
(a) For retreatment only
(b) Must follow the clinical criteria as set by the Maryland Department of Health
(c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at http://www.jaimedicalsystems.com/providers/pharmacy/ or by contacting MC-Rx at 1-800-555-8513

GENERIC: SOLIFENACIN SUCCINATE

Step Therapy Criteria:
Recent trial of formulary product generic Oxybutynin - Cumulative days' supply for more than sixty (60) days within the last one-hundred and eighty (180) days with at least one (1) cumulative fill

GENERIC: SOMATROPIN
BRAND: HUMATROPE®

INDICATIONS:
(1) Growth failure in children due to inadequate growth hormone (GH) secretion
(2) Idiopathic short stature in children defined by height standard deviation (SD) score less than or equal to -2.25 and growth rate not likely to attain normal adult height
(3) Short stature in children associated with Turner syndrome

Criteria:
(a) Patient with open epiphyses (as confirmed by radiograph of wrist and hand) who has not reached final height; **and**
(b) Medication prescribed by an endocrinologist; **and**
(c) Patient meets one of the following criteria:
  (1) Growth Hormone Deficiency (GHD) with diagnosis confirmed by one of the following:
    i. Severe short stature defined as patient's height at ≥ 2 SD below the population mean
    ii. Patient's height ≥ 1.5 SD below the midparental height (average of mother's and father's heights)
    iii. Patient's height ≥ 2 SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1-year decrease of more than 0.5 SD in height
    iv. In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD)

v. Signs indicative of an intracranial lesion
vi. Signs of multiple pituitary hormone deficiencies
vii. Neonatal symptoms and signs of GHD

(2) Idiopathic short stature with patient's height at ≥ 2.25 SD below the mean height for normal children of the same age and gender
(3) Short stature associated with Turner syndrome and height below the 5th percentile of normal growth curve

* *To continue therapy, requests will be reviewed every six months.*
For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC: SUCCIMER
BRAND: CHEMET®

INDICATIONS:
(1) Treatment of lead poisoning in children with blood lead levels > 45 mcg/dl
(2) Unlabeled uses: Succimer may be beneficial in the treatment of other heavy metal poisonings

Criteria:
(a) Diagnosis of lead poisoning with blood levels > 45mcg/dl; **and**
(b) Child is hospitalized; **or**
(c) Child was started on the medication in the hospital and needs to continue upon discharge.

GENERIC: TACROLIMUS
BRAND: PROTOPIC®

INDICATION:
(1) Moderate to severe atopic dermatitis

Criteria:
(a) Patient must be non-immunocompromised **and**
(b) Must be at least 2 years of age or older for the 0.03% strength; **or**
(c) 16 years of age or older for 0.1% strength **and**
(d) Diagnosis of atopic dermatitis
(e) Documented failure of 2 different topical corticosteroids of medium to high potency in the past 90 days
(f) Must be prescribed by a dermatologist, allergist, or for children, a pediatrician

GENERIC: TERIFLUNOMIDE
BRAND: AUBAGIO®

INDICATION:
(1) Diagnosis of a relapsing form of Multiple Sclerosis

Criteria:
(a) Prescribed by neurologist; **and**
(b) Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera.

GENERIC: TESTOSTERONE
BRAND: ANDROGEL®, TESTIM®

INDICATION:
(1) Hypogonadism

Criteria:
(a) Must be prescribed by an Endocrinologist or Urologist
(b) Initial therapy: The patient has documented low testosterone concentration
(c) Renewal: The patient has documented therapeutic concentration to confirm response

Gender Affirming Treatment:

For all requests for gender affirming care, please refer to the Gender-Affirming Treatment Services Under the Maryland Medicaid Program document (for a copy of the criteria see our website at https://jaimedicalsystems.com/providers/pharmacy/.) Please ensure that all necessary documentation required under the criteria is included to show consent for treatment and medical necessity (documentation requirements may vary depending on patient age, type of treatment requested, and specialty of requesting provider).

GENERIC: THROMBIN
BRAND: THROMBIN

INDICATION:
(1) Hemostasis
Criteria:
(a) Diagnosis of a bleeding disorder

GENERIC: TOLTERODINE TARTRATE

Step Therapy Criteria:
Recent trial of formulary product generic Oxybutynin - Cumulative days supply for more than sixty (60) days within the last one-hundred and eighty (180) days with at least one (1) cumulative fill

GENERIC: TRAMADOL ER
BRAND: ULTRAM ER®

INDICATION:
(1) Pain, chronic (moderate to severe)
Criteria:
(a) For patients who have a contraindication or failure of tramadol regular release tablets
(b) Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/

GENERIC: TROSPIUM CHLORIDE

Step Therapy Criteria:
Recent trial of formulary product generic Oxybutynin - Cumulative days supply for more than sixty (60) days within the last one-hundred and eighty (180) days with at least one (1) cumulative fill

GENERIC: UMECLIDINIUM BROMIDE/VILANTEROL RIFENATATE
BRAND: ANORO ELLIPTA®

INDICATION:
(1) Chronic obstructive pulmonary disease (COPD): maintenance of airflow obstruction in patients with COPD, including chronic bronchitis and emphysema.
Criteria:
(a) Currently on, but not controlled by a LAMA for more than sixty (60) days; and
(b) The patient must be reevaluated after 6 months

GENERIC: UPADACITINIB
BRAND: RINVOQ®

INDICATIONS:
(1) Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with rheumatoid arthritis (RA).

(2) Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active psoriatic arthritis (PsA).
(3) Treatment of pediatric patients 12 years and older, who have had an inadequate response or intolerance to other systemic drug products, including biologics, with active atopic dermatitis (AD).
(4) Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active ulcerative colitis (UC).
(5) Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active ankylosing spondylitis (AS).
(6) Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active non-radiographic axial spondyloarthritis (nr-axSpA).

Criteria:

(a) First Prescription and every 12 months:
  i. The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to treatment.
  ii. The patient had a NEGATIVE hepatitis B and C viral screening
(b) For adult patients with RA
  i. Previous treatment, or intolerance of, with Enbrel for more than sixty (60) days; and
  ii. Previous treatment, or intolerance of, with formulary Humira biosimilar for more than sixty (60) days
(c) For adult patients with PsA
  i. Previous treatment, or intolerance of, with Enbrel for more than sixty (60) days; and
  ii. Previous treatment, or intolerance of, with formulary Humira biosimilar for more than sixty (60) days; and
  iii. Previous treatment, or intolerance of, with Taltz for more than sixty (60) days
(d) For pediatric patients 12 years and older with AD
  i. Previous treatment, or intolerance of, with Dupixent, or intolerance of, for more than sixty (60) days
(e) For adult patients with UC
  i. Previous treatment, or intolerance of, with formulary Humira biosimilar for more than sixty (60) days
(f) For adult patients with AS and nr-asSpA
  i. Previous treatment, or intolerance of, with Taltz for more than sixty (60) days

GENERIC: VALSARTAN, VALSARTAN-HCTZ
BRAND: DIOVAN®, DIOVAN-HCT®

INDICATION:

(1) Hypertension

Criteria for Valsartan:

(a) Failure or contraindication of 2 formulary ARBs (Irbesartan, Losartan)

Criteria for Valsartan-HCTZ:

(a) Failure or contraindication of 2 formulary ARB-HCTZ combinations (Irbesartan-HCTZ, Losartan-HCTZ)

GENERIC: ZOLMITRIPTAN TABLETS
BRAND: ZOMIG®

INDICATION:

(1) Acute treatment of migraine headache

Criteria:

(a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID, ergotamine, or combination analgesic); **or**
(b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
(c) Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist

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Abacavir-Lamivudine	3
Abacavir-Lamivudine-Zidovudine	3
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Acetaminophen w/ Codeine Sol*	14
Acetaminophen w/ Codeine*	14
Acetaminophen*	14
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Acetone Tablets	21
Acetone Test*	21
Acetylcysteine*	10
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ACTOS	6
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ADRENACLICK	10
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Al Hydrox-Mag Carb*	12
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ALBENZA	2
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ALBUTEROL NEBULIZER SOLUTION	10
Albuterol*	10
Albuterol-Ipratropium*	10
ALCOHOL PADS	21
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Amantadine*	3
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Amlodipine & Benazepril*	7
Amlodipine*	7
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Amox & K Clavulanate*	1
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Ampicillin*	1
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Benzocaine & Antipyrine*	19
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Benzoyl Peroxide*	20
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Betamethasone Dipropionate*	20
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BEYAZ	5
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Bicalutamide*	4
BICILLIN	1
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CLEOCIN	1
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Clindamycin*	1
Clindamycin*	13
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Clobetasol Propionate*	20
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