Blue Cross complete of Michigan

Pharmacy Update

The formulary changes below meet requirements set by the State of Michigan and the Common Formulary Workgroup. Blue Cross Complete is a member of Michigan Managed Care Common Formulary Workgroup.

Please Note: Changes established by the Common Formulary Workgroup may not be posted immediately. Please allow time for documents to be updated and posted. New information will be posted as soon as possible.

Medication Name	Preferred Drug List Update*	Effective Date
ADALIMUMAB-RYVK(CF) AI 40 MG	Added to formulary as PDL Non-Preferred specialty with PA required	11/1/2024
AMCINONIDE 0.1% CREAM	Added to formulary as PDL Non-Preferred with PA required	11/1/2024
ARNUITY ELLIPTA 50 MCG INH	Moved to PDL Preferred	11/1/2024
ENDARI 5 GRAM POWDER PACKET	Removed from formulary use generic L-Glutamine 5 gram Powder Packet	11/1/2024
EVEROLIMUS 2 MG TAB FOR SUSP EVEROLIMUS 3 MG TAB FOR SUSP EVEROLIMUS 5 MG TAB FOR SUSP	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	11/1/2024
GLUCAGON 1 MG EMERGENCY PEN	Moved to PDL Non-Preferred with PA required	11/1/2024
INVOKAMET 50-500 MG TABLET INVOKAMET 50-1,000 MG TABLET INVOKAMET 150-500 MG TABLET INVOKAMET 150-1,000 MG TABLET	Moved to PDL Non-Preferred with PA required. Grandfathering allowed for current utilizers through 2/28/2025	11/1/2024
INVOKANA 100 MG TABLET INVOKANA 300 MG TABLET	Moved to PDL Non-Preferred with PA required. Grandfathering allowed for current utilizers through 2/28/2025	11/1/2024
KIPROFEN 25 MG CAPSULE	Added to formulary as PDL Non-Preferred with PA required	11/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
L-GLUTAMINE 5 GRAM POWDER PKT	Added to formulary as covered with PA required AL min. of 5 years old with QL 180packets per 30 days *Generic for Endari*	11/1/2024
LINZESS 72 MCG CAPSULE LINZESS 145 MCG CAPSULE LINZESS 290 MCG CAPSULE	Added AL min. of 6 years old and QL of 1 capsule per day	11/1/2024
LOFEXIDINE 0.18 MG TABLET	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	11/1/2024
LOKELMA 5 GRAM POWDER PACKET LOKELMA 10 GRAM POWDER PACKET	Moved to PDL Preferred no PA required	11/1/2024
LOMAIRA 8 MG TABLET	Updated AL to 17 years old	11/1/2024
METFORMIN HCL 625 MG TABLET	Moved to PDL Non-Preferred with PA required	11/1/2024
OPSYNVI 10-20 MG TABLET OPSYNVI 10-40 MG TABLET	Added to formulary as Non-Preferred with PA required, AL min. of 18 years old and QL of 1 tablet per day	11/1/2024
OTEZLA 10-20 MG STARTER 28 DAY OTEZLA 20 MG TABLET	Added to formulary as PDL Non-Preferred Specialty with PA required	11/1/2024
OZEMPIC 0.25-0.5 MG/DOSE PEN OZEMPIC 1 MG/DOSE PEN (4 MG/3 ML) PZEMPIC 2 MG/DOSE PEN (8 MG/3 ML)	Moved to PDL Preferred with PA required with QL of 3 per 28 days and PDL Maintenance	11/1/2024
PENTASA 250 MG CAPSULE PENTASA 500 MG CAPSULE	Moved to PDL Preferred and removed PA requirement	11/1/2024
PHOSLYRA 667 MG/5 ML SOLUTION	Added back to formulary as PDL non-Preferred with PA required	11/1/2024
PRADAXA 110 CAPSULE	Added *Brand over Generic* logic	11/1/2024
PROLATE 5-300 MG TABLET PROLATE 7.5-300 MG TABLET PROLATE 10-300 MG TABLET	Moved to PDL Non-Preferred with PA required and QL	11/1/2024
PROLATE 10 MG-300 MG/5 ML SOLN	Moved to PDL Non-Preferred with PA required and QL	11/1/2024

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PROTONIX DR 20 MG TABLET PROTONIX DR 40 MG TABLET	Moved to PDL Non-Preferred with PA required and QL of 2 tablets per day	11/1/2024
SIMLANDI(CF) AI 40 MG/0.4 ML	Added to formulary as PDL Non-Preferred as Specialty with PA required and QL	11/1/2024
SODIUM PHOSPHATE 15 MMOL/5 ML SODIUM PHOSPHATE 45 MMOL/15 ML SODIUM PHOSPHATE 150 MMOL/50 ML	Added to formulary covered for CSHCS members only	11/1/2024
SYNJARDY XR 5-1,000 MG TABLET SYNJARDY XR 10-1,000 MG TABLET SYNJARDY XR 12.5-1,000 MG TABLET SYNJARDY XR 25-1,000 MG TABLET	Moved to PDL Preferred and removed PA requirement	11/1/2024
TACROLIMUS 0.1% OINTMENT	Moved to PDL Preferred with AL of 16 years old, QL of 30 grams per 30 days and removed PA requirement	11/1/2024
TACROLIMUS 0.03% OINTMENT	Moved to PDL Preferred with AL min of 2 years old, QL of 30 grams per 30 days and removed PA requirement	11/1/2024
TALTZ 20 MG/0.25 ML SYRINGE TALTZ 40 MG/0.5 ML SYRINGE	Added to formulary as Specialty PDL Non-Preferred with PA required	11/1/2024
TIMOPTIC 0.25% OCUDOSE DROP	Added to formulary as PDL Non-Preferred with PA required	11/1/2024
TYENNE 162 MG/0.9 ML AUTOINJECT TYENNE 162 MG/0.9 ML SYRINGE	Added to formulary as PDL Non-Preferred Specialty with PA required and AL	11/1/2024
VELTASSA 8.4 GM POWDER PACKET VELTASSA 16.8 GM POWDER PACKET VELTASSA 25.2 GM POWDER PACKET	Moved to PDL Non-Preferred with PA required	11/1/2024
VORANIGO 10 MG TABLET VORANIGO 40 MG TABLET	Added to formulary as Tier 4; Policy Update 2022-PA-0019	11/1/2024
WINREVAIR 45 MG ONE-VIAL KIT WINREVAIR 45 MG TWO-VIAL KIT WINREVAIR 60 MG ONE-VIAL KIT WINREVAIR 60 MG TWO-VIAL KIT	Added to formulary as PDL Non-Preferred Specialty with PA required and PDL Maintenance	11/1/2024
WIXELA 100-50 INHUB WIXELA 250-50 INHUB WIXELA 500-50 INHUB	Moved to PDL Non-Preferred with PA required and QL 180 per 90 days and PDL Maintenance	11/1/2024

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ZYMFENTRA 120 MG/ML PEN KIT ZYMFENTRA 120 MG/ML SYRINGE KIT	Added to formulary as PDL Non-Preferred Specialty with PA required and AL min. 18 years old	11/1/2024
ACYCLOVIR 5% CREAM	Moved to Tier 1 and PDL Maintenance Generic for Zovirax 5% Cream	8/1/2024
ADVAIR 100-50 DISKUS ADVAIR 250-50 DISKUS ADVAIR 500-50 DISKUS	Added to formulary as Tier 1 with QL of 3 inhalers per 90 days and PDL Maintenance	8/1/2024
ADVAIR HFA 45-21 MCG INHALER ADVAIR HFA 115-21 MCG INHALER ADVAIR HFA 230-21 MCG INHALER	Added to formulary as Tier 1 with QL of 3 inhalers per 90 days and PDL Maintenance	8/1/2024
ARNUITY ELLIPTA 100 MCG INH ARNUITY ELLIPTA 200 MCH INH	Moved to Tier 1 and removed from PDL Maintenance	8/1/2024
CABTREO 1.2%-0.15%-3.15% GEL	Added to formulary under Tier 3 with PA required	8/1/2024
FIRVANQ 25 MG/ML SOLUTION FIRVANQ 50 MG/ML SOLUTION	Moved to Tier 3 with PA required ***Brand over generic no longer applies***	8/1/2024
FLUTICASONE-SALMETEROL 100-50 FLUTICASONE-SALMETEROL 250-50 FLUTICASONE-SALMETEROL 500-50	Moved to Tier 3 with PA required with QL of 180 per 90 days and PDL Maintenance	8/1/2024
FLUTICASONE-SALMETEROL 45-21 FLUTICASONE-SALMETEROL 115-21 FLUTICASONE-SALMETEROL 230-21	Moved to Tier 3 with PA required with QL of 3 inhalers per 90 days and PDL Maintenance	8/1/2024
LIRAGLUTIDE 2-PAK 18 MG/3 ML PEN	Added to formulary with PA required QL of 6 per 30 days and PDL Maintenance *Brand Victoza Preferred*	8/1/2024
LIRAGLUTIDE 3-PAK 18 MG/3 ML PEN	Added to formulary with PA required QL of 9 per 30 days and PDL Maintenance *Brand Victoza Preferred*	8/1/2024
NEOMYCIN-POLYMYXIN-HC EAR SUSP	Moved to Tier 1 and removed from PDL Maintenance	8/1/2024
OFLOXACIN 0.3% EAR DROPS	Moved to Tier 1 and removed from PDL Maintenance	8/1/2024

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OMVOH 100 MG/ML PEN OMVOH 300 MG/15 ML VIAL	Added to formulary as Tier 3 with PA required and AL minimum of 18 years old	8/1/2024
PULMICORT 90 MCG FLEXHALER	Moved to Tier 1 with QL of 3 inhalers per 90 days and remove PA requirement and from PDL Maintenance	8/1/2024
PULMICORT 180 MCG FLEXHALER	Moved to Tier 1 with QL of 6 inhalers per 90 days and remove PA requirement and from PDL Maintenance	8/1/2024
QVAR REDIHALER 40 MCG QVAR REDIHALER 80 MCG	Moved to Tier 1 and removed from PDL Maintenance	8/1/2024
SITAGLIPTIN 25MG TABLET SITAGLIPTIN 50 MG TABLET SITAGLIPTIN 100 MG TABLET	Added to formulary as Tier 3 with PA required and PDL Maintenance	8/1/2024
VANCOMYCIN 25 MG/ML SOLUTION VANCOMYCIN 50 MG/M SOLUTION	Moved to Tier 1 and removed from PDL Maintenance *Generic Firvanq*	8/1/2024
VEVYE 0.1% EYE DROP	Added to formulary as Tier 3 with PA required, AL minimum of 18 years old and QL of 2 mLs per 30 days	8/1/2024
VOQUEZNA DUAL PAK VOQUEZNA TRIPLE PAK	Added to formulary as Tier 3 with PA required	8/1/2024
XPHOZAH 20 MG TABLET XPHOZAH 30 MG TABET	Added to formulary as Tier 3 with PA required and PDL Maintenance	8/1/2024
XULANE 150-35 MCG/DAY PATCH	Removed QL	8/1/2024
ZAFEMY 150-35 MCG/DAY PATCH	Removed QL	8/1/2024
ZITUVIO 25 MG TABLET ZITUVIO 50 MG TABLET ZITUVIO 100 MG TABLET	Added to formulary as Tier 3 with PA required and PDL Maintenance	8/1/2024
ZOVIRAX 5% CREAM	Moved to Tier 3 with PA required ***Brand over generic no longer applies***	8/1/2024
ABRILADA(CF) 20 MG/0.4 ML SYRINGE ABRILADA(CF) 40 MG/0.8 ML PEN ABRILADA(CF) 40 MG/0.8 ML SYRINGE	Added to formulary as Tier 3 with PA required and AL in accordance with PA criteria	5/1/2024

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AIRSUPRA 90-80 MCG INHALER	Added to formulary as Tier 3 with PA required, QL of 6 inhalers per 90 days and PDL Maintenance	5/1/2024
BIMZELX 160 MG/ML AUTOINJECTOR BIMZELX 160 MG/ML SYRINGE	Added to formulary as Tier 3 with AL ≥ 18 years old and PA required	5/1/2024
BREYNA 80-4.5 MCG INHALER BREYNA 160-4.5 MCG INHALER	Added to formulary as Tier 3 with QL of 6 inhalers per 90 days and PA required	5/1/2024
BROMFENAC SOD 0.075% EYE DROP	Added to formulary as Tier 3 with PA required *equivalent to Bromsite Eye Drops*	5/1/2024
BYSTOLIC 2.5 MG TABLET BYSTOLIC 5 MG TABLET BYSTOLIC 10 MG TABLET BYSTOLIC 20 MG TABLET	Removed brand over generic logic	5/1/2024
CARVEDILOL ER 10 MG CAPSULE CARVEDILOL ER 20 MG CAPSULE CARVEDILOL ER 40 MG CAPSULE CARVEDILOL ER 80 MG CAPSULE	Moved to Tier 1 and PDL Maintenance	5/1/2024
COREG CR 10 MG CAPSULE COREG CR 20 MG CAPSULE COREG CR 40 MG CAPSULE COREG CR 80 MG CAPSULE	Moved to Tier 3 with PA required and PDL Maintenance	5/1/2024
DEFLAZACORT 6 MG TABLET DEFLAZACORT 18 MG TABLET DEFLAZACORT 30 MG TABLET DEFLAZACORT 36 MG TABLET	Added to formulary as Tier 4 Specialty Drug	5/1/2024
DOFETILIDE 125 MCG CAPSULE DOFETILIDE 250 MCG CAPSULE DOFETILIDE 500 MCG CAPSULE	Added to formulary as Tier 4 Specialty Drug	5/1/2024
ELIDEL 1% CREAM	Removed brand over generic logic, remains Tier 2 with AL ≥ 2 years old and QL 30 grams per 30 days	5/1/2024
IYUZEH 0.005% EYE DROP	Added to formulary as Tier 3 with PA required	5/1/2024

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JESDUVROQ 1 MG TABLET JESDUVROQ 2 MG TABLET JESDUVROQ 4 MG TABLET JESDUVROQ 6 MG TABLET JESDUVROQ 8 MG TABLET	Added to formulary as Tier 3 with AL ≥ 18 years old and PA required	5/1/2024
JYNARQUE 15 MG TABLET JYNARQUE 15 MG-15 MG TABLET JYNARQUE 30 MG TABLET JYNARQUE 30 MG-15 MG TABLET JYNARQUE 45 MG-15 MG TABLET JYNARQUE 60 MG-30 MG TABLET JYNARQUE 90 MG-30 MG TABLET	Added to formulary as Tier 4 with AL ≥ 18 years old, QL 2 tablets per day and PA required	5/1/2024
LIKMEZ 500 MG/5 ML SUSPENSION	Added to formulary as Tier 3 with QL 400 mLs per 10 days and PA required	5/1/2024
MOXIFLOXACIN 0.5% EYE DROPS	Moved to Tier 1 and removed PA requirement	5/1/2024
NEBIVOLOL 2.5MG TABLET NEBIVOLOL 5 MG TABLET NEBIVOLOL 10 MG TABLET NEBIVOLOL 20 MG TABLET	Moved to Tier 1 and removed PA requirement added PDL Maintenance	5/1/2024
NGENLA PEN 24 MG/1.2 ML NGENLA PEN 60 MG/1.2 ML	Added to formulary as Tier 3 Specialty Drug with PA required	5/1/2024
OLOPATADINE HCL 0.1% EYE DROPS	Rx version moved to Tier 3 with PA required. OTC generic remains Tier 1	5/1/2024
OLOPATADINE HCL 0.2% EYE DROP	Moved to Tier 3 with PA required	5/1/2024
VELSIPITY 2 MG TABLET	Added to formulary as Tier 3 Specialty Drug with AL ≥ 18 years old and PA required	5/1/2024
VIGAMOX 0.5% EYE DROPS	Moved to Tier 3 with PA required - Generic is preferred.	5/1/2024
YUFLYMA(CF) 20 MG/0.2 ML SYRINGE	Added to Tier 3 Specialty Drug with PA required and AL in accordance with PA criteria	5/1/2024
ZADITOR 0.025% (0.035%) DROPS	NDC 00065-4011-05 moved to Tier 3 with PA required for this brand, all other OTC NDCs remain Tier 1	5/1/2024

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ZEPBOUND 2.5 MG/0.5 ML PEN ZEPBOUND 5 MG/0.5 ML PEN ZEPBOUND 7.5 MG/0.5 ML PEN ZEPBOUND 10 MG/0.5 ML PEN ZEPBOUND 12.5 MG/0.5 ML PEN ZEPBOUND 15 MG/0.5 ML PEN	Added to formulary as Tier 2 with PA required and AL ≥ 18 years old	5/1/2024
PIMECROLIMUS 1% CREAM	Moved to Tier 2 with PA required	4/1/2024
ADALIMUMAB-ADAZ(CF) 40 MG SYRG ADALIMUMAB-ADAZ(CF) PEN 40 MG ADALIMUMAB-FKJP(CF) 20 MG SYRG ADALIMUMAB-FKJP(CF) 40 MG SYRG ADALIMUMAB-FKJP(CF) PEN 40 MG	Add to formulary as Tier 3 with PA required	2/1/2024
AJOVY 225 MG/1.5 ML AUTOINJECT AJOVY 225 MG/1.5 ML SYRINGE	Moved to Tier 2 with PA required, AL ≥ 18 years old and QL of 4.5 mL/90 days	2/1/2024
B-COMPLEX 100 INJECTION	Moved to Tier 4 coding by NDC 67457014630	2/1/2024
BEELITH TABLET	Moved to Tier 4 coding by NDC 00486113201	2/1/2024
BELBUCA 75 MCG FILM BELBUCA 150 MCG FILM BELBUCA 300 MCG FILM BELBUCA 450 MCG FILM BELBUCA 600 MCG FILM BELBUCA 750 MCG FILM BELBUCA 900 MCG FILM	MME limit no longer applies, PA required with QL of 60 per 30 days	2/1/2024
BETA-CAROTENE 7,500 MCG SFGL BETA-CAROTENE 25,00 UNIT SFGL	Moved to Tier 4 covered for CSHCS members only	2/1/2024
BUPRENORPHINE 5 MCG/HR PATCH BUPRENORPHINE 7.5 MCG/HR PATCH BUPRENORPHINE 10 MCG/HR PATCH BUPRENORPHINE 15 MCG/HR PATCH BUPRENORPHINE 20 MCG/HR PATCH	MME limit no longer applies, PA required with QL of 6 patches per 28 days	2/1/2024
BUTRANS 5 MCG/HR PATCH BUTRANS 7.5 MCG/HR PATCH BUTRANS 10 MCG/HR PATCH BUTRANS 15 MCG/HR PATCH BUTRANS 20 MCG/HR PATCH	MME limit no longer applies, PA required with QL of 6 patches per 28 days	2/1/2024
CALCIUM CITRATE 250 MG CAPLET CALCIUM CITRATE 250 MG TABLET	Moved to Tier4 covered for CSHCS members only	2/1/2024

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CALCIUM GLUC 1,000 MG/10 ML VL	Covered for CSHCS only and removed NDC 00143918001 from formulary * Inner pack not on MPPL	2/1/2024
CALCIUM GLUC 5,000 MG/50 ML VL CALCIUM GLUC 10,000 MG/100 ML	Moved to Tier 4 covered for CSHCS members only	2/1/2024
CIPRODEX OTIC SUSPENSION	Removed brand over generic requirement	2/1/2024
CIPROFLOX-DEXAMETH OTIC SUSP	Moved to Tier 1	2/1/2024
CYLTEZO(CF) 10 MG/0.2 ML SYRING CYLTEZO(CF) 20 MG/0.4 ML SYRING CYLTEZO(CF) 40 MG//0.8 ML SYRING CYLTEZO(CF) PEN 40 MG/0.8 ML CYLTEZO(CF) PEN CRH-UC-HS 40 MG CYLTEZO(CF) PEN PSORIASIS 40 MG	Added to formulary as Tier 3 with PA required	2/1/2024
ENTACAPONE 20 MG TABLET	Moved to Tier 1; removed PA requirement	2/1/2024
EPINEPHRINE 0.15 MG AUTO-INJECT EPINEPHRINE 0.3 MG AUTO-INJECT	Moved to Tier 1 with QL of 4 pens/claim	2/1/2024
ERGOCALCIFEROL 200 MCG/ML DROP ERGOCALCIFEROL 8,000 UNITS/ML	Covered for CSHCS members only	2/1/2024
FINGOLIMOD 0.5 MG CAPSULE	Moved to Tier 1; removed PA requirement	2/1/2024
FLUTICASONE PROP 50 MCG DISKUS FLUTICASONE PROP 100 MCG DISKUS FLUTICASONE PROP 250 MCG DISK	Added to formulary under Tier 3 with PA required	2/1/2024
GILENYA 0.25 MG CAPSULE	Moved to Tier 3 with PA required	2/1/2024
GILENYA 0.5 MG CAPSULE	Moved to Tier 3 with PA required and removed brand over generic requirement	2/1/2024
HADLIMA 40 MG/0.8 ML SYRINGE HADLIMA PUSHTOUCH 40 MG/0.8 ML HADLIMA(CF) 40 MG/0.8 ML SYRINGE HADLIMA(CF) PUSHTOUCH 40 MG/0.8 ML	Added to formulary as Tier 3 with PA required	2/1/2024
HULIO(CF) 20 MG/0.4 ML SYRINGE HULIO(CF) 40 MG/0.8 ML SYRINGE HULIO(CF) PEN 40 MG/0.8 ML SYRINE	Added to formulary as Tier 3 with PA required	2/1/2024
HYRIMOZ(CF) 10 MG/0.1 ML SYRING HYRIMOZ(CF) 20 MG/0.5 ML SYRING HYRIMOZ(CF) 40 MG/0.4 ML SYRING	Added to formulary as Tier 3 with PA required	2/1/2024

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HYRIMOZ(CF) PEDI CROHN 80 MG HYRIMOZ(CF) PEDI CROHN 80-40 MG HYRIMOZ(CF) PEN 40 MG/0.4 ML HYRIMOZ(CF) PEN 80 MG/0.8 ML HYRIMOZ(CF) PEN CROHN-UC 80 MG HYRIMOZ(CF) PEN PSORIA 80-40 MG		
IDACIO(CF) 40 MG/0.8 ML SYRING IDACIO(CF) PEN 40 MG/0.8 ML IDACIO(CF) PEN CROHNS-UC 40 MG IDACIO(CF) PEN PSIRUASIS 40 MG	Added to formulary as Tier 3 with PA required	2/1/2024
INPEFA 200 MG TABLET	Added to formulary as Tier 3 with PA required and PDL Maintenance	2/1/2024
LIQREV 10 MG/ML ORAL SUSP	Added to formulary as Tier 3 with PA required	2/1/2024
LITFULO 50 MG CAPSULE	Added to formulary as Tier 4 with AL ≥ 12 years old and QL of 1 capsule day with PA required	2/1/2024
L-METHYL-B6-B12 TABLET	Removed from formulary *covered for CSHCS only	2/1/2024
MIEBO 100% EYE DROP	Added to formulary as Tier 4 with PA required with PA required with AL ≥ 18 years old and QL of 3 mL/30 days	2/1/2024
MYFEMBREE 40 MG-1 MG-0.5 MG TB	Updated QL to 28 tablets/28 days	2/1/2024
ORIAHNN 300-1-0.5 MG/300 MG CAPS	Updated QL to 56 capsules/28 days	2/1/2024
ORILISSA 150 MG TABLET	Added QL of 28 tablets/28 days	2/1/2024
ORILISSA 200 MG TABLET	Added QL of 56 tablets/28 days	2/1/2024
PITAVASTATIN 1 MG TABLET PITVASATATIN 2 MG TABLET PITAVASTATIN 4 MG TABLET	Added to formulary as Tier 3 with PA required and QL of 1 tablet/day	2/1/2024
SOD SUL-POTSS SUL-MAG SUL SOL	Added to formulary as Tier 4 and QL of 1 bottle/30 days	2/1/2024
SOGROYA 5 MG/1.5 ML PEN SOGROYA 10 MG/1.5 ML PEN SOGROYA 15 MG/1.5 ML PEN	Added for formulary as Tier 3 with PA required and QL of 8 mg/week	2/1/2024

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PDL Maintenance List = drugs included on this list are eligible for up to a 102-day supply.

Medication Name	Preferred Drug List Update*	Effective Date
TERIFLUNOMIDE 7 MG TABLET TERIFLUNOMIDE 14 MG TABLET	Moved to Tier 1 and removed PA requirement	2/1/2024
TRULICITY 0.75 MG/0.5 ML PEN TRULICITY 1.5 MG/0.5 ML PEN TRULICITY 3 MG/0.5 ML PEN TRULICITY 4.5 MG/0.5 ML PEN	Moved to Tier 2 with PA required and QL of 2 mL/28 days	2/1/2024
VICTOZA 2-PAK 18 MG/3 ML PEN	Moved To Tier 2 with PA required and QL of 6 mL/30 days	2/1/2024
VICTOZA 3-PAK 18 MG/3 ML PEN	Moved to Tier 2 with PA required and QL of 9 mL/30 days	2/1/2024
YUFLYMA (CF) 40 MG/0.4 ML AUTOINJ YUFLYMA (CF) 40 MG/0.4 ML SYRNG	Added to formulary as Tier 3 with PA required	2/1/2024
YUSMIRY(CF) 40 MG/0.8 ML PEN	Added to formulary as Tier 3 with PA required, AL and QL according to PA criteria	2/1/2024
ZAVZPRET 10 MG NASAL SPRAY	Added to formulary as Tier 3 with AL ≥ 18 years old, PA required and QL of 8 units per 30 days	2/1/2024
ZINC-220 CAPSULE ZINC 50 MG TABLET ZINC GLUCONATE 100 MG TABLET ZINC SULFATE 220 MG CAPSULE	Covered For CSHCS members only	2/1/2024
ZORYVE 0.3% CREAM	Update AL ≥ 6 years old	2/1/2024
ABRYSVO VIAL WITH DILUENT	Added to formulary as Tier 4 with AL ≥ 60 years old and QL of 1 dose per lifetime	12/1/2023
AREXVY VIAL KIT	Added to formulary as Tier 4 with AL ≥ 60 years old and QL of 1 dose per lifetime	12/1/2023
AUGTYRO 40 MG CAPSULE	Added to formulary as carved out	12/1/2023
JYLAMVO 2 MG/ML ORAL SOLUTION	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	12/1/2023
LOQTORZI 240 MG/6 ML VIAL	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	12/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
PAXLOVID 150-100 MG DOSE PACK PAXLOVID 150-100 MG PACK (EUA) PAXLOVID 300-100 MG PACK (EUA)	Added to formulary as Tier 4	12/1/2023
SIKLOS 100 MG TABLET SIKLOS 1,000 MG TABLET	Moved to Tier 4, added AL ≥ 2 years old and ≤ 14 years old, PDL maintenance and removed PA requirement	12/1/2023
SOHONOS 1 MG CAPSULE SOHONOS 1.5 MG CAPSULE SOHONOS 2.5 MG CAPSULE SOHONOS 5 MG CAPSULE SOHONOS 10 MG CAPSULE	Added to formulary as carved out	11/9/2023
ADBRY 150 MG/ML SYRINGE	Moved to Tier 2 with PA required	11/1/2023
AKEEGA 50-500 MG TABLET AKEEGA 100-500 MG TABLET	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	11/1/2023
AMJEVITA (CF) 10 MG/0.2 ML SYRING AMJEVITA (CF) 20 MG/0.4 ML SYRING AMJEVITA (CF) 40 MG/0.8 ML AUTOIN AMJEVITA (CF) 40 MG/0.8 ML SYRING	Added to formulary under Tier 3 with PA required and AL managed under PA criteria	11/1/2023
ATORVALIQ 20 MG/5 ML SUSP	Added to formulary under Tier 3 with PA required and AL managed under PA max 20 mLs per day	11/1/2023
BYDUREON BCISE 2 MG AUTOINJECT	Added AL of 3.4 per 28 days (4 doses per 28 days)	11/1/2023
BYETTA 5 MCGDOSE PEN INJ	Moved to Tier 2 with PA required and QL 1.2 mL/30 days 12-month grandfathering allowed for T2 Diabetes diagnosis	11/1/2023
BYETTA 10 MCG DOSE PEN INJ	Moved to Tier 2 with PA required and QL 2.4 mL/30 days 12-month grandfathering allowed for T2 Diabetes diagnosis	11/1/2023
CALCIDOL DROPS	Covered for CSHCS members only	11/1/2023
COSENTYX UNOREADY 300 MG PEN	Added to formulary as Tier 4;	11/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
DILAUDID 4 MG TABLET	Updated QL to 135 tablets per 30 days	11/1/2023
DILAUDID 8 MG TABLET	Updated QL 67 tablets per 30 days	11/1/2023
ENEMA	Added to formulary under Tier 4	11/1/2023
EQL VITAMIN D3 50 MCG SOFTGEL	Added to formulary under Tier 4	11/1/2023
ERGOCALCIFEROL 200 MCG/ML DROP	Removed from formulary * covered for CSHCS only	11/1/2023
FASENRA PEN 30 MG/ML	Moved to Tier 2 with PA and AL min. 12 years old	11/1/2023
FIASP PUMPCART 100 UNIT/ML	Added to formulary under Tier 3 with PA and QL 90 mL per claim	11/1/2023
FLEET MINERAL OIL ENEMA HM ENEMA READY TO USE	Added to formulary under Tier 4 * must be covered for CSHCS	11/1/2023
HYDRALAZINE 20 MG/ML VIAL	NDC 36400010102005 removed from formulary * covered for CSHCS only	11/1/2023
HYDROMORPHONE 4 MG TABLET	Updated QL to 135 tablets per 30 days	11/1/2023
HYDROMORPHONE 8 MG TABLET	Updated QL to 67 tablets per 30 days	11/1/2023
INCRELEX 40 MG/4 ML VIAL	Removed from formulary	11/1/2023
INFANT VITAMIN D 10 MCG/ML DRP	Added to formulary under Tier 4 * must be covered for CSHCS	11/1/2023
INSULIN ASPART 100 UNIT/ML PEN INSULIN ASPART 100 UNIT/ML VL INSULIN ASPAT PRO MIX 70-30 PN	Moved to Tier 1 no longer requires PA and QL remains max 90 per claim ***Brand*** Novolog is now Tier 3, non-preferred	11/1/2023
KONVOMEP 2-84 MG/ML ORAL SUSP	Added to formulary under Tier 3 with PA required	11/1/2023
MOUNJARO 2.5 MG/0.5 ML PEN MOUNJARO 5 MG/0.5 ML PEN MOUNJARO 7.5 MG/0.5 MLPEN MOUNJARO 10 MG/0.5 ML PEN	Added QL of 2 mL per 28 days	11/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
MOUNJARO 12.5 MG/0.5 ML PEN MOUNJARO 15 MG/0.5 ML PEN		
MOVANTIK 12.5 MG TABLET MOVANTIK 25 MG TABLET	Moved to Tier 3 with PA required	11/1/2023
MYFEMBREE 40 MG-1 MG-0.5 MG TB	Add QL of 28 tablets per 28 days PA and AL min. 18 years old remain	11/1/2023
MYCOZYL AC 1% TOPICAL CREAM	Added to formulary by NDC 59088044107 under Tier 3 with PA required	11/1/2023
NALOXONE HCL 4 MG NASAL SPRAY	Added to formulary under Tier 4 with QL max 6 per 90 days	11/1/2023
NASONEX 24 HR ALLERGY 50 MCG SPRY	Added to formulary under Tier 3 with PA required	11/1/2023
NOVOLOG 100 UNIT/ML FLEXPEN NOVOLOG 100 UNIT/ML VIAL NOVOLOG MIX 70-30 FLEXPEN	Moved to Tier 3 with PA required and QL max 90 per claim Generic is preferred – Tier 1	11/1/2023
OPVEE 2.7 MG NASAL SPRAY	Added to formulary under Tier 4 with QL max 6 units per 90 days	11/1/2023
ORIAHNN 300-1-0.5 MG/300 MG CAPS	Add QL of 56 tablets per 28 days PA and AL min. 18 years old remain	11/1/2023
ORILISSA 150 MG TABLET	Add QL of 28 tablets per 28 days PA and AL min. 18 years old remain	11/1/2023
ORILISSA 200 MG TABLET	Add QL of 56 tablets per 28 days PA and AL min. 18 years old remain	11/1/2023
OZEMPIC 0.25-0.5 MG/DOSE PEN OZEMPIC 1 MG/DOSE (4 MG/3 ML) OZEMPIC 2 MG/DOSE (8MG/3 ML)	Added QL 3mL per 30 days PA requirement remains	11/1/2023
PEDIATRIC D-VITE 10 MCG/ML LIQ	Added to formulary under Tier 4 *must be covered for CSHCS	11/1/2023
REZVOGLAR 100 UNIT/ML KWIKPEN	Added to formulary under Tier 3 with PA required and QL max 90 mL per claim	11/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
RYBELSUS 3 MG TABLET RYBELSUS 7 MG TABLET RYBELSUS 14 MG TABLET	Added QL max 1 tablet per day and PA requirement remains	11/1/2023
SAXAGLITPIN HCL 2.5 MG TABLET SAXAGLITPIN HCL 5 MG TABLET SAXAGLIPTIN-METFORMIN ER 5-500 SAXAGLIPTIN-METFORMIN ER 2.5-1000 SAXAGLIPTIN-METFORMIN ER 5-1000	Added to formulary under Tier 3 with PA required and up to 102 day supply for maintenance	11/1/2023
SOLIQUA 100 UNIT-33 MCG/ML PEN	Added QL max 15 per 25 days and PA requirement remains	11/1/2023
TRULICITY 0.75 MG/0.5 ML PEN TRULICITY 1.5 MG/0.5 ML PEN TRULICITY 3 MG/0.5 ML PEN TRULICITY 4.5 MG/0.5 ML PEN	Moved to Tier 2 with PA required and QL max 2 mL per 28 days	11/1/2023
VICTOZA 2-PAK 18 MG/3 ML PEN	Moved to Tier 2 with PA required and QL max 6 mL per30 days	11/1/2023
VICTOZA 3-PAK 18 MG/3 ML PEN	Moved to Tier 2 with PA required and QL max 9 mL per 30 days	11/1/2023
VITAMIN D3 25 MCG TABLET VITAMIN D3 1,000 UNIT TABLET	Moved to Tier 4 *covered for CSHCS only	11/1/2023
VITAMIN D3 50 MCG (2,000 UNIT)	Removed NDC 80681000900 from formulary	11/1/2023
VITAMIN D3 50 MCG CAPSULE VITAMIN D3 50 MCG SOFTGEL	Added to formulary under Tier 4	11/1/2023
VITAMIN D3 50 MCG TABLET	Removed from formulary *covered for CSHCS only	11/1/2023
VITAMIN E 15 UNIT/0.3 ML DROP	Added to formulary under Tier 4 *must be covered for CSHCS	11/1/2023
VITAMIN E 180 MG SOFTGEL	Removed from formulary *covered for CSHCS only	11/1/2023
VYNDAMAX 61 MG CAPSULE	Removed from formulary	11/1/2023
VYNDAQEL 20 MG CAPSULE	Removed from formulary	11/1/2023
XULTOPHY 100 UNIT 3.6MG/ML PEN	Added QL max 15 per 30 days with PA required	11/1/2023
ZEGALOGUE 0.6 MG/0.6 ML AUTOINJ ZEGALOGUE 0.6 MG/0.6 ML SYRINGE	Moved to Tier 1 and removed PA requirement	11/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
BREO ELLIPTA 50-25 MCG INHALER	Added to formulary as Tier 3 with PA required and QL of 3 inhalers per 90 days	10/5/2023
ADLYXIN 10-20 MCG STARTER PACK ADLYXIN 20 MCG MAINTENANCE PK	Removed from formulary Non-rebatable	10/1/2023
BEYFORTUS 50 MG/0.5 ML SYRINGE BEYFORTUS 100 MG/ML SYRINGE	Added for formulary under Tier 4 with PA required	10/1/2023
BRIMONIDINE TARTRATE 0.1%DROP	Added to formulary as Tier 3 with PA required	10/1/2023
CLINDAMYC-BNZ PEROX 1.2-3.75%	Added to formulary as Tier 3 with PA required	10/1/2023
TIOTROPIUM 18 MCG CAP-INHALER	Added to formulary under Tier 3 with PA required and QL1 inhaler per 30 days up to 102 day supply for maintenance	9/1/2023
SPIRIVA HANDIHALER 18 MCG CAP	Tier 1 Brand preferred over generic and QL dependent upon NDC	9/1/2023
PHEXXI 1.8-1-0.4% VAGINAL GEL	Added to formulary under Tier 4 with QL max 180 grams per 30 days (36 applications per 30 days)	8/14/2023
ALVESCO 80 MCG INHALER ALVESCO 160 MCG INHALER	Moved to Tier 1 and removed PA requirement	8/1/2023
ANORO ELLIPTA 62.5-25 MCG INH	Add QL max 3 inhalers/90 days	8/1/2023
APEXICON E 0.05% CREAM	Added to formulary as Tier 3 w/PA	8/1/2023
AQUADEKS PEDIATRIC LIQUID	Obsolete drug. Removed from formulary	8/1/2023
AUSTEDO XR 6 MG TABLET AUSTEDO XR 12 MG TABLET AUSTEDO XR 24 MG TABLET	Added to formulary as Tier 4 Specialty Drug with PA required and AL min. 18 years old	8/1/2023
AUVI-Q 0.1 MG AUTO-INJECTOR	Added to formulary as Tier 3 with PA required and QL max 4/claim	8/1/2023
AZELASTIN-FLUTIC 137-50 MCG SPR	Added to formulary as Tier 3 with PA required	8/1/2023
BEVESPI AEROSPHERE INHALER	Add QL max 3 inhalers/90 days	8/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
BREZTRI AEROSPHERE INHALER	Add QL max 3 inhalers/90 days with PA required	8/1/2023
BUDESONIDE 0.25 MG/ 2 ML SUSP BUDESONIDE 0.5 MG/2 ML SUSP BUDESONIDE 1 MG/2 ML INH SUSP	Add QL max 2 ampules/day	8/1/2023
CAMCEVI 42 MG SYRINGE	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	8/1/2023
CELEBREX 50 MG CAPSULE CELEBREX 100 MG CAPSULE CELEBREX 200 MG CAPSULE	Remove step therapy requirement; brand remains Tier 3 w/PA, generic is preferred	8/1/2023
CELEBREX 400 MG CAPSULE	Update QL to max 1 capsule day with PA required; generic is preferred	8/1/2023
CELECOXIB 50 MG CAPSULE CELECOXIB 100 MG CAPSULE CELECOXIB 200 MG CAPSULE	Removed step therapy requirement and QL max 2 capsules/day remains	8/1/2023
CELECOXIB 400 MG CAPSULE	Update QL to max 1 capsule/day	8/1/2023
CLINDESSE2% VAGINAL CREAM	Moved to Tier 1 and removed PA requirement	8/1/2023
CLOPIDOGREL 75 MG TABLET	Add QL max 1 tablet/day	8/1/2023
COMBIVENT RESPIMAT 20-100 MCG	Add QL max 5 inhalers/90 days	8/1/2023
DABIGATRAN ETEXILATE 75 CAP DABIGATRAN ETEXILATE 150 MG	Add QL max 2 capsules/day with PA required	8/1/2023
DEXAMETHASONE 4 MG/ML SYRINGE DEXAMETHASONE 10 MG/ML SYRINGE	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	8/1/2023
DIFICID 40 MG/ML SUSPENSION DIFICID 200 MG TABLET	Moved to Tier 1 with removal of PA requirement	8/1/2023
DROXIA 200 MG CAPSULE DROXIA 300 MG CAPSULE DROXIA 400 MG CAPSULE	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	8/1/2023
DYMISTA NASAL SPRAY	Added to formulary as Tier 3 with PA required	8/1/2023
ELIQUIS 2.5 MG TABLET	Add QL max 2 tablets/day	8/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
ELIQUIS DVT-PE TREAT START 5 MG	Add to QL max 74 tablets/30 days and removed PDL Maintenance	8/1/2023
EVEROLIMUS 1 MG TABLET	Added to formulary as Tier 4 as a specialty drug; ***Policy Update 2022-PA-0019***	8/1/2023
FLONASE ALLERGY RLF 50 MCG SPR	Removed from formulary Non-rebatable; Use Rx version for coverage.	8/1/2023
GRALISE ER 450 MG TABLET	Add to formulary as Tier 3 with PA required and QL max 4 tablets/day	8/1/2023
GRALISE ER 750 MG TABLET GRALISE ER 900 MG TABLET	Add to formulary as Tier 3 with PA required and QL max 2 tablets/day	8/1/2023
GS DUAL ACTION PAIN 250-125 MG	Add to formulary as Tier 3 with PA required	8/1/2023
INCRUSE ELLIPTA 62.5 MCG INH	Add QL max 3 inhalers/90 days	8/1/2023
JUBLIA 10% TOPICAL SOLUTION	Add AL min. ≥ 6 years old with PA required	8/1/2023
KERYDIN 5% TOPICAL SOLUTION	Add AL min. ≥ 6 years old with PA required	8/1/2023
MELPHALAN 2 MG TABLET	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	8/1/2023
NEXIUM DR 2.5 MG PACKET NEXIUM DR 5 MG PACKET NEXIUM DR 10 MG PACKET NEXIUM DR 20 MG PACKET NEXIUM DR 40 MG PACKET	Add QL max 2 packets/day	8/1/2023
OMEPRAZOLE DR 10 MG CAPSULE OMEPRAZOLE DR 20 MG CAPSULE OMEPRAZOLE DR 40 MG CAPSULE	Add QL max 2 capsules/day	8/1/2023
PANTOPRAZOLE SOD DR 20 MG TAB PANTOPRAZOLE SOD DR 40 MG TAB	Add QL max 2 tablets/day	8/1/2023
PRADAXA 110 MG CAPSULE	Add QL max 4 capsules/day	8/1/2023
PRADAXA 75 MG CAPSULE PRADAXA 150 MG CAPSULE	Add QL max 2 capsules/day	8/1/2023
PROTONIX 40 MG SUSPENSION	Add QL max 2 packets/day	8/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
PROTONIX DR 20 MG TABLET PROTONIX DR 40 MG TABLET	Add QL max 2 tablets/day	8/1/2023
ROFLUMILAST 250 MCG TABLET ROFLUMILAST 500 MCG TABLET	Moved to Tier 2 with PA required	8/1/2023
ROXYBOND 5 MG TABLET ROXYBOND 15 MG TABLET	Added to formulary as Tier 3 with PA required and QL max 90 tablets/30 days	8/1/2023
ROXYBOND 30 MG TABLET	Added to formulary as Tier 3 with PA required and QL max 60 tablets/30 days	8/1/2023
SKYRIZI 180 MG/1.2 ML ON-BODY	Added to formulary as Tier 3 Specialty Drug with PA required	8/1/2023
STIMUFEND 6 MG/0.6 ML SYRINGE	Added to formulary as Tier 4 as a specialty drug with PA required and QL max 0.6mL/14 days	8/1/2023
STIOLTO RESPIMAT INAHL SPRAY	Add QL max 3 inhalers/90 days	8/1/2023
THYROID HORMONES ***Policy Update 2022-PA-0019***	Moved to Tier 4 with no edits	8/1/2023
TOBRAMYCIN 300 MG/5 ML AMPULE	Moved to Tier 1 with removal of PA requirement	8/1/2023
TRELEGY ELLIPTA 100-62.5-25 TRELEGY ELLIPTA 200-62.5-25	Add QL max3 inhalers/90 days	8/1/2023
XARELTO 2.5MG TABLET	Add QL max 2 tablets/day	8/1/2023
XARELTO 10 MG TABLET XARELTO 15 MG TABLET XARELTO 20 MG TABLET	Add QL max 1 tablet/day	8/1/2023
XARELTO STARTER PACK	Add QL of 51 tablets per 30 days and removed from PDL Maintenance	8/1/2023
XOPENEX HFA 45 MCH INHALER	Moved to Tier 1 with removal of PA requirement	8/1/2023
LUPKYNIS 7.9 MG CAPSULE	Removed from formulary Grandfathering allowed for current utilizers through 12/1/2023.	6/1/2023
ADEMPAS 0.5 MG TABLET ADEMPAS 1 MG TABLET ADEMPAS 1.5 MG TABLET	Moved to Tier 2 with PA required	5/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
ADEMPAS 2 MG TABLET ADEMPAS 2.5 MG TABLET		
B-COMPLEX VITAMIN COMBINATIONS	Removed from formulary Non-rebatable	5/1/2023
CALCIPOTRIENE 0.005% CREAM CALCIPOTRIENE 0.005% OINTMENT CALCIPOTRIENE 0.005% SOLUTION	Remains Tier 4 with PA required, AL ≥ 2 years old and QL managed by PA criteria	5/1/2023
CALCITRIOL 3 MCG/G OINTMENT	Added to formulary under Tier 4 with PA required, AL ≥ 2 years old and QL managed by PA criteria	5/1/2023
CALCIUM CLUC 1,000 MG/10 ML VL	Removed from formulary Covered for CSHCS members only	5/1/2023
CAPEX SHAMPOO	Removed from formulary Non-rebatable	5/1/2023
CIBINQO 50 MG TABLET CIBINQO 100 MG TABLET CIBINQO 200 MG TABLET	Updated AL ≥ 12 years old	5/1/2023
COREG CR 10 MG CAPSULE COREG CR 20 MG CAPSULE COREG CR 40 MG CAPSULE COREG CR 80 MG CAPSULE	Moved to Tier 1 *Brand Preferred*	5/1/2023
DROXIA 200 MG CAPSULE DROXIA 300 MG CAPSULE DROXIA 400 MG CAPSULE	Up to 102-day supply allowed	5/1/2023
ELOCON 0.1% CREAM	Removed from formulary “obsolete 3/31/2020”	5/1/2023
ENTADFI 5-5 MG CAPSULE	Added to formulary as Tier 3 with PA required with QL managed by PA criteria	5/1/2023
FYLNETRA 6 MG/0.6 ML SYRINGE	Added to formulary as a Specialty drug covered under Tier 3 with QL 0.6 mL per 14 days with PA required	5/1/2023
ITRACONAZOLE 100 MG CAPSULE	Updated QL to 120 per 30 days with PA required	5/1/2023
LEVEMIR FLEXPEN 100 UNIT/ML	Covered as Tier 1 with QL max 90 per claim and PDL Maintenance	5/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
NIMODIPINE 30 MG CAPSULE	Update QL to 252 tablets/365 days	5/1/2023
ORENITRAM MONTH 1 TITRATION KIT ORENITRAM MONTH 2 TITRATION KIT ORENITRAM MONTH 3 TITRATION KIT	Covered under Tier 3 as Specialty Drug with PA required	5/1/2023
PANCREAZE DR 2,600 UNIT CAP PANCREAZE DR 4,200 UNIT CAP PANCREAZE DR 10,500 UNIT CAP PANCREAZE DR 16,800 UNIT CAP PANCREAZE DR 21,000 UNIT CAP PANCREAZE DR 37,000 UNIT CAP	Removed from formulary Non-rebatable	5/1/2023
RAMIPRIL 1.25 MG CAPSULE RAMIPRIL 2.5 MG CAPSULE RAMIPRIL 5 MG CAPSULE RAMIPRIL 10 MG CAPSULE	Moved to Tier 1	5/1/2023
RELYVRIO 3 GM-1 GM POWDER PKT	Added to formulary as a Specialty Drug covered under Tier 4 with AL ≥ 18 years old, QL 60 grams/30 days and PA required	5/1/2023
REVATIO 10 MG/ML ORAL SUSP	Moved to Tier 3 with PA required *Brand Preferred*	5/1/2023
RYALTRIS 665-25 MCG SPRAY	Added to formulary as Tier 3 with PA required	5/1/2023
SILDENAFIL 10 MG/ML ORAL SUSP	Moved to Tier 2 with PA required	5/1/2023
SOTYKTU 6 MG TABLET	Added to formulary as a Specialty Drug covered under Tier 3 with AL ≥ 18 years old, QL 1 tablet/day and PA required	5/1/2023
SPORANOX 100 MG CAPSULE	Updated QL to 120 per 30 days with PA required	5/1/2023
TADLIQ 20 MG/5 ML SUSPENSION	Added to formulary as a Specialty Drug covered under Tier 3 with AL ≥ 18 years old and PA required	5/1/2023
TASCENSO ODT 0.25 MG TABLET TASCENSO ODT 0.5 MG TABLET	Added to formulary as a Specialty Drug covered under Tier 3 with AL minimum 10 years old and AL max 17 years old with PA required	5/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
TAZAROTENE 0.05% GEL TAZAROTENE 0.1% CREAM TAZAROTENE 0.1% GEL	Added to formulary as Tier 4 with PA required and QL managed by PA criteria	5/1/2023
TEZSPIRE 210 MG/1.91 ML PEN	Moved to Tier 3 covered as a Specialty Drug with AL ≥ 12 years old and PA required	5/1/2023
TRETINOIN 0.025% CREAM TRETINOIN 0.05% CREAM	Removed ST requirement with AL ≤ 30 years old with QL 20 per 30 days	5/1/2023
TYVASO DPI 16 MCG CARTRIDGE TYVASO DPI 16-32 MCG TITR KIT TYVASO DPI 16-32-48 MCG TITRAT TYVASO DPI 32 MCG CARTRIDGE TYVASO DPI 32-48 MCG MAINT KIT TYVASO DPI 48 MCG CARTRIDGE TYVASO DPI 64 MCG CARTRIDGE	Moved to Tier 3 with PA required	5/1/2023
VITAMIN D3 50 MCG TABLET	Removed from formulary obsolete drug	5/1/2023
VTAMA 1% CREAM	Added to formulary as Tier 4 with PA required, AL ≥ 18 years old and QL managed by PA criteria	5/1/2023
XACIATO 2% VAGINAL GEL	Added to formulary as Tier 3 with PA required and AL ≥ 12 years old	5/1/2023
ZORYVE 0.3% CREAM	Added to formulary as Tier 4 with PA required with AL ≥ 12 years old and QL managed by PA criteria	5/1/2023
HYDROXYPROGEST 250 MG/ML VIAL HYDROXYPROGEST 1,250 MG/5 ML	Removed from formulary	4/6/2023
MAKENA 275 MG/1.1 ML AUTOINJCT	Removed from formulary	4/6/2023
ADLARITY 5 MG/DAY WEEKLY PATCH ADLARITY 10 MG/DAY WEEKLY PATCH	Added to formulary as Tier 3 with PA required	2/1/2023
ASPRUZYO SPRINKLE ER 500 MG PKT ASPRUZYO SPRINKLE ER 1000 MG PK	Added to formulary as Tier 4 with AL ≥ 18 years old, PA required and QL 60 sachets/30 days	2/1/2023
BACLOFEN 5 MG/5 ML SOLUTION	Moved to Tier 2 with PA required	2/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
BASAGLAR TEMPO PEN 100 UNIT/ML	Added to formulary as Tier 3 with PA required and QL max 90 per claim; PDL Maintenance List	2/1/2023
CAMZYOS 2.5 MG CAPSULE CAMZYOS 5 MG CAPSULE CAMZYOS 10 MG CAPSULE CAMZYOS 15 MG CAPSULE	Added to formulary as Tier 4 with AL ≥ 18 years old, PA required and QL 30 capsules/30 days	2/1/2023
CHLORZOXAZONE 250 MG TABLET CHLORZOXAZONE 375 MG TABLET CHLORZOXAZONE 500 MG TABLET CHLORZOXAZONE 750 MG TABLET	Moved to Tier 3 with PA required. Grandfathering allowed for current utilizers through 5/1/2023.	2/1/2023
CLOBETSOL 0.05% GEL	Moved to Tier 3 with PA required	2/1/2023
ELYXYB 120 MG/4.8 ML SOLUTION	Updated QL to 14 doses/30 days or 67.2 mL/month with PA required	2/1/2023
FEXOFENADINE HCL 30 MG/5 ML	Removed PA requirement	2/1/2023
HUMALOG 100 UNIT/ML KWIKPEN	Removed *Brand Preferred* Logic. INSULIN LISPRO 100 UNIT/ML PEN moves to preferred status.	2/1/2023
HUMALOG TEMPO PEN 100 UNIT/ML	Added to formulary as Tier 1 with QL max 90 per claim; PDL Maintenance List	2/1/2023
HYDROCORTISONE-ALOE 1% CREAM SM HYDROCORTISONE-ALOE 1% CRM	Moved to Tier 1	2/1/2023
HYFTOR 0.2% GEL	Added to formulary as Tier 3 with AL ≥ 6 years old, PA and QL. QL 6-11 yo = 20gm/30 days QL ≥ 12 yo = 30gm/30 days	2/1/2023
KETOPROFEN 50 MG CAPSULE KETOPROFEN 75 MG CAPSULE	Moved to Tier 3 with PA required	2/1/2023
LEUPROLIDE DEPORT 22.5 MG VIAL	Added to Tier 4 with no edits; ***Policy Update 2022-PA-0019***	2/1/2023
LYUMJEV 100 UNIT/ML KWIKPEN LYUMJEV 100 UNIT/ML VIAL LYUMJEV 200 UNIT/ML KWIKPEN	Removed AL requirement	2/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
LYUMJEV TEMPO PEN 100 UNIT/ML	Added to Tier 3 with PA required; QL = 90 mL/claim; included on PDL Maintenance List.	2/1/2023
LYVISPAH 5 MG GRANULE PACKET LYVISPAH 10 MG GRANULE PACKET LYVISPAH 20 MG GRANULE PACKET	Added to formulary as Tier 3 with PA required	2/1/2023
MOUNIJARO 2.5 MG/0.5 ML PEN MOUNIJARO 5 MG/0.5 ML PEN MOUNIJARO 7.5 MG/0.5 ML PEN MOUNIJARO 10 MG/0.5 ML PEN MOUNIJARO 12.5 MG/0.5 ML PEN MOUNIJARO 15 MG/0.5 ML PEN	Added to formulary as Tier 3 with PA required	2/1/2023
NIASPAN ER 1,000 MG TABLET	Removed *Brand Preferred* Logic. Brand no longer rebatable. Generic remains Tier 3	2/1/2023
NOXAFIL 300 MG POWDERMIX SUSP	Added to formulary as Tier 3 with PA required	2/1/2023
NURTEC ODT 75 MG TABLET	Updated QL to 54 tablets/90 days; remains on PDL Maintenance List	2/1/2023
OMEPRAZOLE MAG DR 20 MG TABLET	Moved to Tier 3 with PA required	2/1/2023
PENCICLOVIR 1% CREAM	Added to formulary as Tier 3 with PA required; included on PDL Maintenance List	2/1/2023
QYSMIA 3.75 MG – 23 MG CAPSULE QYSMIA 7.5 MG – 46 MG CAPSULE QYSMIA 11.25 MG – 69 MG CAPSULE QYSMIA 15 MG – 92 MG CAPSULE	Updated AL to ≥ years old PA requirement remains	2/1/2023
RASAGILINE MESYLATE 0.5 MG TAB RASAGILINE MESYLATE 1 MG TAB	Moved to Tier 2 with AL ≥ 18 years old, PA required and remains on PDL Maintenance List	2/1/2023
REZLIDHIA 150 MG CAPSULE	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	2/1/2023
SODIUM SULF-SULFUR 10-5% CLEANSER SODIUM SULF-SULFUR CLEANSER	Added QL max 2 packages per 34 days (Package size dependent upon NDC)	2/1/2023

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Medication Name	Preferred Drug List Update*	Effective Date
TAFLUPROST 0.0015% EYE DROP (Generic equivalent to ZIOPTAN)	Added to formulary as Tier 3 with PA required	2/1/2023
VEMLIDY 25 MG TABLET	Added AL ≥ 12 years old; PA requirement remains	2/1/2023
VERKAZIA 0.1% EYE EMULSION	Added for formulary as Tier 3 with AL ≥ 4 years old, PA required and QL 120 single-use vials/30 days	2/1/2023
VIVJOA 150 MG CAPSULES	Added to formulary as Tier 3 with PA required and QL max 18 tablets per treatment course	2/1/2023
ACETAMINOP-CODEINE 120-12 MG/5 ACETAMIN-CODEIN 300-30 MG/12.5	Added AL ≥ 12 years old	11/1/2022
ACETAMINOPHEN-COD #2 ACETAMINOPEHN-COD #3 ACETAMINOPEHN-COD #4	Added AL ≥ 12 years old	11/1/2022
ASA-BUTALB-CAFF-COD #3 CAPSULE	Added AL ≥ 12 years old with PA required	11/1/2022
ASCOMP WITH CODEINE CAPSULE	Added AL ≥ 12 years old with PA required	11/1/2022
ATOVAQUONE 750 MG/5 ML SUSP	Removed PA; remains Tier 4	11/1/2022
BUTALB-ACETAMIN-CAF-COD 50-300 BUTALB-ACETAMIN-CAF-COD 50-325	Added AL ≥ 12 years old with PA required	11/1/2022
BUTALBITAL COMP-CODEINE #3 CAP	Added AL ≥ 12 years old with PA required	11/1/2022
CIBINQO 50 MG TABLET CIBINQO 100 MG TABLET CIBNIQO 200 MG TABLET	Moved to Tier 3 with AL ≥ 18 years old with PA required	11/1/2022
CODEINE SULFATE 15 MG TABLET CODEINE SULFATE 30 MG TABLET CODEINE SULFATE 60 MG TABLET	Added AL ≥ 12 years old with QL 180 tablets/30 days	11/1/2022
CONZIP 100 MG CAPSULE CONZIP 200 MG CAPSULE CONZIP 300 MG CAPSULE	Added AL ≥ 12 years old with PA required	11/1/2022
DIAZOXIDE 50 MG/ML ORAL SUSP	Removed QL; remains Tier 3 with PA required	11/1/2022
DICLOFENAC SODIUM 1% GEL	Added to Tier 1	11/1/2022

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Medication Name	Preferred Drug List Update*	Effective Date
EPINEPHRINE 0.15 MG AUTO-INJCT EPINEPHRINE 0.3 MG AUTO-INJECT	Moved to Tier 3 PA required with QL max 4 per claim ***Brand is now Mandatory***	11/1/2022
EPIPEN JR 0.15 MG AUTO-INJECTR EPIPEN JR 2-PAK 0.15 MG INJCTR EPIPEN 2-PAK 0.3 MG AUTO-INJCT	Moved to Tier 1 with QL max 4 per claim ***Brand Mandatory***	11/1/2022
FASENRA 30 MG/ML SYRINGE	Removed from formulary	11/1/2022
FASENRA PEN 30 MG/ML	Added to formulary as Tier 3 PA required, AL ≥ 12 years old	11/1/2022
FIORICET-COD 50-300-40-30 CAP	Added AL ≥ 12 years old and PA required	11/1/2022
FIORINAL-COD 30-50-325-40 CAP	Added AL ≥ 12 years old and PA required	11/1/2022
FLEQSUVY 25 MG/5 ML SUSPENSION	Added to formulary Tier 3 with AL ≥ 18 years old and PA required	11/1/2022
GLYXAMBI 10 MG-5 MG TABLET GLYXAMBI 25 MG-5 MG TABLET	Moved to Tier 3 with PA required	11/1/2022
GVOKE HYPOPEN 1PK 0.5 MG/0.1 ML GVOKE HYPOPEN 2PK 0.5 MG/0.1 ML	Moved to Tier 1 with QL 0.2/30 days and removed PA requirement	11/1/2022
GVOKE HYPOPEN 1-PK 1 MG/0.2 ML GVOKE HYPOPEN 2-PK 1 MG/0.2 ML	Moved to Tier 1 with QL 0.4/30 days and removed PA requirement	11/1/2022
IBSRELA 50 MG TABLET	Added to formulary as Tier 3 with AL ≥ 18 years old, QL 2 tablets/day and PA required	11/1/2022
KATERZIA 1 MG/ML SUSPENSION	Added to formulary as Tier 2 with AL ≥ 6 years old and PA required	11/1/2022
LEVAMLODIPINE MALEATE 5 MG TAB	Added to formulary as Tier 3 with PA required and up to 102-day supply for Maintenance	11/1/2022
MYFEMBREE 40 MG-1 MG-0.5 MG TB	Moved to Tier 2 with AL ≥ 18 years old and PA required	11/1/2022
NORLIQVA 1 MG/ML SOLUTION	Added to formulary as Tier 3 with AL ≥ 6 years old, up to 102-day supply for Maintenance and PA required	11/1/2022

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NUCALA 40 MG/0.4 ML SYRINGE	Added to formulary as Tier 3 with AL nm ≥ 6 years old and PA required	11/1/2022
NUCALA 100 MG VIAL	Removed from formulary. Medical billing only.	11/1/2022
PROTONIX DR 20 MG TABLET PROTONIX DR 40 MG TABLET PROTONIX 40 MG SUSPENSION	Moved to Tier 1 and removed PA requirement ***Brand Preferred over Generic***	11/1/2022
QDOLO 5 MG/ML SOLUTION	Added AL min. ≥ 12 years old	11/1/2022
RELEUKO 300 MCG/ML VIAL RELEUKO 300 MCG/0.5 ML SYRINGE RELEUKO 480 MCG/0.8 ML SYRINGE RELEUKO 480 MCG/1.6 ML VIAL	Added to formulary as Tier 3 with PA required	11/1/2022
SEGLENTIS 56 MG-44 MG TABLET	Added to formulary as Tier 3 with AL ≥ 12 years old, QL 120 tablets/30 days and PA required	11/1/2022
TRAMADOL-ACETAMINOPHEN 37.5-325 TRAMADOL ER 100 MG TABLET TRAMADOL ER 200 MG TABLET TRAMADOL ER 300 MG TABLET TRAMADOL HCL 50 MG TABLET TRAMADOL HCL 100 MG TABLET	Added AL ≥ 12 years old	11/1/2022
TRAMADOL HCL ER 100 MG CAPSULE TRAMADOL HCL ER 200 MG CAPSULE TRAMADOL HCL ER 300 MG CAPSULE	Added AL ≥ 12 years old and PA required	11/1/2022
TYLENOL WITH CODEINE #3 TABLET	Brand product removed from formulary due to HCFA termination.	11/1/2022
UDENYCA 6 MG/0.6 ML SYRINGE	Moved to Tier 3 with PA required	11/1/2022
ULTRACET TABLET	Added AL ≥ 12 years old with PA required	11/1/2022
ULTRAM 50 MG TABLET	Added AL ≥ 12 years old with PA required	11/1/2022
VALGANCICLOVIR 450 MG TABLET	Removed PA requirement; remains Tier 4	11/1/2022
VITAMIN D3 50 MCG SOFTGEL VITAMIN D3 50 MCG TABLET	*Covered for CSHCS members only	11/1/2022

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XOLAIR 150 MG VIAL	Removed from formulary. Medical billing only.	11/1/2022
STRENSIQ 18 MG/0.45 ML VIAL STRENSIQ 28 MG/0.7 ML VIAL STRENSIQ 40 MG/ML VIAL STRENSIQ 80 MG/0.8 ML VIAL	Added to formulary as Carved Out	9/21/2022
PYRUKYND 5 MG TABLET PYRUKYND 5 MG TAPER PACK PYRUKYND 20 MG TABLET PYRUKYND 20-5 MG TAPER PACK PYRUKYND 50 MG TABLET PYRUKNYD 50-20 MG TAPER PACK	Added to formulary as Carved Out	9/6/2022
VIJOICE 50 MG TABLET VIJOICE 125 MG TABLET VIJOICE 250 MG DAILY DOSE PACK	Added to formulary as Carved Out	9/6/2022
CLONIDINE 0.1 MG/DAY PATCH CLONIDINE 0.2 MG/DAY PATCH CLONIDINE 0.3 MG/DAY PATCH	Moved to Tier 1 removed PA requirement with QL max 4 patches/28 days	9/1/2022
ADBRY 150 MG/ML SYRINGE	Added to formulary Tier 3 with QL max of 4 syringes per 28 days (special allowance for initial dose) and PA required	8/1/2022
Antineoplastic ***Policy Update: 2022-PA-0019***	*Policy update 2022-PA-0019 allows medications for the treatment of cancer to process without rejection.	8/1/2022
BESREMI 500 MCG/ML SYRINGE	Added to formulary Tier 4	8/1/2022
CORLANOR 5 MG/5 ML ORAL SOLN CORLANOR 5 MG TABLET CORLANOR 7.5 MG TABLET	Added to formulary with PA required	8/1/2022
DICLOFENAC 2% SOLUTION PUMP	Moved to PDL Tier 3 with PA required	8/1/2022
DUPIXENT 100 MG/067 ML SYRINGE DUPIXENT 200 MG/1.14 ML PEN DUPIXENT 200 MG/1.14 ML SYRINGE DUPIXENT 300 MG/2 ML PEN DUPIXENT 300 MG/2 ML SYRINGE	Added to formulary Tier 2 with AL min. ≥ 6 years old and PA required	8/1/2022
ELYCYB 120 MG/4.8 ML SOLUTION	Added to formulary Tier 3 with PA required	8/1/2022

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Medication Name	Preferred Drug List Update*	Effective Date
FASENRA 30 MG/ML SYRINGE	Added to formulary as Tier 3 with AL min. ≥ 12 years old and PA required	8/1/2022
FEXOFENADINE HCL 60 MG TAB FEXOFENADINE HCL 180 MG TAB HM FEXOFENADINE HCL 60 MG TAB HM FEXOFENADINE HCL 180 MG TAB QC FEXOFENADINE HCL 180 MG TAB SM FEXOFENADINE HCL 60 MG TAB SM FEXOFENADINE HCL 180 MG TAB	Moved to Tier 1	8/1/2022
HYPER-SAL 3.5% VIAL HYPER-SAL 7% VIAL	*Covered for CSHCS members only	8/1/2022
INSULIN GLARGINE 100 UNIT/ML INSULIN GLARGINE SOLOSTAR U100	Moved to Tier 3 with PA required	8/1/2022
LIVTENCITY 200 MG TABLET	Added to formulary with PA required	8/1/2022
MESALAMINE ER 500 MG CAPSULE	Moved to Tier 3 with PA required	8/1/2022
MOXIFLOXACIN 0.5% EYE DROPS	Moved to Tier 3 with PA required and QL remains the same ****generic for Vigamox***	8/1/2022
Medical injectables that are not included on the MPPL ***Policy Update: 2022-PA-0019***	*Policy update 2022-PA-0019 removal of select drugs from the pharmacy benefit they will now process under the medical benefit	8/1/2022
NALOXONE 0.4 MG/ML CARPUJECT NALOXONE 0.4 MG/ML VIAL NALOXONE 2 MG/2 ML SYRINGE NALOXONE 4 MG/10 ML VIAL NALOXONE 10 MG/ML VIAL	Updated QL to 6 per 90 days	8/1/2022
NEBUSAL 3% VIAL NEBUSAL 6% VIAL	*Covered for CSHCS members only	8/1/2022
NUCALA 100 MG/ML AUTO-INJECTOR NUCALA 100 MG/ML SYRINGE	Added to formulary as Tier 3 with AL min. ≥ 6 years old and PA required	8/1/2022
PULMOSAL 7% VIAL	*Covered for CSHCS members only	8/1/2022
SODIUM CHLORIDE 3% VIAL SODIUM CHLORIDE 7% VIAL	*Covered for CSHCS members only	8/1/2022

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TAMIFLU 6 MG/ML SUSPENSION	Moved to Tier 3 with PA required and QL 120 mL/claim	8/1/2022
TAMIFLU 30 MG CAPSULE TAMIFLU 45 MG CAPSULE TAMIFLU 75 MG CAPSULE	Moved to Tier 3 with PA required and QL 14 capsules per claim	8/1/2022
VIGAMOX 0.5% EYE DROPS	Moved to Tier 1 PA removed	8/1/2022
XOLAIR 75 MG/0.5 ML SYRINGE XOLAIR 150 MG/ML SYRINGE XOLAIR 150 MG/ML SYRINGE	Added to formulary as Tier 2 with AL min. ≥ 6 years old and PA required	8/1/2022
XOLAIR 150 MG VIAL	Added to formulary as Tier 3 with AL min. ≥ 6 years old with PA required	8/1/2022
ZOVIRAX 5% OINTMENT	Moved to PDL NonPreferred with PA required	8/1/2022
Asthma and COPD Inhalers - cleanup	*Reported QL updated to allowance of 3-month supply	7/1/2022
MODERNA COVID-19 VACCINE (6mo–5YR) (PF) 25 MCG/0.25 ML IM SUSP	Added to formulary as Tier 4 with an AL of ≥ 6 months old and ≤ 5 years old	6/21/2022
MODERNA COVID-19 VACCINE(6YR-11YR) (PF) 50 MCG/0.5 ML IM SUSPENSION	Added to formulary as Tier 4 with an AL of ≥ 6 years old and ≤ 11 years old	6/21/2022
PFIZER-BioNT COVID-19 TRIS (6M-4YR) VACC (PF) 3MCG/0.2 ML IM SUSP	Added to formulary as Tier 4 with an AL of ≥ 6 months old and ≤ 4 years old	6/21/2022
ACYCLOVIR 5% OINTMENT	Moved to PDL Preferred and removed PA	6/1/2022
DIMETHLY FUMARATE 30D START PK DIMETHYL FUMARATE DR 120 MG CP DIMETHYL FUMARATE DR 240 MG CP	Moved to PDL Preferred and removed PA	6/1/2022
INSULIN LISPRO 100 UNIT/ML PEN INSULIN LISPRO 100 UNIT/ML VL INSULIN LISPRO JR 100 UNIT/ML	Moved to PDL Preferred and removed PA	6/1/2022
NOVOLOG MIX 70-30 VIAL	Moved to PDL NonPreferred with PA required ***generic Insulin Aspart Pro Mix 70-30 VL preferred***	6/1/2022
RIOMET 500 MG/5 ML SOLUTION	Moved to PDL NonPreferred with PA required	6/1/2022

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Medication Name	Preferred Drug List Update*	Effective Date
TECFIDERA STARTER PACK TECFIDERA DR 120 MG CAPSULE TECFIDERA DR 240 MG CAPSULE	Moved to PDL NonPreferred with PA required ***generic Dimethyl Fumarate preferred***	6/1/2022
ZOVIRAX 5% OINTMENT	Moved to PDL NonPreferred with PA required ***generic Acyclovir 5% Ointment preferred***	6/1/2022
CARBOXYMETHYLCELL 1% EYE GEL	Coded as Tier 4 *generic preferred	5/1/2022
CEQUA 0.09% SOLUTION	Added to formulary as Tier 3 with PA required and QL of 60 ampules/30 days	5/1/2022
COMBIGAN 0.2%-0.5% EYE DROPS	Remains Tier 1 *Brand over generic	5/1/2022
Contraceptives – Oral, vaginal ring, and contraceptive hormonal patches ***Policy Update: HASA 22-12***	*Dispensed quantities may not exceed a 12-month supply when allowed by prescriber.	5/1/2022
CYCLOSPORINE 0.005% EYE SMULS	Updated to Tier 3 with PA required and QL of 60 ampules/30 days	5/1/2022
EVEROLIMUS 10 MG TABLET	Moved to Specialty drug and remains Tier 4 with PA required and QL of 1 tablet/day	5/1/2022
EYSUVIS 0.25% EYE DROPS	Removed AL; updated to Tier 3 with PA required and QL of 1 bottle (8.3mL) per 14 days	5/1/2022
GLYCOPYRROLATE 1 MG/5 ML SOLN	Remains Tier 4 with AL ≤ 12 years old *generic preferred	5/1/2022
MAGNESIUM SULF 1 G/100 ML-D5W MAGNESIUM SULF 2 G/50 ML BAG MAGNESIUM SULF 4 G/50 ML BAG MAGNESIUM SULF 4 G/100 ML BAG MAGNESIUM SULF 20 G/500 ML BAG MAGNESIUM SULF 40 G/1,000 ML MAGNESIUM SULFATE 50% SYRINGE	Moved to PDL Non-Formulary	5/1/2022
NALOXONE HCL 4 MG NASAL SPRAY	*New generic added as Tier 4 with QL of 6 units/90 days	5/1/2022

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Medication Name	Preferred Drug List Update*	Effective Date
NURTEC ODT 75 MG TABLET	Updated QL to 48 tablets/96 days and up to 102 day supply for Maintenance	5/1/2022
OLOPATADINE HCL 0.1% EYE DROPS	Generic added to formulary as Tier 1	5/1/2022
OPCICON ONE-STEP 1.5 MG TABLET	*Allowing up to a 12-month supply	5/1/2022
OPZELURA 1.5% CREAM	Added to formulary as Tier 3 with AL ≥ 12 years old, PA required and QL of 240 gm/30 days	5/1/2022
PHOSPHOROUS POWDER PACKET	*Covered for CSHCS only	5/1/2022
POTASSIUM CL ER 20 MEQ TABLET	Added to formulary as Tier 4	5/1/2022
PRALUENT 75 MG/ML PEN PRALUENT 150 MG/ML PEN	Updated to Tier 2 with QL of 2 doses/28 days	5/1/2022
QDOLO 5 MG/ML SOLUTION	Brand removed from formulary *Tramadol HCL 25mg/5 mL cup preferred	5/1/2022
QULIPTA 10 MG TABLET QULIPTA 30 MG TABLET QULIPTA 60 MG TABLET	Added to formulary as Tier 3 with PA required and QL of 90 tablets/90 days and up to 102 day supply for Maintenance	5/1/2022
RESTASIS 0.05% EYE EMULSION	Updated to Tier 1 with QL of 60 ampules per 30 days	5/1/2022
RESTASIS MULTIDOSE 0.05% EYE	Updated to Tier 1 with QL of 5.5mLs per 30 days	5/1/2022
RINVOQ ER 15 MG TABLET RINVOQ ER 30 MG TABLET	Updated to Specialty drug with PA required. Indication dependent age limits apply.	5/1/2022
SKYTROFA 3 MG CARTRIDGE SKYTROFA 3.6 MG CARTRIDGE SKYTROFA 4.3 MG CARTRIDGE SKYTROFA 5.2 MG CARTRIDGE SKYTROFA 6.3 MG CARTRIDGE SKYTROFA 7.6 MG CARTRIDGE SKYTROFA 9.1 MG CARTRIDGE SKYTROFA 11 MG CARTRIDGE SKYTROFA 13.3 MG CARTRIDGE	Added to formulary as Tier 3 Specialty drug with PA required	5/1/2022

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TRAMADOL HCL 25 MG/5 ML CUP	Added to formulary as Tier 3 with AL ≥ 12 years old, PA required and QL of 80 mL/day *Generic for Qdolo	5/1/2022
TYRVAYA 0.03 MG NASAL SPRAY	Added to formulary as Tier 3 with PA required and QL of 8.4mL/30 days	5/1/2022
VITAMIN D3 25 MCG TABLET	GCN 00223 added to formulary. MDRP limits apply.	5/1/2022
XIIDRA 5% EYE DROPS	Added to formulary as Tier 1 with QL of 60 ampules per 30 days	5/1/2022
ZELNORM 6 MG TABLET	Removed from formulary	5/1/2022
ZIMHI 5MG/ 0.5 ML SYRINGE	Added to formulary as Tier 4 with QL of 3 units per 90 days	5/1/2022
ADIPEX-P 37.5 MG CAPSULE ADIPEX-P 37.5 MG TABLET	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022
AEMCOLO DR 194 MG TABLET	Added to formulary PDL NonPreferred with AL ≥ 18 years old, PA required and QL max 12 tablets	2/1/2022
BENZPHETAMINE HCL 50 MG TABLET	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022
BREXAFEMME 150 MG TABLET	Added to formulary PDL NonPreferred with PA required and QL max 4 tablets	2/1/2022
CHANTIX 0.5 MG TABLET CHANTIX 1 MG TABLET	Brand name no longer formulary	2/1/2022
CONTRAVE ER 8-90 MG TABLET	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022
CVS VITAMIN E 200 UNIT SOFTGEL	Removed from formulary	2/1/2022
DESMOPRESSIN 1.5 MG/ML SPRAY	Removed from formulary	2/1/2022

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Medication Name	Preferred Drug List Update*	Effective Date
DIETHYLPROPION 25 MG TABLET DIETHYLPROPION ER 75 MG TABLET	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022
DUPIXENT 100 MG/0.67 ML SYRINGE DUPIXENT 200 MG/1.14 ML PEN DUPIXENT 200 MG/1.14 ML SYRINGE DUPIXENT 300 MG/2 ML PEN DUPIXENT 300 MG/2 ML SYRINGE	Moved to PDL Preferred with PA required	2/1/2022
EXSERVAN 50 MG FILM	Added to formulary with AL ≥ 18 years old and PA required	2/1/2022
FENOFIBRATE 30 MG CAPSULE FENOFIBRATE 90 MG CAPSULE	Added to formulary PDL NonPreferred with PA required	2/1/2022
GVOKE 1 MG/0.2 ML KIT GVOKE 1 MG/0.2 ML VIAL	Added to formulary PDL NonPreferred with QL 0.4 mL/30 days and PA required	2/1/2022
HM VITAMIN E 200 UNIT SOFTGEL	Removed from formulary	2/1/2022
HYDROPROGEST 250 MG/ML VIAL HYDROPROGEST 1,250 MG/5 ML (Generics for Makena)	Moved to PDL Preferred with PA required *Grandfathering allowed for current utilizers	2/1/2022
HYDROPROGESTERONE 1.25 G/5 ML (Generic for Delalutin)	Moved for PDL Preferred with PA required	2/1/2022
HYDROXYUREA 500 MG CAPSULE	*Updated QL up to 102 day supply	2/1/2022
INSULIN GLARGINE-YFGN U100 PEN INSULIN GLARGINE-YFGN U100 VL	Added to formulary PDL NonPreferred with PA required and QL max 90/claim and up to 102 day supply for Maintenance	2/1/2022
KERENDIA 10 MG TABLET KERENDIA 20 MG TABLET	Added to formulary with AL ≥ 18 years old, PA required and QL 1 tablet/day	2/1/2022
LOFENA 25 MG TABLET	Added to formulary PDL NonPreferred with PA required	2/1/2022
LOMAIRA 8 MG TABLET	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022

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MYFEMBREE 40 MG-1 MG-0.5 MG TB	Added to formulary PDL NonPreferred with AL ≥ 18 years old and PA required	2/1/2022
NURTEC ODT 75 MG TABLET	*Updated QL to 16 tablets/32 days	2/1/2022
PHENDIMETRAZINE 35 MG TABLET PHENDIMETRAZINE ER 105 MG CAP	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022
PHENTERMINE 15 MG CAPSULE PHENTERMINE 30 MG CAPSULE PHENTERMINE 37.5 MG CAPSULE PHENTERMINE 37.5 MG TABLET	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022
QSYMIA 3.75 MG-23 MG CAPSULE QSYMIA 7.5 MG-46 MG CAPSULE QSYMIA 11.25 MG-69 MG CAPSULE QSYMIA 15 MG-92 MG CAPSULE	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022
RILUZOLE 50 MG TABLET	Added to formulary removed QL	2/1/2022
SAXENDA 18 MG/3 ML PEN	Added to formulary PDL Preferred with AL ≥ 12 years old and PA required	2/1/2022
SEMGLEE (YFGN) 100 UNIT/ML PEN SEMGLEE (YFGN) 100 UNTI/ML VL	Added to formulary PDL NonPreferred with PA required and QL max 90/claim up to 102 day supply for Maintenance	2/1/2022
SM VITAMIN E 200 UNIT SOFTGEL	Removed from formulary	2/1/2022
STIMATE 1.5 MG/ML NASAL SPRAY	Removed from formulary	2/1/2022
TACROLIMUS 0.1% OINTMENT	*Updated AL ≥ 16 years old PA required	2/1/2022
TIGLUTIK 50 MG/10 ML SUSP	Added to formulary with AL ≥ 18 years old and PA required	2/1/2022
VARENICLINE 0.5 MG TABLET VARENICLINE 1 MG TABLET	Added to formulary with QL 2 tablets/day, max of 2-12 week courses per year	2/1/2022
WEGOVY 0.25 MG/0.5 ML PEN WEGOVY 0.5 MG/0.5 ML PEN WEGOVY 1 MG/0.5 ML PEN WEGOVY 1.7 MG/0.75 ML PEN WEGOVY 2.4 MG/0.75 ML PEN	Added to formulary PDL Preferred with AL ≥ 18 years old and PA required	2/1/2022

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Medication Name	Preferred Drug List Update*	Effective Date
XENICAL 120 MG CAPSULE	Added to formulary PDL Preferred with AL ≥ 12 years old and PA required	2/1/2022
BAQSIMI 3 MG SPRAY ONE PACK BAQSIMI 3 MG SPRAY TWO PACK	Moved to PDL Preferred with QL max 2 devices/30 days and removed AL	11/1/2021
BRONCHITOL 40 MG INHALE CAP	Added to PDL Preferred with AL min ≥ 18 years old, PA required and QL max 560 capsules/28 days	11/1/2021
BUPRENORPHINE 75 MCG FILM BUPRENORPHINE 150 MCG FILM BUPRENORPHINE 300 MCG FILM BUPRENORPHINE 450 MCG FILM BUPRENORPHINE 600 MCG FILM BUPRENORPHINE 750 MCG FILM BUPRENORPHINE 900 MCG FILM	Moved to PDL NonPreferred with QL max 60 films/30 days and PA required	11/1/2021
BYSTOLIC 2.5 MG TABLET BYSTOLIC 5 MG TABLET BYSTOLIC 10 MG TABLET BYSTOLIC 20 MG TABLET	Moved to PDL Preferred *Brand Preferred	11/1/2021
CIMETIDINE 300 MG/5 ML SOLN	Added to PDL Preferred	11/1/2021
COLCHICINE 0.6 MG TABLET	Moved to PDL Preferred	11/1/2021
DESMOPRESSIN 1.5 MG/ML SPRAY	Moved to PDL NonPreferred with PA required	11/1/2021
DIAZOXIDE 50 MG/ML ORAL SOLN	Moved to PDL NonPreferred with PA required *Brand Preferred	11/1/2021
ENALAPRIL 1 MG/ML ORAL SOLN	Added to formulary PDL NonPreferred PA required	11/1/2021
FULPHILA 6 MG/0.6 ML SYRINGE	Moved to PDL NonPreferred with QL max 0.6 mL/14 days and PA required	11/1/2021
GEMTESA 75 MG TABLET	Added to formulary PDL NonPreferred with PA required	11/1/2021
GLUCAGEN 1 MG HYPOKIT	Added to formulary PDL Preferred	11/1/2021

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Medication Name	Preferred Drug List Update*	Effective Date
GLUCAGON 1 MG EMERGENCY KIT	Moved to PDL NonPreferred with PA required *Fresenius Products	11/1/2021
GLUCAGON 1 MG EMERGENCY KIT	Added to formulary PDL Preferred *Amphastar Pharm and Lilly Products	11/1/2021
GVOKE 0.5 MG/0.1 ML SYRINGE GVOKE 1 MG/0.2 ML SYRINGE GVOKE HYPOPEN 1PK 0.5 MG/0.1 ML GVOKE HYPOPEN 1PK 1 MG/0.2 ML GVOKE HYPOPEN 2PK 0.5 MG/0.1 ML GVOKE HYPOPEN 2PK 1 MG/0.2 ML	Moved to PDL NonPreferred with QL max 2 devices/30 days and PA required	11/1/2021
KLOXXADO 8 MG NASAL SPRAY	*Updated QL max 6 units/90 days	11/1/2021
MITIGARE 0.6 MG CAPSULE	Moved to PDL NonPreferred PA required	11/1/2021
NARCAN 4 MG NASAL SPRAY	*Updated QL max 6 units/90 days	11/1/2021
NEBIVOLOL 2.5 MG TABLET NEBIVOLOL 5 MG TABLET NEBIVOLOL 10 MG TABLET NEBIVOLOL 20 MG TABLET	Added to formulary PDL NonPreferred PA required	11/1/2021
PANTOPRZOLE 40 MG SUSPENSION	Moved to PDL NonPreferred PA required	11/1/2021
PONVORY 14-DAY STARTER PACK PONVORY 20 MG TABLET	Added to formulary PDL NonPreferred with AL min. ≥ 18 years old and AL max ≤ 55 years old	11/1/2021
PROGLYCEM 50 MG/ML ORAL SUSP	Moved to PDL Preferred *Brand Preferred	11/1/2021
PROMETHAZINE 12.5 MG SUPPOSITORY PROMETHAZINE 25 MG SUPPOSITORY	Added QL max 4 suppositories/day	11/1/2021
PROMETHAZINE 50 MG SUPPOSITORY	Added QL max 2 suppositories/day	11/1/2021
QDOLO 5 MG/ML SOLUTION	Added to formulary PDL NonPreferred with AL ≥ 12 years old and QL max 80 mL/day (400mg/day)	11/1/2021
RELTONE 200 MG CAPSULE RELTONE 400 MG CAPSULE	Added to formulary PDL NonPreferred with PA required and QL up to 102 day supply	11/1/2021

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SYNJARDY 5-500 MG TABLET SYNJARDY 5-1,000 MG TABLET SYNJARDY 12.5-500 MG TABLET SYNJARDY 12.5-1,000 MG TABLET	Moved to PDL Preferred	11/1/2021
ZEGALOGUE 0.6 MG/0.6 ML AUTOINJECT ZEGALOGUE 0.6 MG/0.6 ML SYRINGE	Added to formulary PDL NonPreferred with PA required	11/1/2021
AJOVY 225 MG/1.5 ML AUTOINJECT	*Updated QL 4.5 mL/90 days	8/1/2021
AMOX-CLAV 200-28.5 MG TAB CHEW AMOX-CLAV 200-28.5 MG/5 ML SUSP AMOX-CLAV 250-62.5 MG/5 ML SUSP AMOX-CLAV 400-57 MG TAB CHEW AMOX-CLAV 400-57 MG/5 ML SUSP AMOX-CLAV 600-42.9 MG/5 ML SUSP	Removed AL	8/1/2021
AMOXICILLIN 125 MG TAB CHEW AMOXICILLIN 125 MG/5 ML SUSP AMOXICILLIN 200 MG/5 ML SUSP AMOXICILLIN 250 MG TAB CHEW AMOXICILLIN 250 MG/5 ML SUSP AMOXICILLIN 400 MG/5 ML SUSP	Removed AL	8/1/2021
ANORO ELLIPTA 62.5-25 MCG INHALER	Moved to PDL Preferred	8/1/2021
ARFORMOTEROL 15 MCG/2 ML SOLN	*Updated QL 102 day supply	8/1/2021
ASMANEX HFA 50 MCG INHALER ASMANEX HFA 100 MCG INHALER ASMANEX HFA 200 MCG INHALER	Added QL 1 inhaler/30 days	8/1/2021
ASMANEX TWISTHALER 220 MCG #120 ASMANEX TWISTHALER 220 MCG #60 ASMANEX TWISTHALER 220 MCG #30 ASMANEX TWISTHALER 220 MCG #14 ASMANEX TWISTHALER 110 MCG #30	*Updated QL 1 inhaler/30 days	8/1/2021
AZITHROMYCIN 100 MG/5 ML SUSP AZITHROMYCIN 200 MG/5 ML SUSP	Removed AL	8/1/2021
BUDESONIDE-FORMOTEROL 80-4.5 BUDESONIDE-FORMOTEROL 160-4.5	*Updated QL 2 inhalers/30 days	8/1/2021
CEFIXIME 100 MG/5 ML SUSP CEFIXIME 200 MG/5 ML SUSP	Moved to PDL NonPreferred with PA required	8/1/2021
CICLOPIROX 0.77% CREAM	Moved to PDL Preferred	8/1/2021

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CICLOPIROX 0.77% TOPICAL SUSP	Moved to PDL NonPreferred with PA required	8/1/2021
CICLOPRIOX 8% SOLUTION	Moved to PDL Preferred with PA required	8/1/2021
CIPRO 5% SUSPENSION CIPRO 10% SUSPENSION	Moved to PDL NonPreferred with PA required	8/1/2021
CIPROFLOXACIN 250 MG/5 ML SUSP CIPROFLOXACIN 500 MG/5 ML SUSP	Moved to PDL Preferred	8/1/2021
CLEMASTINE FUM 2.68 MG TAB	Removed from formulary, grandfathering through 10/31/2021	8/1/2021
CLINDAMYCIN 2% VAGINAL CREAM	Moved to PDL Preferred	8/1/2021
CLINDESSE 2% VAGINAL CREAM	Moved to PDL NonPreferred with PA required	8/1/2021
CROMOLYN 20 MG/2 ML NEB SOLN	Removed from formulary, grandfathering through 10/31/2021	8/1/2021
CUVPOSA 1 MG/5 ML SOLUTION	Added to formulary with AL of ≥ 12 years old	8/1/2021
DILAUDID 4 MG TABLET	*Updated QL 165 tablets/30 days	8/1/2021
DILAUDID 8 MG TABLET	*Updated QL 84 tablets/30 days	8/1/2021
DOXYCYCLINE 25 MG/5 ML SUSP	Removed AL	8/1/2021
E.E.S 200 MG/5 ML SUSPENSION	Moved PDL NonPreferred with PA required	8/1/2021
EYSUVIS 0.25% EYE DROPS	Added to formulary with AL ≥ 18 years old, QL 8.3 mL/14 days and PA required	8/1/2021
FIBRICOR 35 MG TABLET FIBRICOR 105 MG TABLET	Added to formulary as Non-Preferred with PA required	8/1/2021
HYDROCORTISONE 2.5% CREAM	Added to formulary Anorectal preparation – rebatable NDC only	8/1/2021
IMPEKLO 0.05% LOTION	Added to formulary with PA required	8/1/2021
INCRUSE ELLIPTA 62.5 MCG INHALER	Moved to PDL Preferred	8/1/2021
KETOCONAZOLE 200 MG TABLET	Moved to PDL Preferred	8/1/2021

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LEVAQUIN 500 MG TABLET LEVAQUIN 750 MG TABLET	Brand Levaquin removed from formulary * Generic remains on formulary	8/1/2021
LUMAKRAS 120 MG TABLET	Added to formulary with PA required	8/1/2021
METRONIDAZOLE VAGINAL 0.75% GEL	Moved to PDL Preferred	8/1/2021
MOXIFLOXACIN 0.5% EYE DROPS	Moved to PDL Preferred *Generic for Vigamox	8/1/2021
NEOMYCIN 500 MG TABLET	Moved to PDL Preferred	8/1/2021
NYSTATIN 500,000 UNIT ORAL TAB	Moved to PDL Preferred	8/1/2021
NYVEPRIA 6 MG/0.6 ML SYRINGE	Added to formulary with QL of 0.6mls every 14 days	8/1/2021
OPANA 10 MG TABLET	*Updated QL 90 tablets/30 days	8/1/2021
OXYCODONE HCL ER 15 MG TABLET	*Updated QL 120 tablets/30 days	8/1/2021
OXYCODONE HCL ER 20 MG TABLET	*Updated QL 90 tablets/30 days	8/1/2021
OXYCODONE HCL ER 30 MG TABLET	*Updated QL 60 tablets/30 days	8/1/2021
OXYCODONE HCL ER 40 MG TBALET	*Updated QL 45 tablets/30 days	8/1/2021
OXYCODONE HCL ER 60 MG TABLET	*Updated QL 30 tablets/30 days	8/1/2021
OXYCODONE HCL ER 80 MG TABLET	*Updated QL 22 tablets/30 days	8/1/2021
PENICILLIN VK 125 MG/5 ML SOLN PENICILLIN VK 250 MG/5 ML SOLN	Removed AL	8/1/2021
POTASSIUM CITRATE ER 15 MEQ TB	Added to formulary	8/1/2021
PROVENTIL HFA 90 MCG INHALER	Moved to PDL NonPreferred with PA and QL 2 inhalers/30 days, grandfathering through 10/31/2021	8/1/2021
PULMICORT 90 MCG FLEXHALER PULMICORT 180 MCG FLEXHALER	*Updated QL 2 inhalers/30 days	8/1/2021
ROXICODONE 30 MG TABLET	*Updated QL 60 tablets/30 days	8/1/2021

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Medication Name	Preferred Drug List Update*	Effective Date
ROXYBOND 5 MG TABLET	Removed from formulary	8/1/2021
SANTYL OINTMENT	Removed from formulary Non-rebatable – available through medical necessity review ONLY. Must submit PA	8/1/2021
SODIUM CHLORIDE 7% VIAL	Covered for CSHCS only	8/1/2021
SPIRIVA RESPIMAT 1.25 MCG INHALER SPIRIVA RESPIMAT 2.5 MCG INHALER	Moved to PDL Preferred with QL 1 inhaler/30 days	8/1/2021
SYMBICORT 80-4.5 MCG INHALER SYMBICORT 160-4.5 MCG INHALER	*Updated QL 2 inhalers/30 days	8/1/2021
THEOPHYLLINE ER 400 MG TABLET THEOPHYLLINE ER 600 MG TABLET	Added to formulary	8/1/2021
TINIDAZOLE 250 MG TABLET TINIDAZOLE 500 MG TABLET	Moved to PDL Preferred	8/1/2021
TRELEGY ELLIPTA 100-62.5-25 TRELEGY ELLIPTA 200-62.5-25	Added to formulary	8/1/2021
VANDAZOLE VAGINAL 0.75% Gel	Moved to PDL NonPreferred with PA required	8/1/2021
VENTOLIN HFA 90 MCG INHALER	Moved to PDL Preferred with QL 2 inhalers/30 days *Brand over Generic	8/1/2021
VERQUVO 2.5 MG TABLET VERQUVO 5 MG TABLET VERQUVO 10 MG TABLET	Added to formulary with AL ≥ 18 years old, PA required and QL 1 tablet/day	8/1/2021
VIGAMOX 0.5% EYE DROPS	Moved to PDL NonPreferred with PA required	8/1/2021
ZITHROMAX 100 MG/5 ML SUSP ZITHROMAX 200 MG/5 ML SUSP	Removed AL	8/1/2021
ZOVIRAX 5% OINTMENT	Moved to PDL Preferred *Brand over Generic	8/1/2021
ACETAMINOPHEN 160 MG/5 ML ELIX CHILD PAIN & FEVER 160 MG/5 ML	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
ACULAR 0.5% EYE DROPS	Moved to PDL NonPreferred with PA required	5/1/2021
ADULT ONE DAILY GUMMIES ADULT MULTIVITAMIN GUMMIES	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
ALA-CORT 1% CREAM	NDC 00316012601 removed from formulary	5/1/2021

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Medication Name	Preferred Drug List Update*	Effective Date
AMBRISENTAN 5 MG TABLET AMBRISENTAN 10 MG TABLET	Moved to PDL Preferred with PA required	5/1/2021
AMLODIPINE-OLMESARTAN 5-20 MG TAB AMLODIPINE-OLMESARTAN 5-40 MG TAB AMLODIPINE-OLMESARTAN 10-20 MG TAB AMLODIPINE-OLMESARTAN 10-40 MG TAB	Moved to PDL Preferred	5/1/2021
ARTIFICIAL TEARS DROPS	Removed from formulary	5/1/2021
AZELASTINE HCL 0.05% DROPS	Moved to PDL Preferred	5/1/2021
BABY AYR SALINE 0.65% DROPS	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
BAFIERTAM DR 95 MG CAPSULE	Added to PDL NonPreferred with PA required and QL max 120 capsules per 30 days	5/1/2021
B-COMPLEX WITH B-12 TABLET	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
BIOTIN 10 MG TABLET BIOTIN 1,000 MCG TABLET BIOTIN 2,500 MCG SOFTGEL BIOTIN 5,000 MCG BIOTIN 10,000 MCG	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
BREZTRI AEROSPHERE INHALER	Added to PDL NonPreferred with PA required	5/1/2021
BUMETANIDE TABLET (All Strengths)	Removed from formulary for NSO	5/1/2021
BUTRANS 5 MCG/HR PATCH BUTRANS 7.5 MCG/HR PATCH BUTRANS 10 MCG/HR PATCH BUTRANS 15 MCG/HR PATCH BUTRANS 20 MCG/HR PATCH	Moved to PDL Brand Preferred over Generic with QL max 6 patches/28 days	5/1/2021
CALCIUM CIT-VIT D 315-200 TAB CALCIUM CITRATE – VIT D CALCIUM 500 MG CHEWABLE TAB	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
COMPLEX B-50 TABLET COMPLEX B-100 ER CAPLET	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
CVS CREAMY ACNE 4% FACE WASH	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
DORZOLAMIDE-TIMOLOL 2%-0.5%	Moved to PDL NonPreferred with PA	5/1/2021
ENALAPRIL-HCTZ 5-12.5 MG TABLET ENALAPRIL-HCTZ 10-25 MG TABLET	Moved to PDL Preferred removed PA requirement	5/1/2021

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FENOFIBRATE 67 MG CAPSULE FENOFIBRATE 134 MG CAPSULE FENOFIBRATE 200 MG CAPSULE	Moved to PDL Preferred removed PA requirement	5/1/2021
FISH OIL 1,000 MG SOFTGEL FISH OIL 1,200 MG SOFTGEL	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
FLONASE SENSIMIST 27.5 MCG SPR	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
FOLINIC-PLUS CAPLET	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
FOLPLEX 2.2 TABLET	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
GLEOSTINE 40 MG CAPSULE	Removed from formulary	5/1/2021
HAIR, SKIN & NAILS CAPLET	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
HARD NAILS 2.5 MG CAPSULE	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
HYDROCORTISONE 0.5% OINTMENT	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
KESIMPTA 20 MG/0.4 ML PEN	Added to PDL NonPreferred with PA required	5/1/2021
KETOROLAC 0.4% OPHTH SOLUTION	Moved to PDL NonPreferred with PA required	5/1/2021
LETAIRIS 5 MG TABLET LETAIRIS 10 MG TABLET	Moved to PDL NonPreferred with PA required	5/1/2021
LORATADINE 10 MG SOFTGEL	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
MAG-G 500 MG TABLET MAGNESIUM 300 MG CAPSULE MAGNESIUM 400 MG MAGNESIUM 500 MG CAPSULE MAGNESIUM CHLORIDE 64 MG TAB MAGONATE 54 MG/5 ML LIQUID MAG-TAB SR 84 MG CAPLET	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
MERIBIN 5 MG CAPSULE	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
METAMUCIL POWDER	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
MULTIPLE VITAMIN WITH IRON TAB MULTIPLE VITAMIN W-MINERALS TB	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
NATURAL FIBER POWDER NATURAL PSYLLIUM FIBER POWDER	Removed from formulary, no rebatable NDCs under GSN	5/1/2021

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NEPHRONEX LIQUID	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
OLMESARTAN-HCTZ 20-1.5 MG TAB OLMESARTAN-HCTZ 40-12.5 MG TAB OLMESARTAN-HCTZ 40-25 MG TAB OLMESARTAN MEDOXOMIL 5 MG TAB OLMESARTAN MEDOXOMIL 20MG TAB OLMESARTAN MEDOXOMIL 40MG TAB	Moved to PDL Preferred	5/1/2021
ONGENTYS 25 MG CAPSULE ONGENTYS 50 MG CAPSULE	Added to PDL NonPreferred with PA required	5/1/2021
PRENATAL DHA 200 MG SOFTGEL PRENATAL LOW IRON TABLET PRENATAL PLUS IRON TABLET PRENATAL TABLET PRENATAL TRINATE TABLET PRENATAL VIRT NATE TABLET PRENATAL VITAMIN TABLET PRENATAL VOL-NATE TABLET PRENATAL-U CAPSULE	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
REESE PINWORM 144 MG/ML SUSP	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
SEMGLEE 100 UNIT/ML PEN SEMGLEE 100 UNIT/ML PEN	Added to formulary as NonPreferred with PA and QL max 90mL per claim	5/1/2021
SLOW RELEASE IRON 45 MG TAB	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
SODIUM CHLORIDE 7% VIAL	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
THEREA-TABS M CAPLET THERA-M CAPLET	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
TIMOLOL MALEATE 0.5% EYE DROP	Added to PDL NonPreferred with PA required	5/1/2021
TRAVATAN Z 0.004 EYE DROP	Moved to PDL NonPreferred with PA required	5/1/2021
ULTRAVATE 0.05% OINTMENT	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
VICODIN HP 10-300 MG TABLET	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
VITAMIN D3 400 UNIT CHEWTAB	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
VITAMIN D3 2,000 UNIT SOFTGEL	Added to formulary	5/1/2021

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Medication Name	Preferred Drug List Update*	Effective Date
VITAMIN E 400 UNIT CAPSULE VITAMIN E 400 UNIT SOFTGEL VITAMIN E 1,000 UNIT CAPSULE VITAMIN E 1,000 UNIT SOFTGEL	Removed from formulary, no rebatable NDCs under GSN	5/1/2021
XYWAV 0.5 GM/ML ORAL SOLUTION	Added to formulary with AL ≥ 7 years old, PA required and QL max 540 mL per 30 days	5/1/2021
ASMANEX TWISTHALER 110 MCG #30	Added QL max 1 inhaler/fill	2/1/2021
BETAMETHASONE DP 0.05% CRM BETAMETHASONE DP 0.05% LOT BETAMETHASONE DP 0.05% OINT	Moved to PDL Preferred	2/1/2021
BUTRANS 5 MCG/HR PATCH BUTRANS 7.5 MCG/HR PATCH BUTRANS 10 MCG/HR PATCH BUTRANS 15 MCG/HR PATCH BUTRANS 20 MCG/HR PATCH	Moved to PDL Preferred with QL max 6 patches/28 days	2/1/2021
CARBIDOPA-LEVO ER 25-100 TAB CARBIDOPA-LEVO ER 50-200 TAB	Moved to PDL Preferred	2/1/2021
CATAPRES-TTS 1 PATCH CATAPRES-TTS 2 PATCH CATAPRES-TTS 3 PATCH	Moved to PDL Brand Preferred over Generic. Pharmacy must utilize DAW-9 for brand reimbursement	2/1/2021
CLIND PH-BENZOYL PERO 1.2-2.5% CLIND PH-BENZOYL PEROX 1.2-5% CLINDA-BENZOYL PEROX 1-5% PUMP CLINDAMYCIN-BENZOYL PEROX 1-5%	Moved to PDL Preferred and removed PA	2/1/2021
CLONIDINE 0.1 MG/DAY PATCH CLONIDINE 0.2 MG/DAY PATCH CLONIDINE 0.3 MG/DAY PATCH	Moved to PDL NonPreferred *Brand Preferred over generic requirement*	2/1/2021
EUCRISA 2% OINTMENT	Moved to PDL Preferred with PA	2/1/2021
GRALISE ER 300 MG TABLET	Updated QL max 2 tablets/day	2/1/2021
HORIZANT ER 300 MG TABLET	Updated QL max 2 tablets/day	2/1/2021
IMITREX 5 MG NASAL SPRAY IMITREX 20 MG NASAL SPRAY	Moved to PDL Brand Preferred over Generic. Pharmacy must utilize DAW-9 for brand reimbursement	2/1/2021
KYNMOBI 10 MG SL FILM KYNMOBI 15 MG SL FILM	Added to PDL NonPreferred with PA	2/1/2021

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Medication Name	Preferred Drug List Update*	Effective Date
KYNMOBI 20 MG SL FILM KYNMOBI 25 MG SL FILM KYNMOBI 30 MG SL FILM KYNMOBI TITRATION KIT		
LICART 1.3% PATCH	Added to PDL NonPreferred with PA and QL 15 patches/30 days	2/1/2021
LUCEMYRA 0.18 MG TABLET	Moved to PDL NonPreferred with PA and QL max of 224 tablets/14 days	2/1/2021
LYUMJEV 100 UNIT/ML KWIKPEN LYUMJEV 100 UNIT/ML VIAL LYUMJEV 200 UNIT/ML KWIKPEN	Added to PDL NonPreferred with PA, AL ≥ 18 years old and QL 90mL per claim	2/1/2021
NEUPRO 1 MG/24 HR PATCH NEUPRO 2 MG/24 HR PATCH NEUPRO 3 MG/24 HR PATCH NEUPRO 4 MG/24 HR PATCH NEUPRO 6 MG/24 HR PATCH NEUPRO 8 MG/24 HR PATCH	Added QL 30 patches/30 days	2/1/2021
NEXLIZET 180-10 MG TABLET	Added to PDL Preferred with PA and AL ≥ 18 years old	2/1/2021
ORIAHNN 300-1-0.5 MG/300 MG CAPS	Added to PDL Preferred with PA and AL ≥ 18 years old	2/1/2021
ORILISSA 150 MG TABLET ORILISSA 200 MG TABLET	Moved to PDL Preferred with PA and AL ≥ 18 years old	2/1/2021
REBIF 22 MCG/0.5 ML SYRINGE REBIF 44 MCG/0.5 ML SYRINGE REBIF REBIDOSE 22MCG/0.5 ML REBIF REBIDOSE 44MCG/0.5 ML REBIF REBIDOSE TITRATION PACK REBIF TITRATION PACK	Moved to PDL NonPreferred with PA	2/1/2021
RELPAX 20 MG TABLET REPLAX 40 MG TABLET	Moved to PDL NonPreferred with PA	2/1/2021
RETACRIT 20,000 UNIT/ML VIAL RETACRIT 200,00 UNIT/2 ML VIAL	Added to PDL Preferred with PA	2/1/2021
SAVELLA 12.5 MG TABLET SAVELLA 25 MG TABLET SAVELLA 50 MG TABLET SAVELLA 100 MG TABLET SAVELLA TITRATION PACK	Added QL max 60 tablets/ 30 days	2/1/2021
TOSYMRA 10 MG NASAL SPRAY	Added QL max 6mL per claim	2/1/2021

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Medication Name	Preferred Drug List Update*	Effective Date
TRAMADOL-ACETAMINOPHEN 37.5-325 MG TABLET TRAMADOL HCL ER 100 MG TABLET TRAMADOL HCL ER 200 MG TABLET TRAMADOL HCL ER 300 MG TABLET	Moved to PDL Preferred with cumulative max MME of 120mg/day	2/1/2021
XEPI 1% CREAM	Added to formulary as NonPreferred PA required with QL 60 grams/30 days	2/1/2021
ZEPOSIA 0.23-0.46 MG START PCK ZEPOSIA 0.23-0.46-0.92 MG KIT ZEPOSIA 0.92 MG CAPSULE	Added to formulary as NonPreferred PA required	2/1/2021
ZOMIG 2.5 MG NASAL SPRAY ZOMIG 5 MG NASAL SPRAY	Moved to PDL NonPreferred PA required	2/1/2021
CATAPRES-TTS 1 PATCH CATAPRES-TTS 2 PATCH CATAPRES-TTS 3 PATCH CLONIDINE 0.1 MG/DAY PATCH CLONIDINE 0.2 MG/DAY PATCH CLONIDINE 0.3 MG/DAY PATCH	Updated QL to 4 patches/28 days.	1/1/2021
EMFLAZA 6 MG TABLET EMFLAZA 18 MG TABLET EMFLAZA 22.75 MG/ML ORAL SUSP EMFLAZA 30 MG TABLET EMFLAZA 36 MG TABLET	Formulary status updated to covered with PA with AL of ≥ 2 years old	1/1/2021
FARXIGA 5 MG TABLET FARXIGA 10 MG TABLET	Moved to Formulary-Preferred, PA removed	1/1/2021
FULPHILA 6 MG/0.6 ML SYRINGE	Moved to Formulary-Preferred, added QL of 0.6mL/14 days	1/1/2021
HYDROXYPROGESTERONE 250 MG/ML VIAL HYDROXYPROGESTERONE 1,250 MG/ML	Updated QL to max approval of 21 weeks	1/1/2021
INVOKANA 100 MG TABLET INVOKANA 300 MG TABLET	Remains Formulary-Preferred, PA removed	1/1/2021
JARDIANCE 10 MG TABLET JARDIANCE 25 MG TABLET	Remains Formulary-Preferred, PA removed	1/1/2021
NEULASTA 6 MG/0.6 ML SYRINGE NEULASTA ONPRO 6 MG/0.6 ML KIT	Remains Formulary-NonPreferred with QL of 0.6mL/14 days	1/1/2021
NEXLETOL 180 MG TABLET	Added to Formulary as NonPreferred with PA and AL of ≥ 18 years old	1/1/2021

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Medication Name	Preferred Drug List Update*	Effective Date
NURTEC ODT 75 MG TABLET	Added to Formulary as Preferred with PA, AL of ≥ 18 years old and QL of 15/30 days	1/1/2021
PALFORZIA INITIAL DOSE PACK PALFORZIA 3 MG (LEVEL 1) PALFORZIA 6 MG (LEVEL 2) PALFORZIA 12 MG (LEVEL 3) PALFORZIA 20 MG (LEVEL 4) PALFORZIA 40 MG (LEVEL 5) PALFORZIA 80 MG (LEVEL 6) PALFORZIA 120 MG (LEVEL 7) PALFORZIA 160 MG (LEVEL 8) PALFORZIA 200 MG (LEVEL 9) PALFORZIA 240 MG (LEVEL 10) PALFORZIA 300 MG (LEVEL 11) PALFORZIA 300 MG (MAINTENANCE)	Added to formulary and require PA with AL between 4 and 17 years old	1/1/2021
REYVOW 50 MG TABLET REYVOW 100 MG TABLET	Added to Formulary as NonPreferred with PA, AL of ≥ 18 years old and QL of 8/30 days	1/1/2021
STEGLATRO 5 MG TABLET STEGLATRO 15 MG TABLET	Remains Formulary-NonPreferred, PA updated	1/1/2021
SYNJARDY 5-500 MG TAB SYNJARDY 5-1,000 MG TAB SYNJARDY 12.5-500 MG TAB SYNJARDY 12.5-1,000 MG TAB SYNJARDY XR 5-1,000 MG TAB SYNJARDY XR 10-1,000 MG TAB SYNJARDY XR 12.5-1,000 MG TAB SYNJARDY XR 25-1,000 MG TAB	Remains Formulary-NonPreferred, PA updated	1/1/2021
TALICIA DR 10-250-12.5 MG CAP	Added to Formulary as NonPreferred with PA	1/1/2021
TRIJARDY XR 5-2.5-1,000 MG TAB TRIJARDY XR 10-5-1,000 MG TAB TRIJARDY XR 12.5-2.5-1,000 MG TAB TRIJARDY XR 25-5-1,000 MG TAB	Added to Formulary as NonPreferred with PA	1/1/2021
TRULICITY 3 MG/0.5 ML PEN TRULICITY 4.5 MG/0.5 ML PEN	Update to Formulary-NonPreferred and require PA	1/1/2021
UDENYCA 6 MG/0.6 ML SYRINGE	Moved to Formulary-Preferred, added QL of 0.6mL/14 days	1/1/2021

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ZERVIATE 0.24% EYE DROP	Added to Formulary as NonPreferred with PA	1/1/2021
ZIEXTENZO 6 MG/0.6 ML SYRINGE	Remains Formulary-NonPreferred with QL of 0.6mL/14 days	1/1/2021
ABSTRAL 100 MCG TAB SUBLINGUAL ABSTRAL 200 MCG TAB SUBLINGUAL ABSTRAL 300 MCG TAB SUBLINGUAL ABSTRAL 400 MCG TAB SUBLINGUAL ABSTRAL 600 MCG TAB SUBLINGUAL ABSTRAL 800 MCG TAB SUBLINGUAL	Update to Formulary-NonPreferred and require PA	10/1/2020
ACANYA GEL PUMP	Update to Formulary-NonPreferred and require PA	10/1/2020
ACARBOSE 25 MG TABLET ACARBOSE 50 MG TABLET ACARBOSE 100 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
ACCOLATE 10 MG TABLET ACCOLATE 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ACCUPRIL 5 MG TABLET ACCUPRIL 10 MG TABLET ACCUPRIL 20 MG TABLET ACCUPRIL 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ACCURETIC 10-12.5 MG TABLET ACCURETIC 20-12.5 MG TABLET ACCURETIC 20-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ACEBUTOLOL 200 MG CAPSULE ACEBUTOLOL 400 MG CAPSULE	Moves to NonPreferred, PA added	10/1/2020
ACETAMIN-CODEIN 300-30 MG/12.5	Formulary-Preferred	10/1/2020
ACETAMINOP-CODEINE 120-12 MG/5	Formulary-Preferred	10/1/2020
ACETAMINOP-CODEINE 120-12 MG/5	Formulary-Preferred, QL removed	10/1/2020
ACETAMINOPHEN-COD #2 TABLET ACETAMINOPHEN-COD #3 TABLET ACETAMINOPHEN-COD #4 TABLET	Formulary-Preferred, QL removed	10/1/2020
ACIPHEX SPRINKLE DR 5 MG CAP ACIPHEX SPRINKLE DR 10 MG CAP ACIPHEX DR 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ACTEMRA 162 MG/0.9 ML SYRINGE ACTEMRA ACTPEN 162 MG/0.9 ML	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ACTIGALL 300 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ACTIQ 200 MCG LOZENGE ACTIQ 400 MCG LOZENGE ACTIQ 600 MCG LOZENGE ACTIQ 800 MCG LOZENGE ACTIQ 1,200 MCG LOZENGE ACTIQ 1,600 MCG LOZENGE	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ACTONEL 5 MG TABLET ACTONEL 35 MG TABLET ACTONEL 150 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ACTOPLUS MET 15 MG-500 MG TAB ACTOPLUS MET 15 MG-850 MG TAB ACTOPLUS MET XR 15-1,000 MG TB	Update to Formulary-NonPreferred and require PA	10/1/2020
ACTOS 15 MG TABLET ACTOS 30 MG TABLET ACTOS 30 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ACULAR 0.5% EYE DROPS	Formulary-Preferred	10/1/2020
ACULAR LS 0.4% OPHTH SOL	Update to Formulary-NonPreferred and require PA	10/1/2020
ACUVAIL 0.45% OPHTH SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
ACYCLOVIR 200 MG CAPSULE ACYCLOVIR 400 MG TABLET ACYCLOVIR 800 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
ACYCLOVIR 200 MG/5 ML SUSP	Formulary-Preferred, AL removed	10/1/2020
ACYCLOVIR 5% CREAM* ACYCLOVIR 5% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
ACYCLOVIR 800 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
ADALAT CC 30 MG TABLET ADALAT CC 60 MG TABLET ADALAT CC 90 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ADCIRCA 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ADEMPAS 0.5 MG TABLET ADEMPAS 1 MG TABLET ADEMPAS 1.5 MG TABLET ADEMPAS 2 MG TABLET ADEMPAS 2.5 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
ADLYXIN 10-20 MCG STARTER PACK ADLYXIN 20 MCG MAINTENANCE PK	Update to Formulary-NonPreferred and require PA	10/1/2020
ADMELOG 100 UNIT/ML VIAL* ADMELOG SOLOSTAR 100 UNIT/ML*	Moves to NonPreferred, PA added	10/1/2020
ADVAIR 100-50 DISKUS ADVAIR 250-50 DISKUS ADVAIR 250-50 DISKUS	Update to Formulary-Preferred; QL Added	10/1/2020
ADVAIR HFA 45-21 MCG INHALER ADVAIR HFA 115-21 MCG INHALER ADVAIR HFA 230-21 MCG INHALER	Formulary-Preferred, QL Added	10/1/2020
AFREZZA 4 UNIT CARTRIDGE AFREZZA 4 UNIT/8 UNIT/12 UNIT AFREZZA 90-4 UNIT / 90-8 UNIT	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
AGGRENOX 25 MG-200 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
AIMOVIG 70 MG/ML AUTOINJECTOR AIMOVIG 140 MG/ML AUTOINJECTOR	Update to Formulary-NonPreferred, AL removed	10/1/2020
AIRDUO RESPICLICK 55-14 MCG AIRDUO RESPICLICK 113-14 MCG AIRDUO RESPICLICK 232-14 MCG	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
AJOVY 225 MG/1.5 ML SYRINGE	Update to Formulary-NonPreferred, AL removed	10/1/2020
AKYNZEO 300-0.5 MG CAPSULE	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ALA-CORT 1% CREAM ALA-SCALP 2% LOTION	Update to Formulary-NonPreferred and require PA	10/1/2020
ALAWAY 0.025% EYE DROPS CHILD'S ALAWAY 0.025% EYE DROP	Formulary-Preferred, QL removed	10/1/2020
ALBUTEROL HFA 90 MCG INHALER*	Moves to NonPreferred, PA added	10/1/2020
ALBUTEROL SUL 0.63 MG/3 ML SOL ALBUTEROL SUL 1.25 MG/3 ML SOL	Formulary-Preferred, QL removed	10/1/2020
ALCLOMETASONE DIPRO 0.05% CRM ALCLOMETASONE DIPR 0.05% OINT	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ALENDRONATE SOD 70 MG/75 ML	Update to Formulary-NonPreferred and require PA	10/1/2020
ALENDRONATE SODIUM 5 MG TABLET ALENDRONATE SODIUM 10 MG TAB ALENDRONATE SODIUM 40 MG TAB	Formulary-Preferred, QL removed	10/1/2020
ALISKIREN 150 MG TABLET ALISKIREN 300 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
ALLOPURINOL 100 MG TABLET ALLOPURINOL 300 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
ALMOTRIPTAN MALATE 6.25 MG TAB ALMOTRIPTAN MALATE 12.5 MG TAB	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ALOCRIL 2% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
ALOGLIPTIN 6.25 MG TABLET ALOGLIPTIN 12.5 MG TABLET ALOGLIPTIN 25 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
ALOGLIPTIN-METFORMIN 12.5-500 ALOGLIPTIN-METFORMIN 12.5-1000	Moves to NonPreferred, PA added, QL Removed	10/1/2020
ALOGLIPTIN-PIOGLIT 12.5-15 MG ALOGLIPTIN-PIOGLIT 12.5-30 MG ALOGLIPTIN-PIOGLIT 12.5-45 MG ALOGLIPTIN-PIOGLIT 25-15 MG TB ALOGLIPTIN-PIOGLIT 25-30 MG TB ALOGLIPTIN-PIOGLIT 25-45 MG TB	Moves to NonPreferred, PA added, QL Removed	10/1/2020
ALOMIDE 0.1% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
ALOSETRON HCL 0.5 MG TABLET ALOSETRON HCL 1 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ALPHAGAN P 0.1% DROPS ALPHAGAN P 0.15% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
ALREX 0.2% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
ALTACE 1.25 MG CAPSULE ALTACE 2.5 MG CAPSULE ALTACE 5 MG CAPSULE ALTACE 10 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ALTOPREV 20 MG TABLET ALTOPREV 40 MG TABLET ALTOPREV 60 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ALVESCO 80 MCG INHALER ALVESCO 160 MCG INHALER	Update to Formulary-NonPreferred and require PA	10/1/2020
ALYQ 20 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
AMANTADINE 100 MG CAPSULE AMANTADINE 50 MG/5 ML SOLUTION	Formulary-Preferred, QL removed	10/1/2020
AMANTADINE 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
AMARYL 1 MG TABLET AMARYL 2 MG TABLET AMARYL 4 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
AMBRISENTAN 5 MG TABLET AMBRISENTAN 10 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
AMCINONIDE 0.1% CREAM AMCINONIDE 0.1% LOTION	Update to Formulary-NonPreferred and require PA	10/1/2020
AMERGE 1 MG TABLET AMERGE 2.5 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
AMITIZA 8 MCG CAPSULE AMITIZA 24 MCG CAPSULES	Formulary-Preferred, PA removed, QL removed	10/1/2020
AMLODIPINE BESYLATE 2.5 MG TAB AMLODIPINE BESYLATE 5 MG TAB AMLODIPINE BESYLATE 10 MG TAB	Formulary-Preferred, QL removed	10/1/2020
AMLODIPINE-ATORVAST 2.5-10 MG AMLODIPINE-ATORVAST 2.5-20 MG AMLODIPINE-ATORVAST 2.5-40 MG AMLODIPINE-ATORVAST 5-10 MG AMLODIPINE-ATORVAST 5-20 MG AMLODIPINE-ATORVAST 5-40 MG AMLODIPINE-ATORVAST 5-80 MG AMLODIPINE-ATORVAST 10-10 MG AMLODIPINE-ATORVAST 10-20 MG AMLODIPINE-ATORVAST 10-40 MG AMLODIPINE-ATORVAST 10-80 MG	Update to Formulary-NonPreferred and require PA	10/1/2020
AMLODIPINE-OLMESARTAN 5-20 MG AMLODIPINE-OLMESARTAN 5-40 MG AMLODIPINE-OLMESARTAN 10-20 MG AMLODIPINE-OLMESARTAN 10-40 MG	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
AMLOD-VALSA-HCTZ 5-160-12.5 MG AMLOD-VALSA-HCTZ 5-160-25 MG AMLOD-VALSA-HCTZ 10-160-12.5MG AMLOD-VALSA-HCTZ 10-160-25 MG AMLOD-VALSA-HCTZ 10-320-25 MG	Formulary-Preferred	10/1/2020
AMRIX ER 15 MG CAPSULE AMRIX ER 30 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ANCOBON 250 MG CAPSULE ANCOBON 500 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ANDRODERM 2 MG/24HR PATCH ANDRODERM 4 MG/24HR PATCH	Update to Formulary-NonPreferred and require PA	10/1/2020
ANDROGEL 1%(2.5G) GEL PACKET ANDROGEL 1%(5G) GEL PACKET	Formulary-NonPreferred; Clinical PA	10/1/2020
ANDROGEL 1.62% GEL PUMP ANDROGEL 1.62%(1.25G) GEL PCKT ANDROGEL 1.62%(2.5G) GEL PCKT	Formulary-NonPreferred; Clinical PA	10/1/2020
ANORO ELLIPTA 62.5-25 MCG INH	Update to Formulary-NonPreferred and require PA	10/1/2020
ANTARA 30 MG CAPSULE ANTARA 90 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ANTI-DIARRHEAL 2 MG CAPLET ANTI-DIARRHEAL 2 MG TABLET	Formulary-Preferred	10/1/2020
ANTI-FUNGAL 1% POWDER	Formulary-Preferred	10/1/2020
ANTIFUNGAL 2% CREAM	Formulary-Preferred	10/1/2020
APADAZ 4.08-325 MG TABLET APADAZ 6.12-325 MG TABLET APADAZ 8.16-325 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
APEXICON E 0.05% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
APIDRA 100 UNITS/ML VIAL APIDRA SOLOSTAR 100 UNITS/ML	Formulary-Preferred, QL Added	10/1/2020
APRACLONIDINE HCL 0.5% DROPS	Formulary-Preferred, QL removed	10/1/2020
APREPITANT 40 MG CAPSULE* APREPITANT 80 MG CAPSULE* APREPITANT 125 MG CAPSULE APREPITANT 125-80-80 MG PACK	Update to Formulary-NonPreferred and require PA, AL added, QL Added	10/1/2020
APRISO ER 0.375 GRAM CAPSULE	Formulary-Preferred; Brand Preferred	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
AQUA GLYCOLIC HC 2% KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
ARCAPTA NEOHALER 75 MCG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
ARICEPT 5 MG TABLET ARICEPT 10 MG TABLET ARICEPT 23 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ARIXTRA 2.5 MG/0.5 ML SYRINGE ARIXTRA 5 MG/0.4 ML SYRINGE ARIXTRA 7.5 MG/0.6 ML SYRINGE ARIXTRA 10 MG/0.8 ML SYRINGE	Update to Formulary-NonPreferred and require PA	10/1/2020
ARNUITY ELLIPTA 100 MCG INH	Update to Formulary-NonPreferred and require PA	10/1/2020
ARNUITY ELLIPTA 200 MCG INH	Update to Formulary-NonPreferred and require PA	10/1/2020
ARNUITY ELLIPTA 50 MCG INH	Update to Formulary-NonPreferred and require PA	10/1/2020
ARTHROTEC 50 MG-200 MCG TAB ARTHROTEC 75 MG-200 MCG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
ARYMO ER 15 MG TABLET ARYMO ER 30 MG TABLET ARYMO ER 60 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ASACOL HD DR 800 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ASCOMP WITH CODEINE CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ASMANEX HFA 50 MCG INHALER ASMANEX HFA 100 MCG INHALER ASMANEX HFA 200 MCG INHALER	Update to Formulary-NonPreferred and require PA	10/1/2020
ASMANEX TWISTHALER 110 MCG #30	Formulary-Preferred, AL added	10/1/2020
ASMANEX TWISTHALER 220 MCG #14 ASMANEX TWISTHALER 220 MCG #30 ASMANEX TWISTHALER 220 MCG #60 ASMANEX TWISTHALR 220 MCG #120	Formulary-Preferred	10/1/2020
ASPIRIN-DIPYRIDAM ER 25-200 MG	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ATACAND 4 MG TABLET ATACAND 8 MG TABLET ATACAND 16 MG TABLET ATACAND 32 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ATACAND HCT 16-12.5 MG TAB ATACAND HCT 32-12.5 MG TAB ATACAND HCT 32-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ATELVIA DR 35 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ATORVASTATIN 10 MG TABLET ATORVASTATIN 20 MG TABLET ATORVASTATIN 40 MG TABLET ATORVASTATIN 80 MG TABLET	Formulary - Preferred, QL less stringent	10/1/2020
AUBAGIO 7 MG TABLET AUBAGIO 14 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
AURYXIA 210 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
AVALIDE 150-12.5 MG TABLET AVALIDE 300-12.5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
AVANDIA 2 MG TABLET AVANDIA 4 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
AVAPRO 75 MG TABLET AVAPRO 150 MG TABLET AVAPRO 300 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
AVELOX 400 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
AVODART 0.5 MG SOFTGEL	Update to Formulary-NonPreferred and require PA	10/1/2020
AVONEX 30 MCG VIAL KIT AVONEX PREFILLED SYR 30 MCG KT	Formulary-Preferred, PA removed	10/1/2020
AVONEX PEN 30 MCG/0.5 ML KIT	Formulary-Preferred, PA removed, QL removed	10/1/2020
AYGESTIN 5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
AZASITE 1% EYE DROPS	Formulary-Preferred	10/1/2020
AZELASTINE 0.1% (137 MCG) SPRY	Formulary-Preferred, QL removed	10/1/2020
AZELASTINE 0.15% NASAL SPRAY	Formulary-Preferred	10/1/2020
AZELASTINE HCL 0.05% DROPS	Moves to NonPreferred, PA added, QL Removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
AZILECT 1 MG TABLET AZILECT 0.5 MG TABLET	Update to Formulary-NonPreferred and require PA, AL added	10/1/2020
AZOPT 1% EYE DROPS	Formulary-Preferred	10/1/2020
AZOR 5-20 MG TABLET AZOR 5-40 MG TABLET AZOR 10-20 MG TABLET AZOR 10-40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
AZULFIDINE 500 MG TABLET AZULFIDINE ENTAB 500 MG	Update to Formulary-NonPreferred and require PA	10/1/2020
BACLOFEN 5 MG TABLET	Formulary-Preferred	10/1/2020
BALSALAZIDE DISODIUM 750 MG CP	Moves to NonPreferred, PA added	10/1/2020
BASAGLAR 100 UNIT/ML KWIKPEN	Moves to NonPreferred, PA added	10/1/2020
BAXDELA 450 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
BECONASE AQ 0.042% SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
BELBUCA 150 MCG FILM BELBUCA 300 MCG FILM BELBUCA 450 MCG FILM BELBUCA 600 MCG FILM	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
BELBUCA 75 MCG FILM BELBUCA 750 MCG FILM BELBUCA 900 MCG FILM	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
BENAZEPRIL-HCTZ 5-6.25 MG TAB BENAZEPRIL-HCTZ 10-12.5 MG TAB BENAZEPRIL-HCTZ 20-12.5 MG TAB BENAZEPRIL-HCTZ 20-25 MG TAB	Formulary-Preferred	10/1/2020
BENICAR 5 MG TABLET BENICAR 20 MG TABLET BENICAR 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
BENICAR HCT 20-12.5 MG TABLET BENICAR HCT 40-12.5 MG TABLET BENICAR HCT 40-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
BENZACLIN GEL BENZACLIN GEL 35G PUMP BENZACLIN GEL 50G PUMP	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
BEPREVE 1.5% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
BESIVANCE 0.6% SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020
BETAMETHASONE DP 0.05% CRM BETAMETHASONE DP 0.05% LOT BETAMETHASONE DP 0.05% OINT	Moves to NonPreferred, PA added, QL Removed	10/1/2020
BETAMETHASONE DP AUG 0.05% CRM BETAMETHASONE DP AUG 0.05% GEL BETAMETHASONE DP AUG 0.05% LOT BETAMETHASONE DP AUG 0.05% OIN	Moves to NonPreferred, PA added, QL Removed	10/1/2020
BETAMETHASONE VA 0.1% CREAM BETAMETHASONE VA 0.1% LOTION BETAMETHASONE VALER 0.1% OINTM	Formulary-Preferred, QL removed	10/1/2020
BETAMETHASONE VALER 0.12% FOAM	Update to Formulary-NonPreferred and require PA	10/1/2020
BETAPACE 80 MG TABLET BETAPACE 120 MG TABLET BETAPACE 160 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
BETAPACE AF 80 MG TABLET BETAPACE AF 120 MG TABLET BETAPACE AF 160 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
BETASERON 0.3 MG KIT BETASERON 0.3 MG VIAL	Formulary-Preferred	10/1/2020
BETAXOLOL 10 MG TABLET BETAXOLOL 20 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
BETAXOLOL HCL 0.5% EYE DROP	Moves to NonPreferred, PA added	10/1/2020
BETHKIS 300 MG/4 ML AMPULE TOBI PODHALER 28 MG INHALE CAP	Formulary-Preferred, PA removed	10/1/2020
BETOPTIC S 0.25% EYE DROPS	Formulary-Preferred; Brand Preferred	10/1/2020
BEVESPI AEROSPHERE INHALER	Formulary-Preferred, ST removed	10/1/2020
BEVYXXA 40 MG CAPSULE BEVYXXA 80 MG CAPSULE	Update to Formulary-NonPreferred and require PA, AL added, QL Added	10/1/2020
BIMATOPROST 0.03% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
BISOPROLOL FUMARATE 5 MG TAB BISOPROLOL FUMARATE 10 MG TAB	Moves to NonPreferred, PA added, QL Removed	10/1/2020
BISOPROLOL-HCTZ 2.5-6.25 MG TB BISOPROLOL-HCTZ 5-6.25 MG TAB BISOPROLOL-HCTZ 10-6.25 MG TAB	Formulary-Preferred, QL removed	10/1/2020
BONIVA 150 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
BONIVA 3 MG/3 ML SYRINGE	Update to Formulary-NonPreferred and require PA	10/1/2020
BOSENTAN 62.5 MG TABLET* BOSENTAN 125 MG TABLET*	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
BREO ELLIPTA 100-25 MCG INH BREO ELLIPTA 200-25 MCG INH	Update to Formulary-NonPreferred and require PA	10/1/2020
BRILINTA 60 MG TABLET BRILINTA 90 MG TABLET	Formulary-Preferred	10/1/2020
BRIMONIDINE TARTRATE 0.15% DRP	Update to Formulary-NonPreferred and require PA	10/1/2020
BROMFENAC SODIUM 0.09% EYE DRP	Update to Formulary-NonPreferred and require PA	10/1/2020
BROMOCRIPTINE 2.5 MG TABLET BROMOCRIPTINE 5 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
BROMSITE 0.075% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
BROVANA 15 MCG/2 ML SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
BRYHALI 0.01% LOTION	Update to Formulary-NonPreferred and require PA	10/1/2020
BUDESONIDE 0.25 MG/2 ML SUSP BUDESONIDE 0.5 MG/2 ML SUSP BUDESONIDE 1 MG/2 ML INH SUSP	Formulary-Preferred, AL removed, QL removed	10/1/2020
BUDESONIDE 32 MCG NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
BUDESONIDE ER 9 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
BUDESONIDE-FORMOTEROL 80-4.5* BUDESONIDE-FORMOTEROL 160-4.5*	Moves to NonPreferred, PA added, AL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
BUPRENORPHINE 5 MCG/HR PATCH BUPRENORPHINE 7.5 MCG/HR PATCH BUPRENORPHINE 10 MCG/HR PATCH BUPRENORPHINE 15 MCG/HR PATCH BUPRENORPHINE 20 MCG/HR PATCH	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
BUTALB-ACETAMINOPH-CAFF-CODEIN	Update to Formulary-NonPreferred and require PA	10/1/2020
BUTALB-CAFF-ACETAMINOPH-CODEIN	Moves to NonPreferred, PA added, QL Removed	10/1/2020
BUTALBITAL COMP-CODEINE #3 CAP	Moves to NonPreferred, PA added, QL Removed	10/1/2020
BUTENAFINE HCL 1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
BUTORPHANOL 10 MG/ML SPRAY	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
BUTRANS 5 MCG/HR PATCH BUTRANS 7.5 MCG/HR PATCH BUTRANS 10 MCG/HR PATCH BUTRANS 15 MCG/HR PATCH BUTRANS 20 MCG/HR PATCH	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
BYDUREON 2 MG PEN INJECT	Formulary-Preferred	10/1/2020
BYDUREON BCISE 2 MG AUTOINJECT	Update to Formulary-NonPreferred and require PA	10/1/2020
BYETTA 5 MCG DOSE PEN INJ BYETTA 10 MCG DOSE PEN INJ	Formulary-Preferred	10/1/2020
BYSTOLIC 2.5 MG TABLET BYSTOLIC 5 MG TABLET BYSTOLIC 10 MG TABLET BYSTOLIC 20 MG TABLET	Formulary-Preferred	10/1/2020
CADUET 5 MG-10 MG TABLET CADUET 5 MG-20 MG TABLET CADUET 5 MG-40 MG TABLET CADUET 5 MG-80 MG TABLET CADUET 10 MG-10 MG TABLET CADUET 10 MG-20 MG TABLET CADUET 10 MG-40 MG TABLET CADUET 10 MG-80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CALAN 120 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
CALAN SR 120 MG CAPLET CALAN SR 180 MG CAPLET CALAN SR 240 MG CAPLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CALCITONIN-SALMON 200 UNITS SP	Formulary-Preferred, QL removed	10/1/2020
CALCIUM ACETATE 667 MG CAPSULE CALCIUM ACETATE 667 MG GELCAP CALCIUM ACETATE 667 MG TABLET	Clinical PA added	10/1/2020
CANDESARTAN CILEXETIL 4 MG TAB CANDESARTAN CILEXETIL 8 MG TAB CANDESARTAN CILEXETIL 16 MG TB CANDESARTAN CILEXETIL 32 MG TB	Update to Formulary-NonPreferred and require PA	10/1/2020
CANDESARTAN-HCTZ 16-12.5 MG TB CANDESARTAN-HCTZ 32-12.5 MG TB CANDESARTAN-HCTZ 32-25 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
CAPEX SHAMPOO	Update to Formulary-NonPreferred and require PA	10/1/2020
CAPTOPRIL 12.5 MG TABLET CAPTOPRIL 25 MG TABLET CAPTOPRIL 50 MG TABLET CAPTOPRIL 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CAPTOPRIL-HCTZ 25-15 MG TABLET CAPTOPRIL-HCTZ 25-25 MG TABLET CAPTOPRIL-HCTZ 50-15 MG TABLET CAPTOPRIL-HCTZ 50-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CARBIDOPA 25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CARBIDOPA-LEVO 10-100 MG ODT CARBIDOPA-LEVO 25-100 MG ODT CARBIDOPA-LEVO 25-250 MG ODT	Moves to NonPreferred, PA added	10/1/2020
CARBIDOPA-LEVO ER 25-100 TAB CARBIDOPA-LEVO ER 50-200 TAB	Moves to NonPreferred, PA added	10/1/2020
CARBIDOPA-LEVODOPA-ENTA 50 MG CARBIDOPA-LEVODOPA-ENTA 75 MG CARBIDOPA-LEVODOPA-ENTA 100 MG CARBIDOPA-LEVODOPA-ENTA 125 MG CARBIDOPA-LEVODOPA-ENTA 150 MG CARBIDOPA-LEVODOPA-ENTA 200 MG	Update to Formulary-NonPreferred and require PA	10/1/2020
CARDIZEM 120 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
CARDIZEM 30 MG TABLET CARDIZEM 60 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CARDIZEM CD 120 MG CAPSULE CARDIZEM CD 180 MG CAPSULE CARDIZEM CD 240 MG CAPSULE CARDIZEM CD 300 MG CAPSULE CARDIZEM CD 360 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
CARDIZEM LA 120 MG TABLET CARDIZEM LA 180 MG TABLET CARDIZEM LA 240 MG TABLET CARDIZEM LA 300 MG TABLET CARDIZEM LA 360 MG TABLET CARDIZEM LA 420 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CARDURA 1 MG TABLET CARDURA 2 MG TABLET CARDURA 4 MG TABLET CARDURA 8 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CARDURA XL 4 MG TABLET CARDURA XL 8 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CARTIA XT 120 MG CAPSULE CARTIA XT 180 MG CAPSULE CARTIA XT 240 MG CAPSULE CARTIA XT 300 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
CARVEDILOL ER 10 MG CAPSULE CARVEDILOL ER 20 MG CAPSULE CARVEDILOL ER 40 MG CAPSULE CARVEDILOL ER 80 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
CATAPRES 0.1 MG TABLET CATAPRES 0.2 MG TABLET CATAPRES 0.3 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CATAPRES-TTS 1 PATCH CATAPRES-TTS 2 PATCH CATAPRES-TTS 3 PATCH	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020
CAYSTON 75 MG INHAL SOLUTION	Formulary-Preferred, PA removed	10/1/2020
CEFACLOR 125 MG/5 ML SUSP CEFACLOR 250 MG/5 ML SUSP CEFACLOR 375 MG/5 ML SUSPEN	Moves to NonPreferred, PA added, AL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
CEFACLOR 250 MG CAPSULE CEFACLOR 500 MG CAPSULE	Moves to NonPreferred, PA added, QL added	10/1/2020
CEFACLOR ER 500 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
CEFADROXIL 1 GM TABLET	Moves to NonPreferred, PA added, QL added	10/1/2020
CEFADROXIL 250 MG/5 ML SUSP CEFADROXIL 500 MG/5 ML SUSP	Formulary-Preferred, AL removed	10/1/2020
CEFDINIR 125 MG/5 ML SUSP CEFDINIR 250 MG/5 ML SUSP	Formulary-Preferred, AL removed	10/1/2020
CEFDINIR 300 MG CAPSULE	QL added	10/1/2020
CEFIXIME 100 MG/5 ML SUSP CEFIXIME 200 MG/5 ML SUSP	Formulary-Preferred, AL removed	10/1/2020
CEFIXIME 400 MG CAPSULE*	Moves to NonPreferred, PA added	10/1/2020
CEFPODOXIME 100 MG TABLET	PA added, QL added	10/1/2020
CEFPODOXIME 100 MG/5 ML SUSP	PA added, AL removed	10/1/2020
CEFPODOXIME 200 MG TABLET	PA added, QL added	10/1/2020
CEFPODOXIME 50 MG/5 ML SUSP	PA added, AL removed	10/1/2020
CEFPROZIL 125 MG/5 ML SUSP CEFPROZIL 250 MG/5 ML SUSP	Formulary-Preferred, AL removed	10/1/2020
CELEBREX 50 MG CAPSULE CELEBREX 100 MG CAPSULE CELEBREX 200 MG CAPSULE CELEBREX 400 MG CAPSULE	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
CELECOXIB 50 MG CAPSULE CELECOXIB 100 MG CAPSULE CELECOXIB 200 MG CAPSULE CELECOXIB 400 MG CAPSULE	Update to Formulary-Preferred; ST Added	10/1/2020
CENTANY 2% OINTMENT CENTANY AT 2% OINTMENT KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
CEPHALEXIN 125 MG/5 ML SUSP CEPHALEXIN 250 MG/5 ML SUSP	Formulary-Preferred, AL removed	10/1/2020
CEPHALEXIN 250 MG TABLET CEPHALEXIN 500 MG TABLET	Formulary-Preferred	10/1/2020
CEPHALEXIN 750 MG CAPSULE	Formulary-Preferred	10/1/2020
CETIRIZINE HCL 1 MG/ML SOLN and various store brands	Moves to NonPreferred status, AL removed, PA added, QL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
CETIRIZINE HCL 1 MG/ML SOLN CETIRIZINE HCL 1 MG/ML SYRUP	Formulary-Preferred, AL removed, QL removed	10/1/2020
CETIRIZINE HCL 10 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
CETIRIZINE HCL 5 MG CHEW TAB CETIRIZINE HCL 10 MG CHEW TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
CETIRIZINE HCL 5 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
CHLORZOXAZONE 250 MG TABLET CHLORZOXAZONE 375 MG TABLET CHLORZOXAZONE 750 MG TABLET	Formulary-Preferred	10/1/2020
CHLORZOXAZONE 500 MG TABLET	Formulary-Preferred, AL removed	10/1/2020
CICLODAN 0.77% CREAM KIT CICLODAN 0.77% CREAM CICLODAN 8% KIT CICLODAN 8% SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
CICLOPIROX 0.77% GEL CICLOPIROX 0.77% CREAM CICLOPIROX 1% SHAMPOO CICLOPIROX 8% TREATMENT KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
CICLOPIROX 0.77% TOPICAL SUSP	Formulary-Preferred	10/1/2020
CICLOPIROX 8% SOLUTION	Moves to NonPreferred, PA added, QL Removed	10/1/2020
CILOXAN 0.3% EYE DROPS CILOXAN 0.3% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
CIMZIA 200 MG VIAL KIT CIMZIA 2X200 MG/ML SYRINGE KIT CIMZIA 2X200 MG/ML(X3)START KT	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
CIPRO 250 MG TABLET CIPRO 500 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
CIPRO 5% SUSPENSION CIPRO 10% SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
CIPRO HC OTIC SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
CIPRODEX OTIC SUSPENSION	Formulary-Preferred, QL removed	10/1/2020
CIPROFLOXACIN 0.2% OTIC SOLN	Moves to NonPreferred, PA added, QL Removed	10/1/2020

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CIPROFLOXACIN 0.3% EYE DROP	Formulary-Preferred, QL removed	10/1/2020
CIPROFLOXACIN ER 500 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CIPROFLOXACIN HCL 100 MG TAB	Formulary-Preferred, QL Added	10/1/2020
CIPROFLOX-FLUOCINLN 0.3-0.025%	Update to Formulary-NonPreferred and require PA	10/1/2020
CLARINEX 5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CLARITHROMYCIN 125 MG/5 ML SUS CLARITHROMYCIN 250 MG/5 ML SUS	Formulary-Preferred, AL removed	10/1/2020
CLARITHROMYCIN ER 500 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
CLIND PH-BENZOYL PERO 1.2-2.5%	Update to Formulary-NonPreferred and require PA	10/1/2020
CLIND PH-BENZOYL PEROX 1.2-5%	Clinical PA added	10/1/2020
CLINDA-BENZOYL PEROX 1-5% PUMP	Formulary-Preferred w/Clinical PA	10/1/2020
CLINDAMYCIN 2% VAGINAL CREAM	Moves to NonPreferred, PA added	10/1/2020
CLINDAMYCIN-BENZOYL PEROX 1-5%	Formulary-Preferred w/Clinical PA	10/1/2020
CLOBETASOL 0.05% CREAM CLOBETASOL 0.05% OINTMENT CLOBETASOL 0.05% SOLUTION	Formulary-Preferred, PA removed, QL removed	10/1/2020
CLOBETASOL 0.05% GEL	Formulary-Preferred	10/1/2020
CLOBETASOL 0.05% SHAMPOO	Update to Formulary-NonPreferred and require PA	10/1/2020
CLOBETASOL 0.05% TOPICAL LOTN CLOBETASOL EMOLLIENT 0.05% CRM CLOBETASOL EMOLLNT 0.05% FOAM CLOBETASOL EMULSION 0.05% FOAM CLOBETASOL PROP 0.05% FOAM CLOBETASOL PROP 0.05% SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
CLOBEX 0.05% SHAMPOO CLOBEX 0.05% SPRAY CLOBEX 0.05% TOPICAL LOTION	Update to Formulary-NonPreferred and require PA	10/1/2020
CLOCORTOLONE 0.1% CREAM PUMP CLOCORTOLONE PIVALATE 0.1% CRM	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
CLODAN 0.05% KIT CLODAN 0.05% SHAMPOO	Update to Formulary-NonPreferred and require PA	10/1/2020
CLODERM 0.1% CREAM CLODERM 0.1% CREAM PUMP	Update to Formulary-NonPreferred and require PA	10/1/2020
CLONIDINE 0.1 MG/DAY PATCH CLONIDINE 0.2 MG/DAY PATCH CLONIDINE 0.3 MG/DAY PATCH	Moves to Preferred, QL applies	10/1/2020
CLOPIDOGREL 75 MG TABLET CLOPIDOGREL 300 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
CLOTRIMAZOLE 10 MG TROCHE	Formulary-Preferred, QL removed	10/1/2020
CLOTRIMAZOLE-BETAMETHASONE CRM	Formulary-Preferred, QL removed	10/1/2020
CLOTRIMAZOLE-BETAMETHASONE LOT	Moves to NonPreferred, PA added, QL Removed	10/1/2020
COLAZAL 750 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
COLCHICINE 0.6 MG CAPSULE* COLCHICINE 0.6 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
COLCRYS 0.6 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
COLESEVELAM 625 MG TABLET COLESEVELAM HCL 3.75 G PACKET	Update to Formulary-NonPreferred and require PA	10/1/2020
COLESTID 1 GM TABLET COLESTID FLAVORED GRANULES COLESTID GRANULES COLESTID GRANULES PACKET	Update to Formulary-NonPreferred and require PA	10/1/2020
COLESTIPOL HCL GRANULES	Moves to NonPreferred, PA added	10/1/2020
COLESTIPOL HCL GRANULES PACKET	Update to Formulary-NonPreferred and require PA	10/1/2020
COMBIGAN EYE DROPS	Formulary-Preferred	10/1/2020
COMBIVENT RESPIMAT 20-100 MCG	Formulary-Preferred, QL removed	10/1/2020
COMTAN 200 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CONZIP 100 MG CAPSULE CONZIP 200 MG CAPSULE CONZIP 300 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
COPAXONE 20 MG/ML SYRINGE COPAXONE 40 MG/ML SYRINGE	Formulary-Preferred; Brand Preferred	10/1/2020
CORDRAN 4 MCG/SQ CM TAPE LARGE	Update to Formulary-NonPreferred and require PA	10/1/2020
COREG 3.125 MG TABLET COREG 6.25 MG TABLET COREG 12.5 MG TABLET COREG 25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
COREG CR 10 MG CAPSULE COREG CR 20 MG CAPSULE COREG CR 40 MG CAPSULE COREG CR 80 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
CORGARD 20 MG TABLET CORGARD 40 MG TABLET CORGARD 80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CORZIDE 40-5 TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
COSENTYX 150 MG/ML PEN INJECT COSENTYX 150 MG/ML SYRINGE COSENTYX 300 MG DOSE-2 PENS COSENTYX 300 MG DOSE-2 SYRINGE	Formulary-Preferred	10/1/2020
COSOPT PF EYE DROPS COSOPT EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
COUMADIN 1 MG TABLET COUMADIN 2 MG TABLET COUMADIN 2.5 MG TABLET COUMADIN 3 MG TABLET COUMADIN 4 MG TABLET COUMADIN 5 MG TABLET COUMADIN 6 MG TABLET COUMADIN 7.5 MG TABLET COUMADIN 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
COZAAR 25 MG TABLET COZAAR 50 MG TABLET COZAAR 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
CREON DR 3,000 UNITS CAPSULE CREON DR 6,000 UNITS CAPSULE CREON DR 12,000 UNITS CAPSULE CREON DR 24,000 UNITS CAPSULE CREON DR 36,000 UNITS CAPSULE	Clinical PA added	10/1/2020
CRESEMBA 186 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
CRESTOR 5 MG TABLET CRESTOR 10 MG TABLET CRESTOR 20 MG TABLET CRESTOR 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
CRINONE 4% GEL CRINONE 8% GEL	Update to Formulary-NonPreferred and require PA	10/1/2020
CUTIVATE 0.05% CREAM CUTIVATE 0.05% LOTION	Update to Formulary-NonPreferred and require PA	10/1/2020
CYCLOBENZAPRINE 5 MG TABLET CYCLOBENZAPRINE 10 MG TABLET	Formulary-Preferred, AL removed	10/1/2020
CYCLOBENZAPRINE 7.5 MG TABLET	Formulary-Preferred	10/1/2020
CYCLOBENZAPRINE ER 15 MG CAP CYCLOBENZAPRINE ER 30 MG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
CYCLOSET 0.8 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DALIRESP 250 MCG TABLET DALIRESP 500 MCG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DANTRIUM 25 MG CAPSULE DANTRIUM 50 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
DANTROLENE SODIUM 25 MG CAP DANTROLENE SODIUM 50 MG CAP DANTROLENE SODIUM 100 MG CAP	Moves to NonPreferred, PA added, QL Removed	10/1/2020
DARIFENACIN ER 7.5 MG TABLET DARIFENACIN ER 15 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DAYPRO 600 MG CAPLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DELZICOL DR 400 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
DENAVIR 1% CREAM	Formulary-Preferred	10/1/2020
DEPO-PROVERA 400 MG/ML VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
DERMACINRX THERAZOLE PAK	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
DERMA-SMOOTHE-FS BODY OIL	Update to Formulary-NonPreferred and require PA	10/1/2020
DERMA-SMOOTHE-FS SCALP OIL	Update to Formulary-NonPreferred and require PA	10/1/2020
DERMASORB HC 2% COMPLETE KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
DERMASORB TA 0.1% COMPLETE KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
DERMATOP 0.1% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
DESLORATADINE 2.5 MG ODT	Update to Formulary-NonPreferred and require PA, AL added	10/1/2020
DESLORATADINE 5 MG ODT DESLORATADINE 5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DESONATE 0.05% GEL	Update to Formulary-NonPreferred and require PA	10/1/2020
DESONIDE 0.05% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
DESONIDE 0.05% LOTION	Update to Formulary-NonPreferred and require PA	10/1/2020
DESONIDE 0.05% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
DESOWEN 0.05% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
DESOXIMETASONE 0.05% CREAM DESOXIMETASONE 0.05% GEL DESOXIMETASONE 0.05% OINTMENT DESOXIMETASONE 0.25% CREAM DESOXIMETASONE 0.25% OINTMENT DESOXIMETASONE 0.25% SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
DETROL 1 MG TABLET DETROL 2 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DETROL LA 2 MG CAPSULE DETROL LA 4 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
DEXILANT DR 30 MG CAPSULE DEXILANT DR 60 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
DICLOFENAC 1.5% TOPICAL SOLN	Formulary-Preferred	10/1/2020
DICLOFENAC EPOLAMINE 1.3% PTCH	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
DICLOFENAC POT 50 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DICLOFENAC SOD ER 100 MG TAB	Moves to NonPreferred, PA added	10/1/2020
DICLOFENAC SODIUM 1% GEL	Clinical PA added	10/1/2020
DICLOFENAC-MISOPROST 50-200 TB	Update to Formulary-NonPreferred and require PA	10/1/2020
DICLOFENAC-MISOPROST 75-200 TB	Update to Formulary-NonPreferred and require PA	10/1/2020
DIFICID 200 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DIFLORASONE 0.05% CREAM DIFLORASONE 0.05% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
DIFLUCAN 50 MG TABLET DIFLUCAN 100 MG TABLET DIFLUCAN 150 MG TABLET DIFLUCAN 200 MG TABLET DIFLUCAN 10 MG/ML SUSPENSION DIFLUCAN 40 MG/ML SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
DIFLUNISAL 500 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DILAUDID 2 MG TABLET DILAUDID 4 MG TABLET DILAUDID 8 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
DILT XR 120 MG CAPSULE DILT XR 180 MG CAPSULE DILT XR 240 MG CAPSULE	Formulary-Preferred	10/1/2020
DILTIAZEM 12HR ER 60 MG CAP DILTIAZEM 12HR ER 90 MG CAP DILTIAZEM 12HR ER 120 MG CAP	Formulary-Preferred	10/1/2020
DILTIAZEM 24H ER(CD) 120 MG CP DILTIAZEM 24H ER(CD) 180 MG CP DILTIAZEM 24H ER(CD) 240 MG CP DILTIAZEM 24H ER(CD) 300 MG CP DILTIAZEM 24H ER(CD) 360 MG CP	Formulary-Preferred, QL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
DILTIAZEM 24HR ER 120 MG CAP DILTIAZEM 24HR ER 180 MG CAP DILTIAZEM 24HR ER 240 MG CAP DILTIAZEM 24HR ER 300 MG CAP DILTIAZEM 24HR ER 360 MG CAP DILTIAZEM 24HR ER 420 MG CAP DILTIAZEM ER 120 MG CAPSULE DILTIAZEM ER 180 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
DILTIAZEM 24HR ER 180 MG TAB DILTIAZEM 24HR ER 300 MG TAB	Moves to NonPreferred, PA added, QL Removed	10/1/2020
DILTIAZEM 24HR ER 240 MG TAB DILTIAZEM 24HR ER 360 MG TAB DILTIAZEM 24HR ER 420 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
DIOVAN 40 MG TABLET DIOVAN 80 MG TABLET DIOVAN 160 MG TABLET DIOVAN 320 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DIOVAN HCT 80-12.5 MG TABLET DIOVAN HCT 160-12.5 MG TAB DIOVAN HCT 160-25 MG TABLET DIOVAN HCT 320-12.5 MG TAB DIOVAN HCT 320-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DIPENTUM 250 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
DIPHENOXYLAT-ATROP 2.5-0.025/5	Formulary-Preferred	10/1/2020
DIPROLENE 0.05% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
DIPYRIDAMOLE 25 MG TABLET DIPYRIDAMOLE 50 MG TABLET DIPYRIDAMOLE 75 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
DISKETS 40 MG TABLET DISPR	Update to Formulary-NonPreferred and require PA	10/1/2020
DITROPAN XL 5 MG TABLET DITROPAN XL 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DONEPEZIL HCL 23 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
DONEPEZIL HCL 5 MG TABLET DONEPEZIL HCL 10 MG TABLET	Formulary-Preferred, AL removed, QL removed	10/1/2020
DONEPEZIL HCL ODT 5 MG TABLET DONEPEZIL HCL ODT 10 MG TABLET	Formulary-Preferred	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
DORZOLAMIDE HCL 2% EYE DROPS	Formulary-Preferred, QL removed	10/1/2020
DORZOLAMIDE-TIMOLOL 2%-0.5%	Formulary-Preferred	10/1/2020
DORZOLAMIDE-TIMOLOL EYE DROPS	Formulary-Preferred, QL removed	10/1/2020
DOXAZOSIN MESYLATE 1 MG TAB DOXAZOSIN MESYLATE 2 MG TAB DOXAZOSIN MESYLATE 4 MG TAB DOXAZOSIN MESYLATE 8 MG TAB	Formulary-Preferred, QL removed	10/1/2020
DUAC 1.2-5% GEL	Update to Formulary-NonPreferred and require PA	10/1/2020
DUAKLIR PRESSAIR 400-12MCG INH	Update to Formulary-NonPreferred and require PA	10/1/2020
DUETACT 30-2 MG TABLET DUETACT 30-4 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DUEXIS 800-26.6 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
DULERA 50 MCG-5 MCG INHALER DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER	Formulary-Preferred, AL removed, QL removed	10/1/2020
DUOPA 4.63 MG-20 MG/ML SUSPENS	Update to Formulary-NonPreferred and require PA	10/1/2020
DUPIXENT 200 MG/1.14 ML SYRING DUPIXENT 300 MG/2 ML SYRINGE	Update to Formulary-NonPreferred and require PA	10/1/2020
DURAGESIC 12 MCG/HR PATCH DURAGESIC 25 MCG/HR PATCH DURAGESIC 50 MCG/HR PATCH DURAGESIC 75 MCG/HR PATCH DURAGESIC 100 MCG/HR PATCH	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
DUTASTERIDE 0.5 MG CAPSULE	Formulary-Preferred	10/1/2020
DUTASTERIDE-TAMSULOSIN 0.5-0.4	Update to Formulary-NonPreferred and require PA	10/1/2020
DYMISTA NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
E.E.S. 200 MG/5 ML GRANULES E.E.S. 200 MG/5 ML SUSPENSION	Formulary-Preferred	10/1/2020
E.E.S. 400 FILMTAB	Update to Formulary-NonPreferred and require PA	10/1/2020
ECONAZOLE NITRATE 1% CREAM	Moves to NonPreferred, PA added, QL Removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
EDARBI 40 MG TABLET EDARBI 80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
EDARBYCLOR 40-12.5 MG TABLET EDARBYCLOR 40-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
EFFIENT 5 MG TABLET EFFIENT 10 MG TABLET	Update to Formulary-NonPreferred and require PA, AL added	10/1/2020
ELETRIPTAN HBR 20 MG TABLET* ELETRIPTAN HBR 40 MG TABLET*	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ELIDEL 1% CREAM	Formulary-Preferred; Brand Preferred w/Clinical PA, AL added, QL Added	10/1/2020
ELIQUIS 2.5 MG TABLET ELIQUIS 5 MG TABLET ELIQUIS 5 MG STARTER PACK	Formulary-Preferred, AL removed, QL removed	10/1/2020
ELLZIA PAK	Update to Formulary-NonPreferred and require PA	10/1/2020
ELOCON 0.1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
EMBEDA ER 20-0.8 MG CAPSULE EMBEDA ER 30-1.2 MG CAPSULE EMBEDA ER 50-2 MG CAPSULE EMBEDA ER 60-2.4 MG CAPSULE EMBEDA ER 80-3.2 MG CAPSULE EMBEDA ER 100-4 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
EMEND 40 MG CAPSULE EMEND 80 MG CAPSULE	Formulary-Preferred; Brand Preferred, AL added, QL Added	10/1/2020
EMEND TRIFOLD PACK	Update to Formulary-NonPreferred and require PA, AL added, QL Added	10/1/2020
EMGALITY 120 MG/ML PEN EMGALITY 100 MG/ML SYRINGE EMGALITY 120 MG/ML SYRINGE	Formulary-Preferred w/Clinical PA, AL removed	10/1/2020
ENABLEX 7.5 MG TABLET ENABLEX 15 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ENALAPRIL-HCTZ 5-12.5 MG TAB ENALAPRIL-HCTZ 10-25 MG TABLET	Moves to NonPreferred, PA added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ENBREL 25 MG/0.5 ML SYRINGE ENBREL 50 MG/ML SURECLICK ENBREL 50 MG/ML MINI CARTRIDGE ENBREL 50 MG/ML SYRINGE	Formulary-Preferred, PA removed, QL removed	10/1/2020
ENDOCET 5-325 TABLET ENDOCET 7.5-325 MG TABLET ENDOCET 10-325 MG TABLET	Formulary-Preferred	10/1/2020
ENOXAPARIN 30 MG/0.3 ML SYR ENOXAPARIN 40 MG/0.4 ML SYR ENOXAPARIN 60 MG/0.6 ML SYR ENOXAPARIN 80 MG/0.8 ML SYR ENOXAPARIN 100 MG/ML SYRINGE ENOXAPARIN 120 MG/0.8 ML SYR ENOXAPARIN 150 MG/ML SYRINGE	Formulary-Preferred, PA removed	10/1/2020
ENOXAPARIN 300 MG/3 ML VIAL	Formulary-Preferred	10/1/2020
ENTACAPONE 200 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
ENTRESTO 24 MG-26 MG TABLET ENTRESTO 49 MG-51 MG TABLET ENTRESTO 97 MG-103 MG TABLET	Formulary-Preferred, ST removed, AL removed	10/1/2020
ENTYVIO 300 MG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
EPANED 1 MG/ML ORAL SOLUTION	Moves to NonPreferred, PA added, AL removed	10/1/2020
EPINASTINE HCL 0.05% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
EPINEPHRINE 0.15 MG AUTO-INJCT	Moves to NonPreferred, PA added Generics for Epi-Pen are preferred	10/1/2020
EPINEPHRINE 0.15 MG AUTO-INJECT EPINEPHRINE 0.3 MG AUTO-INJECT	Formulary - Preferred, QL less stringent	10/1/2020
EPIPEN JR 2-PAK 0.15 MG INJCTR EPIPEN 2-PAK 0.3 MG AUTO-INJCT	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
EPROSARTAN MESYLATE 600 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
ERTACZO 2% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
ERYPED 200 MG/5 ML SUSPENSION ERYPED 400 MG/5 ML SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ERY-TAB DR 250 MG TABLET ERY-TAB DR 333 MG TABLET ERY-TAB DR 500 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ERYTHROCIN 250 MG FILMTAB	Formulary-Preferred	10/1/2020
ERYTHROMYCIN 200 MG/5 ML SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020
ERYTHROMYCIN 250 MG FILMTAB ERYTHROMYCIN 500 MG FILMTAB	Update to Formulary-NonPreferred and require PA	10/1/2020
ERYTHROMYCIN 400 MG/5 ML SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020
ERYTHROMYCIN DR 250 MG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
ERYTHROMYCIN DR 250 MG TABLET ERYTHROMYCIN DR 333 MG TABLET ERYTHROMYCIN DR 500 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ERYTHROMYCIN EC 250 MG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
ERYTHROMYCIN ES 400 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
ESOMEPRAZOLE MAG DR 20 MG CAP ESOMEPRAZOLE MAG DR 40 MG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
ETODOLAC 200 MG CAPSULE ETODOLAC 300 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
ETODOLAC 400 MG TABLET ETODOLAC 500 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
ETODOLAC ER 400 MG TABLET ETODOLAC ER 500 MG TABLET ETODOLAC ER 600 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
EUCRISA 2% OINTMENT	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
EVISTA 60 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
EXELDERM 1% CREAM EXELDERM 1% SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
EXELON 4.6 MG/24HR PATCH EXELON 9.5 MG/24HR PATCH EXELON 13.3 MG/24HR PATCH	Formulary-Preferred; Brand Preferred	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
EXFORGE 5-160 MG TABLET EXFORGE 5-320 MG TABLET EXFORGE 10-160 MG TABLET EXFORGE 10-320 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
EXFORGE HCT 5-160-12.5 MG TAB EXFORGE HCT 5-160-25 MG TAB EXFORGE HCT 10-160-12.5 MG TAB EXFORGE HCT 10-160-25 MG TAB EXFORGE HCT 10-320-25 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
EXTAVIA 0.3 MG KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
EXTAVIA 0.3 MG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
EXTINA 2% FOAM	Update to Formulary-NonPreferred and require PA	10/1/2020
EZALLOR SPRINKLE 5 MG CAPSULE EZALLOR SPRINKLE 10 MG CAPSULE EZALLOR SPRINKLE 20 MG CAPSULE EZALLOR SPRINKLE 40 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
EZETIMIBE 10 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
EZETIMIBE-SIMVASTATIN 10-10 MG EZETIMIBE-SIMVASTATIN 10-20 MG EZETIMIBE-SIMVASTATIN 10-40 MG EZETIMIBE-SIMVASTATIN 10-80 MG	Update to Formulary-NonPreferred and require PA	10/1/2020
FAMCICLOVIR 125 MG TABLET FAMCICLOVIR 250 MG TABLET FAMCICLOVIR 500 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
FARXIGA 5 MG TABLET FARXIGA 10 MG TABLET	Formulary-Preferred w/Clinical PA	10/1/2020
FEBUXOSTAT 40 MG TABLET FEBUXOSTAT 80 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
FELDENE 10 MG CAPSULE FELDENE 20 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
FELODIPINE ER 2.5 MG TABLET FELODIPINE ER 5 MG TABLET FELODIPINE ER 10 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
FENOFIBRATE 130 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
FENOFIBRATE 150 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
FENOFIBRATE 160 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
FENOFIBRATE 43 MG CAPSULE FENOFIBRATE 50 MG CAPSULE FENOFIBRATE 67 MG CAPSULE FENOFIBRATE 134 MG CAPSULE FENOFIBRATE 200 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
FENOFIBRATE 48 MG TABLET FENOFIBRATE 145 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
FENOFIBRATE 54 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
FENOFIBRIC ACID 105 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FENOFIBRIC ACID DR 135 MG CAP FENOFIBRIC ACID DR 45 MG CAP	Moves to NonPreferred, PA added, QL Removed	10/1/2020
FENOGLIDE 120 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FENOGLIDE 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FENOPROFEN 400 MG CAPSULE FENOPROFEN 600 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FENTANYL 12 MCG/HR PATCH FENTANYL 25 MCG/HR PATCH FENTANYL 37.5 MCG/HR PATCH FENTANYL 50 MCG/HR PATCH FENTANYL 62.5 MCG/HR PATCH FENTANYL 75 MCG/HR PATCH FENTANYL 87.5 MCG/HR PATCH FENTANYL 100 MCG/HR PATCH	Formulary-Preferred, PA removed	10/1/2020
FENTANYL CIT 100 MCG BUCCAL TB FENTANYL CIT 200 MCG BUCCAL TB FENTANYL CIT 400 MCG BUCCAL TB FENTANYL CIT 600 MCG BUCCAL TB FENTANYL CIT 800 MCG BUCCAL TB	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
FENTANYL CITRATE OTFC 200 MCG FENTANYL CITRATE OTFC 400 MCG FENTANYL CITRATE OTFC 600 MCG FENTANYL CITRATE OTFC 800 MCG FENTANYL CIT OTFC 1,200 MCG FENTANYL CIT OTFC 1,600 MCG	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
FENTORA 100 MCG BUCCAL TABLET FENTORA 200 MCG BUCCAL TABLET FENTORA 400 MCG BUCCAL TABLET FENTORA 600 MCG BUCCAL TABLET FENTORA 800 MCG BUCCAL TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
FEXMID 7.5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FEXOFENADINE HCL 30 MG/5 ML FEXOFENADINE HCL 60 MG TABLET FEXOFENADINE HCL 180 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FIASP 100 UNIT/ML FLEXTOUCH FIASP 100 UNIT/ML VIAL FIASP PENFILL 100 UNIT/ML CART	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
FIBRICOR 105 MG TABLET FIBRICOR 35 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FINASTERIDE 5 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
FIORINAL-COD 30-50-325-40 CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
FLAGYL 375 CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
FLAGYL 500 MG TABLET FLAGYL 250 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FLECTOR 1.3% PATCH	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
FLOMAX 0.4 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
FLONASE ALLERGY RLF 50 MCG SPR FLUTICASONE PROP 50 MCG SPRAY (OTC)	Moves to NonPreferred, PA added, QL Removed Rx Form is Preferred	10/1/2020
FLONASE SENSIMIST 27.5 MCG SPR	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
FLOVENT 50 MCG DISKUS FLOVENT 100 MCG DISKUS FLOVENT 250 MCG DISKUS	Update to Formulary-NonPreferred and require PA	10/1/2020
FLOVENT HFA 44 MCG INHALER FLOVENT HFA 110 MCG INHALER FLOVENT HFA 220 MCG INHALER	Formulary-Preferred, AL removed	10/1/2020
FLUCONAZOLE 10 MG/ML SUSP FLUCONAZOLE 40 MG/ML SUSP	Formulary-Preferred, AL removed	10/1/2020
FLUCYTOSINE 250 MG CAPSULE FLUCYTOSINE 500 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
FLUMADINE 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FLUNISOLIDE 0.025% SPRAY	Moves to NonPreferred, PA added, QL Removed	10/1/2020
FLUOCINOLONE 0.01% BODY OIL	Update to Formulary-NonPreferred and require PA	10/1/2020
FLUOCINOLONE 0.01% CREAM FLUOCINOLONE 0.01% SOLUTION FLUOCINOLONE 0.025% CREAM FLUOCINOLONE 0.025% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
FLUOCINOLONE 0.01% SCALP OIL	Update to Formulary-NonPreferred and require PA	10/1/2020
FLUOCINONIDE 0.05% CREAM FLUOCINONIDE 0.05% OINTMENT FLUOCINONIDE 0.05% SOLUTION	Moves to NonPreferred, PA added, QL Removed	10/1/2020
FLUOCINONIDE 0.05% GEL FLUOCINONIDE 0.1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
FLUOCINONIDE-E 0.05% CREAM	Moves to NonPreferred, PA added, QL Removed	10/1/2020
FLURANDRENOLIDE 0.05% CREAM FLURANDRENOLIDE 0.05% LOTION FLURANDRENOLIDE 0.05% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
FLURBIPROFEN 50 MG TABLET FLURBIPROFEN 100 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
FLUTICASONE PROP 0.005% OINT FLUTICASONE PROP 0.05% CREAM	Formulary-Preferred, QL removed	10/1/2020
FLUTICASONE PROP 0.05% LOTION	Update to Formulary-NonPreferred and require PA	10/1/2020
FLUTICASONE PROP 50 MCG SPRAY	Formulary-Preferred, QL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
FLUTICASONE-SALMETEROL 100-50 FLUTICASONE-SALMETEROL 250-50 FLUTICASONE-SALMETEROL 500-50	Moves to NonPreferred, AL removed, PA added	10/1/2020
FLUTICASONE-SALMETEROL 55-14 FLUTICASONE-SALMETEROL 113-14 FLUTICASONE-SALMETEROL 232-14	Moves to NonPreferred, PA added	10/1/2020
FLUVASTATIN SODIUM 20 MG CAP FLUVASTATIN SODIUM 40 MG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
FONDAPARINUX 2.5 MG/0.5 ML SYR FONDAPARINUX 5 MG/0.4 ML SYR FONDAPARINUX 7.5 MG/0.6 ML SYR FONDAPARINUX 10 MG/0.8 ML SYR	Update to Formulary-NonPreferred and require PA	10/1/2020
FORTAMET ER 500 MG TABLET FORTAMET ER 1,000 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
FORTEO 600 MCG/2.4 ML PEN INJ	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
FORTESTA 10 MG GEL PUMP	Update to Formulary-NonPreferred and require PA	10/1/2020
FOSAMAX 70 MG TABLET FOSAMAX PLUS D 70 MG-2,800 IU FOSAMAX PLUS D 70 MG-5,600 IU	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
FOSINOPRIL SODIUM 10 MG TAB FOSINOPRIL SODIUM 20 MG TAB FOSINOPRIL SODIUM 40 MG TAB	Moves to NonPreferred, PA added	10/1/2020
FOSINOPRIL-HCTZ 10-12.5 MG TAB FOSINOPRIL-HCTZ 20-12.5 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
FOSRENOL 500 MG TABLET CHEW FOSRENOL 750 MG TABLET CHEW FOSRENOL 1,000 MG TABLET CHEW	Update to Formulary-NonPreferred and require PA	10/1/2020
FOSRENOL 750 MG POWDER PACKET FOSRENOL 1,000 MG POWDER PACK	Update to Formulary-NonPreferred and require PA	10/1/2020
FRAGMIN 2,500 UNITS/0.2 ML SYR FRAGMIN 5,000 UNITS/0.2 ML SYR FRAGMIN 7,500 UNITS/0.3 ML SYR FRAGMIN 10,000 UNITS/ML SYRING FRAGMIN 12,500 UNITS/0.5 ML FRAGMIN 15,000 UNITS/0.6 ML FRAGMIN 18,000 UNITS/0.72 ML FRAGMIN 95,000 UNITS/3.8 ML VL	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
FROVA 2.5 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
FROVATRIPTAN SUCC 2.5 MG TAB	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
FULPHILA 6 MG/0.6 ML SYRINGE	Formulary-Preferred, PA removed	10/1/2020
GALANTAMINE 4 MG/ML ORAL SOLN	Moves to NonPreferred, PA added, QL Removed	10/1/2020
GALANTAMINE ER 8 MG CAPSULE GALANTAMINE ER 16 MG CAPSULE GALANTAMINE ER 24 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
GALANTAMINE HBR 4 MG TABLET GALANTAMINE HBR 8 MG TABLET GALANTAMINE HBR 12 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
GATIFLOXACIN 0.5% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
GEMFIBROZIL 600 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
GENOTROPIN 5 MG CARTRIDGE GENOTROPIN 12 MG CARTRIDGE	Formulary-Preferred w/Clinical PA	10/1/2020
GENOTROPIN MINIQUICK 0.2 MG GENOTROPIN MINIQUICK 0.4 MG GENOTROPIN MINIQUICK 0.6 MG GENOTROPIN MINIQUICK 0.8 MG GENOTROPIN MINIQUICK 1 MG GENOTROPIN MINIQUICK 1.2 MG GENOTROPIN MINIQUICK 1.4 MG GENOTROPIN MINIQUICK 1.6 MG GENOTROPIN MINIQUICK 1.8 MG GENOTROPIN MINIQUICK 2 MG	Formulary-Preferred w/Clinical PA	10/1/2020
GILENYA 0.25 MG CAPSULE	Formulary-Preferred	10/1/2020
GILENYA 0.5 MG CAPSULE	Formulary-Preferred, PA removed, QL removed	10/1/2020
GLATIRAMER 20 MG/ML SYRINGE* GLATOPA 20 MG/ML SYRINGE* GLATIRAMER 40 MG/ML SYRINGE* GLATOPA 40 MG/ML SYRINGE*	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
GLIPIZIDE-METFORMIN 2.5-250 MG GLIPIZIDE-METFORMIN 2.5-500 MG GLIPIZIDE-METFORMIN 5-500 MG	Moves to NonPreferred, PA added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
GLUCOPHAGE 500 MG TABLET GLUCOPHAGE 850 MG TABLET GLUCOPHAGE 1,000 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
GLUCOPHAGE XR 500 MG TAB GLUCOPHAGE XR 750 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
GLUCOTROL 5 MG TABLET GLUCOTROL 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
GLUCOTROL XL 2.5 MG TABLET GLUCOTROL XL 5 MG TABLET GLUCOTROL XL 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
GLUMETZA ER 500 MG TABLET GLUMETZA ER 1,000 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
GLYNASE 1.5 MG PRESTAB GLYNASE 3 MG PRESTAB GLYNASE 6 MG PRESTAB	Update to Formulary-NonPreferred and require PA	10/1/2020
GLYSET 25 MG TABLET GLYSET 50 MG TABLET GLYSET 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
GLYXAMBI 10 MG-5 MG TABLET GLYXAMBI 25 MG-5 MG TABLET	Formulary-Preferred	10/1/2020
GOCOVRI ER 137 MG CAPSULE GOCOVRI ER 68.5 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
GRALISE ER 300 MG TABLET GRALISE ER 600 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
GRANISETRON HCL 1 MG TABLET	Formulary-Preferred, ST removed, QL removed	10/1/2020
GRISEOFULVIN MICRO 500 MG TAB	Moves to NonPreferred, PA added	10/1/2020
GRISEOFULVIN ULTRA 125 MG TAB GRISEOFULVIN ULTRA 250 MG TAB	Moves to NonPreferred, PA added	10/1/2020
GUANFACINE 1 MG TABLET GUANFACINE 2 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
HALCINONIDE 0.1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
HALOBETASOL PROP 0.05% CREAM HALOBETASOL PROP 0.05% OINTMNT	Formulary-Preferred, QL removed	10/1/2020
HALOG 0.1% CREAM HALOG 0.1% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
HEARTBURN TREATMNT 24 HR 15 MG (Lansoprazole)	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
HEMANGEOL 4.28 MG/ML ORAL SOLN	Moves to NonPreferred, PA added, AL removed	10/1/2020
HORIZANT ER 300 MG TABLET HORIZANT ER 600 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
HUMALOG 100 UNIT/ML VIAL	Update to Formulary - Preferred, Brand Preferred added, PA removed	10/1/2020
HUMALOG 100 UNITS/ML CARTRIDGE HUMALOG 100 UNITS/ML KWIKPEN	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020
HUMALOG 200 UNITS/ML KWIKPEN	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
HUMALOG JR 100 UNIT/ML KWIKPEN	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020
HUMALOG MIX 50-50 KWIKPEN HUMALOG MIX 75-25 KWIKPEN	Formulary-Preferred, AL removed	10/1/2020
HUMALOG MIX 50-50 VIAL HUMALOG MIX 75-25 VIAL HUMULIN 70-30 VIAL	Update to Formulary - Preferred, QL less stringent	10/1/2020
HUMATROPE 5 MG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
HUMATROPE 6 MG CARTRIDGE HUMATROPE 12 MG CARTRIDGE HUMATROPE 24 MG CARTRIDGE	Update to Formulary-NonPreferred and require PA	10/1/2020
HUMIRA 10 MG/0.2 ML SYRINGE HUMIRA 20 MG/0.4 ML SYRINGE HUMIRA 40 MG/0.8 ML SYRINGE HUMIRA PEN 40 MG/0.8 ML HUMIRA PEN CROHN-UC-HS 40 MG HUMIRA PEN PS-UV-ADOL HS 40 MG	Formulary-Preferred, PA removed, QL removed	10/1/2020
HUMIRA(CF) 10 MG/0.1 ML SYRING HUMIRA(CF) 20 MG/0.2 ML SYRING HUMIRA(CF) 40 MG/0.4 ML SYRING HUMIRA(CF) PEDI CROHN 80-40 MG HUMIRA(CF) PEDI CROHN 80MG/0.8 HUMIRA(CF) PEN 40 MG/0.4 ML HUMIRA(CF) PEN CRHN-UC-HS 80MG HUMIRA(CF) PEN PS-UV-AHS 80-40	Formulary-Preferred, PA removed, QL removed	10/1/2020
HUMULIN 70/30 KWIKPEN	Updated to Formulary-Preferred, AL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
HUMULIN N 100 UNIT/ML VIAL HUMULIN R 100 UNIT/ML VIAL	Formulary - Preferred, QL less stringent	10/1/2020
HUMULIN N 100 UNITS/ML KWIKPEN	Moves to NonPreferred, PA added, AL removed	10/1/2020
HUMULIN R 500 UNITS/ML KWIKPEN	Formulary-Preferred, QL Added	10/1/2020
HUMULIN R 500 UNITS/ML VIAL	Formulary-Preferred, PA removed, QL added	10/1/2020
HYDROCODONE ER 10 MG CAPSULE HYDROCODONE ER 15 MG CAPSULE HYDROCODONE ER 30 MG CAPSULE HYDROCODONE ER 40 MG CAPSULE HYDROCODONE ER 50 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
HYDROCODONE-ACETAMIN 2.5-108/5 HYDROCODONE-ACETAMIN 5-217/10	Formulary-Preferred	10/1/2020
HYDROCODONE-ACETAMIN 5-300 MG HYDROCODONE-ACETAMIN 7.5-300 HYDROCODONE-ACETAMIN 10-300 MG	Formulary-Preferred	10/1/2020
HYDROCODONE-ACETAMIN 5-325 MG HYDROCODONE-ACETAMIN 7.5-325 HYDROCODONE-ACETAMIN 10-325 MG	Formulary-Preferred, QL removed	10/1/2020
HYDROCODONE-ACETAMN 7.5-325/15	Formulary-Preferred, QL removed	10/1/2020
HYDROCODONE-IBUPROFEN 10-200	Update to Formulary-NonPreferred and require PA	10/1/2020
HYDROCODONE-IBUPROFEN 5-200 MG HYDROCODONE-IBUPROFEN 7.5-200	Moves to NonPreferred, PA added, QL Removed	10/1/2020
HYDROCORT BUTY 0.1% LIPID CRM HYDROCORT BUTY 0.1% LIPO CREAM HYDROCORTISONE BUTY 0.1% CREAM HYDROCORTISONE BUTYR 0.1% LOTN HYDROCORTISONE BUTYR 0.1% OINT	Update to Formulary-NonPreferred and require PA	10/1/2020
HYDROCORTISONE 0.1% SOLN	Update to Formulary-NonPreferred and require PA	10/1/2020
HYDROCORTISONE 0.5% CREAM ANTI-ITCH 1% CREAM HM HYDROCORTISONE 1% CREAM	Formulary-Preferred	10/1/2020
HYDROCORTISONE VAL 0.2% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020

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HYDROCORTISONE VAL 0.2% OINTMT	Update to Formulary-NonPreferred and require PA	10/1/2020
HYDROCORTISONE-ALOE 1% CREAM SM HYDROCORTISONE-ALOE 1% CRM	Update to Formulary-NonPreferred and require PA	10/1/2020
HYDROMORPHONE 3 MG SUPPOS	Moves to NonPreferred, PA added, QL Removed	10/1/2020
HYDROMORPHONE 8 MG TABLET	Formulary-Preferred, QL Added	10/1/2020
HYDROMORPHONE HCL ER 8 MG TAB HYDROMORPHONE HCL ER 12 MG TAB HYDROMORPHONE HCL ER 16 MG TAB HYDROMORPHONE HCL ER 32 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
HYDROXYPROGEST 250 MG/ML VIAL HYDROXYPROGESTERONE 1.25 G/5ML	Formulary-Preferred w/Clinical PA	10/1/2020
HYDROXYZINE 10 MG/5 ML SOLN	Formulary-Preferred, AL removed	10/1/2020
HYDROXYZINE HCL 10 MG TABLET HYDROXYZINE HCL 25 MG TABLET HYDROXYZINE HCL 50 MG TABLET	Formulary-Preferred, AL removed	10/1/2020
HYDROXYZINE PAM 25 MG CAP HYDROXYZINE PAM 50 MG CAP HYDROXYZINE PAM 100 MG CAP	Formulary-Preferred, AL removed	10/1/2020
HYSINGLA ER 20 MG TABLET HYSINGLA ER 30 MG TABLET HYSINGLA ER 40 MG TABLET HYSINGLA ER 60 MG TABLET HYSINGLA ER 80 MG TABLET HYSINGLA ER 100 MG TABLET HYSINGLA ER 120 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
HYZAAR 50-12.5 TABLET HYZAAR 100-12.5 TABLET HYZAAR 100-25 TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
IBUPROFEN 100 MG/5 ML SUSP	Formulary-Preferred, QL removed	10/1/2020
ILEVRO 0.3% OPHTH DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
ILUMYA 100 MG/ML SYRINGE	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
IMITREX 25 MG TABLET IMITREX 50 MG TABLET IMITREX 100 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
IMITREX 4 MG/0.5 ML CARTRIDGES IMITREX 4 MG/0.5 ML PEN INJECT IMITREX 6 MG/0.5 ML CARTRIDGES IMITREX 6 MG/0.5 ML PEN INJECT IMITREX 6 MG/0.5 ML VIAL	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
IMITREX 5 MG NASAL SPRAY IMITREX 20 MG NASAL SPRAY	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
INBRIJA 42 MG INHALATION CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
INCRUSE ELLIPTA 62.5 MCG INH	Moves to NonPreferred, PA added, QL Removed	10/1/2020
INDERAL LA 60 MG CAPSULE INDERAL LA 80 MG CAPSULE INDERAL LA 120 MG CAPSULE INDERAL LA 160 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
INDERAL XL 120 MG CAPSULE INDERAL XL 80 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
INDOCIN 25 MG/5 ML SUSPENSION INDOCIN 50 MG SUPPOSITORY	Update to Formulary-NonPreferred and require PA	10/1/2020
INDOMETHACIN 25 MG CAPSULE INDOMETHACIN 50 MG CAPSULE	Formulary-Preferred, AL removed	10/1/2020
INDOMETHACIN ER 75 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
INNOPRAN XL 80 MG CAPSULE INNOPRAN XL 120 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
INSULIN ASPART 100 UNIT/ML CRT* INSULIN ASPART 100 UNIT/ML PEN* INSULIN ASPART 100 UNIT/ML VL*	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
INSULIN ASPART PROT-INSULN ASP VIAL* INSULIN ASPART PROT-INSULN ASP Pen*	Moved to NonPreferred, PA added, AL removed for pen	10/1/2020
INSULIN LISPRO 100 UNIT/ML PEN* INSULIN LISPRO 100 UNIT/ML VL*	Moved to NonPreferred, PA added	10/1/2020
INVOKAMET 50-500 MG TABLET INVOKAMET 50-1,000 MG TABLET INVOKAMET 150-500 MG TABLET INVOKAMET 150-1,000 MG TABLET	Formulary-Preferred, PA removed, QL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
INVOKAMET XR 50-500 MG TABLET INVOKAMET XR 50-1,000 MG TAB INVOKAMET XR 150-500 MG TABLET INVOKAMET XR 150-1,000 MG TAB	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
INVOKANA 100 MG TABLET INVOKANA 300 MG TABLET	Formulary-Preferred w/Clinical PA, QL Removed	10/1/2020
IOPIDINE 0.5% EYE DROPS IOPIDINE 1% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	Formulary-Preferred, QL removed	10/1/2020
IPRATROPIUM 0.03% SPRAY IPRATROPIUM 0.06% SPRAY	Formulary-Preferred, QL removed	10/1/2020
IRBESARTAN 75 MG TABLET IRBESARTAN 150 MG TABLET IRBESARTAN 300 MG TABLET	Moved to NonPreferred, PA added	10/1/2020
IRBESARTAN-HCTZ 150-12.5 MG TB IRBESARTAN-HCTZ 300-12.5 MG TB	Moves to NonPreferred, PA added	10/1/2020
ISRADIPINE 2.5 MG CAPSULE ISRADIPINE 5 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
ISTALOL 0.5% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
ITRACONAZOLE 10 MG/ML SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
ITRACONAZOLE 100 MG CAPSULE	Moves to NonPreferred, PA added, QL added	10/1/2020
JALYN 0.5-0.4 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
JANUMET 50-500 MG TABLET JANUMET 50-1,000 MG TABLET	Formulary-Preferred, PA removed	10/1/2020
JANUMET XR 50-500 MG TABLET JANUMET XR 50-1,000 MG TABLET JANUMET XR 100-1,000 MG TABLET	Formulary-Preferred, PA removed, QL removed	10/1/2020
JANUVIA 25 MG TABLET JANUVIA 50 MG TABLET JANUVIA 100 MG TABLET	Formulary-Preferred, PA removed	10/1/2020
JARDIANCE 10 MG TABLET JARDIANCE 25 MG TABLET	Formulary-Preferred, PA removed, QL removed	10/1/2020
JENTADUETO 2.5 MG-500 MG TAB JENTADUETO 2.5 MG-850 MG TAB JENTADUETO 2.5 MG-1000 MG TAB	Formulary-Preferred, PA removed, QL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
JUBLIA 10% TOPICAL SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
KADIAN ER 10 MG CAPSULE KADIAN ER 20 MG CAPSULE KADIAN ER 30 MG CAPSULE KADIAN ER 40 MG CAPSULE KADIAN ER 50 MG CAPSULE KADIAN ER 60 MG CAPSULE KADIAN ER 80 MG CAPSULE KADIAN ER 100 MG CAPSULE KADIAN ER 200 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
KAPSPARGO SPRINKLE 25 MG CAP KAPSPARGO SPRINKLE 50 MG CAP KAPSPARGO SPRINKLE 100 MG CAP KAPSPARGO SPRINKLE 200 MG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
KATERZIA 1 MG/ML SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
KAZANO 12.5-500 MG TABLET KAZANO 12.5-1,000 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
KEFLEX 250 MG CAPSULE KEFLEX 500 MG CAPSULE KEFLEX 750 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
KENALOG 0.147 MG/GRAM SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
KERYDIN 5% TOPICAL SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
KETOCONAZOLE 2% CREAM KETOCONAZOLE 2% SHAMPOO	Formulary-Preferred, QL removed	10/1/2020
KETOCONAZOLE 2% FOAM	Update to Formulary-NonPreferred and require PA	10/1/2020
KETOCONAZOLE 200 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
KETOPROFEN 50 MG CAPSULE KETOPROFEN 75 MG CAPSULE	Formulary-Preferred	10/1/2020
KETOPROFEN ER 200 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
KETOROLAC 0.4% OPHTH SOLUTION	Formulary-Preferred	10/1/2020
KETOROLAC 0.5% OPHTH SOLUTION	Formulary-Preferred, QL removed	10/1/2020
KETOROLAC 10 MG TABLET	QL added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
KETOROLAC 15.75 MG NASAL SPRAY	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
KETOTIFEN FUM 0.025% EYE DROPS	Formulary-Preferred, QL removed	10/1/2020
KEVZARA 150 MG/1.14 ML PEN INJ KEVZARA 150 MG/1.14 ML SYRINGE KEVZARA 200 MG/1.14 ML PEN INJ KEVZARA 200 MG/1.14 ML SYRINGE	Update to Formulary-NonPreferred and require PA	10/1/2020
KITABIS PAK 300 MG/5 ML	Formulary - Preferred, Brand Preferred added, PA removed	10/1/2020
KOMBIGLYZE XR 2.5-1,000 MG TAB KOMBIGLYZE XR 5-500 MG TABLET KOMBIGLYZE XR 5-1,000 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
LANSOPRAZOL-AMOXICIL-CLARITHRO	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
LANSOPRAZOLE DR 15 MG CAPSULE LANSOPRAZOLE DR 30 MG CAPSULE	Moves to NonPreferred, PA added	10/1/2020
LANSOPRAZOLE ODT 15 MG TABLET LANSOPRAZOLE ODT 30 MG TABLET	Moves to NonPreferred, PA added, AL removed, QL Removed	10/1/2020
LANTUS 100 UNIT/ML VIAL LANTUS SOLOSTAR 100 UNIT/ML	Formulary-Preferred, QL Added	10/1/2020
LASTACAFT 0.25% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
LATANOPROST 0.005% EYE DROPS	Formulary-Preferred, QL removed	10/1/2020
LESCOL XL 80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LETAIRIS 5 MG TABLET LETAIRIS 10 MG TABLET	Formulary-Preferred w/Clinical PA	10/1/2020
LEUKINE 250 MCG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
LEVALBUTEROL 0.31 MG/3 ML SOL LEVALBUTEROL 0.63 MG/3 ML SOL LEVALBUTEROL 1.25 MG/3 ML SOL	Moves to NonPreferred, PA added, QL Removed	10/1/2020
LEVALBUTEROL CONC 1.25 MG/0.5	Update to Formulary-NonPreferred and require PA	10/1/2020
LEVALBUTEROL TAR HFA 45MCG INH	Moves to NonPreferred, PA added	10/1/2020
LEVAQUIN 500 MG TABLET LEVAQUIN 750 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
LEVEMIR 100 UNIT/ML VIAL LEVEMIR FLEXTOUCH 100 UNIT/ML	Formulary-Preferred, QL Added	10/1/2020
LEVOBUNOLOL 0.5% EYE DROPS	Moves to NonPreferred, PA added	10/1/2020
LEVOCETIRIZINE 2.5 MG/5 ML SOL	Update to Formulary-NonPreferred and require PA	10/1/2020
LEVOCETIRIZINE 5 MG TABLET	Formulary-Preferred	10/1/2020
LEVOFLOXACIN 0.5% EYE DROPS	Moves to NonPreferred, PA added	10/1/2020
LEVOFLOXACIN 25 MG/ML SOLUTION	Formulary-Preferred, AL removed	10/1/2020
LEVORPHANOL 2 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LEXETTE 0.05% FOAM	Update to Formulary-NonPreferred and require PA	10/1/2020
LIALDA DR 1.2 GM TABLET	Formulary-Preferred; Brand Preferred	10/1/2020
LINEZOLID 100 MG/5 ML SUSP	Formulary-Preferred, PA removed	10/1/2020
LINEZOLID 600 MG TABLET	Formulary-Preferred, PA removed, QL added	10/1/2020
LINZESS 72 MCG CAPSULE LINZESS 145 MCG CAPSULE LINZESS 290 MCG CAPSULE	Formulary-Preferred w/Clinical PA	10/1/2020
LIPITOR 10 MG TABLET LIPITOR 20 MG TABLET LIPITOR 40 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
LIPITOR 80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LIPOFEN 50 MG CAPSULE LIPOFEN 150 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
LIVALO 1 MG TABLET LIVALO 2 MG TABLET LIVALO 4 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LOCOID 0.1% CREAM LOCOID 0.1% LOTION LOCOID 0.1% SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
LODOSYN 25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LONHALA MAGNAIR 25 MCG REFILL LONHALA MAGNAIR 25 MCG STARTER	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
LOPID 600 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LOPRESSOR 50 MG TABLET LOPRESSOR 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LOPROX 1% SHAMPOO	Update to Formulary-NonPreferred and require PA	10/1/2020
LORATADINE 10 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
LORATADINE 5 MG/5 ML SYRUP	Formulary-Preferred, AL removed, QL removed	10/1/2020
LORCET 5-325 MG TABLET LORCET HD 10-325 MG TABLET LORCET PLUS 7.5-325 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LORTAB 10 MG-300 MG/15 ML ELXR	Update to Formulary-NonPreferred and require PA	10/1/2020
LORZONE 375 MG TABLET LORZONE 750 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LOTENSIN 20 MG TABLET LOTENSIN 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LOTENSIN HCT 10-12.5 MG TABLET LOTENSIN HCT 20-12.5 MG TABLET LOTENSIN HCT 20-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LOTREL 5-10 MG CAPSULE LOTREL 5-20 MG CAPSULE LOTREL 10-20 MG CAPSULE LOTREL 10-40 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
LOTRIMIN AF 1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
LOTRISONE CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
LOTRONEX 0.5 MG TABLET LOTRONEX 1 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
LOVASTATIN 10 MG TABLET LOVASTATIN 20 MG TABLET LOVASTATIN 40 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
LOVAZA 1 GM CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
LOVENOX 30 MG/0.3 ML SYRINGE LOVENOX 40 MG/0.4 ML SYRINGE LOVENOX 60 MG/0.6 ML SYRINGE LOVENOX 80 MG/0.8 ML SYRINGE LOVENOX 100 MG/ML SYRINGE LOVENOX 120 MG/0.8 ML SYRINGE LOVENOX 150 MG/ML SYRINGE LOVENOX 300 MG/3 ML VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
LUMIGAN 0.01% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
LUXIQ 0.12% FOAM	Update to Formulary-NonPreferred and require PA	10/1/2020
LUZU 1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
MAKENA 250 MG/ML VIAL MAKENA 1,250 MG/5 ML VIAL MAKENA 275 MG/1.1 ML AUTOINJCT	Update to Formulary-NonPreferred and require PA	10/1/2020
MATZIM LA 180 MG TABLET MATZIM LA 240 MG TABLET MATZIM LA 300 MG TABLET MATZIM LA 360 MG TABLET MATZIM LA 420 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
MAVENCLAD 10 MG X 4 TABLET PK MAVENCLAD 10 MG X 5 TABLET PK MAVENCLAD 10 MG X 6 TABLET PK MAVENCLAD 10 MG X 7 TABLET PK MAVENCLAD 10 MG X 8 TABLET PK MAVENCLAD 10 MG X 9 TABLET PK MAVENCLAD 10 MG X 10 TABLET PK	Update to Formulary-NonPreferred and require PA	10/1/2020
MAXALT 10 MG TABLET MAXALT MLT 10 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
MAYZENT 0.25 MG TABLET MAYZENT 0.25 MG STARTER PACK MAYZENT 2 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
MECLOFENAMATE 50 MG CAPSULE MECLOFENAMATE 100 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
MEFENAMIC ACID 250 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
MEGACE ES 625 MG/5 ML SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
MEGESTROL 625 MG/5 ML SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020
MELOXICAM 7.5 MG TABLET MELOXICAM 15 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
MEMANTINE HCL 2MG/ML SOLUTION	Formulary-Preferred	10/1/2020
MEMANTINE HCL 5 MG TABLET MEMANTINE HCL 10 MG TABLET MEMANTINE 5-10 TITRATION PK	Formulary-Preferred, AL removed, QL removed	10/1/2020
MEMANTINE HCL ER 7 MG CAPSULE MEMANTINE HCL ER 14 MG CAPSULE MEMANTINE HCL ER 21 MG CAPSULE MEMANTINE HCL ER 28 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
MENTAX 1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
MEPERIDINE 50 MG TABLET MEPERIDINE 100 MG TABLET	Moves to NonPreferred, PA added, AL removed	10/1/2020
MESALAMINE 800 MG DR TABLET MESALAMINE DR 1.2 GM TABLET*	Moves to NonPreferred, PA added, QL Removed	10/1/2020
MESALAMINE DR 400 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
MESALAMINE ER 0.375 GRAM CAP*	Moves to NonPreferred, PA added, QL Removed	10/1/2020
METAXALONE 400 MG TABLET METAXALONE 800 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
METFORMIN ER 500 MG GASTRC-TB METFORMIN ER 1,000 MG GASTR-TB	Update to Formulary-NonPreferred and require PA	10/1/2020
METFORMIN ER 500 MG OSMOTIC TB METFORMIN ER 1,000 MG OSM-TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
METFORMIN HCL 500 MG TABLET METFORMIN HCL 850 MG TABLET METFORMIN HCL 1,000 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
METHADONE 10 MG/ML ORAL CONC	Moves to NonPreferred, PA added, QL Removed	10/1/2020
METHADONE 40 MG TABLET DISPR METHADONE INTENSOL 10 MG/ML	Update to Formulary-NonPreferred and require PA	10/1/2020
METHADONE 5 MG/5 ML SOLUTION METHADONE 10 MG/5 ML SOLUTION MEPERIDINE 50 MG/5 ML SOLUTION	Moves to NonPreferred, PA added, QL Removed	10/1/2020
METHADONE HCL 5 MG TABLET METHADONE HCL 10 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
METHADOSE 40 MG TABLET DISPR METHADOSE 10 MG/ML ORAL CONC	Update to Formulary-NonPreferred and require PA	10/1/2020
METHOCARBAMOL 500 MG TABLET METHOCARBAMOL 750 MG TABLET	Moves to NonPreferred, PA added, AL removed	10/1/2020
METHYLDOPA 250 MG TABLET METHYLDOPA 500 MG TABLET	Formulary-Preferred, AL removed	10/1/2020
METHYLDOPA-HCTZ 250-15 MG TAB METHYLDOPA-HCTZ 250-25 MG TAB	Moves to NonPreferred, PA added	10/1/2020
METOPROLOL SUCC ER 25 MG TAB METOPROLOL SUCC ER 50 MG TAB METOPROLOL SUCC ER 100 MG TAB METOPROLOL SUCC ER 200 MG TAB	Formulary-Preferred, QL removed	10/1/2020
METOPROLOL TARTRATE 25 MG TAB METOPROLOL TARTRATE 50 MG TAB METOPROLOL TARTRATE 100 MG TAB	Formulary-Preferred, QL removed	10/1/2020
METOPROLOL-HCTZ 50-25 MG TAB METOPROLOL-HCTZ 100-25 MG TAB METOPROLOL-HCTZ 100-50 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
METRONIDAZOLE 375 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
METRONIDAZOLE VAGINAL 0.75% GL	Moves to NonPreferred, PA added	10/1/2020
MICARDIS 20 MG TABLET MICARDIS 40 MG TABLET MICARDIS 80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
MICARDIS HCT 40-12.5 MG TABLET MICARDIS HCT 80-12.5 MG TABLET MICARDIS HCT 80-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
MICORT HC 2.5% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
MIGLITOL 25 MG TABLET MIGLITOL 50 MG TABLET MIGLITOL 100 MG TABLET	Formulary-Preferred w/Clinical PA	10/1/2020
MINIPRESS 1 MG CAPSULE MINIPRESS 2 MG CAPSULE MINIPRESS 5 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
MIRAPEX 1.5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
MIRAPEX ER 0.375 MG TABLET MIRAPEX ER 0.75 MG TABLET MIRAPEX ER 1.5 MG TABLET MIRAPEX ER 2.25 MG TABLET MIRAPEX ER 3 MG TABLET MIRAPEX ER 3.75 MG TABLET MIRAPEX ER 4.5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
MITIGARE 0.6 MG CAPSULE	Formulary-Preferred; Brand Preferred	10/1/2020
MOBIC 7.5 MG TABLET MOBIC 15 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
MOEXIPRIL HCL 7.5 MG TABLET MOEXIPRIL HCL 15 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
MOMETASONE FUROATE 0.1% CREAM MOMETASONE FUROATE 0.1% OINT MOMETASONE FUROATE 0.1% SOLN	Formulary-Preferred, QL removed	10/1/2020
MOMETASONE FUROATE 50 MCG SPRY	Update to Formulary-NonPreferred and require PA	10/1/2020
MONTELUKAST SOD 10 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
MONTELUKAST SOD 4 MG GRANULES	Moves to NonPreferred, PA added, QL Removed	10/1/2020
MONTELUKAST SOD 4 MG TAB CHEW MONTELUKAST SOD 5 MG TAB CHEW	AL added	10/1/2020
MORPHABOND ER 15 MG TABLET MORPHABOND ER 30 MG TABLET MORPHABOND ER 60 MG TABLET MORPHABOND ER 100 MG TABLET	Formulary-Preferred	10/1/2020
MORPHINE SULF 5 MG SUPPOS MORPHINE SULF 10 MG SUPPOS MORPHINE SULF 20 MG SUPPOS MORPHINE SULF 30 MG SUPPOS	Formulary-Preferred	10/1/2020
MORPHINE SULF ER 15 MG TABLET MORPHINE SULF ER 30 MG TABLET MORPHINE SULF ER 60 MG TABLET MORPHINE SULF ER 100 MG TABLET MORPHINE SULF ER 200 MG TABLET	Formulary-Preferred, QL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
MORPHINE SULFATE ER 10 MG CAP MORPHINE SULFATE ER 20 MG CAP MORPHINE SULFATE ER 30 MG CAP MORPHINE SULFATE ER 40 MG CAP MORPHINE SULFATE ER 45 MG CAP MORPHINE SULFATE ER 50 MG CAP MORPHINE SULFATE ER 60 MG CAP MORPHINE SULFATE ER 75 MG CAP MORPHINE SULFATE ER 80 MG CAP MORPHINE SULFATE ER 90 MG CAP MORPHINE SULFATE ER 100 MG CAP MORPHINE SULFATE ER 120 MG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
MOTEGRITY 1 MG TABLET MOTEGRITY 2 MG TABLET	Formulary-NonPreferred, AL removed, QL Removed	10/1/2020
MOVANTIK 12.5 MG TABLET MOVANTIK 25 MG TABLET	Formulary-Preferred	10/1/2020
MOXEZA 0.5% EYE DROPS	Formulary-Preferred; Brand Preferred	10/1/2020
MOXIFLOXACIN 0.5% EYE DROPS*	Update to Formulary-NonPreferred and require PA	10/1/2020
MUPIROCIN 2% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
MUPIROCIN 2% OINTMENT	Formulary-Preferred, QL removed	10/1/2020
MYRBETRIQ ER 25 MG TABLET MYRBETRIQ ER 50 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NABUMETONE 500 MG TABLET NABUMETONE 750 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
NADOLOL 20 MG TABLET NADOLOL 40 MG TABLET NADOLOL 80 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
NADOLOL-BENDROFLU 80-5 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
NAFTIFINE HCL 1% CREAM NAFTIFINE HCL 2% CREAM NAFTIFINE HCL 1% GEL	Update to Formulary-NonPreferred and require PA	10/1/2020
NAFTIN 2% CREAM NAFTIN 1% GEL NAFTIN 2% GEL	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
NALFON 400 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
NAMENDA 5 MG TABLET NAMENDA 10 MG TABLET NAMENDA 5-10 MG TITRATION PK NAMENDA XR 7 MG CAPSULE NAMENDA XR 14 MG CAPSULE NAMENDA XR 21 MG CAPSULE NAMENDA XR 28 MG CAPSULE NAMENDA XR TITRATION PACK	Update to Formulary-NonPreferred and require PA	10/1/2020
NAMZARIC 14 MG-10 MG CAPSULE NAMZARIC 28 MG-10 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
NAPRELAN CR 375 MG TABLET NAPRELAN CR 500 MG TABLET NAPRELAN CR 750 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NAPROXEN 125 MG/5 ML SUSPEN	Update to Formulary-NonPreferred, AL removed	10/1/2020
NAPROXEN DR 375 MG TABLET NAPROXEN DR 500 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
NAPROXEN SOD CR 375 MG TABLET NAPROXEN SOD CR 500 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NAPROXEN SOD ER 500 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NAPROXEN SODIUM 220 MG CAPLET NAPROXEN SODIUM 220 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
NAPROXEN SODIUM 275 MG TAB NAPROXEN SODIUM 550 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
NAPROXEN-ESOMEPRAZ DR 500-20MG	Update to Formulary-NonPreferred and require PA	10/1/2020
NARATRIPTAN HCL 1 MG TABLET NARATRIPTAN HCL 2.5 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
NASONEX 50 MCG NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
NATEGLINIDE 60 MG TABLET NATEGLINIDE 120 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
NEOMYCIN 500 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
NESINA 6.25 MG TABLET NESINA 12.5 MG TABLET NESINA 25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
NEUAC GEL NEUAC 1.2-5% KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
NEULASTA 6 MG/0.6 ML SYRINGE NEULASTA ONPRO 6 MG/0.6 ML KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
NEUPOGEN 300 MCG/0.5 ML SYR NEUPOGEN 300 MCG/ML VIAL	Formulary-Preferred, PA removed	10/1/2020
NEUPOGEN 480 MCG/0.8 ML SYR NEUPOGEN 480 MCG/1.6 ML VIAL	Formulary-Preferred, PA removed	10/1/2020
NEUPRO 1 MG/24 HR PATCH NEUPRO 2 MG/24 HR PATCH NEUPRO 3 MG/24 HR PATCH NEUPRO 4 MG/24 HR PATCH NEUPRO 6 MG/24 HR PATCH NEUPRO 8 MG/24 HR PATCH	Update to Formulary-NonPreferred and require PA	10/1/2020
NEVANAC 0.1% DROPTAINER	Update to Formulary-NonPreferred and require PA	10/1/2020
NEXIUM DR 20 MG CAPSULE NEXIUM DR 40 MG CAPSULE NEXIUM DR 2.5 MG PACKET NEXIUM DR 5 MG PACKET NEXIUM DR 10 MG PACKET NEXIUM DR 20 MG PACKET NEXIUM DR 40 MG PACKET	Update to Formulary-NonPreferred and require PA	10/1/2020
NIACIN 100 MG TABLET NIACIN 500 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
NIACIN ER 500 MG TABLET* NIACIN ER 750 MG TABLET* NIACIN ER 1,000 MG TABLET*	Update to Formulary-NonPreferred and require PA	10/1/2020
NIACIN TR 500 MG CAPLET NIACIN 500 MG CAPSULE SA NIACIN TR 500 MG CAPSULE NIACIN ER 500 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
NIASPAN ER 500 MG TABLET NIASPAN ER 750 MG TABLET NIASPAN ER 1,000 MG TABLET	Formulary-Preferred; Brand Preferred	10/1/2020
NICARDIPINE 20 MG CAPSULE NICARDIPINE 30 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
NIFEDIPINE 10 MG CAPSULE NIFEDIPINE 20 MG CAPSULE	Formulary-Preferred, AL removed, QL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
NIFEDIPINE ER 30 MG TABLET NIFEDIPINE ER 60 MG TABLET NIFEDIPINE ER 90 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
NISOLDIPINE ER 8.5 MG TABLET NISOLDIPINE ER 17 MG TABLET NISOLDIPINE ER 20 MG TABLET NISOLDIPINE ER 25.5 MG TABLET NISOLDIPINE ER 30 MG TABLET NISOLDIPINE ER 34 MG TABLET NISOLDIPINE ER 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NIZORAL 2% SHAMPOO	Update to Formulary-NonPreferred and require PA	10/1/2020
NORCO 5-325 TABLET NORCO 7.5-325 TABLET NORCO 10-325 TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NORETHINDRONE 5 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
NORVASC 2.5 MG TABLET NORVASC 5 MG TABLET NORVASC 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NOURIANZ 20 MG TABLET NOURIANZ 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NOVOLIN 70-30 FLEXPEN NOVOLIN 70-30 100 UNIT/ML VIAL	Moves to NonPreferred, PA added	10/1/2020
NOVOLIN N 100 UNIT/ML FLEXPEN NOVOLIN R 100 UNIT/ML FLEXPEN	Formulary-Preferred, QL Added	10/1/2020
NOVOLIN N 100 UNIT/ML VIAL NOVOLIN R 100 UNIT/ML VIAL	Formulary - Preferred, QL less stringent	10/1/2020
NOVOLOG 100 UNIT/ML CARTRIDGE NOVOLOG 100 UNIT/ML FLEXPEN NOVOLOG 100 UNIT/ML VIAL	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020
NOVOLOG MIX 70-30 FLEXPEN NOVOLOG MIX 70-30 VIAL	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020
NOXAFIL DR 100 MG TABLET NOXAFIL 40 MG/ML SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
NUCYNTA 50 MG TABLET NUCYNTA 75 MG TABLET NUCYNTA 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
NUCYNTA ER 50 MG TABLET NUCYNTA ER 100 MG TABLET NUCYNTA ER 150 MG TABLET NUCYNTA ER 200 MG TABLET NUCYNTA ER 250 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
NUTROPIN AQ NUSPIN 5 INJECTOR NUTROPIN AQ NUSPIN 10 INJECTOR NUTROPIN AQ NUSPIN 20 INJECTOR	Formulary-Preferred w/Clinical PA	10/1/2020
NYSTATIN 100,000 UNIT/GM POWD NYAMYC 100,000 UNITS/GM POWDER NYSTOP 100,000 UNITS/GM POWDER	Formulary-Preferred, QL removed	10/1/2020
NYSTATIN 500,000 UNIT ORAL TAB	Moves to NonPreferred, PA added	10/1/2020
NYSTATIN-TRIAMCINOLONE CREAM NYSTATIN-TRIAMCINOLONE OINTM	Moves to NonPreferred, PA added, QL Removed	10/1/2020
OCUFLOX 0.3% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
OLMESARTAN MEDOXOMIL 5 MG TAB OLMESARTAN MEDOXOMIL 20 MG TAB OLMESARTAN MEDOXOMIL 40 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
OLMESARTAN/AMLODIPIN/HCTHIAZID 20-5-12.5 MG TABLET OLMESARTAN/AMLODIPIN/HCTHIAZID 40-5-12.5 MG TABLET OLMESARTAN/AMLODIPIN/HCTHIAZID 40-5-25 MG TABLET OLMESARTAN/AMLODIPIN/HCTHIAZID 40-10-12.5 MG TABLET OLMESARTAN/AMLODIPIN/HCTHIAZID 40-10-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
OLMESARTAN-HCTZ 20-12.5 MG TAB OLMESARTAN-HCTZ 40-12.5 MG TAB OLMESARTAN-HCTZ 40-25 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
OLOPATADINE 665 MCG NASAL SPRY	Update to Formulary-NonPreferred and require PA	10/1/2020
OLOPATADINE HCL 0.1% EYE DROPS OLOPATADINE HCL 0.2% EYE DROP	Formulary-Preferred	10/1/2020
OLUMIANT 1 MG TABLET OLUMIANT 2 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
OLUX 0.05% FOAM OLUX-E 0.05% FOAM	Update to Formulary-NonPreferred and require PA	10/1/2020
OMECLAMOX-PAK COMBO PACK	Update to Formulary-NonPreferred and require PA	10/1/2020
OMEGA-3 ETHYL ESTERS 1 GM CAP	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
OMEPRAZOLE DR 10 MG CAPSULE OMEPRAZOLE DR 20 MG CAPSULE OMEPRAZOLE DR 40 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
OMEPRAZOLE DR 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
OMEPRAZOLE MAG DR 20.6 MG CAP	Moves to NonPreferred, PA added, QL Removed	10/1/2020
OMEPRAZOLE-BICARB 20-1,100 CAP OMEPRAZOLE-BICARB 40-1,100 CAP OMEPRAZOLE-BICARB 20-1,680 PKT OMEPRAZOLE-BICARB 40-1,680 PKT	Update to Formulary-NonPreferred and require PA	10/1/2020
OMNARIS 50 MCG NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
OMNITROPE 5 MG/1.5 ML CRTG OMNITROPE 10 MG/1.5 ML CRTG OMNITROPE 5.8 MG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
ONDANSETRON 4 MG/5 ML SOLUTION	QL more stringent	10/1/2020
ONDANSETRON HCL 4 MG TABLET ONDANSETRON HCL 8 MG TABLET	QL more stringent	10/1/2020
ONDANSETRON ODT 4 MG TABLET ONDANSETRON ODT 8 MG TABLET	QL more stringent	10/1/2020
ONEXTON GEL PUMP ONEXTON 1.2%-3.75% GEL	Update to Formulary-NonPreferred and require PA	10/1/2020
ONGLYZA 2.5 MG TABLET ONGLYZA 5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ONMEL 200 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ONZETRA XSAIL 11 MG/NOSEPIECE	Update to Formulary-NonPreferred and require PA	10/1/2020
OPANA 10 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
OPSUMIT 10 MG TABLET	Formulary-Preferred w/Clinical PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ORAVIG 50 MG BUCCAL TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ORENCIA 50 MG/0.4 ML SYRINGE ORENCIA 87.5 MG/0.7 ML SYRINGE ORENCIA 125 MG/ML SYRINGE ORENCIA CLICKJECT 125 MG/ML	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
ORENITRAM ER 0.125 MG TABLET ORENITRAM ER 0.25 MG TABLET ORENITRAM ER 1 MG TABLET ORENITRAM ER 2.5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ORENITRAM ER 5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ORPHENADRINE ER 100 MG TABLET	Formulary-Preferred, AL removed, QL removed	10/1/2020
OSELTAMIVIR 6 MG/ML SUSPENSION	Formulary-Preferred, AL removed	10/1/2020
OSELTAMIVIR PHOS 30 MG CAPSULE OSELTAMIVIR PHOS 45 MG CAPSULE OSELTAMIVIR PHOS 75 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
OSENI 12.5-15 MG TABLET OSENI 12.5-30 MG TABLET OSENI 12.5-45 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
OSENI 25-15 MG TABLET OSENI 25-30 MG TABLET OSENI 25-45 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
OSMOLEX ER 129 MG TABLET OSMOLEX ER 193 MG TABLET OSMOLEX ER 258 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
OTEZLA 28 DAY STARTER PACK OTEZLA 30 MG TABLET	Formulary-NonPreferred, AL removed, QL Removed	10/1/2020
OTOVEL 0.3%-0.025% EAR DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
OXAPROZIN 600 MG CAPLET OXAPROZIN 600 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
OXISTAT 1% CREAM OXISTAT 1% LOTION	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
OXYBUTYNIN 5 MG TABLET OXYBUTYNIN 5 MG/5 ML SYRUP OXYBUTYNIN CL ER 5 MG TABLET OXYBUTYNIN CL ER 10 MG TABLET OXYBUTYNIN CL ER 15 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
OXYCODON-ACETAMINOPHEN 2.5-325	Formulary-Preferred	10/1/2020
OXYCODON-ACETAMINOPHEN 7.5-325	Formulary-Preferred, QL removed	10/1/2020
OXYCODONE HCL 10 MG TABLET OXYCODONE HCL 15 MG TABLET	Formulary-Preferred, QL Added	10/1/2020
OXYCODONE HCL 100 MG/5 ML SOLN	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
OXYCODONE HCL 20 MG TABLET OXYCODONE HCL 30 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
OXYCODONE HCL 5 MG CAPSULE	Formulary-Preferred, QL Added	10/1/2020
OXYCODONE HCL ER 10 MG TABLET OXYCODONE HCL ER 20 MG TABLET OXYCODONE HCL ER 40 MG TABLET OXYCODONE HCL ER 60 MG TABLET OXYCODONE HCL ER 80 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
OXYCODONE-ACETAMINOPHEN 5-325 OXYCODONE-ACETAMINOPHEN 10-325	Formulary-Preferred, QL removed	10/1/2020
OXYCODONE-ASPIRIN 4.8355-325	Update to Formulary-NonPreferred and require PA	10/1/2020
OXYCONTIN ER 10 MG TABLET OXYCONTIN ER 15 MG TABLET OXYCONTIN ER 20 MG TABLET OXYCONTIN ER 30 MG TABLET OXYCONTIN ER 40 MG TABLET OXYCONTIN ER 60 MG TABLET OXYCONTIN ER 80 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
OXYMORPHONE HCL 5 MG TABLET OXYMORPHONE HCL 10 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
OXYMORPHONE HCL ER 5 MG TABLET OXYMORPHONE HCL ER 7.5 MG TAB OXYMORPHONE HCL ER 10 MG TAB OXYMORPHONE HCL ER 15 MG TAB OXYMORPHONE HCL ER 20 MG TAB OXYMORPHONE HCL ER 30 MG TAB OXYMORPHONE HCL ER 40 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
OXYTROL 3.9 MG/24HR PATCH	Update to Formulary-NonPreferred and require PA	10/1/2020
OZEMPIC 0.25-0.5 MG DOSE PEN OZEMPIC 1 MG DOSE PEN	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
PANCREAZE DR 2,600 UNIT CAP PANCREAZE DR 4,200 UNIT CAP PANCREAZE DR 10,500 UNIT CAP PANCREAZE DR 16,800 UNIT CAP PANCREAZE DR 21,000 UNIT CAP	Moves to NonPreferred, PA added, QL Removed	10/1/2020
PANDEL 0.1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
PANTOPRAZOLE SOD DR 20 MG TAB	Formulary-Preferred, QL removed	10/1/2020
PANTOPRAZOLE SOD DR 40 MG TAB	Formulary-Preferred, QL removed	10/1/2020
PARLODEL 2.5 MG TABLET PARLODEL 5 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
PATADAY 0.2% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
PATANASE 665 MCG NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
PATANOL 0.1% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
PAZEO 0.7% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
PENLAC 8% SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
PENNSAID 2% PUMP	Update to Formulary-NonPreferred and require PA	10/1/2020
PENTASA 250 MG CAPSULE PENTASA 500 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
PENTAZOCINE-NALOXONE TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
PERCOCET 2.5-325 MG TABLET PERCOCET 5-325 MG TABLET PERCOCET 7.5-325 MG TABLET PERCOCET 10-325 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PERFOROMIST 20 MCG/2 ML SOLN	Update to Formulary-NonPreferred and require PA	10/1/2020
PERINDOPRIL ERBUMINE 2 MG TAB PERINDOPRIL ERBUMINE 4 MG TAB	Moves to NonPreferred, PA added	10/1/2020
PERINDOPRIL ERBUMINE 8 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
PERTZYE DR 4,000 UNIT CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
PERTZYE DR 8,000 UNIT CAPSULE PERTZYE DR 16,000 UNIT CAPSULE PERTZYE DR 24,000 UNIT CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
PHOSLYRA 667 MG/5 ML SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
PIMECROLIMUS 1% CREAM*	Moves to NonPreferred, AL added, PA added	10/1/2020
PINDOLOL 5 MG TABLET PINDOLOL 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PIOGLITAZONE HCL 15 MG TABLET PIOGLITAZONE HCL 30 MG TABLET PIOGLITAZONE HCL 45 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
PIOGLITAZONE-GLIMEPIRIDE 30-2 PIOGLITAZONE-GLIMEPIRIDE 30-4	Update to Formulary-NonPreferred and require PA	10/1/2020
PIOGLITAZONE-METFORMIN 15-500 PIOGLITAZONE-METFORMIN 15-850	Update to Formulary-NonPreferred and require PA	10/1/2020
PIROXICAM 10 MG CAPSULE PIROXICAM 20 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
PLAVIX 75 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PLEGRIDY 125 MCG/0.5 ML PEN PLEGRIDY 125 MCG/0.5 ML SYRING PLEGRIDY PEN INJ STARTER PACK PLEGRIDY SYRINGE STARTER PACK	Update to Formulary-NonPreferred and require PA	10/1/2020
POSACONAZOLE DR 100 MG TABLET POSACONAZOLE 200 MG/5 ML SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
PRADAXA 75 MG CAPSULE PRADAXA 110 MG CAPSULE PRADAXA 150 MG CAPSULE	Formulary-Preferred	10/1/2020
PRALUENT 75 MG/ML PEN PRALUENT 150 MG/ML PEN	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
PRAMIPEXOLE 0.125 MG TABLET PRAMIPEXOLE 0.25 MG TABLET PRAMIPEXOLE 0.5 MG TABLET PRAMIPEXOLE 0.75 MG TABLET PRAMIPEXOLE 1 MG TABLET PRAMIPEXOLE 1.5 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
PRAMIPEXOLE ER 0.375 MG TABLET PRAMIPEXOLE ER 0.75 MG TABLET PRAMIPEXOLE ER 1.5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PRANDIN 1 MG TABLET PRANDIN 2 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PRASUGREL 5 MG TABLET PRASUGREL 10 MG TABLET	AL added	10/1/2020
PRAVACHOL 20 MG TABLET PRAVACHOL 40 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
PRAVASTATIN SODIUM 10 MG TAB PRAVASTATIN SODIUM 20 MG TAB PRAVASTATIN SODIUM 40 MG TAB PRAVASTATIN SODIUM 80 MG TAB	Formulary - Preferred, QL less stringent	10/1/2020
PRAZOSIN 1 MG CAPSULE PRAZOSIN 2 MG CAPSULE PRAZOSIN 5 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
PRECOSE 25 MG TABLET PRECOSE 50 MG TABLET PRECOSE 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PREDNICARBATE 0.1% CREAM PREDNICARBATE 0.1% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
PREVACID DR 15 MG CAPSULE PREVACID DR 30 MG CAPSULE PREVACID 15 MG SOLUTAB PREVACID 30 MG SOLUTAB PREVACID 24HR DR 15 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
PREVALITE PACKET PREVALITE POWDER	Formulary-Preferred	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
PRILOSEC DR 2.5 MG SUSPENSION PRILOSEC DR 10 MG SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
PRIMLEV 5-300 MG TABLET PRIMLEV 7.5-300 MG TABLET PRIMLEV 10-300 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PRINIVIL 5 MG TABLET PRINIVIL 10 MG TABLET PRINIVIL 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PROAIR DIGIHALER 90 MCG INHALR PROAIR RESPICLICK INHAL POWDER	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
PROAIR HFA 90 MCG INHALER	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020
PROCARDIA 10 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
PROCARDIA XL 30 MG TABLET PROCARDIA XL 60 MG TABLET PROCARDIA XL 90 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PROGESTERONE 100 MG CAPSULE PROGESTERONE 200 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
PROGESTERONE OIL 50 MG/ML VL	Update to Formulary-NonPreferred and require PA	10/1/2020
PROLENSA 0.07% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
PROMETRIUM 100 MG CAPSULE PROMETRIUM 200 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
PROPRANOLOL ER 60 MG CAPSULE PROPRANOLOL ER 80 MG CAPSULE PROPRANOLOL ER 120 MG CAPSULE PROPRANOLOL ER 160 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
PROPRANOLOL-HCTZ 40-25 MG TAB PROPRANOLOL-HCTZ 80-25 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
PROSCAR 5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PROTONIX 40 MG SUSPENSION PROTONIX DR 20 MG TABLET PROTONIX DR 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PROTOPIC 0.03% OINTMENT PROTOPIC 0.1% OINTMENT	Update to Formulary-NonPreferred and require PA, AL added, QL Added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
PROVENTIL HFA 90 MCG INHALER	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020
PROVERA 2.5 MG TABLET PROVERA 5 MG TABLET PROVERA 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
PROVIL 200 MG TABLET	Formulary-Preferred	10/1/2020
PULMICORT 0.25 MG/2 ML RESPUL PULMICORT 0.5 MG/2 ML RESPULE PULMICORT 1 MG/2 ML RESPULE	Update to Formulary-NonPreferred and require PA	10/1/2020
PULMICORT 90 MCG FLEXHALER PULMICORT 180 MCG FLEXHALER	Moves to NonPreferred, PA added	10/1/2020
PYLERA CAPSULE	Formulary-Preferred	10/1/2020
QBRELIS 1MG/ML SOLUTION	Moves to NonPreferred, PA added, AL removed	10/1/2020
QMIIZ ODT 7.5 MG TABLET QMIIZ ODT 15 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
QNASL CHILDREN'S 40 MCG SPRAY QNASL 80 MCG NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
QTERN 10 MG-5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
QUESTRAN LIGHT POWDER QUESTRAN PACKET QUESTRAN POWDER	Update to Formulary-NonPreferred and require PA	10/1/2020
QUINAPRIL 5 MG TABLET QUINAPRIL 10 MG TABLET QUINAPRIL 20 MG TABLET QUINAPRIL 40 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
QUINAPRIL-HCTZ 10-12.5 MG TAB QUINAPRIL-HCTZ 20-12.5 MG TAB QUINAPRIL-HCTZ 20-25 MG TAB	Moves to NonPreferred, PA added	10/1/2020
QVAR REDIHALER 40 MCG QVAR REDIHALER 80 MCG	Moves to NonPreferred, PA added, QL Removed	10/1/2020
RABEPRAZOLE SOD DR 20 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
RALOXIFENE HCL 60 MG TABLET	Formulary-Preferred, AL removed, QL removed	10/1/2020
RAMIPRIL 1.25 MG CAPSULE RAMIPRIL 2.5 MG CAPSULE RAMIPRIL 5 MG CAPSULE RAMIPRIL 10 MG CAPSULE	Moves to NonPreferred, PA added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
RAPAFLO 4 MG CAPSULE RAPAFLO 8 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
RASAGILINE MESYLATE 0.5 MG TAB RASAGILINE MESYLATE 1 MG TAB	Update to Formulary-NonPreferred and require PA, AL added	10/1/2020
RAZADYNE 4 MG TABLET RAZADYNE 8 MG TABLET RAZADYNE 12 MG TABLET RAZADYNE ER 8 MG CAPSULE RAZADYNE ER 16 MG CAPSULE RAZADYNE ER 24 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
REBIF 22 MCG/0.5 ML SYRINGE	Formulary-Preferred	10/1/2020
REBIF 44 MCG/0.5 ML SYRINGE	Formulary-Preferred, QL Added	10/1/2020
REBIF REBIDOSE 22 MCG/0.5 ML REBIF REBIDOSE 44 MCG/0.5 ML REBIF REBIDOSE TITRATION PACK REBIF TITRATION PACK	Formulary-Preferred	10/1/2020
RELAFEN DS 1,000 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
RELENZA 5 MG DISKHALER	Formulary-Preferred, AL removed	10/1/2020
RELION NOVOLIN 70-30 VIAL	Formulary-Preferred, QL Added	10/1/2020
RELION NOVOLIN N 100 UNIT/ML RELION NOVOLIN R 100 UNIT/ML	Formulary-Preferred, QL Added	10/1/2020
RELISTOR 8 MG/0.4 ML SYRINGE RELISTOR 12 MG/0.6 ML SYRINGE RELISTOR 12 MG/0.6 ML VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
RELPAX 20 MG TABLET RELPAX 40 MG TABLET	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020
RENAGEL 800 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
RENVELA 0.8 GM POWDER PACKET RENVELA 2.4 GM POWDER PACKET	Update to Formulary-NonPreferred and require PA	10/1/2020
RENVELA 800 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
REPAGLINIDE 0.5 MG TABLET REPAGLINIDE 1 MG TABLET REPAGLINIDE 2 MG TABLET	Formulary-Preferred, QL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
REPATHA 140 MG/ML SURECLICK REPATHA 140 MG/ML SYRINGE REPATHA 420 MG/3.5ML PUSHTRONX	Formulary-Preferred w/Clinical PA, QL Added	10/1/2020
REQUIP XL 4 MG TABLET REQUIP XL 6 MG TABLET REQUIP XL 8 MG TABLET REQUIP XL 12 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
REVATIO 10 MG/ML ORAL SUSP	Formulary-Preferred; Brand Preferred w/Clinical PA	10/1/2020
REVATIO 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
RHOPRESSA 0.02% OPHTH SOLUTION	Formulary-Preferred	10/1/2020
RINVOQ ER 15 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
RIOMET 500 MG/5 ML SOLUTION	Formulary-Preferred	10/1/2020
RIOMET ER 500 MG/5 ML SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020
RISEDRONATE SOD DR 35 MG TAB RISEDRONATE SODIUM 35 MG TAB	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
RISEDRONATE SODIUM 5 MG TABLET RISEDRONATE SODIUM 30 MG TAB RISEDRONATE SODIUM 150 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
RIVASTIGMINE 1.5 MG CAPSULE RIVASTIGMINE 3 MG CAPSULE RIVASTIGMINE 4.5 MG CAPSULE RIVASTIGMINE 6 MG CAPSULE	Formulary-Preferred, AL removed, QL removed	10/1/2020
RIVASTIGMINE 4.6 MG/24HR PATCH* RIVASTIGMINE 9.5 MG/24HR PATCH* RIVASTIGMINE 13.3 MG/24HR PTCH*	Update to Formulary-NonPreferred and require PA	10/1/2020
RIZATRIPTAN 5 MG ODT RIZATRIPTAN 5 MG TABLET RIZATRIPTAN 10 MG ODT RIZATRIPTAN 10 MG TABLET	Formulary - Preferred, QL less stringent	10/1/2020
ROBAXIN-750 TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ROCKLATAN 0.02%-0.005% EYE DRP	Formulary-Preferred	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ROPINIROLE HCL 0.25 MG TABLET ROPINIROLE HCL 0.5 MG TABLET ROPINIROLE HCL 1 MG TABLET ROPINIROLE HCL 2 MG TABLET ROPINIROLE HCL 3 MG TABLET ROPINIROLE HCL 4 MG TABLET ROPINIROLE HCL 5 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
ROPINIROLE HCL ER 2 MG TABLET ROPINIROLE HCL ER 4 MG TABLET ROPINIROLE HCL ER 6 MG TABLET ROPINIROLE HCL ER 8 MG TABLET ROPINIROLE HCL ER 12 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ROSUVASTATIN CALCIUM 5 MG TAB ROSUVASTATIN CALCIUM 10 MG TAB ROSUVASTATIN CALCIUM 20 MG TAB ROSUVASTATIN CALCIUM 40 MG TAB	Formulary-Preferred, QL removed	10/1/2020
ROXICODONE 5 MG TABLET ROXICODONE 15 MG TABLET ROXICODONE 30 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
RYBELSUS 3 MG TABLET RYBELSUS 7 MG TABLET RYBELSUS 14 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
RYTARY ER 23.75 MG-95 MG CAP RYTARY ER 36.25 MG-145 MG CAP RYTARY ER 48.75 MG-195 MG CAP RYTARY ER 61.25 MG-245 MG CAP	Update to Formulary-NonPreferred and require PA	10/1/2020
SAIZEN 5 MG VIAL SAIZEN 8.8 MG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
SANCUSO 3.1 MG/24 HR PATCH	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
SAVAYSA 15 MG TABLET SAVAYSA 30 MG TABLET SAVAYSA 60 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
SAVELLA 12.5 MG TABLET SAVELLA 25 MG TABLET SAVELLA 50 MG TABLET SAVELLA 100 MG TABLET SAVELLA TITRATION PACK	Formulary-Preferred	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
SCALPICIN 1% ANTI-ITCH LIQUID	Update to Formulary-NonPreferred and require PA	10/1/2020
SEEBRI NEOHALER 15.6 MCG INHAL	Update to Formulary-NonPreferred and require PA	10/1/2020
SELEGILINE HCL 5 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
SELEGILINE HCL 5 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
SERNIVO 0.05% SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
SEROSTIM 4 MG VIAL SEROSTIM 5 MG VIAL SEROSTIM 6 MG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
SEVELAMER 0.8 GM POWDER PACKET SEVELAMER 2.4 GM POWDER PACKET	Formulary-NonPreferred w/Clinical PA	10/1/2020
SILDENAFIL 10 MG/ML ORAL SUSP*	Update to Formulary-NonPreferred and require PA	10/1/2020
SILIQ 210 MG/1.5 ML SYRINGE	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
SILODOSIN 4 MG CAPSULE SILODOSIN 8 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
SIMBRINZA 1%-0.2% EYE DROPS	Formulary-Preferred	10/1/2020
SIMPONI 50 MG/0.5 ML PEN INJEC SIMPONI 50 MG/0.5 ML SYRINGE SIMPONI 100 MG/ML PEN INJECTOR SIMPONI 100 MG/ML SYRINGE SIMPONI ARIA 50 MG/4 ML VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
SIMVASTATIN 5 MG TABLET SIMVASTATIN 10 MG TABLET SIMVASTATIN 20 MG TABLET SIMVASTATIN 40 MG TABLET SIMVASTATIN 80 MG TABLET	Formulary - Preferred, QL less stringent	10/1/2020
SINEMET 10-100 MG TABLET SINEMET 25-100 MG TABLET SINEMET 25-250 MG TABLET SINEMET CR 25-100 TABLET SINEMET CR 50-200 TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
SINGULAIR 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
SINGULAIR 4 MG GRANULES SINGULAIR 4 MG TABLET CHEW SINGULAIR 5 MG TABLET CHEW	Update to Formulary-NonPreferred and require PA, AL added	10/1/2020
SITAVIG 50 MG BUCCAL TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
SIVEXTRO 200 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
SKELAXIN 800 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
SKYRIZI 75 MG/0.83 ML SYRINGE SKYRIZI 150 MG DOSE KIT-2 SYRN	Update to Formulary-NonPreferred and require PA	10/1/2020
SOLIFENACIN 5 MG TABLET SOLIFENACIN 10 MG TABLET	Update to Formulary-Preferred	10/1/2020
SOLIQUA 100 UNIT-33 MCG/ML PEN	Update to Formulary-NonPreferred and require PA	10/1/2020
SORINE 80 MG TABLET SORINE 120 MG TABLET SORINE 160 MG TABLET SORINE 240 MG TABLET	Formulary-Preferred	10/1/2020
SOTALOL 80 MG TABLET SOTALOL 120 MG TABLET SOTALOL 160 MG TABLET SOTALOL 240 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
SOTALOL AF 80 MG TABLET SOTALOL AF 120 MG TABLET SOTALOL AF 160 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
SOTYLIZE 5 MG/ML ORAL SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
SPIRIVA 18 MCG CP-HANDIHALER	Formulary-Preferred, QL Added	10/1/2020
SPIRIVA RESPIMAT 1.25 MCG INH SPIRIVA RESPIMAT 2.5 MCG INH	Formulary-NonPreferred, AL removed, QL Removed	10/1/2020
SPORANOX 100 MG CAPSULE SPORANOX 10 MG/ML SOLUTION	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
SPRIX 15.75 MG NASAL SPRAY	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
STALEVO 50 TABLET STALEVO 75 TABLET STALEVO 100 TABLET STALEVO 125 TABLET STALEVO 150 TABLET STALEVO 200 TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
STARLIX 60 MG TABLET STARLIX 120 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
STEGLUJAN 5-100 MG TABLET STEGLUJAN 15-100 MG TABLET	Update to Formulary-NonPreferred, AL removed	10/1/2020
STELARA 45 MG/0.5 ML SYRINGE STELARA 90 MG/ML SYRINGE STELARA 130 MG/26 ML VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
STIOLTO RESPIMAT INHAL SPRAY	Formulary-Preferred	10/1/2020
STRIVERDI RESPIMAT INHAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
SULAR ER 8.5 MG TABLET SULAR ER 17 MG TABLET SULAR ER 34 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
SUMATRIPTAN 4 MG/0.5 ML CART SUMATRIPTAN 4 MG/0.5 ML INJECT	Formulary-Preferred, PA removed	10/1/2020
SUMATRIPTAN 6 MG/0.5 ML INJECT SUMATRIPTAN 6 MG/0.5 ML REFILL SUMATRIPTAN 6 MG/0.5 ML VIAL	Formulary-Preferred, PA removed	10/1/2020
SUMATRIPTAN 6 MG/0.5 ML SYRNG	Formulary-Preferred, QL Added	10/1/2020
SUMATRIPTAN SUCC 25 MG TABLET SUMATRIPTAN SUCC 50 MG TABLET SUMATRIPTAN SUCC 100 MG TABLET	Formulary - Preferred, QL less stringent	10/1/2020
SUMATRIPTAN-NAPROXEN 85-500 MG	Update to Formulary-NonPreferred and require PA	10/1/2020
SUPRAX 100 MG TABLET CHEWABLE SUPRAX 200 MG TABLET CHEWABLE	Formulary-Preferred	10/1/2020
SUPRAX 100 MG/5 ML SUSPENSION SUPRAX 200 MG/5 ML SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
SUPRAX 400 MG CAPSULE	Formulary-Preferred; Brand Preferred	10/1/2020
SUPRAX 500 MG/5 ML SUSPENSION	PA added, AL removed	10/1/2020
SYMBICORT 80-4.5 MCG INHALER SYMBICORT 160-4.5 MCG INHALER	Formulary-Preferred; Brand Preferred, QL Added	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
SYMJEPI 0.3 MG/0.3 ML SYRINGE	Moves to NonPreferred, PA added, QL Removed Generics for Epi-Pen are preferred	10/1/2020
SYMLINPEN 120 PEN INJECTOR SYMLINPEN 60 PEN INJECTOR	Formulary-Preferred	10/1/2020
SYMPROIC 0.2 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
SYNALAR 0.01% SOLUTION SYNALAR 0.025% CREAM SYNALAR 0.025% CREAM KIT SYNALAR 0.025% OINTMENT SYNALAR 0.025% OINTMENT KIT SYNALAR TS 0.01% KIT	Update to Formulary-NonPreferred and require PA	10/1/2020
SYNJARDY 5-500 MG TABLET SYNJARDY 5-1,000 MG TABLET SYNJARDY 12.5-500 MG TABLET SYNJARDY 12.5-1,000 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
SYNJARDY XR 5-1,000 MG TABLET SYNJARDY XR 10-1,000 MG TABLET SYNJARDY XR 12.5-1,000 MG TAB SYNJARDY XR 25-1,000 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
TACROLIMUS 0.03% OINTMENT TACROLIMUS 0.1% OINTMENT	Moves to NonPreferred, AL added, PA added	10/1/2020
TADALAFIL 20 MG TABLET	Formulary-Preferred w/Clinical PA, QL Removed	10/1/2020
TALTZ 80 MG/ML AUTOINJ (2-PK) TALTZ 80 MG/ML AUTOINJECTOR TALTZ 80 MG/ML SYRINGE	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
TAMIFLU 30 MG CAPSULE TAMIFLU 45 MG CAPSULE TAMIFLU 75 MG CAPSULE	Formulary-Preferred, QL Added	10/1/2020
TAMIFLU 6 MG/ML SUSPENSION	Formulary-Preferred, QL Added	10/1/2020
TAMSULOSIN HCL 0.4 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
TARKA ER 2-180 MG TABLET TARKA ER 2-240 MG TABLET TARKA ER 4-240 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
TASMAR 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TAZTIA XT 120 MG CAPSULE TAZTIA XT 180 MG CAPSULE TAZTIA XT 240 MG CAPSULE TAZTIA XT 300 MG CAPSULE TAZTIA XT 360 MG CAPSULE	Formulary-Preferred	10/1/2020
TECFIDERA DR 120 MG CAPSULE TECFIDERA DR 240 MG CAPSULE TECFIDERA STARTER PACK	Formulary-Preferred, PA removed, QL removed	10/1/2020
TEKTURNA 150 MG TABLET TEKTURNA 300 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TEKTURNA HCT 150-12.5 MG TAB TEKTURNA HCT 150-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TEKTURNA HCT 300-12.5 MG TAB TEKTURNA HCT 300-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TELMISARTAN 20 MG TABLET TELMISARTAN 40 MG TABLET TELMISARTAN 80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TELMISARTAN-AMLODIPINE 40-5 MG TELMISARTAN-AMLODIPINE 40-10 TELMISARTAN-AMLODIPINE 80-5 MG TELMISARTAN-AMLODIPINE 80-10	Update to Formulary-NonPreferred and require PA	10/1/2020
TELMISARTAN-HCTZ 40-12.5 MG TB TELMISARTAN-HCTZ 80-12.5 MG TB TELMISARTAN-HCTZ 80-25 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
TEMOVATE 0.05% CREAM TEMOVATE 0.05% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
TENORETIC 50 TABLET TENORETIC 100 TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TENORMIN 25 MG TABLET TENORMIN 50 MG TABLET TENORMIN 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TERAZOSIN 1 MG CAPSULE TERAZOSIN 2 MG CAPSULE TERAZOSIN 5 MG CAPSULE TERAZOSIN 10 MG CAPSULE	Formulary-Preferred, QL removed	10/1/2020
TESTIM 1% (50MG) GEL	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
TESTOSTERONE 1.62% GEL PUMP* TESTOSTERONE 1.62%(1.25 G) PKT* TESTOSTERONE 1.62% (2.5 G) PKT*	Update to Formulary-Preferred and require PA	10/1/2020
TESTOSTERONE 10 MG GEL PUMP	Update to Formulary-NonPreferred and require PA	10/1/2020
TESTOSTERONE 12.5 MG/1.25 GRAM TESTOSTERONE 50 MG/5 GRAM GEL	Update to Formulary-NonPreferred and require PA	10/1/2020
TESTOSTERONE 25 MG/2.5 GM PKT* TESTOSTERONE 50 MG/5 GRAM PKT*	Formulary-Preferred, PA remains, QL Removed	10/1/2020
TESTOSTERONE 30 MG/1.5 ML PUMP	Moves to NonPreferred, PA added, QL Removed	10/1/2020
TEXACORT 2.5% SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
TIAZAC ER 120 MG CAPSULE TIAZAC ER 180 MG CAPSULE TIAZAC ER 240 MG CAPSULE TIAZAC ER 300 MG CAPSULE TIAZAC ER 360 MG CAPSULE TIAZAC ER 420 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
TIMOLOL 0.25% GEL-SOLUTION TIMOLOL 0.25% GFS GEL-SOLUTION TIMOLOL 0.5% GEL-SOLUTION TIMOLOL 0.5% GFS GEL-SOLUTION	Formulary-Preferred	10/1/2020
TIMOLOL 0.5% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
TIMOLOL MALEATE 5 MG TABLET TIMOLOL MALEATE 10 MG TABLET TIMOLOL MALEATE 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TIMOPTIC 0.25% OCUDOSE DROP TIMOPTIC 0.5% OCUDOSE DROP	Update to Formulary-NonPreferred and require PA	10/1/2020
TINIDAZOLE 250 MG TABLET TINIDAZOLE 500 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
TIVORBEX 20 MG CAPSULE TIVORBEX 40 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
TIZANIDINE HCL 2 MG CAPSULE TIZANIDINE HCL 4 MG CAPSULE TIZANIDINE HCL 6 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
TIZANIDINE HCL 2 MG TABLET TIZANIDINE HCL 4 MG TABLET	Formulary-Preferred, AL removed	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
TOBI 300 MG/5 ML SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
TOLCAPONE 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TOLMETIN SODIUM 200 MG TAB TOLMETIN SODIUM 400 MG CAP TOLMETIN SODIUM 600 MG TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
TOLNAFTATE 1% CREAM	Formulary-Preferred	10/1/2020
TOLSURA 65 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
TOLTERODINE TART ER 2 MG CAP TOLTERODINE TART ER 4 MG CAP	Moves to NonPreferred, PA added, QL Removed	10/1/2020
TOLTERODINE TARTRATE 1 MG TAB TOLTERODINE TARTRATE 2 MG TAB	Moves to NonPreferred, PA added, QL Removed	10/1/2020
TOPICORT 0.05% CREAM TOPICORT 0.05% GEL TOPICORT 0.05% OINTMENT TOPICORT 0.25% CREAM TOPICORT 0.25% OINTMENT TOPICORT 0.25% SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
TOPROL XL 25 MG TABLET TOPROL XL 50 MG TABLET TOPROL XL 100 MG TABLET TOPROL XL 200 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TOSYMRA 10 MG NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
TOUJEO MAX SOLOSTR 300 UNIT/ML TOUJEO SOLOSTAR 300 UNIT/ML	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
TOVIAZ ER 4 MG TABLET TOVIAZ ER 8 MG TABLET	Formulary-Preferred	10/1/2020
TRACLEER 32 MG TABLET FOR SUSP	Update to Formulary-NonPreferred, AL removed	10/1/2020
TRACLEER 62.5 MG TABLET TRACLEER 125 MG TABLET	Formulary-Preferred; Brand Preferred w/Clinical PA	10/1/2020
TRADJENTA 5 MG TABLET	Formulary-Preferred, PA removed, QL removed	10/1/2020
TRAMADOL ER 100 MG TABLET TRAMADOL ER 200 MG TABLET TRAMADOL ER 300 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
TRAMADOL HCL 50 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
TRAMADOL HCL ER 100 MG CAPSULE TRAMADOL HCL ER 200 MG CAPSULE TRAMADOL HCL ER 300 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
TRAMADOL HCL ER 100 MG TABLET TRAMADOL HCL ER 200 MG TABLET TRAMADOL HCL ER 300 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TRAMADOL-ACETAMINOPHN 37.5-325	Update to Formulary-NonPreferred and require PA	10/1/2020
TRANDOLAPRIL 1 MG TABLET TRANDOLAPRIL 2 MG TABLET TRANDOLAPRIL 4 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
TRANDOLAPR-VERAPAM ER 1-240 MG TRANDOLAPR-VERAPAM ER 2-180 MG TRANDOLAPR-VERAPAM ER 2-240 MG TRANDOLAPR-VERAPAM ER 4-240 MG	Update to Formulary-NonPreferred and require PA	10/1/2020
TRAVATAN Z 0.004% EYE DROP	Formulary-Preferred; Brand Preferred	10/1/2020
TRAVOPROST 0.004% EYE DROP*	Update to Formulary-NonPreferred and require PA	10/1/2020
TRELEGY ELLIPTA 100-62.5-25	Update to Formulary-NonPreferred and require PA	10/1/2020
TREMFYA 100 MG/ML INJECTOR TREMFYA 100 MG/ML SYRINGE	Update to Formulary-NonPreferred and require PA	10/1/2020
TRESIBA 100 UNIT/ML VIAL TRESIBA FLEXTOUCH 100 UNIT/ML TRESIBA FLEXTOUCH 200 UNIT/ML	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
TREXIMET 85-500 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TRIAMCINOLONE 0.025% CREAM TRIAMCINOLONE 0.025% OINT TRIAMCINOLONE 0.1% CREAM TRIAMCINOLONE 0.1% LOTION TRIAMCINOLONE 0.1% OINTMENT TRIAMCINOLONE 0.5% CREAM	Formulary-Preferred, QL removed	10/1/2020
TRIAMCINOLONE 0.05% OINTMENT	Formulary-Preferred	10/1/2020
TRIAMCINOLONE 0.147 MG/G SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
TRIAMCINOLONE 55 MCG NASAL SPR	Moves to NonPreferred, PA added, QL Removed	10/1/2020
TRIANEX 0.05% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
TRIBENZOR 20-5-12.5 MG TABLET TRIBENZOR 40-5-12.5 MG TABLET TRIBENZOR 40-5-25 MG TABLET TRIBENZOR 40-10-12.5 MG TABLET TRIBENZOR 40-10-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TRICOR 48 MG TABLET TRICOR 145 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TRIDERM 0.1% CREAM	Formulary-Preferred	10/1/2020
TRIGLIDE 160 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TRILIPIX DR 45 MG CAPSULE TRILIPIX DR 135 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
TROSPIUM CHLORIDE 20 MG TABLET	Moves to NonPreferred, PA added, QL Removed	10/1/2020
TROSPIUM CHLORIDE ER 60 MG CAP	Moves to NonPreferred, PA added	10/1/2020
TRULANCE 3 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TRULICITY 0.75 MG/0.5 ML PEN TRULICITY 1.5 MG/0.5 ML PEN	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
TRUSOPT 2% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
TUDORZA PRESSAIR 400 MCG INHAL	Update to Formulary-NonPreferred and require PA	10/1/2020
TYLENOL WITH CODEINE #3 TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
TYVASO 1.74 MG/2.9 ML SOLUTION TYVASO INHALATION REFILL KIT TYVASO INHALATION STARTER KIT TYVASO INSTITUTIONAL START KIT	Formulary-Preferred w/Clinical PA	10/1/2020
UCERIS 9 MG ER TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
UDENYCA 6 MG/0.6 ML SYRINGE	Formulary-Preferred	10/1/2020
ULORIC 40 MG TABLET ULORIC 80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ULTRACET TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ULTRAM 50 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ULTRAVATE 0.05% CREAM ULTRAVATE 0.05% LOTION ULTRAVATE 0.05% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
ULTRAVATE X CREAM COMBO PACK ULTRAVATE X OINTMENT COMBO PAC	Update to Formulary-NonPreferred and require PA	10/1/2020
UPTRAVI 200 MCG TABLET UPTRAVI 400 MCG TABLET UPTRAVI 600 MCG TABLET UPTRAVI 800 MCG TABLET UPTRAVI 1,000 MCG TABLET UPTRAVI 1,200 MCG TABLET UPTRAVI 1,400 MCG TABLET UPTRAVI 1,600 MCG TABLET UPTRAVI 200-800 TITRATION PACK	Formulary-Preferred w/Clinical PA	10/1/2020
URSO 250 MG TABLET URSO FORTE 500 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
URSODIOL 300 MG CAPSULE	Updated to Formulary-Preferred, QL Removed	10/1/2020
UTIBRON NEOHALER 27.5-15.6 MCG	Update to Formulary-NonPreferred and require PA	10/1/2020
VALACYCLOVIR HCL 500 MG TABLET VALACYCLOVIR HCL 1 GRAM TABLET	Formulary-Preferred, QL removed	10/1/2020
VALSARTAN 40 MG TABLET VALSARTAN 80 MG TABLET VALSARTAN 160 MG TABLET VALSARTAN 320 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
VALSARTAN-HCTZ 80-12.5 MG TAB VALSARTAN-HCTZ 160-12.5 MG TAB VALSARTAN-HCTZ 160-25 MG TAB VALSARTAN-HCTZ 320-12.5 MG TAB VALSARTAN-HCTZ 320-25 MG TAB	Formulary-Preferred, QL removed	10/1/2020
VALTREX 500 MG CAPLET VALTREX 1 GM CAPLET	Update to Formulary-NonPreferred and require PA	10/1/2020
VANCOCIN HCL 250 MG CAPSULE VANCOCIN HCL 125 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
VANCOMYCIN 250 MG/5 ML SOLN	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
VANOS 0.1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
VARUBI 90 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
VASCEPA 0.5 GM CAPSULE VASCEPA 1 GM CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
VASERETIC 10-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
VASOTEC 2.5 MG TABLET VASOTEC 5 MG TABLET VASOTEC 10 MG TABLET VASOTEC 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
VELPHORO 500 MG CHEWABLE TAB	Update to Formulary-NonPreferred and require PA	10/1/2020
VENTAVIS 10 MCG/1 ML SOLUTION VENTAVIS 20 MCG/1 ML SOLUTION	Formulary-Preferred w/Clinical PA	10/1/2020
VENTOLIN HFA 90 MCG INHALER	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
VERAPAMIL 360 MG CAP PELLET	Update to Formulary-NonPreferred and require PA	10/1/2020
VERAPAMIL ER 120 MG CAPSULE VERAPAMIL ER 180 MG CAPSULE VERAPAMIL ER 240 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
VERAPAMIL ER 120 MG TABLET VERAPAMIL ER 180 MG TABLET VERAPAMIL ER 240 MG TABLET	Formulary-Preferred, QL removed	10/1/2020
VERAPAMIL ER PM 100 MG CAPSULE VERAPAMIL ER PM 200 MG CAPSULE VERAPAMIL ER PM 300 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
VERAPAMIL SR 120 MG CAPSULE VERAPAMIL SR 180 MG CAPSULE VERAPAMIL SR 240 MG CAPSULE	Moves to NonPreferred, PA added, QL Removed	10/1/2020
VERELAN 120 MG CAP PELLET VERELAN 180 MG CAP PELLET VERELAN 240 MG CAP PELLET VERELAN 360 MG CAP PELLET	Update to Formulary-NonPreferred and require PA	10/1/2020
VERELAN PM 100 MG CAP PELLET VERELAN PM 200 MG CAP PELLET VERELAN PM 300 MG CAP PELLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
VESICARE 5 MG TABLET VESICARE 10 MG TABLET	Formulary-NonPreferred; PA required	10/1/2020
VFEND 50 MG TABLET VFEND 200 MG TABLET VFEND 40 MG/ML SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
VIBERZI 75 MG TABLET VIBERZI 100 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
VICODIN HP 10-300 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
VICTOZA 2-PAK 18 MG/3 ML PEN VICTOZA 3-PAK 18 MG/3 ML PEN	Formulary-Preferred, PA removed, QL removed	10/1/2020
VIGAMOX 0.5% EYE DROPS	Formulary-Preferred; Brand Preferred	10/1/2020
VIMOVO DR 375-20 MG TABLET VIMOVO DR 500-20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
VIOKACE 20,880-78,300 UNITS TB VIOKACE 10,440-39,150 UNITS TB	Moves to NonPreferred, PA added, QL Removed	10/1/2020
VISTARIL 25 MG CAPSULE VISTARIL 50 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
VIVLODEX 5 MG CAPSULE VIVLODEX 10 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
VOGELXO 12.5 MG/1.25 GRAM PUMP VOGELXO 50 MG/5 GRAM GEL VOGELXO 50 MG/5 GRAM GEL PACKT	Update to Formulary-NonPreferred and require PA	10/1/2020
VOLTAREN 1% GEL	Update to Formulary-NonPreferred and require PA	10/1/2020
VORICONAZOLE 50 MG TABLET VORICONAZOLE 200 MG TABLET VORICONAZOLE 40 MG/ML SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020
VUSION OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
VYTORIN 10-10 MG TABLET VYTORIN 10-20 MG TABLET VYTORIN 10-40 MG TABLET VYTORIN 10-80 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
VYZULTA 0.024% OPHTH SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
WELCHOL 3.75G PACKET WELCHOL 625 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
WIXELA 100-50 INHUB WIXELA 250-50 INHUB WIXELA 500-50 INHUB	Moves to NonPreferred, AL removed, PA added	10/1/2020
XADAGO 50 MG TABLET XADAGO 100 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
XALATAN 0.005% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
XARELTO 2.5 MG TABLET XARELTO 10 MG TABLET XARELTO 20 MG TABLET XARELTO 15 MG TABLET XARELTO STARTER PACK	Formulary-Preferred	10/1/2020
XELJANZ 5 MG TABLET XELJANZ 10 MG TABLET XELJANZ XR 11 MG TABLET XELJANZ XR 22 MG TABLET	Formulary-Non-Preferred, PA remains, QL Removed	10/1/2020
XELPROS 0.005% EYE DROP	Update to Formulary-NonPreferred and require PA	10/1/2020
XERESE 5%-1% CREAM	Update to Formulary-NonPreferred and require PA	10/1/2020
XHANCE 93 MCG NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
XIFAXAN 200 MG TABLET	Update to Formulary-NonPreferred and require PA, AL added, QL Added	10/1/2020
XIFAXAN 550 MG TABLET	Update to Formulary-NonPreferred and require PA, AL added	10/1/2020
XIGDUO XR 2.5 MG-1,000 MG TAB XIGDUO XR 5 MG-500 MG TABLET XIGDUO XR 5 MG-1,000 MG TABLET XIGDUO XR 10 MG-500 MG TABLET XIGDUO XR 10 MG-1,000 MG TAB	Formulary-Preferred	10/1/2020
XOFLUZA 20 MG TAB (40 MG DOSE) XOFLUZA 40 MG TAB (80 MG DOSE)	Formulary-Preferred	10/1/2020
XOPENEX 0.31 MG/3 ML SOLUTION XOPENEX 0.63 MG/3 ML SOLUTION XOPENEX 1.25 MG/3 ML SOLUTION XOPENEX CONC 1.25 MG/0.5 ML	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
XOPENEX HFA 45 MCG INHALER	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
XTAMPZA ER 9 MG CAPSULE XTAMPZA ER 13.5 MG CAPSULE XTAMPZA ER 18 MG CAPSULE XTAMPZA ER 27 MG CAPSULE XTAMPZA ER 36 MG CAPSULE	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
XULTOPHY 100 UNIT-3.6MG/ML PEN	Update to Formulary-NonPreferred and require PA	10/1/2020
YOSPRALA DR 81-40 MG TABLET YOSPRALA DR 325-40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
YUPELRI 175 MCG/3 ML SOLUTION	Update to Formulary-NonPreferred and require PA	10/1/2020
ZADITOR 0.025% (0.035%) DROPS	Formulary-Preferred, QL removed	10/1/2020
ZAFIRLUKAST 10 MG TABLET ZAFIRLUKAST 20 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZANAFLEX 2 MG CAPSULE ZANAFLEX 4 MG CAPSULE ZANAFLEX 6 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ZANAFLEX 4 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZEGERID 20 MG CAPSULE ZEGERID 40 MG CAPSULE ZEGERID 20 MG PACKET ZEGERID 40 MG PACKET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZELAPAR 1.25 MG ODT TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZEMBRACE SYMTOUCH 3 MG/0.5 ML	Update to Formulary-NonPreferred and require PA	10/1/2020
ZENPEP DR 3,000 UNIT CAPSULE ZENPEP DR 5,000 UNIT CAPSULE ZENPEP DR 10,000 UNIT CAPSULE ZENPEP DR 15,000 UNIT CAPSULE ZENPEP DR 20,000 UNIT CAPSULE ZENPEP DR 25,000 UNIT CAPSULE ZENPEP DR 40,000 UNIT CAPSULE	Clinical PA added	10/1/2020
ZESTORETIC 10-12.5 MG TABLET ZESTORETIC 20-12.5 MG TABLET ZESTORETIC 20-25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ZESTRIL 2.5 MG TABLET ZESTRIL 5 MG TABLET ZESTRIL 10 MG TABLET ZESTRIL 20 MG TABLET ZESTRIL 30 MG TABLET ZESTRIL 40 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZETIA 10 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZETONNA 37 MCG NASAL SPRAY	Update to Formulary-NonPreferred and require PA	10/1/2020
ZIAC 2.5-6.25 MG TABLET ZIAC 5-6.25 MG TABLET ZIAC 10-6.25 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZILEUTON ER 600 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZIOPTAN 0.0015% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
ZIPSOR 25 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ZITHROMAX 1 GM POWDER PACKET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ZITHROMAX 100 MG/5 ML SUSP ZITHROMAX 200 MG/5 ML SUSP	Update to Formulary-NonPreferred and require PA, AL added	10/1/2020
ZITHROMAX 250 MG TABLET ZITHROMAX 500 MG TABLET ZITHROMAX 250 MG Z-PAK TABLET ZITHROMAX TRI-PAK 500 MG TAB	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ZOCOR 10 MG TABLET ZOCOR 20 MG TABLET ZOCOR 40 MG TABLET ZOCOR 80 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ZOFRAN 4 MG TABLET ZOFRAN 8 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ZOHYDRO ER 10 MG CAPSULE ZOHYDRO ER 15 MG CAPSULE ZOHYDRO ER 20 MG CAPSULE ZOHYDRO ER 30 MG CAPSULE ZOHYDRO ER 40 MG CAPSULE ZOHYDRO ER 50 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020

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Medication Name	Preferred Drug List Update*	Effective Date
ZOLMITRIPTAN 2.5 MG ODT ZOLMITRIPTAN 5 MG ODT	Moves to NonPreferred, PA added	10/1/2020
ZOLMITRIPTAN 2.5 MG TABLET ZOLMITRIPTAN 5 MG TABLET	Moves to NonPreferred, PA added	10/1/2020
ZOMACTON 5 MG VIAL ZOMACTON 10 MG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
ZOMIG 2.5 MG NASAL SPRAY ZOMIG 5 MG NASAL SPRAY	Formulary-Preferred	10/1/2020
ZOMIG 2.5 MG TABLET ZOMIG 5 MG TABLET ZOMIG ZMT 2.5 MG TABLET ZOMIG ZMT 5 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020
ZONTIVITY 2.08 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZORBTIVE 8.8 MG VIAL	Update to Formulary-NonPreferred and require PA	10/1/2020
ZORVOLEX 18 MG CAPSULE ZORVOLEX 35 MG CAPSULE	Update to Formulary-NonPreferred and require PA	10/1/2020
ZOVIRAX 200 MG/5 ML SUSP	Update to Formulary-NonPreferred and require PA	10/1/2020
ZOVIRAX 5% CREAM	Formulary-Preferred; Brand Preferred	10/1/2020
ZOVIRAX 5% OINTMENT	Update to Formulary-NonPreferred and require PA	10/1/2020
ZUPLENZ 8 MG SOLUBLE FILM ZUPLENZ 4 MG SOLUBLE FILM	Update to Formulary-NonPreferred and require PA	10/1/2020
ZYFLO 600 MG FILMTAB	Update to Formulary-NonPreferred and require PA	10/1/2020
ZYLOPRIM 100 MG TABLET ZYLOPRIM 300 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZYMAXID 0.5% EYE DROPS	Update to Formulary-NonPreferred and require PA	10/1/2020
ZYPITAMAG 1 MG TABLET ZYPITAMAG 2 MG TABLET ZYPITAMAG 4 MG TABLET	Update to Formulary-NonPreferred and require PA	10/1/2020
ZYVOX 100 MG/5 ML SUSPENSION	Update to Formulary-NonPreferred and require PA	10/1/2020
ZYVOX 600 MG TABLET	Update to Formulary-NonPreferred; PA/QL Added	10/1/2020

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CHANGES PRIOR TO OCTOBER 1, 2020

Medication Name	Preferred Drug List Update*	Limit*	Effective Date
EZETIMIBE 10 MG TABLET	PA removed, QL added	QL max 1 tablet/day	7/1/2020
GLUCAGON 1 MG EMERGENCY KIT	Updated QL	QL max 2 kits/month	7/1/2020
GVOKE 0.5 MG/0.1 ML SYRINGE GVOKE 1 MG/0.2 ML SYRINGE	Added to formulary with AL and QL	AL min. ≥ 2 years old QL max 2 doses/30 days	7/1/2020
MYNATAL ULTRACAPLET	Removed from formulary		7/1/2020
NEPHRO-VITE RX TABLET	Removed form formulary		7/1/2020
NIMODIPINE 30 MG CAPSULE	Added QL	QL max 21 tablets/365 days	7/1/2020
OXBRYTA 500 MG TABLET	Added to formulary with AL, PA, and QL	AL min. ≥ 12 years old QL max 90 tablets/30 days	7/1/2020
OXERVATE 0.002% EYE DROP	Added to formulary with AL, PA, and QL	AL min. ≥ 2 years old QL max 8 kits/per eye/lifetime	7/1/2020
PODIAPN CAPSULE	Removed from formulary		7/1/2020
PRASUGREL 5 MG TABLET PRASUGREL 10 MG TABLET	Added to formulary with QL	QL max 1 tablet/day	7/1/2020
PRENATAL 19 TABLET	Removed from formulary		7/1/2020
RESTASIS 0.05% EYE EMULSION RESTASIS MULTIDOSE 0.05% EYE	Added to formulary AL, PA, and QL	AL min. ≥ 16 years old QL max of 60 ampules <u>or</u>	7/1/2020

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
		1 bottle (5.5 mL)/30 days (multidose)	
STROVITE FORTE CAPLET STROVITE ONE CAPLET	Removed from formulary		7/1/2020
TAZVERIK 200 MG TABLET	Added to formulary with PA		7/1/2020
TRIFLURIDINE 1% EYE DROPS	Removed from formulary		7/1/2020
VERAPAMIL ER PM 100MG, 200MG, and 300 MG CAPSULES	Removed from formulary		7/1/2020
FAMOTIDINE 40 MG/5 ML SUSP	Added to formulary with AL and QL due to ranitidine recall Note: tablets are already on formulary	AL min. ≤ 6 years old QL max 5 mL/day	4/17/2020
RANITIDINE 75MG, 150 MG, and 300MG TABLETS RANITIDINE 15 MG/ML SYRUP	Removed from formulary due to recall of all ranitidine products. See April 1st FDA notice.		4/9/2020
AJOVY 225 MG/1.5 ML SYRINGE	Added to formulary with AL, PA, and QL	AL min. ≥18 years old QL max 3 mL/90 days	4/1/2020
AMMONIUM LACTATE 12% CREAM	Added QL Ammonium Lactate 12% cream OTC added to formulary	QL max 280 grams/30 days	4/1/2020
AMMONIUM LACTATE 12% LOTION	Added QL Ammonium Lactate 12% lotion OTC added to formulary	QL max 550 mL/30 days	4/1/2020
AMNESTEEM 10 MG CAPSULE AMNESTEEM 20 MG CAPSULE AMNESTEEM 40 MG CAPSULE	Added to formulary with PA and QL	QL max 2 capsules/day	4/1/2020
AUBAGIO 7 MG TABLET AUBAGIO 14 MG TABLET	Added to formulary with PA and QL	QL max 1 tablet/day	4/1/2020
BAQSIMI 3 MG SPRAY ONE PACK BAQSIMI 3 MG SPRAY TWO PACK	Added to formulary with AL and QL	AL min. ≥ 4 years old	4/1/2020

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
		QL max 2/30 days	
BICALUTAMIDE 50 MG TABLET	Added QL	QL max 1 tablet/day	4/1/2020
CLINDAMYCIN PH 1% SOLUTION	Added QL	QL max 180 mL/30 days	4/1/2020
EMBEDA ER 20-0.8 MG CAPSULE EMBEDA ER 30-1.2 MG CAPSULE EMBEDA ER 50-2 MG CAPSULE EMBEDA ER 60-2.4 MG CAPSULE EMBEDA ER 80-3.2 MG CAPSULE EMBEDA ER 100-4 MG CAPSULE	Removed from formulary		4/1/2020
EMAGALITY 100 MG/ML SYRINGE	Added to formulary with AL, PA, and QL	AL min. ≥ 18 years old QL max 3 mL/30 days	4/1/2020
EMGALITY 120 MG/ML PEN	Added to formulary with AL, PA, and QL	AL min. ≥ 18 years old QL max 1/30 days	4/1/2020
ENTACAPONE 200 MG TABLET	Added to formulary with QL	QL max 4 tablets/day	4/1/2020
MYORISAN 10 MG CAPSULE MYORISAN 20 MG CAPSULE MYORISAN 30 MG CAPSULE MYORISAN 40 MG CAPSULE	Added to formulary with PA and QL	QL max 2 capsules/day	4/1/2020
OLUMIANT 1 MG TABLET	Added formulary with PA and QL *Only covered for patients with renal impairment*	QL max 1 tablet/day	4/1/2020
POMALYST 1 MG CAPSULE POMALYST 2 MG CAPSULE POMALYST 3 MG CAPSULE POMALYST 4 MG CAPSULE	Added QL	QL max 1 capsule/day	4/1/2020
REVLIMID 2.5 MG CAPSULE REVLIMID 20 MG CAPSULE	Added QL	QL max 1 capsule/day	4/1/2020

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
SPINOSAD 0.9% TOPICAL SUSP	Added to formulary with QL and ST	QL max 240 mL/180 days Trial of Permethrin lotion	4/1/2020
VIRT-VITE PLUS TABLET	Removed from formulary, discontinued		4/1/2020
YONSA 125 MG TABLET	Removed from formulary *Preferred Abiraterone 250 mg*		4/1/2020
ZENATANE 10 MG CAPSULE ZENATANE 20 MG CAPSULE ZENATANE 30 MG CAPSULE ZENATANE 40 MG CAPSULE	Added to formulary with PA and QL	QL max 2 capsules/day	4/1/2020
ZYTIGA 500 MG TABLET	Removed from formulary *Preferred Abiraterone 250 mg*		4/1/2020
INSULIN LISPRO 100 UNIT/ML VL	Added to formulary with QL	QL max 60 mL/month	3/22/2020
PRIFTIN 150 MG TABLET	Added to formulary with QL	QL max 24 tablets/28 days	2/4/2020
MOTEGRITY 1 MG TABLET MOTEGRITY 2 MG TABLET	Added to formulary with AL, PA, QL	AL min. ≥ 18 years old QL max 1 tablet/day	1/1/2020
PAREGORIC LIQUID	Removed from formulary		1/1/2020
TROSPIUM CHLORIDE 20 MG TABLET TROSPIUM CHLORIDE ER 60 MG CAPSULE	***Grandfathering for utilizers with at least one 30 day supply in the last 90 days*** New starts only ST and QL	Trial of Oxybutynin QL max 2 tablets/day	1/1/2020
VYNDAMAX 61 MG CAPSULE	Added to formulary with AL, QL, and PA	Al min. ≥ 18 years old QL 1 capsule/day	1/1/2020

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
VYNDAQEL 20 MG CAPSULE	Added to formulary with AL, QL, and PA	AL min. ≥ 18 years old QL max 4 capsules/day	1/1/2020
DANTROLENE 25 MG CAPSULE DANTROLENE 50 MG CAPSULE DANTROLENE 100 MG CAPSULE	Added to formulary with QL	QL max 4 tablets/day	12/1/2019
LUCEMYRA 0.18 MG TABLET	Added to formulary with AL, PA, and QL	AL min. ≥ 18 QL max 16 tablets/day no more than 14 days	12/1/2019
MESALAMINE DR 1.2 GM TABLET	Added to formulary with QL and ST	QL 4 tablets/day Trial of Balsalazide, Sulfasalazine, or Sulfasalazine DR within past 180 days	12/1/2019
NUBEQA 300 MG TABLET	Added to formulary with PA		12/1/2019
PANTOPRAZOLE DR 20 MG TABLET PANTOPRAZOLE DR 40 MG TABLET	Limited to preferred NDCs		12/1/2019
STEGLUJAN 5-100 MG TABLET STEGLUJAN 15-100 MG TABLET	Added to formulary with AL and PA	AL min. ≥ 18 years old	12/1/2019
TRULICITY 0.75 MG/0.5 ML PEN TRULICITY 1.5 MG/0.5 ML PEN	Added to formulary with PA and QL	QL 2 mL/28 days	12/1/2019
XPOVIO 60 MG ONCE WEEKLY DOSE XPOVIO 80 MG ONCE WEEKLY DOSE XPOVIO 80 MG TWICE WEEKLY DOSE XPOVIO 100 MG ONCE WEEKLY DOSE	Added to formulary with PA		12/1/2019

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER	Added to formulary with AL and QL	AL min. ≤ 17 years old QL 1 inhaler/30 days	11/1/2019
ORILISSA 150 MG TABLET ORILISSA 200 MG TABLET	Added to formulary with PA		11/1/2019
SYMBICORT 80-4.5 MCG INHALER SYMBICORT 160-4.5 MCG INHALER	Added to formulary with AL and QL	AL min. ≤ 17 years old QL 1 inhaler/30 days	11/1/2019
ADEFOVIR DIPIVOXIL 10 MG TABLET	Added QL	5 tablets/day	10/1/2019
CIMZIA 200 MG/ML STARTER KIT	Starter Kit QL updated	1 kit per year	10/1/2019
CIPROFLOXACIN HCL 100 MG TABLET	Removed from formulary		10/1/2019
CLOTRIMAZOLE-BETAMETHASONE LOT	Added QL	60 mL/30 days	10/1/2019
ENTECAVIR 0.5 MG TABLET	Added QL	1 tablet/day	10/1/2019
ENTECAVIR 1 MG TABLET	Added QL	2 tablets/day	10/1/2019
FEBUXOSTAT 40 MG TABLET FEBUXOSTAT 80 MG TABLET	Must use preferred generic for Uloric		10/1/2019
HUMIRA PEN CROHN-UC-HS 40 MG HUMIRA PEN PS-UV-ADOL HS 40 MG HUMIRA(CF) PEDI CROHN 80-40 MG HUMIRA(CF) PEDI CROHN 80MG/0.8 ML HUMIRA(CF) PEN CRHN-UC-HS 80 MG HUMIRA(CF) PEN PS-UV-AHS 80-40	Starter pack QL updated	1 kit per year	10/1/2019
KRINTAFEL 150 MG TABLET	Added to formulary with PA, AL, and QL	AL min. ≥ 16 years old	10/1/2019

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
		QL max 2 tablets/365 days	
LAMIVUDINE 100 MG TABLET	Added QL	3 tablets/day	10/1/2019
LAMIVUDINE HBV 100 MG TABLET	Added QL	4 tablets/day	10/1/2019
NYSTATIN-TRIAMCINOLONE CREAM NYSTATIN-TRIAMCINOLONE OINTMENT	Added QL	60 Gm/30 days	10/1/2019
PEDIATRIC ENEMA	Added to formulary		10/1/2019
SPIRIVA RESPIMAT 1.25 MCG INH	Added to formulary with PA, AL, and QL	AL min. ≥ 6 years old 1 inhaler/30 days	10/1/2019
SYMBICORT 160-4.5 MCG INHALER	Previous Grandfathering expired on 7/31/2019		N/A
SYMJEPI 0.3 MG/0.3 ML SYRINGE	Added to formulary with QL	1 unit/90 days	10/1/2019
TRETINOIN 0.025% CREAM	Added to formulary with AL, QL, and ST	AL Min. ≥ 18 years old QL max 20 gams/30 days Trial and failure of Differin 0.1% OTC (two claims in previous 90 days)	10/1/2019
ACTEMRA 162 MG/0.9 ML SYRINGE ACTEMRA ACTPEN 162 MG/0.9 ML	Added to formulary with PA		7/1/2019
AIMOVIG 70 MG/ML AUTOINJECTOR AIMOVIG 140 MG DOSE-2 AUTOINJ AIMOVIG 140 MG/ML AUTOINJECTOR	PA updated with AL	AL Min. ≥ 18 years old	7/1/2019

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
CAPSAICIN 0.025% CREAM	Product limited to single NDC Must use 00536252525		7/1/2019
CAPTOPRIL 12.5 MG TABLET CAPTOPRIL 25 MG TABLET CAPTOPRIL 50 MG TABLET CAPTOPRIL 100 MG TABLET	Removed from formulary Indefinite grandfathering for current utilizers with 180 day lookback		7/1/2019
CIMZIA 200 MG VIAL KIT CIMZIA 200 MG/ML STARTER KIT CIMZIA 200 MG/ML SYRINGE KIT	Added to formulary with PA		7/1/2019
ENTRESTO 24 MG – 26 MG TABLET ENTRESTO 49 MG – 51 MG TABLET ENTRESTO 97 MG – 103 MG TABLET	Removed PA Added AL, QL	AL Min. ≥ 18 years old Max 2 tabs/day	7/1/2019
DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER ***Update***	**Non-Formulary Grandfathering for current utilizers (all ages) extended through 7/31/2019.** Preferred alternatives for "New Starts" are AirDuo – Generic **and** Advair Diskus - Generics	QL 1inhaler/month	7/1/2019
FLUTICASONE-SALMETEROL 100-50 WIXELA 100-50 INHUB (Generics for Advair Diskus)	Will pay at POS with AL and QL	AL Min. ≥ 4 years old 1 inhaler per 30 days	7/1/2019
FLUTICASONE-SALMETEROL 250-50 WIXELA 250-50 INHUB FLUTICASONE-SALMETEROL 500-50 WIXELA 500-50 INHUB (Generics for Advair Diskus)	Will pay at POS with AL and QL	AL Min. ≥ 12 years old 1 inhaler per 30 days	7/1/2019
LIDOCAINE 3% CREAM	Not on MPPL Must use Aspercreme 4% OTC	85 grams/30 days	7/1/2019

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
LIDOCAINE 4% CREAM	Must use Aspercreme 4% OTC Cream	153 grams/30 days	7/1/2019
NIVESTYM 300 MCG/0.5 ML SYRINGE NIVESTYM 480 MCG/0.8 ML SYRINGE	Added to formulary with PA		7/1/2019
ORENCIA 50 MG/0.4 ML SYRINGE ORENCIA 87.5 MG/0.7 ML SYRINGE ORENCIA 125 MG/ML SYRINGE ORENCIA CLICKJET 125 MG/ML	Added to formulary with PA		7/1/2019
POLYETHYLENE GLYCOL 3350 POWD	Multi-dose bottles preferred 238 or 510 gram bottle		7/1/2019
SILIQ 210 MG/1.5 ML SYRINGE	Added to formulary with PA		7/1/2019
SYMBICORT 160-4.5 MCG INHALER ***Update***	**Grandfathering for current utilizers (all ages) extended through 7/31/2019.** Preferred alternatives for "New Starts" are AirDuo – Generic **and** Advair Diskus - Generic	AL Min. ≥12 years old QL 1inhaler/month	7/1/2019
TEKTURNA HCT 150-12.5 MG TABLET TEKTURNA HCT 150-25 MG TABLET TEKTURNA HCT 300-12.5 MG TABLET TEKTURNA HCT 300-25 MG TABLET	Removed from formulary		7/1/2019
VIRT-VITE PLUS TABLET	Only NDC 76439021090 will pay at POS		7/1/2019
XELJANZ 5 MG TABLET XELJANZ 10 MG TABLET	Added to formulary with PA and QL	2 tablets/day	7/1/2019
XELJANZ XR 11 MG TABLET	Added to formulary with PA and QL	1 tablet/day	7/1/2019
AIMOVIG 70 MG/ML AUTOINJECTOR	Added to formulary with AL, PA, and QL	AL Min. ≥ 18 years old	4/1/2019

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
		1 dose/month	
AIMOVIG 140 MG DOSE-2 AUTOINJ	Added to formulary with AL, PA, and QL Initial trial of 70mg/month dose for 2 months	AL Min. ≥ 18 years old 1 dose/month	4/1/2019
ALBUTEROL SUL HFA 90 MCG INH	Added to formulary with QL Generic for Proair and Ventolin	1 inhaler/30 days	4/1/2019
AMANTADINE 100 MG TABLET	Removed from formulary Amantadine capsules are preferred		4/1/2019
ANORO ELLIPTA 62.5-25 MCH INH	Removed from formulary for new starts only. Grandfathering allowed for previous utilizers until discontinuation.		4/1/2019
ARNUITY ELLIPTA 50 MCG INH ARNUITY ELLIPTA 100 MCG INH ARNUITY ELLIPTA 200 MCG INH	Removed from formulary for new starts only. Grandfathering allowed for previous utilizers until discontinuation.		4/1/2019
ASMANEX HFA 100 MCG INHALER ASMANEX HFA 200 MCG INHALER	Removed from formulary for new starts only. Grandfathering allowed for previous utilizers until discontinuation.		4/1/2019
ASMANEX TWISTHALR 110 MCG #7 ASMANEX TWISTHALR 110 MCG #30	Removed from formulary for new starts only.		4/1/2019

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
ASMANEX TWISTHALR 220 MCG #14 ASMANEX TWISTHALR 220 MCG #30 ASMANEX TWISTHALR 220 MCG #60 ASMANEX TWISTHALR 220 MCG #120	Grandfathering allowed for previous utilizers until discontinuation.		
BEVESPI AEROSPHERE INHALER	Added to formulary with ST	T/F Serevent or Incruse Ellipta	4/1/2019
BROMOCRIPTINE 5 MG CAPSULE	Added QL	3 capsules/day	4/1/2019
CARBIDOPA-LEVO 25-100 ODT	Removed QL		4/1/2019
DALFAMPRIDINE ER 10 MG TABLET	Added QL	2 tablets/day	4/1/2019
DAURISMO 25 MG TABLET DAURISMO 100 MG TABLET	Added to formulary with PA		4/1/2019
DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER ***Update***	Removed from formulary during July 2018 Common Formulary Workgroup Meeting, effective 10/1/2018. Generic AirDuo is preferred **Grandfathering for current utilizers (all ages) extended through 4/30/2019.**		1/18/2018
FENOPROFEN 600 MG TABLET	Removed from formulary Formulary NSAIDs preferred		4/1/2019
FLOVENT 50 MCG DISKUS FLOVENT 100 MCG DISKUS FLOVENT 250 MCG DISKUS	Removed from formulary for new starts only.		4/1/2019

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	Grandfathering allowed for previous utilizers until discontinuation.		
FULPHILA 6 MG/0.6 ML SYRINGE	Added to formulary with PA		4/1/2019
GLEOSTINE 10 MG CAPSULE GLEOSTINE 40 MG CAPSULE GLEOSTINE 100 MG CAPSULE	Brand available with PA, generic is no longer available		4/1/2019
GRANIX 300 MCG/ML VIAL GRANIX 480 MCG/1.6 ML VIAL	Added to formulary with PA		4/1/2019
HUMALOG 100 UNITS/ML VIAL	Added to formulary with PA for insulin pump use Added QL	3 vials (30 ML) per 30 days	4/1/2019
HYDROXYZINE PAM 100 MG CAPSULE	Removed from formulary Must use Hydroxyzine Pamoate 50 mg capsules X2		4/1/2019
IMIQUIMOD 5% CREAM PACKET	Removed PA		4/1/2019
OLUMIANT 2 MG TABLET	Added to formulary with PA and QL	1 tablet/day	4/1/2019
PRO COMFORT SPACER-ADULT MASK PRO COMFORT SPACER-CHILD MASK	Added to formulary with QL	4 units/365 days	4/1/2019
RANITIDINE 150 MG CAPSULE RANITIDINE 300 MG CAPSULE	Removed from formulary Ranitidine tablets are preferred		4/1/2019
RETACRIT 2,000 UNIT/ML VIAL RETACRIT 3,000 UNIT/ML VIAL RETACRIT 4,000 UNIT/ML VIAL RETACRIT 10,000 UNITL/ML VIAL RETACRIT 40,000 UNIT/ML VIAL	Added to formulary with PA		4/1/2019
RIVASTIGMINE 1.5 MG CAPSULE RIVASTIGMINE 3 MG CAPSULE RIVASTIGMINE 4 MG CAPSULE RIVASTIGMINE 6 MG CAPSULE	Added QL	2 capsules/day	4/1/2019

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SYMBICORT 160-4.5 MCG INHALER SYMBICORT 80-4.5 MCG INHALER ***Update***	Formulary with AL Generic AirDuo is preferred for members ≥ 13 years old. **Grandfathering for current utilizers (all ages) extended through 4/30/2019.**	AL = ≤ 12 years old	1/18/2019
VENCLEXTA 10 MG TABLET VENCLEXTA 50 MG TABLET VENCLEXTA 100 MG TABLET VENCLEXTA STARTING PACK	Added to formulary with PA		4/1/2019
VENTOLIN HFA 90 MCG INH	Removed from formulary Generic Albuterol SUL HFA 90 MCG preferred		4/1/2019
XYREM 500 MG/ML ORAL SOLUTION	Added to formulary with PA and QL	540 ML/30 days	4/1/2019
CHOLINE CITRATE 650 MG TABLET	Added to formulary		3/1/2019
CHOLINE SR 300 MG TABLET	Added to formulary		3/1/2019
SODIUM CHLORIDE 3% VIAL	Added to formulary		3/1/2019
TESTOSTERONE 12.5 MG/1.25 GRAM GEL	Removed from formulary		3/1/2019
TESTOSTERONE 25 MG/2.5 GM PKT TESTOSTERONE 50 MG/5 GRAM PKT	Added to formulary with PA and QL	60 packets/30 days	3/1/2019
TESTOSTERONE 30 MG/1.5 ML PUMP	Added to formulary with PA and QL	180 mL/30 days	3/1/2019
TESTOSTERON ENAN 1,000 MG/5 ML TESTOSTERONE ENAN 200 MG/ML	Removed from formulary		3/1/2019
AFINITOR 10 MG TABLET AFINITOR 7.5 MG TABLET	Added to formulary with PA and QL	1 tablet/day	1/1/2019
ALOGLIPTIN 6.25 MG TABLET ALOGLIPTIN 12.5 MG TABLET ALOGLIPTIN 25 MG TABLET	Removed PA added ST	T/F Metformin or Metformin ER at min.	1/1/2019

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
ALOGLIPTIN-METFORMIN 12.5-500 ALOGLIPTIN-METFORMIN 12.5-1000		dose of at least 1500mg/day for at least 90 days	
ALOGLIPTIN-PIOGLIT 12.5-15 MG ALOGLIPTIN-PIOGLIT 12.5-30 MG ALOGLIPTIN-PIOGLIT 12.5-45 MG ALOGLIPTIN-PIOGLIT 25-15 MG TB ALOGLIPTIN-PIOGLIT 25-30 MG TB ALOGLIPTIN-PIOGLIT 25-45 MG TB	Removed PA added ST	T/F Metformin or Metformin ER at min. dose of at least 1500mg/day for at least 90 days	1/1/2019
AMITIZA 8 MCG CAPSULE AMITIZA 24 MCG CAPSULES	Added AL and QL	AL ≥ 18 2 capsules/day	1/1/2019
BLISOVI 24 FE TABLET	Added to formulary	Max 3 month supply/claim	1/1/2019
BLISOVI FE 1-20 TABLET BLISOVI FE 1.5-30 TABLET	Added to formulary	Max 3 month supply/claim	1/1/2019
CHLORZOXAZONE 500 MG TABLET	Added AL	≥ 18 to ≤ 64	1/1/2019
CYCLOBENZAPRINE 5 MG TABLET CYCLOBENZAPRINE 10 MG TABLET	Added AL	≥ 15 to ≤ 64	1/1/2019
DIPHENOXYLAT-ATROP 2.5-0.025/5	Removed from formulary		1/1/2019
ELIQUIS 2.5 MG TABLET ELIQUIS 5 MG TABLET	Added AL	AL Min. ≥ 18	1/1/2019
ELIQUIS 5 MG STARTER PACK	Added AL and QL	AL Min. ≥ 18 1 Starter Pack per 90 days	1/1/2019
ERLEADA 60 MG TABLET	Added to formulary with PA and QL	4 tablets/day	1/1/2019
ESTRADIOL 0.5 MG TABLET ESTRADIOL 1 MG TABLET ESTRADIOL 2 MG TABLET	Removed AL		1/1/2019
ESTROPIPATE 0.625(0.75 MG) TAB ESTROPIPATE 1.25(1.5 MG) TAB	Removed AL		1/1/2019

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ESTROPIPATE 2.5(3 MG) TAB			
JULEBER 28 DAY TABLET	Added to formulary	Max 3 month supply/claim	1/1/2019
LARISSIA-28 TABLET	Added to formulary	Max 3 month supply/claim	1/1/2019
METHOCARBAMOL 500 MG TABLET METHOCARBAMOL 750 MG TABLET	Added AL	AL ≥ 16 to ≤ 64	1/1/2019
ORPHENADRINE ER 10 MG TABLET	Added AL	AL ≥ 18 to ≤ 64	1/1/2019
OZEMPIC 0.25-0.5 MG DOSE PEN	Added to formulary with QL	1.5mL/28 days (1 pen per 28 days	1/1/2019
OZEMPIC 1 MG DOSE PEN	Added to formulary with QL	3mL /28 days (2 pens per 28 days)	1/1/2019
PERTZYE DR 16,000 UNIT CAPSULE PERTZYE DR 24,000 UNIT CAPSULE	Added to formulary with QL	480 caps/month	1/1/2019
PERTZYE DR 8,000 UNIT CAPSULE	Added to formulary with QL	720 caps/month	1/1/2019
PREMARIN 0.3 MG TABLET PREMARIN 0.45 MG TABLET PREMARIN 0.625 MG TABLET PREMARIN 0.9 MG TABLET PREMARIN 1.25 MG TABLET	Removed AL added QL	1 tablet/day	1/1/2019
REESE PINWORM 144 MG/ML SUSP	Brand Added to formulary		1/1/2019
TIBSOVO 250 MG TABLET	Added to formulary with PA and QL	2 tablets/day	1/1/2019
TIZANIDINE HCL 2 MG TABLET TIZANIDINE HCL 4 MG TABLET	Added AL	AL ≥ 18	1/1/2019
TRI-LO-MARZIA TABLET	Added to formulary	Max 3 month supply/claim	1/1/2019
TRINESSA LO TABLET	Added to formulary	Max 3 month supply/claim	1/1/2019
VIENVA-28 TABLET	Added to formulary	Max 3 month supply/claim	1/1/2019
VIOKACE 10,440-39,150 UNITS TB VIOKACE 20,880-78,300 UNITS TB	Added to formulary with QL	480 tabs/month	1/1/2019

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XARELTO 10 MG TABLET XARELTO 15 MG TABLET XARELTO 20 MG TABLET	Added AL	AL ≥ 18	1/1/2019
XARELTO STARTER PACK	Added AL	≥18	1/1/2019
ZYTIGA 500 MG TABLET	Added PA and QL	2 tablets/day	1/1/2019
AEROSPAN 80 MCG INHALER	Product is discontinued		10/1/2018
APIDRA 100 UNITS/ML VIAL APIDRA SOLOSTAR 100 UNITS/ML	Removed from formulary Admelog vials are preferred Admelog Solostar = AL <21 Ages ≥ 21 require PA		10/1/2018
BRAFTOVI 50 MG CAPSULE BRAFTOVI 75 MG CAPSULE	Added to formulary with PA		10/1/2018
DULERA 100 MCG/5 MCG INHALER DULERA 200 MCG/5 MCG INHALER	Removed from formulary Generic AirDuo is preferred		10/1/2018
EPINEPHRINE 0.15 MG AUTO-INJCT EPINEPHRINE 0.3 MG AUTO-INJECT	QL updated	2 pens/90 days	10/1/2018
FLONASE ALLERGY RLF 50 MCG SPR FLUTICASONE PROP 50 MCG SPRAY	QL added	1 unit/month	10/1/2018
FORADIL AEROLIZER 12 MCG CAP	Product is discontinued		10/1/2018
HUMALOG 100 UNITS/ML CARTRIDGE HUMALOG 100 UNITS/ML KWIKPEN HUMALOG 100 UNITS/ML VIAL HUMALOG JR 100 UNIT/ML KWIKPEN	Removed from formulary Admelog vials are preferred Admelog Solostar = AL <21 Ages ≥ 21 require PA		10/1/2018
ISOTRETINOIN 10 MG CAPSULE ISOTRETINOIN 20 MG CAPSULE ISOTRETINOIN 30 MG CAPSULE ISOTRETINOIN 40 MG CAPSULE	Added to formulary with PA	2 capsules/day	10/1/2018
MONTELUKAST SOD 10 MG TABLET	Removed AL	1 tablet/day	10/1/2018

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MONTELUKAST SOD 4 MG TAB CHEW MONTELUKAST SOD 5 MG TAB CHEW			
NOVOLOG 100 UNIT/ML CARTRIDGE NOVOLOG 100 UNIT/ML VIAL NOVOLOG 100 UNITS/ML FLEXPEN	Removed from formulary Admelog vials are preferred Admelog Solostar = AL <21 Ages ≥ 21 require PA		10/1/2018
NP THYROID 120 MG TABLET NP THYROID 15 MG TABLET	Added to formulary		10/1/2018
QVAR 40 MCG ORAL INHALER QVAR 80 MCG ORAL INHALER	Product is discontinued Must use new QVAR Respiclick inhaler		10/1/2018
SYMBICORT 160-4.5 MCG INHALER SYMBICORT 80-4.5 MCG INHALER	Removed from formulary PA available for 5-11 yr olds Generic AirDuo is preferred		10/1/2018
YONSA 125 MG TABLET	Added to formulary with PA		10/1/2018
Prescription Opioid Cough and Cold Medicines (if included on the formulary or under medical necessity)	Implementing consistent QL	120 mL/month	9/1/2018
DIFICID 200mg TABLET	Added to formulary with PA		9/1/2018
ZENPEP DR 3,000 UNIT CAPSULE ZENPEP DR 5,000 UNIT CAPSULE ZENPEP DR 10,000 UNIT CAPSULE	Added to formulary with QL	720 capsules/30 days	9/1/2018
ZENPEP DR 15,000 UNIT CAPSULE ZENPEP DR 25,000 UNIT CAPSULE	Added to formulary with QL	480 capsules/30 days	9/1/2018
HUMIRA PEDIATR CROHN'S 80-40MG HUMIRA 40 MG/0.4 ML SYRINGE HUMIRA 40 MG/0.4 ML PEN	Added to formulary with PA		8/15/2018

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HUMIRA 20 MG/0.2 ML SYRINGE HUMIRA 10 MG/0.1 ML SYRINGE HUMIRA PED CROHNS 80 MG/0.8 ML			
ARMONAIR RESPICLICK 113 MCG ARMONAIR RESPICLICK 232 MCG ARMONAIR RESPICLICK 55 MCG	Added to formulary with QL	1 unit/30 days	7/1/2018
BENZNIDAZOLE 100 MG TABLET BENZNIDAZOLE 12.5 MG TABLET	Added to formulary with PA		7/1/2018
DIPYRIDAMOLE 50 MG TABLET	QL Added	4 tablets/day	7/1/2018
ELITE-OB CAPLET	Removed from formulary		7/1/2018
ENDARI 5 GRAM POWDER PACKET	Added to formulary with PA		7/1/2018
FIRVANQ 25 MG/ML SOLUTION FIRVANQ 50 MG/ML SOLUTION	Added to formulary		7/1/2018
FLOVENT HFA 110 MCG INHALER FLOVENT HFA 44 MCG INHALER	AL and QL added. Current utilizers ≥13 years old referred to Armonair Respiclick.	1 inhaler/30 days Covered for ages 0-12	7/1/2018
FLOVENT HFA 220 MCG INHALER	AL and QL added. Current utilizers ≥13 years old referred to Armonair Respiclick.	2 inhalers/30 days Covered for ages 0-12	7/1/2018
HUMIRA PEN PSORIASIS-UVEITIS	QL Added	4 pens/28 days	7/1/2018
IDHIFA 100 MG TABLET IDHIFA 50 MG TABLET	Added to formulary with PA		7/1/2018
MULTIVIT & FLUOR 0.5 MG/ML DRP MULTI-VIT W-FLUOR 0.25 MG/ML MULTIVIT-FLUOR 0.25 MG/ML DROP MULTIVIT-FLUOR 0.5 MG/ML DROP MULTIVIT-FLUOR-IRON 0.25 MG/ML	Added to formulary with AL and QL	2 mL/day Covered for ages 0-12	7/1/2018
MULTIVITAMINS CHEWABLES TABLET MULTIVIT-FLUOR 0.25 MG TAB CHW	Added to formulary with AL and QL	1 tablet/day Covered for ages 0-12	7/1/2018

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MULTIVIT-FLUORIDE 1 MG TAB CHW			
MVC-FLUORIDE 0.5 MG TAB CHEW MVC-FLUORIDE 0.25 MG TAB CHEW MVC-FLUORIDE 1 MG TAB CHEW	Added to formulary with AL and QL	1 tablet/day Covered for ages 0-12	7/1/2018
NEOMYCIN-POLY-HC EYE DROPS	Removed from formulary		7/1/2018
NICOTINE TRANSDERMAL SYSTEM	QL added	56 patches/56 days	7/1/2018
NITROGLYCERIN LINGUAL 0.4 MG	ST added for NSO	Nitroglycerin SL Tablets	7/1/2018
OTEZLA 28 DAY STARTER PACK OTEZLA STARTER PACK	QL added	1 starter pack/365 days	7/1/2018
PINDOLOL 10 MG TABLET PINDOLOL 5 MG TABLET	Removed from formulary for NSO		7/1/2018
PRENATE AM TABLET	Removed from formulary for NSO		7/1/2018
PSEUDOEPHED 30 MG/5 ML SOLN	Added AL and QL	4mL/day; 120 mL/30 days Covered for ages 4-11	7/1/2018
PSEUDOEPHEDRINE 30 MG TABLET	Added AL and QL	1.6 tablets per day; 48 tablets/30 days Covered for ages 12-65	7/1/2018
PSEUDOEPHEDRINE 60 MG TABLET	Added AL and QL	1 tablet per day; 30 tablets/30 days Covered for ages 12-65	7/1/2018
QBRELIS 1MG/ML SOLUTION	Added to formulary with AL	Covered for ages 0-12	7/1/2018
TIMOLOL MALEATE 10 MG TABLET TIMOLOL MALEATE 20 MG TABLET TIMOLOL MALEATE 5 MG TABLET	Removed from formulary for NSO		7/1/2018

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TRI-VIT-FLUOR 0.25 MG/ML DROP	Added AL and QL	2mL/day Covered for ages 0-12	7/1/2018
TRI-VIT-FLUOR 0.5 MG/ML DROP TRI-VIT-FLUOR-IRON 0.25 MG/ML	Added to formulary with AL and QL	2mL/day Covered for ages 0-12	7/1/2018
XATMEP 2.5MG/ML ORAL SOLUTION	Added to the formulary with PA		7/1/2018
Admelog Solostar	Added to formulary with AL and QL	30 mL/30 days (2 boxes of 5 pens) ≤ 21 years old covered without PA	5/1/2018
Admelog Vial	Added to formulary with QL	60 mL/30 days (6 vials)	5/1/2018
Prescription Opioid Cough and Cold Medicines (if included on the formulary)	Adopted FDA guidance on age limits. Updated minimum age to 18 years old.		5/1/2018
Steglatro	Added to formulary with PA		5/1/2018
Segluromet	Added to formulary with PA		5/1/2018
AMANTADINE 100 MG TABLET	QL added	4 tablets/day	4/1/2018
ASPERCREME 4% PATCH	Added to formulary with QL	1 patch/day	4/1/2018
CAPACET CAPSULE ESGIC CAPSULE MARGESIC CAPSULE ZEBUTAL 50-325-40 MG CAPSULE	Capsules removed from formulary. Tablets are the preferred dosage form for this combination.		4/1/2018
CELECOXIB 100 MG CAPSULE CELECOXIB 200 MG CAPSULE CELECOXIB 400 MG CAPSULE CELECOXIB 50 MG CAPSULE	PA removed, QL remains active	1 capsule/day	4/1/2018
DICLOFENAC SODIUM 1% GEL	ST removed, QL added	500 gm/30 days	4/1/2018
DICLOFENAC SODIUM 3% GEL	PA criteria updated		4/1/2018

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FLUOROURACIL 0.5% CREAM FLUOROURACIL 5% CREAM	PA criteria updated		4/1/2018
FORTEO 600 MCG/2.4 ML PEN INJ	PA criteria updated	1 unit/month	4/1/2018
IMIQUIMOD 5% CREAM PACKET	PA criteria updated	12 packets/month	4/1/2018
KETOPROFEN 50 MG CAPSULE KETOPROFEN 75 MG CAPSULE	Removed from formulary		4/1/2018
LIDOCAINE 3% CREAM	QL added	85 grams/30 days	4/1/2018
LIDOCAINE 5% PATCH	QL updated	1 patch/day	4/1/2018
MEMANTINE 5-10 TITRATION PK	PA criteria retired QL and AL added	49 tablets/year	4/1/2018
MEMANTINE HCL 10 MG TABLET MEMANTINE HCL 5 MG TABLET	PA criteria retired QL and AL added	2 tablets/day	4/1/2018
METHADONE 40 MG TABLET DISPR	Removed from formulary		4/1/2018
METHERGINE 0.2 MG TABLET	QL added	28 tablets/180 days	4/1/2018
NAPROXEN 125 MG/5 ML SUSPEN	Added to formulary with PA and AL	Max age 12 years	4/1/2018
ODOMZO 200 MG CAPSULE	Added to formulary with PA		4/1/2018
SSD 1% CREAM	Added to formulary		4/1/2018
SUMATRIPTAN 20 MG NASAL SPRAY	Added to formulary with PA and QL	1 box/month	4/1/2018
SUMATRIPTAN 5 MG NASAL SPRAY	Added to formulary with PA and QL	2 boxes/month	4/1/2018
TRACLEER 32 MG TABLET FOR SUSP	Added to formulary with PA, AL	Ages 3 – 12 years old	4/1/2018
TYMLOS 80 MCG DOSE PEN INJECTR	Added to formulary with PA		4/1/2018
ZENPEP DR 20,000 UNIT CAPSULE	Coding update for new NDC	16 capsules/day	4/1/2018
ZENPEP DR 40,000 UNIT CAPSULE	Coding update for new NDC	16 capsules/day	4/1/2018
ARMONAIR RespiClick	Added to formulary with QL	1 unit/month	3/1/2018
PREVACID SoluTab 15mg PREVACID SoluTab 30mg	Updated QL, AL remains No AL for CSHCS	1 tablet/day	3/1/2018

*__AL__=Age Limit, **PA**=Prior Authorization, **ST**=Requires Step Therapy, **QL**=Quantity Limit, **CO**=Carve Out, **GSN**=Generic Sequence Number, **NDC**=National Drug Code, **CSHCS**=Children's Special Healthcare Services, **NSO**=New Starts Only, **Tier 1** = Preferred, Tier 2 = Preferred w/PA, **Tier 3** = Non-Preferred, **Tier 4** = Formulary (Non-PDL); Note: Tier drugs may have additional edits as reported.
PDL Maintenance List = drugs included on this list are eligible for up to a 102-day supply.

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
ASACOL HD DR 800 MG TABLET	Brand name removed from formulary – generic is covered		1/1/2018
CAYA CONTOURED DIAPHRAGM	Added to formulary		1/1/2018
COMPLEX B-50 TABLET	No PA required		1/1/2018
ESOMEPRAZOLE MAG DR 20 MG CAP	Removed from formulary		1/1/2018
ETIDRONATE DISODIUM 200 MG TAB ETIDRONATE DISODIUM 400 MG TAB	Removed from formulary		1/1/2018
FARXIGA 5 MG TABLET FARXIGA 10 MG TABLET	Removed from formulary		1/1/2018
FOLTANX RF CAPSULE	Removed from formulary Not on MPPL		1/1/2018
GLATIRAMER 40 MG/ML SYRINGE	Added to formulary with PA	12/28 days	1/1/2018
HUMALOG JR 100 UNIT/ML KWIKPEN	Added to formulary	Max age 21, 30ml/ 30 days;1ml/day	1/1/2018
INVOKAMET XR 150-1,000 MG TAB INVOKAMET XR 50-500 MG TABLET INVOKAMET XR 150-500 MG TABLET INVOKAMET XR 50-1,000 MG TAB	QL added	2 tablets/day	1/1/2018
JARDIANCE 10 MG TABLET JARDIANCE 25 MG TABLET	Added to formulary with PA	1 tablet/day	1/1/2018
LEVOMEFOL-PYRIDOXAL-MEC-ALGAL	Removed from formulary Not on MPPL		1/1/2018
L-METHYLFOLATE CA P-5-P ME-CBL	Removed from formulary Not on MPPL		1/1/2018
METANX CAPSULE	Removed from formulary Not on MPPL		1/1/2018
METHERGINE 0.2 MG TABLET	Brand added to formulary	Min age 12	1/1/2018

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Medication Name	Preferred Drug List Update*	Limit*	Effective Date
METHYLERGONOVINE 0.2 MG TABLET	Generic discontinued Brand covered		1/1/2018
NEXIUM 24HR 20 MG CAPSULE	Added to formulary with step-therapy requirements - ST: Step 1 omeprazole and pantoprazole Step 2 Nexium OTC and lansoprazole	2 capsules/day	1/1/2018
NEXIUM DR 20 MG CAPSULE	Removed from formulary		1/1/2018
SYNJARDY 5-1,000 MG TABLET SYNJARDY 12.5-1,000 MG TABLET SYNJARDY 5-500 MG TABLET SYNJARDY 12.5-500 MG TABLET	Added to formulary with PA	2 tablets/day	1/1/2018
SYNJARDY XR 10-1,000 MG TABLET SYNJARDY XR 25-1,000 MG TABLET	Added to formulary with PA	1 tablet/day	1/1/2018
SYNJARDY XR 12.5-1,000 MG TAB SYNJARDY XR 5-1,000 MG TABLET	Added to formulary with PA	2 tablets/day	1/1/2018
WIDE SEAL DIAPHRAGM 60MM WIDE SEAL DIAPHRAGM 65MM WIDE SEAL DIAPHRAGM 70MM WIDE SEAL DIAPHRAGM 75MM WIDE SEAL DIAPHRAGM 80MM WIDE SEAL DIAPHRAGM 85MM WIDE SEAL DIAPHRAGM 90MM WIDE SEAL DIAPHRAGM 95MM	Added to formulary		1/1/2018

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PDL Maintenance List = drugs included on this list are eligible for up to a 102-day supply.

Nondiscrimination Notice and Language Services

Discrimination is against the law

Blue Cross Complete of Michigan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross Complete of Michigan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross Complete of Michigan:

- Provides free (no cost) aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (large print, audio, accessible electronic formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross Complete of Michigan Customer Service, 24 hours a day, 7 days a week at **1-800-228-8554 (TDD/TTY: 1-888-987-5832).**

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

- **Blue Cross Complete of Michigan Member Grievances**
  P.O. Box 41789
  North Charleston, SC 29423
  1-800-228-8554
  (**TDD/TTY: 1-888-987-5832**)
- If you need help filing a grievance, Blue Cross Complete of Michigan Customer Service is available to help you.

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

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

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

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Multi-language interpreter services

English: ATTENTION: If you speak English, language assistance services, at no cost, are available to you. Call **1-800-228-8554 (TTY: 1-888-987-5832)**.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-228-8554 (TTY: 1-888-987-5832)**.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-228-8554** **(TTY: 1-888-987-5832)**.

Chinese Mandarin: 注意：如果您说中文普通话/国语，我们可为您提供免费语言援助服务。请致电：**1-800-228-8554 (TTY: 1-888-987-5832)**。

Chinese Cantonese: 注意：如果您使用粵語，您可以免費獲得語言援助服務。請致電 **1-800-228-8554 (TTY: 1-888-987-5832)**。

Syriac:
ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܐܝܬܠܘܢ ܕܫܩܠܝܬܘܢ ܡܝܠܚܝܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ **1-800-228-8554** **(TTY: 1-888-987-5832)**

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-228-8554 (TTY: 1-888-987-5832)**.

Albanian: VINI RE: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në **1-800-228-8554 (TTY: 1-888-987-5832)**.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-228-8554 (TTY: 1-888-987-5832)** 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলায় কথা বলেন, তাহলে নিঃখরচায় ভাষা সহায়তা পেতে পারেন। **1-800-228-8554 (TTY: 1-888-987-5832)** নম্বরে ফোন করুন।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-228-8554 (TTY: 1-888-987-5832)**.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-228-8554 (TTY: 1-888-987-5832)**.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-228-8554 (TTY: 1-888-987-5832)**.

Japanese: 注意事項：日本語を話される場合、無料の通訳サービスをご利用いただけます。**1-800-228-8554 (TTY: 1-888-987-5832)** まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-228-8554 (TTY: 1-888-987-5832)**.

Serbo-Croatian: PAŽNJA: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-800-228-8554 (TTY: 1-888-987-5832)**.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-228-8554 (TTY: 1-888-987-5832)**.

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