

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

ABIRATERONE ACETATE 250 MG TAB	ARCALYST 220 MG VIAL
ABIRATERONE ACETATE 500 MG TAB	ARIKAYCE 590 MG/8.4 ML VIAL
ABIRTEGA 250 MG TABLET	ARMODAFINIL 150 MG TABLET
ACTHAR 40 UNIT/0.5 ML SELFJECT	ARMODAFINIL 200 MG TABLET
ACTHAR 80 UNIT/ML SELFJECT	ARMODAFINIL 250 MG TABLET
ACTHAR GEL 400 UNIT/5 ML VIAL	ARMODAFINIL 50 MG TABLET
ACYCLOVIR 5% CREAM	ASTAGRAF XL 0.5 MG CAPSULE
ACYCLOVIR 5% OINTMENT	ASTAGRAF XL 1 MG CAPSULE
ADALIMUMAB-ADAZ(CF) 10MG/0.1ML	ASTAGRAF XL 5 MG CAPSULE
ADALIMUMAB-ADAZ(CF) 20MG/0.2ML	ATTRUBY 356 MG TABLET
ADALIMUMAB-ADAZ(CF) 40 MG SYRG	AUGTYRO 160 MG CAPSULE
ADALIMUMAB-ADAZ(CF) PEN 40 MG	AUGTYRO 40 MG CAPSULE
ADALIMUMAB-ADAZ(CF) PEN 80 MG	AUSTEDO 12 MG TABLET
ADALIMUMAB-ADB(M)CF 10 MG SYRG	AUSTEDO 6 MG TABLET
ADALIMUMAB-ADB(M)CF 20 MG SYRG	AUSTEDO 9 MG TABLET
ADALIMUMAB-ADB(M)CF 40 MG SYRG	AUSTEDO XR 12 MG TABLET
ADALIMUMAB-ADB(M)CF PEN 40 MG	AUSTEDO XR 18 MG TABLET
ADALIMUMAB-RYVK(CF) 40 MG SYRG	AUSTEDO XR 24 MG TABLET
ADBRY 150 MG/ML SYRINGE	AUSTEDO XR 30 MG TABLET
ADBRY 300 MG/2 ML AUTOINJECTOR	AUSTEDO XR 36 MG TABLET
ADDYI 100 MG TABLET	AUSTEDO XR 42 MG TABLET
ADEMPAS 0.5 MG TABLET	AUSTEDO XR 48 MG TABLET
ADEMPAS 1 MG TABLET	AUSTEDO XR 6 MG TABLET
ADEMPAS 1.5 MG TABLET	AUSTEDO XR TITR(12-18-24-30MG)
ADEMPAS 2 MG TABLET	AVMAPKI-FAKZYNJA CO-PACK
ADEMPAS 2.5 MG TABLET	AVONEX 30 MCG/0.5 ML SYR (4PK)
AIMOVIG 140 MG/ML AUTOINJECTOR	AYVAKIT 100 MG TABLET
AIMOVIG 70 MG/ML AUTOINJECTOR	AYVAKIT 200 MG TABLET
AJOVY 225 MG/1.5 ML AUTOINJECT	AYVAKIT 25 MG TABLET
AJOVY 225 MG/1.5 ML SYRINGE	AYVAKIT 300 MG TABLET
ALECENSA 150 MG CAPSULE	AYVAKIT 50 MG TABLET
ALUNBRIG 180 MG TABLET	BACLOFEN 10 MG/5 ML SOLUTION
ALUNBRIG 30 MG TABLET	BACLOFEN 5 MG/5 ML SOLUTION
ALUNBRIG 90 MG TABLET	BAFIERTAM DR 95 MG CAPSULE
ALUNBRIG 90 MG-180 MG TAB PACK	BALVERSA 3 MG TABLET
ALYFTREK 10-50-125 MG TABLET	BALVERSA 4 MG TABLET
ALYFTREK 4-20-50 MG TABLET	BALVERSA 5 MG TABLET
ALYQ 20 MG TABLET	BENLYSTA 200 MG/ML AUTOINJECT
AMBRISANTAN 10 MG TABLET	BENLYSTA 200 MG/ML SYRINGE
AMBRISANTAN 5 MG TABLET	BENZPHETAMINE HCL 50 MG TABLET
AQNEURSA 1 GRAM GRANULE PACKET	BETAINE 1 GRAM/SCOOP POWDER
ARAZLO 0.045% LOTION	BETASERON 0.3 MG KIT

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

BETHKIS 300 MG/4 ML AMPULE	CAVERJECT IMPULSE 20 MCG KIT
BEXAROTENE 1% GEL	CAVERJECT IMPULSE 20 MCG SYRNG
BEXAROTENE 75 MG CAPSULE	CEQUA 0.09% SOLUTION
BONSITY 560 MCG/2.24 ML PEN	CERDELGA 84 MG CAPSULE
BOSENTAN 125 MG TABLET	CHEMET 100 MG CAPSULE
BOSENTAN 32 MG TABLET FOR SUSP	CHLORZOXAZONE 250 MG TABLET
BOSENTAN 62.5 MG TABLET	CHLORZOXAZONE 375 MG TABLET
BOSULIF 100 MG CAPSULE	CHLORZOXAZONE 750 MG TABLET
BOSULIF 100 MG TABLET	CHOLBAM 250 MG CAPSULE
BOSULIF 400 MG TABLET	CHOLBAM 50 MG CAPSULE
BOSULIF 50 MG CAPSULE	CIBINQO 100 MG TABLET
BOSULIF 500 MG TABLET	CIBINQO 200 MG TABLET
BRAFTOVI 75 MG CAPSULE	CIBINQO 50 MG TABLET
BRIMONIDINE 0.33% GEL PUMP	CINRYZE 500 UNIT VIAL
BRINSUPRI 10 MG TABLET	CINRYZE 500 UNIT VIAL-DILUENT
BRINSUPRI 25 MG TABLET	CLOBAZAM 10 MG TABLET
BRONCHITOL 40 MG INHALE CAP	CLOBAZAM 2.5 MG/ML SUSPENSION
BRUKINSA 160 MG TABLET	CLOBAZAM 20 MG TABLET
BRUKINSA 80 MG CAPSULE	COMETRIQ 100 MG DAILY-DOSE PK
BUPHENYL 500 MG TABLET	COMETRIQ 140 MG DAILY-DOSE PK
BUPHENYL POWDER	COMETRIQ 60 MG DAILY-DOSE PACK
BYLVAY 1,200 MCG CAPSULE	CONSENSI 10-200 MG TABLET
BYLVAY 200 MCG PELLET	CONSENSI 2.5-200 MG TABLET
BYLVAY 400 MCG CAPSULE	CONSENSI 5-200 MG TABLET
BYLVAY 600 MCG PELLET	CONTRACE ER 8-90 MG TABLET
CABLIVI 11 MG KIT	COPIKTRA 15 MG CAPSULE
CABOMETYX 20 MG TABLET	COPIKTRA 25 MG CAPSULE
CABOMETYX 40 MG TABLET	COTELLIC 20 MG TABLET
CABOMETYX 60 MG TABLET	CRENESSITY 100 MG CAPSULE
CALQUENCE 100 MG TABLET	CRENESSITY 25 MG CAPSULE
CAMZYOS 10 MG CAPSULE	CRENESSITY 50 MG CAPSULE
CAMZYOS 15 MG CAPSULE	CRENESSITY 50 MG/ML SOLUTION
CAMZYOS 2.5 MG CAPSULE	CRESEMBA 186 MG CAPSULE
CAMZYOS 5 MG CAPSULE	CRESEMBA 74.5 MG CAPSULE
CAPECITABINE 150 MG TABLET	CTEXLI 250 MG TABLET
CAPECITABINE 500 MG TABLET	CVS OMEPRAZOLE-BICARB 20-1,100
CAPRELSA 100 MG TABLET	CYCLOBENZAPRINE 7.5 MG TABLET
CAPRELSA 300 MG TABLET	CYCLOBENZAPRINE ER 15 MG CAP
CAVERJECT 20 MCG VIAL	CYCLOBENZAPRINE ER 30 MG CAP
CAVERJECT 40 MCG VIAL	CYCLOSPORINE 0.05% EYE EMULS
CAVERJECT IMPULSE 10 MCG KIT	CYLTEZO(CF) 10 MG/0.2 ML SYRNG
CAVERJECT IMPULSE 10 MCG SYRNG	CYLTEZO(CF) 20 MG/0.4 ML SYRNG

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

CYLTEZO(CF) 40 MG/0.4 ML SYRNG	DIACOMIT 500 MG POWDER PACKET
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	DICHLORPHENAMIDE 50 MG TABLET
CYLTEZO(CF) PEN 40 MG/0.4 ML	DICLOFENAC SODIUM 3% GEL
CYLTEZO(CF) PEN 40 MG/0.8 ML	DIETHYLPROPION 25 MG TABLET
CYLTEZO(CF) PEN CRH-UC-HS 40MG	DIETHYLPROPION ER 75 MG TABLET
CYLTEZO(CF) PEN PSORIA-UV 40MG	DIMETHYL FUMARATE 30D START PK
DALFAMPRIDINE ER 10 MG TABLET	DIMETHYL FUMARATE DR 120 MG CP
DANZITEN 71 MG TABLET	DIMETHYL FUMARATE DR 240 MG CP
DANZITEN 95 MG TABLET	DOJOLVI LIQUID
DARAPRIM 25 MG TABLET	DOPTELET (10 TAB PK) 20 MG TAB
DASATINIB 100 MG TABLET	DOPTELET (15 TAB PK) 20 MG TAB
DASATINIB 140 MG TABLET	DOPTELET (30 TAB PK) 20 MG TAB
DASATINIB 20 MG TABLET	DOPTELET SPRINKLE 10 MG CAP
DASATINIB 50 MG TABLET	DRONABINOL 10 MG CAPSULE
DASATINIB 70 MG TABLET	DRONABINOL 2.5 MG CAPSULE
DASATINIB 80 MG TABLET	DRONABINOL 5 MG CAPSULE
DAURISMO 100 MG TABLET	DROXIDOPA 100 MG CAPSULE
DAURISMO 25 MG TABLET	DROXIDOPA 200 MG CAPSULE
DEFERASIROX 125 MG TB FOR SUSP	DROXIDOPA 300 MG CAPSULE
DEFERASIROX 180 MG GRANULE PKT	DUPIXENT 200 MG/1.14 ML PEN
DEFERASIROX 180 MG TABLET	DUPIXENT 200 MG/1.14 ML SYRING
DEFERASIROX 250 MG TB FOR SUSP	DUPIXENT 300 MG/2 ML PEN
DEFERASIROX 360 MG GRANULE PKT	DUPIXENT 300 MG/2 ML SYRINGE
DEFERASIROX 360 MG TABLET	EBGLYSS 250 MG/2 ML PEN
DEFERASIROX 500 MG TB FOR SUSP	EBGLYSS 250 MG/2 ML SYRINGE
DEFERASIROX 90 MG GRANULE PKT	EDEX 10 MCG CARTRIDGE 2-PK KIT
DEFERASIROX 90 MG TABLET	EDEX 10 MCG CARTRIDGE 6-PK KIT
DEFERIPRONE 1,000 MG TB(3X/DY)	EDEX 20 MCG CARTRIDGE 2-PK KIT
DEFERIPRONE 500 MG TABLET	EDEX 20 MCG CARTRIDGE 6-PK KIT
DEFLAZACORT 18 MG TABLET	EDEX 40 MCG CARTRIDGE 2-PK KIT
DEFLAZACORT 30 MG TABLET	EDEX 40 MCG CARTRIDGE 6-PK KIT
DEFLAZACORT 36 MG TABLET	EGRIFTA SV 2 MG VIAL
DEFLAZACORT 6 MG TABLET	EGRIFTA WR 11.6 MG VIAL
DEMSEER 250 MG CAPSULE	EGRIFTA WR 11.6MG FOUR-VL KIT
DEPEN 250 MG TITRATAB	EMGALITY 100 MG/ML SYR(1 OF 3)
DEXABLISS 11 DAY 1.5 MG TAB PK	EMGALITY 120 MG/ML PEN
DEXAMETHASONE 10 DAY 1.5 MG TB	EMGALITY 120 MG/ML SYRINGE
DEXAMETHASONE 6 DAY 1.5 MG TAB	EMGALITY 300 MG (100 MG X3SYR)
DEXCHLORPHENIRAMINE 2 MG/5 ML	EMPAVELI 1,080 MG/20 ML VIAL
DIACOMIT 250 MG CAPSULE	ENBREL 25 MG/0.5 ML SYRINGE
DIACOMIT 250 MG POWDER PACKET	ENBREL 25 MG/0.5 ML VIAL
DIACOMIT 500 MG CAPSULE	ENBREL 50 MG/ML MINI CARTRIDGE

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

ENBREL 50 MG/ML SURECLICK	FILSPARI 200 MG TABLET
ENBREL 50 MG/ML SYRINGE	FILSPARI 400 MG TABLET
ENSACOVE 100 MG CAPSULE	FILSUVEZ 10% GEL
ENSACOVE 25 MG CAPSULE	FINGOLIMOD 0.5 MG CAPSULE
ENSPRYNG 120 MG/ML SYRINGE	FIORICET 50-300-40 MG CAPSULE
ENTRESTO 24 MG-26 MG TABLET	FIRDAPSE 10 MG TABLET
ENTRESTO 49 MG-51 MG TABLET	FRUZAQLA 1 MG CAPSULE
ENTRESTO 97 MG-103 MG TABLET	FRUZAQLA 5 MG CAPSULE
EPCLUSA 150-37.5 MG PELLET PKT	GALAFOLD 123 MG CAPSULE
EPCLUSA 200 MG-50 MG TABLET	GAMMAGARD LIQUID 10% VIAL
EPCLUSA 200-50 MG PELLET PACK	GAMMAGARD S-D 10 G (IGA<1) SOL
EPCLUSA 400 MG-100 MG TABLET	GAMMAGARD S-D 5 G (IGA<1) SOLN
EPIDIOLEX 100 MG/ML SOLN PACK	GAMUNEX-C 1 GRAM/10 ML VIAL
EPIDIOLEX 100 MG/ML SOLUTION	GAMUNEX-C 10 GRAM/100 ML VIAL
EPIPEN 0.3 MG AUTO-INJECTOR	GAMUNEX-C 2.5 GRAM/25 ML VIAL
EPIPEN 2-PAK 0.3 MG AUTO-INJECT	GAMUNEX-C 20 GRAM/200 ML VIAL
EPIPEN JR 0.15 MG AUTO-INJECTR	GAMUNEX-C 40 GRAM/400 ML VIAL
EPIPEN JR 2-PAK 0.15 MG INJECTR	GAMUNEX-C 5 GRAM/50 ML VIAL
ERIVEDGE 150 MG CAPSULE	GAVRETO 100 MG CAPSULE
ERLEADA 240 MG TABLET	GEFITINIB 250 MG TABLET
ERLEADA 60 MG TABLET	GENOTROPIN 12 MG CARTRIDGE
ERLOTINIB HCL 100 MG TABLET	GENOTROPIN 5 MG CARTRIDGE
ERLOTINIB HCL 150 MG TABLET	GENOTROPIN MINIUICK 0.2 MG
ERLOTINIB HCL 25 MG TABLET	GENOTROPIN MINIUICK 0.4 MG
EVEROLIMUS 10 MG TABLET	GENOTROPIN MINIUICK 0.6 MG
EVEROLIMUS 2 MG TAB FOR SUSP	GENOTROPIN MINIUICK 0.8 MG
EVEROLIMUS 2.5 MG TABLET	GENOTROPIN MINIUICK 1 MG
EVEROLIMUS 3 MG TAB FOR SUSP	GENOTROPIN MINIUICK 1.2 MG
EVEROLIMUS 5 MG TAB FOR SUSP	GENOTROPIN MINIUICK 1.4 MG
EVEROLIMUS 5 MG TABLET	GENOTROPIN MINIUICK 1.6 MG
EVEROLIMUS 7.5 MG TABLET	GENOTROPIN MINIUICK 1.8 MG
EVRYSDI 5 MG TABLET	GENOTROPIN MINIUICK 2 MG
EVRYSDI 60 MG/80 ML(0.75MG/ML)	GILOTRIF 20 MG TABLET
EYSUVIS 0.25% EYE DROPS	GILOTRIF 30 MG TABLET
FABHALTA 200 MG CAPSULE	GILOTRIF 40 MG TABLET
FASENRA PEN 30 MG/ML	GLATIRAMER 20 MG/ML SYRINGE
FENOFIBRATE 120 MG TABLET	GLATIRAMER 40 MG/ML SYRINGE
FERRIPROX 1,000 MG TAB(2X/DAY)	GLATOPA 20 MG/ML SYRINGE
FERRIPROX 1,000 MG TAB(3X/DAY)	GLATOPA 40 MG/ML SYRINGE
FERRIPROX 100 MG/ML SOLUTION	GLYCEROL PHENYLBUT 1.1 GRAM/ML
FERRIPROX 500 MG TABLET	GOMEKLI 1 MG CAPSULE
FEXMID 7.5 MG TABLET	GOMEKLI 1 MG TABLET FOR SUSP

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

GOMEKLI 2 MG CAPSULE	ICOSAPENT ETHYL 1 GRAM CAPSULE
GRASSTK 2,800 BAU SL TABLET	ICOSAPENT ETHYL 500 MG CAPSULE
GS OMEPRAZOLE-BICARB 20-1,100	IDHIFA 100 MG TABLET
HAEGARDA 2,000 UNIT VIAL	IDHIFA 50 MG TABLET
HAEGARDA 3,000 UNIT VIAL	IMATINIB MESYLATE 100 MG TAB
HARVONI 33.75-150 MG PELLET PK	IMATINIB MESYLATE 400 MG TAB
HARVONI 45-200 MG PELLET PACKT	IMBRUVICA 140 MG CAPSULE
HARVONI 45-200 MG TABLET	IMBRUVICA 140 MG TABLET
HARVONI 90-400 MG TABLET	IMBRUVICA 280 MG TABLET
HEMANGEOL 4.28 MG/ML ORAL SOLN	IMBRUVICA 420 MG TABLET
HEMLIBRA 105 MG/0.7 ML VIAL	IMBRUVICA 70 MG CAPSULE
HEMLIBRA 12 MG/0.4 ML VIAL	IMBRUVICA 70 MG/ML SUSPENSION
HEMLIBRA 150 MG/ML VIAL	IMCIVREE 10 MG/ML VIAL
HEMLIBRA 30 MG/ML VIAL	IMKELDI 80 MG/ML SOLUTION
HEMLIBRA 300 MG/2 ML VIAL	IMULDOSA 45 MG/0.5 ML SYRINGE
HEMLIBRA 60 MG/0.4 ML VIAL	IMULDOSA 90 MG/ML SYRINGE
HETLIOZ 20 MG CAPSULE	INBRIJA 42 MG INHALATION CAP
HETLIOZ LQ 4 MG/ML SUSPENSION	INCRELEX 40 MG/4 ML VIAL
HIZENTRA 1 GRAM/5 ML SYRINGE	INGREZZA 40 MG CAPSULE
HIZENTRA 1 GRAM/5 ML VIAL	INGREZZA 40 MG SPRINKLE CAP
HIZENTRA 10 GRAM/50 ML SYRINGE	INGREZZA 60 MG CAPSULE
HIZENTRA 10 GRAM/50 ML VIAL	INGREZZA 60 MG SPRINKLE CAP
HIZENTRA 2 GRAM/10 ML SYRINGE	INGREZZA 80 MG CAPSULE
HIZENTRA 2 GRAM/10 ML VIAL	INGREZZA 80 MG SPRINKLE CAP
HIZENTRA 4 GRAM/20 ML SYRINGE	INGREZZA INITIATION PK(TARDIV)
HIZENTRA 4 GRAM/20 ML VIAL	INLYTA 1 MG TABLET
HYCANTIN 0.25 MG CAPSULE	INLYTA 5 MG TABLET
HYCANTIN 1 MG CAPSULE	IQIRVO 80 MG TABLET
HYFTOR 0.2% GEL	IRESSA 250 MG TABLET
IBRANCE 100 MG CAPSULE	IVABRADINE HCL 5 MG TABLET
IBRANCE 100 MG TABLET	IVABRADINE HCL 7.5 MG TABLET
IBRANCE 125 MG CAPSULE	IVERMECTIN 3 MG TABLET
IBRANCE 125 MG TABLET	IVERMECTIN 6 MG TABLET
IBRANCE 75 MG CAPSULE	IWILFIN 192 MG TABLET
IBRANCE 75 MG TABLET	JAVYGTOR 100 MG POWDER PACKET
IBTROZI 200 MG CAPSULE	JAVYGTOR 100 MG TABLET
ICATIBANT 30 MG/3 ML SYRINGE	JAVYGTOR 500 MG POWDER PACKET
ICLUSIG 10 MG TABLET	JAYTHARI 18 MG TABLET
ICLUSIG 15 MG TABLET	JAYTHARI 30 MG TABLET
ICLUSIG 30 MG TABLET	JAYTHARI 36 MG TABLET
ICLUSIG 45 MG TABLET	JAYTHARI 6 MG TABLET
ICOSAPENT ETHYL 0.5 GM CAPSULE	JOENJA 70 MG TABLET

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

JUXTAPID 10 MG CAPSULE	LENVIMA 20 MG DAILY DOSE
JUXTAPID 20 MG CAPSULE	LENVIMA 24 MG DAILY DOSE
JUXTAPID 30 MG CAPSULE	LENVIMA 4 MG CAPSULE
JUXTAPID 5 MG CAPSULE	LENVIMA 8 MG DAILY DOSE
JYNARQUE 15 MG TABLET	LEQSELVI 8 MG TABLET
JYNARQUE 15 MG-15 MG TABLET	L-GLUTAMINE 5 GRAM POWDER PKT
JYNARQUE 30 MG TABLET	LIRAGLUTIDE 18 MG/3 ML PEN
JYNARQUE 30 MG-15 MG TABLET	LIRAGLUTIDE 5-PAK 18 MG/3 ML
JYNARQUE 45 MG-15 MG TABLET	LITFULO 50 MG CAPSULE
JYNARQUE 60 MG-30 MG TABLET	LIVDELZI 10 MG CAPSULE
JYNARQUE 90 MG-30 MG TABLET	LIVMARLI 10 MG TABLET
KALYDECO 13.4 MG GRANULES PKT	LIVMARLI 15 MG TABLET
KALYDECO 150 MG TABLET	LIVMARLI 19 MG/ML ORAL SOLN
KALYDECO 25 MG GRANULES PACKET	LIVMARLI 20 MG TABLET
KALYDECO 5.8 MG GRANULES PKT	LIVMARLI 30 MG TABLET
KALYDECO 50 MG GRANULES PACKET	LIVMARLI 9.5 MG/ML ORAL SOLN
KALYDECO 75 MG GRANULES PACKET	LIVTENCITY 200 MG TABLET
KERENDIA 10 MG TABLET	LOFEXIDINE 0.18 MG TABLET
KERENDIA 20 MG TABLET	LOMAIRA 8 MG TABLET
KERENDIA 40 MG TABLET	LONSURF 15 MG-6.14 MG TABLET
KESIMPTA 20 MG/0.4 ML PEN	LONSURF 20 MG-8.19 MG TABLET
KETOPROFEN 25 MG CAPSULE	LORBRENA 100 MG TABLET
KISQALI 200 MG DAILY DOSE	LORBRENA 25 MG TABLET
KISQALI 400 MG DAILY DOSE	LORZONE 375 MG TABLET
KISQALI 600 MG DAILY DOSE	LORZONE 750 MG TABLET
KITABIS PAK 300 MG/5 ML	LUMAKRAS 120 MG TABLET
KOSELUGO 10 MG CAPSULE	LUMAKRAS 240 MG TABLET
KOSELUGO 25 MG CAPSULE	LUMAKRAS 320 MG TABLET
LANREOTIDE 120 MG/0.5 ML SYRNG	LUPKYNIS 7.9 MG CAPSULE
LAPATINIB 250 MG TABLET	LYNPARZA 100 MG TABLET
LAZCLUZE 240 MG TABLET	LYNPARZA 150 MG TABLET
LAZCLUZE 80 MG TABLET	LYTGOBI 12 MG DOSE (3X 4MG TB)
LENALIDOMIDE 10 MG CAPSULE	LYTGOBI 16 MG DOSE (4X 4MG TB)
LENALIDOMIDE 15 MG CAPSULE	LYTGOBI 20 MG DOSE (5X 4MG TB)
LENALIDOMIDE 2.5 MG CAPSULE	MARINOL 10 MG CAPSULE
LENALIDOMIDE 20 MG CAPSULE	MARINOL 2.5 MG CAPSULE
LENALIDOMIDE 25 MG CAPSULE	MARINOL 5 MG CAPSULE
LENALIDOMIDE 5 MG CAPSULE	MAVENCLAD 10 MG X 10 TABLET PK
LENVIMA 10 MG DAILY DOSE	MAVENCLAD 10 MG X 4 TABLET PK
LENVIMA 12 MG DAILY DOSE	MAVENCLAD 10 MG X 5 TABLET PK
LENVIMA 14 MG DAILY DOSE	MAVENCLAD 10 MG X 6 TABLET PK
LENVIMA 18 MG DAILY DOSE	MAVENCLAD 10 MG X 7 TABLET PK

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

MAVENCLAD 10 MG X 8 TABLET PK	NITISINONE 10 MG CAPSULE
MAVENCLAD 10 MG X 9 TABLET PK	NITISINONE 2 MG CAPSULE
MAYZENT 0.25 MG TABLET	NITISINONE 20 MG CAPSULE
MAYZENT 0.25MG START-1MG MAINT	NITISINONE 5 MG CAPSULE
MAYZENT 0.25MG START-2MG MAINT	NITYR 10 MG TABLET
MAYZENT 1 MG TABLET	NITYR 2 MG TABLET
MAYZENT 2 MG TABLET	NITYR 5 MG TABLET
MEKINIST 0.05 MG/ML SOLUTION	NIVESTYM 300 MCG/0.5 ML SYRING
MEKINIST 0.5 MG TABLET	NIVESTYM 300 MCG/ML VIAL
MEKINIST 2 MG TABLET	NIVESTYM 480 MCG/0.8 ML SYRING
MEKTOVI 15 MG TABLET	NIVESTYM 480 MCG/1.6 ML VIAL
METFORMIN ER 1,000 MG GASTR-TB	NORGESIC 25-385-30 MG TABLET
METFORMIN ER 1,000 MG OSM-TAB	NORGESIC FORTE 50-770-60 MG TB
METFORMIN ER 500 MG GASTRC-TB	NOXAFIL 300 MG POWDERMIX SUSP
METFORMIN ER 500 MG OSMOTIC TB	NOXAFIL 40 MG/ML SUSPENSION
METYROSINE 250 MG CAPSULE	NUBEQA 300 MG TABLET
MIEBO 100% EYE DROP	NUCALA 100 MG/ML AUTO-INJECTOR
MIFEPRISTONE 300 MG TABLET	NUCALA 100 MG/ML SYRINGE
MIGLUSTAT 100 MG CAPSULE	NUCALA 40 MG/0.4 ML SYRINGE
MIRVASO 0.33% GEL PUMP	NUEDEXTA 20-10 MG CAPSULE
MODAFINIL 100 MG TABLET	NUPLAZID 10 MG TABLET
MODAFINIL 200 MG TABLET	NUPLAZID 34 MG CAPSULE
MODEYSO 125 MG CAPSULE	NURTEC ODT 75 MG TABLET
MYALEPT 11.3 MG (5 MG/ML) VIAL	OCTREOTIDE 1,000 MCG/5 ML VIAL
MYCAPSSA DR 20 MG CAPSULE	OCTREOTIDE 5,000 MCG/5 ML VIAL
MYFEMBREE 40 MG-1 MG-0.5 MG TB	OCTREOTIDE ACET 0.05 MG/ML VL
NALOCET 2.5-300 MG TABLET	OCTREOTIDE ACET 100 MCG/ML AMP
NAYZILAM 5 MG NASAL SPRAY	OCTREOTIDE ACET 100 MCG/ML SYR
NEMLUVIO 30 MG PEN	OCTREOTIDE ACET 100 MCG/ML VL
NERLYNX 40 MG TABLET	OCTREOTIDE ACET 50 MCG/ML AMP
NEXAVAR 200 MG TABLET	OCTREOTIDE ACET 50 MCG/ML SYR
NEXLETOL 180 MG TABLET	OCTREOTIDE ACET 50 MCG/ML VIAL
NEXLIZET 180-10 MG TABLET	OCTREOTIDE ACET 500 MCG/ML AMP
NIACIN 500 MG TABLET	OCTREOTIDE ACET 500 MCG/ML SYR
NIACOR 500 MG TABLET	OCTREOTIDE ACET 500 MCG/ML VL
NILOTINIB 150 MG CAPSULE	OCTREOTIDE ACET ER 10 MG IM VL
NILOTINIB 200 MG CAPSULE	OCTREOTIDE ACET ER 20 MG IM VL
NILOTINIB 50 MG CAPSULE	OCTREOTIDE ACET ER 30 MG IM VL
NILUTAMIDE 150 MG TABLET	ODACTRA 12 SQ-HDM SL TABLET
NINLARO 2.3 MG CAPSULE	ODOMZO 200 MG CAPSULE
NINLARO 3 MG CAPSULE	OFEV 100 MG CAPSULE
NINLARO 4 MG CAPSULE	OFEV 150 MG CAPSULE

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

OGSIVEO 100 MG TABLET	ORENITRAM ER 0.25 MG TABLET
OGSIVEO 150 MG TABLET	ORENITRAM ER 1 MG TABLET
OGSIVEO 50 MG TABLET	ORENITRAM ER 2.5 MG TABLET
OJEMDA 100 MG TAB (400MG DOSE)	ORENITRAM ER 5 MG TABLET
OJEMDA 100 MG TAB (500MG DOSE)	ORENITRAM MONTH 1 TITRATION KT
OJEMDA 100 MG TAB (600MG DOSE)	ORENITRAM MONTH 2 TITRATION KT
OJEMDA 25 MG/ML ORAL SUSP	ORENITRAM MONTH 3 TITRATION KT
OLPRUVA 2 GRAM DOSE ENVELOPE	ORFADIN 10 MG CAPSULE
OLPRUVA 2 GRAM DOSE KIT	ORFADIN 2 MG CAPSULE
OLPRUVA 3 GRAM DOSE ENVELOPE	ORFADIN 20 MG CAPSULE
OLPRUVA 3 GRAM DOSE KIT	ORFADIN 4 MG/ML SUSPENSION
OLPRUVA 4 GRAM DOSE ENVELOPE	ORFADIN 5 MG CAPSULE
OLPRUVA 4 GRAM DOSE KIT	ORIAHNN 300-1-0.5MG/300MG CAPS
OLPRUVA 5 GRAM DOSE ENVELOPE	ORKAMBI 100 MG-125 MG TABLET
OLPRUVA 5 GRAM DOSE KIT	ORKAMBI 100-125 MG GRANULE PKT
OLPRUVA 6 GRAM DOSE ENVELOPE	ORKAMBI 150-188 MG GRANULE PKT
OLPRUVA 6 GRAM DOSE KIT	ORKAMBI 200 MG-125 MG TABLET
OLPRUVA 6.67 GM DOSE ENVELOPE	ORKAMBI 75-94 MG GRANULE PKT
OLPRUVA 6.67 GRAM DOSE KIT	ORLADEYO 110 MG CAPSULE
OMEGA-3 ETHYL ESTERS 1 GM CAP	ORLADEYO 150 MG CAPSULE
OMEPRAZOLE-BICARB 20-1,100 CAP	ORLISTAT 120 MG CAPSULE
OMEPRAZOLE-BICARB 20-1,680 PKT	ORMALVI 50 MG TABLET
OMEPRAZOLE-BICARB 40-1,100 CAP	ORPHENADRIN-ASA-CAF 25-385-30MG
OMEPRAZOLE-BICARB 40-1,680 PKT	ORPHENGESIC FORTE 50-770-60 MG
OMNITROPE 10 MG/1.5 ML CRTG	ORSERDU 345 MG TABLET
OMNITROPE 5 MG/1.5 ML CRTG	ORSERDU 86 MG TABLET
OMNITROPE 5.8 MG VIAL	OTEZLA 10-20 MG STARTER 28 DAY
OMVOH 100 MG/ML PEN	OTEZLA 10-20-30MG START 28 DAY
OMVOH 100 MG/ML SYRINGE	OTEZLA 20 MG TABLET
OMVOH 200 MG DOSE - 2 PENS	OTEZLA 30 MG TABLET
OMVOH 200 MG DOSE - 2 SYRINGES	OTEZLA XR 75 MG TABLET
OMVOH 300 MG DOSE - 2 PENS	OTEZLA XR INITIATION PK 28 DAY
OMVOH 300 MG DOSE - 2 SYRINGES	OXERVATE 0.002% EYE DROP
ONGENTYS 25 MG CAPSULE	OXYCODON-ACETAMINOPHEN 7.5-300
ONGENTYS 50 MG CAPSULE	OXYCODONE-ACETAMINOPH 10-300/5
OPFOLDA 65 MG CAPSULE	OXYCODONE-ACETAMINOPHEN 10-300
OPSUMIT 10 MG TABLET	OXYCODONE-ACETAMINOPHEN 5-300
OPSYNVI 10-20 MG TABLET	OXYCODONE-ACETAMINOPHN 2.5-300
OPSYNVI 10-40 MG TABLET	PALYNZIQ 10 MG/0.5 ML SYRINGE
OPZELURA 1.5% CREAM	PALYNZIQ 2.5 MG/0.5 ML SYRINGE
ORALAIR 300 IR SUBLINGUAL TAB	PALYNZIQ 20 MG/ML SYRINGE
ORENITRAM ER 0.125 MG TABLET	PANRETIN 0.1% GEL

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

PAZOPANIB HCL 200 MG TABLET	PROLATE 5-300 MG TABLET
PEMAZYRE 13.5 MG TABLET	PROLATE 7.5-300 MG TABLET
PEMAZYRE 4.5 MG TABLET	PYQUVI 22.75 MG/ML ORAL SUSP
PEMAZYRE 9 MG TABLET	PYRIMETHAMINE 25 MG TABLET
PENICILLAMINE 250 MG CAPSULE	PYRUKYND 20 MG TABLET
PENICILLAMINE 250 MG TABLET	PYRUKYND 20-5 MG TAPER PACK
PHEBURANE PELLET	PYRUKYND 5 MG TABLET
PHENDIMETRAZINE 35 MG TABLET	PYRUKYND 5 MG TAPER PACK
PHENDIMETRAZINE ER 105 MG CAP	PYRUKYND 50 MG TABLET
PHENOXYBENZAMINE HCL 10 MG CAP	PYRUKYND 50-20 MG TAPER PACK
PHENTERMINE 15 MG CAPSULE	QSYMIA 11.25 MG-69 MG CAPSULE
PHENTERMINE 30 MG CAPSULE	QSYMIA 15 MG-92 MG CAPSULE
PHENTERMINE 37.5 MG CAPSULE	QSYMIA 3.75 MG-23 MG CAPSULE
PHENTERMINE 37.5 MG TABLET	QSYMIA 7.5 MG-46 MG CAPSULE
PHENTERMINE 8 MG TABLET	QULIPTA 10 MG TABLET
PHENTERMINE-TOPIR ER 11.25-69	QULIPTA 30 MG TABLET
PHENTERMINE-TOPIR ER 15-92 MG	QULIPTA 60 MG TABLET
PHENTERMINE-TOPIR ER 3.75-23MG	RA NIACIN 500 MG TABLET
PHENTERMINE-TOPIR ER 7.5-46 MG	RAGWITEK SUBLINGUAL TABLET
PIQRAY 200 MG DAILY DOSE PACK	REBIF 22 MCG/0.5 ML SYRINGE
PIQRAY 250 MG DAILY DOSE PACK	REBIF 44 MCG/0.5 ML SYRINGE
PIQRAY 300 MG DAILY DOSE PACK	REBIF REBIDOSE 22 MCG/0.5 ML
PIRFENIDONE 267 MG CAPSULE	REBIF REBIDOSE 44 MCG/0.5 ML
PIRFENIDONE 267 MG TABLET	REBIF REBIDOSE TITRATION PACK
PIRFENIDONE 801 MG TABLET	REBIF TITRATION PACK
PLAIN NIACIN 500 MG TABLET	REPATHA 140 MG/ML SURECLICK
PLEGRIDY 125 MCG/0.5 ML PEN	REPATHA 140 MG/ML SYRINGE
PLEGRIDY 125 MCG/0.5 ML SYRING	REPATHA 420 MG/3.5ML PUSHTRONX
PLEGRIDY PEN INJ STARTER PACK	RESTASIS 0.05% EYE EMULSION
PLEGRIDY SYRINGE STARTER PACK	RESTASIS MULTIDOSE 0.05% EYE
POMALYST 1 MG CAPSULE	RETEVMO 120 MG TABLET
POMALYST 2 MG CAPSULE	RETEVMO 160 MG TABLET
POMALYST 3 MG CAPSULE	RETEVMO 40 MG TABLET
POMALYST 4 MG CAPSULE	RETEVMO 80 MG TABLET
POSACONAZOLE 200 MG/5 ML SUSP	REVATIO 20 MG TABLET
POSACONAZOLE DR 100 MG TABLET	REVCovi 2.4 MG/1.5 ML VIAL
PREGABALIN ER 165 MG TABLET	REVUFORJ 110 MG TABLET
PREGABALIN ER 330 MG TABLET	REVUFORJ 160 MG TABLET
PREGABALIN ER 82.5 MG TABLET	REVUFORJ 25 MG TABLET
PRETOMANID 200 MG TABLET	REYVOW 100 MG TABLET
PRIVIGEN 10% VIAL	REYVOW 50 MG TABLET
PROLATE 10-300 MG TABLET	REZDIFFRA 100 MG TABLET

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

REZDIFFRA 60 MG TABLET	SILDENAFIL 20 MG TABLET
REZDIFFRA 80 MG TABLET	SIMLANDI(CF) 20 MG/0.2 ML SYRG
REZUROCK 200 MG TABLET	SIMLANDI(CF) 40 MG/0.4 ML SYRG
RHOFADE 1% CREAM	SIMLANDI(CF) AI 40 MG/0.4 ML
RILUZOLE 50 MG TABLET	SIMLANDI(CF) AI 80 MG/0.8 ML
RINVOQ ER 15 MG TABLET	SIMPONI 100 MG/ML PEN INJECTOR
RINVOQ ER 30 MG TABLET	SIMPONI 100 MG/ML SYRINGE
RINVOQ ER 45 MG TABLET	SIRTURO 100 MG TABLET
RINVOQ LQ 1 MG/ML SOLUTION	SIRTURO 20 MG TABLET
ROFLUMILAST 250 MCG TABLET	SKYCLARYS 50 MG CAPSULE
ROFLUMILAST 500 MCG TABLET	SKYRIZI 150 MG/ML PEN
ROMVIMZA 14 MG CAPSULE	SKYRIZI 150 MG/ML SYRINGE
ROMVIMZA 20 MG CAPSULE	SKYRIZI 180 MG/1.2 ML ON-BODY
ROMVIMZA 30 MG CAPSULE	SKYRIZI 360 MG/2.4 ML ON-BODY
ROZLYTREK 100 MG CAPSULE	SODIUM PHENYLBUTYRATE 500MG TB
ROZLYTREK 200 MG CAPSULE	SODIUM PHENYLBUTYRATE POWDER
ROZLYTREK 50 MG PELLET PACKET	SOHONOS 1 MG CAPSULE
RUCONEST 2,100 UNIT VIAL	SOHONOS 1.5 MG CAPSULE
RUFINAMIDE 200 MG TABLET	SOHONOS 10 MG CAPSULE
RUFINAMIDE 40 MG/ML SUSPENSION	SOHONOS 2.5 MG CAPSULE
RUFINAMIDE 400 MG TABLET	SOHONOS 5 MG CAPSULE
RYDAPT 25 MG CAPSULE	SOMATULINE DEPOT 120 MG/0.5 ML
RYPLAZIM 68.8 MG VIAL	SOMATULINE DEPOT 60 MG/0.2 ML
SAJAZIR 30 MG/3 ML SYRINGE	SOMATULINE DEPOT 90 MG/0.3 ML
SANDOSTATIN 0.05 MG/ML AMPUL	SORAFENIB 200 MG TABLET
SANDOSTATIN 0.1 MG/ML AMPUL	SOTYKTU 6 MG TABLET
SANDOSTATIN 0.5 MG/ML AMPUL	SPEVIGO 150 MG/ML SYRINGE
SAPROPTERIN 100 MG POWDER PKT	SPEVIGO 300 MG/2 ML SYRINGE
SAPROPTERIN 100 MG TABLET	STIVARGA 40 MG TABLET
SAPROPTERIN 500 MG POWDER PKT	STRENSIQ 18 MG/0.45 ML VIAL
SCSEMBLIX 100 MG TABLET	STRENSIQ 28 MG/0.7 ML VIAL
SCSEMBLIX 20 MG TABLET	STRENSIQ 40 MG/ML VIAL
SCSEMBLIX 40 MG TABLET	STRENSIQ 80 MG/0.8 ML VIAL
SELARSDI 45 MG/0.5 ML SYRINGE	STROMECTOL 3 MG TABLET
SELARSDI 90 MG/ML SYRINGE	SUNITINIB MALATE 12.5 MG CAP
SEROSTIM 4 MG VIAL	SUNITINIB MALATE 25 MG CAPSULE
SEROSTIM 5 MG VIAL	SUNITINIB MALATE 37.5 MG CAP
SEROSTIM 6 MG VIAL	SUNITINIB MALATE 50 MG CAPSULE
SIGNIFOR 0.3 MG/ML AMPULE	SUNLENCA 300 MG TABLET
SIGNIFOR 0.6 MG/ML AMPULE	SUNLENCA 4- 300 MG TABLET
SIGNIFOR 0.9 MG/ML AMPULE	SUNLENCA 5- 300 MG TABLET
SILDENAFIL 10 MG/ML ORAL SUSP	SUNOSI 150 MG TABLET

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

SUNOSI 75 MG TABLET	TAPERDEX 6 DAY 1.5 MG TABLET
SUTENT 12.5 MG CAPSULE	TAPERDEX 7 DAY 1.5 MG TAB PACK
SUTENT 25 MG CAPSULE	TARGRETIN 1% GEL
SUTENT 37.5 MG CAPSULE	TARPEYO DR 4 MG CAPSULE
SUTENT 50 MG CAPSULE	TASIMELTEON 20 MG CAPSULE
SYMDEKO 100/150 MG-150 MG TABS	TAVALISSE 100 MG TABLET
SYMDEKO 50/75 MG-75 MG TABLETS	TAVALISSE 150 MG TABLET
SYMPAZAN 10 MG FILM	TAVNEOS 10 MG CAPSULE
SYMPAZAN 20 MG FILM	TAZAROTENE 0.05% CREAM
SYMPAZAN 5 MG FILM	TAZAROTENE 0.05% GEL
SYNAREL 2 MG/ML NASAL SPRAY	TAZAROTENE 0.1% CREAM
SYNDROS 5 MG/ML SOLUTION	TAZAROTENE 0.1% GEL
SYPRINE 250 MG CAPSULE	TAZORAC 0.05% CREAM
TABRECTA 150 MG TABLET	TAZORAC 0.05% GEL
TABRECTA 200 MG TABLET	TAZORAC 0.1% CREAM
TADALAFIL 20 MG TABLET	TAZORAC 0.1% GEL
TAFINLAR 10 MG TABLET FOR SUSP	TAZVERIK 200 MG TABLET
TAFINLAR 50 MG CAPSULE	TEGLUTIK 5 MG/ML SUSPENSION
TAFINLAR 75 MG CAPSULE	TEMOZOLOMIDE 100 MG CAPSULE
TAGRISSE 40 MG TABLET	TEMOZOLOMIDE 140 MG CAPSULE
TAGRISSE 80 MG TABLET	TEMOZOLOMIDE 180 MG CAPSULE
TAKHZYRO 150 MG/ML SYRINGE	TEMOZOLOMIDE 20 MG CAPSULE
TAKHZYRO 300 MG/2 ML SYRINGE	TEMOZOLOMIDE 250 MG CAPSULE
TAKHZYRO 300 MG/2 ML VIAL	TEMOZOLOMIDE 5 MG CAPSULE
TALTZ 20 MG/0.25 ML SYRINGE	TERIFLUNOMIDE 14 MG TABLET
TALTZ 40 MG/0.5 ML SYRINGE	TERIFLUNOMIDE 7 MG TABLET
TALTZ 80 MG/ML AUTOINJ (2-PK)	TERIPARATIDE 560MCG/2.24ML PEN
TALTZ 80 MG/ML AUTOINJ (3-PK)	TETRABENAZINE 12.5 MG TABLET
TALTZ 80 MG/ML AUTOINJECTOR	TETRABENAZINE 25 MG TABLET
TALTZ 80 MG/ML SYRINGE	TEZSPIRE 210 MG/1.91 ML PEN
TALZENNA 0.1 MG CAPSULE	THALOMID 100 MG CAPSULE
TALZENNA 0.1 MG SOFTGEL	THALOMID 50 MG CAPSULE
TALZENNA 0.25 MG CAPSULE	TIBSOVO 250 MG TABLET
TALZENNA 0.25 MG SOFTGEL	TIGLUTIK 50 MG/10 ML SUSP
TALZENNA 0.35 MG SOFTGEL	TIOPRONIN 100 MG TABLET
TALZENNA 0.5 MG CAPSULE	TIOPRONIN DR 100 MG TABLET
TALZENNA 0.5 MG SOFTGEL	TIOPRONIN DR 300 MG TABLET
TALZENNA 0.75 MG CAPSULE	TIZANIDINE HCL 2 MG CAPSULE
TALZENNA 0.75 MG SOFTGEL	TIZANIDINE HCL 4 MG CAPSULE
TALZENNA 1 MG CAPSULE	TIZANIDINE HCL 6 MG CAPSULE
TALZENNA 1 MG SOFTGEL	TOBI PODHALER 28 MG INHALE CAP
TAPERDEX 12 DAY 1.5 MG TABLET	TOBRAMYCIN 300 MG/4 ML AMPULE

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

TOBRAMYCIN 300 MG/5 ML AMPULE	TYVASO DPI 32 MCG CARTRIDGE
TOBRAMYCIN PAK 300 MG/5 ML	TYVASO DPI 48 MCG CARTRIDGE
TOLVAPTAN 15 MG TABLET	TYVASO DPI 64 MCG CARTRIDGE
TOLVAPTAN 15 MG-15 MG TABLET	TYVASO INHALATION REFILL KIT
TOLVAPTAN 30 MG TABLET	TYVASO INHALATION STARTER KIT
TOLVAPTAN 30 MG-15 MG TABLET	TYVASO INSTITUTIONAL START KIT
TOLVAPTAN 45 MG-15 MG TABLET	UBRELVY 100 MG TABLET
TOLVAPTAN 60 MG-30 MG TABLET	UBRELVY 50 MG TABLET
TOLVAPTAN 90 MG-30 MG TABLET	UPTRAVI 1,000 MCG TABLET
TORPENZ 10 MG TABLET	UPTRAVI 1,200 MCG TABLET
TORPENZ 2.5 MG TABLET	UPTRAVI 1,400 MCG TABLET
TORPENZ 5 MG TABLET	UPTRAVI 1,600 MCG TABLET
TORPENZ 7.5 MG TABLET	UPTRAVI 200 MCG TABLET
TRACLEER 125 MG TABLET	UPTRAVI 200-800 TITRATION PACK
TRACLEER 32 MG TABLET FOR SUSP	UPTRAVI 400 MCG TABLET
TRACLEER 62.5 MG TABLET	UPTRAVI 600 MCG TABLET
TREMFYA 100 MG/ML ONE-PRESS	UPTRAVI 800 MCG TABLET
TREMFYA 100 MG/ML PEN	USTEKINUMAB-TTWE 45 MG SYRINGE
TREMFYA 100 MG/ML SYRINGE	USTEKINUMAB-TTWE 90 MG/ML SYR
TREMFYA 200 MG/2 ML PEN	VALCHLOR 0.016% GEL
TREMFYA 200 MG/2 ML SYRINGE	VALTOCO 10 MG NASAL SPRAY
TREMFYA INDCT 200MG/2ML X2 PEN	VALTOCO 15 MG NASAL SPRAY
TRIENTINE HCL 250 MG CAPSULE	VALTOCO 20 MG NASAL SPRAY
TRIKAFTA 100-50-75 MG/150 MG	VALTOCO 5 MG NASAL SPRAY
TRIKAFTA 100-50-75 MG/75MG PKT	VANRAFIA 0.75 MG TABLET
TRIKAFTA 50-25-37.5 MG/75 MG	VASCEPA 0.5 GM CAPSULE
TRIKAFTA 80-40-60MG/59.5MG PKT	VASCEPA 1 GM CAPSULE
TRUQAP 160 MG TABLET	VELSIPITY 2 MG TABLET
TRUQAP 200 MG TABLET	VENCLEXTA 10 MG TAB (10MG X 2)
TRYNGOLZA 80 MG/0.8 ML AUTOINJ	VENCLEXTA 10 MG TABLET
TRYPTYR 0.003% EYE DROP	VENCLEXTA 100 MG TABLET
TUKYSA 150 MG TABLET	VENCLEXTA 50 MG TABLET
TUKYSA 50 MG TABLET	VENCLEXTA STARTING PACK
TURALIO 125 MG CAPSULE	VENLAFAXINE HCL ER 150 MG TAB
TYENNE 162 MG/0.9 ML AUTOINJCT	VENLAFAXINE HCL ER 225 MG TAB
TYENNE 162 MG/0.9 ML SYRINGE	VENLAFAXINE HCL ER 37.5 MG TAB
TYMLOS 80 MCG DOSE PEN INJECTR	VENLAFAXINE HCL ER 75 MG TAB
TYRVAYA 0.03 MG NASAL SPRAY	VENTAVIS 10 MCG/1 ML SOLUTION
TYSABRI 300 MG/15 ML VIAL	VENXXIVA DR 100 MG TABLET
TYVASO 1.74 MG/2.9 ML SOLUTION	VENXXIVA DR 300 MG TABLET
TYVASO DPI 16 MCG CARTRIDGE	VERZENIO 100 MG TABLET
TYVASO DPI 16-32-48 MCG TITRAT	VERZENIO 150 MG TABLET

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

VERZENIO 200 MG TABLET	WAKIX 17.8 MG TABLET
VERZENIO 50 MG TABLET	WAKIX 4.45 MG TABLET
VEVYE 0.1% EYE DROP	WEGOVY 0.25 MG/0.5 ML PEN
VFEND 40 MG/ML SUSPENSION	WEGOVY 0.5 MG/0.5 ML PEN
VIGABATRIN 500 MG POWDER PACKET	WEGOVY 1 MG/0.5 ML PEN
VIGABATRIN 500 MG TABLET	WEGOVY 1.7 MG/0.75 ML PEN
VIGADRONE 500 MG POWDER PACKET	WEGOVY 2.4 MG/0.75 ML PEN
VIGADRONE 500 MG TABLET	WELIREG 40 MG TABLET
VIJOICE 125 MG TABLET	WINREVAIR 45 MG ONE-VIAL KIT
VIJOICE 250 MG DAILY DOSE PACK	WINREVAIR 45 MG TWO-VIAL KIT
VIJOICE 50 MG GRANULE PACKET	WINREVAIR 60 MG ONE-VIAL KIT
VIJOICE 50 MG TABLET	WINREVAIR 60 MG TWO-VIAL KIT
VISTOGARD 10 GRAM PACKET	XALKORI 150 MG PELLET
VITRAKVI 100 MG CAPSULE	XALKORI 20 MG PELLET
VITRAKVI 20 MG/ML SOLUTION	XALKORI 200 MG CAPSULE
VITRAKVI 25 MG CAPSULE	XALKORI 250 MG CAPSULE
VIVJOA 150 MG CAPSULE	XALKORI 50 MG PELLET
VIZIMPRO 15 MG TABLET	XELJANZ 1 MG/ML SOLUTION
VIZIMPRO 30 MG TABLET	XELJANZ 10 MG TABLET
VIZIMPRO 45 MG TABLET	XELJANZ 5 MG TABLET
VONJO 100 MG CAPSULE	XELJANZ XR 11 MG TABLET
VORANIGO 10 MG TABLET	XELJANZ XR 22 MG TABLET
VORANIGO 40 MG TABLET	XELODA 150 MG TABLET
VORICONAZOLE 200 MG TABLET	XELODA 500 MG TABLET
VORICONAZOLE 40 MG/ML SUSP	XENICAL 120 MG CAPSULE
VORICONAZOLE 50 MG TABLET	XERMELO 250 MG TABLET
VOSEVI 400-100-100 MG TABLET	XIIDRA 5% EYE DROPS
VOTRIENT 200 MG TABLET	XOLAIR 150 MG/1.2 ML POWDER VL
VOXZOGO 0.4 MG VIAL	XOLAIR 150 MG/ML AUTOINJECTOR
VOXZOGO 0.56 MG VIAL	XOLAIR 150 MG/ML SYRINGE
VOXZOGO 1.2 MG VIAL	XOLAIR 300 MG/2 ML AUTOINJECT
VOYDEYA 100 MG TABLET	XOLAIR 300 MG/2 ML SYRINGE
VOYDEYA 150 MG DOSE TABLET	XOLAIR 75 MG/0.5 ML AUTOINJECT
VUMERITY DR 231 MG CAPSULE	XOLAIR 75 MG/0.5 ML SYRINGE
VYJUVEK GEL	XOLREMDI 100 MG CAPSULE
VYKAT XR 150 MG TABLET	XOSPATA 40 MG TABLET
VYKAT XR 25 MG TABLET	XTANDI 40 MG CAPSULE
VYKAT XR 75 MG TABLET	XTANDI 40 MG TABLET
VYLEESI 1.75 MG/0.3 ML AUTOINJ	XTANDI 80 MG TABLET
VYNDAMAX 61 MG CAPSULE	YARGESA 100 MG CAPSULE
VYNDAQEL 20 MG CAPSULE	YESINTEK 45 MG/0.5 ML SYRINGE
VYVGART HYTRULO 1,000MG-10,000	YESINTEK 45 MG/0.5 ML VIAL

National Preferred Formulary - Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

YESINTEK 90 MG/ML SYRINGE
YONSA 125 MG TABLET
YORVIPATH 168 MCG/0.56 ML PEN
YORVIPATH 294 MCG/0.98 ML PEN
YORVIPATH 420 MCG/1.4 ML PEN
YUTREPIA 106 MCG INHAL CAP
YUTREPIA 26.5 MCG INHAL CAP
YUTREPIA 53 MCG INHAL CAP
YUTREPIA 79.5 MCG INHAL CAP
ZCORT 7 DAY 1.5 MG TABLET
ZELBORAF 240 MG TABLET
ZELVYSIA 100 MG POWDER PACKET
ZELVYSIA 500 MG POWDER PACKET
ZEPATIER 50-100 MG TABLET
ZEPBOUND 10 MG/0.5 ML PEN
ZEPBOUND 12.5 MG/0.5 ML PEN
ZEPBOUND 15 MG/0.5 ML PEN
ZEPBOUND 2.5 MG/0.5 ML PEN
ZEPBOUND 5 MG/0.5 ML PEN
ZEPBOUND 7.5 MG/0.5 ML PEN
ZEPOSIA 0.92 MG CAPSULE
ZEPOSIA STARTER KIT (28-DAY)
ZEPOSIA STARTER PACK (7-DAY)
ZOKINVY 50 MG CAPSULE
ZOKINVY 75 MG CAPSULE
ZOLINZA 100 MG CAPSULE
ZONTIVITY 2.08 MG TABLET
ZOVIRAX 5% CREAM
ZTALMY 50 MG/ML SUSPENSION
ZYDELIG 100 MG TABLET
ZYDELIG 150 MG TABLET
ZYKADIA 150 MG TABLET
ZYMFENTRA 120 MG/ML PEN KIT
ZYMFENTRA 120 MG/ML SYRINGE KT

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

ABSORICA 10 MG CAPSULE	AMCINONIDE 0.1% OINTMENT
ABSORICA 20 MG CAPSULE	AMZEEQ 4% FOAM
ABSORICA 25 MG CAPSULE	ANALPRAM HC 2.5%-1% LOTION
ABSORICA 30 MG CAPSULE	ANALPRAM-HC CREAM
ABSORICA 35 MG CAPSULE	ANALPRAM HC 2.5%-1% CREAM
ABSORICA 40 MG CAPSULE	ANAPROX DS 550 MG TABLET
ACETAMINOP-CODEINE 120-12 MG/5	ANNOVERA VAGINAL RING
ACETAMINOPHEN-CODEINE SOLUTION	ARICEPT 10 MG TABLET
ACETAMINOPHEN-COD #2 TABLET	ARICEPT 23 MG TABLET
ACETAMINOPHEN/COD #2 TABLET	ARICEPT 5 MG TABLET
ACETAMINOPHEN-COD #3 TABLET	ARTHROTEC 50 MG-200 MCG TAB
ACETAMINOPHEN/COD #3 TABLET	ARTHROTEC 50 EC TABLET
ACETAMIN-CODEIN 300-30 MG/12.5	ARTHROTEC 75 MG-200 MCG TAB
ACETAMINOPHEN-COD #4 TABLET	ARTHROTEC 75 TABLET EC
ACETAMINOPHEN/COD #4 TABLET	ARTHROTEC EC 75 TABLET
ACETAMN-CAF-DIHYDRCODEIN 320.5	ARTHROTEC 75 TABLET
ACTONEL 150 MG TABLET	ASCOMP WITH CODEINE CAPSULE
ACTONEL 35 MG TABLET	ATELVIA DR 35 MG TABLET
ACULAR 0.5% EYE DROPS	AUVELITY ER 45-105 MG TABLET
ACULAR LS 0.4% OPHTH SOL	AVANAFIL 100 MG TABLET
ACZONE 5% GEL	AVANAFIL 200 MG TABLET
ACZONE 7.5% GEL PUMP	AVANAFIL 50 MG TABLET
ADAPALENE 0.1% LOTION	AVAR CLEANSER
ADAPALENE 0.1% SWAB	AVAR LS CLEANSER
ADLARITY 10MG/DAY WEEKLY PATCH	AVAR-E EMOLLIENT CREAM
ADLARITY 5 MG/DAY WEEKLY PATCH	AVIDOXY DK KIT
ADVAIR HFA 115-21 MCG INHALER	AVSOLA 100 MG VIAL
ADVAIR HFA 230-21 MCG INHALER	AZELEX 20% CREAM
ADVAIR HFA 45-21 MCG INHALER	AZILECT 0.5 MG TABLET
ADZENYS XR-ODT 12.5 MG TABLET	AZILECT 1 MG TABLET
ADZENYS XR-ODT 15.7 MG TABLET	AZSTARYS 26.1 MG-5.2 MG CAP
ADZENYS XR-ODT 18.8 MG TABLET	AZSTARYS 39.2 MG-7.8 MG CAP
ADZENYS XR-ODT 3.1 MG TABLET	AZSTARYS 52.3 MG-10.4 MG CAP
ADZENYS XR-ODT 6.3 MG TABLET	BELBUCA 150 MCG FILM
ADZENYS XR-ODT 9.4 MG TABLET	BELBUCA 300 MCG FILM
AKLIEF 0.005% CREAM	BELBUCA 450 MCG FILM
ALA-SCALP 2% LOTION	BELBUCA 600 MCG FILM
ALMOTRIPTAN MALATE 12.5 MG TAB	BELBUCA 75 MCG FILM
ALMOTRIPTAN MALATE 6.25 MG TAB	BELBUCA 750 MCG FILM
ALTABAX 1% OINTMENT	BELBUCA 900 MCG FILM
AMCINONIDE 0.1% CREAM	BELLADONNA-OPIMUM 16.2-30 SUPP

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

BELLADONNA-OPIMUM 16.2-60 SUPP	BUPRENORPHINE 7.5 MCG/HR PATCH
BELSOMRA 10 MG TABLET	BUTALB-ACETAMIN-CAF-COD 50-300
BELSOMRA 15 MG TABLET	BUTALB-ACETAMIN-CAF-COD 50-325
BELSOMRA 20 MG TABLET	BUTALB-CAFF-ACETAMINOPH-CODEIN
BELSOMRA 5 MG TABLET	BUTALBITAL-CAFF-APAP-COD CP
BENZAMYCIN GEL	BUTALBITAL-CAFF-APAP-COD CAP
BENZEPRO 7% CREAMY WASH	BUTORPHANOL 10 MG/ML SPRAY
BEPOTASTINE 1.5% EYE DROP	CADUET 10 MG-10 MG TABLET
BESER 0.05% LOTION	CADUET 10 MG-20 MG TABLET
BETAMETHASONE VALER 0.12% FOAM	CADUET 10 MG-40 MG TABLET
BETAPACE 120 MG TABLET	CADUET 10 MG-80 MG TABLET
BETAPACE 160 MG TABLET	CADUET 5 MG-10 MG TABLET
BETAPACE 240 MG TABLET	CADUET 5 MG-20 MG TABLET
BETAPACE 80 MG TABLET	CADUET 5 MG-40 MG TABLET
BETAPACE AF 120 MG TABLET	CADUET 5 MG-80 MG TABLET
BETAPACE AF 160 MG TABLET	CALCIPOTRIENE-BETAMETH DP OINT
BETAPACE AF 80 MG TABLET	CAPEX SHAMPOO
BEYAZ 28 TABLET	CARBINOXAMINE MALEATE 6 MG TAB
BIMATOPROST 0.03% EYE DROPS	CARBZAH 4 MG/5 ML SOLUTION
BINOSTO 70 MG TABLET EFF	CARDURA 1 MG TABLET
BINOSTO 70 MG EFFERVESCENT TAB	CARDURA 2 MG TABLET
BP 10-1 WASH	CARDURA 4 MG TABLET
BREO ELLIPTA 100-25 MCG INHALR	CARDURA 8 MG TABLET
BREO ELLIPTA 200-25 MCG INHALR	CARDURA XL 4 MG TABLET
BREO ELLIPTA 50-25 MCG INHALER	CARDURA XL 8 MG TABLET
BREXAFEMME 150 MG TABLET	CARISOPRODOL CPD-CODEINE TAB
BREYNA 160-4.5 MCG INHALER	CARISOPRODOL-ASPIRIN-CODEIN TB
BREYNA 80-4.5 MCG INHALER	CENTANY 2% OINTMENT
BRIVIACT 10 MG TABLET	CENTANY AT 2% OINTMENT KIT
BRIVIACT 10 MG/ML ORAL SOLN	CICLODAN 8% KIT
BRIVIACT 100 MG TABLET	CINACALCET HCL 30 MG TABLET
BRIVIACT 25 MG TABLET	CINACALCET HCL 60 MG TABLET
BRIVIACT 50 MG TABLET	CINACALCET HCL 90 MG TABLET
BRIVIACT 75 MG TABLET	CLEOCIN T 1% LOTION
BRYHALI 0.01% LOTION	CLINDACIN 1% FOAM
BUDESONIDE-FORMOTEROL 160-4.5	CLINDACIN ETZ KIT
BUDESONIDE-FORMOTEROL 80-4.5	CLINDACIN PAC KIT
BUPRENORPHINE 10 MCG/HR PATCH	CLINDAMYCIN PHOSPHATE 1% FOAM
BUPRENORPHINE 15 MCG/HR PATCH	CLINDAMYCIN PHOSPHATE 1% GEL
BUPRENORPHINE 20 MCG/HR PATCH	CLOBETASOL 0.05% TOPICAL LOTN
BUPRENORPHINE 5 MCG/HR PATCH	CLOBETASOL 0.05% SHAMPOO

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

CLOBETASOL PROP 0.05% FOAM	DEPAKOTE 500 MG TABLET EC
CLOBETASOL PROP 0.05% SPRAY	DEPAKOTE ER 250 MG TABLET
CLOBETASOL EMULSION 0.05% FOAM	DEPAKOTE ER 500 MG TABLET
CLOBETASOL EMOLLNT 0.05% FOAM	DEPAKOTE ER 500 MG TAB SA
CLOBEX 0.05% SHAMPOO	DEPAKOTE DR 125 MG SPRINKLE CP
CLOBEX 0.05% SPRAY	DERMACINRX LIDOCAN 5% PATCH
CLODAN 0.05% SHAMPOO	DERMA-SMOOTH-ES BODY OIL
CLODAN 0.05% KIT	DERMA-SMOOTH-ES SCALP OIL
CODEINE SULFATE 15 MG TABLET	DESONIDE 0.05% LOTION
CODEINE SULFATE 30 MG TABLET	DESONIDE 0.05% GEL
CODEINE SULFATE 60 MG TABLET	DESOXIMETASONE 0.05% CREAM
ASA-BUTALB-CAFF-COD #3 CAPSULE	DESOXIMETASONE 0.05% GEL
COLCHICINE 0.6 MG CAPSULE	DESOXIMETASONE 0.05% OINTMENT
COLESTID 1 GM TABLET	DESOXIMETASONE 0.25% CREAM
COLESTID GRANULES	DESOXIMETASONE 0.25% OINTMENT
CORDRAN 4 MCG/SQ CM TAPE LARGE	DESOXIMETASONE 0.25% SPRAY
COREG CR 10 MG CAPSULE	DESVENLAFAXINE ER 100 MG TAB
COREG CR 20 MG CAPSULE	DESVENLAFAXINE ER 50 MG TAB
COREG CR 40 MG CAPSULE	DESVENLAFAXINE SUCCNT ER 100MG
COREG CR 80 MG CAPSULE	DESVENLAFAXINE SUCCNT ER 25 MG
COTEMPLA XR-ODT 17.3 MG TABLET	DESVENLAFAXINE SUCCNT ER 50 MG
COTEMPLA XR-ODT 25.9 MG TABLET	DEXEDRINE SPANSULE 10 MG
COTEMPLA XR-ODT 8.6 MG TABLET	DEXEDRINE SPANSULE 15 MG CAP
CREXONT ER 35 MG-140 MG CAP	DICLOFENAC 2% SOLUTION PUMP
CREXONT ER 52.5 MG-210 MG CAP	DICLOFENAC POTASSIUM 25 MG CAP
CREXONT ER 70 MG-280 MG CAP	DICLOFENAC POT 25 MG TABLET
CREXONT ER 87.5 MG-350 MG CAP	DICLOFENAC POT 50 MG POWDR PKT
CYANOCOBALAMIN 500 MCG SPRAY	DIFFERIN 0.1% LOTION
DAYTRANA 10 MG/9 HR PATCH	DIFFERIN 0.1% CREAM
DAYTRANA 15 MG/9 HR PATCH	DIFFERIN 0.3% GEL PUMP
DAYTRANA 20 MG/9 HOUR PATCH	DIHYDROERGOTAMINE 4 MG/ML SPRY
DAYTRANA 30 MG/9 HOUR PATCH	DILAUDID 5 MG/5 ML ORAL LIQUID
DAYVIGO 10 MG TABLET	DILAUDID 2 MG TABLET
DAYVIGO 5 MG TABLET	DILAUDID 4 MG TABLET
DEFLAZACORT 22.75 MG/ML SUSP	DILAUDID 8 MG TABLET
DEPAKOTE DR 125 MG TABLET	DIPROLENE 0.05% OINTMENT
DEPAKOTE EC 125 MG TABLET	DONEPEZIL HCL 23 MG TABLET
DEPAKOTE DR 250 MG TABLET	DOXEPIN HCL 3 MG TABLET
DEPAKOTE EC 250 MG TABLET	DOXEPIN HCL 6 MG TABLET
DEPAKOTE 250 MG TABLET EC	DOXERCALCIFEROL 0.5 MCG CAP
DEPAKOTE DR 500 MG TABLET	DOXERCALCIFEROL 1 MCG CAPSULE

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

DOXERCALCIFEROL 2.5 MCG CAP	EPIDUO FORTE 0.3-2.5% GEL PUMP
DOXYCYCLINE HYC DR 100 MG TAB	EPIFOAM FOAM
DOXYCYCLINE HYCLATE 150 MG TAB	ERMEZA 150 MCG/5 ML SOLUTION
DOXYCYCLINE HYC DR 150 MG TAB	ESCITALOPRAM OXALATE 10MG/10ML
DOXYCYCLINE HYC DR 200 MG TAB	ESCITALOPRAM OXALATE 5 MG/5 ML
DOXYCYCLINE 50 MG TABLET	ESCITALOPRAM 10 MG/10 ML CUP
DOXYCYCLINE HYC DR 50 MG TAB	ESOMEPRAZOLE DR 10 MG PACKET
DOXYCYCLINE HYCLATE 75 MG TAB	ESOMEPRAZOLE DR 2.5 MG PACKET
DOXYCYCLINE HYC DR 75 MG TAB	ESOMEPRAZOLE DR 20 MG PACKET
DOXYCYCLINE MONO 150 MG CAP	ESOMEPRAZOLE DR 40 MG PACKET
DOXYCYCLINE IR-DR 40 MG CAP	ESOMEPRAZOLE DR 5 MG PACKET
DOXYCYCLINE MONO 75 MG CAPSULE	EUCRISA 2% OINTMENT
DULERA 100 MCG-5 MCG INHALER	EVOCLIN 1% FOAM
DULERA 200 MCG-5 MCG INHALER	EXELON 13.3 MG/24HR PATCH
DULERA 50 MCG-5 MCG INHALER	EXELON 4.6 MG/24HR PATCH
DULOXETINE HCL DR 40 MG CAP	EXELON 9.5 MG/24HR PATCH
DUOBRII 0.01%-0.045% LOTION	EXENATIDE 10 MCG DOSE PEN INJ
DUTASTERIDE 0.5 MG CAPSULE	EXENATIDE 5 MCG DOSE PEN INJ
DUTASTERIDE-TAMSULOSIN 0.5-0.4	EXTINA 2% FOAM
EC-NAPROSYN EC 375 MG TABLET	FARXIGA 10 MG TABLET
NAPROSYN 375 MG TABLET EC	FARXIGA 5 MG TABLET
NAPROSYN EC 500 MG TABLET	FEBUXOSTAT 40 MG TABLET
NAPROSYN 500 MG TABLET EC	FEBUXOSTAT 80 MG TABLET
EC-NAPROSYN EC 500 MG TABLET	FENOFIBRATE 40 MG TABLET
EDECIN 25 MG TABLET	FENOFIBRATE 130 MG CAPSULE
EDLUAR 10 MG SL TABLET	FENOPROFEN 400 MG CAPSULE
EDLUAR 5 MG SL TABLET	FENOPROFEN CALCIUM 400 MG CAP
ELEPSIA XR 1,000 MG TABLET	FENOPROFEN 600 MG TABLET
ELEPSIA XR 1,500 MG TABLET	FENTANYL 100 MCG/HR PATCH
ELTROMBOPAG 12.5 MG SUSP PKT	FENTANYL 12 MCG/HR PATCH
ELTROMBOPAG 12.5 MG TABLET	FENTANYL 25 MCG/HR PATCH
ELTROMBOPAG 25 MG SUSP PACKET	FENTANYL 37.5 MCG/HR PATCH
ELTROMBOPAG 25 MG TABLET	FENTANYL CIT 400 MCG BUCCAL TB
ELTROMBOPAG 50 MG TABLET	FENTANYL 50 MCG/HR PATCH
ELTROMBOPAG 75 MG TABLET	FENTANYL CIT 600 MCG BUCCAL TB
ENDOCET 10-325 MG TABLET	FENTANYL 62.5 MCG/HR PATCH
ENDOCET 2.5-325 MG TABLET	FENTANYL 75 MCG/HR PATCH
ENDOCET 5-325 MG TABLET	FENTANYL CIT 800 MCG BUCCAL TB
ENDOCET 5-325 TABLET	FENTANYL 87.5 MCG/HR PATCH
ENDOCET 7.5-325 MG TABLET	FETZIMA ER 120 MG CAPSULE
ENSTILAR 0.005%-0.064% FOAM	FETZIMA 20-40 MG TITRATION PAK

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

FETZIMA ER 20 MG CAPSULE	GRALISE ER 300 MG TABLET
FETZIMA ER 40 MG CAPSULE	GRALISE ER 450 MG TABLET
FETZIMA ER 80 MG CAPSULE	GRALISE ER 600 MG TABLET
FIBRICOR 105 MG TABLET	GRALISE ER 750 MG TABLET
FINACEA 15% FOAM	GRALISE ER 900 MG TABLET
FLECTOR 1.3% PATCH	HALOBETASOL PROP 0.05% FOAM
FLOLIPID 20 MG/5 ML ORAL SUSP	HALOG 0.1% CREAM
FLOLIPID 40 MG/5 ML ORAL SUSP	HERCESSI 150 MG VIAL
FLUNISOLIDE 0.025% SPRAY	HERCESSI 420 MG VIAL
FLUOCINONIDE 0.1% CREAM	HORIZANT ER 300 MG TABLET
FLUOXETINE HCL 10 MG TABLET	HORIZANT ER 600 MG TABLET
FLUOXETINE HCL 20 MG TABLET	HYDROCODONE-ACETAMIN 10-300 MG
FLUOXETINE HCL 60 MG TABLET	HYDROCODON-ACETAMINOPHN 10-300
FLUOXETINE DR 90 MG CAPSULE	HYDROCODONE-ACETAMIN 10-300/15
FLUTICASONE-SALMETEROL 100-50	HYDROCODONE-ACETAMIN 10-325 MG
FLUTICASONE-SALMETEROL 250-50	HYDROCODON-ACETAMINOPHN 10-325
FLUTICASONE-SALMETEROL 500-50	HYDROCODONE-APAP 10-325 TABLET
FLUTICASONE PROP 0.05% LOTION	HYDROCODONE-ACETAMIN 10-325/15
FLUVOXAMINE ER 100 MG CAPSULE	HYDROCODONE-IBUPROFEN 10-200
FLUVOXAMINE ER 150 MG CAPSULE	HYDROCODONE-ACETAMIN 2.5-325
FML LIQUIFILM 0.1% EYE DROP	HYDROCODONE-ACETAMIN 5-300 MG
FOSAMAX 70 MG TABLET	HYDROCODON-ACETAMINOPHEN 5-300
FOSAMAX PLUS D 70 MG-2,800 IU	HYDROCODON-ACETAMINOPHEN 5-325
FOSAMAX PLUS D 70 MG-2800 UNIT	HYDROCODONE-ACETAMIN 5-325 MG
FOSAMAX PLUS D 70 MG-5600 UNIT	HYDROCODONE-APAP 5-325 TABLET
FROVA 2.5 MG TABLET	HYDROCODONE-IBUPROFEN 5-200 MG
FROVATRIPTAN SUCC 2.5 MG TAB	HYDROCODONE-ACETAMIN 7.5-300
FULPHILA 6 MG/0.6 ML SYRINGE	HYDROCODON-ACETAMINOPH 7.5-300
GABAPENTIN ER 300 MG TABLET	HYDROCODONE-ACETAMIN 7.5-325
GABAPENTIN ER 450 MG TABLET	HYDROCODON-ACETAMINOPH 7.5-325
GABAPENTIN ER 600 MG TABLET	HYDROCODONE-APAP 7.5-325 TAB
GABAPENTIN ER 750 MG TABLET	HYDROCODONE-ACETAMIN 5-217/10
GABAPENTIN ER 900 MG TABLET	HYDROCODONE-ACETAMN 7.5-325/15
GANIRELIX ACET 250 MCG/0.5 ML	HYDROCODONE-ACETAMIN 2.5-108/5
GLYXAMBI 10 MG-5 MG TABLET	HYDROCODONE-IBUPROFEN 7.5-200
GLYXAMBI 25 MG-5 MG TABLET	HYDROCODONE BT-IBUPROFEN TB
GONAL-F 1,050 UNITS VIAL	HYDROCODONE BT-IBUPROFEN TAB
GONAL-F 450 UNITS VIAL	HYDROCODONE ER 10 MG CAPSULE
GONAL-F RFF REDI-JECT 300 UNIT	HYDROCODONE ER 100 MG TABLET
GONAL-F RFF REDI-JECT 450 UNIT	HYDROCODONE ER 120 MG TABLET
GONAL-F RFF REDI-JECT 900 UNIT	HYDROCODONE ER 15 MG CAPSULE

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

HYDROCODONE ER 20 MG CAPSULE
HYDROCODONE ER 20 MG TABLET
HYDROCODONE ER 30 MG CAPSULE
HYDROCODONE ER 30 MG TABLET
HYDROCODONE ER 40 MG CAPSULE
HYDROCODONE ER 40 MG TABLET
HYDROCODONE ER 50 MG CAPSULE
HYDROCODONE ER 60 MG TABLET
HYDROCODONE ER 80 MG TABLET
HYDROCORTISONE BUTYR 0.1% LOTN
HYDROCORTISONE BUTYR 0.1% OINT
HYDROCORTISONE 0.1% SOLN
HYDROCORTISONE BUTYR 0.1% SOLN
HYDROCORT-PRAMOXINE 2.5-1% CRM
HYDROMORPHONE 1 MG/ML SOLUTION
HYDROMORPHONE 5 MG/5 ML SOLN
HYDROMORPHONE 5 MG/5 ML CUP
HYDROMORPHONE 2 MG TABLET
HYDROMORPHONE 3 MG SUPPOS
HYDROMORPHONE 4 MG TABLET
HYDROMORPHONE 8 MG TABLET
HYDROMORPHONE HCL 8 MG TAB
HYDROMORPHONE HCL ER 12 MG TAB
HYDROMORPHONE HCL ER 16 MG TAB
HYDROMORPHONE HCL ER 32 MG TAB
HYDROMORPHONE HCL ER 8 MG TAB
HYSINGLA ER 100 MG TABLET
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
INDOMETHACIN 25 MG/5 ML SUSP
INFLIXIMAB 100 MG VIAL
INVELTYS 1% EYE DROP
JAKAFI 10 MG TABLET
JAKAFI 15 MG TABLET
JAKAFI 20 MG TABLET
JAKAFI 25 MG TABLET
JAKAFI 5 MG TABLET
JALYN 0.5-0.4 MG CAPSULE

JANUMET 50-1,000 MG TABLET
JANUMET 50-500 MG TABLET
JANUMET XR 100-1,000 MG TABLET
JANUMET XR 50-1,000 MG TABLET
JANUMET XR 50-500 MG TABLET
JANUVIA 100 MG TABLET
JANUVIA 25 MG TABLET
JANUVIA 50 MG TABLET
JARDIANCE 10 MG TABLET
JARDIANCE 25 MG TABLET
JORNAY PM 100 MG CAPSULE
JORNAY PM 20 MG CAPSULE
JORNAY PM 40 MG CAPSULE
JORNAY PM 60 MG CAPSULE
JORNAY PM 80 MG CAPSULE
JUBLIA 10% TOPICAL SOLUTION
KENALOG 0.147 MG/GRAM SPRAY
KETOCONAZOLE 2% FOAM
KETODAN 2% FOAM
KETODAN 2% FOAM KIT
KETOPROFEN ER 200 MG CAPSULE
KETOPROFEN 200 MG CAPSULE SA
KLARON 10% LOTION
LAMICTAL XR START KIT (BLUE)
LAMICTAL XR START KIT (GREEN)
LAMICTAL XR START KIT (ORANGE)
LANSOPRAZOLE DR 15 MG ODT
LANSOPRAZOLE ODT 15 MG TABLET
GS LANSOPRAZOLE DR 15 MG ODT
CVS LANSOPRAZOLE DR 15 MG ODT
LANSOPRAZOLE DR 30 MG ODT
LANSOPRAZOLE ODT 30 MG TABLET
LASIX 20 MG TABLET
LASIX 40 MG TABLET
LASIX 80 MG TABLET
LATANOPROST 0.005% EYE DROPS
LESCOL XL 80 MG TABLET
LESCOL XL 80 MG TABLET SA
LEUPROLIDE 2WK 14 MG/2.8 ML KT
LEUPROLIDE 1 MG/0.2 ML KIT
LEUPROLIDE 2WK 1 MG/0.2 ML KT

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

LEUPROLIDE 2WK 1 MG/0.2 ML KIT
LEVETIRACETAM 250 MG TAB SUSP
LEXETTE 0.05% FOAM
LICART 1.3% PATCH
LIDOCAINE 5% PATCH
LIDOCAN III 5% PATCH
LIDOCAN IV 5% PATCH
LIDOCAN V 5% PATCH
LIRAGLUTIDE 18 MG/3 ML PEN
LIRAGLUTIDE 2-PAK 18 MG/3 ML
LIRAGLUTIDE 3-PAK 18 MG/3 ML
LISDEXAMFETAMINE 10 MG TB CHEW
LISDEXAMFETAMINE 20 MG TB CHEW
LISDEXAMFETAMINE 30 MG TB CHEW
LISDEXAMFETAMINE 40 MG TB CHEW
LISDEXAMFETAMINE 50 MG TB CHEW
LISDEXAMFETAMINE 60 MG TB CHEW
LODINE 400 MG TABLET
LOFENA 25 MG TABLET
LOPRESSOR 100 MG TABLET
LOPRESSOR 50 MG TABLET
LOTEMAX 0.5% OPHTHALMIC GEL
LOTEMAX 0.5% EYE OINTMENT
LOTEMAX SM 0.38% OPHTH GEL
LOTEPREDNOL ETABONATE 0.2% DRP
LOTEPREDNOL ETABONATE 0.5% DRP
LOTEPREDNOL 0.5% OPHTHALMC GEL
LUMRYZ ER 4.5 GM PACKET
LUMRYZ ER 6 GM PACKET
LUMRYZ ER 7.5 GM PACKET
LUMRYZ ER 9 GM PACKET
LUMRYZ 4.5-6-7.5 GM STARTER PK
MELOXICAM 10 MG CAPSULE
MELOXICAM 5 MG CAPSULE
MEMANTINE-DONEPEZIL ER 14-10MG
MEMANTINE-DONEPEZIL ER 21-10MG
MEMANTINE-DONEPEZIL ER 28-10MG
MEPERIDINE 50 MG TABLET
MEPERIDINE 50 MG/5 ML SOLUTION
MERCAPTOPURINE 20 MG/ML SUSPEN
METADATE CD 10 MG CAPSULE

METADATE CD 20 MG CAPSULE
METADATE CD 30 MG CAPSULE
METADATE CD 40 MG CAPSULE
METADATE CD 50 MG CAPSULE
METADATE CD 60 MG CAPSULE
METFORMIN HCL 500 MG/5 ML SOLN
METFORMIN HCL 500 MG/5 ML CUP
METFORMIN HCL 850 MG/8.5ML CUP
METFORMIN HCL 750 MG TABLET
METHYLPHENIDATE 10 MG/9HR PTCH
METHYLPHENIDATE 15 MG/9HR PTCH
METHYLPHENIDATE 20 MG/9HR PTCH
METHYLPHENIDATE 30 MG/9HR PTCH
METHYLPHENIDATE ER 10 MG CAP
METHYLPHENIDATE ER 15 MG CAP
METHYLPHENIDATE ER 20 MG CAP
METHYLPHENIDATE ER 30 MG CAP
METHYLPHENIDATE ER 40 MG CAP
METHYLPHENIDATE ER 50 MG CAP
METHYLPHENIDATE ER 60 MG CAP
METROCREAM 0.75% CREAM
METROGEL TOPICAL 1% GEL
MIGRANAL NASAL SPRAY
MIGRANAL 4 MG/ML NASAL SPRAY
MINOCYCLINE HCL 100 MG TABLET
MINOCYCLINE HCL 50 MG TABLET
MINOCYCLINE HCL 75 MG TABLET
MINOCYCLINE ER 105 MG TABLET
MINOCYCLINE ER 115 MG TABLET
MINOCYCLINE ER 135 MG TABLET
MINOCYCLINE ER 45 MG TABLET
MINOCYCLINE ER 55 MG TABLET
MINOCYCLINE ER 65 MG TABLET
MINOCYCLINE ER 80 MG TABLET
MINOCYCLINE ER 90 MG TABLET
MITIGARE 0.6 MG CAPSULE
MOMETASONE FUROATE 50 MCG SPRY
MONDOXYNE NL 75 MG CAPSULE
MORGIDOX 1X50 MG KIT
MORGIDOX 1X100 MG KIT
MORGIDOX 2X100 MG KIT

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

MORPHINE SULF 10 MG SUPPOS
MORPHINE SULF 10 MG/5 ML SOLN
MORPHINE SULF 20 MG/10 ML SOLN
MORPHINE SULF 10 MG/5 ML CUP
MORPHINE SULFATE IR 15 MG TAB
MORPHINE SULF 20 MG SUPPOS
MORPHINE SULF 20 MG/5 ML SOLN
MORPHINE SULFATE IR 30 MG TAB
MORPHINE SULF 30 MG SUPPOS
MORPHINE SULF 5 MG SUPPOS
MORPHINE SULF 100 MG/5 ML SOLN
MORPHINE SULF 100 MG/5 ML CONC
MORPHINE SULFATE 20 MG/ML SOLN
MORPHINE SULFATE ER 10 MG CAP
MORPHINE SULFATE ER 100 MG CAP
MORPHINE SULF 100 MG TAB SA
MORPHINE SULF ER 100 MG TABLET
MORPHINE SULF CR 100 MG TABLET
MORPHINE SULF ER 100 MG TAB
MORPHINE SULFATE ER 120 MG CAP
MORPHINE SULF 15 MG TAB SA
MORPHINE SULF ER 15 MG TABLET
MORPHINE SULF CR 15 MG TABLET
MORPHINE SULFATE ER 20 MG CAP
MORPHINE SULF 200 MG TAB SA
MORPHINE SULF ER 200 MG TABLET
MORPHINE SULF CR 200 MG TABLET
MORPHINE SULF ER 200 MG TAB
MORPHINE SULFATE ER 30 MG CAP
MORPHINE SULF 30 MG TAB SA
MORPHINE SULF ER 30 MG TABLET
MORPHINE SULF CR 30 MG TABLET
MORPHINE SULFATE 30 MG TAB SA
MORPHINE SULFATE ER 45 MG CAP
MORPHINE SULFATE ER 50 MG CAP
MORPHINE SULFATE ER 60 MG CAP
MORPHINE SULF 60 MG TAB SA
MORPHINE SULF ER 60 MG TABLET
MORPHINE SULF CR 60 MG TABLET
MORPHINE SULF ER 60 MG TAB
MORPHINE SULFATE ER 75 MG CAP

MORPHINE SULFATE ER 80 MG CAP
MORPHINE SULFATE ER 90 MG CAP
MOUNJARO 10 MG/0.5 ML PEN
MOUNJARO 12.5 MG/0.5 ML PEN
MOUNJARO 15 MG/0.5 ML PEN
MOUNJARO 2.5 MG/0.5 ML PEN
MOUNJARO 5 MG/0.5 ML PEN
MOUNJARO 7.5 MG/0.5 ML PEN
MS CONTIN 15 MG TABLET
MS CONTIN ER 15 MG TABLET
MS CONTIN 15 MG TABLET SA
MS CONTIN CR 30 MG TABLET
MS CONTIN ER 30 MG TABLET
MS CONTIN 60 MG TABLET
MS CONTIN ER 60 MG TABLET
MUPIROCIN 2% CREAM
MYDAYIS ER 12.5 MG CAPSULE
MYDAYIS ER 25 MG CAPSULE
MYDAYIS ER 37.5 MG CAPSULE
MYDAYIS ER 50 MG CAPSULE
NALFON 600 MG TABLET
NAMZARIC 14 MG-10 MG CAPSULE
NAMZARIC 21 MG-10 MG CAPSULE
NAMZARIC 28 MG-10 MG CAPSULE
NAMZARIC 7 MG-10 MG CAPSULE
NAPRELAN CR 375 MG TABLET
NAPRELAN CR 500 MG TABLET
NAPRELAN CR 750 MG TABLET
NAPROSYN 125 MG/5 ML SUSPEN
NAPROSYN 500 MG TABLET
NAPROXEN 125 MG/5 ML SUSPEN
NAPROXEN DR 500 MG TABLET
NAPROXEN EC 500 MG TABLET
NAPROXEN 500 MG TABLET EC
NAPROXEN SOD ER 375 MG TABLET
NAPROXEN SOD CR 375 MG TABLET
NAPROXEN SOD ER 500 MG TABLET
NAPROXEN SOD CR 500 MG TABLET
NAPROXEN SOD ER 750 MG TABLET
NAPROXEN SOD CR 750 MG TABLET
NASCOBAL 500 MCG NASAL SPRAY

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

NEUAC 1.2-5% KIT	OXYCODONE-ACETAMINOPHN 7.5-325
NGENLA PEN 24 MG/1.2 ML	OXYCODON-ACETAMINOPHEN 7.5-325
NGENLA PEN 60 MG/1.2 ML	OXYCODONE-APAP 7.5-325 MG TAB
NUCORT LOTION	OXYCONTIN 10 MG TABLET
OGIVRI 150 MG VIAL	OXYCONTIN ER 10 MG TABLET
OGIVRI 420 MG VIAL	OXYCONTIN ER 15 MG TABLET
OLUX 0.05% FOAM	OXYCONTIN 20 MG TABLET
ONEXTON GEL PUMP	OXYCONTIN ER 20 MG TABLET
ORGOVYX 120 MG TABLET	OXYCONTIN 30 MG TABLET
ORILISSA 150 MG TABLET	OXYCONTIN ER 30 MG TABLET
ORILISSA 200 MG TABLET	OXYCONTIN 40 MG TABLET
OXYCODONE HCL (IR) 10 MG TAB	OXYCONTIN ER 40 MG TABLET
OXYCODONE HCL 10 MG TABLET	OXYCONTIN 60 MG TABLET
OXYCODONE HCL IR 10 MG TABLET	OXYCONTIN ER 60 MG TABLET
OXYCODONE HCL (IR) 15 MG TAB	OXYCONTIN 80 MG TABLET
OXYCODONE HCL 15 MG TABLET	OXYCONTIN ER 80 MG TABLET
OXYCODONE HCL (IR) 20 MG TAB	OXYMORPHONE HCL 10 MG TABLET
OXYCODONE HCL 20 MG TABLET	OXYMORPHONE HCL 5 MG TABLET
OXYCODONE HCL 100 MG/5 ML CONC	OXYMORPHONE HCL ER 10 MG TAB
OXYCODONE HCL 20 MG/ML SOLN	OXYMORPHONE HCL ER 15 MG TAB
OXYCODONE CONC 20 MG/ML SOLN	OXYMORPHONE HCL ER 20 MG TAB
OXYCODONE HCL (IR) 30 MG TAB	OXYMORPHONE HCL ER 30 MG TAB
OXYCODONE HCL 30 MG TABLET	OXYMORPHONE HCL ER 40 MG TAB
OXYCODONE HCL 5 MG CAPSULE	OXYMORPHONE HCL ER 5 MG TABLET
OXYCODONE HCL (IR) 5 MG CAP	OXYMORPHONE HCL ER 7.5 MG TAB
OXYCODONE HCL IR 5 MG CAPSULE	OXYTROL 3.9 MG/24HR PATCH
OXYCODONE 5 MG CAPSULE	OZEMPIC 0.25-0.5 MG/DOSE PEN
OXYCODONE HCL (IR) 5 MG TABLET	OZEMPIC 1 MG/DOSE (4 MG/3 ML)
OXYCODONE HCL 5 MG TABLET	OZEMPIC 2 MG/DOSE (8 MG/3 ML)
OXYCODONE HCL IR 5 MG TABLET	PACNEX 7% WASH
OXYCODONE 5 MG TABLET	PANDEL 0.1% CREAM
OXYCODONE HCL 5 MG/5 ML SOLN	PANTOPRAZOLE DR 40 MG SUSP PKT
OXYCODONE HCL 5 MG/5 ML CUP	PARICALCITOL 1 MCG CAPSULE
OXYCODONE HCL 5 MG/5 ML SOL	PARICALCITOL 2 MCG CAPSULE
OXYCODONE-ACETAMINOPHEN 10-325	PARICALCITOL 4 MCG CAPSULE
OXYCODONE-APAP 10-325 MG TAB	PAROXETINE HCL 10 MG/5 ML SUSP
OXYCODON-ACETAMINOPHEN 2.5-325	PAROXETINE ER 12.5 MG TABLET
OXYCODONE-ACETAMINOPHN 2.5-325	PAROXETINE CR 12.5 MG TABLET
OXYCODONE-ACETAMINOPHEN 5-325	PAROXETINE ER 25 MG TABLET
OXYCODONE-APAP 5/325 TABLET	PAROXETINE CR 25 MG TABLET
OXYCODONE-APAP 5-325 MG TAB	PAROXETINE ER 37.5 MG TABLET

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

PAROXETINE CR 37.5 MG TABLET	QELBREE ER 100 MG CAPSULE
PAXIL 10 MG TABLET	QELBREE ER 150 MG CAPSULE
PAXIL 20 MG TABLET	QELBREE ER 200 MG CAPSULE
PAXIL 30 MG TABLET	QUESTRAN POWDER
PAXIL 40 MG TABLET	QUESTRAN PACKET
PAXIL CR 12.5 MG TABLET	QUESTRAN LIGHT POWDER
PAXIL CR 25 MG TABLET	QUVIVIQ 25 MG TABLET
PAXIL CR 37.5 MG TABLET	QUVIVIQ 50 MG TABLET
PENTAZOCINE-NALOXONE TABLET	RAYALDEE ER 30 MCG CAP (SOFT)
PIMECROLIMUS 1% CREAM	RAYALDEE ER 30 MCG CAP (HARD)
PLEXION 9.8-4.8% LOTION	RELISTOR 12 MG/0.6 ML VIAL
PLEXION 9.8-4.8% CLEANSER	RELISTOR 12 MG/0.6 ML SYRINGE
PLEXION 9.8-4.8% CREAM	RELISTOR 8 MG/0.4 ML SYRINGE
PLEXION 9.8-4.8% CLNSING CLOTH	RETACRIT 10,000 UNIT/ML VIAL
PODOFILOX 0.5% GEL	RETACRIT 2,000 UNIT/ML VIAL
PR BENZOYL PEROXIDE 7% WASH	RETACRIT 20,000 UNIT/2 ML VIAL
PRAMOSONE 1% LOTION	RETACRIT 20,000 UNIT/ML VIAL
PRAMOSONE 1% CREAM	RETACRIT 3,000 UNIT/ML VIAL
PRAMOSONE 1%-1% CREAM	RETACRIT 4,000 UNIT/ML VIAL
PRAMOSONE 1% OINTMENT	RETACRIT 40,000 UNIT/ML VIAL
PRAMOSONE 1%-1% OINTMENT	RIBAVIRIN 200 MG CAPSULE
PRAMOSONE 2.5%-1% OINTMENT	RIBAVIRIN 200 MG TABLET
PRAMOSONE 2.5% LOTION	RIOMET 500 MG/5 ML SOLUTION
PRAMOSONE 2.5%-1% LOTION	ROCALTROL 1 MCG/ML ORAL SOLN
PRESTALIA 14 MG-10 MG TABLET	ROCKLATAN 0.02%-0.005% EYE DRP
PRESTALIA 3.5 MG-2.5 MG TABLET	ROSADAN 0.75% CREAM KIT
PRESTALIA 7 MG-5 MG TABLET	ROSADAN 0.75% GEL KIT
PROCARDIA XL 30 MG TABLET	ROSULA 10%-4.5% WASH
PROCARDIA XL 60 MG TABLET	ROSZET 10-10 MG TABLET
PROCARDIA XL 90 MG TABLET	ROSZET 20-10 MG TABLET
PROCRIT 10,000 UNITS/ML VIAL	ROSZET 40-10 MG TABLET
PROCRIT 2,000 UNITS/ML VIAL	ROSZET 5-10 MG TABLET
PROCRIT 20,000 UNIT/2 ML VIAL	ROXICODONE 15 MG TABLET
PROCRIT 20,000 UNITS/ML VIAL	ROXICODONE 30 MG TABLET
PROCRIT 3,000 UNITS/ML VIAL	RYALTRIS 665-25 MCG SPRAY
PROCRIT 4,000 UNITS/ML VIAL	RYBELSUS 14 MG TABLET
PROCRIT 40,000 UNITS/ML VIAL	RYBELSUS 3 MG TABLET
PROCTOCORT 1% CREAM	RYBELSUS 7 MG TABLET
PROCTOCORT 30 MG SUPPOSITORY	RYTARY ER 23.75 MG-95 MG CAP
PROSCAR 5 MG TABLET	RYTARY ER 36.25 MG-145 MG CAP
PURIXAN 20 MG/ML ORAL SUSP	RYTARY ER 48.75 MG-195 MG CAP

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

RYTARY ER 61.25 MG-245 MG CAP	SULFACETAMIDE-SULFUR 10-5% LOT
RYVENT 6 MG TABLET	SOD SULFACETAMIDE-SULFUR LOTN
SAVELLA 100 MG TABLET	SODIUM SULF-SULFUR LOTION
SAVELLA TITRATION PACK	SOD SULFACET-SULFUR 10-5% LOTN
SAVELLA 12.5 MG TABLET	SOD.SULFACET/SULFUR LOTION
SAVELLA 25 MG TABLET	SULFACETAMIDE-SULFUR 10-5% SUS
SAVELLA 50 MG TABLET	SOD SULFACETAMIDE-SULFUR SUSP
SAXAGLIPTIN HCL 2.5 MG TABLET	SOD.SULFACET-SULFUR SUSP
SAXAGLIPTN-METFORM ER 2.5-1000	SULFACETAMIDE-SULFUR 8-4% SUSP
SAXAGLIPTIN HCL 5 MG TABLET	SULFACETAMIDE-SULFUR 9-4% WASH
SAXAGLIPTIN-METFORMN ER 5-1000	SOD SULFACE-SULFUR 9-4.5% WASH
SAXAGLIPTIN-METFORMIN ER 5-500	SULFACLEANSE 8-4 SUSPENSION
SCALACORT DK 2% KIT	SUMADAN 9%-4.5% WASH
SERTRALINE 150 MG CAPSULE	SUMADAN KIT
SERTRALINE 200 MG CAPSULE	SUMADAN XLT KIT
SEYSARA 100 MG TABLET	SUMAXIN CLEANSING PADS
SEYSARA 150 MG TABLET	SUMAXIN 9%-4% WASH
SEYSARA 60 MG TABLET	SUMAXIN CP KIT
SILDENAFIL 100 MG TABLET	SUMAXIN TS TOPICAL SUSPENSION
SILDENAFIL 25 MG TABLET	SYNALAR 0.01% SOLUTION
SILDENAFIL 50 MG TABLET	SYNALAR 0.025% CREAM
SILENOR 3 MG TABLET	SYNALAR 0.025% OINTMENT
SILENOR 6 MG TABLET	SYNALAR 0.025% CREAM KIT
SODIUM OXYBATE 0.5 G/ML SOLN	SYNALAR 0.025% OINTMENT KIT
SOOLANTRA 1% CREAM	SYNALAR TS 0.01% KIT
SPRITAM 1,000 MG TABLET	SYNJARDY 12.5-1,000 MG TABLET
SPRITAM 250 MG TABLET	SYNJARDY 12.5-500 MG TABLET
SPRITAM 500 MG TABLET	SYNJARDY 5-1,000 MG TABLET
SPRITAM 750 MG TABLET	SYNJARDY 5-500 MG TABLET
SSS 10-5 FOAM	SYNJARDY XR 10-1,000 MG TABLET
STENDRA 100 MG TABLET	SYNJARDY XR 12.5-1,000 MG TAB
STENDRA 200 MG TABLET	SYNJARDY XR 25-1,000 MG TABLET
STENDRA 50 MG TABLET	SYNJARDY XR 5-1,000 MG TABLET
SULAR ER 17 MG TABLET	TACROLIMUS 0.03% OINTMENT
SULAR ER 34 MG TABLET	TACROLIMUS 0.1% OINTMENT
SULAR ER 8.5 MG TABLET	TADALAFIL 10 MG TABLET
SOD SULFAC-SULFUR 9.8-4.8% LOT	TADALAFIL 2.5 MG TABLET
SOD SULFACE-SULF 9.8-4.8% CLSR	TADALAFIL 20 MG TABLET
SOD SULFAC-SULFUR 9.8-4.8% CRM	TADALAFIL 5 MG TABLET
SOD SULFACET-SULFUR 10-2% CLSR	TARGADOX 50 MG TABLET
SULFACETAMIDE-SULFUR 10-2% CRM	TAVABOROLE 5% TOPICAL SOLUTION

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

TENORETIC 100 TABLET
TENORETIC 50 TABLET
TENORMIN 100 MG TABLET
TENORMIN 25 MG TABLET
TENORMIN 50 MG TABLET
TETRACYCLINE 250 MG TABLET
TETRACYCLINE 500 MG TABLET
TEXACORT 2.5% SOLUTION
TOLECTIN 600 MG TABLET
TOLMETIN SODIUM 400 MG CAP
TOLMETIN SODIUM 600 MG TAB
TOPICORT 0.05% CREAM
TOPICORT 0.05% GEL
TOPICORT 0.05% OINTMENT
TOPICORT 0.25% CREAM
TOPICORT 0.25% OINTMENT
TOPIRAMATE ER 100 MG CAPSULE
TOPIRAMATE ER 100MG SPRINK CAP
TOPIRAMATE ER 150 MG CAPSULE
TOPIRAMATE ER 150MG SPRINK CAP
TOPIRAMATE ER 200 MG CAPSULE
TOPIRAMATE ER 200MG SPRINK CAP
TOPIRAMATE ER 25 MG CAPSULE
TOPIRAMATE ER 25MG SPRINKL CAP
TOPIRAMATE ER 50 MG CAPSULE
TOPIRAMATE ER 50MG SPRINKL CAP
TOSYMRA 10 MG NASAL SPRAY
TOVET EMOLLIENT 0.05% FOAM
TRAMADOL HCL 100 MG TABLET
TRAMADOL-ACETAMINOPHN 37.5-325
TRAMADOL HCL 50 MG TABLET
TRAMADOL HCL ER 100 MG TABLET
TRAMADOL ER 100 MG TABLET
TRAMADOL HCL ER 200 MG TABLET
TRAMADOL ER 200 MG TABLET
TRAMADOL HCL ER 300 MG TABLET
TRAMADOL ER 300 MG TABLET
TREZIX 320.5-30-16 MG CAPSULE
TRIAMCINOLONE 0.05% OINTMENT
TRIAMCINOLONE 0.05% OINT
TRIAMCINOLONE 0.147 MG/G SPRAY

TRIDERM 0.5% CREAM
TRIJARDY XR 10-5-1,000 MG TAB
TRIJARDY XR 12.5-2.5-1,000 MG
TRIJARDY XR 25-5-1,000 MG TAB
TRIJARDY XR 5-2.5-1,000 MG TAB
TRINTELLIX 10 MG TABLET
TRINTELLIX 20 MG TABLET
TRINTELLIX 5 MG TABLET
TROKENDI XR 100 MG CAPSULE
TROKENDI XR 200 MG CAPSULE
TROKENDI XR 25 MG CAPSULE
TROKENDI XR 50 MG CAPSULE
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
VANOXIDE-HC LOTION
VARDENAFIL HCL 10 MG ODT
VARDENAFIL HCL 10 MG TABLET
VARDENAFIL HCL 2.5 MG TABLET
VARDENAFIL HCL 20 MG TABLET
VARDENAFIL HCL 5 MG TABLET
VERAPAMIL ER PM 100 MG CAPSULE
VERAPAMIL ER PM 200 MG CAPSULE
VERAPAMIL ER PM 300 MG CAPSULE
VILAZODONE HCL 10 MG TABLET
VILAZODONE HCL 20 MG TABLET
VILAZODONE HCL 40 MG TABLET
VOQUEZNA 10 MG TABLET
VOQUEZNA 20 MG TABLET
VTAMA 1% CREAM
WIXELA 100-50 INHUB
WIXELA 250-50 INHUB
WIXELA 500-50 INHUB
WYNZORA 0.005%-0.064% CREAM
XEPI 1% CREAM
XHANCE 93 MCG NASAL SPRAY
XIGDUO XR 10 MG-1,000 MG TAB
XIGDUO XR 10 MG-500 MG TABLET
XIGDUO XR 2.5 MG-1,000 MG TAB
XIGDUO XR 5 MG-1,000 MG TABLET

National Preferred Formulary – Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. This list may not apply to all plans or benefits. List subject to change.

XIGDUO XR 5 MG-500 MG TABLET
XYWAV 0.5 GM/ML ORAL SOLUTION
YAZ 28 TABLET
ZEMBRACE SYMTOUCH 3 MG/0.5 ML
ZEMPLAR 1 MCG CAPSULE
ZEMPLAR 2 MCG CAPSULE
ZIANA GEL
ZIEXTENZO 6 MG/0.6 ML SYRINGE
ZOLMITRIPTAN 2.5 MG NASAL SPRY
ZOLMITRIPTAN 2.5MG NASAL SPRAY
ZOLMITRIPTAN 5 MG NASAL SPRAY
ZOMIG 2.5 MG NASAL SPRAY
ZOMIG 5 MG NASAL SPRAY
ZONALON 5% CREAM
ZORYVE 0.15% CREAM
ZORYVE 0.3% CREAM
ZORYVE 0.3% FOAM
ZTLIDO 1.8% TOPICAL SYSTEM
ZYPITAMAG 2 MG TABLET
ZYPITAMAG 4 MG TABLET

Please submit completed PA and Step Therapy forms to:
Pharmacy Help Desk
Mail to: 165 Court Street, Rochester, NY 14647
Fax: 1 (800) 956-2397
Phone: 1 (800) 499-1275