

2025 SCAN Health Plan Formulary

List of Covered Drugs or “Drug List”

Formulario de SCAN Health Plan

Lista de medicamentos cubiertos o “Lista de medicamentos”



This formulary was updated on 10/1/2024. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-855-827-7226 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.

Este formulario se actualizó el 10/1/2024. Para obtener información más reciente o si tiene pregunta, comuníquese con Servicios para Miembros de SCAN Health Plan al 1-855-827-7226 (los usuarios de TTY deben llamar al 711), de 8:00 a. m. a 8:00 p. m., los 7 días de la semana, desde el 1 de octubre hasta el 31 de marzo. Desde el 1 de abril hasta el 30 de septiembre, el horario es de 8:00 a. m. a 8:00 p. m., de lunes a viernes (los mensajes recibidos en días festivos y fuera del horario de atención se responderán en el plazo de un día hábil). También puede visitar www.scanhealthplan.com.

SCAN Health Plan

2025 Formulary (List of Covered Drugs or “Drug List”)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

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Note to existing members: This Formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this Drug List (Formulary) refers to “we,” “us,” or “our,” it means SCAN Health Plan. When it refers to “plan” or “our plan,” it means SCAN Classic (HMO), SCAN Compass (HMO), SCAN MyChoice (HMO), SCAN Balance (HMO C-SNP), and SCAN Strive (HMO C-SNP).

This document includes a Drug List (formulary) for our plan which is current as of October 2024. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2026, and from time to time during the year. You will receive notice when necessary.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Express Scripts PharmacySM is our Preferred mail order pharmacy. While you can fill your prescription medications at any of our network mail order pharmacies, you may pay less at the Preferred mail order pharmacy. Typically, you should expect to receive your prescription drugs within 14 days from the time that Express Scripts mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact SCAN Health Plan’s Member Services. For your mail order prescriptions, you have the option to sign up for an automatic refill program by contacting Express Scripts Pharmacy at 1-866-553-4125, 24 hours a day, 7 days a week. TTY users should call 711. You may opt out of automatic deliveries at any time.

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

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What is the SCAN Health Plan formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by SCAN Health Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. SCAN Health Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a SCAN Health Plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the formulary change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: <https://www.scanhealthplan.com/scan-resources/plan-materials/formulary>.

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

- **Immediate substitutions of certain new versions of brand-name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand-name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

We can make these immediate changes only if we are adding a new generic version of a brand-name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand-name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled "How do I request an exception to the SCAN Health Plan's Formulary?"

Some of these drug types may be new to you. For more information, see the section below titled "What are original biological products and how are they related to biosimilars?"

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand-name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand-name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the SCAN Health Plan’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of October 2024. To get updated information about the drugs covered by SCAN Health Plan, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 24. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the list that begins on page number 24. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 63. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

SCAN Health Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs work just as well as and usually cost less than brand-name drugs. There are generic drug substitutes available for many brand-name drugs. Generic drugs usually can be substituted for the brand-name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand-name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5 Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** SCAN Health Plan requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from SCAN Health Plan before you fill your prescriptions. If you don't get approval, SCAN Health Plan may not cover the drug.
- **Quantity Limits:** For certain drugs, SCAN Health Plan limits the amount of the drug that SCAN Health Plan will cover. For example, SCAN Health Plan provides 30 tablets per prescription for rimegepant. This may be in addition to a standard one-month or three-month supply.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 24. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explain our prior authorization restriction. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask SCAN Health Plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the SCAN Health Plan’s formulary?” on page 6 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that SCAN Health Plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by SCAN Health Plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by SCAN Health Plan.
- You can ask SCAN Health Plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the SCAN Health Plan's Formulary?

You can ask SCAN Health Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, SCAN Health Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
- You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

Generally, SCAN Health Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or, formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary

Date of last formulary update 10/1/2024

exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary 30-day supply if you are not in a long-term care facility or a 31-day supply if you are a resident of a long-term care facility. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication if you are not in a long-term care facility or a 31-day supply of medication if you are a resident of a long-term care facility. If coverage is not approved, after your first 30-day supply if you are not in a long-term care facility or a 31-day supply if you are a resident of a long-term care facility, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you are a current member transitioning to a different level of care, you may be prescribed medications not on our formulary or your ability to get your drugs may be limited. In these instances, you need to talk with your doctor about the appropriate alternative therapies available on our formulary. If there are no appropriate alternative therapies on our formulary, you or your doctor can request an exception and ask the plan to cover the drug or remove restrictions from the drug. While you are talking with your doctor to determine the course of action, you are eligible to receive a 30-day transition supply of the drug if you are moving from a long-term care facility or a hospital stay to home or a 31-day transition supply of the drug if you are moving from home or a hospital stay to a long-term care facility.

For more information

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

If you have questions about SCAN Health Plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit <http://www.medicare.gov>.

The charts below list what you will pay as your share of the costs for covered prescription drugs at our network pharmacies when you are in the Initial Coverage Stage.

Preferred cost-sharing is lower cost-sharing that may be available to you for certain covered Part D drugs at certain network pharmacies. For more information, please visit our online searchable Pharmacy Directory at www.scanhealthplan.com or call Member Services. Our contact information appears on the front and back cover pages.

Please refer to your Evidence of Coverage for information about the costs at Long-Term Care (LTC) pharmacies and out-of-network pharmacies.

If you receive "Extra Help," your share of the cost for covered prescription drugs may vary based on the level of "Extra Help" you receive. For more information about your drug costs, look at the "LIS Rider".

You won't pay more than \$35 for a one-month supply and no more than \$105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Most adult Part D vaccines are covered by our plan at no cost to you, even if you haven't paid your deductible.

SCAN Classic (HMO): Clark and Nye Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		\$0	\$0	\$5	\$10
2	Generic		\$0	\$0	\$9	\$18
3	Preferred Brand	Insulin	\$35	\$85	\$35	\$85
		Other Drugs	\$42	\$126	\$47	\$141
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

SCAN Compass (HMO): Clark and Nye Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		\$0	\$0	\$5	\$10
2	Generic		\$0	\$0	\$9	\$18
3	Preferred Brand	Insulin	\$35	\$85	\$35	\$85
		Other Drugs	\$42	\$126	\$47	\$141
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

SCAN MyChoice (HMO): Clark County

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		\$0	\$0	\$0	\$0
2	Generic		\$0	\$0	\$0	\$0
3	Preferred Brand	Insulin	\$35	\$85	\$35	\$85
		Other Drugs	\$42	\$126	\$43	\$129
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

SCAN Balance (HMO C-SNP): Clark and Nye Counties

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		\$0	\$0	\$5	\$10
2	Generic		\$0	\$0	\$9	\$18
3	Preferred Brand	Insulin	\$0	\$0	\$0	\$0
		Other Drugs	\$42	\$126	\$47	\$141
4	Non-Preferred Drug		50%	50%	50%	50%
5	Specialty Tier		33%	N/A	33%	N/A

SCAN Strive (HMO C-SNP): Clark County

Drug Tier	Tier Name		Retail & Mail Order			
			Preferred		Standard	
			30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic		\$0	\$0	\$0	\$0
2	Generic		\$0	\$0	\$0	\$0
3	Preferred Brand	Insulin	\$35	\$105	\$35	\$105
		Other Drugs	24%	24%	25%	25%
4	Non-Preferred Drug		45%	45%	45%	45%
5	Specialty Tier		25%	N/A	25%	N/A

SCAN Health Plan's Formulary

The formulary that begins on page 24 provides coverage information about the drugs covered by SCAN Health Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 63.

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

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

- The symbol [PA] indicates that prior authorization applies.
- The symbol [B vs D] indicates that this drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- The symbol [QL] indicates that quantities dispensed are limited. To see the quantity limit amount for the formulary drugs with quantity limits, turn to the page 58.
- The symbol [LD] indicates that limited distribution applies. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 1-855-827-7226 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.
- The symbol [EDS] indicates that this drug is available for an extended day supply (e.g., greater than a 30-day supply) at mail-order and many retail pharmacies.

SCAN Health Plan

Formulario de 2025 (Lista de medicamentos cubiertos o “Lista de medicamentos”)

LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

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Este formulario se actualizó el 10/01/2024. Para obtener información más reciente o si tiene preguntas, comuníquese con Servicios para Miembros de SCAN Health Plan, al 1-855-827-7226 (los usuarios de TTY deben llamar al 711), de 8:00 a.m. a 8:00 p.m., los 7 días de la semana, del 1 de octubre al 31 de marzo. Del 1 de abril al 30 de septiembre, el horario es de 8:00 a.m. a 8:00 p.m., de lunes a viernes (los mensajes recibidos en días feriados y fuera del horario de atención se responderán en el plazo de un día hábil). También puede visitar www.scanhealthplan.com.

Nota para miembros actuales: Este Formulario ha cambiado desde el año pasado. Revise este documento para asegurarse que todavía se incluyen los medicamentos que toma.

Cuando esta Lista de medicamentos (Formulario) hace referencia a “nosotros” o “nuestro”, quiere decir SCAN Health Plan. Cuando se hace referencia al “plan” o a “nuestro plan”, quiere decir SCAN Classic (HMO), SCAN Compass (HMO), SCAN MyChoice (HMO), SCAN Balance (HMO C-SNP) y SCAN Strive (HMO C-SNP).

Este documento incluye una Lista de medicamentos (formulario) para nuestro plan que está vigente desde octubre de 2024. Para obtener una Lista de medicamentos (formulario) actualizada, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la Lista de medicamentos (formulario), aparece en las páginas de portada y contraportada.

Por lo general, debe acudir a las farmacias de la red para usar el beneficio de medicamentos con receta. Los beneficios, el formulario, la red de farmacias, o los copagos/coseguros pueden cambiar el 1 de enero de 2026 y de vez en cuando durante el año. Recibirá un aviso cuando sea necesario.

Puede solicitar que se le envíen los medicamentos con receta a su hogar a través de nuestro programa de entrega de pedido por correo de la red. Express Scripts PharmacySM es nuestra farmacia de pedido por correo preferida. Si bien puede surtir sus medicamentos con receta en cualquiera de las farmacias de pedido por correo de nuestra red, posiblemente pague menos en la farmacia de pedido por correo preferida. Por lo general, debería recibir sus medicamentos con receta dentro de los 14 días a partir del momento en que la farmacia de pedido por correo Express Scripts reciba el pedido. Si no recibe su(s) medicamento(s) con receta dentro de ese plazo, comuníquese con Servicios para Miembros de SCAN Health Plan. Para las recetas de pedido por correo, tiene la opción de inscribirse en un programa de resurtido automático comunicándose con Express Scripts Pharmacy al 1-866-553-4125, las 24 horas, los 7 días de la semana. Los usuarios de TTY deben llamar al 711. Puede desinscribirse de los envíos automáticos en cualquier momento.

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

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Fecha de la última actualización del formulario 10/1/2024

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¿Qué es el formulario de SCAN Health Plan?

En este documento, usamos los términos Lista de medicamentos y formulario para hacer referencia a lo mismo. Un formulario es una lista de medicamentos cubiertos elegidos por SCAN Health Plan con el asesoramiento de un equipo de proveedores de atención médica, que representa las terapias con medicamentos con receta que se consideran una parte necesaria de un programa de tratamiento de calidad. Por lo general, SCAN Health Plan cubre los medicamentos que aparecen en nuestro formulario siempre y cuando el medicamento sea médicamente necesario, la receta se surta en una farmacia de la red de SCAN Health Plan y se respeten las demás normas del plan. Para obtener más información acerca de cómo surtir las recetas, revise la Evidencia de cobertura.

¿Puede cambiar el formulario?

La mayoría de los cambios en la cobertura de medicamentos se realizan el 1 de enero, pero podemos añadir o retirar medicamentos del formulario durante el año, pasarlos a diferentes niveles de gastos compartidos o añadir nuevas restricciones. Debemos seguir las normas de Medicare a la hora de hacer estos cambios. Las actualizaciones del formulario se publican mensualmente en nuestro sitio web aquí: <https://www.scanhealthplan.com/scan-resources/plan-materials/formulary>.

Los cambios que pueden afectarle este año: En los siguientes casos, se verá afectado por cambios los de cobertura durante el año:

- **Sustitución inmediata de ciertas versiones nuevas de medicamentos de marca y productos biológicos originales.** Podemos retirar inmediatamente un medicamento de nuestro formulario si lo reemplazamos con una determinada versión nueva de ese medicamento que aparecerá en el mismo nivel de gasto compartido o en uno menor y con las mismas restricciones o menos. Cuando agregamos una nueva versión de un medicamento a nuestro formulario, podemos decidir mantener el medicamento de marca o el producto biológico original en nuestro formulario, pero cambiarlo inmediatamente a un nivel de gastos compartidos diferente o agregar nuevas restricciones.

Podemos hacer estos cambios inmediatos solo si agregamos una nueva versión genérica de un medicamento de marca, o si agregamos ciertas versiones biosimilares nuevas de un producto biológico original, que ya estaba en el formulario (por ejemplo, al agregar un biosimilar intercambiable que puede ser sustituido por un producto biológico original en una farmacia sin una nueva receta).

Si actualmente toma el medicamento de marca o el producto biológico original, es posible que no le informemos por adelantado antes de hacer un cambio inmediato, pero luego le brindaremos información sobre los cambios específicos que hemos hecho.

Si implementamos dicho cambio, usted u otra persona autorizada a dar recetas pueden solicitarnos que hagamos una excepción y sigamos cubriendo para usted el medicamento que se está cambiando. Para obtener más información, consulte la sección a continuación titulada “¿Cómo solicito una excepción para el Formulario de SCAN Health Plan?”

Algunos de estos tipos de medicamentos pueden ser nuevos para usted. Para obtener más información, consulte la sección a continuación titulada “¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?”

- **Medicamentos retirados del mercado.** Si un medicamento es retirado de la venta por el fabricante, o la Administración de Alimentos y Medicamentos (FDA) determina su retiro por motivos de seguridad o eficacia, podemos retirar inmediatamente el medicamento de nuestro formulario y luego notificar a los miembros que lo toman.
- **Otros cambios.** Podemos realizar otros cambios que afecten a los miembros que toman actualmente un medicamento. Por ejemplo, podemos retirar un medicamento de marca del formulario al agregar un equivalente genérico o retirar un producto biológico original al agregar un biosimilar. También podemos aplicar nuevas restricciones al medicamento de marca o al producto biológico original, o moverlo a un nivel de gastos compartidos diferente, o ambas opciones. Podemos realizar cambios según nuevas pautas clínicas. Si retiramos medicamentos de nuestro formulario, agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada a un medicamento, o si movemos un medicamento a un nivel de gastos compartidos más alto, debemos notificar a los miembros afectados sobre el cambio, al menos 30 días antes de que el cambio esté vigente. O bien, cuando un miembro solicita un resurtido del medicamento, puede recibir un suministro del medicamento para 30 días y un aviso del cambio.

Si implementamos estos cambios, usted u otra persona autorizada a dar recetas pueden solicitarle que hagamos una excepción para usted y que sigamos cubriendo el medicamento que ha estado tomando. El aviso que le proporcionaremos también incluye información sobre cómo solicitar una excepción y, además, puede encontrar información en la sección a continuación, “¿Cómo solicito una excepción para el Formulario de SCAN Health Plan?”

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si toma un medicamento que se encuentra en nuestro formulario de 2025 que estaba cubierto al comienzo del año, no descontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2025, excepto en los casos que se describieron anteriormente. Esto significa que estos medicamentos permanecerán disponibles con los mismos gastos compartidos y sin nuevas restricciones para aquellos miembros que los tomen durante el resto del año de cobertura. No recibirá un aviso directo sobre los cambios que no le afecten este año. Sin embargo, dichos cambios podrían afectarle a partir del 1 de enero del año siguiente, y es importante que revise el formulario del nuevo año de beneficios para ver los cambios en los medicamentos.

El formulario adjunto está vigente desde octubre de 2024. Para obtener información actualizada acerca de los medicamentos cubiertos por SCAN Health Plan, póngase en contacto con nosotros. Nuestra información de contacto aparece en las páginas de la cubierta del frente y del dorso.

¿Cómo uso el Formulario?

Existen dos maneras de buscar un medicamento dentro del formulario:

Afección médica

El formulario comienza en la página 24. En este formulario, los medicamentos se dividen en categorías según el tipo de afección médica que tratan. Por ejemplo, los medicamentos usados para tratar una afección cardíaca se indican en la categoría “Agentes cardiovasculares”. Si usted sabe para qué se usa su medicamento, busque el nombre de la categoría en la lista que comienza en la página número 24. Luego busque el nombre del medicamento debajo del nombre de la categoría.

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Orden alfabético

Si no sabe en qué categoría buscar, debe buscar el medicamento en el Índice que comienza en la página 63. El Índice le proporciona una lista en orden alfabético de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca como los medicamentos genéricos figuran en el Índice. Consulte el Índice y busque su medicamento. Al lado de medicamento, verá el número de página en donde puede encontrar la información de cobertura. Vaya a la página que figura en el Índice y busque el nombre del medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

SCAN Health Plan cubre medicamentos de marca y genéricos. La Administración de Alimentos y Medicamentos (FDA) aprueba un medicamento genérico cuando considera que contiene el mismo ingrediente activo que el medicamento de marca. Por lo general, los medicamentos genéricos funcionan igual de bien que los medicamentos de marca y, en general, cuestan menos. Hay sustitutos genéricos disponibles para muchos medicamentos de marca. Por lo general, los medicamentos genéricos pueden sustituir al medicamento de marca en la farmacia sin necesidad de una nueva receta, según las leyes estatales.

¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?

En el formulario, cuando hablamos de medicamentos, podríamos hacer referencia a un medicamento o un producto biológico. Los productos biológicos son medicamentos que son más complejos que los medicamentos típicos. Dado que los productos biológicos son más complejos que los medicamentos típicos, en lugar de tener una forma genérica, tienen alternativas que se llaman biosimilares. En general, los biosimilares funcionan tan bien como el producto biológico original y pueden costar menos. Existen alternativas biosimilares para algunos productos biológicos originales. Algunos biosimilares son biosimilares intercambiables y, según las leyes estatales, pueden ser sustituidos por el producto biológico original en la farmacia sin necesidad de una nueva receta, al igual que los medicamentos genéricos pueden ser sustituidos por medicamentos de marca.

- Para obtener información sobre los tipos de medicamentos, consulte la Evidencia de cobertura, Sección 3.1 del Capítulo 5, "La 'Lista de medicamentos' indica qué medicamentos de la Parte D están cubiertos".

¿Existe alguna restricción en mi cobertura?

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

- **Autorización previa:** SCAN Health Plan requiere que usted o la persona autorizada a dar recetas obtengan una autorización previa para determinados medicamentos. Esto significa que deberá obtener la aprobación de SCAN Health Plan antes de surtir sus recetas. Si no obtiene la aprobación, es posible que SCAN Health Plan no cubra el medicamento.
- **Límites de cantidad:** Para determinados medicamentos, SCAN Health limita la cantidad del medicamento que cubrirá SCAN Health Plan. Por ejemplo, SCAN Health Plan proporciona 30 comprimidos por receta para ramelteon. Esto puede ser un surtido adicional al suministro

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estándar de un mes o de tres meses.

Puede averiguar si su medicamento tiene algún requisito o límite adicional buscando en el formulario que comienza en la página 24. También puede obtener más información sobre las restricciones que se aplican a los medicamentos cubiertos específicos en nuestro sitio web. Hemos publicado un documento donde se explica nuestra restricción de autorización previa. Además, puede solicitarnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Puede solicitar a SCAN Health Plan que realice una excepción para estas restricciones o estos límites o para una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección, “¿Cómo solicito una excepción para el formulario de SCAN Health Plan?” en la página 17 para obtener información sobre cómo solicitar una excepción.

¿Qué sucede si el medicamento que necesito no se incluye en el Formulario?

Si el medicamento que necesita no está incluido en este formulario (lista de medicamentos cubiertos), primero debe comunicarse con Servicios para Miembros y preguntar si su medicamento está cubierto.

Si le informan que SCAN Health Plan no cubre su medicamento, tiene dos opciones:

- Puede solicitar a Servicios para Miembros una lista de medicamentos similares que estén cubiertos por SCAN Health Plan. Cuando reciba la lista, muéstrese a su médico/a y pídale que le recete un medicamento similar que esté cubierto por SCAN Health Plan.
- Puede solicitar a SCAN Health Plan que realice una excepción y cubra su medicamento. Consulte a continuación para obtener más información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción para el Formulario de SCAN Health Plan?

Puede solicitar a SCAN Health Plan que realice una excepción en nuestras normas de cobertura. Existen diferentes tipos de excepciones que puede pedirnos que hagamos.

- Puede pedirnos que cubramos un medicamento incluso si no figura en nuestro formulario. Si se aprueba, este medicamento estará cubierto a un nivel de participación de costo predeterminado y no podrá pedirnos que proporcionemos el medicamento a un nivel de gastos compartidos inferior.
- Puede pedirnos que no apliquemos una restricción de cobertura que incluya una autorización previa, un tratamiento escalonado o un límite de cantidad para su medicamento. Por ejemplo, para ciertos medicamentos, SCAN Health Plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que no apliquemos el límite y que cubramos un monto mayor.
- Puede pedirnos que cubramos un medicamento del formulario a un nivel de gastos compartidos más bajo, a menos que el medicamento se encuentre entre los medicamentos de especialidad. Si se aprueba, esto disminuiría el monto que debe pagar por su medicamento.

Por lo general, SCAN Health Plan solo aprobará su solicitud de una excepción si los medicamentos

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alternativos incluidos en el formulario del plan, el medicamento con menor gasto compartido o la aplicación de la restricción no resultaran tan eficaces para usted ni provocaran efectos adversos.

Usted o la persona autorizada a dar recetas deben comunicarse con nosotros para solicitar una excepción de nivel o formulario, incluida una excepción a una restricción de cobertura. **Cuando solicite una excepción, la persona autorizada a dar recetas deberá explicarle los motivos médicos por los que necesita la excepción.** Por lo general, debemos tomar una decisión en un plazo de 72 horas después de recibir la declaración de apoyo de su recetador/a. Puede solicitar una decisión acelerada (rápida) si cree, y estamos de acuerdo, que su salud podría verse gravemente perjudicada si espera hasta 72 horas por una decisión. Si estamos de acuerdo, o si la persona autorizada a dar recetas solicita una decisión rápida, debemos comunicarle una decisión en un plazo máximo de 24 horas después de recibir la declaración de apoyo de la persona autorizada a dar recetas.

¿Qué puedo hacer si mi medicamento no está en el formulario o tiene una restricción?

Como miembro nuevo o actual de nuestro plan, es posible que esté tomando medicamentos que no estén en nuestro formulario. O bien, puede estar tomando un medicamento que está en nuestro formulario, pero que tiene una restricción de cobertura, como una autorización previa. Debe hablar con la persona autorizada a dar recetas sobre solicitar una decisión de cobertura para demostrar que cumple con los criterios de aprobación, cambiar a un medicamento alternativo que cubramos o solicitar una excepción al formulario para que cubramos el medicamento que toma. Mientras usted y su médico/a determinan el curso de acción correcto para usted, podemos cubrir el medicamento en ciertos casos durante los primeros 90 días tras convertirse en miembro de nuestro plan.

Para cada uno de sus medicamentos que no estén en nuestro formulario o que tengan una restricción de cobertura, cubriremos un suministro temporal de 30 días si no se encuentra en un centro de atención médica a largo plazo, o un suministro de 31 días si es residente de un centro de atención médica a largo plazo. Si su receta está escrita por menos días, permitiremos resurtidos para proporcionar un suministro máximo de medicamentos para 30 días si no se encuentra en un centro de atención médica a largo plazo o un suministro de medicamentos para 31 días si es residente de un centro de atención médica a largo plazo. Si no se aprueba la cobertura, después primer suministro para 30 días, si no se encuentra en un centro de atención médica a largo plazo, o un suministro para 31 días si es residente de un centro de atención médica a largo plazo, no pagaremos por estos medicamentos, incluso si ha sido miembro del plan por menos de 90 días.

Si es residente de un centro de atención médica a largo plazo y necesita un medicamento que no está en nuestro formulario, o si su capacidad para obtener sus medicamentos es limitada pero pasó los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia de ese medicamento para 31 días mientras solicita una excepción del formulario.

Si es un miembro actual que se está cambiando a un nivel de atención diferente, es probable que le receten medicamentos que no están en nuestro formulario o que su capacidad para obtener los medicamentos sea limitada. En estos casos, tiene que hablar con su médico/a sobre los tratamientos alternativos adecuados que se encuentran disponibles en nuestro formulario. Si no hay tratamientos alternativos adecuados en nuestro formulario, usted o su médico/a pueden solicitar una excepción y pedirle al plan que cubra el medicamento o quite las restricciones del medicamento. Mientras habla con su médico/a para determinar el curso de acción, es elegible para recibir un suministro del medicamento

para 30 días, si está pasando de un centro de atención médica a largo plazo o de una hospitalización a su hogar, o un suministro de transición del medicamento para 31 días, si está pasando de una hospitalización o de su hogar a un centro de atención médica a largo plazo.

Para obtener más información

Para obtener información más detallada sobre su cobertura para medicamentos con receta de SCAN Health Plan, revise su Evidencia de cobertura y el resto de los materiales del plan.

Si tiene preguntas sobre SCAN Health Plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

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

Las tablas a continuación enumeran lo que pagará por compartir los costos de los medicamentos con receta cubiertos en las farmacias de nuestra red cuando se encuentre en la etapa de cobertura inicial.

El gasto compartido preferido es más bajo que el gasto compartido que pueda tener disponible para ciertos medicamentos cubiertos de la Parte D en determinadas farmacias de la red. Para obtener más información, visite nuestro directorio de farmacias en línea donde se pueden realizar búsquedas en www.scanhealthplan.com o llame a Servicios para Miembros. Nuestra información de contacto aparece en las páginas de la cubierta del frente y del dorso.

Consulte la Evidencia de cobertura para obtener información sobre los costos en farmacias para cuidado a largo plazo (LTC) y farmacias fuera de la red.

Si recibe “Ayuda adicional”, su parte del costo para medicamentos con receta cubiertos puede variar según el nivel de “Ayuda adicional” que reciba. Para obtener más información sobre los costos de los medicamentos, consulte la “Cláusula adicional LIS”.

No pagará más de \$35 por un suministro para un mes, ni más de \$105 por un suministro para tres meses, de cada producto de insulina cubierto por nuestro plan, sin importar en qué nivel de gasto compartido se encuentre, incluso si no ha pagado el deducible.

La mayoría de las vacunas para adultos de la Parte D están cubiertas por nuestro plan sin costo alguno para usted, incluso si no ha pagado el deducible.

SCAN Classic (HMO): Condados de Clark y Nye

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		\$0	\$0	\$5	\$10
2	Medicamentos genéricos		\$0	\$0	\$9	\$18
3	Medicamentos de marca preferidos	Insulina	\$35	\$85	\$35	\$85
		Otros medicamentos	\$42	\$126	\$47	\$141
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN Compass (HMO): Condados de Clark y Nye

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		\$0	\$0	\$5	\$10
2	Medicamentos genéricos		\$0	\$0	\$9	\$18
3	Medicamentos de marca preferidos	Insulina	\$35	\$85	\$35	\$85
		Otros medicamentos	\$42	\$126	\$47	\$141
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN MyChoice (HMO): Condado de Clark

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		\$0	\$0	\$0	\$0
2	Medicamentos genéricos		\$0	\$0	\$0	\$0
3	Medicamentos de marca preferidos	Insulina	\$35	\$85	\$35	\$85
		Otros medicamentos	\$42	\$126	\$43	\$129
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN Balance (HMO C-SNP): Condados de Clark y Nye

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		\$0	\$0	\$5	\$10
2	Medicamentos genéricos		\$0	\$0	\$9	\$18
3	Medicamentos de marca preferidos	Insulina	\$0	\$0	\$0	\$0
		Otros medicamentos	\$42	\$126	\$47	\$141
4	Medicamentos no preferidos		50%	50%	50%	50%
5	Medicamentos de especialidad		33%	N/C	33%	N/C

SCAN Strive (HMO C-SNP): Condado de Clark

Nivel del medicamento	Nombre del nivel		Minorista y de pedido por correo			
			Preferida		Estándar	
			Suministro para 30 días	Suministro para 100 días	Suministro para 30 días	Suministro para 100 días
1	Medicamentos genéricos preferidos		\$0	\$0	\$0	\$0
2	Medicamentos genéricos		\$0	\$0	\$0	\$0
3	Medicamentos de marca preferidos	Insulina	\$35	\$105	\$35	\$105
		Otros medicamentos	24%	24%	25%	25%
4	Medicamentos no preferidos		45%	45%	45%	45%
5	Medicamentos de especialidad		25%	N/C	25%	N/C

Formulario de SCAN Health Plan

El formulario que comienza en la página 24 proporciona información sobre la cobertura de los medicamentos cubiertos por SCAN Health Plan. Si no encuentra el medicamento en la lista, vaya al Índice que comienza en la página 63.

En la primera columna de la tabla aparece el nombre del medicamento. Los medicamentos de marca están en mayúscula (p. ej., JANUVIA) y los medicamentos genéricos aparecen en minúscula y cursiva (p. ej., *metformina*).

La información en la columna de Requisitos/limitaciones le indica si SCAN Health Plan tiene algún requisito especial para la cobertura de su medicamento.

- El símbolo [PA] indica que aplica una autorización previa.
- El símbolo [B vs D] indica que este medicamento puede estar cubierto por la Parte B o la Parte D de Medicare según las circunstancias. Es posible que tenga que enviar información describiendo el uso y entorno del medicamento para realizar la determinación.
- El símbolo [QL] indica que las cantidades suministradas son limitadas. Para ver el límite de cantidad para los medicamentos del formulario con límites de cantidad, vaya a la página 58.
- El símbolo [LD] indica que aplica una distribución limitada. Es posible que este medicamento con receta esté disponible solo en ciertas farmacias. Para obtener más información, consulte con su Directorio de farmacias o llame a Servicios para Miembros al 1-855-827-7226 (los usuarios de TTY deben llamar al 711), de 8:00 a.m. a 8:00 p.m., los 7 días de la semana, del 1 de octubre al 31 de marzo. Del 1 de abril al 30 de septiembre, el horario es de 8:00 a.m. a 8:00 p.m., de lunes a viernes (los mensajes recibidos en días feriados y fuera del horario de atención se responderán en el plazo de un día hábil). También puede visitar www.scanhealthplan.com.
- El símbolo [EDS] indica que este medicamento está disponible para un suministro extendido (p. ej., un suministro para más de 30 días) con el servicio de pedido por correo y en muchas farmacias minoristas.

**FORMULARY DRUGS ARRANGED BY THERAPEUTIC CLASS
 MEDICAMENTOS DEL FORMULARIO COORDINADOS POR LA CLASE TERAPÉUTICA**

Formulary ID: 25409 (Version 16)
 ID de Formulario: 25409 (Versión 16)

Updated: 10/2024
 Actualizado: 10/2024

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
ANALGESICS			Opioid Analgesics, Long-acting		
<i>Nonsteroidal Anti-inflammatory Drugs</i>			<i>fentanyl patches</i>	3	[QL] [EDS]
<i>celecoxib</i>	2	[EDS]	<i>12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr & 100mcg/hr</i>		
<i>diclofenac potassium tab 50mg</i>	1	[EDS]	<i>methadone oral</i>	2	[EDS]
<i>diclofenac sodium dr</i>	1	[EDS]	<i>morphine sulfate er tabs</i>	3	[QL] [EDS]
<i>diclofenac sodium er</i>	1	[EDS]	OXYCODONE ER TABS	4	[QL] [EDS]
<i>diclofenac sodium soln 1.5%</i>	4	[QL] [EDS]	<i>tramadol er tabs</i>	3	[QL] [EDS]
<i>diclofenac sodium soln 2%</i>	4	[QL] [EDS]	Opioid Analgesics, Short-acting		
<i>diflunisal</i>	2	[EDS]	<i>acetaminophen & codeine</i>	2	[QL] [EDS]
<i>ec-naproxen</i>	1	[EDS]	<i>butorphanol tartrate nasal</i>	2	[QL] [EDS]
<i>etodolac</i>	2	[EDS]	<i>codeine sulfate</i>	2	[EDS]
<i>etodolac er</i>	2	[EDS]	<i>endocet</i>	3	[QL] [EDS]
<i>ibu</i>	1	[EDS]	<i>fentanyl citrate lozenges 200mcg</i>	4	[PA] [EDS]
<i>ibuprofen</i>	1	[EDS]	<i>fentanyl citrate lozenges 400mcg, 600mcg, 800mcg, 1200mcg & 1600mcg</i>	5	[PA]
<i>indomethacin er</i>	2	[EDS]	<i>hydrocodone & acetaminophen soln 7.5-325mg/15ml</i>	2	[QL] [EDS]
<i>indomethacin ir caps</i>	2	[EDS]	<i>hydrocodone & acetaminophen tabs 5-325mg, 7.5-325mg & 10-325mg</i>	2	[QL] [EDS]
<i>ketorolac oral tabs</i>	2	[EDS]			
LODINE TABS	2	[EDS]			
<i>meloxicam tabs</i>	1	[EDS]			
<i>nabumetone</i>	2	[EDS]			
<i>naproxen tabs 250mg, 375mg & 500mg</i>	1	[EDS]			
<i>naproxen sodium ir tabs</i>	1	[EDS]			
<i>piroxicam</i>	2	[EDS]			
<i>sulindac</i>	2	[EDS]			

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
Nombre del Medicamento	Nivel	Requisitos/Límites	Nombre del Medicamento	Nivel	Requisitos/Límites
<i>hydrocodone & ibuprofen tabs 7.5-200mg</i>	2	[QL] [EDS]	<i>buprenorphine & naloxone sublingual film</i>	2	[EDS]
<i>hydromorphone immediate-release oral soln & tabs</i>	2	[EDS]	<i>buprenorphine & naloxone sublingual tabs</i>	2	[EDS]
<i>morphine sulfate oral</i>	2	[EDS]	Opioid Reversal Agents		
<i>oxycodone immediate-release</i>	2	[EDS]	KLOXXADO	3	[EDS]
<i>oxycodone oral soln</i>	2	[EDS]	<i>naloxone inj</i>	2	[EDS]
<i>oxycodone & acetaminophen 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg</i>	3	[QL] [EDS]	<i>naloxone nasal</i>	2	[EDS]
<i>tramadol tab 50mg</i>	2	[EDS]	OPVEE	4	[EDS]
<i>tramadol ir tab 100mg</i>	2	[QL] [EDS]	Smoking Cessation Agents		
<i>tramadol & acetaminophen</i>	2	[QL] [EDS]	<i>bupropion sr 150mg</i>	2	[EDS]
ANESTHETICS			NICOTROL INHALER	4	[EDS]
Local Anesthetics			NICOTROL NASAL	4	[EDS]
<i>lidocaine ointment</i>	4	[QL] [EDS]	<i>varenicline starting month box</i>	4	[EDS]
<i>lidocaine patch</i>	3	[PA] [EDS]	<i>varenicline tartrate</i>	4	[EDS]
<i>lidocaine topical soln</i>	2	[QL] [EDS]	ANTIBACTERIALS		
<i>lidocaine & prilocaine cream</i>	3	[QL] [EDS]	Aminoglycosides		
<i>lidocaine III</i>	3	[PA] [EDS]	<i>amikacin inj</i>	2	[EDS]
<i>tridacaine ii patch</i>	3	[PA] [EDS]	ARIKAYCE	5	[PA]
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS			<i>gentamicin cream 0.1% & oint 0.1%</i>	2	[EDS]
Alcohol Deterrents/Anti-Craving			<i>gentamicin inj 40mg/ml</i>	2	[EDS]
<i>acamprosate calcium dr</i>	2	[EDS]	<i>neomycin sulfate oral</i>	2	[EDS]
<i>disulfiram</i>	2	[EDS]	<i>streptomycin inj</i>	4	[EDS]
<i>naltrexone</i>	1	[EDS]	<i>tobramycin sulfate inj</i>	2	[EDS]
Opioid Dependence			Antibacterials, Other		
<i>buprenorphine sublingual tabs</i>	1	[EDS]	<i>aztreonam inj</i>	4	[EDS]
			CLEOCIN VAGINAL SUPP	3	[EDS]
			<i>clindamycin oral</i>	2	[EDS]
			<i>clindamycin phosphate inj</i>	2	[EDS]
			<i>clindamycin phosphate/dextrose inj</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>clindamycin swab</i>	2	[EDS]	<i>ceftazidime inj</i>	2	[EDS]
<i>clindamycin vaginal cream</i>	2	[EDS]	<i>ceftriaxone inj</i>	2	[EDS]
<i>colistimethate inj</i>	4	[EDS]	<i>cefuroxime oral</i>	2	[EDS]
<i>daptomycin inj</i>	5		<i>cefuroxime inj</i>	2	[EDS]
<i>fosfomycin pack</i>	4	[EDS]	<i>cephalexin caps 250mg & 500mg</i>	1	[EDS]
<i>linezolid inj</i>	4	[EDS]	<i>cephalexin oral susp</i>	1	[EDS]
<i>linezolid oral susp and tabs</i>	4	[EDS]	<i>tazicef inj</i>	2	[EDS]
<i>methenamine hippurate</i>	2	[EDS]	TEFLARO INJ	5	
<i>metronidazole inj</i>	2	[EDS]	Beta-lactam, Penicillins		
<i>metronidazole oral</i>	2	[EDS]	<i>amoxicillin</i>	1	[EDS]
<i>metronidazole vaginal gel</i>	2	[EDS]	<i>amoxicillin & clavulanate potassium chew tabs 400-57mg</i>	2	[EDS]
<i>nitrofurantoin caps</i>	2	[EDS]	<i>amoxicillin & clavulanate potassium er</i>	2	[EDS]
SIVEXTRO TABS & INJ	5		<i>amoxicillin & clavulanate potassium oral susp & tabs</i>	2	[EDS]
<i>tigecycline inj</i>	5		<i>ampicillin inj</i>	2	[EDS]
<i>tinidazole tabs</i>	3	[EDS]	<i>ampicillin oral</i>	2	[EDS]
<i>trimethoprim</i>	2	[EDS]	<i>ampicillin & sulbactam inj 10- 5gm, 2-1gm & 1- 0.5gm</i>	2	[EDS]
<i>vancomycin caps</i>	4	[EDS]	BICILLIN L-A INJ	4	[EDS]
<i>vancomycin inj 500mg, 750mg, 1gm & 10gm</i>	3	[EDS]	<i>dicloxacillin sodium</i>	2	[EDS]
<i>vancomycin oral soln 250mg/5ml</i>	4	[EDS]	<i>nafcillin sodium inj</i>	4	[EDS]
<i>vandazole</i>	2	[EDS]	<i>penicillin g inj 5 million units & 20 million units</i>	2	[EDS]
Beta-lactam, Cephalosporins			<i>penicillin v potassium</i>	2	[EDS]
<i>cefaclor</i>	2	[EDS]	<i>piperacillin/tazobact am inj</i>	3	[EDS]
<i>cefaclor er</i>	2	[EDS]	ZOSYN INJ	4	[EDS]
<i>cefadroxil caps & tabs</i>	2	[EDS]			
<i>cefazolin inj</i>	2	[EDS]			
<i>cefdinir</i>	2	[EDS]			
<i>cefepime inj</i>	2	[EDS]			
<i>cefixime caps</i>	3	[EDS]			
<i>cefixime susp</i>	4	[EDS]			
<i>cefoxitin sodium</i>	2	[EDS]			
<i>cefpodoxime tabs</i>	2	[EDS]			
<i>cefprozil</i>	2	[EDS]			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
Carbapenems			<i>sulfamethoxazole & trimethoprim oral susp</i>		
<i>cilastatin/imipenem inj</i>	2	[EDS]		2	[EDS]
<i>ertapenem inj</i>	4	[EDS]	Tetracyclines		
<i>meropenem inj</i>	3	[EDS]	<i>demeclocycline</i>	4	[EDS]
Macrolides			<i>doxy 100 inj</i>	2	[EDS]
<i>azithromycin tabs & oral susp bottle</i>	2	[EDS]	<i>doxycycline hyclate immediate-release caps 50mg & 100mg</i>	2	[EDS]
<i>azithromycin inj</i>	2	[EDS]	<i>doxycycline hyclate immediate-release tabs 100mg</i>	2	[EDS]
<i>clarithromycin</i>	2	[EDS]	<i>doxycycline monohydrate immediate-release tabs, caps & oral susp</i>	2	[EDS]
<i>clarithromycin er</i>	2	[EDS]	<i>minocycline ir</i>	2	[EDS]
DIFICID	5		<i>tetracycline</i>	3	[EDS]
ERYTHROCIN LACTOBIONATE INJ	4	[EDS]	ANTICONVULSANTS		
<i>erythromycin caps & tabs</i>	4	[EDS]	Anticonvulsants, Other		
<i>erythromycin dr</i>	4	[EDS]	BRIVIACT ORAL SOLN	4	[PA] [EDS]
Quinolones			BRIVIACT TABS	5	[PA]
<i>ciprofloxacin in d5w inj</i>	2	[EDS]	EPIDIOLEX	5	[PA] [LD]
<i>ciprofloxacin tabs immediate-release 250mg, 500mg & 750mg</i>	1	[EDS]	<i>felbamate tabs 400mg</i>	2	[EDS]
<i>levofloxacin in d5w inj</i>	2	[EDS]	<i>felbamate tabs 600mg</i>	4	[EDS]
<i>levofloxacin oral soln</i>	2	[EDS]	<i>felbamate oral susp 600mg/5ml</i>	5	
<i>levofloxacin tabs</i>	1	[EDS]	FINTEPLA	5	[PA]
<i>moxifloxacin inj</i>	4	[EDS]	FYCOMPA	4	[PA] [EDS]
<i>moxifloxacin oral</i>	2	[EDS]	<i>levetiracetam er</i>	2	[EDS]
<i>ofloxacin oral</i>	2	[EDS]	<i>levetiracetam oral</i>	2	[EDS]
Sulfonamides			NAYZILAM	4	[PA] [EDS]
<i>sulfacetamide sodium topical lotion 10%</i>	2	[EDS]	<i>roweepra 500mg</i>	2	[EDS]
<i>sulfadiazine tabs</i>	4	[EDS]	SPRITAM	4	[EDS]
<i>sulfamethoxazole & trimethoprim tabs</i>	1	[EDS]	<i>valproic acid oral caps & soln</i>	2	[EDS]
<i>sulfamethoxazole & trimethoprim ds tabs</i>	1	[EDS]			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
Calcium Channel Modifying Agents			DILANTIN INFATABS	3	[EDS]
<i>ethosuximide</i>	2	[EDS]	DILANTIN SUSP	3	[EDS]
<i>methsuximide</i>	4	[EDS]	<i>epitol</i>	2	[EDS]
Gamma-aminobutyric Acid (GABA) Modulating Agents			<i>lacosamide oral</i>	4	[EDS]
<i>clobazam</i>	4	[PA] [EDS]	<i>oxcarbazepine tabs</i>	2	[EDS]
<i>clonazepam</i>	3	[EDS]	<i>oxcarbazepine susp</i>	4	[EDS]
<i>clonazepam odt</i>	4	[EDS]	<i>phenytek</i>	2	[EDS]
DIACOMIT	5	[PA]	<i>phenytoin oral susp & chewable tabs</i>	2	[EDS]
DIAZEPAM RECTAL GEL	4	[EDS]	<i>phenytoin er</i>	2	[EDS]
<i>divalproex sodium dr</i>	2	[EDS]	<i>rufinamide</i>	4	[PA] [EDS]
<i>divalproex sodium er</i>	2	[EDS]	TEGRETOL	3	[EDS]
<i>gabapentin caps, ir tabs & oral soln</i>	2	[EDS]	TEGRETOL XR	3	[EDS]
LIBERVANT	4	[PA] [EDS]	TRILEPTAL	4	[EDS]
<i>phenobarbital elixir & tabs</i>	2	[EDS]	XCOPRI TABS	5	[PA]
<i>pregabalin</i>	2	[EDS]	XCOPRI MAINTENANCE PACK	5	[PA]
<i>primidone tabs 50mg & 250mg</i>	2	[EDS]	XCOPRI TITRATION PACK 12.5-25MG	4	[PA] [EDS]
PRIMIDONE TABS 125MG	3	[EDS]	XCOPRI TITRATION PACK 50-100MG, & 150-200MG	5	[PA]
SYMPAZAN 5MG	4	[PA] [EDS]	ZONISADE	4	[EDS]
SYMPAZAN 10MG & 20MG	5	[PA]	<i>zonisamide</i>	2	[EDS]
<i>tiagabine</i>	4	[EDS]	ANTIDEMENTIA AGENTS		
VALTOCO	4	[PA] [EDS]	Antidementia Agents, Other		
<i>vigabatrin</i>	5	[LD]	<i>ergoloid mesylates</i>	3	[PA] [EDS]
<i>vigadrone</i>	5	[LD]	Cholinesterase Inhibitors		
VIGAFYDE	5		<i>donepezil tabs 5mg & 10mg</i>	2	[EDS]
<i>vigpoder</i>	5	[LD]	<i>donepezil odt</i>	2	[EDS]
ZTALMY SUSP	5	[LD]	<i>galantamine tabs</i>	2	[QL] [EDS]
Sodium Channel Agents			<i>galantamine er caps</i>	2	[QL] [EDS]
APTIOM	5	[PA]	<i>galantamine soln</i>	4	[QL] [EDS]
<i>carbamazepine tabs, chewable tabs & oral susp</i>	2	[EDS]	<i>rivastigmine caps</i>	3	[QL] [EDS]
<i>carbamazepine er tabs & caps</i>	3	[EDS]	<i>rivastigmine patches</i>	4	[QL] [EDS]
DILANTIN CAPS	3	[EDS]	N-methyl-D-aspartate (NMDA) Receptor Antagonists		
			<i>memantine hcl immediate release</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>memantine hcl soln</i>	4	[EDS]	<i>fluoxetine hcl oral soln</i>	2	[EDS]
<i>memantine hcl titration pack</i>	4	[EDS]	<i>fluvoxamine</i>	2	[EDS]
ANTIDEPRESSANTS			<i>nefazodone</i>	2	[EDS]
<i>Antidepressants, Other</i>			<i>paroxetine hcl ir tabs</i>	1	[EDS]
AUVELITY	5		<i>paroxetine hcl er</i>	4	[EDS]
<i>bupropion hcl tabs</i>	2	[EDS]	<i>paroxetine hcl susp</i>	4	[EDS]
<i>bupropion sr</i>	2	[EDS]	<i>pmdd fluoxetine hcl tabs 10mg & 20mg</i>	2	[EDS]
<i>bupropion xl 150mg & 300mg</i>	2	[EDS]	<i>sertraline tabs</i>	1	[EDS]
<i>bupropion xl 450mg</i>	3	[EDS]	<i>sertraline oral soln</i>	2	[EDS]
<i>mirtazapine</i>	1	[EDS]	<i>trazodone</i>	1	[EDS]
<i>mirtazapine odt</i>	1	[EDS]	TRINTELLIX	4	[EDS]
<i>perphenazine & amitriptyline</i>	4	[PA] [EDS]	<i>venlafaxine ir tabs</i>	2	[EDS]
ZURZUVAE	5	[PA]	<i>venlafaxine hcl er caps</i>	2	[EDS]
<i>Monoamine Oxidase Inhibitors</i>			<i>vilazodone</i>	3	[EDS]
EMSAM	5		<i>Tricyclics</i>		
MARPLAN	4	[EDS]	<i>amitriptyline</i>	4	[PA] [EDS]
<i>phenelzine</i>	2	[EDS]	<i>amoxapine</i>	3	[EDS]
<i>tranylcypromine</i>	4	[EDS]	<i>clomipramine</i>	4	[PA] [EDS]
<i>SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin & Norepinephrine Reuptake Inhibitors)</i>			<i>desipramine</i>	4	[PA] [EDS]
<i>citalopram tabs</i>	1	[EDS]	<i>doxepin caps</i>	4	[PA] [EDS]
<i>citalopram oral soln</i>	2	[EDS]	<i>doxepin oral soln</i>	4	[PA] [EDS]
DESVENLAFAXINE ER	4	[EDS]	<i>imipramine hcl tabs</i>	4	[PA] [EDS]
<i>desvenlafaxine succinate er</i>	3	[EDS]	<i>nortriptyline</i>	4	[EDS]
DRIZALMA SPRINKLE	4	[EDS]	<i>protriptyline</i>	3	[EDS]
<i>escitalopram</i>	2	[EDS]	<i>trimipramine maleate</i>	2	[EDS]
FETZIMA	4	[EDS]	ANTIEMETICS		
FETZIMA TITRATION PACK	4	[EDS]	<i>Antiemetics, Other</i>		
<i>fluoxetine hcl caps 10mg, 20mg & 40mg</i>	2	[EDS]	<i>compro</i>	4	[EDS]
<i>fluoxetine hcl tabs 10mg & 20mg</i>	2	[EDS]	<i>meclizine</i>	2	[EDS]
			<i>prochlorperazine oral</i>	2	[EDS]
			<i>prochlorperazine supp</i>	4	[EDS]
			<i>promethazine supp</i>	3	[EDS]
			<i>promethazine syrup</i>	2	[EDS]
			<i>promethazine tabs</i>	2	[EDS]
			<i>promethegan supp</i>	4	[EDS]

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Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>scopolamine patch</i>	3	[EDS]	<i>nystop</i>	2	[EDS]
Emetogenic Therapy Adjuncts			<i>posaconazole dr tabs</i>	5	[PA]
<i>aprepitant caps 80mg & 125mg</i>	4	[PA] [EDS]	<i>posaconazole suspension</i>	4	[PA] [EDS]
<i>aprepitant pack</i>	4	[PA] [EDS]	<i>terbinafine</i>	2	[EDS]
<i>dronabinol</i>	4	[PA] [EDS]	<i>terconazole</i>	2	[EDS]
<i>granisetron oral</i>	2	[PA] [B vs D] [EDS]	<i>voriconazole inj</i>	5	[PA]
<i>ondansetron odt</i>	2	[PA] [B vs D] [EDS]	<i>voriconazole oral suspension</i>	5	
<i>ondansetron oral soln</i>	2	[PA] [B vs D] [EDS]	<i>voriconazole tabs</i>	4	[EDS]
<i>ondansetron tabs 4mg & 8mg</i>	2	[PA] [B vs D] [EDS]	ANTIGOUT AGENTS		
ANTIFUNGALS			Antigout Agents		
Antifungals			<i>allopurinol tabs 100mg & 300mg</i>	1	[EDS]
ABELCET INJ	4	[PA] [B vs D] [EDS]	<i>colchicine tabs</i>	3	[QL] [EDS]
AMBISOME INJ	5	[PA] [B vs D]	<i>febuxostat</i>	3	[EDS]
<i>amphotericin b inj</i>	2	[PA] [B vs D] [EDS]	<i>probenecid</i>	2	[EDS]
<i>amphotericin b liposome inj</i>	5	[PA] [B vs D]	<i>probenecid & colchicine</i>	2	[EDS]
<i>casprofungin inj</i>	4	[EDS]	ANTIMIGRAINE AGENTS		
<i>clotrimazole cream 1%</i>	2	[EDS]	Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists		
<i>clotrimazole topical soln 1%</i>	2	[EDS]	AIMOVI INJ	3	[PA] [EDS]
<i>clotrimazole troche</i>	2	[EDS]	EMGALITY INJ	3	[PA] [EDS]
<i>econazole nitrate</i>	4	[EDS]	NURTEC ODT	3	[PA] [EDS]
<i>fluconazole in sodium chloride inj</i>	2	[EDS]	UBRELVY	3	[PA] [EDS]
<i>fluconazole oral</i>	2	[EDS]	Ergot Alkaloids		
<i>flucytosine</i>	5		<i>caffeine-ergotamine</i>	3	[EDS]
<i>griseofulvin microsize</i>	4	[EDS]	<i>dihydroergotamine mesylate nasal</i>	5	[PA] [QL]
<i>itraconazole</i>	4	[EDS]	Prophylactic		
<i>ketoconazole cream, shampoo & tabs</i>	2	[EDS]	EPRONTIA	4	[EDS]
<i>nyamyc</i>	2	[EDS]	<i>timolol oral</i>	1	[EDS]
<i>nystatin</i>	2	[EDS]	<i>topiramate immediate-release</i>	2	[EDS]
			Serotonin (5-HT) Receptor Agonist		
			<i>naratriptan</i>	2	[QL] [EDS]
			<i>rizatriptan</i>	2	[EDS]
			<i>rizatriptan odt</i>	2	[EDS]
			<i>sumatriptan nasal</i>	4	[EDS]

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Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>sumatriptan succinate inj</i>	4	[EDS]	Antiangiogenic Agents		
<i>sumatriptan succinate tabs</i>	2	[EDS]	<i>lenalidomide</i>	5	[PA] [LD]
<i>zolmitriptan tabs</i>	3	[QL] [EDS]	POMALYST	5	[PA] [LD]
<i>zolmitriptan odt</i>	3	[QL] [EDS]	REVLIMID	5	[PA] [LD]
ANTIMYASTHENIC AGENTS			THALOMID	5	[PA]
Parasympathomimetics			Antiestrogens/Modifiers		
<i>pyridostigmine soln</i>	4	[EDS]	ORSERDU TABS	5	[PA]
<i>pyridostigmine tabs 60mg</i>	3	[EDS]	SOLTAMOX	5	
<i>pyridostigmine er tabs 180mg</i>	4	[EDS]	<i>tamoxifen</i>	2	[EDS]
ANTIMYCOBACTERIALS			<i>toremifene citrate</i>	5	
Antimycobacterials, Other			Antimetabolites		
<i>dapsone tabs</i>	3	[EDS]	<i>hydroxyurea</i>	2	[EDS]
<i>rifabutin</i>	4	[EDS]	<i>mercaptopurine</i>	2	[EDS]
Antituberculars			PURIXAN	5	
<i>ethambutol</i>	2	[EDS]	Antineoplastics, Other		
<i>isoniazid</i>	2	[EDS]	AKEEGA	5	[PA] [LD]
PRIFTIN	4	[EDS]	INREBIC	5	[PA] [LD]
<i>pyrazinamide</i>	4	[EDS]	IWILFIN	5	[PA] [LD]
<i>rifampin oral and inj</i>	2	[EDS]	LONSURF	5	[PA]
SIRTURO	5		LYSODREN	5	
TRECTOR	4	[EDS]	OGSIVEO	5	[PA]
ANTINEOPLASTICS			ONUREG	5	[PA]
Alkylating Agents			VONJO	5	[PA]
<i>cyclophosphamide</i>	3	[PA] [B vs D] [EDS]	Aromatase Inhibitors, 3rd Generation		
GLEOSTINE	4	[EDS]	<i>anastrozole</i>	2	[EDS]
MATULANE	5		<i>exemestane</i>	3	[EDS]
VALCHLOR	5	[PA]	<i>letrozole</i>	2	[EDS]
Antiandrogens			Molecular Target Inhibitors		
<i>abiraterone acetate</i>	5	[PA]	ALECENSA	5	[PA]
<i>bicalutamide</i>	2	[EDS]	ALUNBRIG	5	[PA]
ERLEADA	5	[PA]	ALUNBRIG INITIATION PACK	5	[PA]
<i>nilutamide</i>	5		AUGTYRO	5	[PA]
NUBEQA	5	[PA] [LD]	AYVAKIT	5	[PA] [LD]
XTANDI	5	[PA]	BALVERSA	5	[PA]
YONSA	5	[PA]	BOSULIF	5	[PA]
			BRAFTOVI	5	[PA] [LD]
			BRUKINSA	5	[PA] [LD]
			CABOMETYX	5	[PA]
			CALQUENCE	5	[PA] [LD]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
CAPRELSA	5	[PA]	NERLYNX	5	[PA] [LD]
COMETRIQ	5	[PA]	NINLARO	5	[PA]
COPIKTRA	5	[PA] [LD]	ODOMZO	5	[PA]
COTELLIC	5	[PA]	OJEMDA	5	[PA]
DAURISMO	5	[PA]	OJJAARA	5	[PA]
ERIVEDGE	5	[PA]	<i>pazopanib</i>	5	[PA]
<i>erlotinib</i>	5	[PA]	PEMAZYRE	5	[PA] [LD]
<i>everolimus tabs 2.5mg, 5mg, 7.5mg & 10mg</i>	5	[PA]	PIQRAY	5	[PA]
<i>everolimus tabs for suspension 2mg, 3mg & 5mg</i>	5	[PA]	QINLOCK	5	[PA] [LD]
FOTIVDA	5	[PA] [LD]	RETEVMO	5	[PA] [LD]
FRUZAQLA	5	[PA]	REZLIDHIA CAPS	5	[PA]
GAVRETO	5	[PA] [LD]	ROZLYTREK	5	[PA]
<i>gefitinib</i>	5	[PA]	RUBRACA	5	[PA] [LD]
GILOTRIF	5	[PA]	RYDAPT	5	[PA]
IBRANCE	5	[PA]	SCEMBLIX	5	[PA]
ICLUSIG	5	[PA]	<i>sorafenib</i>	5	[PA]
IDHIFA	5	[PA] [LD]	SPRYCEL	5	[PA]
<i>imatinib</i>	5	[PA]	STIVARGA	5	[PA]
IMBRUVICA	5	[PA]	<i>sunitinib malate</i>	5	[PA]
INLYTA	5	[PA]	TABRECTA	5	[PA]
INQOVI	5	[PA]	TAFINLAR	5	[PA]
JAKAFI	5	[PA]	TAGRISSO	5	[PA]
JAYPIRCA TABS	5	[PA]	TALZENNA	5	[PA]
KISQALI	5	[PA]	TASIGNA	5	[PA]
KISQALI FEMARA CO-PACK	5	[PA]	TAZVERIK	5	[PA] [LD]
KOSELUGO	5	[PA]	TEPMETKO	5	[PA] [LD]
KRAZATI	5	[PA]	TIBSOVO	5	[PA]
<i>lapatinib</i>	5	[PA]	<i>torpenz</i>	5	[PA]
LENVIMA	5	[PA]	TRUQAP	5	[PA]
LORBRENA	5	[PA]	TUKYSA	5	[PA] [LD]
LUMAKRAS	5	[PA]	TURALIO	5	[PA] [LD]
LYNPARZA	5	[PA]	VANFLYTA	5	[PA]
LYTGOBI TABS	5	[PA] [LD]	VENCLEXTA TABS 10MG & 50MG	3	[PA] [EDS]
MEKINIST	5	[PA]	VENCLEXTA TABS 100MG	5	[PA]
MEKTOVI	5	[PA] [LD]	VENCLEXTA STARTING PACK	5	[PA]
			VERZENIO	5	[PA] [LD]
			VITRAKVI	5	[PA] [LD]
			VIZIMPRO	5	[PA]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
XALKORI	5	[PA]	ANTIPARKINSON AGENTS		
XOSPATA	5	[PA] [LD]	<i>Anticholinergics</i>		
XPOVIO	5	[PA] [LD]	<i>benztropine tabs</i>	4	[PA] [EDS]
ZEJULA TABS	5	[PA] [LD]	<i>trihexyphenidyl elixir & tabs</i>	3	[EDS]
ZELBORAF	5	[PA]	<i>Antiparkinson Agents, Other</i>		
ZOLINZA	5	[PA]	<i>carbidopa & levodopa & entacapone</i>	4	[EDS]
ZYDELIG	5	[PA]	<i>entacapone</i>	4	[EDS]
ZYKADIA TABS	5	[PA]	<i>Dopamine Agonists</i>		
<i>Retinoids</i>			<i>apomorphine hydrochloride inj</i>	5	[PA]
<i>bexarotene</i>	5	[PA]	<i>bromocriptine</i>	2	[EDS]
PANRETIN	5		NEUPRO PATCH	4	[QL] [EDS]
<i>tretinoin caps</i>	5		<i>pramipexole ir</i>	2	[EDS]
<i>Treatment Adjuncts</i>			<i>ropinirole ir</i>	2	[EDS]
<i>leucovorin oral</i>	2	[EDS]	<i>Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors</i>		
MESNEX TABS	4	[EDS]	<i>carbidopa</i>	4	[EDS]
ANTIPARASITICS			<i>carbidopa & levodopa ir, er, odt</i>	2	[EDS]
<i>Anthelmintics</i>			<i>Monoamine Oxidase B (MAO-B) Inhibitors</i>		
<i>albendazole</i>	4	[EDS]	<i>rasagiline</i>	4	[EDS]
<i>ivermectin tabs</i>	2	[EDS]	<i>selegiline</i>	2	[EDS]
<i>praziquantel tabs</i>	4	[EDS]	ANTIPSYCHOTICS		
<i>Antiprotozoals</i>			<i>1st Generation/Typical</i>		
<i>atovaquone susp</i>	4	[EDS]	<i>chlorpromazine oral</i>	4	[PA] [EDS]
<i>atovaquone/proguan il</i>	2	[EDS]	<i>fluphenazine oral</i>	4	[EDS]
<i>chloroquine</i>	2	[EDS]	<i>fluphenazine decanoate inj</i>	4	[EDS]
COARTEM	3	[EDS]	<i>fluphenazine inj</i>	4	[EDS]
<i>hydroxychloroquine tab 200mg</i>	2	[EDS]	<i>haloperidol oral</i>	2	[EDS]
<i>mefloquine</i>	2	[EDS]	<i>haloperidol decanoate inj</i>	2	[EDS]
NEBUPENT NEBULIZER	4	[PA] [B vs D] [EDS]	<i>haloperidol lactate inj</i>	2	[EDS]
<i>nitazoxanide</i>	5		<i>loxapine</i>	2	[EDS]
<i>pentamidine inhalation soln</i>	3	[PA] [B vs D] [EDS]	<i>molindone</i>	2	[EDS]
<i>pentamidine inj</i>	4	[EDS]	<i>perphenazine</i>	4	[EDS]
PRIMAQUINE	3	[EDS]			
<i>pyrimethamine</i>	5	[PA]			
<i>quinine sulfate caps</i>	3	[PA] [EDS]			

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
Nombre del Medicamento	Nivel	Requisitos/Límites	Nombre del Medicamento	Nivel	Requisitos/Límites
<i>pimozide</i>	2	[EDS]	REXULTI	5	
<i>thioridazine</i>	2	[EDS]	<i>risperidone</i>	2	[EDS]
<i>thiothixene</i>	2	[EDS]	<i>risperidone er inj 12.5mg & 25mg</i>	4	[EDS]
<i>trifluoperazine</i>	2	[EDS]	<i>risperidone er inj 37.5mg & 50mg</i>	5	
2nd Generation/Atypical			<i>risperidone odt</i>	2	[EDS]
ABILIFY ASIMTUFII INJ	5		SECUADO	5	[PA]
ABILIFY MAINTENA INJ	5		UZEDY INJ	5	
<i>aripiprazole odt 10mg</i>	5	[EDS]	VRAYLAR	4	[EDS]
<i>aripiprazole odt 15mg</i>	4	[EDS]	<i>ziprasidone inj</i>	3	[EDS]
<i>aripiprazole soln</i>	3	[EDS]	<i>ziprasidone oral</i>	2	[EDS]
<i>aripiprazole tabs</i>	3	[EDS]	ZYPREXA RELPREVV INJ 210MG	4	[EDS]
ARISTADA INJ	5		Treatment-Resistant		
ARISTADA INITIO INJ	4	[EDS]	<i>clozapine</i>	3	[EDS]
<i>asenapine maleate sublingual</i>	4	[EDS]	<i>clozapine odt</i>	4	[EDS]
CAPLYTA	5	[PA]	VERSACLOZ	5	
FANAPT	4	[PA] [EDS]	ANTISPASTICITY AGENTS		
FANAPT TITRATION PACK	4	[PA] [EDS]	Antispasticity Agents		
INVEGA HAFYERA INJ	5		<i>baclofen tabs</i>	2	[EDS]
INVEGA SUSTENNA INJ 39MG	4	[EDS]	<i>tizanidine caps</i>	3	[EDS]
INVEGA SUSTENNA INJ 78MG, 117MG, 156MG & 234MG	5		<i>tizanidine tabs</i>	2	[EDS]
INVEGA TRINZA INJ	5		ANTIVIRALS		
<i>lurasidone hcl tabs</i>	4	[EDS]	Anti-cytomegalovirus (CMV) Agents		
NUPLAZID	5	[PA]	LIVTENCITY	5	[PA] [QL] [LD]
<i>olanzapine inj & tabs</i>	2	[EDS]	PREVYMIS	5	[PA] [QL]
<i>olanzapine odt</i>	4	[EDS]	<i>valganciclovir oral soln</i>	4	[EDS]
<i>paliperidone er tabs</i>	4	[EDS]	<i>valganciclovir tabs</i>	3	[EDS]
<i>quetiapine fumarate 25mg, 50mg, 100mg, 200mg, 300mg & 400mg tabs</i>	2	[EDS]	Anti-hepatitis B (HBV) Agents		
<i>quetiapine er tabs</i>	3	[EDS]	<i>adefovir dipivoxil</i>	4	[EDS]
			BARACLUE ORAL SOLN 0.05MG/ML	4	[EDS]
			<i>entecavir tabs</i>	4	[EDS]
			<i>lamivudine tabs 100mg</i>	3	[EDS]
			VEMLIDY	5	
			Anti-hepatitis C (HCV) Agents		
			EPCLUSA	5	[PA]
			HARVONI	5	[PA]

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Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
LEDIPASVIR/ SOFOSBUVIR	5	[PA]	<i>efavirenz & emtricitabine & tenofovir disoproxil fumarate tabs</i>	5	
<i>ribavirin</i>	3	[EDS]	<i>efavirenz & lamivudine & tenofovir disoproxil fumarate tabs</i>	5	
SOFOSBUVIR/ VELPATASVIR	5	[PA]	<i>etravirine tabs 100mg</i>	4	[EDS]
VOSEVI	5	[PA]	<i>etravirine tabs 200mg</i>	5	
Antiherpetic Agents			INTELENCE TAB 25MG	4	[EDS]
<i>acyclovir caps & tabs</i>	2	[EDS]	<i>nevirapine er & susp</i>	4	[EDS]
<i>acyclovir inj</i>	2	[PA] [B vs D] [EDS]	<i>nevirapine tabs</i>	2	[EDS]
<i>acyclovir oral susp</i>	4	[EDS]	PIFELTRO	5	
<i>famciclovir</i>	2	[EDS]	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
<i>valacyclovir</i>	2	[EDS]	<i>abacavir soln & tabs</i>	4	[EDS]
Anti-HIV Agents, Integrase Inhibitors (INSTI)			<i>abacavir & lamivudine</i>	4	[EDS]
BIKTARVY	5		CIMDUO	5	
DOVATO	5		DESCOVY	5	
GENVOYA	5		<i>emtricitabine caps 200mg</i>	4	[EDS]
ISENTRESS CHEW TABS 25MG	3	[EDS]	<i>emtricitabine & tenofovir disoproxil fumarate tabs 200mg-300mg</i>	4	[EDS]
ISENTRESS 100MG CHEW TABS	5		<i>emtricitabine & tenofovir disoproxil fumarate tabs 100mg-150mg, 133mcg-200mg & 167mg-250mg</i>	5	
ISENTRESS ORAL POWDER	5		EMTRIVA SOLN	4	[EDS]
ISENTRESS TABS	5		<i>lamivudine tabs 150mg & 300mg</i>	3	[EDS]
ISENTRESS HD TABS	5		<i>lamivudine soln</i>	2	[EDS]
JULUCA	5				
STRIBILD	5				
TIVICAY TAB 10MG	4	[EDS]			
TIVICAY TABS 25MG & 50MG	5				
TIVICAY PD	4	[EDS]			
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)					
COMPLERA	5				
DELSTRIGO	5				
EDURANT	5				
<i>efavirenz tabs</i>	4	[EDS]			

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Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>lamivudine & zidovudine</i>	3	[EDS]	Anti-influenza Agents		
ODEFSEY	5		<i>amantadine</i>	2	[EDS]
<i>tenofovir disoproxil fumarate</i>	4	[EDS]	<i>oseltamivir caps</i>	2	[EDS]
TRIUMEQ	5		<i>oseltamivir susp</i>	3	[EDS]
TRIUMEQ PD	4	[EDS]	RELENZA	3	[EDS]
VIREAD TABS 150MG, 200MG & 250MG	5		DISKHALER		
VIREAD POWDER	4	[EDS]	<i>rimantadine</i>	2	[EDS]
<i>zidovudine</i>	2	[EDS]	XOFLUZA	4	[EDS]
Anti-HIV Agents, Other			Antiviral, Coronavirus Agents		
FUZEON INJ	4	[EDS]	PAXLOVID	3	[EDS]
<i>maraviroc</i>	5		ANXIOLYTICS		
RUKOBIA	5		Anxiolytics, Other		
SELZENTRY SOLN	3	[EDS]	<i>bupirone</i>	2	[EDS]
SELZENTRY 25MG & 75MG	3	[EDS]	<i>meprobamate</i>	4	[EDS]
SUNLENCA	5		Benzodiazepines		
TYBOST	3	[EDS]	<i>alprazolam ir tabs</i>	2	[QL] [EDS]
Anti-HIV Agents, Protease Inhibitors (PI)			<i>clorazepate</i>	4	[EDS]
APTIVUS CAPS	5		<i>diazepam soln</i>	4	[PA] [EDS]
<i>atazanavir sulfate caps</i>	4	[EDS]	<i>diazepam tabs</i>	3	[PA] [EDS]
<i>darunavir tab 600mg</i>	4	[EDS]	<i>lorazepam soln</i>	3	[EDS]
<i>darunavir tab 800mg</i>	5		<i>lorazepam tabs</i>	2	[EDS]
EVOTAZ	5		BIPOLAR AGENTS		
<i>fosamprenavir tabs</i>	5		Mood Stabilizers		
<i>lopinavir & ritonavir</i>	4	[EDS]	<i>lamotrigine odt</i>	4	[EDS]
NORVIR POWDER	3	[EDS]	<i>lamotrigine chewable tabs</i>	2	[EDS]
PREZCOBIX	5		<i>lamotrigine immediate-release tabs</i>	2	[EDS]
PREZISTA SUSP 100MG/ML	4	[EDS]	<i>lithium carbonate</i>	2	[EDS]
PREZISTA TABS 75MG & 150MG	4	[EDS]	<i>lithium carbonate er</i>	2	[EDS]
REYATAZ ORAL POWDER	5		<i>lithium oral soln</i>	2	[EDS]
<i>ritonavir tabs</i>	3	[EDS]	<i>subvenite tabs</i>	2	[EDS]
SYMTUZA	5		BLOOD GLUCOSE REGULATORS		
VIRACEPT	5		Antidiabetic Agents		
			<i>acarbose</i>	2	[EDS]
			BYDUREON BCISE INJ	3	[PA] [QL] [EDS]
			<i>glimepiride</i>	1	[EDS]

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<i>glimepiride & pioglitazone</i>	2	[QL] [EDS]	Insulins		
<i>glipizide er</i>	1	[EDS]	HUMALOG CARTRIDGE INJ	3	[EDS]
<i>glipizide tabs 5mg & 10mg</i>	1	[EDS]	HUMALOG JUNIOR KWIKPEN INJ	3	[EDS]
<i>glipizide & metformin tabs</i>	1	[EDS]	HUMALOG KWIKPEN INJ	3	[EDS]
GLYXAMBI	3	[QL] [EDS]	HUMALOG MIX 50/50 KWIKPEN INJ	3	[EDS]
JANUMET	3	[QL] [EDS]	HUMALOG MIX 75/25 KWIKPEN INJ	3	[EDS]
JANUMET XR	3	[QL] [EDS]	HUMALOG MIX 75/25 VIAL INJ	3	[EDS]
JANUVIA	3	[QL] [EDS]	HUMALOG VIAL INJ	3	[EDS]
JENTADUETO	3	[QL] [EDS]	HUMULIN 70/30 KWIKPEN INJ	3	[EDS]
JENTADUETO XR	3	[QL] [EDS]	HUMULIN 70/30 VIAL INJ	3	[EDS]
<i>metformin tabs</i>	1	[EDS]	HUMULIN N KWIKPEN INJ	3	[EDS]
<i>metformin er uncoated tabs 500mg & 750mg</i>	1	[EDS]	HUMULIN N VIAL INJ	3	[EDS]
MOUNJARO INJ	3	[PA] [QL] [EDS]	HUMULIN R U-500 (CONCENTRATED) KWIKPEN INJ	3	[EDS]
<i>nateglinide</i>	2	[EDS]	HUMULIN R U-500 (CONCENTRATED) VIAL INJ	3	[EDS]
OZEMPIC INJ	3	[PA] [QL] [EDS]	HUMULIN R VIAL INJ	3	[EDS]
<i>pioglitazone</i>	1	[EDS]	INSULIN LISPRO VIAL INJ	3	[EDS]
<i>pioglitazone & metformin</i>	2	[EDS]	LANTUS SOLOSTAR PEN INJ	3	[EDS]
<i>repaglinide</i>	2	[EDS]	LANTUS VIAL INJ	3	[EDS]
RYBELSUS	3	[PA] [QL] [EDS]	LYUMJEV VIAL INJ	3	[EDS]
SOLIQUA INJ	3	[EDS]	LYUMJEV KWIKPEN INJ	3	[EDS]
SYMLINPEN INJ	5		TOUJEO SOLOSTAR INJ	3	[EDS]
SYNJARDY	3	[QL] [EDS]	TOUJEO MAX SOLOSTAR INJ	3	[EDS]
SYNJARDY XR	3	[QL] [EDS]	TRESIBA VIAL INJ	3	[EDS]
TRADJENTA	3	[QL] [EDS]			
TRIJARDY XR	3	[QL] [EDS]			
TRULICITY INJ	3	[PA] [QL] [EDS]			
XIGDUO XR	3	[QL] [EDS]			
Glycemic Agents					
<i>diazoxide</i>	5				
GLUCAGON EMERGENCY KIT INJ	3	[EDS]			
GVOKE INJ	3	[EDS]			
ZEGALOGUE INJ	3	[EDS]			

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Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
TRESIBA FLEXTOUCH INJ	3	[EDS]	RETACRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML,10000 UNIT/ML, 20000UNIT/2ML & 20000UNIT/ML	3	[PA] [EDS]
BLOOD PRODUCTS AND MODIFIERS					
Anticoagulants					
<i>dabigatran etexilate</i>	4	[QL] [EDS]	RETACRIT INJ 40000UNIT/ML	5	[PA]
ELIQUIS STARTER PACK & TABS	3	[QL] [EDS]	UDENYCA INJ	5	[PA]
<i>enoxaparin inj syringe</i>	4	[EDS]	Hemostasis Agents		
<i>fondaparinux inj 2.5mg/0.5ml & 5mg/0.4ml</i>	4	[EDS]	<i>tranexamic acid tabs</i>	3	[EDS]
<i>fondaparinux inj 7.5mg/0.6ml & 10mg/0.8ml</i>	5		Platelet Modifying Agents		
<i>heparin inj vials 1000u/ml, 5000u/ml, 10000u/ml & 20000u/ml</i>	2	[PA] [B vs D] [EDS]	BRILINTA	3	[EDS]
<i>jantoven</i>	1	[EDS]	<i>cilostazol</i>	2	[EDS]
<i>warfarin</i>	1	[EDS]	<i>clopidogrel tabs 75mg</i>	1	[EDS]
XARELTO ORAL SUSP & TABS	3	[QL] [EDS]	<i>dipyridamole er & aspirin</i>	4	[EDS]
XARELTO STARTER PACK	3	[QL] [EDS]	<i>dipyridamole oral</i>	2	[EDS]
Blood Products and Modifiers, Other			<i>prasugrel</i>	2	[EDS]
<i>anagrelide</i>	2	[EDS]	CARDIOVASCULAR AGENTS		
NIVESTYM INJ	5	[PA]	Alpha-adrenergic Agonists		
PROCRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML & 10000UNIT/ML	3	[PA] [EDS]	<i>clonidine patches</i>	4	[EDS]
PROCRIT INJ 20000UNIT/ML & 40000UNIT/ML	5	[PA]	<i>clonidine tabs immediate-release</i>	1	[EDS]
PROMACTA	5	[PA] [QL] [LD]	<i>droxidopa</i>	5	[PA]
RELEUKO INJ	4	[PA]	<i>guanfacine ir</i>	2	[EDS]
			<i>midodrine tabs</i>	3	[EDS]
			Angiotensin-converting Enzyme (ACE) Inhibitors		
			<i>benazepril</i>	1	[EDS]
			<i>captopril</i>	1	[EDS]
			<i>enalapril tabs</i>	1	[EDS]
			<i>fosinopril</i>	1	[EDS]
			<i>lisinopril</i>	1	[EDS]
			<i>moexipril</i>	1	[EDS]
			<i>perindopril</i>	1	[EDS]
			<i>quinapril</i>	1	[EDS]
			<i>ramipril</i>	1	[EDS]
			<i>trandolapril</i>	1	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
Angiotensin II Receptor Antagonists			<i>propranolol ir tabs</i>		
<i>candesartan</i>	2	[EDS]	<i>propranolol er caps</i>	2	[EDS]
<i>irbesartan</i>	1	[EDS]	<i>propranolol oral soln</i>	2	[EDS]
<i>losartan</i>	1	[EDS]	Calcium Channel Blocking Agents, Dihydropyridines		
<i>olmesartan</i>	2	[EDS]	<i>amlodipine</i>	1	[EDS]
<i>telmisartan</i>	2	[EDS]	<i>felodipine er</i>	2	[EDS]
<i>valsartan tabs</i>	1	[EDS]	<i>isradipine</i>	2	[EDS]
Antiarrhythmics			<i>nicardipine caps</i>	2	[EDS]
<i>amiodarone tabs</i>	2	[EDS]	<i>nifedipine caps</i>	2	[EDS]
<i>digoxin oral soln</i>	2	[EDS]	<i>nifedipine er</i>	2	[EDS]
<i>digoxin tabs 125mcg & 250mcg</i>	2	[EDS]	<i>nimodipine</i>	4	[EDS]
<i>disopyramide phosphate</i>	4	[EDS]	Calcium Channel Blocking Agents, Nondihydropyridines		
<i>dofetilide</i>	4	[EDS]	<i>cartia xt</i>	2	[EDS]
<i>flecainide acetate</i>	2	[EDS]	<i>diltiazem tabs</i>	2	[EDS]
LANOXIN ORAL	3	[EDS]	<i>diltiazem er caps</i>	2	[EDS]
<i>mexiletine</i>	2	[EDS]	<i>dilt-xr</i>	2	[EDS]
MULTAQ	3	[EDS]	<i>tiadylt er</i>	2	[EDS]
<i>pacerone tabs</i>	2	[EDS]	<i>verapamil ir</i>	1	[EDS]
<i>propafenone tabs</i>	2	[EDS]	<i>verapamil er</i>	2	[EDS]
<i>quinidine gluconate cr</i>	4	[EDS]	<i>verapamil sr</i>	2	[EDS]
<i>quinidine sulfate</i>	2	[EDS]	Cardiovascular Agents, Other		
<i>sorine</i>	2	[EDS]	<i>aliskiren</i>	3	[EDS]
<i>sotalol tabs</i>	2	[EDS]	<i>amiloride & hydrochlorothiazide</i>	1	[EDS]
Beta-adrenergic Blocking Agents			<i>amlodipine & atorvastatin</i>	2	[EDS]
<i>acebutolol</i>	2	[EDS]	<i>amlodipine & benazepril</i>	1	[EDS]
<i>atenolol</i>	1	[EDS]	<i>amlodipine & valsartan & hydrochlorothiazide tabs</i>	2	[EDS]
<i>bisoprolol</i>	2	[EDS]	<i>atenolol & chlorthalidone</i>	1	[EDS]
<i>carvedilol</i>	1	[EDS]	<i>benazepril & hydrochlorothiazide</i>	1	[EDS]
<i>labetalol oral</i>	2	[EDS]	<i>bisoprolol & hydrochlorothiazide</i>	2	[EDS]
<i>metoprolol succinate er</i>	2	[EDS]	CORLANOR TABS	4	[PA] [EDS]
<i>metoprolol tartrate tabs 25mg, 50mg & 100mg</i>	1	[EDS]			
<i>nadolol</i>	2	[EDS]			
<i>nebivolol hcl</i>	2	[EDS]			
<i>pindolol</i>	2	[EDS]			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>enalapril & hydrochlorothiazide</i>	1	[EDS]	<i>indapamide</i>	1	[EDS]
ENTRESTO TABS	3	[QL] [EDS]	<i>metolazone</i>	2	[EDS]
<i>fosinopril & hydrochlorothiazide</i>	1	[EDS]	<i>Dyslipidemics, Fibrin Acid Derivatives</i>		
<i>irbesartan hct</i>	1	[EDS]	<i>fenofibrate caps 43mg & 130mg</i>	2	[EDS]
<i>ivabradine</i>	4	[PA] [EDS]	<i>fenofibrate micronized caps 67mg, 134mg & 200mg</i>	2	[EDS]
<i>lisinopril & hydrochlorothiazide</i>	1	[EDS]	<i>fenofibrate tabs 48mg, 54mg, 145mg & 160mg</i>	2	[EDS]
<i>losartan hct</i>	1	[EDS]	<i>fenofibric acid dr caps</i>	3	[EDS]
<i>metoprolol & hydrochlorothiazide</i>	2	[EDS]	<i>gemfibrozil</i>	2	[EDS]
<i>metyrosine caps</i>	5	[PA]	<i>Dyslipidemics, HMG CoA Reductase Inhibitors</i>		
<i>olmesartan & amlodipine</i>	2	[EDS]	<i>atorvastatin</i>	1	[EDS]
<i>olmesartan hct</i>	2	[EDS]	<i>lovastatin</i>	1	[EDS]
<i>olmesartan medoxomil & amlodipine & hydrochlorothiazide tabs</i>	2	[EDS]	<i>pravastatin</i>	1	[EDS]
<i>pentoxifylline er</i>	2	[EDS]	<i>rosuvastatin</i>	1	[EDS]
<i>ranolazine er</i>	3	[EDS]	<i>simvastatin</i>	1	[EDS]
<i>spironolactone & hydrochlorothiazide</i>	1	[EDS]	<i>Dyslipidemics, Other</i>		
<i>triamterene & hydrochlorothiazide</i>	1	[EDS]	<i>cholestyramine</i>	2	[EDS]
<i>valsartan & amlodipine</i>	1	[EDS]	<i>cholestyramine light</i>	2	[EDS]
<i>valsartan hct</i>	1	[EDS]	<i>colesevelam</i>	4	[EDS]
<i>Diuretics, Loop</i>			<i>colestipol pack</i>	2	[EDS]
<i>bumetanide inj</i>	2	[EDS]	<i>colestipol tabs</i>	2	[EDS]
<i>bumetanide tabs</i>	2	[EDS]	<i>ezetimibe</i>	2	[EDS]
<i>furosemide oral</i>	1	[EDS]	<i>ezetimibe & simvastatin</i>	3	[EDS]
<i>furosemide inj</i>	2	[EDS]	<i>icosapent ethyl</i>	4	[EDS]
<i>toremide</i>	2	[EDS]	<i>niacin er tabs</i>	3	[QL] [EDS]
<i>Diuretics, Potassium-sparing</i>			<i>omega-3-acid ethyl esters</i>	2	[EDS]
<i>amiloride</i>	2	[EDS]	<i>prevalite</i>	2	[EDS]
<i>Diuretics, Thiazide</i>			REPATHA INJ	3	[PA] [EDS]
<i>chlorthalidone</i>	1	[EDS]	VASCEPA CAPS	4	[EDS]
<i>hydrochlorothiazide</i>	1	[EDS]	<i>Mineralocorticoid Receptor Antagonists</i>		
			<i>eplerenone</i>	3	[EDS]
			KERENDIA	3	[PA] [EDS]
			<i>spironolactone tabs</i>	1	[EDS]

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Nombre del Medicamento	Nivel	Requisitos/Límites	Nombre del Medicamento	Nivel	Requisitos/Límites
Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)			<i>methylphenidate er tabs 10mg & 20mg</i>	3	[EDS]
FARXIGA	3	[QL] [EDS]	<i>methylphenidate ir tabs 5mg, 10mg & 20mg</i>	2	[EDS]
JARDIANCE	3	[QL] [EDS]	Central Nervous System, Other		
Vasodilators, Direct-acting Arterial			AUSTEDO	5	[PA] [QL] [LD]
<i>hydralazine oral</i>	2	[EDS]	AUSTEDO XR 6MG, 12MG & 24MG	5	[PA] [QL] [LD]
<i>minoxidil</i>	2	[EDS]	AUSTEDO XR 18MG, 30MG, 36MG, 42MG & 48MG	5	[PA] [QL]
Vasodilators, Direct-acting Arterial/Venous			AUSTEDO XR PATIENT TITRATION KIT	5	[PA] [QL]
<i>isosorbide dinitrate tabs 5mg, 10mg, 20mg & 30mg</i>	2	[EDS]	NUDEXTA	5	[PA]
<i>isosorbide mononitrate</i>	2	[EDS]	<i>riluzole</i>	3	[EDS]
<i>isosorbide mononitrate er</i>	2	[EDS]	<i>tetrabenazine</i>	5	[PA] [QL]
<i>nitro-bid oint</i>	2	[EDS]	Fibromyalgia Agents		
<i>nitroglycerin lingual</i>	2	[EDS]	<i>duloxetine hcl</i>	2	[EDS]
<i>nitroglycerin patches</i>	2	[EDS]	SAVELLA	3	[EDS]
<i>nitroglycerin sublingual</i>	2	[EDS]	SAVELLA TITRATION PACK	3	[EDS]
VERQUVO	4	[PA] [EDS]	Multiple Sclerosis Agents		
CENTRAL NERVOUS SYSTEM AGENTS			AVONEX INJ	5	[PA]
Attention Deficit Hyperactivity Disorder Agents, Amphetamines			AVONEX PEN INJ	5	[PA]
<i>amphetamine & dextroamphetamine tabs</i>	2	[QL] [EDS]	BETASERON INJ	5	[PA]
<i>dextroamphetamine sulfate tabs 5mg & 10mg</i>	3	[QL] [EDS]	COPAXONE INJ 40MG/ML	5	[PA]
<i>dextroamphetamine sulfate er</i>	4	[QL] [EDS]	<i>dalfampridine er</i>	3	[PA] [EDS]
<i>zenzedi tabs 5mg & 10mg</i>	3	[QL] [EDS]	<i>dimethyl fumarate caps</i>	5	[PA]
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines			<i>dimethyl fumarate starter pack</i>	5	[PA]
<i>atomoxetine</i>	3	[EDS]	<i> fingolimod hcl</i>	5	[PA]
<i>clonidine er 0.1mg</i>	2	[EDS]	<i> glatiramer acetate inj</i>	5	[PA]
<i>dexmethylphenidate ir tabs</i>	2	[EDS]	<i> glatopa inj</i>	5	[PA]
			<i> teriflunomide tabs</i>	5	[PA]
			VUMERITY	5	[PA]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
DENTAL AND ORAL AGENTS			<i>betamethasone dipropionate</i>		
<i>Dental and Oral Agents</i>			2 [EDS]		
<i>cevimeline</i>	3	[EDS]	<i>betamethasone dipropionate augmented</i>	2	[EDS]
<i>chlorhexidine gluconate</i>	2	[EDS]	<i>betamethasone valerate cream, oint & lotion</i>	2	[EDS]
<i>doxycycline hyclate immediate-release tabs 20mg</i>	2	[EDS]	<i>clobetasol propionate cream, foam, gel, oint & soln</i>	4	[EDS]
<i>kourzeq</i>	2	[EDS]	<i>clobetasol propionate emollient</i>	4	[EDS]
<i>lidocaine viscous soln</i>	2	[EDS]	<i>desonide lotion, oint & cream</i>	3	[QL] [EDS]
<i>periogard</i>	2	[EDS]	<i>desoximetasone topical cream, gel & oint 0.05%</i>	4	[QL] [EDS]
<i>pilocarpine tabs</i>	3	[EDS]	<i>desoximetasone topical cream & oint 0.25%</i>	3	[QL] [EDS]
<i>triamcinolone dental paste</i>	2	[EDS]	<i>fluocinolone acetonide cream, oint, soln</i>	3	[EDS]
DERMATOLOGICAL AGENTS			<i>fluocinolone acetonide scalp oil</i>	3	[EDS]
<i>Acne and Rosacea Agents</i>			<i>fluocinonide cream 0.05%, gel & oint</i>	2	[QL] [EDS]
<i>acitretin</i>	4	[PA] [EDS]	<i>fluocinonide emulsified base cream</i>	2	[QL] [EDS]
<i>accutane</i>	4	[EDS]	<i>fluocinonide soln</i>	2	[EDS]
<i>adapalene cream 0.1%</i>	4	[EDS]	<i>fluticasone propionate cream & oint</i>	2	[EDS]
<i>adapalene gel 0.3%</i>	4	[EDS]	<i>halobetasol propionate cream & ointment</i>	2	[EDS]
ALTRENO	3	[PA] [EDS]	<i>hydrocortisone lotion & oint 2.5%</i>	2	[EDS]
<i>amnestem caps</i>	4	[EDS]			
<i>claravis</i>	4	[EDS]			
<i>isotretinoin caps 10mg, 20mg, 30mg & 40mg</i>	4	[EDS]			
<i>metronidazole topical</i>	3	[EDS]			
<i>tazarotene cream</i>	4	[EDS]			
<i>tazarotene gel</i>	4	[QL] [EDS]			
<i>tretinoin cream</i>	3	[PA] [EDS]			
<i>tretinoin gel 0.01%, 0.025% & 0.05%</i>	3	[PA] [EDS]			
<i>zenatane</i>	4	[EDS]			
<i>Dermatitis and Pruritus Agents</i>					
<i>alclometasone dipropionate</i>	2	[EDS]			
<i>ammonium lactate</i>	2	[EDS]			

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Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>hydrocortisone butyrate cream & soln</i>	2	[EDS]	<i>permethrin cream</i>	2	[EDS]
<i>hydrocortisone valerate</i>	2	[EDS]	Topical Anti-infectives		
<i>mometasone cream, oint & soln</i>	2	[EDS]	<i>acyclovir cream & oint 5%</i>	4	[QL] [EDS]
<i>pimecrolimus</i>	4	[QL] [EDS]	<i>ciclopirox cream, gel, nail soln, shampoo & susp</i>	2	[EDS]
<i>selenium sulfide lotion</i>	2	[EDS]	<i>clindamycin gel 1%</i>	3	[EDS]
<i>tacrolimus oint</i>	4	[QL] [EDS]	<i>clindamycin lotion & soln</i>	2	[EDS]
<i>triamcinolone acetonide topical cream & lotion</i>	2	[EDS]	<i>erythromycin topical gel & soln</i>	2	[EDS]
<i>triamcinolone acetonide topical oint 0.025%, 0.1% & 0.5%</i>	2	[EDS]	<i>mupirocin ointment</i>	2	[EDS]
<i>triderm cream 0.1%</i>	2	[EDS]	<i>mupirocin cream</i>	4	[QL] [EDS]
Dermatological Agents, Other			ELECTROLYTES/MINERALS/METALS/ VITAMINS		
<i>calcipotriene cream & oint</i>	4	[QL] [EDS]	Electrolyte/Mineral/Metal Modifiers		
<i>calcipotriene soln</i>	3	[EDS]	<i>deferasirox granule pack, tabs & tabs for soln</i>	3	[PA] [EDS]
<i>clotrimazole & betamethasone</i>	2	[EDS]	<i>deferiprone</i>	5	[PA]
<i>diclofenac sodium gel 3%</i>	4	[PA] [EDS]	<i>penicillamine tabs</i>	5	
<i>fluorouracil topical 2% and 5%</i>	3	[EDS]	<i>trientine cap 250mg</i>	5	
<i>imiquimod cream 5%</i>	3	[EDS]	Electrolyte/Mineral Replacement		
<i>methoxsalen</i>	5		<i>carglumic acid</i>	5	[PA]
<i>nystatin & triamcinolone</i>	3	[EDS]	CLINISOL SF INJ	4	[PA] [B vs D] [EDS]
OTEZLA	5	[PA] [QL]	<i>dextrose inj</i>	2	[EDS]
<i>podofilox soln</i>	2	[EDS]	<i>dextrose (10%, 5% or 2.5%) & sodium chloride inj</i>	2	[EDS]
<i>silver sulfadiazine</i>	2	[EDS]	<i>klor-con pack</i>	4	[EDS]
REGRANEX	5	[PA] [QL]	<i>klor-con tabs</i>	2	[EDS]
SANTYL	3	[QL] [EDS]	<i>magnesium sulfate inj</i>	2	[EDS]
<i>ssd</i>	2	[EDS]	<i>plenamine inj</i>	2	[PA] [B vs D] [EDS]
Pediculicides/Scabicides			<i>potassium chloride oral soln</i>	4	[EDS]
<i>malathion</i>	4	[EDS]	<i>potassium chloride inj</i>	2	[EDS]

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Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>potassium chloride pack 20meq</i>	4	[EDS]	<i>enulose</i>	2	[EDS]
<i>potassium chloride er & cr</i>	2	[EDS]	<i>generlac</i>	2	[EDS]
<i>potassium chloride & dextrose 20mEq/5% inj</i>	2	[EDS]	<i>lactulose soln 10g/15ml</i>	2	[EDS]
<i>potassium chloride & dextrose & lactated ringers inj</i>	2	[EDS]	LINZESS	3	[EDS]
<i>potassium chloride & dextrose & sodium chloride inj 10mEq/5%/0.45%, 20mEq/5%/0.2%, 20mEq/5%/0.45%, 20mEq/5%/0.9%, 30mEq/5%/0.45% 40mEq/5%/0.9% & 40mEq/5%/0.45%</i>	2	[EDS]	<i>lubiprostone</i>	3	[EDS]
<i>potassium citrate er</i>	2	[EDS]	MOVANTIK	3	[EDS]
PROSOL INJ	4	[PA] [B vs D] [EDS]	RELISTOR INJ	5	[PA]
<i>sodium chloride inj</i>	2	[EDS]	RELISTOR TABS	5	[PA]
TPN ELECTROLYTES INJ	3	[EDS]	Anti-Diarrheal Agents		
TRAVASOL INJ	4	[PA] [B vs D] [EDS]	<i>alose tron hcl tab 0.5mg</i>	4	[PA] [EDS]
Potassium Binders			<i>alose tron hcl tab 1mg</i>	5	[PA]
<i>kionex susp</i>	2	[EDS]	<i>diphenoxylate & atropine oral soln</i>	4	[EDS]
LOKELMA	3	[EDS]	<i>diphenoxylate & atropine tabs</i>	4	[EDS]
<i>sodium polystyrene sulfonate powder</i>	2	[EDS]	<i>loperamide caps 2mg</i>	2	[EDS]
<i>sps suspension</i>	2	[EDS]	XERMELO	5	[PA]
VELTASSA	3	[EDS]	Antispasmodics, Gastrointestinal		
Vitamins			<i>dicyclomine</i>	4	[PA] [EDS]
<i>prenatal multi-vitamin</i>	2	[EDS]	<i>glycopyrrolate tabs 1mg & 2mg</i>	2	[EDS]
GASTROINTESTINAL AGENTS			Gastrointestinal Agents, Other		
Anti-Constipation Agents			<i>gavilyte-c</i>	2	[EDS]
<i>constulose soln</i>	2	[EDS]	<i>gavilyte-g</i>	2	[EDS]
			<i>gavilyte-n</i>	2	[EDS]
			<i>metoclopramide oral tablets & soln</i>	2	[EDS]
			<i>nitroglycerin rectal oint</i>	4	[EDS]
			<i>peg 3350 & electrolytes</i>	2	[EDS]
			<i>peg 3350 & sodium chloride & sodium bicarbonate & potassium chloride</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
Nombre del Medicamento	Nivel	Requisitos/Límites	Nombre del Medicamento	Nivel	Requisitos/Límites
<i>peg 3350 & sodium sulfate & sodium chloride & potassium chloride & sodium ascorbate & ascorbic</i>	3	[EDS]	CYSTAGON	3	[EDS]
PLENVU	3	[EDS]	ENDARI	5	[PA]
<i>sodium sulfate, potassium sulfate and magnesium sulfate</i>	3	[EDS]	<i>l-glutamine</i>	5	[PA]
<i>ursodiol cap 300mg & tabs 250mg & 500mg</i>	3	[EDS]	<i>miglustat</i>	5	[PA] [LD]
VOWST	5	[PA] [LD]	<i>nitisinone</i>	5	[PA]
XIFAXAN TABS 200MG	3	[PA] [EDS]	PROLASTIN C INJ	5	[PA] [LD]
XIFAXAN TABS 550MG	5	[PA]	<i>sapropterin</i>	5	
Histamine2 (H2) Receptor Antagonists			<i>sodium phenylbutyrate powder & tabs</i>	5	
<i>cimetidine tabs</i>	2	[EDS]	WELIREG	5	[PA] [LD]
<i>famotidine tabs</i>	1	[EDS]	GENITOURINARY AGENTS		
Protectants			Antispasmodics, Urinary		
<i>misoprostol</i>	2	[EDS]	<i>fesoterodine fumarate er</i>	3	[EDS]
<i>sucralfate tabs</i>	2	[EDS]	GEMTESA	4	[EDS]
Proton Pump Inhibitors			MYRBETRIQ	3	[EDS]
<i>esomeprazole magnesium dr caps</i>	3	[EDS]	<i>oxybutynin ir</i>	2	[EDS]
<i>lansoprazole dr caps</i>	2	[EDS]	<i>oxybutynin er</i>	2	[EDS]
<i>omeprazole caps</i>	1	[EDS]	<i>solifenacin succinate</i>	3	[EDS]
<i>pantoprazole tabs</i>	1	[EDS]	<i>tolterodine tartrate er</i>	4	[QL] [EDS]
<i>rabeprazole sodium</i>	3	[EDS]	<i>trosipium ir</i>	2	[EDS]
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT			Benign Prostatic Hypertrophy Agents		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment			<i>alfuzosin hcl er</i>	2	[EDS]
<i>betaine anhydrous</i>	5		<i>doxazosin</i>	2	[EDS]
CERDELGA	5	[PA]	<i>dutasteride</i>	3	[EDS]
CREON DR	3	[EDS]	<i>dutasteride & tamsulosin</i>	3	[EDS]
<i>cromolyn sodium oral</i>	4	[EDS]	<i>finasteride tabs 5mg</i>	1	[EDS]
			<i>prazosin</i>	2	[EDS]
			<i>tadalafil 2.5mg & 5mg</i>	4	[PA] [QL] [EDS]
			<i>tamsulosin</i>	1	[EDS]
			<i>terazosin</i>	1	[EDS]
			Genitourinary Agents, Other		
			<i>bethanechol</i>	2	[EDS]
			ELMIRON	4	[EDS]
			<i>tiopronin</i>	5	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)			HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</i>			<i>Androgens</i>		
<i>dexamethasone dose pack</i>	2	[EDS]	<i>desmopressin acetate oral</i>	2	[EDS]
<i>dexamethasone elixir</i>	2	[EDS]	GENOTROPIN INJ	5	[PA]
<i>dexamethasone tabs</i>	2	[EDS]	GENOTROPIN MINIQUICK INJ 0.2MG, 0.4MG, 0.6MG & 0.8MG	4	[PA] [EDS]
<i>fludrocortisone acetate</i>	2	[EDS]	GENOTROPIN MINIQUICK INJ 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG & 2MG	5	[PA]
HEMADY	4	[EDS]	HUMATROPE INJ CARTRIDGE 6MG	4	[PA] [EDS]
<i>hydrocortisone oral</i>	2	[EDS]	HUMATROPE INJ CARTRIDGE 12MG & 24MG	5	[PA]
MEDROL TABS	4	[PA] [B vs D] [EDS]	INCRELEX INJ	5	[PA]
<i>methylprednisolone dose pack</i>	2	[EDS]	LUPRON DEPOT- PED (6-MONTH) INJ	5	[PA]
<i>methylprednisolone oral</i>	2	[PA] [B vs D] [EDS]	HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
ORAPRED ODT	4	[PA] [B vs D] [EDS]	<i>Estrogens</i>		
<i>prednisolone oral soln</i>	2	[PA] [B vs D] [EDS]	<i>altavera</i>	2	[EDS]
<i>prednisolone odt</i>	4	[PA] [B vs D] [EDS]	<i>alyacen 1/35</i>	2	[EDS]
<i>prednisolone tablet 5mg</i>	4	[PA] [B vs D] [EDS]	<i>apri</i>	2	[EDS]
PREDNISON INTENSOL	4	[PA] [B vs D] [EDS]	<i>aranelle</i>	2	[EDS]
<i>prednisone oral soln</i>	2	[PA] [B vs D] [EDS]	<i>aubra eq</i>	2	[EDS]
<i>prednisone tabs</i>	1	[PA] [B vs D] [EDS]	HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)		
<i>prednisone tab pack</i>	1	[EDS]	<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</i>		
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)			<i>desmopressin acetate nasal</i>		
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</i>			4		
<i>desmopressin acetate nasal</i>	4	[EDS]			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>aviane</i>	2	[EDS]	<i>introvale</i>	2	[EDS]
<i>azurette</i>	2	[EDS]	<i>isibloom</i>	2	[EDS]
<i>blisovi fe 1.5/30</i>	2	[EDS]	<i>jasmiel</i>	2	[EDS]
<i>briellyn</i>	2	[EDS]	<i>jinteli</i>	2	[EDS]
<i>cyred eq</i>	2	[EDS]	<i>juleber</i>	2	[EDS]
<i>desogestrel & ethinyl estradiol</i>	2	[EDS]	<i>junel 21 day</i>	2	[EDS]
<i>dotti</i>	2	[EDS]	<i>junel fe 1/20</i>	2	[EDS]
<i>drospirenone & ethinyl estradiol 3mg/0.02mg</i>	2	[EDS]	<i>kariva</i>	2	[EDS]
<i>eluryng</i>	3	[EDS]	<i>kelnor 1/35 & 1/50</i>	2	[EDS]
<i>enilloring</i>	3	[EDS]	<i>kurvelo</i>	2	[EDS]
<i>enpresse-28</i>	2	[EDS]	<i>larin</i>	2	[EDS]
<i>enskyce</i>	2	[EDS]	<i>larin fe</i>	2	[EDS]
<i>estarylla</i>	2	[EDS]	<i>leena</i>	2	[EDS]
<i>estradiol oral</i>	2	[EDS]	<i>levonest</i>	2	[EDS]
<i>estradiol patches</i>	2	[EDS]	<i>levonorgestrel & ethinyl estradiol 0.1- 0.02mg & 0.15- 0.03mg & triphasic packs</i>	2	[EDS]
<i>estradiol vaginal cream</i>	2	[EDS]	<i>levonorgestrel & ethinyl estradiol and ethinyl estradiol 0.1/0.02mg-0.01mg packs</i>	2	[EDS]
<i>estradiol vaginal tabs</i>	2	[EDS]	<i>levora</i>	2	[EDS]
<i>estradiol & norethindrone acetate 0.5mg/0.1mg & 1mg/0.5mg</i>	2	[EDS]	<i>loryna</i>	2	[EDS]
ESTRING	3	[EDS]	<i>low-ogestrel</i>	2	[EDS]
<i>ethinyl estradiol & ethynodiol</i>	2	[EDS]	<i>lyllana</i>	2	[EDS]
<i>ethinyl estradiol & norethindrone acetate 5mcg/1mg & 2.5mcg-0.5mg</i>	2	[EDS]	<i>marlissa 28 day</i>	2	[EDS]
<i>etonogestrel & ethinyl estradiol ring</i>	3	[EDS]	MENEST	3	[EDS]
<i>falmina</i>	2	[EDS]	<i>microgestin 1/20 & 1.5/30</i>	2	[EDS]
<i>fyavolv</i>	2	[EDS]	<i>microgestin 24 fe</i>	2	[EDS]
<i>haloette</i>	3	[EDS]	<i>microgestin fe 1/20 & 1.5/30</i>	2	[EDS]
IMVEXXY PACK	3	[EDS]	<i>mili</i>	2	[EDS]
			<i>mimvey</i>	2	[EDS]
			<i>necon</i>	2	[EDS]
			<i>nikki</i>	2	[EDS]
			<i>norelgestromin/ethin yl estradiol patch</i>	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>norethindrone, ethinyl estradiol, ferrous fumarate 0.4mg/0.035mg</i>	2	[EDS]	Progestins		
<i>norethindrone, ethinyl estradiol, ferrous fumarate 20mcg/75mg/1mg</i>	2	[EDS]	<i>deblitane</i>	2	[EDS]
<i>norgestimate-ethinyl estradiol</i>	2	[EDS]	DEPO-SUBQ PROVERA 104 INJ	3	[EDS]
<i>nylia 7/7/7 & 1/35</i>	2	[EDS]	<i>heather tabs</i>	2	[EDS]
<i>nymyo</i>	2	[EDS]	<i>incassia</i>	2	[EDS]
<i>pimtrea</i>	2	[EDS]	LILETTA	3	[EDS]
PREMARIN ORAL	3	[EDS]	<i>lyleq</i>	2	[EDS]
PREMARIN VAGINAL CREAM	3	[EDS]	<i>lyza</i>	2	[EDS]
PREMPHASE	3	[EDS]	<i>medroxyprogesteron e acetate inj</i>	2	[EDS]
PREMPRO	3	[EDS]	<i>medroxyprogesteron e acetate tabs</i>	2	[EDS]
<i>reclipsen</i>	2	[EDS]	<i>megestrol acetate oral susp 40mg/ml</i>	2	[EDS]
<i>setlakin</i>	2	[EDS]	<i>megestrol tabs</i>	2	[EDS]
<i>tarina fe 1/20 eq</i>	2	[EDS]	NEXPLANON	3	[EDS]
<i>tri-estarylla</i>	2	[EDS]	<i>norethindrone</i>	2	[EDS]
<i>tri-lo-estarylla</i>	2	[EDS]	<i>progesterone caps</i>	2	[EDS]
<i>tri-lo-sprintec</i>	2	[EDS]	<i>sharobel</i>	2	[EDS]
<i>tri-mili</i>	2	[EDS]	Selective Estrogen Receptor Modifying Agents		
<i>tri-nymyo</i>	2	[EDS]	DUAVEE	3	[EDS]
<i>tri-sprintec</i>	2	[EDS]	<i>raloxifene hcl</i>	3	[EDS]
<i>tri-vylibra</i>	2	[EDS]	HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
<i>tri-vylibra lo</i>	2	[EDS]	Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
<i>trivora-28</i>	2	[EDS]	CYTOMEL	3	[EDS]
<i>turqoz</i>	2	[EDS]	<i>levothyroxine tabs</i>	1	[EDS]
<i>velivet</i>	2	[EDS]	<i>levoxyl</i>	1	[EDS]
<i>vestura</i>	2	[EDS]	<i>liothyronine tabs</i>	2	[EDS]
<i>vienva</i>	2	[EDS]	SYNTHROID	3	[EDS]
<i>vyfemla</i>	2	[EDS]	<i>unithroid</i>	1	[EDS]
<i>vylibra</i>	2	[EDS]	HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)		
<i>wymzya fe</i>	2	[EDS]	Hormonal Agents, Suppressant (Adrenal or Pituitary)		
<i>xulane</i>	3	[EDS]	<i>cabergoline</i>	2	[EDS]
<i>yuvafem</i>	2	[EDS]	ELIGARD INJ	4	[PA] [EDS]
<i>zafemy</i>	3	[EDS]	<i>leuprolide acetate inj kit 1mg/0.2ml</i>	4	[PA] [EDS]
<i>zovia</i>	2	[EDS]			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
LUPRON DEPOT INJ	5	[PA]	DUPIXENT INJ	5	[PA] [QL]
LUPRON DEPOT-PED (1-MONTH & 3-MONTH) INJ	5	[PA]	ORENCIA INJ	5	[PA] [QL]
<i>mifepristone tabs 300mg</i>	5	[PA]	OTEZLA STARTER	5	[PA] [QL]
<i>octreotide inj 50mcg/ml, 100mcg/ml, 200mcg/ml & 500mcg/ml</i>	4	[PA] [EDS]	RIDAURA	5	
<i>octreotide inj 1000mcg/ml</i>	5	[PA]	RINVOQ	5	[PA] [QL]
ORGOVYX	5	[PA] [LD]	SKYRIZI INJ	5	[PA] [QL]
SIGNIFOR INJ	5	[PA]	STELARA INJ	5	[PA] [QL]
SOMAVERT INJ	5	[PA]	TREMFYA INJ	5	[PA] [QL]
SYNAREL	4	[EDS]	XELJANZ	5	[PA] [QL]
TRELSTAR MIXJECT INJ	4	[PA] [EDS]	XELJANZ XR	5	[PA] [QL]
HORMONAL AGENTS, SUPPRESSANT (THYROID)			XOLAIR INJ	5	[PA] [QL] [LD]
<i>Antithyroid Agents</i>			<i>Immunostimulants</i>		
<i>methimazole</i>	2	[EDS]	ACTIMMUNE INJ	5	[PA]
<i>propylthiouracil</i>	2	[EDS]	BESREMI INJ	5	[PA] [LD]
IMMUNOLOGICAL AGENTS			PEGASYS VIAL INJ	5	[PA]
<i>Angioedema Agents</i>			<i>Immunosuppressants</i>		
CINRYZE INJ	5	[PA]	ASTAGRAF XL	4	[PA] [B vs D] [EDS]
<i>icatibant inj</i>	5	[PA] [QL]	AZASAN	4	[PA] [B vs D] [EDS]
<i>sajazir inj</i>	5	[PA]	<i>azathioprine tabs 50mg</i>	2	[PA] [B vs D] [EDS]
<i>Immunoglobulins</i>			<i>azathioprine tabs 75mg & 100mg</i>	4	[PA] [B vs D] [EDS]
GAMMAGARD INJ	5	[PA] [B vs D]	CELLCEPT CAPS	4	[PA] [B vs D] [EDS]
GAMUNEX-C INJ	5	[PA] [B vs D]	CELLCEPT ORAL SUSPENSION & TABS	5	[PA] [B vs D]
<i>Immunological Agents, Other</i>			<i>cyclosporine caps</i>	3	[PA] [B vs D] [EDS]
ARCALYST INJ	5	[PA]	<i>cyclosporine modified</i>	2	[PA] [B vs D] [EDS]
BENLYSTA INJ	5	[PA]	ENBREL INJ	5	[PA] [QL]
COSENTYX INJ	5	[PA] [QL]	ENBREL MINI INJ	5	[PA] [QL]
COSENTYX SENSOREADY PEN INJ	5	[PA] [QL]	ENBREL SURECLICK INJ	5	[PA] [QL]
COSENTYX UNOREADY PEN INJ	5	[PA] [QL]	ENVARUSUS XR	4	[PA] [B vs D] [EDS]

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<i>everolimus 0.25mg</i>	4	[PA] [B vs D] [EDS]	RAPAMUNE SOLN	5	[PA] [B vs D]
<i>everolimus 0.5mg, 0.75mg & 1mg</i>	5	[PA] [B vs D]	RAPAMUNE TABS	4	[PA] [B vs D] [EDS]
<i>gengraf</i>	2	[PA] [B vs D] [EDS]	SANDIMMUNE CAPS 25MG & 100MG	4	[PA] [B vs D] [EDS]
HUMIRA INJ	5	[PA] [QL]	<i>sirolimus soln</i>	5	[PA] [B vs D]
HUMIRA PEN- CD/UC/HS STARTER INJ	5	[PA] [QL]	<i>sirolimus tabs</i>	4	[PA] [B vs D] [EDS]
HUMIRA PEN- PEDIATRIC UC STARTER PACK INJ	5	[PA] [QL]	<i>tacrolimus caps 0.5mg & 1mg</i>	3	[PA] [B vs D] [EDS]
HUMIRA PEN-PS/UV STARTER INJ	5	[PA] [QL]	<i>tacrolimus caps 5mg</i>	4	[PA] [B vs D] [EDS]
HUMIRA PEN INJ	5	[PA] [QL]	Vaccines		
IMURAN TABS	4	[PA] [B vs D] [EDS]	ABRYSVO INJ	3	[EDS]
JYLAMVO SOLN	4	[EDS]	ACTHIB INJ	3	[EDS]
<i>leflunomide</i>	2	[QL] [EDS]	ADACEL INJ	3	[EDS]
<i>methotrexate inj 50mg/2ml</i>	2	[EDS]	AREXVY INJ	3	[EDS]
<i>methotrexate oral</i>	2	[EDS]	BCG INJ	3	[EDS]
<i>mycophenolate mofetil caps & tabs</i>	2	[PA] [B vs D] [EDS]	BEXSERO INJ	3	[EDS]
<i>mycophenolate mofetil oral susp</i>	5	[PA] [B vs D]	BOOSTRIX INJ	3	[EDS]
<i>mycophenolic acid dr</i>	4	[PA] [B vs D] [EDS]	DAPTACEL INJ	3	[EDS]
MYFORTIC	4	[PA] [B vs D] [EDS]	DIPHTHERIA & TETANUS TOXOIDS PEDIATRIC INJ	3	[EDS]
MYHIBBIN	4	[PA] [B vs D] [EDS]	ENGERIX-B INJ	3	[PA] [B vs D] [EDS]
NEORAL	4	[PA] [B vs D] [EDS]	GARDASIL 9 INJ	4	[EDS]
PEGASYS SYRINGE INJ	5	[PA]	HAVRIX INJ	3	[EDS]
PROGRAF CAPS	4	[PA] [B vs D] [EDS]	HEPLISAV-B INJ	3	[PA] [B vs D] [EDS]
PROGRAF PACK	4	[PA] [B vs D] [EDS]	HIBERIX INJ	3	[EDS]
			IMOVAX RABIES INJ	3	[EDS]
			INFANRIX INJ	3	[EDS]
			IPOL INACTIVATED IPV INJ	3	[EDS]
			IXCHIQ INJ	3	[EDS]
			IXIARO INJ	4	[EDS]
			JYNNEOS INJ	3	[PA] [B vs D] [EDS]
			KINRIX INJ	3	[EDS]
			MENACTRA INJ	3	[EDS]

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Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
MENQUADFI INJ	3	[EDS]	Glucocorticoids		
MENVEO-A/C/Y/W-135 INJ	3	[EDS]	<i>budesonide ec caps</i>	4	[PA] [EDS]
MRESVIA INJ	3	[EDS]	<i>budesonide er tabs 9mg</i>	5	[PA]
M-M-R II INJ	3	[EDS]	<i>hydrocortisone cream 2.5%</i>	2	[EDS]
PEDIARIX INJ	3	[EDS]	<i>hydrocortisone enema</i>	2	[EDS]
PEDVAX HIB INJ	3	[EDS]	<i>procto-med hc</i>	2	[EDS]
PENBRAYA INJ	3	[EDS]	<i>proctosol hc</i>	2	[EDS]
PENTACEL INJ	3	[EDS]	<i>proctozone-hc</i>	2	[EDS]
PREHEVBRIO INJ	3	[PA] [B vs D] [EDS]	METABOLIC BONE DISEASE AGENTS		
PRIORIX INJ	3	[EDS]	Metabolic Bone Disease Agents		
PROQUAD INJ	3	[EDS]	<i>alendronate tabs</i>	1	[EDS]
QUADRACEL INJ	3	[EDS]	<i>calcitonin-salmon nasal</i>	2	[EDS]
RABAVERT INJ	3	[EDS]	<i>calcitriol caps</i>	2	[PA] [B vs D] [EDS]
RECOMBIVAX HB INJ	3	[PA] [B vs D] [EDS]	<i>cinacalcet tab 30mg & 60mg</i>	4	[PA] [B vs D] [EDS]
ROTARIX	3	[EDS]	<i>cinacalcet tab 90mg</i>	5	[PA] [B vs D]
ROTATEQ	3	[EDS]	<i>doxercalciferol oral</i>	4	[PA] [B vs D] [EDS]
SHINGRIX INJ	3	[EDS]	<i>ibandronate oral</i>	2	[EDS]
TDVAX INJ	3	[EDS]	<i>paricalcitol caps</i>	3	[PA] [B vs D] [EDS]
TENIVAC INJ	3	[EDS]	PROLIA INJ	4	[PA] [EDS]
TICOVAC INJ	4	[EDS]	RAYALDEE	5	
TRUMENBA INJ	3	[EDS]	<i>risedronate sodium</i>	3	[EDS]
TWINRIX INJ	3	[EDS]	<i>risedronate sodium dr</i>	3	[EDS]
TYPHIM VI INJ	3	[EDS]	TERIPARATIDE INJ	5	[PA]
VAQTA INJ	3	[EDS]	TYMLOS INJ	5	[PA]
VARIVAX INJ	3	[EDS]	XGEVA INJ	5	[PA]
VAXCHORA INJ	3	[EDS]	MISCELLANEOUS THERAPEUTIC AGENTS		
YF-VAX INJ	3	[EDS]	Miscellaneous Therapeutic Agents		
INFLAMMATORY BOWEL DISEASE AGENTS			<i>alcohol pads</i>	2	[PA] [EDS]
Aminosalicylates			<i>bd insulin syringe</i>	2	[PA] [EDS]
<i>balsalazide</i>	3	[EDS]	<i>ultrafine</i>		
<i>mesalamine dr</i>	4	[EDS]			
<i>mesalamine enema</i>	4	[EDS]			
<i>mesalamine er caps</i>	4	[QL] [EDS]			
<i>mesalamine rectal suppository</i>	4	[EDS]			
<i>sulfasalazine</i>	2	[EDS]			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>bd insulin syringe safetyglide</i>	2	[PA] [EDS]	<i>neomycin & polymyxin & hydrocortisone</i>	2	[EDS]
<i>bd pen needle ultrafine</i>	2	[PA] [EDS]	<i>neo-polycin ophthalmic ointment</i>	2	[EDS]
<i>gauze pads 2"x2"</i>	2	[PA] [EDS]	<i>neo-polycin hc ophthalmic ointment</i>	2	[EDS]
INTRALIPID INJ	4	[PA] [B vs D] [EDS]	<i>polycin ophthalmic ointment</i>	2	[EDS]
<i>levocarnitine oral</i>	2	[PA] [B vs D] [EDS]	<i>polymyxin b sulfate & trimethoprim sulfate ophthalmic soln</i>	2	[EDS]
<i>sodium chloride irrigation soln</i>	2	[EDS]	ROCKLATAN	3	[EDS]
OPHTHALMIC AGENTS			SIMBRINZA	4	[EDS]
<i>Ophthalmic Agents, Other</i>			<i>sulfacetamide sodium & prednisolone sodium phosphate ophthalmic</i>	2	[EDS]
<i>atropine sulfate soln</i>	2	[EDS]	TOBRADEX OINT	3	[EDS]
<i>bacitracin & polymyxin b ointment</i>	2	[EDS]	<i>tobramycin & dexamethasone ophthalmic suspension</i>	2	[EDS]
<i>brimonidine & timolol maleate</i>	4	[EDS]	XIIDRA	3	[EDS]
<i>cyclosporine emulsion 0.05%</i>	3	[EDS]	<i>Ophthalmic Anti-allergy Agents</i>		
CYSTARAN	5		<i>azelastine 0.05%</i>	2	[EDS]
<i>dorzolamide & timolol maleate</i>	2	[EDS]	<i>cromolyn sodium ophthalmic soln</i>	2	[EDS]
<i>neomycin & polymyxin & bacitracin</i>	2	[EDS]	<i>Ophthalmic Anti-infectives</i>		
<i>neomycin & polymyxin & bacitracin & hydrocortisone</i>	2	[EDS]	AZASITE	3	[EDS]
<i>neomycin & polymyxin & dexamethasone</i>	2	[EDS]	<i>bacitracin ophthalmic ointment</i>	2	[EDS]
<i>neomycin & polymyxin & gramicidin ophthalmic</i>	2	[EDS]	<i>ciprofloxacin ophthalmic soln 0.3%</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>erythromycin ophthalmic oint</i>	2	[EDS]	<i>timolol ophthalmic gel forming</i>	2	[EDS]
<i>gentamicin ophthalmic soln 0.3%</i>	2	[EDS]	<i>timolol ophth soln 12 hours 0.25% & 0.5% multi-use bottles</i>	1	[EDS]
<i>moxifloxacin hcl ophthalmic</i>	2	[EDS]	Ophthalmic Intraocular Pressure Lowering Agents, Other		
<i>ofloxacin ophthalmic</i>	2	[EDS]	<i>acetazolamide tabs</i>	2	[EDS]
<i>sulfacetamide sodium ophthalmic oint & soln 10%</i>	2	[EDS]	<i>acetazolamide er caps</i>	2	[EDS]
<i>tobramycin ophthalmic solution</i>	2	[EDS]	<i>brimonidine tartrate soln 0.15% & 0.1%</i>	4	[EDS]
<i>trifluridine</i>	2	[EDS]	<i>brimonidine tartrate soln 0.2%</i>	2	[EDS]
XDEMYVY	5	[PA] [QL]	<i>dorzolamide</i>	2	[EDS]
ZIRGAN	4	[EDS]	<i>methazolamide</i>	4	[EDS]
Ophthalmic Anti-inflammatories			<i>pilocarpine soln</i>	2	[EDS]
<i>bromfenac ophthalmic soln 0.07% & 0.075%</i>	4	[EDS]	RHOPRESSA	3	[EDS]
<i>bromfenac ophthalmic soln 0.09%</i>	3	[EDS]	Ophthalmic Prostaglandin and Prostanoid Analogs		
<i>dexamethasone ophthalmic soln</i>	2	[EDS]	<i>latanoprost</i>	1	[EDS]
<i>diclofenac sodium ophthalmic soln 0.1%</i>	2	[EDS]	LUMIGAN	3	[EDS]
<i>difluprednate</i>	3	[EDS]	<i>travoprost</i>	3	[EDS]
<i>fluorometholone</i>	2	[EDS]	VYZULTA	4	[EDS]
<i>ketorolac soln</i>	2	[EDS]	OTIC AGENTS		
LOTEMAX OINT	4	[EDS]	Otic Agents		
LOTEMAX SM GEL 0.38%	4	[EDS]	<i>acetic acid & hydrocortisone</i>	2	[EDS]
PRED MILD	3	[EDS]	CIPRO HC	4	[EDS]
<i>prednisolone acetate</i>	2	[EDS]	<i>ciprofloxacin & dexamethasone otic susp</i>	4	[EDS]
<i>prednisolone sodium phosphate</i>	2	[EDS]	<i>fluocinolone acetonide otic soln</i>	3	[EDS]
Ophthalmic Beta-Adrenergic Blocking Agents			<i>neomycin & polymyxin & hydrocortisone</i>	2	[EDS]
<i>betaxolol soln</i>	2	[EDS]	<i>ofloxacin otic</i>	2	[EDS]
<i>carteolol</i>	1	[EDS]	RESPIRATORY TRACT/PULMONARY AGENTS		
<i>levobunolol</i>	2	[EDS]	Antihistamines		
			<i>azelastine nasal 0.1%</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>cyproheptadine</i>	4	[EDS]	<i>albuterol sulfate tabs</i>	4	[EDS]
<i>desloratadine tabs</i>	2	[EDS]	<i>arformoterol tartrate nebulizer</i>	4	[PA] [B vs D] [EDS]
<i>hydroxyzine hcl tabs</i>	4	[PA] [EDS]	BROVANA NEBULIZER	4	[PA] [B vs D] [EDS]
<i>hydroxyzine pamoate caps</i>	4	[PA] [EDS]	EPINEPHRINE AUTO-INJECTOR 0.15MG/0.3ML & 0.3MG/0.3ML	3	[EDS]
<i>levocetirizine</i>	2	[EDS]	<i>formoterol fumarate nebulizer</i>	4	[PA] [B vs D] [EDS]
Anti-inflammatories, Inhaled Corticosteroids			<i>levalbuterol nebulizer</i>	2	[PA] [B vs D] [EDS]
ARNUITY ELLIPTA	3	[EDS]	LEVALBUTEROL TARTRATE HFA	4	[EDS]
ASMANEX HFA	3	[EDS]	PERFOROMIST NEBULIZER	5	[PA] [B vs D]
ASMANEX TWISTHALER	3	[EDS]	PROAIR RESPICLICK	3	[EDS]
<i>budesonide nebulizer</i>	4	[PA] [B vs D] [EDS]	SEREVENT DISKUS	3	[EDS]
<i>flunisolide nasal</i>	2	[QL] [EDS]	STRIVERDI RESPIMAT	3	[EDS]
<i>fluticasone propionate nasal</i>	2	[QL] [EDS]	<i>terbutaline sulfate oral</i>	4	[EDS]
<i>mometasone furoate nasal</i>	3	[QL] [EDS]	Cystic Fibrosis Agents		
PULMICORT NEBULIZER	4	[PA] [B vs D] [EDS]	BETHKIS	5	[PA] [B vs D]
QVAR REDHALER	3	[EDS]	CAYSTON	5	[PA] [LD]
Antileukotrienes			KALYDECO	5	[PA]
<i>montelukast</i>	2	[EDS]	KITABIS NEBULIZER	5	[PA] [B vs D]
<i>zafirlukast</i>	2	[QL] [EDS]	ORKAMBI	5	[PA]
Bronchodilators, Anticholinergic			PULMOZYME	5	[PA] [B vs D]
ATROVENT HFA	3	[QL] [EDS]	TOBI SOLN	5	[PA] [B vs D]
<i>ipratropium bromide nasal</i>	2	[QL] [EDS]	TOBI PODHALER	5	
<i>ipratropium bromide nebulizer</i>	2	[PA] [B vs D] [EDS]	<i>tobramycin nebulizer</i>	5	[PA] [B vs D]
SPIRIVA RESPIMAT	3	[QL] [EDS]	Mast Cell Stabilizers		
YUPELRI	5	[PA] [B vs D]	<i>cromolyn sodium nebulizer soln</i>	3	[PA] [B vs D] [EDS]
Bronchodilators, Sympathomimetic			Phosphodiesterase Inhibitors, Airways Disease		
<i>albuterol sulfate hfa 6.7gm inhaler</i>	2	[QL] [EDS]	OHTUVAYRE NEBULIZER	5	[PA] [B vs D]
<i>albuterol sulfate hfa 8.5gm inhaler</i>	2	[QL] [EDS]	<i>roflumilast tabs</i>	3	[EDS]
<i>albuterol sulfate nebulizer</i>	2	[PA] [B vs D] [EDS]	<i>theophylline er tabs</i>	4	[EDS]
<i>albuterol sulfate syrup</i>	2	[EDS]			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites	Nombre del Medicamento	Nivel	Requisitos/ Límites
Pulmonary Antihypertensives			SKELETAL MUSCLE RELAXANTS		
ADEMPAS	5	[PA] [LD]	STIOLTO RESPIMAT	3	[EDS]
<i>alyq</i>	5	[PA]	TRELEGY ELLIPTA	3	[QL] [EDS]
<i>ambrisentan</i>	5	[PA] [LD]	<i>wixela inhub</i>	3	[QL] [EDS]
<i>bosentan tabs 62.5mg & 125mg</i>	5	[PA] [LD]	Skeletal Muscle Relaxants		
OPSUMIT	5	[PA] [LD]	<i>carisoprodol tabs 350mg</i>	2	[EDS]
<i>sildenafil tab 20mg</i>	3	[PA] [EDS]	<i>chlorzoxazone tabs 500mg</i>	2	[EDS]
<i>tadalafil tab 20mg</i>	5	[PA]	<i>cyclobenzaprine hcl ir</i>	2	[PA] [EDS]
TRACLEER 32MG	5	[PA] [LD]	<i>methocarbamol tabs</i>	2	[EDS]
UPTRAVI	5	[PA]	SLEEP DISORDER AGENTS		
Pulmonary Fibrosis Agents			Sleep Promoting Agents		
OFEV	5	[PA] [QL]	<i>ramelteon</i>	3	[QL] [EDS]
<i>pirfenidone</i>	5	[PA] [QL]	<i>tasimelteon caps</i>	5	[PA]
Respiratory Tract Agents, Other			<i>temazepam caps</i>	4	[PA] [EDS]
<i>acetylcysteine nebulizer soln</i>	2	[PA] [B vs D] [EDS]	<i>zolpidem ir tabs 5mg & 10mg</i>	2	[EDS]
ADVAIR HFA	3	[EDS]	Wakefulness Promoting Agents		
ANORO ELLIPTA	3	[EDS]	<i>armodafinil</i>	3	[PA] [EDS]
BEVESPI AEROSPHERE	3	[EDS]	<i>modafinil</i>	3	[PA] [EDS]
BREO ELLIPTA	3	[EDS]	XYWAV	5	[PA] [LD]
<i>brey-na</i>	4	[QL] [EDS]			
BREZTRI AEROSPHERE	3	[QL] [EDS]			
<i>budesonide- formoterol fumarate dihydrate</i>	4	[QL] [EDS]			
COMBIVENT RESPIMAT	3	[QL] [EDS]			
DULERA	3	[EDS]			
FASENRA INJ	5	[PA] [QL]			
<i>fluticasone propionate/salmeterol diskus 100mcg- 50mcg, 250mcg- 50mcg & 500mcg- 50mcg</i>	3	[QL] [EDS]			
<i>ipratropium bromide & albuterol sulfate nebulizer</i>	2	[PA] [B vs D] [EDS]			

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Additional Covered Drugs

Your plan has additional coverage for the prescription drugs listed below if you are enrolled in one of these plans:

- **SCAN Classic (HMO):** Clark, Nye Counties
- **SCAN Compass (HMO):** Clark, Nye Counties
- **SCAN MyChoice (HMO):** Clark County

These prescription drugs are not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your out of pocket drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs.

Drug Name	Drug Tier	Requirements/Limits
Nombre del medicamento	Nivel	Requisitos/limitaciones
ERECTILE DYSFUNCTION		
<i>sildenafil tabs 25mg, 50mg, 100mg (generic for Viagra)</i>	1	[QL] (4 tablets per 30-day supply with a maximum of 49 tablets per year)
PRESCRIPTION VITAMINS		
<i>cyanocobalamin inj 1000 mcg/ml (vitamin B12)</i>	1	
<i>ergocalciferol caps 1.25mg (50,000 units) (vitamin D2)</i>	1	
<i>folic acid tabs 1 mg (vitamin B9)</i>	1	

Medicamentos adicionales cubiertos

Su plan tiene cobertura adicional para los medicamentos con receta que se enumeran a continuación si está inscrito/a en uno de estos planes:

- **SCAN Classic (HMO):** Condados de Clark y Nye
- **SCAN Compass (HMO):** Condados de Clark y Nye
- **SCAN MyChoice (HMO):** Condado de Clark

Estos medicamentos con receta normalmente no están cubiertos en un plan de medicamentos con receta de Medicare. El monto que paga cuando surte una receta para estos medicamentos no cuenta para el costo de sus medicamentos que paga de bolsillo (es decir, el monto que paga no le ayuda a calificar para la cobertura catastrófica). Además de esto, si recibe ayuda adicional para pagar sus medicamentos con receta, no recibirá ayuda adicional para pagar estos medicamentos.

Nombre del medicamento	Nivel del medicamento	Requisitos/limitaciones
DISFUNCIÓN ERÉCTIL		
<i>sildenafil, comprimidos de 25 mg, 50 mg, 100 mg (genérico de Viagra)</i>	1	[QL] (4 comprimidos por suministro para 30 días con un máximo de 49 comprimidos por año)
VITAMINAS CON RECETA		
<i>cianocobalamina, inyectable de 1000 mcg/ml (vitamina B12)</i>	1	
<i>ergocalciferol, cápsulas de 1.25 mg (50,000 unidades) (vitamina D2)</i>	1	
<i>ácido fólico, comprimidos de 1 mg (vitamina B9)</i>	1	

**FORMULARY DRUGS WITH QUANTITY LIMITS
MEDICAMENTOS DEL FORMULARIO CON LÍMITES DE CANTIDAD**

Drugs with Quantity Limits Medicamentos con Límites de Cantidad	
Drug Name Nombre del Medicamento	Quantity Limits Límites de Cantidad
<i>acetaminophen & codeine #2 & #3 tabs</i>	360 tabs per 30 days
<i>acetaminophen & codeine #4 tabs</i>	180 tabs per 30 days
<i>acetaminophen & codeine elixir</i>	5000ml per 30 days
<i>acyclovir cream</i>	5gm per 30 days
<i>acyclovir ointment</i>	30gm per 30 days
<i>albuterol sulfate hfa 6.7gm inhaler</i>	13.4gm per 30 days
<i>albuterol sulfate hfa 8.5gm inhaler</i>	17gm per 30 days
<i>alprazolam ir tabs</i>	0.25mg, 0.5mg & 1mg: 120 tabs per 30 days; 2mg: 150 tabs per 30 days
<i>amphetamine & dextroamphetamine</i>	60 tabs per 30 days
ATROVENT HFA	2 inhalers per 30 days
AUSTEDO	6mg: 60 tabs per 30 days; 9mg & 12mg: 120 tabs per 30 days
AUSTEDO XR 18MG, 30MG, 36MG, 42MG & 48MG	18mg: 60 tabs per 30 days; 30mg, 36mg, 42mg & 48mg: 30 tabs per 30 days
AUSTEDO XR 6MG, 12MG & 24MG	6mg & 12mg: 90 tabs per 30 days; 24mg: 60 tabs per 30 days
AUSTEDO XR PATIENT TITRATION KIT	1 pack per 28 days
<i>breyna</i>	10.3gm per 30 days
BREZTRI AEROSPHERE	10.7gm per 30 days
<i>budesonide-formoterol fumarate dihydrate</i>	10.20gm per 30 days
<i>butorphanol tartrate nasal</i>	4 bottles per 30 days
BYDUREON BCISE INJ	4mL per 30 days
<i>calcipotriene cream</i>	60gm: 2 tubes per 30 days; 120gm: 1 tube per 30 days
<i>calcipotriene oint</i>	60gm: 2 tubes per 30 days
<i>colchicine tabs</i>	120 tabs per 30 days
COMBIVENT RESPIMAT	8gm per 30 days
COSENTYX INJ	150mg/mL: 10mL per 30 days; 75mg/0.5mL: 2.5mL per 30 days
COSENTYX SENSOREADY PEN INJ	10mL per 30 days
COSENTYX UNOREADY PEN INJ	10mL per 30 days
<i>dabigatran etexilate</i>	60 caps per 30 days
<i>desonide lotion, oint & cream</i>	cream & oint: 120gm per 30 days lotion: 118ml per 30 days
<i>desoximetasone topical cream & oint 0.25%</i>	120gm per 30 days

Drugs with Quantity Limits
Medicamentos con Límites de Cantidad

Drug Name Nombre del Medicamento	Quantity Limits Límites de Cantidad
<i>desoximetasone topical cream, gel & oint 0.05%</i>	120gm per 30 days
<i>dextroamphetamine sulfate</i>	5mg: 120 tabs per 30 days; 10mg: 180 tabs per 30 days
<i>dextroamphetamine sulfate er</i>	5mg: 30 caps per 30 days; 10mg & 15mg: 120 caps per 30 days
<i>diclofenac sodium soln 1.5%</i>	450mL per 28 days
<i>diclofenac sodium soln 2%</i>	224gm per 28 days
<i>dihydroergotamine mesylate nasal</i>	8mL per 30 days
DUPIXENT INJ	100mg/0.67mL: 1.34mL per 30 days; 200mg/1.14mL: 3.42mL per 28 days; 300mg/2mL pen: 8mL per 28 days; 300mg/2mL syringe: 8mL per 30 days
ELIQUIS STARTER PACK & TABS	Starter pack: 74 tabs per 180 days; tabs: 60 tabs per 30 days
ENBREL INJ	8 mL per 30 days
ENBREL MINI INJ	8 mL per 30 days
ENBREL SURECLICK INJ	8 mL per 30 days
<i>endocet tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg</i>	2.5-325mg & 5-325mg: 360 tabs per 30 days; 7.5-325mg: 240 tabs per 30 days; 10-325mg: 180 tabs per 30 days
ENTRESTO TABS	60 tabs per 30 days
FARXIGA	30 tabs per 30 days
FASENRA INJ	30mg/mL: 1mL per 30 days; 10mg/0.5mL: 1.50mL per 28 days
<i>fentanyl patches</i>	15 patches per 30 days
<i>flunisolide nasal</i>	2 bottles per 30 days
<i>fluocinonide cream, gel & ointment</i>	15gm: 4 tubes per 30 days; 30gm: 2 tubes per 30 days; 60g: 1 tube per 30 days
<i>fluticasone propionate nasal</i>	2 bottles per 30 days
<i>fluticasone propionate/salmeterol diskus 100mcg-50mcg, 250mcg-50mcg & 500mcg-50mcg</i>	60 blisters per 30 days
<i>galantamine er caps</i>	30 caps per 30 days
<i>galantamine soln</i>	200mL per 30 days
<i>galantamine tabs</i>	60 tabs per 30 days
<i>glimepiride & pioglitazone</i>	30 tabs per 30 days
GLYXAMBI	30 tabs per 30 days

**Drugs with Quantity Limits
Medicamentos con Límites de Cantidad**

Drug Name Nombre del Medicamento	Quantity Limits Límites de Cantidad
HUMIRA INJ	40mg/0.4mL & 40mg/0.8mL: 4 inj per 28 days; 10mg/0.1mL & 20mg/0.2mL: 2 inj per 28 days
HUMIRA PEN INJ	40mg/0.4mL & 40mg/0.8mL: 4 pens per 28 days; 80mg/0.8mL: 2 pens per 28 days
HUMIRA PEN-CD/UC/HS STARTER INJ	3 pens per 180 days
HUMIRA PEN-PEDIATRIC UC STARTER PACK INJ	4 pens per 180 days
HUMIRA PEN-PS/UV STARTER INJ	3 pens per 180 days
<i>hydrocodone & acetaminophen soln 7.5- 325mg/15ml</i>	2700ml per 30 days
<i>hydrocodone & acetaminophen tabs 5- 325mg, 7.5-325mg & 10-325mg</i>	5-325mg: 360 tabs per 30 days; 7.5-325mg & 10-325mg: 180 tabs per 30 days
<i>hydrocodone & ibuprofen tabs 7.5-200mg</i>	150 tabs per 30 days
<i>icatibant inj</i>	18mL per 30 days
<i>ipratropium bromide nasal</i>	1 bottle per 30 days
JANUMET	60 tabs per 30 days
JANUMET XR	60 tabs per 30 days
JANUVIA	30 tabs per 30 days
JARDIANCE	30 tabs per 30 days
JENTADUETO	60 tabs per 30 days
JENTADUETO XR	2.5-1000mg: 60 tabs per 30 days; 5-1000mg: 30 tabs per 30 days
<i>leflunomide</i>	30 tabs per 30 days
<i>lidocaine & prilocaine</i>	30gm: 1 tube per 30 days
<i>lidocaine ointment</i>	1 tube per 30 days
<i>lidocaine topical soln</i>	1 bottle per 30 days
LIVTENCITY	120 tabs per 30 days
<i>mesalamine er caps</i>	375mg: 120 caps per 30 days; 500mg: 240 caps per 30 days
<i>mometasone furoate nasal</i>	3 bottles per 30 days
<i>morphine sulfate er tabs</i>	120 tabs per 30 days
MOUNJARO INJ	2mL per 30 days
<i>mupirocin cream</i>	30gm per 30 days
<i>naratriptan</i>	8 tabs per 30 days
NEUPRO PATCH	30 patches per 30 days
<i>niacin er tabs</i>	60 caps per 30 days
OFEV	60 caps per 30 days
ORENCIA INJ	125mg/mL: 4.00mL per 30 days; 50mg/0.4mL: 1.60mL per 30 days; 87.5mg/0.7mL: 2.80mL per 30 days
OTEZLA	60 tabs per 30 days

Drugs with Quantity Limits
Medicamentos con Límites de Cantidad

Drug Name Nombre del Medicamento	Quantity Limits Límites de Cantidad
OTEZLA STARTER	55 tabs per 180 days
<i>oxycodone & acetaminophen tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg</i>	2.5-325mg & 5-325mg: 360 tabs per 30 days; 7.5-325mg: 240 tabs per 30 days; 10-325mg: 180 tabs per 30 days
OXYCODONE ER TABS 10MG & 20MG	60 tabs per 30 days
OZEMPIC INJ	3mL per 30 days
<i>pimecrolimus</i>	30gm: 3 tubes per 30 days
<i>pirfenidone</i>	267mg: 270 tabs/caps per 30 days; 534mg & 801mg: 90 tabs per 30 days
PREVYMIS	30 tabs per 30 days
PROMACTA	12.5mg & 25mg: 30 tabs per 30 days; 50mg & 75mg: 60 tabs per 30 days; oral susp: 180 packets per 30 days
<i>ramelteon</i>	30 tabs per 30 days
REGRANEX	2 tubes per 30 days
RINVOQ	15mg & 30mg: 30 tabs per 30 days; 45mg: 84 tabs per 180 days
<i>rivastigmine caps</i>	60 caps per 30 days
<i>rivastigmine patches</i>	30 patches per 30 days
RYBELSUS	30 tabs per 30 days
SANTYL	90gm per 30 days
SKYRIZI INJ	150mg/mL: 2mL per 30 days; 360mg/2.4ml: 2.4mL per 60 days; 180mg/1.2ml: 1.20mL per 60 days
SPIRIVA RESPIMAT	4gm per 30 days
STELARA INJ	45mg/0.5mL: 0.50mL per 30 days; 90mg/mL: 1mL per 30 days
SYNJARDY	60 tabs per 30 days
SYNJARDY XR	5-1000mg & 12.5-1000mg: 60 tabs per 30 days; 10-1000mg & 25-1000mg: 30 tabs per 30 days
<i>tacrolimus oint</i>	100g per 30days
<i>tadalafil 2.5mg & 5mg</i>	2.5mg: 60 tabs per 30 days; 5mg: 30 tabs per 30 days
<i>tazarotene gel</i>	30gm: 3 tubes per 30 days; 100gm: 1 tube per 30 days
<i>tetrabenazine</i>	12.5mg: 240 tabs per 30 days; 25mg: 120 tabs per 30 days
<i>tolterodine tartrate er</i>	30 caps per 30 days
TRADJENTA	30 tabs per 30 days

Drugs with Quantity Limits
Medicamentos con Límites de Cantidad

Drug Name Nombre del Medicamento	Quantity Limits Límites de Cantidad
<i>tramadol & acetaminophen tabs 37.5-325mg</i>	240 tabs per 30 days
<i>tramadol er tabs</i>	30 tabs per 30 days
<i>tramadol ir tab 100mg</i>	120 tabs per 30 days
TRELEGY ELLIPTA	60 blisters per 30 days
TREMFYA INJ	2mL per 30 days
TRIJARDY XR	5-2.5-1000mg & 12.5-2.5-1000mg: 60 tabs per 30 days; 25-5-1000mg & 10-5-1000mg: 30 tabs per 30 days
TRULICITY INJ	2mL per 30 days
<i>wixela inhub</i>	60 blisters per 30 days
XARELTO ORAL SUSP & TABS	oral susp: 775mL per 30 days; 2.5mg: 60 tabs per 30 days; 10mg, 15mg & 20mg: 30 tabs per 30 days
XARELTO STARTER PACK	51 tabs per 180 days
XDEMVY	10mL per 42 days
XELJANZ	tabs: 60 tabs per 30 days; soln: 300mL per 30 days
XELJANZ XR	30 tabs per 30 days
XIGDUO XR	5-500mg, 5-1000mg & 2.5-1000mg: 60 tabs per 30 days; 10-500mg & 10-1000mg: 30 tabs per 30 days
XOLAIR INJ	150mg/mL & 300mg/2mL: 8mL per 28 days; 75mg/0.5mL: 1mL per 28 days
<i>zafirlukast</i>	60 tabs per 30 days
<i>zenzedi</i>	5mg: 120 tabs per 30 days 10mg: 180 tabs per 30 days
<i>zolmitriptan</i>	2.5mg: 12 tabs per 30 days 5mg: 6 tabs per 30 days

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SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, or sex. SCAN Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats). SCAN Health Plan provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact SCAN Member Services.

If you believe that SCAN Health Plan 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 in person, by phone, mail, or fax, at:

SCAN Health Plan, Nevada
Attention: Grievance and Appeals Department
P.O. Box 22616
Long Beach, CA 90801-5616

SCAN Member Services
PHONE: 1-855-827-7226
FAX: 1-562-989-0958
TTY: 711

Or by filling out the “File a Grievance” form on our website at:

<https://www.scanhealthplan.com/contact-us/file-a-grievance>

If you need help filing a grievance, SCAN Member Services 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, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Services).
- In writing: Fill out a complaint form or send a letter to:
Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov

SCAN Health Plan cumple con las leyes de derechos civiles federales vigentes y no discriminan, excluyen ni tratan a las personas de forma diferente por su raza, color, nacionalidad, edad, discapacidad o sexo. SCAN Health Plan ofrece recursos y servicios gratuitos a personas que tienen dificultades para comunicarse, como intérpretes de lenguaje de señas calificados e información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, etc.). SCAN Health Plan ofrece servicios lingüísticos gratuitos a personas cuyo idioma principal no es el inglés, como intérpretes calificados e información escrita en otros idiomas. Si necesita estos servicios, comuníquese con Servicios para Miembros de SCAN.

Si cree que SCAN Health Plan no le ha proporcionado estos servicios o le ha discriminado por su raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo personalmente, por teléfono, por correo o por fax:

SCAN Health Plan
Attention: Grievance and Appeals Department
P.O. Box 22616
Long Beach, CA 90801-5616

SCAN Member Services
PHONE: 1-855-827-7226
FAX: 1-568-989-0958
TTY: 711

O puede completar el formulario "Presentar un reclamo" en nuestro sitio web:

<https://www.scanhealthplan.com/contact-us/file-a-grievance>

Si necesita ayuda para presentar un reclamo, Servicios para Miembros de SCAN puede ayudarlo.

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de manera electrónica a través del portal de quejas de la Oficina de Derechos Civiles disponible en

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> o por correo o teléfono:

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

Puede encontrar los formularios de quejas en

<https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.

Puede presentar un reclamo de derechos civiles ante la Oficina de Derechos Civiles del Dpto. de Servicios de Atención Médica de California por teléfono, por escrito o de manera electrónica:

- Por teléfono: Llame al 1-916-440-7370. Si tiene dificultades para hablar u oír, llame al servicio de TTY: 711.
- Por escrito: Complete un formulario de reclamo o envíe una carta a la siguiente dirección:
Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Puede encontrar los formularios de quejas en
http://www.dhcs.ca.gov/Pages/Language_Access.aspx.
- De manera electrónica: Envíe un correo electrónico a CivilRights@dhcs.ca.gov.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-827-7226. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, llame al 1-855-827-7226. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Cantonese (Traditional): 我們提供免費的口譯服務，以解答您對我們的健康或藥物計劃可能有的任何問題。如需獲得口譯服務，請致電 1-855-827-7226 聯絡我們。我們有會說中文的工作人員可以為您提供幫助。這是一項免費服務。

Chinese Mandarin (Simplified): 我们提供免费的口译服务，以解答您对我们的健康或药物计划可能有的任何问题。如需获得口译服务，请致电 1-855-827-7226 联系我们。我们有会说中文的工作人员可以为您提供帮助。这是一项免费服务。

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi quý vị có thể có về chương sức khỏe và chương trình thuốc men. Để được thông dịch, chỉ cần gọi theo số 1-855-827-7226. Người nói Tiếng Việt có thể trợ giúp quý vị. Đây là dịch vụ miễn phí.

Tagalog: Mayroon kaming mga libreng serbisyo ng interpreter upang masagot ang anumang katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng interpreter, tawagan lamang kami sa 1-855-827-7226. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-827-7226 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

W

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سوالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیست با شماره 1-855-827-7226 تماس بگیرید. شخصی که به زبان فارسی صحبت می کند، می تواند به شما کمک کند. این یک سرویس رایگان است.

Russian: Если у вас возникнут вопросы относительно плана медицинского обслуживания или обеспечения лекарственными препаратами, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номеру 1-855-827-7226. Вам окажет помощь сотрудник, который говорит на русском языке. Данная услуга бесплатная.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご利用になるには、1-855-827-7226にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة لديك تتعلق بخططنا الصحية أو جدول الدواء. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم 1-855-827-7226. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه الخدمة المجانية.

Punjabi: ਸਾਡੀ ਸਿਹਤ ਜਾਂ ਦਵਾਈ ਯੋਜਨਾ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲਾਂ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫਤ ਦੁਬਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਬਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ 1-855-827-7226 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫਤ ਸੇਵਾ ਹੈ।

Mon-Khmer, Cambodian:

យើងខ្ញុំមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាព ឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-855-827-7226។ មានគេដែលនិយាយភាសាខ្មែរអាចជួយលោកអ្នកបាន។ សេវាកម្មនេះមិនគិតថ្លៃទេ។

Hmong: Peb muaj cov kev pab cuam txhais lus los teb koj cov lus nug uas koj muaj txog ntawm peb lub phiaj xwm kho mob thiab tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu peb ntawm 1-855-827-7226. Muaj qee tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov no yog kev pab cuam pab dawb.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-827-7226 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Thai: เรามีบริการล่ามฟรีเพื่อตอบสนองข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-855-827-7226 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງ ພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພາລາດໂທຫາພວກເຮົາທີ່ເບີ 1-855-827-7226. ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-827-7226. Quelqu'un parlant français pourra vous aider. Ce service est gratuit.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-827-7226. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per usufruire di un interprete, contattare il numero 1-855-827-7226. Un nostro incaricato che parla Italiano Le fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-827-7226. Irá encontrar alguém que fale português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan sante oswa medikaman nou yo. Pou w jwenn yon entèprèt, jis rele nou nan 1-855-827-7226. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-827-7226. Ta usługa jest bezpłatna.

Hmong-Mien: Peb muaj kev pab cuam txhais lus pub dawb los teb cov lus nug uas koj muaj txog ntawm peb lub phiaj xwm kev noj qab haus huv los sis phiaj xwm tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu peb ntawm 1-855-827-7226. Muaj tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov kev pab cuam no yog pab dawb xwb.

Ukrainian: Ми надаємо безкоштовні послуги усного перекладача, який відповість на будь-які ваші запитання щодо нашого плану медичного обслуговування або лікарського забезпечення. Щоб отримати послуги перекладача, просто зателефонуйте нам за номером 1-855-827-7226. Вам може допомогти людина, яка володіє українською мовою. Ця послуга безкоштовна.



The formulary and pharmacy network may change at any time. You will receive notice when necessary.

This formulary was updated on 10/1/2024. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-855-827-7226 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.

El formulario y la red de farmacias pueden cambiar en cualquier momento. Usted recibirá un aviso cuando sea necesario.

Este formulario se actualizó el 10/1/2024. Para obtener información más reciente o si tiene preguntas, comuníquese con Servicios para Miembros de SCAN Health Plan al 1-855-827-7226 (los usuarios de TTY deben llamar al 711), de 8:00 a. m. a 8:00 p. m., los 7 días de la semana, desde el 1 de octubre hasta el 31 de marzo. Desde el 1 de abril hasta el 30 de septiembre, el horario es de 8:00 a. m. a 8:00 p. m., de lunes a viernes (los mensajes recibidos en días feriados y fuera del horario de atención se responderán en el plazo de un día hábil). También puede visitar www.scanhealthplan.com.

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