
2024

SCAN Health Plan Formulary

List of Covered Drugs

Formulario de SCAN Health Plan

Lista de medicamentos cubiertos



This formulary was updated on 05/01/2024. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-855-844-7226 (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 05/01/2024. Para obtener información más reciente o si tiene preguntas, comuníquese con Servicios para Miembros de SCAN Health Plan, al 1-855-844-7226 (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.

SCAN Health Plan 2024 Formulary (List of Covered Drugs)

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

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This formulary was updated on 05/01/2024. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-855-844-7226 (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.

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 Venture (HMO), SCAN Balance (HMO C-SNP), SCAN Heart First (HMO C-SNP) and SCAN Strive (HMO C-SNP).

This document includes a list of the drugs (formulary) for our plan which is current as of May 2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the 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, 2025, 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 one of our mail order pharmacies. You can fill your prescription medications at any of our network mail order pharmacies. 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?

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 (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that 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 the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled “How do I request an exception to the SCAN Health Plan’s Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and 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 add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or 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, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. 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 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 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 Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of May, 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 61. 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 cost less than brand-name drugs.

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 physician 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 BELSOMRA. 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 5 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 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.
- You can ask us to waive coverage restrictions or limits 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.

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 additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber’s supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

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 your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to 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 if your ability to get your drugs is limited, 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. 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.

Most adult Part D vaccines are covered by our plan at no cost to you.

SCAN Classic (HMO): Bexar and Harris 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	\$0	\$0
2	Generic		\$0	\$0	\$7	\$14
3	Preferred Brand	Insulin	\$25	\$55	\$35	\$85
		Other Drugs	\$35	\$85	\$40	\$100
4	Non-Preferred Drug		\$90	\$250	\$100	\$280
5	Specialty Tier		33%	N/A	33%	N/A
6	Select Care Drugs		\$11	\$33	\$11	\$33
We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand –insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.						

SCAN Heart First (HMO C-SNP): Bexar and Harris 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	\$0	\$0
2	Generic		\$0	\$0	\$7	\$14
3	Preferred Brand	Insulin	\$25	\$55	\$35	\$85
		Other Drugs	\$35	\$85	\$40	\$100
4	Non-Preferred Drug		\$90	\$250	\$100	\$280
5	Specialty Tier		33%	N/A	33%	N/A
6	Select Care Drugs		\$0	\$0	\$0	\$0
<p>We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand –insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.</p>						

SCAN Balance (HMO C-SNP): Bexar and Harris 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	\$0	\$0
2	Generic		\$0	\$0	\$7	\$14
3	Preferred Brand	Insulin	\$0	\$0	\$0	\$0
		Other Drugs	\$35	\$85	\$40	\$100
4	Non-Preferred Drug		\$90	\$250	\$100	\$280
5	Specialty Tier		33%	N/A	33%	N/A
6	Select Care Drugs		\$0	\$0	\$0	\$0
<p>We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand –insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.</p>						

SCAN Venture (HMO): Bexar and Harris 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	\$0	\$0
2	Generic		\$0	\$0	\$7	\$14
3	Preferred Brand	Insulin	\$25	\$55	\$35	\$85
		Other Drugs	\$40	\$100	\$47	\$121
4	Non-Preferred Drug		\$95	\$265	\$100	\$280
5	Specialty Tier		33%	N/A	33%	N/A
6	Select Care Drugs		\$11	\$33	\$11	\$33
<p>We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand –insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.</p>						

The chart below lists 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.

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

SCAN Strive (HMO C-SNP): Bexar and Harris Counties

Members with no "Extra Help" Retail & Mail Order Pharmacies (one-, two- or three-month supply)	Members with "Extra Help" Retail & Mail Order Pharmacies (one-, two- or three-month supply)
You pay a 25% coinsurance of the total drug cost for all Part D prescription drugs covered on our Drug List, which begins on page 24.	You pay a \$0 copayment for all Part D prescription drugs covered on our Drug List, which begins on page 24.
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, even if you haven't paid your deductible.	You won't pay more than \$0 for a one-month through three-month supply of each insulin product covered by our plan.
Most adult Part D vaccines are covered by our plan at no cost to you, even if you haven't paid your deductible.	Most Part D vaccines are covered by our plan at no cost to you.
Some medications (e.g., Specialty drugs) are available for up to a one-month supply. To see which medications are available for an extended day supply, turn to page 24.	

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 61.

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 59.
- 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 1-855-844-7226 (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 2024 (Lista de medicamentos cubiertos)

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

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Este formulario se actualizó el 05/01/2024. Para obtener información más reciente o si tiene preguntas, comuníquese con Servicios para Miembros de SCAN Health Plan, al 1-855-844-7226 (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 festivos 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 Venture (HMO), SCAN Balance (HMO C-SNP), SCAN Heart First (HMO C-SNP) y SCAN Strive (HMO C-SNP).

Este documento incluye una lista de medicamentos (formulario) para nuestro plan que está vigente desde mayo de 2024. Para obtener un formulario actualizado, 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.

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 2025 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 una de nuestras farmacias de pedido por correo. Puede surtir sus medicamentos con receta en cualquiera de las farmacias de pedido por correo de nuestra red. 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 la solicitud. 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, 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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¿Qué es el Formulario de SCAN Health Plan?

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 el Formulario (lista de medicamentos) cambiar?

La mayoría de los cambios en la cobertura de medicamentos se realizan el 1 de enero, pero podemos añadir o retirar medicamentos de la lista de medicamentos 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.

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

- **Medicamentos genéricos nuevos.** Podemos retirar de inmediato un medicamento de marca de nuestra Lista de medicamentos si lo reemplazamos por un nuevo medicamento genérico que aparecerá en el mismo nivel de gasto compartido o en uno menor y con las mismas restricciones o menos. Además, al añadir el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de medicamentos, pero cambiarlo de inmediato a un nivel de gastos compartidos diferente o añadir nuevas restricciones. Si actualmente toma ese medicamento de marca, es posible que no informemos por adelantado que haremos ese cambio, 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 solicitarle al plan que realice una excepción y siga cubriendo el medicamento de marca para usted. El aviso que le proporcionaremos también incluye información sobre cómo solicitar una excepción, y puede encontrar información en la sección a continuación, titulada “¿Cómo solicito una excepción para el Formulario de SCAN Health Plan?”
- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos (FDA) considera que un medicamento de nuestro formulario es inseguro o si el fabricante del medicamento retira el medicamento del mercado, inmediatamente retiraremos el medicamento de nuestro formulario y les proporcionaremos un aviso a los miembros que toman el medicamento.
- **Otros cambios.** Podemos realizar otros cambios que afecten a los miembros que toman actualmente un medicamento. Por ejemplo, podríamos añadir un medicamento genérico que no sea nuevo en el mercado para reemplazar un medicamento de marca que figure actualmente en el formulario, o añadir nuevas restricciones al medicamento de marca o moverlo a un nivel de gastos compartidos diferentes, o ambas opciones. O bien, podemos realizar cambios según nuevas pautas clínicas. Si retiramos medicamentos de nuestro formulario, o 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 cuando el miembro solicite un resurtido del medicamento, en cuyo momento el miembro recibirá un suministro del medicamento para 30 días.

- Si implementamos estos cambios, usted u otra persona autorizada a dar recetas pueden solicitarle al plan que realice una excepción y siga cubriendo el medicamento de marca para usted. El aviso que le proporcionaremos también incluye información sobre cómo solicitar una excepción y, además, puede encontrar información en la sección a continuación, titulada “¿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 2024 que estaba cubierto al comienzo del año, no descontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2024, 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 la Lista de medicamentos del nuevo año de beneficios para ver los cambios.

El formulario adjunto está vigente desde mayo 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 portada y contraportada.

¿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 sabe para qué se usa un 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.

Orden alfabético

Si no sabe en qué categoría buscar, debe buscar el medicamento en el Índice que comienza en la página 61. 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 cuestan menos que los de marca.

¿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 su médico/a 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 BELSOMRA. Esto puede ser un surtido adicional al suministro 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 16 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, muéstrele a su médico/a y pídale que le recete un medicamento similar que esté cubierto por SCAN Health Plan.
- Puede solicitarle 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 gastos compartidos predeterminado y no podrá pedirnos que proporcionemos el medicamento a un nivel de gastos compartidos inferior.

- 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.
- Puede pedirnos que no apliquemos restricciones o límites a la cobertura del 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.

Por lo general, SCAN Health Plan solo aprobará su solicitud de una excepción si los medicamentos alternativos incluidos en el formulario del plan, el medicamento con menor gasto compartido o las restricciones de uso adicionales no resultaran tan eficaces a la hora de tratar su afección o provocarían efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión de cobertura inicial de un formulario, nivel o excepción de restricción de uso. **Cuando solicite una excepción de un formulario, de un nivel o de restricción de uso, debe enviar una declaración de la persona autorizada a dar recetas o médico/a apoyando la solicitud.** Por lo general, debemos tomar una decisión en un plazo de 72 horas después de recibir la declaración de apoyo de su recetador. Puede solicitar una excepción acelerada (rápida) si usted o su médico/a creen que su salud podría ser perjudicada gravemente al esperar hasta 72 horas por una decisión. Si se concede su solicitud de apelación acelerada, debemos comunicarle una decisión en un plazo máximo de 24 horas después de recibir una declaración de apoyo de su médico/a u otro recetador.

¿Qué hago antes de poder hablar con mi médico/a sobre cambiar de medicamentos o solicitar una excepción?

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 sí está en nuestro formulario, pero su capacidad para obtenerlo es limitada. Por ejemplo, es posible que necesite una autorización previa de nuestra parte antes de que pueda surtir sus medicamentos con receta. Debe hablar con su médico/a para decidir si debe cambiar a un medicamento adecuado que cubramos o solicitar una excepción para el formulario para que cubramos el medicamento que toma. Mientras habla con su médico/a para determinar el curso de acción correcto para usted, podemos cubrir el medicamento en ciertos casos durante los primeros 90 días tras convertirse en un miembro del nuestro plan.

Para cada uno de los medicamentos que no están en nuestro formulario o si su capacidad para conseguir el medicamento es limitada, cubriremos un suministro temporal 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. 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. Después de su 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, usted 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), 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 portada y contraportada.

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.

La mayoría de las vacunas para adultos de la Parte D están cubiertas por nuestro plan sin costo alguno para usted.

SCAN Classic (HMO): Condados de Bexar y Harris

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	\$7	\$14
3	Medicamentos de marca preferidos	Insulina	\$25	\$55	\$35	\$85
		Otros medicamentos	\$35	\$85	\$40	\$100
4	Medicamentos no preferidos		\$90	\$250	\$100	\$280
5	Medicamentos de especialidad		33%	N/C	33%	N/C
6	Medicamentos de atención selecta		\$11	\$33	\$11	\$33

Proporcionamos cobertura adicional para medicamentos con receta en el Nivel 1 (genéricos preferidos), en el Nivel 2 (genéricos) y en el Nivel 3 (de marca preferidos: solo insulina) durante la interrupción en la cobertura. Consulte la Evidencia de cobertura para obtener más información sobre esta cobertura.

SCAN Heart First (HMO C-SNP): Condados de Bexar y Harris

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	\$7	\$14
3	Medicamentos de marca preferidos	Insulina	\$25	\$55	\$35	\$85
		Otros medicamentos	\$35	\$85	\$40	\$100
4	Medicamentos no preferidos		\$90	\$250	\$100	\$280
5	Medicamentos de especialidad		33%	N/C	33%	N/C
6	Medicamentos de atención selecta		\$0	\$0	\$0	\$0
Proporcionamos cobertura adicional para medicamentos con receta en el Nivel 1 (genéricos preferidos), en el Nivel 2 (genéricos) y en el Nivel 3 (de marca preferidos: solo insulina) durante la interrupción en la cobertura. Consulte la Evidencia de cobertura para obtener más información sobre esta cobertura.						

SCAN Balance (HMO C-SNP): Condados de Bexar y Harris

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	\$7	\$14
3	Medicamentos de marca preferidos	Insulina	\$0	\$0	\$0	\$0
		Otros medicamentos	\$35	\$85	\$40	\$100
4	Medicamentos no preferidos		\$90	\$250	\$100	\$280
5	Medicamentos de especialidad		33%	N/C	33%	N/C
6	Medicamentos de atención selecta		\$0	\$0	\$0	\$0
Proporcionamos cobertura adicional para medicamentos con receta en el Nivel 1 (genéricos preferidos), en el Nivel 2 (genéricos) y en el Nivel 3 (de marca preferidos: solo insulina) durante la interrupción en la cobertura. Consulte la Evidencia de cobertura para obtener más información sobre esta cobertura.						

SCAN Venture (HMO): Condados de Bexar y Harris

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	\$7	\$14
3	Medicamentos de marca preferidos	Insulina	\$25	\$55	\$35	\$85
		Otros medicamentos	\$40	\$100	\$47	\$121
4	Medicamentos no preferidos		\$95	\$265	\$100	\$280
5	Medicamentos de especialidad		33%	N/C	33%	N/C
6	Medicamentos de atención selecta		\$11	\$33	\$11	\$33

Proporcionamos cobertura adicional para medicamentos con receta en el Nivel 1 (genéricos preferidos), en el Nivel 2 (genéricos) y en el Nivel 3 (de marca preferidos: solo insulina) durante la interrupción en la cobertura. Consulte la Evidencia de cobertura para obtener más información sobre esta cobertura.

La tabla a continuación enumera lo que pagará como su parte de los costos de los medicamentos con receta cubiertos en las farmacias de nuestra red cuando se encuentre en la Etapa de cobertura inicial.

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.

SCAN Strive (HMO C-SNP): Condados de Bexar y Harris

Miembros sin "Ayuda adicional"	Miembros con "Ayuda adicional"
Farmacias minoristas y de pedido por correo (suministro para uno, dos o tres meses)	Farmacias minoristas y de pedido por correo (suministro para uno, dos o tres meses)
<p>Paga un coseguro del 25% por el costo total de los medicamentos de todos los medicamentos con receta de la Parte D cubiertos en nuestra Lista de medicamentos, que comienza en la página 24.</p>	<p>Paga un copago de \$0 por todos los medicamentos con receta de la Parte D cubiertos en nuestra Lista de medicamentos, que comienza en la página 24.</p>
<p>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, incluso si no ha pagado el deducible.</p>	<p>No pagará más de \$0 por un suministro para un mes a tres meses de cada producto de insulina cubierto por nuestro plan.</p>
<p>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.</p>	<p>La mayoría de las vacunas para de la Parte D están cubiertas por nuestro plan sin costo alguno para usted.</p>
<p>Algunos medicamentos (p. ej., medicamentos de especialidad) están disponibles con un suministro para hasta un mes. Para saber qué medicamentos están disponibles para un suministro extendido, consulte a la página 24.</p>	

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 61.

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 del 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 59.
- 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 1-855-844-7226 (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 festivos 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: 24429 (Version 13)
 ID de Formulario: 24429 (Versión 13)**

**Updated: 5/2024
 Actualizado: 5/2024**

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
ANALGESICS		
Opioid Analgesics, Long-acting		
<i>fentanyl patches 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr & 100mcg/hr</i>	3	[QL] [EDS]
<i>methadone oral</i>	2	[EDS]
<i>morphine sulfate er tabs</i>	3	[QL] [EDS]
OXYCODONE ER TABS	4	[QL] [EDS]
<i>tramadol er tabs</i>	3	[QL] [EDS]
Opioid Analgesics, Short-acting		
<i>acetaminophen & codeine</i>	2	[QL] [EDS]
<i>butorphanol tartrate nasal</i>	2	[QL] [EDS]
<i>codeine sulfate</i>	2	[EDS]
<i>endocet</i>	3	[QL] [EDS]
<i>fentanyl citrate lozenges 200mcg</i>	4	[PA] [EDS]
<i>fentanyl citrate lozenges 400mcg, 600mcg, 800mcg, 1200mcg & 1600mcg</i>	5	[PA]
<i>hydrocodone & acetaminophen soln 7.5-325mg/15ml</i>	2	[QL] [EDS]
<i>hydrocodone & acetaminophen tabs 5-325mg, 7.5-325mg & 10-325mg</i>	2	[QL] [EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>hydrocodone & ibuprofen</i>	2	[QL] [EDS]
<i>hydromorphone immediate-release oral soln & tabs</i>	2	[EDS]
<i>hydromorphone inj</i>	3	[EDS]
<i>morphine sulfate oral</i>	2	[EDS]
<i>oxycodone immediate-release</i>	2	[EDS]
<i>oxycodone oral soln</i>	2	[EDS]
<i>oxycodone & acetaminophen 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg</i>	3	[QL] [EDS]
<i>tramadol tab 50mg</i>	2	[EDS]
<i>tramadol ir tab 100mg</i>	2	[QL] [EDS]
<i>tramadol & acetaminophen</i>	2	[QL] [EDS]
ANESTHETICS		
Local Anesthetics		
<i>lidocaine ointment</i>	4	[QL] [EDS]
<i>lidocaine patch</i>	3	[PA] [EDS]
<i>lidocaine topical soln</i>	2	[QL] [EDS]
<i>lidocaine & prilocaine cream</i>	3	[QL] [EDS]
<i>lidocan III</i>	3	[PA] [EDS]
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
Alcohol Deterrents/Anti-Craving		
<i>acamprosate calcium dr</i>	2	[EDS]
<i>disulfiram</i>	2	[EDS]

[PA] = Prior Authorization [B vs D] = B versus D [QL] = Quantity Limit
 [LD] = Limited Distribution [EDS] = Extended Day Supply

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Opioid Dependence		
<i>buprenorphine sublingual tabs</i>	1	[EDS]
<i>buprenorphine & naloxone sublingual film</i>	2	[EDS]
<i>buprenorphine & naloxone sublingual tabs</i>	2	[EDS]
<i>naltrexone</i>	1	[EDS]
Opioid Reversal Agents		
KLOXXADO	3	[EDS]
<i>naloxone inj</i>	2	[EDS]
<i>naloxone nasal</i>	2	[EDS]
Smoking Cessation Agents		
<i>bupropion sr 150mg</i>	2	[EDS]
NICOTROL INHALER	3	[EDS]
NICOTROL NASAL	3	[EDS]
<i>varenicline starting month box</i>	4	[EDS]
<i>varenicline tartrate</i>	4	[EDS]
ANTI-INFLAMMATORY AGENTS		
Nonsteroidal Anti-inflammatory Drugs		
<i>celecoxib</i>	2	[EDS]
<i>diclofenac potassium tab 50mg</i>	1	[EDS]
<i>diclofenac sodium dr</i>	1	[EDS]
<i>diclofenac sodium er</i>	1	[EDS]
<i>diflunisal</i>	2	[EDS]
<i>etodolac</i>	2	[EDS]
<i>etodolac er</i>	2	[EDS]
<i>ibu</i>	1	[EDS]
<i>ibuprofen</i>	1	[EDS]
<i>indomethacin er</i>	2	[EDS]
<i>indomethacin ir caps</i>	2	[EDS]
<i>ketorolac oral tabs</i>	2	[EDS]
LODINE TABS	2	[EDS]
<i>meloxicam tabs</i>	1	[EDS]
<i>nabumetone</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>naproxen tabs 250mg, 375mg & 500mg</i>	1	[EDS]
<i>naproxen dr tabs</i>	1	[EDS]
<i>naproxen sodium ir tabs</i>	1	[EDS]
<i>piroxicam</i>	2	[EDS]
<i>sulindac</i>	2	[EDS]
ANTIBACTERIALS		
Aminoglycosides		
<i>amikacin inj</i>	2	[EDS]
<i>gentamicin cream 0.1% & oint 0.1%</i>	2	[EDS]
<i>gentamicin inj 40mg/ml</i>	2	[EDS]
<i>neomycin sulfate oral</i>	2	[EDS]
<i>streptomycin inj</i>	2	[EDS]
<i>tobramycin sulfate inj</i>	2	[EDS]
Antibacterials, Other		
<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]
<i>clindamycin vaginal cream</i>	2	[EDS]
<i>colistimethate inj</i>	2	[EDS]
<i>daptomycin inj</i>	5	
<i>fosfomicin pack</i>	4	[EDS]
<i>linezolid inj</i>	4	[EDS]
<i>linezolid oral susp and tabs</i>	4	[EDS]
<i>methenamine hippurate</i>	2	[EDS]
<i>metronidazole inj</i>	2	[EDS]
<i>metronidazole oral</i>	2	[EDS]
<i>metronidazole topical</i>	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>metronidazole vaginal gel</i>	2	[EDS]
<i>nitrofurantoin caps</i>	2	[EDS]
SIVEXTRO TABS & INJ	5	
<i>tigecycline inj</i>	5	
<i>trimethoprim</i>	2	[EDS]
<i>vancomycin caps</i>	4	[EDS]
<i>vancomycin inj</i> 500mg, 750mg, 1gm & 10gm	3	[EDS]
<i>vancomycin oral soln</i> 250mg/5ml	4	[EDS]
<i>vandazole</i>	2	[EDS]
XIFAXAN TABS 200MG	3	[PA] [EDS]
XIFAXAN TABS 550MG	5	[PA]
Beta-lactam, Cephalosporins		
<i>cefactor</i>	2	[EDS]
<i>cefactor er</i>	2	[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]
<i>ceftazidime inj</i>	2	[EDS]
<i>ceftriaxone inj</i>	2	[EDS]
<i>cefuroxime oral</i>	2	[EDS]
<i>cefuroxime inj</i>	2	[EDS]
<i>cephalexin caps & tabs</i> 250mg & 500mg	1	[EDS]
<i>cephalexin oral susp</i>	1	[EDS]
<i>tazicef inj</i>	2	[EDS]
TEFLARO INJ	5	
ZERBAXA INJ	5	

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Beta-lactam, Penicillins		
<i>amoxicillin</i>	1	[EDS]
<i>amoxicillin & clavulanate potassium</i>	2	[EDS]
<i>amoxicillin & clavulanate potassium er</i>	2	[EDS]
<i>ampicillin inj</i>	2	[EDS]
<i>ampicillin oral</i>	2	[EDS]
<i>ampicillin & sulbactam inj</i> 10-5gm, 2-1gm & 1-0.5gm	2	[EDS]
BICILLIN L-A INJ	4	[EDS]
<i>dicloxacillin sodium</i>	2	[EDS]
<i>nafcillin sodium inj</i>	4	[EDS]
<i>penicillin g inj</i> 5 million units & 20 million units	2	[EDS]
<i>penicillin v potassium</i>	2	[EDS]
<i>piperacillin/tazobactam inj</i>	3	[EDS]
ZOSYN INJ	4	[EDS]
Carbapenems		
<i>cilastatin/imipenem inj</i>	2	[EDS]
<i>ertapenem inj</i>	4	[EDS]
<i>meropenem inj</i>	4	[EDS]
Macrolides		
<i>azithromycin tabs & oral susp bottle</i>	2	[EDS]
<i>azithromycin inj</i>	2	[EDS]
<i>clarithromycin</i>	2	[EDS]
<i>clarithromycin er</i>	2	[EDS]
DIFICID	5	
ERYTHROCIN LACTOBIONATE INJ	4	[EDS]
<i>erythrocin stearate</i>	3	[EDS]
<i>erythromycin caps & tabs</i>	3	[EDS]
<i>erythromycin dr</i>	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Quinolones		
<i>ciprofloxacin in d5w inj</i>	2	[EDS]
<i>ciprofloxacin tabs immediate-release 250mg, 500mg & 750mg</i>	1	[EDS]
<i>levofloxacin in d5w inj</i>	2	[EDS]
<i>levofloxacin oral soln</i>	2	[EDS]
<i>levofloxacin tabs</i>	1	[EDS]
<i>moxifloxacin inj</i>	4	[EDS]
<i>moxifloxacin oral</i>	2	[EDS]
<i>ofloxacin oral</i>	2	[EDS]
Sulfonamides		
<i>sulfacetamide sodium topical lotion 10%</i>	2	[EDS]
<i>sulfadiazine tabs</i>	4	[EDS]
<i>sulfamethoxazole & trimethoprim tabs</i>	1	[EDS]
<i>sulfamethoxazole & trimethoprim ds tabs</i>	1	[EDS]
<i>sulfamethoxazole & trimethoprim oral susp</i>	2	[EDS]
Tetracyclines		
<i>demeclocycline</i>	4	[EDS]
<i>doxy 100 inj</i>	2	[EDS]
<i>doxycycline immediate-release tabs, caps & oral susp</i>	2	[EDS]
<i>minocycline ir</i>	2	[EDS]
<i>tetracycline</i>	3	[EDS]
ANTICONVULSANTS		
Anticonvulsants, Other		
BRIVIACT ORAL SOLN	4	[EDS]
BRIVIACT TABS	5	
EPIDIOLEX	5	[PA] [LD]
EPRONTIA	4	[EDS]
<i>felbamate tabs 400mg</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>felbamate tabs 600mg</i>	4	[EDS]
<i>felbamate oral susp 600mg/5ml</i>	5	
FINTEPLA	5	[PA] [LD]
FYCOMPA	4	[EDS]
<i>levetiracetam er</i>	2	[EDS]
<i>levetiracetam oral</i>	2	[EDS]
NAYZILAM	4	[EDS]
<i>roweepra 500mg</i>	2	[EDS]
SPRITAM	4	[EDS]
<i>valproic acid oral caps & soln</i>	2	[EDS]
XCOPRI TABS	5	
XCOPRI MAINTENANCE PACK	5	
XCOPRI TITRATION PACK 12.5-25MG	4	[EDS]
XCOPRI TITRATION PACK 50-100MG, & 150-200MG	5	
ZTALMY SUSP	5	[LD]
Calcium Channel Modifying Agents		
CELONTIN	4	[EDS]
<i>ethosuximide</i>	2	[EDS]
<i>methsuximide</i>	4	[EDS]
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
<i>clobazam</i>	4	[EDS]
<i>clonazepam</i>	2	[EDS]
<i>clonazepam odt</i>	2	[EDS]
DIACOMIT	5	[PA]
DIAZEPAM RECTAL GEL	3	[EDS]
<i>divalproex sodium dr</i>	2	[EDS]
<i>divalproex sodium er</i>	2	[EDS]
<i>gabapentin caps, ir tabs & oral soln</i>	2	[EDS]
<i>phenobarbital elixir & tabs</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>pregabalin</i>	2	[EDS]
<i>primidone tabs 50mg & 250mg</i>	2	[EDS]
PRIMIDONE TABS 125MG	3	[EDS]
SYMPAZAN 5MG	4	[EDS]
SYMPAZAN 10MG & 20MG	5	
<i>tiagabine</i>	4	[EDS]
VALTOCO	4	[EDS]
<i>vigabatrin</i>	5	[LD]
<i>vigadrone</i>	5	[LD]
<i>vigpoder</i>	5	[LD]
Sodium Channel Agents		
APTIOM	5	
<i>carbamazepine tabs, chewable tabs & oral susp</i>	2	[EDS]
<i>carbamazepine er tabs & caps</i>	3	[EDS]
DILANTIN CAPS	3	[EDS]
DILANTIN INFATABS	3	[EDS]
DILANTIN SUSP	3	[EDS]
<i>epitol</i>	2	[EDS]
<i>lacosamide oral</i>	4	[EDS]
<i>oxcarbazepine tabs</i>	2	[EDS]
<i>oxcarbazepine susp</i>	4	[EDS]
<i>phenytek</i>	2	[EDS]
<i>phenytoin suspension & chewable tabs</i>	2	[EDS]
<i>phenytoin er</i>	2	[EDS]
<i>phenytoin oral susp</i>	2	[EDS]
<i>rufinamide</i>	4	[EDS]
TEGRETOL	3	[EDS]
TEGRETOL XR	3	[EDS]
TRILEPTAL	4	[EDS]
ZONISADE	4	[EDS]
<i>zonisamide</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
ANTIDEMENTIA AGENTS		
Antidementia Agents, Other		
<i>ergoloid mesylates</i>	3	[PA] [EDS]
Cholinesterase Inhibitors		
<i>donepezil tabs 5mg & 10mg</i>	2	[EDS]
<i>donepezil odt</i>	2	[EDS]
<i>galantamine tabs</i>	2	[EDS]
<i>galantamine er caps</i>	2	[EDS]
<i>galantamine soln</i>	4	[EDS]
<i>rivastigmine caps</i>	3	[EDS]
<i>rivastigmine patches</i>	4	[EDS]
N-methyl-D-aspartate (NMDA) Receptor Antagonists		
<i>memantine hcl immediate release</i>	2	[EDS]
<i>memantine hcl soln</i>	2	[EDS]
<i>memantine hcl titration pack</i>	2	[EDS]
ANTIDEPRESSANTS		
Antidepressants, Other		
AUVELITY	5	
<i>bupropion hcl tabs</i>	2	[EDS]
<i>bupropion sr</i>	2	[EDS]
<i>bupropion xl 150mg & 300mg</i>	2	[EDS]
<i>bupropion xl 450mg</i>	3	[EDS]
FORFIVO XL	3	[EDS]
<i>mirtazapine</i>	1	[EDS]
<i>mirtazapine odt</i>	1	[EDS]
<i>nefazodone</i>	2	[EDS]
<i>perphenazine & amitriptyline</i>	2	[EDS]
<i>trazodone</i>	1	[EDS]
TRINTELLIX	4	[EDS]
ZURZUVAE	5	[PA]
Monoamine Oxidase Inhibitors		
EMSAM	5	
MARPLAN	4	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>phenelzine</i>	2	[EDS]
<i>tranylcypromine</i>	4	[EDS]
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin & Norepinephrine Reuptake Inhibitors)		
<i>citalopram tabs</i>	1	[EDS]
<i>citalopram oral soln</i>	2	[EDS]
DESVENLAFAXINE ER	4	[EDS]
<i>desvenlafaxine succinate er</i>	3	[EDS]
<i>escitalopram</i>	2	[EDS]
FETZIMA	4	[EDS]
FETZIMA TITRATION PACK	4	[EDS]
<i>fluoxetine hcl caps 10mg, 20mg & 40mg</i>	2	[EDS]
<i>fluoxetine hcl tabs 10mg & 20mg</i>	2	[EDS]
<i>fluoxetine hcl oral soln</i>	2	[EDS]
<i>fluvoxamine</i>	2	[EDS]
<i>fluvoxamine er</i>	4	[EDS]
<i>paroxetine hcl ir tabs</i>	1	[EDS]
<i>paroxetine hcl er</i>	2	[EDS]
<i>paroxetine hcl susp</i>	4	[EDS]
<i>sertraline tabs</i>	1	[EDS]
<i>sertraline oral soln</i>	2	[EDS]
VENLAFAXINE BESYLATE ER TAB 112.5MG	4	[EDS]
<i>venlafaxine ir tabs</i>	2	[EDS]
<i>venlafaxine hcl er tabs</i>	3	[EDS]
<i>venlafaxine hcl er caps</i>	2	[EDS]
<i>vilazodone</i>	3	[EDS]
Tricyclics		
<i>amitriptyline</i>	2	[EDS]
<i>amoxapine</i>	2	[EDS]
<i>clomipramine</i>	4	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>desipramine</i>	2	[EDS]
<i>doxepin caps</i>	2	[EDS]
<i>doxepin oral soln</i>	2	[EDS]
<i>imipramine hcl tabs</i>	2	[EDS]
<i>nortriptyline</i>	2	[EDS]
<i>protriptyline</i>	3	[EDS]
<i>trimipramine maleate</i>	2	[EDS]
ANTIEMETICS		
Antiemetics, Other		
<i>compro</i>	2	[EDS]
<i>meclizine</i>	2	[EDS]
<i>prochlorperazine oral</i>	2	[EDS]
<i>prochlorperazine suppositories</i>	2	[EDS]
<i>promethazine suppositories</i>	3	[EDS]
<i>promethazine syrup</i>	2	[EDS]
<i>promethazine tabs</i>	2	[EDS]
<i>promethegan</i>	3	[EDS]
<i>scopolamine patch</i>	3	[EDS]
Emetogenic Therapy Adjuncts		
<i>aprepitant caps 80mg & 125mg</i>	4	[PA] [EDS]
<i>aprepitant pack</i>	4	[PA] [EDS]
<i>dronabinol</i>	4	[PA] [EDS]
<i>granisetron oral</i>	2	[PA] [B vs D] [EDS]
<i>ondansetron odt</i>	2	[PA] [B vs D] [EDS]
<i>ondansetron oral soln</i>	2	[PA] [B vs D] [EDS]
<i>ondansetron tabs 4mg & 8mg</i>	2	[PA] [B vs D] [EDS]
ANTIFUNGALS		
Antifungals		
ABELCET INJ	4	[PA] [B vs D] [EDS]
AMBISOME INJ	5	[PA] [B vs D]
<i>amphotericin b inj</i>	2	[PA] [B vs D] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>amphotericin b liposome inj</i>	5	[PA] [B vs D]
<i>casprofungin inj 50mg</i>	5	
<i>casprofungin inj 70mg</i>	4	[EDS]
<i>clotrimazole cream 1%</i>	2	[EDS]
<i>clotrimazole topical soln 1%</i>	2	[EDS]
<i>clotrimazole troche</i>	2	[EDS]
CRESEMBA ORAL	5	[PA]
<i>econazole nitrate</i>	4	[EDS]
<i>fluconazole in sodium chloride inj</i>	2	[EDS]
<i>fluconazole oral</i>	2	[EDS]
<i>flucytosine</i>	5	
<i>griseofulvin microsize</i>	2	[EDS]
<i>itraconazole</i>	4	[EDS]
<i>ketoconazole cream, shampoo & tabs</i>	2	[EDS]
<i>nyamyc</i>	2	[EDS]
<i>nystatin</i>	2	[EDS]
<i>nystop</i>	2	[EDS]
<i>posaconazole dr tabs</i>	5	[PA]
<i>posaconazole suspension</i>	4	[PA] [EDS]
<i>terbinafine</i>	2	[EDS]
<i>terconazole</i>	2	[EDS]
<i>voriconazole inj</i>	5	[PA]
<i>voriconazole oral suspension</i>	5	
<i>voriconazole tabs</i>	4	[EDS]
ANTIGOUT AGENTS		
Antigout Agents		
<i>allopurinol tabs 100mg & 300mg</i>	1	[EDS]
COLCHICINE CAPS	4	[EDS]
<i>colchicine tabs</i>	3	[EDS]
<i>febuxostat</i>	3	[EDS]
<i>probenecid</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>probenecid & colchicine</i>	2	[EDS]
ANTIMIGRAINE AGENTS		
Antimigraine Agents, Other		
UBRELVY	3	[PA] [EDS]
Ergot Alkaloids		
<i>caffeine-ergotamine</i>	3	[EDS]
<i>dihydroergotamine mesylate nasal</i>	5	
<i>migergot suppository</i>	4	[EDS]
Prophylactic		
AIMOVIG INJ	3	[PA] [EDS]
EMGALITY INJ	3	[PA] [EDS]
NURTEC ODT	3	[PA] [EDS]
QULIPTA TABS	3	[PA] [EDS]
<i>topiramate immediate-release</i>	2	[EDS]
Serotonin (5-HT) Receptor Agonist		
<i>naratriptan</i>	2	[EDS]
<i>rizatriptan</i>	2	[EDS]
<i>rizatriptan odt</i>	2	[EDS]
<i>sumatriptan nasal</i>	4	[EDS]
<i>sumatriptan succinate inj</i>	4	[EDS]
<i>sumatriptan succinate tabs</i>	2	[EDS]
<i>zolmitriptan nasal soln 5mg</i>	4	[EDS]
<i>zolmitriptan tabs</i>	3	[EDS]
<i>zolmitriptan odt</i>	3	[EDS]
ZOMIG NASAL 2.5MG	4	[EDS]
ANTIMYASTHENIC AGENTS		
Parasympathomimetics		
<i>pyridostigmine soln</i>	4	[EDS]
<i>pyridostigmine tabs 60mg</i>	3	[EDS]
<i>pyridostigmine er tabs 180mg</i>	4	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
ANTIMYCOBACTERIALS		
Antimycobacterials, Other		
<i>dapsone tabs</i>	3	[EDS]
<i>rifabutin</i>	4	[EDS]
Antituberculars		
<i>ethambutol</i>	2	[EDS]
<i>isoniazid</i>	2	[EDS]
PRIFTIN	4	[EDS]
<i>pyrazinamide</i>	2	[EDS]
<i>rifampin oral and inj</i>	2	[EDS]
<i>rifampin inj</i>	2	[EDS]
SIRTURO	5	
TRECTOR	4	[EDS]
ANTINEOPLASTICS		
Alkylating Agents		
<i>cyclophosphamide</i>	3	[PA] [B vs D] [EDS]
GLEOSTINE	4	[EDS]
LEUKERAN	4	[EDS]
MATULANE	5	
VALCHLOR	5	[PA]
Antiandrogens		
<i>abiraterone acetate</i>	5	[PA]
<i>bicalutamide</i>	2	[EDS]
ERLEADA	5	[PA]
<i>nilutamide</i>	5	
NUBEQA	5	[PA] [LD]
XTANDI	5	[PA]
YONSA	5	[PA]
Antiangiogenic Agents		
FOTIVDA	5	[PA] [LD]
<i>lenalidomide</i>	5	[PA] [LD]
POMALYST	5	[PA] [LD]
QINLOCK	5	[PA] [LD]
TABRECTA	5	[PA]
THALOMID	5	[PA]
Antiestrogens/Modifiers		
SOLTAMOX	3	[EDS]
<i>tamoxifen</i>	2	[EDS]
<i>toremifene citrate</i>	5	

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Antimetabolites		
<i>hydroxyurea</i>	2	[EDS]
<i>mercaptopurine</i>	2	[EDS]
PURIXAN	5	
TABLOID	4	[EDS]
Antineoplastics, Other		
AKEEGA	5	[PA] [LD]
BESREMI INJ	5	[PA] [LD]
GAVRETO	5	[PA] [LD]
IDHIFA	5	[PA] [LD]
INREBIC	5	[PA] [LD]
IWILFIN	5	[PA] [LD]
KRAZATI	5	[PA]
LONSURF	5	[PA]
LUMAKRAS	5	[PA]
LYTGOBI TABS	5	[PA] [LD]
NINLARO	5	[PA]
ONUREG	5	[PA]
ORSERDU TABS	5	[PA]
PEMAZYRE	5	[PA] [LD]
RETEVMO	5	[PA] [LD]
ROZLYTREK	5	[PA]
TAZVERIK	5	[PA] [LD]
TUKYSA	5	[PA] [LD]
VONJO	5	[PA]
XPOVIO	5	[PA] [LD]
Aromatase Inhibitors, 3rd Generation		
<i>anastrozole</i>	2	[EDS]
<i>exemestane</i>	3	[EDS]
<i>letrozole</i>	2	[EDS]
Enzyme Inhibitors		
BALVERSA	5	[PA]
ZOLINZA	5	[PA]
Molecular Target Inhibitors		
AUGTYRO	5	[PA]
ALECENSA	5	[PA]
ALUNBRIG	5	[PA]
ALUNBRIG INITIATION PACK	5	[PA]
AYVAKIT	5	[PA] [LD]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
BOSULIF	5	[PA]
BRAFTOVI	5	[PA] [LD]
BRUKINSA	5	[PA] [LD]
CABOMETYX	5	[PA]
CALQUENCE	5	[PA] [LD]
CAPRELSA	5	[PA]
COMETRIQ	5	[PA]
COPIKTRA	5	[PA] [LD]
COTELLIC	5	[PA]
DAURISMO	5	[PA]
ERIVEDGE	5	[PA]
<i>erlotinib</i>	5	[PA]
<i>everolimus tabs 2.5mg, 5mg, 7.5mg & 10mg</i>	5	[PA]
<i>everolimus tabs for suspension 2mg, 3mg & 5mg</i>	5	[PA]
EXKIVITY	5	[PA] [LD]
FRUZAQLA	5	[PA]
<i>gefitinib</i>	5	[PA]
GILOTRIF	5	[PA]
IBRANCE	5	[PA]
ICLUSIG	5	[PA]
<i>imatinib</i>	5	[PA]
IMBRUVICA	5	[PA]
INLYTA	5	[PA]
INQOVI	5	[PA]
IRESSA	5	[PA]
JAKAFI	5	[PA]
JAYPIRCA TABS	5	[PA]
KISQALI	5	[PA]
KISQALI FEMARA CO-PACK	5	[PA]
<i>lapatinib</i>	5	[PA]
LENVIMA	5	[PA]
LORBRENA	5	[PA]
LYNPARZA	5	[PA]
MEKINIST	5	[PA]
MEKTOVI	5	[PA] [LD]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
NERLYNX	5	[PA] [LD]
ODOMZO	5	[PA]
OJJAARA	5	[PA]
<i>pazopanib</i>	5	[PA]
PIQRAY	5	[PA]
REZLIDHIA CAPS	5	[PA]
RUBRACA	5	[PA] [LD]
RYDAPT	5	[PA]
SCEMBLIX	5	[PA]
<i>sorafenib</i>	5	[PA]
SPRYCEL	5	[PA]
STIVARGA	5	[PA]
<i>sunitinib malate</i>	5	[PA]
TAFINLAR	5	[PA]
TAGRISSE	5	[PA]
TALZENNA	5	[PA]
TASIGNA	5	[PA]
TEPMETKO	5	[PA] [LD]
TIBSOVO	5	[PA]
TRUQAP	5	[PA]
TURALIO	5	[PA] [LD]
VENCLEXTA TABS 10MG & 50MG	3	[PA] [EDS]
VENCLEXTA TABS 100MG	5	[PA]
VENCLEXTA STARTING PACK	5	[PA]
VERZENIO	5	[PA] [LD]
VITRAKVI	5	[PA] [LD]
VIZIMPRO	5	[PA]
VOTRIENT	5	[PA]
WELIREG	5	[PA] [LD]
XALKORI	5	[PA]
XOSPATA	5	[PA] [LD]
VANFLYTA	5	[PA]
ZEJULA	5	[PA] [LD]
ZELBORAF	5	[PA]
ZYDELIG	5	[PA]
ZYKADIA TABS	5	[PA]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Retinoids		
<i>bexarotene</i>	5	[PA]
PANRETIN	5	
<i>tretinoin caps</i>	5	
Treatment Adjuncts		
<i>leucovorin oral</i>	2	[EDS]
MESNEX TABS	4	[EDS]
ANTIPARASITICS		
Anthelmintics		
<i>albendazole</i>	4	[EDS]
<i>ivermectin tabs</i>	2	[EDS]
Antiprotozoals		
<i>atovaquone susp</i>	4	[EDS]
<i>atovaquone/proguanil</i>	2	[EDS]
<i>chloroquine</i>	2	[EDS]
COARTEM	3	[EDS]
<i>hydroxychloroquine tab 200mg</i>	2	[EDS]
<i>mefloquine</i>	2	[EDS]
NEBUPENT NEBULIZER	4	[PA] [B vs D] [EDS]
<i>nitazoxanide</i>	5	
<i>pentamidine inhalation soln</i>	3	[PA] [B vs D] [EDS]
<i>pentamidine inj</i>	4	[EDS]
PRIMAQUINE	3	[EDS]
<i>pyrimethamine</i>	5	[PA]
<i>quinine sulfate caps</i>	3	[PA] [EDS]
ANTIPARKINSON AGENTS		
Anticholinergics		
<i>benztropine tabs</i>	2	[EDS]
<i>trihexyphenidyl elixir & tabs</i>	2	[EDS]
Antiparkinson Agents, Other		
<i>amantadine</i>	2	[EDS]
<i>carbidopa & levodopa & entacapone</i>	4	[EDS]
<i>entacapone</i>	4	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Dopamine Agonists		
<i>apomorphine hydrochloride inj</i>	5	[PA]
<i>bromocriptine</i>	2	[EDS]
NEUPRO PATCH	4	[EDS]
<i>pramipexole ir</i>	2	[EDS]
<i>ropinirole ir</i>	2	[EDS]
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
<i>carbidopa</i>	4	[EDS]
<i>carbidopa & levodopa ir, er, odt</i>	2	[EDS]
Monoamine Oxidase B (MAO-B) Inhibitors		
<i>rasagiline</i>	4	[EDS]
<i>selegiline</i>	2	[EDS]
ANTIPSYCHOTICS		
1st Generation/Typical		
<i>chlorpromazine oral</i>	4	[EDS]
<i>fluphenazine oral</i>	2	[EDS]
<i>fluphenazine decanoate inj</i>	2	[EDS]
<i>fluphenazine inj</i>	2	[EDS]
<i>haloperidol oral</i>	2	[EDS]
<i>haloperidol decanoate inj</i>	2	[EDS]
<i>haloperidol lactate inj</i>	2	[EDS]
<i>loxapine</i>	2	[EDS]
<i>molindone</i>	2	[EDS]
<i>perphenazine</i>	2	[EDS]
<i>pimozide</i>	2	[EDS]
<i>thioridazine</i>	2	[EDS]
<i>thiothixene</i>	2	[EDS]
<i>trifluoperazine</i>	2	[EDS]
2nd Generation/Atypical		
ABILIFY ASIMTUFII INJ	5	
ABILIFY MAINTENA INJ	5	
<i>aripiprazole odt</i>	5	
<i>aripiprazole soln</i>	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>aripiprazole tabs</i>	3	[EDS]
ARISTADA INJ	5	
ARISTADA INITIO INJ	4	[EDS]
<i>asenapine maleate sublingual</i>	4	[EDS]
CAPLYTA	5	
FANAPT	4	[EDS]
FANAPT TITRATION PACK	4	[EDS]
INVEGA HAFYERA INJ	5	
INVEGA SUSTENNA INJ 39MG	4	[EDS]
INVEGA SUSTENNA INJ 78MG, 117MG, 156MG & 234MG	5	
INVEGA TRINZA INJ	5	
<i>lurasidone hcl tabs</i>	5	
LYBALVI	5	[PA]
NUPLAZID	5	[PA]
<i>olanzapine inj, tabs & odt tabs</i>	2	[EDS]
<i>paliperidone er tabs</i>	4	[EDS]
PERSERIS INJ	5	
<i>quetiapine fumarate 25mg, 50mg, 100mg, 200mg, 300mg & 400mg tabs</i>	2	[EDS]
QUETIAPINE FUMARATE 150MG TABS	3	[EDS]
<i>quetiapine er tabs</i>	3	[EDS]
REXULTI	5	
RISPERDAL CONSTA INJ 12.5MG & 25MG	4	[EDS]
RISPERDAL CONSTA INJ 37.5MG & 50MG	5	
<i>risperidone</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>risperidone er inj 12.5mg & 25mg</i>	4	[EDS]
<i>risperidone er inj 37.5mg & 50mg</i>	5	
<i>risperidone odt</i>	2	[EDS]
SECUADO	5	[PA]
SEROQUEL XR	4	[EDS]
UZEDY INJ	5	
VRAYLAR CAPSULES	5	
VRAYLAR DOSE PACK	4	[EDS]
<i>ziprasidone inj</i>	3	[EDS]
<i>ziprasidone oral</i>	2	[EDS]
ZYPREXA RELPREVV INJ 210MG	4	[EDS]
Treatment-Resistant		
<i>clozapine</i>	2	[EDS]
<i>clozapine odt</i>	4	[EDS]
VERSACLOZ	5	
ANTISPASTICITY AGENTS		
Antispasticity Agents		
<i>baclofen tabs</i>	2	[EDS]
<i>tizanidine caps</i>	3	[EDS]
<i>tizanidine tabs</i>	2	[EDS]
ANTIVIRALS		
Anti-cytomegalovirus (CMV) Agents		
PREVYMIS	5	[PA]
<i>valganciclovir</i>	3	[EDS]
Anti-hepatitis B (HBV) Agents		
<i>adefovir dipivoxil</i>	4	[EDS]
BARACLUDE ORAL SOLN 0.05MG/ML	4	[EDS]
<i>entecavir tabs</i>	4	[EDS]
<i>lamivudine tabs 100mg</i>	3	[EDS]
VEMLIDY	5	

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Anti-hepatitis C (HCV) Agents		
EPCLUSA	5	[PA]
HARVONI	5	[PA]
LEDIPASVIR/ SOFOSBUVIR	5	[PA]
<i>ribavirin</i>	3	[EDS]
SOFOSBUVIR/ VELPATASVIR	5	[PA]
VOSEVI	5	[PA]
Antiherpetic Agents		
<i>acyclovir caps & tabs</i>	2	[EDS]
<i>acyclovir inj</i>	2	[PA] [B vs D] [EDS]
<i>acyclovir oral susp</i>	4	[EDS]
<i>famciclovir</i>	2	[EDS]
<i>valacyclovir</i>	2	[EDS]
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
BIKTARVY	5	
DOVATO	5	
GENVOYA	5	
ISENTRESS CHEW TABS 25MG	3	[EDS]
ISENTRESS 100MG CHEW TABS	5	
ISENTRESS ORAL POWDER	5	
ISENTRESS TABS	5	
ISENTRESS HD TABS	5	
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	

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>efavirenz caps & tabs</i>	4	[EDS]
<i>efavirenz & emtricitabine & tenofovir disoproxil fumarate tabs</i>	5	
<i>efavirenz & lamivudine & tenofovir disoproxil fumarate tabs</i>	5	
<i>etravirine tabs 100mg</i>	4	[EDS]
<i>etravirine tabs 200mg</i>	5	
INTELENCE TAB 25MG	4	[EDS]
<i>nevirapine er</i>	2	[EDS]
<i>nevirapine susp & tabs</i>	2	[EDS]
ODEFSEY	5	
PIFELTRO	5	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
<i>abacavir soln & tabs</i>	4	[EDS]
<i>abacavir & lamivudine</i>	4	[EDS]
CIMDUO	5	
DESCOVY	5	
<i>emtricitabine caps 200mg</i>	4	[EDS]
<i>emtricitabine & tenofovir disoproxil fumarate tabs 200mg- 300mg</i>	4	[EDS]
<i>emtricitabine & tenofovir disoproxil fumarate tabs 100mg- 150mg, 133mcg- 200mg & 167mg- 250mg</i>	5	
EMTRIVA SOLN	4	[EDS]
<i>lamivudine tabs 150mg & 300mg</i>	3	[EDS]
<i>lamivudine soln</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>lamivudine & zidovudine</i>	3	[EDS]
<i>tenofovir disoproxil fumarate</i>	4	[EDS]
TRIUMEQ	5	
TRIUMEQ PD	5	
TRIZIVIR	5	
VIREAD TABS 150MG, 200MG & 250MG	5	
VIREAD POWDER	4	[EDS]
<i>zidovudine</i>	2	[EDS]
Anti-HIV Agents, Other		
FUZEON INJ	3	[EDS]
<i>maraviroc</i>	5	
RUKOBIA	5	
SELZENTRY SOLN	3	[EDS]
SELZENTRY 25MG & 75MG	3	[EDS]
SUNLENCA	5	
TYBOST	3	[EDS]
Anti-HIV Agents, Protease Inhibitors (PI)		
APTIVUS CAPS	5	
<i>atazanavir sulfate caps</i>	4	[EDS]
<i>darunavir tab 600mg</i>	4	[EDS]
<i>darunavir tab 800mg</i>	5	
EVOTAZ	5	
<i>fosamprenavir tabs</i>	5	
LEXIVA ORAL SUSP	4	[EDS]
<i>lopinavir & ritonavir</i>	4	[EDS]
NORVIR POWDER	3	[EDS]
PREZCOBIX	5	
PREZISTA SUSP 100MG/ML	4	[EDS]
PREZISTA TABS 75MG & 150MG	4	[EDS]
PREZISTA TABS 600MG & 800MG	5	

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
REYATAZ ORAL POWDER	5	
<i>ritonavir tabs</i>	3	[EDS]
SYMTUZA	5	
VIRACEPT	5	
Anti-influenza Agents		
<i>oseltamivir caps</i>	2	[EDS]
<i>oseltamivir susp</i>	3	[EDS]
RELENZA DISKHALER	3	[EDS]
<i>rimantadine</i>	2	[EDS]
XOFLUZA	4	[EDS]
ANXIOLYTICS		
Anxiolytics, Other		
<i>bupirone</i>	2	[EDS]
<i>meprobamate</i>	4	[EDS]
Benzodiazepines		
<i>alprazolam ir tabs</i>	2	[EDS]
<i>alprazolam er tabs</i>	2	[EDS]
<i>alprazolam soln</i>	2	[EDS]
<i>clorazepate</i>	2	[EDS]
<i>diazepam soln & tabs</i>	2	[EDS]
<i>lorazepam soln & tabs</i>	2	[EDS]
<i>oxazepam</i>	3	[EDS]
BIPOLAR AGENTS		
Mood Stabilizers		
<i>lamotrigine odt</i>	4	[EDS]
<i>lamotrigine odt kit</i>	4	[EDS]
<i>lamotrigine chewable tabs</i>	2	[EDS]
<i>lamotrigine immediate-release tabs</i>	2	[EDS]
<i>lamotrigine starter kit</i>	4	[EDS]
<i>lamotrigine titration kit</i>	4	[EDS]
<i>lithium carbonate</i>	2	[EDS]
<i>lithium carbonate er</i>	2	[EDS]
<i>lithium citrate oral soln</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>subvenite starter kit</i>	4	[EDS]
<i>subvenite tabs</i>	2	[EDS]
BLOOD GLUCOSE REGULATORS		
Antidiabetic Agents		
<i>acarbose</i>	2	[EDS]
BYDUREON BCISE INJ	3	[EDS]
BYETTA INJ	3	[EDS]
CYCLOSET	3	[EDS]
FARXIGA	6	[EDS]
<i>glimepiride</i>	1	[EDS]
<i>glimepiride & pioglitazone</i>	2	[EDS]
<i>glipizide er</i>	1	[EDS]
<i>glipizide tabs 5mg & 10mg</i>	1	[EDS]
<i>glipizide & metformin tabs</i>	1	[EDS]
GLYXAMBI	6	[EDS]
JANUMET	6	[EDS]
JANUMET XR	6	[EDS]
JANUVIA	6	[EDS]
JARDIANCE	6	[EDS]
JENTADUETO	6	[EDS]
JENTADUETO XR	6	[EDS]
<i>metformin tabs</i>	1	[EDS]
<i>metformin er uncoated tabs 500mg & 750mg</i>	1	[EDS]
MOUNJARO INJ	3	[EDS]
<i>nateglinide</i>	2	[EDS]
OZEMPIC INJ	3	[EDS]
<i>pioglitazone</i>	1	[EDS]
<i>pioglitazone & metformin</i>	2	[EDS]
<i>repaglinide</i>	2	[EDS]
RYBELSUS	3	[EDS]
SYMLINPEN INJ	5	
SYNJARDY	6	[EDS]
SYNJARDY XR	6	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
TRADJENTA	6	[EDS]
TRIJARDY XR	6	[EDS]
TRULICITY INJ	3	[EDS]
VICTOZA INJ	3	[EDS]
XIGDUO XR	6	[EDS]
Glycemic Agents		
BAQSIMI	3	[EDS]
<i>diazoxide</i>	4	[EDS]
GLUCAGEN	3	[EDS]
HYPOKIT INJ		
GLUCAGON EMERGENCY KIT INJ	3	[EDS]
GVOKE INJ	3	[EDS]
ZEGALOGUE INJ	3	[EDS]
Insulins		
HUMALOG CARTRIDGE INJ	3	[EDS]
HUMALOG JUNIOR KWIKPEN INJ	3	[EDS]
HUMALOG KWIKPEN INJ	3	[EDS]
HUMALOG MIX 50/50 KWIKPEN INJ	3	[EDS]
HUMALOG MIX 75/25 KWIKPEN INJ	3	[EDS]
HUMALOG MIX 75/25 VIAL INJ	3	[EDS]
HUMALOG VIAL INJ	3	[EDS]
HUMULIN 70/30 KWIKPEN INJ	3	[EDS]
HUMULIN 70/30 VIAL INJ	3	[EDS]
HUMULIN N KWIKPEN INJ	3	[EDS]
HUMULIN N VIAL INJ	3	[EDS]
HUMULIN R U-500 (CONCENTRATED) KWIKPEN INJ	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
HUMULIN R U-500 (CONCENTRATED) VIAL INJ	3	[EDS]
HUMULIN R VIAL INJ	3	[EDS]
INSULIN GLARGINE VIAL INJ 100UNIT/ML	3	[EDS]
INSULIN GLARGINE SOLOSTAR INJ 100UNIT/ML	3	[EDS]
INSULIN LISPRO VIAL INJ	3	[EDS]
LANTUS SOLOSTAR PEN INJ	3	[EDS]
LANTUS VIAL INJ	3	[EDS]
LEVEMIR VIAL INJ	3	[EDS]
LEVEMIR FLEXPEN INJ	3	[EDS]
LYUMJEV VIAL INJ	3	[EDS]
LYUMJEV KWIKPEN INJ	3	[EDS]
SOLIQUA INJ	3	[EDS]
TOUJEO SOLOSTAR INJ	3	[EDS]
TOUJEO MAX SOLOSTAR INJ	3	[EDS]
TRESIBA VIAL INJ	3	[EDS]
TRESIBA FLEXTOUCH INJ	3	[EDS]
BLOOD PRODUCTS AND MODIFIERS		
Anticoagulants		
<i>dabigatran etexilate</i>	4	[EDS]
ELIQUIS STARTER PACK & TABS	6	[EDS]
<i>enoxaparin inj syringe</i>	4	[EDS]
<i>fondaparinux inj 2.5mg/0.5ml & 5mg/0.4ml</i>	4	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>fondaparinux inj 7.5mg/0.6ml & 10mg/0.8ml</i>	5	
<i>heparin inj vials 1000u/ml, 5000u/ml, 10000u/ml & 20000u/ml</i>	2	[PA] [B vs D] [EDS]
<i>jantoven</i>	1	[EDS]
<i>warfarin</i>	1	[EDS]
XARELTO ORAL SUSP TABS & STARTER PACK	6	[EDS]
XARELTO STARTER PACK	6	[EDS]
Blood Products and Modifiers, Other		
<i>anagrelide</i>	2	[EDS]
LEUKINE INJ	5	[PA]
NIVESTYM INJ	5	[PA]
PROCRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML & 10000UNIT/ML	3	[PA] [EDS]
PROCRIT INJ 20000UNIT/ML & 40000UNIT/ML	5	[PA]
PROMACTA	5	[PA] [LD]
RETACRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML, 10000 UNIT/ML, 20000UNIT/2ML & 20000UNIT/ML	3	[PA] [EDS]
RETACRIT INJ 40000UNIT/ML	5	[PA]
UDENYCA INJ	5	[PA]
ZARXIO INJ	5	[PA]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Hemostasis Agents		
<i>tranexamic acid tabs</i>	3	[EDS]
Platelet Modifying Agents		
BRILINTA	3	[EDS]
<i>cilostazol</i>	2	[EDS]
<i>clopidogrel tabs 75mg</i>	1	[EDS]
<i>dipyridamole er & aspirin</i>	4	[EDS]
<i>dipyridamole oral</i>	2	[EDS]
<i>prasugrel</i>	2	[EDS]
CARDIOVASCULAR AGENTS		
Alpha-adrenergic Agonists		
<i>clonidine patches</i>	4	[EDS]
<i>clonidine tabs immediate-release</i>	1	[EDS]
<i>droxidopa</i>	5	[PA]
<i>guanfacine ir</i>	2	[EDS]
<i>midodrine tabs</i>	3	[EDS]
Alpha-adrenergic Blocking Agents		
<i>doxazosin</i>	2	[EDS]
<i>prazosin</i>	2	[EDS]
<i>terazosin</i>	1	[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]
Angiotensin II Receptor Antagonists		
<i>candesartan</i>	2	[EDS]
<i>irbesartan</i>	1	[EDS]
<i>losartan</i>	1	[EDS]
<i>olmesartan</i>	2	[EDS]
<i>telmisartan</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>valsartan tabs</i>	1	[EDS]
Antiarrhythmics		
<i>amiodarone tabs</i>	2	[EDS]
<i>disopyramide phosphate</i>	4	[EDS]
<i>dofetilide</i>	4	[EDS]
<i>flecainide acetate</i>	2	[EDS]
<i>mexiletine</i>	2	[EDS]
MULTAQ	3	[EDS]
<i>pacerone tabs</i>	2	[EDS]
<i>propafenone tabs</i>	2	[EDS]
<i>quinidine gluconate cr</i>	4	[EDS]
<i>quinidine sulfate</i>	2	[EDS]
<i>sorine</i>	2	[EDS]
<i>sotalol tabs</i>	2	[EDS]
Beta-adrenergic Blocking Agents		
<i>acebutolol</i>	2	[EDS]
<i>atenolol</i>	1	[EDS]
<i>bisoprolol</i>	2	[EDS]
<i>carvedilol</i>	1	[EDS]
<i>carvedilol phosphate er</i>	4	[EDS]
<i>labetalol oral</i>	2	[EDS]
<i>metoprolol succinate er</i>	2	[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]
<i>propranolol ir tabs</i>	1	[EDS]
<i>propranolol er caps</i>	2	[EDS]
<i>propranolol oral soln</i>	2	[EDS]
<i>timolol oral</i>	1	[EDS]
Calcium Channel Blocking Agents, Dihydropyridines		
<i>amlodipine</i>	1	[EDS]
<i>felodipine er</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>isradipine</i>	2	[EDS]
<i>nicardipine caps</i>	2	[EDS]
<i>nifedipine caps</i>	2	[EDS]
<i>nifedipine er</i>	2	[EDS]
<i>nimodipine</i>	4	[EDS]
<i>nisoldipine er</i>	4	[EDS]
Calcium Channel Blocking Agents, Nondihydropyridines		
<i>cartia xt</i>	2	[EDS]
<i>diltiazem tabs</i>	2	[EDS]
<i>diltiazem er caps</i>	2	[EDS]
<i>dilt-xr</i>	2	[EDS]
<i>taztia xt</i>	2	[EDS]
<i>tiadylt er</i>	2	[EDS]
<i>verapamil ir</i>	1	[EDS]
<i>verapamil er</i>	2	[EDS]
<i>verapamil sr</i>	2	[EDS]
Cardiovascular Agents, Other		
<i>aliskiren</i>	3	[EDS]
<i>amiloride & hydrochlorothiazide</i>	1	[EDS]
<i>amlodipine & atorvastatin</i>	2	[EDS]
<i>amlodipine & benazepril</i>	1	[EDS]
<i>amlodipine & valsartan & hydrochlorothiazide tabs</i>	2	[EDS]
<i>atenolol & chlorthalidone</i>	1	[EDS]
<i>benazepril & hydrochlorothiazide</i>	1	[EDS]
<i>bisoprolol & hydrochlorothiazide</i>	2	[EDS]
CORLANOR	4	[EDS]
<i>digoxin oral soln</i>	2	[EDS]
<i>digoxin tabs 125mcg & 250mcg</i>	2	[EDS]
<i>digoxin tab 62.5mcg</i>	3	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>enalapril & hydrochlorothiazide</i>	1	[EDS]
ENTRESTO	6	[EDS]
<i>fosinopril & hydrochlorothiazide</i>	1	[EDS]
<i>irbesartan hct</i>	1	[EDS]
KERENDIA	3	[EDS]
LANOXIN ORAL	3	[EDS]
<i>lisinopril & hydrochlorothiazide</i>	1	[EDS]
<i>losartan hct</i>	1	[EDS]
<i>metoprolol & hydrochlorothiazide</i>	2	[EDS]
<i>metyrosine caps</i>	5	[PA]
<i>olmesartan & amlodipine</i>	2	[EDS]
<i>olmesartan hct</i>	2	[EDS]
<i>olmesartan medoxomil & amlodipine & hydrochlorothiazide tabs</i>	2	[EDS]
<i>pentoxifylline er</i>	2	[EDS]
<i>ranolazine er</i>	3	[EDS]
<i>spironolactone & hydrochlorothiazide</i>	1	[EDS]
<i>triamterene & hydrochlorothiazide</i>	1	[EDS]
<i>valsartan & amlodipine</i>	1	[EDS]
<i>valsartan hct</i>	1	[EDS]
VERQUVO	4	[PA] [EDS]
Diuretics, Loop		
<i>bumetanide inj</i>	2	[EDS]
<i>bumetanide tabs</i>	2	[EDS]
<i>furosemide oral</i>	1	[EDS]
<i>furosemide inj</i>	2	[EDS]
<i>toremide</i>	2	[EDS]
Diuretics, Potassium-sparing		
<i>amiloride</i>	2	[EDS]
<i>eplerenone</i>	3	[EDS]

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Drug Name	Drug Tier	Requirements/Limits
Nombre del Medicamento	Nivel	Requisitos/Límites
<i>spironolactone tabs</i>	1	[EDS]
Diuretics, Thiazide		
<i>chlorthalidone</i>	1	[EDS]
<i>hydrochlorothiazide</i>	1	[EDS]
<i>indapamide</i>	1	[EDS]
<i>metolazone</i>	2	[EDS]
Dyslipidemics, Fibric Acid Derivatives		
<i>fenofibrate caps 43mg & 130mg</i>	2	[EDS]
<i>fenofibrate micronized caps 67mg, 134mg & 200mg</i>	2	[EDS]
<i>fenofibrate tabs 48mg, 54mg, 145mg & 160mg</i>	2	[EDS]
<i>fenofibric acid dr caps</i>	3	[EDS]
<i>gemfibrozil</i>	2	[EDS]
Dyslipidemics, HMG CoA Reductase Inhibitors		
<i>atorvastatin</i>	1	[EDS]
<i>lovastatin</i>	1	[EDS]
<i>pravastatin</i>	1	[EDS]
<i>rosuvastatin</i>	1	[EDS]
<i>simvastatin</i>	1	[EDS]
Dyslipidemics, Other		
<i>cholestyramine</i>	2	[EDS]
<i>cholestyramine light</i>	2	[EDS]
<i>colesevelam</i>	4	[EDS]
<i>colestipol pack</i>	2	[EDS]
<i>colestipol tabs</i>	2	[EDS]
<i>ezetimibe</i>	2	[EDS]
<i>ezetimibe & simvastatin</i>	3	[EDS]
<i>icosapent ethyl</i>	4	[EDS]
JUXTAPID	5	[PA] [LD]
<i>niacin er tabs</i>	3	[EDS]
<i>omega-3-acid ethyl esters</i>	2	[EDS]
<i>prevalite</i>	2	[EDS]
REPATHA INJ	3	[EDS]
VASCEPA CAPS	4	[EDS]

Drug Name	Drug Tier	Requirements/Limits
Nombre del Medicamento	Nivel	Requisitos/Límites
Vasodilators, Direct-acting Arterial		
<i>hydralazine oral</i>	2	[EDS]
<i>minoxidil</i>	2	[EDS]
Vasodilators, Direct-acting Arterial/Venous		
<i>isosorbide dinitrate tabs 5mg, 10mg, 20mg & 30mg</i>	2	[EDS]
<i>isosorbide mononitrate</i>	2	[EDS]
<i>isosorbide mononitrate er</i>	2	[EDS]
<i>nitro-bid oint</i>	2	[EDS]
NITRO-DUR PATCHES 0.3MG/HR & 0.8MG/HR	3	[EDS]
<i>nitroglycerin lingual</i>	2	[EDS]
<i>nitroglycerin patches</i>	2	[EDS]
<i>nitroglycerin sublingual</i>	2	[EDS]
CENTRAL NERVOUS SYSTEM AGENTS		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
<i>amphetamine & dextroamphetamine tabs</i>	2	[QL] [EDS]
<i>dextroamphetamine sulfate tabs 5mg & 10mg</i>	3	[QL] [EDS]
<i>dextroamphetamine sulfate er</i>	4	[QL] [EDS]
<i>zenzedi tabs 5mg & 10mg</i>	3	[QL] [EDS]
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
<i>atomoxetine</i>	3	[EDS]
<i>clonidine er 0.1mg</i>	2	[EDS]
<i>dexmethylphenidate ir tabs</i>	2	[EDS]
<i>methylphenidate er tabs 10mg & 20mg</i>	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>methylphenidate ir tabs 5mg, 10mg & 20mg</i>	2	[EDS]
Central Nervous System, Other		
AUSTEDO	5	[PA] [LD]
AUSTEDO XR	5	[PA] [LD]
AUSTEDO XR PATIENT TITRATION KIT	5	[PA]
NUEDEXTA	5	[PA]
<i>riluzole</i>	3	[EDS]
<i>tetrabenazine</i>	5	[PA]
Fibromyalgia Agents		
<i>duloxetine hcl</i>	2	[EDS]
SAVELLA	3	[EDS]
SAVELLA TITRATION PACK	3	[EDS]
Multiple Sclerosis Agents		
AVONEX INJ	5	[PA]
AVONEX PEN INJ	5	[PA]
BETASERON INJ	5	[PA]
COPAXONE INJ 40MG/ML	5	[PA]
<i>dalfampridine er</i>	3	[PA] [EDS]
<i>dimethyl fumarate caps</i>	5	[PA]
<i>dimethyl fumarate starter pack</i>	5	[PA]
<i>fingolimod</i>	5	[PA]
<i>glatiramer acetate inj</i>	5	[PA]
<i>glatopa inj</i>	5	[PA]
PLEGRIDY INJ	5	[PA]
REBIF INJ	5	[PA]
REBIF REBIDOSE INJ	5	[PA]
REBIF REBIDOSE TITRATION PACK INJ	5	[PA]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
REBIF TITRATION PACK INJ	5	[PA]
<i>teriflunomide tabs</i>	5	[PA]
VUMERITY	5	[PA]
DENTAL AND ORAL AGENTS		
Dental and Oral Agents		
<i>cevimeline</i>	3	[EDS]
<i>chlorhexidine gluconate</i>	2	[EDS]
<i>kourzeq</i>	2	[EDS]
<i>lidocaine viscous soln</i>	2	[EDS]
<i>periogard</i>	2	[EDS]
<i>pilocarpine tabs</i>	3	[EDS]
<i>triamcinolone dental paste</i>	2	[EDS]
DERMATOLOGICAL AGENTS		
Acne and Rosacea Agents		
<i>acitretin</i>	4	[PA] [EDS]
<i>accutane</i>	4	[EDS]
<i>adapalene cream 0.1%</i>	4	[EDS]
<i>adapalene gel 0.3%</i>	4	[EDS]
ALTRENO	3	[PA] [EDS]
<i>amnesteam caps</i>	4	[EDS]
<i>claravis</i>	4	[EDS]
<i>clindamycin & benzoyl peroxide gel 5%-1% & 5%-1.2%</i>	3	[EDS]
<i>isotretinoin caps 10mg, 20mg, 30mg & 40mg</i>	4	[EDS]
<i>tazarotene cream</i>	4	[EDS]
<i>tazarotene gel</i>	4	[QL] [EDS]
TAZORAC CREAM 0.05%	4	[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]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Dermatitis and Pruritus Agents		
<i>alclometasone dipropionate</i>	2	[EDS]
<i>ammonium lactate</i>	2	[EDS]
<i>betamethasone dipropionate</i>	2	[EDS]
<i>betamethasone dipropionate augmented</i>	2	[EDS]
<i>betamethasone valerate cream, oint & lotion</i>	2	[EDS]
CAPEX SHAMPOO	4	[EDS]
<i>clobetasol propionate cream, foam, gel, oint & soln</i>	4	[EDS]
<i>clobetasol propionate emollient</i>	4	[EDS]
<i>desonide lotion, oint & cream</i>	3	[QL] [EDS]
<i>desoximetasone topical cream, gel & oint 0.05%</i>	4	[QL] [EDS]
<i>desoximetasone topical cream & oint 0.25%</i>	3	[QL] [EDS]
<i>diflorasone diacetate</i>	4	[QL] [EDS]
<i>fluocinolone acetonide cream, oint, soln</i>	3	[EDS]
<i>fluocinolone acetonide scalp oil</i>	3	[EDS]
<i>fluocinonide cream 0.05%, gel & oint</i>	2	[QL] [EDS]
<i>fluocinonide emulsified base cream</i>	2	[QL] [EDS]
<i>fluocinonide soln</i>	2	[EDS]
<i>fluticasone propionate cream & oint</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>halobetasol propionate cream & ointment</i>	2	[EDS]
<i>hydrocortisone cream, lotion & oint 2.5%</i>	2	[EDS]
<i>hydrocortisone butyrate cream, oint & soln</i>	2	[EDS]
<i>hydrocortisone valerate</i>	2	[EDS]
<i>mometasone cream, oint & soln</i>	2	[EDS]
<i>pimecrolimus</i>	4	[QL] [EDS]
<i>selenium sulfide lotion</i>	2	[EDS]
<i>tacrolimus oint</i>	4	[QL] [EDS]
<i>triamcinolone acetonide topical cream & lotion</i>	2	[EDS]
<i>triamcinolone acetonide topical oint 0.025%, 0.1% & 0.5%</i>	2	[EDS]
<i>triderm cream 0.1%</i>	2	[EDS]
Dermatological Agents, Other		
<i>calcipotriene cream & oint</i>	4	[QL] [EDS]
<i>calcipotriene soln</i>	3	[EDS]
<i>clotrimazole & betamethasone</i>	2	[EDS]
<i>diclofenac sodium gel 1%</i>	3	[EDS]
<i>diclofenac sodium gel 3%</i>	4	[PA] [EDS]
FLUOROURACIL CREAM 0.5%	5	
<i>fluorouracil topical 2% and 5%</i>	3	[EDS]
<i>imiquimod cream 3.75%</i>	4	[EDS]
<i>imiquimod cream 5%</i>	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>methoxsalen</i>	5	
<i>nystatin & triamcinolone</i>	3	[EDS]
<i>podofilox soln</i>	2	[EDS]
<i>silver sulfadiazine</i>	2	[EDS]
REGRANEX	5	[QL]
SANTYL	3	[QL] [EDS]
<i>ssd</i>	2	[EDS]
Pediculicides/Scabicides		
<i>malathion</i>	4	[EDS]
<i>permethrin cream</i>	2	[EDS]
Topical Anti-infectives		
<i>acyclovir cream & oint 5%</i>	4	[QL] [EDS]
<i>ciclopirox cream, gel, nail soln shampoo & susp</i>	2	[EDS]
<i>clindamycin topical gel, lotion, soln & swab</i>	2	[EDS]
<i>erythromycin topical gel & soln</i>	2	[EDS]
<i>mupirocin ointment</i>	2	[EDS]
<i>mupirocin cream</i>	4	[QL] [EDS]
<i>penciclovir cream</i>	4	[EDS]
ELECTROLYTES/MINERALS/METALS/ VITAMINS		
Electrolyte/Mineral/Metal Modifiers		
<i>deferasirox granule pack</i>	5	[PA]
<i>deferasirox tabs 90mg</i>	4	[PA] [EDS]
<i>deferasirox tabs 180mg & 360mg</i>	5	[PA]
<i>deferasirox tabs for soln 125mg</i>	4	[PA] [EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>deferasirox tabs for soln 250mg & 500mg</i>	5	[PA]
<i>deferiprone</i>	5	[PA]
FERRIPROX SOLN	5	[PA]
FERRIPROX TAB 1000MG	5	[PA]
INTRALIPID INJ	4	[PA] [B vs D] [EDS]
<i>penicillamine tabs</i>	5	
<i>trientine cap 250mg</i>	5	
Electrolyte/Mineral Replacement		
<i>carglumic acid</i>	5	[PA]
CLINISOL SF INJ	4	[PA] [B vs D] [EDS]
<i>dextrose inj</i>	2	[EDS]
<i>dextrose (10%, 5% or 2.5%) & sodium chloride inj</i>	2	[EDS]
<i>klor-con pack</i>	4	[EDS]
<i>klor-con tabs</i>	2	[EDS]
<i>magnesium sulfate inj</i>	2	[EDS]
<i>plenamine inj</i>	2	[PA] [B vs D] [EDS]
<i>potassium chloride oral soln</i>	4	[EDS]
<i>potassium chloride inj</i>	2	[EDS]
<i>potassium chloride pack 20meq</i>	4	[EDS]
<i>potassium chloride er & cr</i>	2	[EDS]
<i>potassium chloride & dextrose 20mEq/5% inj</i>	2	[EDS]
<i>potassium chloride & dextrose & lactated ringers inj</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>potassium chloride & dextrose & sodium chloride inj</i> 2mEq/5%/0.2%, 10mEq/5%/0.45%, 20mEq/5%/0.45%, 20mEq/5%/0.9%, 30mEq/5%/0.45% 40mEq/5%/0.9% & 40mEq/5%/0.45%	2	[EDS]
<i>potassium citrate er</i>	2	[EDS]
PROSOL INJ	4	[PA] [B vs D] [EDS]
<i>sodium chloride inj</i>	2	[EDS]
TPN ELECTROLYTES INJ	3	[EDS]
TRAVASOL INJ	4	[PA] [B vs D] [EDS]
Phosphate Binders		
AURYXIA	5	[PA]
<i>calcium acetate</i>	2	[EDS]
<i>lanthanum carbonate</i>	5	
<i>sevelamer carbonate powder</i>	4	[EDS]
<i>sevelamer carbonate tabs</i>	4	[EDS]
VELPHORO	5	[PA]
Potassium Binders		
LOKELMA	3	[EDS]
<i>sodium polystyrene sulfonate powder</i>	2	[EDS]
<i>sps suspension</i>	2	[EDS]
VELTASSA	3	[EDS]
Vitamins		
<i>prenatal multi-vitamin</i>	2	[EDS]
GASTROINTESTINAL AGENTS		
Anti-Constipation Agents		
<i>constulose soln</i>	2	[EDS]
<i>enulose</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>generlac</i>	2	[EDS]
<i>lactulose soln</i> 10g/15ml	2	[EDS]
LINZESS	3	[EDS]
<i>lubiprostone</i>	3	[EDS]
MOVANTIK	3	[EDS]
RELISTOR INJ	5	[PA]
RELISTOR TABS	5	[PA]
<i>sodium sulfate, potassium sulfate and magnesium sulfate</i>	3	[EDS]
Anti-Diarrheal Agents		
<i>alosetron hcl tab</i> 0.5mg	4	[PA] [EDS]
<i>alosetron hcl tab</i> 1mg	5	[PA]
<i>diphenoxylate & atropine oral soln</i>	3	[EDS]
<i>diphenoxylate & atropine tabs</i>	2	[EDS]
<i>loperamide caps</i> 2mg	2	[EDS]
XERMELO	5	[PA]
Antispasmodics, Gastrointestinal		
<i>dicyclomine</i>	2	[EDS]
<i>glycopyrrolate tabs</i> 1mg & 2mg	2	[EDS]
Gastrointestinal Agents, Other		
<i>cromolyn sodium oral</i>	4	[EDS]
GATTEX INJ	5	[PA]
<i>gavilyte-c</i>	2	[EDS]
<i>gavilyte-g</i>	2	[EDS]
<i>metoclopramide oral tablets & soln</i>	2	[EDS]
<i>peg 3350 & electrolytes</i>	2	[EDS]
<i>peg 3350 & sodium chloride & sodium bicarbonate & potassium chloride</i>	2	[EDS]

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[LD] = Distribución Limitada [EDS] = Suministro Extendido

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>peg 3350 & sodium sulfate & sodium chloride & potassium chloride & sodium ascorbate & ascorbic</i>	3	[EDS]
PLENVU	3	[EDS]
RECTIV	4	[EDS]
<i>ursodiol cap 300mg & tabs 250mg & 500mg</i>	3	[EDS]
Histamine2 (H2) Receptor Antagonists		
<i>cimetidine tabs</i>	2	[EDS]
<i>famotidine tabs</i>	1	[EDS]
Protectants		
<i>misoprostol</i>	2	[EDS]
<i>sucralfate tabs</i>	2	[EDS]
Proton Pump Inhibitors		
<i>esomeprazole magnesium dr caps</i>	3	[EDS]
<i>lansoprazole dr caps</i>	2	[EDS]
<i>omeprazole caps</i>	1	[EDS]
<i>pantoprazole tabs</i>	1	[EDS]
<i>rabeprazole sodium</i>	3	[EDS]
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
<i>betaine anhydrous</i>	5	
CERDELGA	5	[PA]
CREON DR	3	[EDS]
CYSTAGON	3	[EDS]
<i>miglustat</i>	5	[PA] [LD]
<i>nitisinone</i>	5	[PA]
ORFADIN CAPS 20MG	5	[PA] [LD]
ORFADIN SUSP	5	[PA] [LD]
RAVICTI	5	
<i>sapropterin</i>	5	

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>sodium phenylbutyrate powder & tabs</i>	5	
SUCRAID	5	
GENITOURINARY AGENTS		
Antispasmodics, Urinary		
<i>fesoterodine fumarate er</i>	3	[EDS]
<i>flavoxate</i>	2	[EDS]
GEMTESA	4	[EDS]
MYRBETRIQ	3	[EDS]
<i>oxybutynin ir</i>	2	[EDS]
<i>oxybutynin er</i>	2	[EDS]
OXYTROL	4	[EDS]
<i>solifenacin succinate</i>	3	[EDS]
<i>tolterodine tartrate er</i>	2	[EDS]
<i>trospium ir</i>	2	[EDS]
<i>trospium er</i>	2	[EDS]
Benign Prostatic Hypertrophy Agents		
<i>alfuzosin hcl er</i>	2	[EDS]
<i>dutasteride</i>	3	[EDS]
<i>dutasteride & tamsulosin</i>	3	[EDS]
<i>finasteride tabs 5mg</i>	1	[EDS]
<i>tamsulosin</i>	1	[EDS]
Genitourinary Agents, Other		
<i>bethanechol</i>	2	[EDS]
ELMIRON	4	[EDS]
THIOLA EC	5	
<i>tiopronin</i>	5	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
<i>dexamethasone dose pack</i>	2	[EDS]
<i>dexamethasone elixir</i>	2	[EDS]
<i>dexamethasone tabs</i>	2	[EDS]
<i>fludrocortisone acetate</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
HEMADY	4	[EDS]
<i>hydrocortisone oral</i>	2	[EDS]
MEDROL TABS	4	[PA] [B vs D] [EDS]
<i>methylprednisolone dose pack</i>	2	[EDS]
<i>methylprednisolone oral</i>	2	[PA] [B vs D] [EDS]
MILLIPRED	4	[PA] [B vs D] [EDS]
ORAPRED ODT	4	[PA] [B vs D] [EDS]
<i>prednisolone oral soln</i>	2	[PA] [B vs D] [EDS]
<i>prednisolone odt</i>	4	[PA] [B vs D] [EDS]
<i>prednisolone tablet 5mg</i>	4	[PA] [B vs D] [EDS]
<i>prednisone tab pack</i>	1	[EDS]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
<i>desmopressin acetate nasal</i>	4	[EDS]
<i>desmopressin acetate oral</i>	2	[EDS]
GENOTROPIN INJ	5	[PA]
GENOTROPIN MINIQUICK INJ 0.2MG, 0.4MG, 0.6MG & 0.8MG	4	[PA] [EDS]
GENOTROPIN MINIQUICK INJ 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG & 2MG	5	[PA]
HUMATROPE INJ CARTRIDGE 6MG	4	[PA] [EDS]
HUMATROPE INJ CARTRIDGE 12MG & 24MG	5	[PA]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
INCRELEX INJ	5	[PA]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
Androgens		
<i>danazol</i>	3	[EDS]
<i>testosterone cypionate inj</i>	2	[EDS]
<i>testosterone enanthate inj</i>	2	[EDS]
<i>testosterone gel 1% & 1.62%</i>	3	[EDS]
<i>testosterone gel 25mg/2.5g, 20.25mg/1.25g, 40.5mg/2.5g & 50mg/5g</i>	3	[EDS]
Estrogens		
<i>altavera</i>	2	[EDS]
<i>alyacen 1/35</i>	2	[EDS]
<i>amabelz</i>	2	[EDS]
<i>apri</i>	2	[EDS]
<i>aranelle</i>	2	[EDS]
<i>abra eq</i>	2	[EDS]
<i>aviane</i>	2	[EDS]
<i>blisovi fe 1.5/30</i>	2	[EDS]
<i>briellyn</i>	2	[EDS]
<i>cyred eq</i>	2	[EDS]
<i>desogestrel & ethinyl estradiol</i>	2	[EDS]
<i>dotti</i>	2	[EDS]
<i>drospirenone & ethinyl estradiol 3mg/0.02mg</i>	2	[EDS]
<i>eluryng</i>	4	[EDS]
<i>enilloring</i>	4	[EDS]
<i>enpresse-28</i>	2	[EDS]
<i>enskyce</i>	2	[EDS]
<i>estarylla</i>	2	[EDS]
<i>estradiol oral</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>estradiol patches</i>	2	[EDS]
<i>estradiol vaginal cream</i>	2	[EDS]
<i>estradiol vaginal tabs</i>	2	[EDS]
<i>estradiol & norethindrone acetate 0.5mg/0.1mg & 1mg/0.5mg</i>	2	[EDS]
ESTRING	3	[EDS]
<i>ethinyl estradiol & ethynodiol</i>	2	[EDS]
<i>ethinyl estradiol & norethindrone acetate 5mcg/1mg & 2.5mcg-0.5mg</i>	2	[EDS]
<i>etonogestrel & ethinyl estradiol ring</i>	4	[EDS]
<i>falmina</i>	2	[EDS]
<i>fyavolv</i>	2	[EDS]
<i>haloette</i>	4	[EDS]
IMVEXXY PACK	3	[EDS]
<i>introvale</i>	2	[EDS]
<i>isibloom</i>	2	[EDS]
<i>jasmiel</i>	2	[EDS]
<i>jinteli</i>	2	[EDS]
<i>juleber</i>	2	[EDS]
<i>junel 21 day</i>	2	[EDS]
<i>junel fe 1/20</i>	2	[EDS]
<i>kariva</i>	2	[EDS]
<i>kelnor 1/35 & 1/50</i>	2	[EDS]
<i>kurvelo</i>	2	[EDS]
<i>larin</i>	2	[EDS]
<i>larin fe</i>	2	[EDS]
<i>leena</i>	2	[EDS]
<i>levonest</i>	2	[EDS]
<i>levonorgestrel & ethinyl estradiol 0.1-0.02mg & 0.15-0.03mg & triphasic packs</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>levonorgestrel & ethinyl estradiol and ethinyl estradiol 0.1/0.02mg-0.01mg packs</i>	2	[EDS]
<i>levora</i>	2	[EDS]
<i>loryna</i>	2	[EDS]
<i>low-ogestrel</i>	2	[EDS]
<i>lyllana</i>	2	[EDS]
<i>marlissa 28 day</i>	2	[EDS]
MENEST	3	[EDS]
<i>microgestin 1/20 & 1.5/30</i>	2	[EDS]
<i>microgestin 24 fe</i>	2	[EDS]
<i>microgestin fe 1/20 & 1.5/30</i>	2	[EDS]
<i>mili</i>	2	[EDS]
<i>mimvey</i>	2	[EDS]
<i>necon</i>	2	[EDS]
<i>nikki</i>	2	[EDS]
<i>norgestimate-ethinyl estradiol</i>	2	[EDS]
<i>norethindrone, ethinyl estradiol, ferrous fumarate 0.4mg/0.035mg</i>	2	[EDS]
<i>norethindrone, ethinyl estradiol, ferrous fumarate 20mcg/75mg/1mg</i>	2	[EDS]
<i>nylia 7/7/7 & 1/35</i>	2	[EDS]
<i>nymyo</i>	2	[EDS]
<i>pimtrea</i>	2	[EDS]
PREMARIN ORAL	3	[EDS]
PREMARIN VAGINAL CREAM	3	[EDS]
PREMPHASE	3	[EDS]
PREMPRO	3	[EDS]
<i>reclipsen</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>setlakin</i>	2	[EDS]
<i>tarina fe 1/20 eq</i>	2	[EDS]
<i>tri-estarylla</i>	2	[EDS]
<i>tri-lo-estarylla</i>	2	[EDS]
<i>tri-lo-sprintec</i>	2	[EDS]
<i>tri-mili</i>	2	[EDS]
<i>tri-nymyo</i>	2	[EDS]
<i>tri-sprintec</i>	2	[EDS]
<i>tri-vylibra</i>	2	[EDS]
<i>tri-vylibra lo</i>	2	[EDS]
<i>trivora-28</i>	2	[EDS]
<i>turqoz</i>	2	[EDS]
<i>velivet</i>	2	[EDS]
<i>vestura</i>	2	[EDS]
<i>vienva</i>	2	[EDS]
<i>vyfemla</i>	2	[EDS]
<i>vylibra</i>	2	[EDS]
<i>wymzya fe</i>	2	[EDS]
<i>yuvafem</i>	2	[EDS]
<i>zovia</i>	2	[EDS]
Progestins		
<i>deblitane</i>	2	[EDS]
DEPO-SUBQ PROVERA 104 INJ	3	[EDS]
<i>heather tabs</i>	2	[EDS]
<i>incassia</i>	2	[EDS]
<i>lyleq</i>	2	[EDS]
<i>lyza</i>	2	[EDS]
<i>medroxyprogesterone acetate inj</i>	2	[EDS]
<i>medroxyprogesterone acetate tabs</i>	2	[EDS]
<i>megestrol acetate oral susp 40mg/ml</i>	2	[EDS]
<i>megestrol tabs</i>	2	[EDS]
<i>norethindrone</i>	2	[EDS]
<i>progesterone caps</i>	2	[EDS]
<i>sharobel</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Selective Estrogen Receptor Modifying Agents		
DUAVEE	3	[EDS]
<i>raloxifene hcl</i>	3	[EDS]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
CYTOMEL	3	[EDS]
<i>levothyroxine tabs</i>	1	[EDS]
<i>levoxyl</i>	1	[EDS]
<i>liothyronine tabs</i>	2	[EDS]
SYNTHROID	3	[EDS]
<i>unithroid</i>	1	[EDS]
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	5	
ISTURISA	5	[PA]
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
Hormonal Agents, Suppressant (Pituitary)		
<i>cabergoline</i>	2	[EDS]
ELIGARD INJ	4	[PA] [EDS]
<i>leuprolide acetate inj kit 1mg/0.2ml</i>	2	[EDS]
LUPRON DEPOT INJ	5	[PA]
<i>octreotide inj 50mcg/ml, 100mcg/ml, 200mcg/ml & 500mcg/ml</i>	4	[EDS]
<i>octreotide inj 1000mcg/ml</i>	5	
ORGOVYX	5	[PA] [LD]
SIGNIFOR INJ	5	[PA]
SOMAVERT INJ	5	[PA]
SYNAREL	4	[EDS]
TRELSTAR MIXJECT INJ	4	[PA] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
Antithyroid Agents		
<i>methimazole</i>	2	[EDS]
<i>propylthiouracil</i>	2	[EDS]
IMMUNOLOGICAL AGENTS		
Angioedema Agents		
CINRYZE INJ	5	[PA]
<i>icatibant inj</i>	5	[PA]
<i>sajazir inj</i>	5	[PA]
Immunoglobulins		
GAMMAGARD INJ	5	[PA] [B vs D]
GAMUNEX-C INJ	5	[PA] [B vs D]
Immunological Agents, Other		
ARCALYST INJ	5	[PA]
BENLYSTA INJ	5	[PA]
COSENTYX INJ	5	[PA]
COSENTYX SENSOREADY PEN INJ	5	[PA]
COSENTYX UNOREADY PEN INJ	5	[PA]
DUPIXENT INJ	5	[PA]
KINERET INJ	5	[PA]
ORENCIA INJ PF SYRINGE	5	[PA]
ORENCIA CLICKJET	5	[PA]
OTEZLA	5	[PA]
OTEZLA STARTER	5	[PA]
RIDAURA	5	
RINVOQ	5	[PA]
SKYRIZI INJ	5	[PA]
STELARA INJ	5	[PA]
XELJANZ	5	[PA]
XELJANZ XR	5	[PA]
XOLAIR INJ	5	[PA] [LD]
Immunostimulants		
ACTIMMUNE INJ	5	[PA]
PEGASYS INJ	5	

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
Immunosuppressants		
ASTAGRAF XL	4	[PA] [B vs D] [EDS]
AZASAN	4	[PA] [B vs D] [EDS]
<i>azathioprine tabs 50mg</i>	2	[PA] [B vs D] [EDS]
<i>azathioprine tabs 75mg & 100mg</i>	4	[PA] [B vs D] [EDS]
CELLCEPT CAPS	4	[PA] [B vs D] [EDS]
CELLCEPT ORAL SUSPENSION & TABS	5	[PA] [B vs D]
<i>cyclosporine caps</i>	3	[PA] [B vs D] [EDS]
<i>cyclosporine modified</i>	2	[PA] [B vs D] [EDS]
ENBREL INJ	5	[PA]
ENBREL MINI INJ	5	[PA]
ENBREL SURECLICK INJ	5	[PA]
ENVARUSUS XR	4	[PA] [B vs D] [EDS]
<i>everolimus 0.25mg</i>	4	[PA] [B vs D] [EDS]
<i>everolimus 0.5mg, 0.75mg & 1mg</i>	5	[PA] [B vs D]
<i>gengraf</i>	2	[PA] [B vs D] [EDS]
HUMIRA INJ	5	[PA]
HUMIRA PEDIATRIC CROHNS STARTER PACK INJ	5	[PA]
HUMIRA PEN- CD/UC/HS STARTER INJ	5	[PA]
HUMIRA PEN- PEDIATRIC UC STARTER PACK INJ	5	[PA]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
HUMIRA PEN-PS/UV STARTER INJ	5	[PA]
HUMIRA PEN INJ	5	[PA]
IMURAN TABS	4	[PA] [B vs D] [EDS]
<i>leflunomide</i>	2	[EDS]
<i>methotrexate inj 50mg/2ml</i>	2	[EDS]
<i>methotrexate oral</i>	2	[EDS]
<i>mycophenolate mofetil caps & tabs</i>	2	[PA] [B vs D] [EDS]
<i>mycophenolate mofetil oral susp</i>	5	[PA] [B vs D]
<i>mycophenolic acid dr</i>	4	[PA] [B vs D] [EDS]
MYFORTIC	4	[PA] [B vs D] [EDS]
NEORAL	4	[PA] [B vs D] [EDS]
PROGRAF CAPS	4	[PA] [B vs D] [EDS]
PROGRAF PACK	4	[PA] [B vs D] [EDS]
RAPAMUNE SOLN	5	[PA] [B vs D]
RAPAMUNE TABS	4	[PA] [B vs D] [EDS]
SANDIMMUNE ORAL SOLN 100MG/ML	4	[PA] [B vs D] [EDS]
SANDIMMUNE CAPS 25MG & 100MG	4	[PA] [B vs D] [EDS]
<i>sirolimus soln</i>	5	[PA] [B vs D]
<i>sirolimus tabs</i>	4	[PA] [B vs D] [EDS]
<i>tacrolimus caps 0.5mg & 1mg</i>	3	[PA] [B vs D] [EDS]
<i>tacrolimus caps 5mg</i>	4	[PA] [B vs D] [EDS]
XATMEP	4	[EDS]
ZORTRESS TABS 0.25MG	4	[PA] [B vs D] [EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
ZORTRESS TABS 0.5MG, 0.75MG & 1MG	5	[PA] [B vs D]
Vaccines		
ABRYSCO INJ	3	[EDS]
ACTHIB INJ	3	[EDS]
ADACEL INJ	3	[EDS]
AREXVY INJ	3	[EDS]
BCG INJ	3	[EDS]
BEXSERO INJ	3	[EDS]
BOOSTRIX INJ	3	[EDS]
DAPTACEL INJ	3	[EDS]
DIPHThERIA & TETANUS TOXOIDS PEDIATRIC INJ	3	[EDS]
ENGERIX-B INJ	3	[PA] [B vs D] [EDS]
GARDASIL 9 INJ	4	[EDS]
HAVRIX INJ	3	[EDS]
HEPLISAV-B INJ	3	[PA] [B vs D] [EDS]
HIBERIX INJ	3	[EDS]
IMOVAX RABIES INJ	3	[EDS]
INFANRIX INJ	3	[EDS]
IPOLE 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]
MENQUADFI INJ	3	[EDS]
MENVEO-A/C/Y/W- 135 INJ	3	[EDS]
M-M-R II INJ	3	[EDS]
PEDIARIX INJ	3	[EDS]
PEDVAX HIB INJ	3	[EDS]
PENBRAYA INJ	3	[EDS]
PENTACEL INJ	3	[EDS]

[PA] = Autorización Previa [B vs D] = B versus D [QL] = Límite de Cantidad

[LD] = Distribución Limitada [EDS] = Suministro Extendido

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
PREHEVBRIO INJ	3	[PA] [B vs D] [EDS]
PRIORIX INJ	3	[EDS]
PROQUAD INJ	3	[EDS]
QUADRACEL INJ	3	[EDS]
RABAVERT INJ	3	[EDS]
RECOMBIVAX HB INJ	3	[PA] [B vs D] [EDS]
ROTARIX	3	[EDS]
ROTATEQ	3	[EDS]
SHINGRIX INJ	3	[EDS]
TDVAX INJ	3	[EDS]
TENIVAC INJ	3	[EDS]
TICOVAC INJ	4	[EDS]
TRUMENBA INJ	3	[EDS]
TWINRIX INJ	3	[EDS]
TYPHIM VI INJ	3	[EDS]
VAQTA INJ	3	[EDS]
VARIVAX INJ	3	[EDS]
YF-VAX INJ	3	[EDS]
INFLAMMATORY BOWEL DISEASE AGENTS		
Aminosalicylates		
<i>balsalazide</i>	3	[EDS]
DIPENTUM	5	
<i>mesalamine dr</i>	4	[EDS]
<i>mesalamine enema</i>	4	[EDS]
<i>mesalamine er caps</i>	4	[EDS]
<i>mesalamine rectal suppository</i>	4	[EDS]
PENTASA CAP 250MG	4	[EDS]
<i>sulfasalazine</i>	2	[EDS]
Glucocorticoids		
<i>budesonide ec caps</i>	4	[EDS]
<i>budesonide er tabs 9mg</i>	5	
<i>hydrocortisone enema</i>	2	[EDS]
<i>prednisone tabs</i>	1	[PA] [B vs D] [EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>prednisone oral soln</i>	2	[PA] [B vs D] [EDS]
PREDNISONE INTENSOL	4	[PA] [B vs D] [EDS]
<i>procto-med hc</i>	2	[EDS]
<i>procto-pak</i>	2	[EDS]
<i>proctosol hc</i>	2	[EDS]
<i>proctozone-hc</i>	2	[EDS]
METABOLIC BONE DISEASE AGENTS		
Metabolic Bone Disease Agents		
<i>alendronate tabs</i>	1	[EDS]
<i>alendronate oral soln</i>	3	[EDS]
<i>calcitonin-salmon nasal</i>	2	[EDS]
<i>calcitriol caps</i>	2	[PA] [B vs D] [EDS]
<i>cinacalcet tab 30mg</i>	3	[PA] [B vs D] [EDS]
<i>cinacalcet tab 60mg</i>	4	[PA] [B vs D] [EDS]
<i>cinacalcet tab 90mg</i>	5	[PA] [B vs D]
<i>doxercalciferol oral</i>	3	[PA] [B vs D] [EDS]
FORTEO INJ	5	[PA]
<i>ibandronate oral</i>	2	[EDS]
<i>paricalcitol caps</i>	3	[PA] [B vs D] [EDS]
PROLIA INJ	4	[PA] [EDS]
RAYALDEE	5	
<i>risedronate sodium</i>	3	[EDS]
<i>risedronate sodium dr</i>	3	[EDS]
TERIPARATIDE INJ	5	[PA]
TYMLOS INJ	5	[PA]
XGEVA INJ	5	[PA]
MISCELLANEOUS THERAPEUTIC AGENTS		
Miscellaneous Therapeutic Agents		
<i>alcohol pads</i>	2	[EDS]
<i>bd insulin syringe</i>	2	[EDS]
<i>ultrafine</i>		

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>bd insulin syringe safetyglide</i>	2	[EDS]
<i>bd pen needle ultrafine</i>	2	[EDS]
ENDARI	5	[PA]
<i>gauze pads 2"x2"</i>	2	[EDS]
KORLYM	5	[PA]
KOSELUGO	5	[PA]
LAGEVRIO	4	[EDS]
<i>levocarnitine oral</i>	2	[PA] [B vs D] [EDS]
<i>mifepristone tabs</i>	5	[PA]
<i>paroxetine mesylate</i>	3	[EDS]
PAXLOVID	3	[EDS]
<i>pmdd fluoxetine hcl tabs 10mg & 20mg</i>	2	[EDS]
OPHTHALMIC AGENTS		
Ophthalmic Agents, Other		
<i>atropine sulfate soln</i>	2	[EDS]
<i>brimonidine & timolol maleate</i>	3	[EDS]
<i>cyclosporine emulsion 0.05%</i>	3	[EDS]
CYSTARAN	5	
<i>dorzolamide & timolol maleate</i>	2	[EDS]
LACRISERT	4	[EDS]
<i>neomycin & polymyxin & bacitracin</i>	2	[EDS]
<i>neomycin & polymyxin & bacitracin & hydrocortisone</i>	2	[EDS]
<i>neomycin & polymyxin & dexamethasone</i>	2	[EDS]
<i>neomycin & polymyxin & gramicidin ophthalmic</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>neomycin & polymyxin & hydrocortisone</i>	2	[EDS]
ROCKLATAN	3	[EDS]
SIMBRINZA	4	[EDS]
<i>sulfacetamide sodium & prednisolone sodium phosphate ophthalmic</i>	2	[EDS]
TOBRADEX OINT	3	[EDS]
<i>tobramycin & dexamethasone ophthalmic suspension</i>	2	[EDS]
XIIDRA	3	[EDS]
Ophthalmic Anti-allergy Agents		
<i>azelastine 0.05%</i>	2	[EDS]
<i>cromolyn sodium ophthalmic soln</i>	2	[EDS]
Ophthalmic Anti-infectives		
AZASITE	3	[EDS]
<i>bacitracin ophthalmic ointment</i>	2	[EDS]
<i>bacitracin & polymyxin b ointment</i>	2	[EDS]
<i>ciprofloxacin ophthalmic soln 0.3%</i>	2	[EDS]
<i>erythromycin ophthalmic oint</i>	2	[EDS]
<i>gentamicin ophthalmic soln 0.3%</i>	2	[EDS]
<i>moxifloxacin hcl ophthalmic</i>	2	[EDS]
NATACYN	4	[EDS]
<i>neo-polycin ophthalmic ointment</i>	2	[EDS]
<i>neo-polycin hc ophthalmic ointment</i>	2	[EDS]
<i>ofloxacin ophthalmic</i>	2	[EDS]
<i>polycin ophthalmic ointment</i>	2	[EDS]

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[LD] = Distribución Limitada [EDS] = Suministro Extendido

Puede encontrar información sobre el significado de los símbolos y abreviaturas de esta tabla en la página 23.

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>polymyxin b sulfate & trimethoprim sulfate ophthalmic soln</i>	2	[EDS]
<i>sulfacetamide sodium ophthalmic oint & soln 10%</i>	2	[EDS]
<i>tobramycin ophthalmic solution</i>	2	[EDS]
<i>trifluridine</i>	2	[EDS]
ZIRGAN	4	[EDS]
Ophthalmic Anti-inflammatorys		
<i>brufenac ophthalmic soln 0.09%</i>	3	[EDS]
BROMSITE	4	[EDS]
<i>dexamethasone ophthalmic soln</i>	2	[EDS]
<i>diclofenac sodium ophthalmic soln 0.1%</i>	2	[EDS]
<i>difluprednate</i>	3	[EDS]
<i>fluorometholone</i>	2	[EDS]
<i>ketorolac soln</i>	2	[EDS]
LOTEMAX OINT	4	[EDS]
LOTEMAX SM GEL 0.38%	4	[EDS]
PRED MILD	3	[EDS]
<i>prednisolone acetate</i>	2	[EDS]
<i>prednisolone sodium phosphate</i>	2	[EDS]
PROLENSA	3	[EDS]
Ophthalmic Beta-Adrenergic Blocking Agents		
<i>betaxolol soln</i>	2	[EDS]
<i>carteolol</i>	1	[EDS]
<i>levobunolol</i>	2	[EDS]
<i>timolol ophthalmic gel forming</i>	2	[EDS]
<i>timolol ophth soln 12 hours 0.25% & 0.5% multi-use bottles</i>	1	[EDS]
Ophthalmic Intraocular Pressure Lowering Agents, Other		
<i>acetazolamide tabs</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>acetazolamide er caps</i>	2	[EDS]
ALPHAGAN P 0.1%	3	[EDS]
<i>brimonidine tartrate soln 0.15%</i>	3	[EDS]
<i>brimonidine tartrate soln 0.2%</i>	2	[EDS]
<i>dorzolamide</i>	2	[EDS]
<i>methazolamide</i>	4	[EDS]
PHOSPHOLINE IODIDE	3	[EDS]
<i>pilocarpine soln</i>	2	[EDS]
RHOPRESSA	3	[EDS]
Ophthalmic Prostaglandin and Prostamide Analogs		
<i>latanoprost</i>	1	[EDS]
LUMIGAN	3	[EDS]
<i>travoprost</i>	3	[EDS]
VYZULTA	4	[EDS]
OTIC AGENTS		
Otic Agents		
<i>acetic acid & hydrocortisone</i>	2	[EDS]
CIPRO HC	3	[EDS]
<i>ciprofloxacin & dexamethasone otic susp</i>	3	[EDS]
<i>fluocinolone acetate otic soln</i>	3	[EDS]
<i>neomycin & polymyxin & hydrocortisone</i>	2	[EDS]
<i>ofloxacin otic</i>	2	[EDS]
RESPIRATORY TRACT/PULMONARY AGENTS		
Antihistamines		
<i>azelastine nasal 0.1%</i>	2	[EDS]
<i>cyproheptadine</i>	2	[EDS]
<i>desloratadine tabs</i>	2	[EDS]
<i>hydroxyzine hcl tabs</i>	2	[EDS]
<i>hydroxyzine pamoate caps</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>levocetirizine</i>	2	[EDS]
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA	3	[EDS]
ASMANEX HFA	3	[EDS]
ASMANEX TWISTHALER	3	[EDS]
BREZTRI AEROSPHERE	3	[EDS]
<i>budesonide nebulizer</i>	3	[PA] [B vs D] [EDS]
<i>flunisolide nasal</i>	2	[QL] [EDS]
<i>fluticasone propionate nasal</i>	2	[QL] [EDS]
<i>mometasone furoate nasal</i>	3	[QL] [EDS]
PULMICORT NEBULIZER	4	[PA] [B vs D] [EDS]
QVAR REDHALER	3	[EDS]
Antileukotrienes		
<i>montelukast</i>	2	[EDS]
<i>zafirlukast</i>	2	[EDS]
Bronchodilators, Anticholinergic		
ATROVENT HFA	3	[QL] [EDS]
<i>ipratropium bromide nasal</i>	2	[QL] [EDS]
<i>ipratropium bromide nebulizer</i>	2	[PA] [B vs D] [EDS]
SPIRIVA HANDIHALER	3	[EDS]
SPIRIVA RESPIMAT	3	[EDS]
YUPELRI	5	[PA] [B vs D]
Bronchodilators, Sympathomimetic		
<i>albuterol sulfate hfa 6.7gm inhaler</i>	2	[QL] [EDS]
<i>albuterol sulfate hfa 8.5gm inhaler</i>	2	[QL] [EDS]
<i>albuterol sulfate nebulizer</i>	2	[PA] [B vs D] [EDS]
<i>albuterol sulfate syrup</i>	2	[EDS]
<i>albuterol sulfate tabs</i>	4	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>arformoterol tartrate nebulizer</i>	4	[PA] [B vs D] [EDS]
BROVANA NEBULIZER	4	[PA] [B vs D] [EDS]
EPINEPHRINE AUTO-INJECTOR 0.15MG/0.3ML & 0.3MG/0.3ML	3	[EDS]
<i>formoterol fumarate nebulizer</i>	4	[PA] [B vs D] [EDS]
<i>levalbuterol nebulizer</i>	2	[PA] [B vs D] [EDS]
LEVALBUTEROL TARTRATE HFA	4	[EDS]
PERFOROMIST NEBULIZER	5	[PA] [B vs D]
PROAIR RESPICLICK	3	[EDS]
SEREVENT DISKUS	3	[EDS]
STRIVERDI RESPIMAT	3	[EDS]
<i>terbutaline sulfate oral</i>	3	[EDS]
Cystic Fibrosis Agents		
BETHKIS	5	[PA] [B vs D]
CAYSTON	5	[PA] [LD]
KALYDECO	5	[PA]
KITABIS NEBULIZER	5	[PA] [B vs D]
ORKAMBI	5	[PA]
PULMOZYME	5	[PA] [B vs D]
TOBI SOLN	5	[PA] [B vs D]
TOBI PODHALER	5	
<i>tobramycin nebulizer</i>	5	[PA] [B vs D]
TRIKAFTA	5	[PA]
Mast Cell Stabilizers		
<i>cromolyn sodium nebulizer soln</i>	4	[PA] [B vs D] [EDS]
Phosphodiesterase Inhibitors, Airways Disease		
<i>roflumilast tabs</i>	3	[EDS]
<i>theophylline er tabs</i>	2	[EDS]
Pulmonary Antihypertensives		
ADEMPAS	5	[PA] [LD]

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Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
<i>alyq</i>	5	[PA]
<i>ambrisentan</i>	5	[PA] [LD]
<i>bosentan tabs 62.5mg & 125mg</i>	5	[PA] [LD]
OPSUMIT	5	[PA] [LD]
<i>sildenafil tab 20mg</i>	3	[PA] [EDS]
<i>tadalafil tab 20mg</i>	5	[PA]
TRACLEER 32MG	5	[PA] [LD]
UPTRAVI	5	[PA]
VENTAVIS	5	[PA] [B vs D]
Pulmonary Fibrosis Agents		
OFEV	5	[PA]
<i>pirfenidone tabs</i>	5	[PA]
Respiratory Tract Agents, Other		
<i>acetylcysteine nebulizer soln</i>	2	[PA] [B vs D] [EDS]
ADVAIR HFA	3	[EDS]
ANORO ELLIPTA	3	[EDS]
BEVESPI AEROSPHERE	3	[EDS]
BREO ELLIPTA	3	[EDS]
COMBIVENT RESPIMAT	3	[EDS]
DULERA	3	[EDS]
FASENRA INJ	5	[PA]
<i>fluticasone propionate/salmeterol diskus 100mcg- 50mcg, 250mcg- 50mcg & 500mcg- 50mcg</i>	2	[EDS]
<i>ipratropium bromide & albuterol sulfate nebulizer</i>	2	[PA] [B vs D] [EDS]
PROLASTIN C INJ	5	[PA] [LD]
STIOLTO RESPIMAT	3	[EDS]
TRELEGY ELLIPTA	3	[EDS]
<i>wixela inhub</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
Nombre del Medicamento	Nivel	Requisitos/ Límites
SKELETAL MUSCLE RELAXANTS		
Skeletal Muscle Relaxants		
<i>carisoprodol tabs 350mg</i>	2	[EDS]
<i>chlorzoxazone tabs 500mg</i>	2	[EDS]
<i>cyclobenzaprine hcl ir</i>	2	[EDS]
<i>methocarbamol tabs</i>	2	[EDS]
SLEEP DISORDER AGENTS		
Sleep Promoting Agents		
BELSOMRA	3	[QL] [EDS]
<i>doxepin tabs</i>	3	[EDS]
<i>estazolam</i>	2	[EDS]
<i>flurazepam caps</i>	2	[EDS]
<i>ramelteon</i>	3	[EDS]
<i>tasimelteon caps</i>	5	[PA]
<i>temazepam caps 7.5mg, 15mg & 30mg</i>	2	[EDS]
<i>temazepam caps 22.5mg</i>	3	[EDS]
<i>triazolam</i>	2	[EDS]
<i>zolpidem ir tabs 5mg & 10mg</i>	2	[EDS]
Wakefulness Promoting Agents		
<i>armodafinil</i>	3	[PA] [EDS]
<i>modafinil</i>	3	[PA] [EDS]
SODIUM OXYBATE ORAL SOLN	5	[PA][LD]
XYWAV	5	[PA] [LD]

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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): Bexar, Harris Counties
- SCAN Venture (HMO): Bexar, Harris Counties

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 total 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 en uno de estos planes:

- SCAN Classic (HMO): Condados de Bexar y Harris
- SCAN Venture (HMO): Condados de Bexar y Harris

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 total de sus medicamentos (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.

Drug Name	Drug Tier	Requirements/Limits
Nombre del medicamento	Nivel	Requisitos/limitaciones
DISFUNCIÓN ERÉCTIL		
<i>sildenafil tabs 25mg, 50mg, 100mg (generic for Viagra)</i>	1	[QL] (4 comprimidos por suministro para 30 días con un máximo de 49 comprimidos por año)
VITAMINAS CON RECETA		
<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	

**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>amphetamine & dextroamphetamine</i>	60 tabs per 30 days
ATROVENT HFA	2 inhalers per 30 days
BELSOMRA	30 tabs per 30 days
<i>butorphanol tartrate nasal</i>	4 bottles 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>desonide lotion, oint & cream</i>	cream & oint: 120gm per 30 days lotion: 118ml per 30 days
<i>desoximetasone topical cream, gel & oint 0.05%</i>	120gm per 30 days
<i>desoximetasone topical cream & oint 0.25%</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>diflorasone diacetate</i>	60gm 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
<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>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

Drugs with Quantity Limits
Medicamentos con Límites de Cantidad

Drug Name Nombre del Medicamento	Quantity Limits Límites de Cantidad
<i>hydrocodone & ibuprofen tabs 5-200mg, 7.5-200mg & 10-200mg</i>	150 tabs per 30 days
<i>ipratropium bromide nasal</i>	1 bottle per 30 days
<i>lidocaine ointment</i>	1 tube per 30 days
<i>lidocaine topical soln</i>	1 bottle per 30 days
<i>lidocaine & prilocaine</i>	30gm: 1 tube per 30 days
<i>mometasone furoate nasal</i>	3 bottles per 30 days
<i>morphine sulfate er tabs</i>	120 tabs per 30 days
<i>mupirocin cream</i>	30gm per 30 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
<i>pimecrolimus</i>	30gm: 3 tubes per 30 days
REGRANEX	2 tubes per 30 days
SANTYL	90gm per 30 days
<i>tacrolimus oint</i>	100g per 30days
<i>tazarotene gel</i>	30gm: 3 tubes per 30 days; 100gm: 1 tube per 30
<i>tramadol er tabs</i>	30 tabs per 30 days
<i>tramadol ir tab 100mg</i>	120 tabs per 30 days
<i>tramadol & acetaminophen tabs 37.5-325mg</i>	240 tabs per 30 days
<i>zenzedi</i>	5mg: 120 tabs per 30 days 10mg: 180 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
Attention: Grievance and Appeals Department
P.O. Box 22616
Long Beach, CA 90801-5616

SCAN Member Services
PHONE: 1-855-844-7226
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: 1-855-844-7226
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 ayudarle.

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 1-855-844-7226. 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 1-855-844-7226. 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 1-855-844-7226 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 1-855-844-7226 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 1-855-844-7226. 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 1-855-844-7226. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-844-7226 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Armenian: Առողջութեան կամ դեղերի ծրագրի վերաբերյալ որևէ հարց առաջանալու դեպքում կարող եք օգտվել անվճար թարգմանչական ծառայությունից: Թարգմանչի ծառայությունից օգտվելու համար զանգահարե՛ք 1-855-844-7226 հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیسست با شماره 1-855-844-7226 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 1-855-844-7226. 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、1-855-844-7226 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 1-855-844-7226. 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 1-855-844-7226 '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 1-855-844-7226។ 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 1-855-844-7226. 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 1-855-844-7226 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Thai: เรามีบริการล่ามฟรีเพื่อตอบสนองข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-855-844-7226 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງ ພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພວງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-855-844-7226. 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 1-855-844-7226. 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 1-855-844-7226. 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 1-855-844-7226. 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 1-855-844-7226. 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 1-855-844-7226. 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 1-855-844-7226. 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 1-855-844-7226. 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 1-855-844-7226. 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 05/01/2024. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-855-844-7226 (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 05/01/2024. Para obtener información más reciente o si tiene preguntas, comuníquese con Servicios para Miembros de SCAN Health Plan, al 1-855-844-7226 (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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