SUMMARY PLAN DESCRIPTION

Plan Name: MCWAH Health Plan [Plan # 501]

Plan Type: Group Health Insurance

Plan Year: July 1 – June 30

Employer\Policyholder\Plan Administrator\Plan Sponsor:

Medical College of Wisconsin Affiliated Hospitals, Inc.
8701 Watertown Plank Road
Milwaukee WI 53226
414-955-4575

EIN 39-1341366

Type of Plan, Funding and Administration:

Fully Insured Group Health Plan
Group Insurance Policy underwritten by Insurer

Insurer: Wisconsin Physicians Insurance Corporation (WPS)
1717 W. Broadway
Madison WI 53708

Claims Processing: Insurer

Premium Payments: Employees contribute to the cost based upon a % of the actual premium paid

Agent for Legal Process - Service for legal process may be made upon the Plan Administrator as shown above or:

Mark D. Hohenwalter, MD - Interim Executive Director
Medical College of Wisconsin Affiliated Hospitals, Inc.
8701 Watertown Plank Road
Milwaukee WI 53226

MCWAH Website\Provider Network:

See the MCWAH Website at www.mcw.edu\gme, under Health Insurance, for links to online listings of providers in the network (WPS Statewide Network), Plan Customer Service phone #s, and Plan Websites.

Notices\Information\Insurance Plan Certificate: The Summary of Benefits and Coverage (SBC), General Notice of COBRA Continuation Coverage Rights, and additional Notices\Information\Insurance Plan Certificate included in this Summary Plan Description are an important part of this Summary Plan Description. See those sections for general descriptions of coverage as well as detailed information including but not limited to: Eligibility, Effective Dates, Payment of Benefits, Covered Expenses, Deductibles, Copayments, Coinsurance, Annual Out-of-Pocket Limits, Cost Containment Provisions, Pre-Authorization Procedure, Termination of Benefits, Coordination of Benefits, COBRA continuation of Benefits, and other General Provisions.

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Other Information:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Each covered person who participates in the plan has access to this summary plan description. A hard copy will be provided to covered persons by the employer, without charge, upon request for a hard copy. Network Provider listings will be provided, without charge, as a separate document if requested. Qualified Medical Child Support Order (QMCSO) information and procedures are available upon request, without charge, from the plan administrator.

The Plan contract, plan certificate, plan benefits, and\or employee premium contributions may be modified or amended from time to time. The plan may be terminated at any time by the Plan Sponsor. Significant changes to the plan, including termination, will be communicated to participants.

If there is a conflict between the summary plan description and the group policy contract, the group policy contract governs.

Statement of ERISA Rights:

If you are a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA):

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits - Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage - Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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Prudent Actions by Plan Fiduciaries - In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called ``fiduciaries'' of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights - If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions - If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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SEE the FOLLOWING PAGES for the items below
that are an important part of this
SUMMARY PLAN DESCRIPTION

- **Who to Contact – How to Find Information**
  - **Includes Provider Network and Directory Information**
- **Summary of Benefits and Coverage (SBC)**
- **Notice of Health Care Exchange Marketplace**
- **Medicaid and the Children's Health Insurance Program (CHIP)**
- **Women's Health and Cancer Rights Act Notice**
- **Statement of Rights under the Newborns' and Mothers' Health Protection Act**
- **General Notice of COBRA Continuation Coverage Rights**
- **General Information**

  Your Health Plan ID Card, Customer Service
  Changes in Coverage Status, Miscellaneous Coverage Issues
  How to File Claims
  Members' Rights and Responsibilities
  2024 Preferred Formulary List
  WPS Drug Preauthorization (including FAQs)
  Telehealth Services Overview
  Notice of Privacy Practices, Privacy Notice

- **Medical Benefits (Preferred Provider Plan Certificate)**

  See *TABLE OF CONTENTS*

MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS

YOUR WPS HEALTH INSURANCE PLAN

WHO TO CONTACT - HOW TO FIND INFORMATION

	Customer Service
WPS Health Insurance Company	**1-800-223-6048**
Group Number 10006555	**www.wpsic.com**
Express Scripts (RX Prescription Drug Coverage)	**1-800-818-0107**
(Use your WPS card)	**www.express-scripts.com**

- Immediate Coverage upon effective starting date in MCWAH program.
- No waiting period for pre-existing conditions (including maternity care).
- Annual Open Enrollment prior to every July 1st.
- Housestaff pay 20% of the premium with a pre-tax monthly payroll deduction.
- The pre-tax monthly payroll deduction is $154.83 single and $383.28 family as of 7/1/24.

See the Summary of Benefits and Coverage (SBC) for summary information as to Covered Health Benefits, Prescription Drug Coverage, Cost-Sharing (Deductibles, Copayments, Coinsurance, and Out of Pocket Costs), Limitations & Exceptions, Coverage Examples and more.
The SBC follows a standardized template utilizing a uniform glossary of terms and can be used to compare this benefit plan to other benefit plans available to you. Note: Exact details and coverage are subject to the terms of the plan certificate.

Provider Network – WPS STATEWIDE NETWORK

Most members of MCW faculty participate. Most MCWAH Affiliated Hospitals participate.

To Find a Doctor or Facility

Go To www.wpsic.com , click "Find A Doctor".

If you have a WPS Subscriber # (example: 000123456 - from your WPS card):

1. Use "Existing Subscriber"
2. Enter your Subscriber #
3. Click "continue" and Start your Provider Search

Or, Call WPS Customer Service at 1-800-223-6048

If you are not yet enrolled:

1. Use "Open Enrollee or Visitor"
2. Select "Statewide" from the "select a network" list
3. Enter a Zip Code
4. Click "continue" and Start your Provider Search

Once you chose a provider, you are urged to **Confirm with the provider that they participate in the WPS Statewide Network**, before having services performed.

YOUR INDIVIDUAL SUBSCRIBER INFORMATION – Go to www.wpsic.com and click "Customers", then "Group Health Customer". Once you register, you can login to your account and do the following:

– Check the status of a claim
– Update your contact information
– Review your benefits
– Replace lost ID cards and more

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit wpshealth.com or call 1-800-223-6048. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary /or call 1-800-223-6048 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: $300 / Covered Person or $900 / Family; For non-preferred providers: $900 / Covered Person or $2,700 / Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, office visits and prescription drugs purchased from a pharmacy are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For preferred providers: $800 / Covered Person or $2,400 / Family; (excludes copayments), up to a maximum out-of-pocket (includes copayments) of $7,350 Person / $14,700 Family. For non-preferred providers: $2,400 / Covered Person or $7,200 / Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do or call 1-800-223-6048 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment / office visit (deductible waived) and 10% coinsurance for other outpatient services	$25 copayment / office visit (deductible waived) and 30% coinsurance for other outpatient services	$10 copayment / Teladoc ® visit charge $20 copayment / office visit charge for a preferred convenient care clinic visit $20 copayment / visit for a preferred chiropractor
	Specialist visit	$35 copayment / office visit (deductible waived) and 10% coinsurance for other outpatient services	$45 copayment / office visit (deductible waived) and 30% coinsurance for other outpatient services	None
	Preventive care/screening/ immunization	No charge	$25 copayment / office visit (deductible waived) and 30% coinsurance for other outpatient services	You may have to pay for services that aren't preventive care. Ask your provider if the services you need are preventive care. Then check what your plan will pay for. You also have no charge for immunizations provided by a non-preferred provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance, deductible does not apply if provided in an office or outpatient	30% coinsurance, deductible does not apply if provided in an office or outpatient	Certain genetic tests and high-technology imaging require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Imaging (CT/PET scans, MRIs)	10% coinsurance, deductible does not apply if provided in an office or outpatient	30% coinsurance, deductible does not apply if provided in an office or outpatient	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://wpshealth.com/resources/files/32053_2024-preferred-drug-guide.pdf	Generic drugs	Retail: $10 copayment / prescription & $20 copayment / prescription for home delivery	Retail: $10 copayment / prescription & $20 copayment / prescription for home delivery	Deductible does not apply to prescription drugs purchased from a pharmacy. Covers up to a 90-day supply. Retail copayments applied as follows: 1-30-day supply = one copayment 31-60-day supply = two copayments 61-90-day supply = three copayments If brand is dispensed when a generic is available, you are responsible for the cost difference between the brand and generic which does not count toward your out–of–pocket limit. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization. Specialty drugs are always limited to a 30-day supply. Specialty drugs require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Preferred brand drugs	Retail: $20 copayment / prescription & $40 copayment / prescription for home delivery	Retail: $20 copayment / prescription & $40 copayment / prescription for home delivery	
	Non-preferred brand drugs	Retail: $30 copayment / prescription & $60 copayment / prescription for home delivery	Retail: $30 copayment / prescription & $60 copayment / prescription for home delivery	
	Specialty drugs	Retail: $40 copayment / prescription & $40 copayment / prescription for home delivery	Retail: $40 copayment / prescription & $40 copayment / prescription for home delivery	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Urgent care services from a non-preferred provider for treatment of a condition which does not require immediate medical attention will be subject to the non-preferred provider deductible and coinsurance. Urgent care billed from a clinic location (a location outside of the hospital emergency room or any other facility as an extension of a
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				hospital emergency room) maybe be subject to the $20 primary care office copayment or $35 specialist office visit copayment depending on the specialty of the physician providing treatment.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment / therapy office visit (deductible waived) and 10% coinsurance for other outpatient services	$25 copayment / therapy office visit (deductible waived) and 30% coinsurance for other outpatient services	$10 copayment / Teladoc ® visit charge All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	$20 copayment / office visit (deductible waived) and 10% coinsurance for other outpatient services	$25 copayment / office visit (deductible waived) and 30% coinsurance for other outpatient services	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is limited to 100 visits in a 12 month period
	Rehabilitation services	10% coinsurance	30% coinsurance	None
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage is limited to 30 days per confinement in a skilled nursing facility. All non-emergent admissions require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Durable medical equipment	10% coinsurance	30% coinsurance	Prior authorization required for: • All CPAP purchases • Purchases over $1,000 • All other rentals as stated on our website Benefits may not be payable if you do not obtain prior authorization.
	Hospice services	10% coinsurance	30% coinsurance	Hospice services require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	None
	Children's glasses	Not covered	Not covered	Not Covered
	Children's dental check-up	Not covered	Not covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Routine Foot Care (unless associated with a specific medical diagnosis)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Acupuncture, limited to adults over age 18 for postoperative nausea and vomiting, nausea and vomiting due to anti-neoplastic agents, and postoperative dental pain
- Dental Care (adult), limited to certain oral surgical procedures, treatment of an injury, and extraction of teeth and sealants on existing teeth related to treatment of neoplastic disease
- Bariatric Surgery
- Hearing aids, limited to the cost of one hearing aid, per ear, for each member under age 18 every three years
- Routine eye care, limited to eye exams

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for the U.S. Department of Labor, Employee Benefits Security Administration 1-866-444-3272 or www.dol.gov/ebsa, or the Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: WPS at 1-800-223-6048. You may also contact your state insurance department at 1-800-236-8517 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al (888) 915-4001.
Hmong (Hmoob): Kev pab nyob rau hauv Hmoob hu (888) 915-4001.
Traditional Chinese (傳統中文): 有關中文協助,請致電 (888) 915-4001.
German (Deutsch): Für Hilfe in deutscher Sprache rufen (888) 915-4001.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$300
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$580

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$300
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,000
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,210

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$300
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$560

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination and Language Access Policy

Wisconsin Physicians Service Insurance Corporation/WPS Health Plan, Inc./The EPIC Life Insurance Company (WPS/EPIC) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WPS/EPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WPS/EPIC:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call us at the phone number on the attached correspondence, your ID card, or the number listed on wpshealth.com, wpshealth.com/healthplan, or epiclife.com.

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

WPS/EPIC
Nondiscrimination Grievance Coordinator
P.O. Box 7458 Madison, WI 53707
Email: WPSNondiscrimination@wpsic.com

You can file a grievance in person, by mail, or by email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator 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 ocrportal.hhs.gov/ocr/portal/lobby.jsf; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C., 20201; or by phone at 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

29792-054-2007

EPIC SPECIALTY BENEFITS

WPS HEALTH INSURANCE · HEALTH PLAN

Albanian VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Na telefononi në numrin e telefonit që gjendet në korrespondencën e bashkëngjitur, në pjesën e përparme të kartës suaj ID ose në numrin e renditur në adresën wpshealth.com, wpshealth.com/healthplan or epiclife.com (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانا. اتصل بنا على رقم الهاتف الموجود بالرسالة المرفقة أو بالجهة الأمامية لبطاقة تعريف الهوية الخاصة بك أو على الرقم المدرج بالمواقع الإلكترونية التالية wpshealth.com أو wpshealth.com/healthplan أو epiclife.com (الهاتف النصي 711).

French À NOTER : Si vous parlez le français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez-nous au numéro de téléphone indiqué sur le courrier joint, au recto de votre carte d'identité ou au numéro indiqué sur le site Internet wpshealth.com, wpshealth.com/healthplan ou epiclife.com (ATS : 711).

German HINWEIS: Wenn Sie Deutsch sprechen, stehen für Sie kostenlos Sprachassistenzdienste zur Verfügung. Sie finden die entsprechende Telefonnummer auf dem beigefügten Schreiben, auf der Vorderseite Ihrer ID-Karte oder unter wpshealth.com, wpshealth.com/healthplan oder epiclife.com (TTY: 711).

Hindi ध्यान दें: अगर आप हिनदी बोलते हैं तो आपकेलिए भाषा सहायता सेवाएँ निःशुलक उपलबध हैं। हमें संलगन पतराचार पता, आपके पहचान पतर (आईडी काडर) केसामने केपृषठ पर
दिए गए फ़ोन नंबर या wpshealth.com, wpshealth.com/healthplan, epiclife.com पर दिए गए नंबर पर कॉल करें (TTY: 711)।

Hmong TSHWJ XEEB: Yog hais tias koj hais lus Hmoob, peb muaj cov kev pab cuam hais ua koj hom lus pub rau koj yam tsis xam tus nqi hlo li. Hu rau peb tus nab npawb xov tooj nyob rau ntawm daim ntawv, sab hauv ntej ntawm koj daim id lossis nab npawb xov tooj nyob rau hauv wpshealth.com, wpshealth.com/healthplan lossis epiclife.com
(TTY: 711).

Korean 주목해 주세요: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 첨부된 서신, ID 카드 앞면 또는
wpshealth.com, wpshealth.com/healthplan, epiclife.com 에 나와 있는 전화번호로 연락해 주십시오(TTY: 711).

Polish UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer podany w załączonej korespondencji, z przodu karty identyfikacyjnej lub numer podany na stronie wpshealth.com, wpshealth.com/healthplan lub epiclife.com (TTY: 711).

Russian ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться услугами переводчика. Позвоните по любому номеру, указанному: в прикрепленном письме, на лицевой стороне Вашей идентификационной карты или на сайте wpshealth.com, wpshealth.com/healthplan и epiclife.com (телетайп: 711).

Spanish ATENCIÓN: Si habla español, los servicios de asistencia de idioma están disponibles para usted, sin costo. Llámenos al número de teléfono que se encuentra en la correspondencia adjunta, en la parte de adelante de su tarjeta de identificación o al número indicado en wpshealth.com, wpshealth.com/healthplan o epiclife.com(TTY: 711).

Tagalog BIGYANG-PANSIN: Kung Tagalog ang ginagamit mong wika, may mga serbisyong tulong sa wika na makukuha mo nang walang babayaran. Tawagan kami sa numero ng telepono na nasa nakalakip na sulat, nasa harapang bahagi ng iyong id card o nakalistang numero sa wpshealth.com, wpshealth.com/healthplan o epiclife.com (TTY: 711).

Traditional Chinese 注意：如果您使用繁體中文，您可以免费獲得語言援助服務。請撥打隨附之通訊上、ID 卡正面或以下網址：
wpshealth.com, wpshealth.com/healthplan 或 epiclife.com 列出的電話號碼與我們聯絡 (TTY: 711)。

Vietnamese CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi cho chúng tôi theo số điện thoại có trên thư từ đính kèm, mặt trước thẻ id của quý vị hoặc số điện thoại được niêm yết trên wpshealth.com, wpshealth.com/healthplan hoặc epiclife.com (TTY: 711).

Pennsylvania Dutch GEB ACHT: Wann du Deitsch schwetzscht, du kannscht Schprooch Services griege, mitaus Koschd. Ruf uns mit der Nummer uff die attached correspondence, die vonne Seide vun dei ID Kaarde odder die Nummer uff wpshealth.com, wpshealth.com/healthplan or epiclife.com (TTY: 711).

Lao ສ ำ ລ ับ ท่ า น ท ี่ ส น ใ จ : ถ ้ า ท่ า น เ ว ้ ิ พ า ส า ล า ว , ม ี บ ร ิ ก า ร ช ่ ว ย เ ห ล ื อ ด ้ า น พ า ส า โ ด ย บ ่ ค ิ ด ค ่ า ใ ช ้ จ ่ า ย ส ำ ล ับ ท ่ า น .
ท่ า น ส า ม า ด โ ท ห า พ ว ก เ ร ิ า ไ ด ้ ท ี่ ห ม า ย เ ล ข ท ี่ อ ย ู่ เ ท ิ ง จ ด ห ม า ย ต ิ ด ต ี ้ ด ั ด ม า , ด ้ า น ห ้ า บ ั ด ป ะ จ ำ ต ั ว ข อ ง ท ่ า น ห ร ื อ ห ม า ย เ ล ข ท ี่ ล ะ บ ุ ไ ว ้ ใ น wpshealth.com, wpshealth.com/healthplan or epiclife.com (TTY: 711).

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Medical College of Wisconsin Affiliated Hospitals, Inc.	39-1341366
5. Employer address 8701 Watertown Plank Road	6. Employer phone number (414) 955-4575

7. City	8. State	9. ZIP code
Milwaukee	WI	53226

10. Who can we contact about employee health coverage at this job?	
Graduate Medical Education Department	
11. Phone number (if different from above)	12. Email address gme@mcw.edu

Here is some basic information about health coverage offered by this employer:

- We offer a health plan to employees and their dependents based upon eligibility as defined in the Health Plan Summary Plan Description. Most employees are eligible.

[V] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid	**ALASKA Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

THIS NOTIFICATION CONTAINS IMPORTANT INFORMATION ABOUT YOUR HEALTH INSURANCE

PLEASE READ CAREFULLY

As an employer, you are receiving these notices as part of your group annual renewal materials. You must forward this notice free of charge to all of your employees, regardless of whether or not they are enrolled in your group health plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

Reconstructive Surgery Following Mastectomy

This renewal includes benefits made available through the Women's Health and Cancer Rights Act of 1998, which applies to your benefit plan. This law mandates that a participant/member or eligible beneficiary who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the policy/plan.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the policy/plan may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the policy/plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hours (or 96 hours) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a policy/plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain provider or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

NOTICE OF QUALIFYING EVENT FOR COBRA CONTINUATIONCOVERAGE

<DATE>

<WHO>
<ADDRESS>
<CITY>

You have been receiving group health insurance as an employee benefit of <COMPANY>. Due to your <QUALIFYING EVENT>, insurance coverage from all group health plans will be terminated effective <COVERAGE ENDS>. **To provide options for individuals who lose coverage from an employer-sponsored health insurance plan, the Federal Government enacted the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA."** This notification is designed to explain the law and how it affects you (and your covered dependents) in regards to continuing under our group plan(s), **as well as other health coverage alternatives that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov** or call 1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

COBRA LAW - Most employers providing health insurance benefits must offer a temporary extension of the organization's group insurance coverage when an employee (or covered dependent) experiences a "qualifying event." COBRA views your <QUALIFYING EVENT> as a qualifying event and offers you (and covered dependents) the right to continue your current group insurance coverage for a maximum of <TIME FRAME> months.<NY STATE CONTIN>

This procedure differs from "converting" your group coverage to an individual policy. The major advantages are that you cannot be discriminated against for having a pre-existing medical condition and will receive the company's group rates (plus an administrative fee). In addition, COBRA benefits remain identical to that of an active employee. On the other hand, conversion insurance policies calculate rates based on factors such as the age and sex of the applicant, offer different benefits and can be less expensive for some individuals. For these reasons, we recommend you directly contact the insurance company for further information on their conversion policies. (Note - Not all group health plans are required to offer a conversion policy.)

QUALIFIED BENEFICIARIES - You are eligible to continue your group coverage based upon your qualifying event. Any of your dependents who were enrolled in a plan on the day prior to the qualifying event also have an independent right to continue their coverage and shall be known as a "qualified beneficiary." If you are enrolled in more than one plan, each qualified beneficiary may select which plan he or she would like to continue. For example, a person having family coverage for both medical and dental insurance may elect to continue just medical or dental and can enroll the family or just one qualified beneficiary. In most cases, qualified beneficiaries may only continue with plans in which they were enrolled on the day prior to the qualifying event. [There are two exceptions to this rule. First, a child born to (or placed for adoption with) the employee will be granted all rights of a qualified beneficiary. Second, if coverage is terminated in anticipation of a future qualifying event (i.e. divorce), the spouse and covered dependents shall be eligible for COBRA continuation coverage]

EXTENDING COBRA COVERAGE - After electing to continue coverage under COBRA, there are certain situations that may allow Qualified Beneficiaries to increase the time frame of continuation coverage. If the initial qualifying was termination of employment or a reduction in work hours, qualifying individuals may be eligible to increase their time frame under COBRA. In each of the two situations described below, eligible individuals must notify the Plan Administrator (in writing) as explained.

Disability Extension - If your qualifying event is termination of employment or a reduction in work hours and you (or a covered dependent) are determined by Social Security to be "disabled" at the time of the qualifying event (or within the first

sixty days of COBRA continuation) through the end of your initial eighteen months, you (and covered dependents) are eligible for the "disability extension." If Social Security determines you (or covered dependent) to be "disabled," COBRA coverage will be extended from eighteen to twenty-nine months. To receive the additional eleven months of coverage, you must provide written documentation from Social Security confirming your disability status during the initial eighteen month time frame and within sixty days of the date that Social Security makes its determination.

The law allows plans to charge up to a fifty percent administration fee during the eleven month disability extension period for a disabled employee and all family members who elect the disability extension. The company has elected to charge an administration fee of <DISABLED FEE>% during this time frame. If the disabled employee elects not to continue coverage during the extended period, the remaining family unit may still continue coverage and will be charged the standard administration fee (<ADMIN FEE>%). If you are offered the disability extension and at some point during your eleven month extension Social Security determines that you are no longer "disabled," COBRA continuation coverage will be terminated for the entire family unit. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator within thirty days after SSA's determination.

Multiple Qualifying Event - If your initial qualifying event entitles you and your covered dependents to less than thirty-six months of continuation coverage and during your period of continuation coverage, a covered dependent experiences another (or "multiple") qualifying event, their period of coverage may be extended to thirty-six months. The thirty-six month period is calculated from the employee's original COBRA start date (<COBRA START>). If a multiple qualifying event occurs, the dependent has sixty days to provide written notification to our office. If this notification is not received within the sixty day time frame, the extension to thirty-six months will be denied. (Note: Employees who experience a reduction in work hours followed by termination of employment shall only be eligible for eighteen months of COBRA continuation coverage.) In no event will COBRA continuation coverage be for longer than thirty-six months. The following shall be considered multiple qualifying events but only if they would have caused the qualified beneficiary to lose coverage had the first qualifying event not occurred.

1) Former employee becomes entitled to Medicare;
2) Death of former employee;
3) Divorce/legal separation; or
4) Covered dependent child who is no longer considered a "dependent" under the plan.

COBRA TERMINATION - As stated, COBRA has maximum time frames for which you may continue coverage under the company's group plan but you may voluntarily terminate coverage at any time by notifying our office in advance. COBRA provides the plan the right to terminate continuation coverage for any of the following reasons:

1) If the company terminates the plan(s) you are continuing for all active employees. (If a replacement plan is offered, you will be offered the right to enroll);
2) If your COBRA premiums are not paid in a timely manner (as explained below);
3) If you (or covered dependent) become covered under another group health plan after electing to continue coverage, and that plan does not exclude coverage for a pre-existing medical condition affecting you (or covered dependent) Note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act;
4) If you become entitled to Medicare (Parts A and/or B);
5) If you (or a covered dependent) are enrolled in a plan that requires you to live or visit contracted providers in the plan's service area and you move out of that plan's service area, coverage will be terminated. If another plan is available to similarly situated active employees who move out of the service area, coverage under that plan will be offered to you;
6) If you have filed fraudulent claims or engage in other activities for which a similarly situated active employee would be terminated "for cause;"
7) If you have reached the end of the maximum coverage period under COBRA. You may (or may not) have the right to convert to an individual policy upon completion of your COBRA term; or
8) If a "disabled" participant is deemed by Social Security to be no longer disabled during the eleven month extension. (In this case, the entire family unit will be terminated from COBRA).

PREMIUM COSTS - Your cost for continuation coverage is based upon the current premiums charged for similarly situated active employees under the plan (or calculated equivalent premiums for self-funded plans). COBRA allows employers to charge up to 2% of the total premium for administrative costs for standard COBRA participants. Our company has elected to charge a <ADMIN FEE>% administration fee.

Plan Name	Coverage	COBRA Premium	Plan Year Ends

<CURRENT PLANS>
<CURRENT PLANS PRORATE>
Remember, you (and covered dependents) have the right to continue coverage under any or all of the above plans. Rates for other tiers are shown on the COBRA Summary and Election Form. Premiums for the plans are set for a 12 month period, commonly known as the "Plan Year" and COBRA participants will be notified of renewal rates prior to the beginning of a new Plan Year (or when reasonably available). If the insurer delivers a premium increase or reduction, the COBRA participant's premiums will be adjusted accordingly.

All premium payments should be mailed by the first of the month to:

<BILLTO ADMIN FIRM>
<BILLTO ADMIN ADDRESS>
<BILLTO ADMIN CITY>
<BILLTO ADMIN PHONE>

PLAN YEAR - The Plan Year is based upon the initial effective date of the health plan and therefore may differ between insurance plans. The following displays the Plan Year for your group health plans.

<PLAN YEAR>

PREMIUM PAYMENT REQUIREMENTS - Premium payments are due the first of the month for that month of coverage. (If you are unable to provide a complete monthly premium, equal weekly payments will be accepted.) COBRA provides a forty-five day grace period (beginning on the date you inform us of your desire to continue coverage) for the initial premium payment. Your initial premium payment must include premiums retroactive to the date you would have lost coverage. You are responsible for making sure the amount of your initial payment is correct. Subsequent premium payments will have a thirty day grace period. If your premium payment is not delivered or post marked within the grace period, your coverage will be terminated back to the last day for which we received a full premium payment. Remember, it is your responsibility to see that premiums are paid in a timely fashion.

COVERAGE UNDER COBRA - Since COBRA is a continuation of benefits, your coverage/benefits will remain the same as prior to the qualifying event. If the company elects to change plans and/or benefits, you will be eligible to enroll in the changed plan and will therefore receive the same benefits as a similarly situated active employee. If your plan has deductibles and coinsurance maximums, how much you still need to pay in deductibles and coinsurance maximums will be based upon expenses incurred prior to the qualifying event by only those family members electing to continue under the plan.

COBRA participants who move out of the plan's service area may lose coverage under the group health plan (as would a similarly situated active employee). If the company offers a plan that provides coverage in the new area, the COBRA participant will be offered the right to enroll in that plan.
<125INFO>
OPEN ENROLLMENT - COBRA participants are offered the same rights as similarly situated active employees during open enrollment. They may change plans and add/delete eligible dependents. Although part of the family unit, dependents (other than newborn children and adopted children of the employee) added during open enrollment will not have the same COBRA rights as the initial qualified beneficiaries.

CONVERSION TO AN INDIVIDUAL PLAN - A conversion policy allows individuals covered under a group health plan to convert their coverage to an individual policy without pre-existing condition limitations or a lapse in coverage upon termination from the group health plan. Not all group health plans are subject to offering a conversion right. If you are enrolled in a plan that allows conversion, you will receive a notification explaining your conversion privileges in the last 180 days of your COBRA term. It will be your responsibility to work directly with the insurance carrier to establish a conversion to an individual policy.

MEDICARE AND COBRA EXPLANATION - How COBRA and Medicare work together is complex and varies depending on numerous situations. There are five unique situations when COBRA and Medicare intersect and may affect

your coverage differently. The following rules apply to Medicare and COBRA.

1) Special Medicare Rule - If an active employee becomes entitled to Medicare and later experiences a termination of employment or reduction in work hours, covered dependents are eligible for up to thirty-six months of continuation coverage commencing from the Medicare entitlement date. For example, if an active employee terminates coverage on his 66th birthday, covered dependents would be eligible for 24 months (36 total - 12 covered months) from the date of termination.
2) An active employee who is entitled to Medicare prior to experiencing a qualifying event is eligible to elect COBRA.
3) When an active employee becomes entitled to Medicare, dependents losing coverage are eligible for thirty-six months of continuation coverage. (Rarely do the dependents lose coverage because of this qualifying event.)
4) When a qualified beneficiary is enrolled on COBRA and becomes entitled to Medicare, the law states this is a qualifying event. But the IRS has ruled it is not a qualifying event unless the Medicare entitlement would have caused a loss of coverage for the dependents.
5) When a qualified beneficiary is enrolled on COBRA and becomes entitled to Medicare, the qualified beneficiary may be terminated from COBRA.

<STATEINFO>
COBRA ACCEPTANCE/ENROLLMENT PROCEDURES - You have 60 days from the later of this letter's date or your coverage termination date to accept COBRA continuation coverage. Remember, your coverage ends <COVERAGE ENDS>; therefore you do not have benefits during the sixty day election period. If you elect to continue coverage, your plan coverage will be retroactively placed back into effect <COBRA START> and any eligible claims occurring during this time frame will be paid in accordance with the plan's terms. Any person or organization may elect COBRA for you (or covered dependents) and even make premium payments on your behalf.

If you do not notify our office of your desire to elect COBRA by <ELIM PERIOD>, you (and your covered dependents) will not be able to continue your group health coverage. By law, we are required to respond to inquiries by medical providers regarding to your election and payment status. Until we receive an election form from you or your covered dependents electing continuation coverage, and you pay your initial premium, we will advise such medical providers that you (and your covered dependents) do not currently have coverage but that you may have retroactive coverage if you elect coverage under COBRA and pay your premium. If you need medical services prior to electing COBRA or making premium payments, medical providers may require you to pay for their services in full as a condition of treatment.

To notify our office of your continuation acceptance, we request you complete the attached COBRA Summary and Election Form and return it to the Plan Administrator (as shown below). Some insurance companies require COBRA participants to complete their own preprinted COBRA applications. If you were covered by an insurance plan with that rule, upon receipt of the COBRA Summary and Election Form, you will be provided the necessary COBRA application(s). Please complete the form(s) and return it to the Plan Administrator.
<CAL356>

HEALTH INSURANCE MARKETPLACE - The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

MARKETPLACE COVERAGE ENROLLMENT TIME FRAME -You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

GENERAL GUIDELINES AND ENROLLMENT PROCEDURES WITH RESPECT TO COBRA AND THE

MARKETPLACE - If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

OTHER GROUP HEALTH PLAN ENROLLMENT OPTIONS - You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

FACTORS YOU SHOULD CONSIDER WHEN CHOOSING COVERAGE OPTIONS - When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Deductibles: If you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.
- Gap in coverage: Unlike COBRA coverage, which begins retroactively to the day that you lost coverage, Marketplace coverage applies prospectively. Therefore you may have a gap in coverage between the time that you lost your employer's coverage and the time your coverage will begin on the Marketplace.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

PLAN ADMINISTRATOR - The Plan Administrator is your contact as it relates to COBRA and your continuation coverage. If you have any questions regarding this notification or your continuation coverage, you may contact the Plan Administrator. It is your responsibility to notify the Plan Administrator of any multiple qualifying events, SSA disability determinations or if you have a change of address.

<ADMINISTRATOR>
<ADMIN FIRM>
<ADMIN ADDRESS>
<ADMIN CITY>
<ADMIN PHONE>

SUMMARY - This notice is designed to explain your rights under COBRA. You and your covered dependents have an

independent right to continue one or more of the group plans offered by <COMPANY>. You have until <ELIM PERIOD> to notify the Plan Administrator of your desire to continue coverage by sending a completed Summary and Election Form. (If you elect not to continue your group health coverage, your benefits will be terminated effective <COVERAGE ENDS>.) The monthly premiums for continuation coverage are shown on the Summary and Election Form. If the Plan Administrator does not receive your premium payments within the associated grace periods, coverage will be terminated. Once you have experienced one of the described COBRA termination reasons, your continuation coverage will end. For further information about your rights under ERISA, including COBRA, HIPAA and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-888-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

<SIGNEDBY>
<TITLE>

<COMPANY>'s
COBRA SUMMARY AND ELECTION FORM

SUMMARY

Employee Name: <EMPLOYEE>
Qualified Beneficiary(ies): <WHO>
Mailing Address: <ADDRESS ONE LINE>
City, State ZIP: <CITY>
Current Group Health Plan Coverage Ends: <COVERAGE ENDS>
Qualifying Event: <QUALIFYING EVENT>
Qualifying Event Date: <QUALIFYING EVENT DATE>
COBRA Notification Date: <NOTIFICATION DATE>
Number of months initially offered for COBRA continuation coverage: <TIME FRAME>
Qualified Beneficiary(ies) shall be ineligible to elect COBRA after: <ELIM PERIOD>

MONTHLY COBRA PREMIUMS

<STATUS>	<TIER1>	<TIER2>	<TIER3>	<TIER4>	<TIER5>
<PLAN & RATES>					
<PLAN & RATES PRORATE>					

COBRA ELECTION FORM INFORMATION

EMPLOYEE NAME: _____

ADDRESS: _____

CITY, STATE ZIP: _____

PHONE NUMBER: _____

E-MAIL ADDRESS: _____

Qualified Beneficiaries Electing COBRA (Name/Date of Birth/Social Security #)	Selected Plan(s)	Premium
_____	_____	_____
_____	_____	_____
_____	_____	_____
	Premiums Submitted:	_____

NOTE: Each qualified Beneficiary listed above has an independent right to elect or waive COBRA continuation coverage. Although the employee or spouse can elect coverage for all other qualified beneficiaries listed, the employee or spouse cannot independently waive coverage for all other qualified beneficiaries without their authorization, unless such qualified beneficiary is a minor.

Per my rights under COBRA, I have elected to continue benefits under the plans listed above and acknowledge that I am responsible for the associated premiums. I have read and understand the information presented in this document and myresponsibilities under the law.

Signature: _____ **Date:** _____

YOUR HEALTH PLAN ID CARD

Whenever you or your covered dependents receive care, please present your ID Card to the provider's office staff. They need the information provided on your card in order to complete any claims for payments.

Important things to remember:

- Carry your ID Card at all times.
- Present it when you receive any services.
- Notify our Customer Service Department if your ID Card is lost or stolen.
- It is illegal to let anyone not specified on your plan to use your ID Card.

If you need additional ID Cards, please contact our Customer Service Department at the number shown on your ID Card or at 1-800-221-5313.

CUSTOMER SERVICE

What to do if you have questions about your benefits:

Our Customer Service Department is prepared to answer questions about your benefits. Be sure to tell us the customer number shown on your ID Card whenever you call or write us.

To contact us:

- Call the toll-free number shown on your ID Card.
- Write to the WPS address shown on your ID Card and include: "Attention: Customer Service."

When to call our Customer Service Department:

- For an explanation of your covered benefits.
- To request additional or replacement ID Cards.
- For benefits and eligibility information.
- To find out whether a particular health care provider is a preferred provider.

CHANGES IN COVERAGE STATUS

To make sure you receive the coverage you're entitled to, it's important you notify us about changes in status. If you're part of a group plan, you can notify your employer of such changes. If you have an individual policy, please contact our Customer Service Department.

Whenever you are requesting coverage for a new spouse or dependent, or changing existing coverage (i.e., single to family or family to single), you must complete an enrollment application and return it to us within the time period specified in your benefit plan information. If you apply for coverage outside of the specified time periods and/or you have an individual policy, some requests for coverage may require health underwriting.

Name change - Submit an enrollment application with the appropriate name change(s).

Your marriage - You may apply for coverage for your spouse within 31 days of marriage.

Newborn children, grandchildren, and newly adopted or prospective adoptive children - Requirements differ for adding newborn children, grandchildren, and newly adopted or prospective adoptive children. For further details, please refer to your certificate of insurance, benefits booklet or policy.

Marriage of a covered dependent - If a covered dependent marries, coverage for that dependent ends on the date he/she marries.

Covered dependent reaching limiting age or is now self-supporting - If a covered dependent reaches the limiting age identified in your benefit information or provides 50% of his/her own support, he/she is no longer eligible for coverage under your benefit plan.

If your child is disabled, coverage may continue beyond the age limit specified in your benefit plan for dependent children (not dependent students.). Please notify us within 31 days of the date dependent coverage would typically end, explaining the child's disability and the name and address of the physician treating your child for the disability.

Divorce or Annulment - Your covered spouse's coverage ends on the date you are no longer married due to divorce or annulment.

Death of a member, spouse or dependent - Coverage ends on the date of death.

If a participant's coverage ends, he/she may be eligible for state continuation of coverage, federal continuation (COBRA) coverage, or a conversion policy. For further details, please see the appropriate sections of your certificate of insurance, benefits booklet or policy.

A certificate of insurance, benefits booklet, or policy is included in or with this Member Guide. Please review this information for answers to any eligibility questions you may have. If you need further assistance, please do not hesitate to contact our Customer Service Department at the number shown on your ID card.

MISCELLANEOUS COVERAGE ISSUES

If you have any questions about the following coverage issues or any other aspect of your coverage, please feel free to call our Customer Service Department at the number shown on your ID Card.

- **Other Insurance Coverage** – If you, or any family member enrolled in our benefit plan, are also covered by another health insurance plan or health benefit plan, you must inform us as soon as possible. Having multiple health insurance or health benefit plans requires proper coordination. Once we are aware of any other existing plans you may have, we will be able to coordinate your benefits with them.

  Coordination means that whenever two or more plans are involved, the plans work together to pay up to 100% of the covered charges-but not more. If you have questions about coordination of benefits, please call our Customer Service Department.

- **Medicare Carve-Out** – If covered charges are incurred by a member who is eligible to apply for Medicare, we will determine the benefits, if any, payable for those charges for covered health care services using our Medicare "Carve-Out" method. A member who is eligible for Medicare is considered enrolled in and covered under Medicare Parts A and B, whether or not he/she is actually enrolled in one or both parts of Medicare.

  For example, if a member is eligible to enroll in Medicare Part B, but fails to do so, or terminates his/her Medicare Part B coverage, we will still determine the covered benefits payable under the policy as if that member had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare didn't pay any Part B benefits.

HOW TO FILE CLAIMS

How Do My Claims Get Processed?

Present your ID Card to your provider at the time of your visit.

Most providers will file your claim for you.They may need additional information from you, such as whether you have other group medical coverage, before filing claims. If this does not occur, please contact your provider for a copy of the completed claim or itemized bill and forward it to the address shown on your ID Card. A specialized claim form isn't needed.

Both you and your provider will receive an Explanation of Benefits (EOB) explaining the processing of your claim. Payments will be forwarded directly to your provider unless otherwise indicated on the claim.

If you have a question, please contact our Customer Service Department at the toll-free phone number shown on your ID Card. To efficiently serve your needs, please present your customer number (shown on your ID Card) when placing the call.

What Should be Submitted?

Written proof of your claim should be submitted within 120 days of the date on which you receive the health care service and should contain the following items:

- Your customer number.
- The actual itemized bill for each health care service, including the diagnosis.
- The patient's name, date of birth, and nickname, if applicable, on each bill.
- If applicable, attach an Explanation of Benefits from another insurance company.
- Finally, please note if the bill(s) has been paid.

Send the bill(s) to the address shown on your ID card.

Should you have any questions, please feel free to call us between the hours of:

7:00 a.m. and 7:00 p.m., CST - Monday through Thursday

7:00 a.m. and 4:30 p.m., CST - Friday

MEMBERS' RIGHTS AND RESPONSIBILITIES

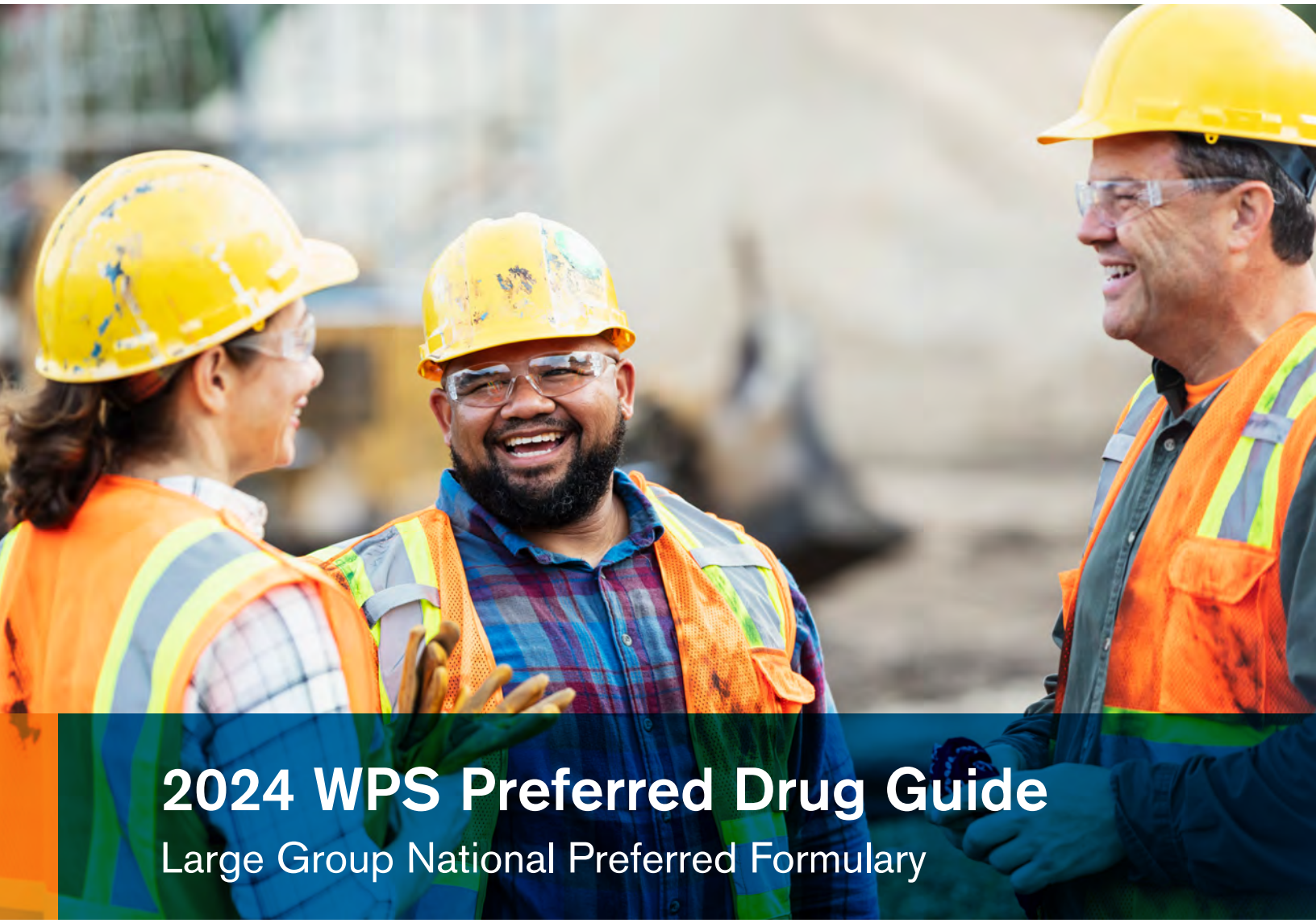
As a member of WPS Health Insurance Company, we believe you have certain basic rights and responsibilities regarding your health care.

You have the Right To:

1. Be treated with respect and recognition of your dignity and your right to privacy. You also have the right to privacy of your medical information received by us unless you allow the release of such information.
2. Participate with your physician or other health care provider in any decision making regarding your health care.
3. Have a candid discussion of appropriate or medically necessary treatment options for your medical condition.
4. Receive the right care at the right level at the right time by the right type of provider for your medical condition.
5. Receive information about preventive health care that is age and sex specific, and information about remaining as healthy as possible including self care and maintenance care for specific chronic diseases.
6. Receive care according to federal and state mandates.
7. Voice complaints or appeals about service from WPS Health Insurance or about care received.

You Have the Responsibility To:

1. Provide, to the extent possible, information that WPS Health Insurance and your physician or health care provider need to care for you.
2. Be aware of your health care coverage and requirements/limitations under your certificate of coverage, including , but not limited to, precertification or prior authorization requirements and exclusions.
3. Ask questions about your diagnosis, your treatment plan and how to best manage your health.
4. Follow the plans and instructions for care on which you have agreed with your physician or other health care provider.



2024 WPS Preferred Drug Guide

Large Group National Preferred Formulary

August 2024

WPS

HEALTH INSURANCE • HEALTH PLAN

32053-100-2408

Table of Contents

LIST OF ABBREVIATIONS

CHEW	chewable
CR	controlled-release
DISP	dispersible
DR	delayed release
EC	enteric coated
ER	extended release
IR	immediate release
INH	inhalation
INJ	injection
IM	intramuscular
IV	intravenous
LA	long acting
MISC	miscellaneous
OPHTH	ophthalmic
SC	subcutaneous
SL	sublingual
SUSP	suspension
TRANSDERM	transdermal
XR	extended release

Requirements / Limits

ACA	Affordable Care Act. The ACA requires that certain medications be provided at no cost to members for non-grandfathered plans.
LA, LD	Limited Availability/Limited Distribution. This prescription may be available only at certain pharmacies. For more information, please call Customer Service.
PA	Prior Authorization. The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug. Please check here to find who would review your request.
QL	Quantity Limit. For certain drugs, the Plan limits the amount of the drug that we will cover.
SP	Specialty drug. These drugs are typically higher cost and require special handling, administration, or monitoring. They may be available from a specialty pharmacy or via your retail pharmacy.
ST	Step Therapy. In some cases, the Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. Please check here to find who would review your request.

ACA PREVENTIVE DRUG LIST

This includes drugs covered at no cost to members for non-grandfathered plans per ACA rules and guidance.
Coverage is limited to: (1) generic drugs and (2) brand-name drugs when there is no generic equivalent.

1. **Aspirin** for the prevention of cardiovascular disease if you are between 50 - 69 years old.
2. **Fluoride supplements** if you are older than six months and less than 17 years old.
3. **Folic acid**.
4. **Oral contraceptives**, **contraceptive patches**, **contraceptive device**s for example, diaphragms, sponges, gel and female condoms) and **contraceptive vaginal rings** for birth control.
5. **Nicotine replacements** (for example, patches and gum) and covered drugs used for smoking cessation if you are at least 18 years old.
6. **Tamoxifen, raloxifene, anastrozole, or exemestate** for women ≥ 35 years old who are at increased risk for breast cancer and at low risk for adverse medication effects. A prior authorization may be required for coverage under the ACA mandate.
7. **Routine immunizations** recommended by the Centers for Disease Control Advisory Committee on Immunization Practices used in pediatrics and adults (not travel immunizations).
8. **Bowel preps** (limit of 2 prescriptions per year).
9. **Statins** (low/moderate dose, generic only) if you are between 40 - 75 years old.
10. **Preexposure prophylaxis (PrEP)** antiretroviral therapy for covered persons at high risk of HIV acquisition.
11. **Selective Serotonin Reuptake Inhibitors (SSRIs)** including citalopram, escitalopram, fluoxetine IR/DR, fluvoxamine IR/CR/ER, paroxetine IR/CR/ER, and sertraline.

ALPHABETICAL LISTING BY THERAPEUTIC CATEGORY AND DRUG CLASS

Inclusion on the list does not guarantee coverage. The products and prescription medical supplies on this list are subject to change.

The following list is not a complete list of products and prescription medical supplies that are on the formulary.

PLEASE NOTE: Brand-name drugs may move to nonformulary status if a generic version becomes available during the year. Not all the drugs listed are covered by all prescription drug benefit programs.

PLEASE NOTE: The Federal COVID Public Health Emergency ended 5/11/2023. For coverage of COVID vaccines, test kits, and oral anti-virals starting 5/12/2023, please refer to your Plan Documents.

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ANTI - INFECTIVES				
ANTIFUNGAL AGENTS				
clotrimazole	*troche*	*10 mg*	MUCOUS MEMBRANE	
CRESEMBA	CAPSULE	74.5 MG	ORAL	PA
CRESEMBA	CAPSULE	186 MG	ORAL	PA
fluconazole	*suspension; reconstituted; oral (ml)*	*10 mg/ml*	ORAL	
fluconazole	*suspension; reconstituted; oral (ml)*	*40 mg/ml*	ORAL	
fluconazole	*tablet*	*50 mg*	ORAL	
fluconazole	*tablet*	*100 mg*	ORAL	
fluconazole	*tablet*	*150 mg*	ORAL	QL
fluconazole	*tablet*	*200 mg*	ORAL	
flucytosine	capsule	250 mg	ORAL	
flucytosine	capsule	500 mg	ORAL	
griseofulvin	suspension; oral (final dose form)	125 mg/5 ml	ORAL	
griseofulvin	tablet	500 mg	ORAL	
griseofulvin ultramicrosize	tablet	125 mg	ORAL	
griseofulvin ultramicrosize	tablet	250 mg	ORAL	
itraconazole	capsule	100 mg	ORAL	QL
itraconazole	solution; oral	10 mg/ml	ORAL	QL
ketoconazole	*tablet*	*200 mg*	ORAL	
nystatin	*suspension; oral (final dose form)*	*100000/ml*	ORAL	
nystatin	*tablet*	*500k unit*	ORAL	
posaconazole	suspension; oral (final dose form)	200 mg/5 ml	ORAL	PA
posaconazole	tablet; enteric coated	100 mg	ORAL	PA
terbinafine	*tablet*	*250 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
voriconazole	suspension; reconstituted; oral (ml)	200 mg/5 ml	ORAL	PA
voriconazole	tablet	50 mg	ORAL	PA
voriconazole	tablet	200 mg	ORAL	PA
ANTIMALARIALS				
atovaquone-proguanil hcl	tablet	62.5-25 mg	ORAL	QL
atovaquone-proguanil hcl	tablet	250-100 mg	ORAL	QL
chloroquine phosphate	*tablet*	*250 mg*	ORAL	
chloroquine phosphate	*tablet*	*500 mg*	ORAL	
COARTEM	TABLET	20 MG-120 MG	ORAL	QL
hydroxychloroquine sulfate	*tablet*	*100 mg*	ORAL	
hydroxychloroquine sulfate	*tablet*	*200 mg*	ORAL	
hydroxychloroquine sulfate	*tablet*	*300 mg*	ORAL	
hydroxychloroquine sulfate	*tablet*	*400 mg*	ORAL	
mefloquine hcl	*tablet*	*250 mg*	ORAL	QL
primaquine generic	tablet	26.3 mg	ORAL	QL
pyrimethamine	tablet	25 mg	ORAL	PA
quinine sulfate	capsule	324 mg	ORAL	QL
ANTIMYCOBACTERIALS				
ethambutol hcl	*tablet*	*100 mg*	ORAL	
ethambutol hcl	*tablet*	*400 mg*	ORAL	
isoniazid	*solution; oral*	*50 mg/5 ml*	ORAL	
isoniazid	*tablet*	*100 mg*	ORAL	
isoniazid	*tablet*	*300 mg*	ORAL	
PRIFTIN	TABLET	150 MG	ORAL	
pyrazinamide	tablet	500 mg	ORAL	
rifabutin	capsule	150 mg	ORAL	
rifampin	capsule	150 mg	ORAL	
rifampin	capsule	300 mg	ORAL	
SIRTURO	TABLET	20 MG	ORAL	LA; PA
SIRTURO	TABLET	100 MG	ORAL	LA; PA
ANTIPARASITICS				
albendazole	tablet	200 mg	ORAL	QL
ALINIA	SUSPENSION; RECONSTITUTED; ORAL (ML)	100 MG/5 ML	ORAL	QL
atovaquone	suspension; oral (final dose form)	750 mg/5 ml	ORAL	
BENZNIDAZOLE	TABLET	12.5 MG	ORAL	QL

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
BENZNIDAZOLE	TABLET	100 MG	ORAL	QL
EMVERM	TABLET; CHEWABLE	100 MG	ORAL	QL
IMPAVIDO	CAPSULE	50 MG	ORAL	PA; QL
ivermectin	*tablet*	*3 mg*	ORAL	PA; QL
metronidazole	capsule	375 mg	ORAL	
metronidazole	*tablet*	*250 mg*	ORAL	
metronidazole	*tablet*	*500 mg*	ORAL	
nitazoxanide	tablet	500 mg	ORAL	QL
paromomycin sulfate	capsule	250 mg	ORAL	
pentamidine isethionate	vial; nebulizer (ea)	300 mg	INH	QL
praziquantel	tablet	600 mg	ORAL	
SOLOSEC	GRANULES; DELAYED RELEASE; IN PACKET	2 G	ORAL	QL
tinidazole	tablet	250 mg	ORAL	QL
tinidazole	tablet	500 mg	ORAL	QL
ERYTHROMYCINS & OTHER MACROLIDES				
azithromycin	*packet (ea)*	*1 g*	ORAL	
azithromycin	*suspension; reconstituted; oral (ml)*	*100 mg/5 ml*	ORAL	
azithromycin	*suspension; reconstituted; oral (ml)*	*200 mg/5 ml*	ORAL	
azithromycin	*tablet*	*250 mg*	ORAL	
azithromycin	*tablet*	*500 mg*	ORAL	
azithromycin	*tablet*	*600 mg*	ORAL	
clarithromycin	suspension; reconstituted; oral (ml)	125 mg/5 ml	ORAL	
clarithromycin	suspension; reconstituted; oral (ml)	250 mg/5 ml	ORAL	
clarithromycin	*tablet*	*250 mg*	ORAL	
clarithromycin	*tablet*	*500 mg*	ORAL	
clarithromycin er	*tablet; extended release 24 hr*	*500 mg*	ORAL	
e.e.s.	tablet	400 mg	ORAL	
ery-tab	tablet; enteric coated	250 mg	ORAL	
ery-tab	tablet; enteric coated	333 mg	ORAL	
erythrocin stearate	tablet	250 mg	ORAL	
erythromycin	capsule; delayed release (enteric coated)	250 mg	ORAL	
erythromycin	tablet	250 mg	ORAL	
erythromycin	tablet	500 mg	ORAL	
erythromycin	tablet; enteric coated	250 mg	ORAL	
erythromycin	tablet; enteric coated	333 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
erythromycin	tablet; enteric coated	500 mg	ORAL	
erythromycin ethylsuccinate	suspension; reconstituted; oral (ml)	200 mg/5 ml	ORAL	
erythromycin ethylsuccinate	suspension; reconstituted; oral (ml)	400 mg/5 ml	ORAL	
erythromycin ethylsuccinate	tablet	400 mg	ORAL	
FIRST GENERATION CEPHALOSPORINS				
cefadroxil	*capsule*	*500 mg*	ORAL	
cefadroxil	*suspension; reconstituted; oral (ml)*	*250 mg/5 ml*	ORAL	
cefadroxil	*suspension; reconstituted; oral (ml)*	*500 mg/5 ml*	ORAL	
cefadroxil	*tablet*	*1 g*	ORAL	
cefazolin sodium	vial (ea)	3 g	INJ	ST
cephalexin	*capsule*	*250 mg*	ORAL	
cephalexin	*capsule*	*500 mg*	ORAL	
cephalexin	capsule	750 mg	ORAL	
cephalexin	*suspension; reconstituted; oral (ml)*	*125 mg/5 ml*	ORAL	
cephalexin	*suspension; reconstituted; oral (ml)*	*250 mg/5 ml*	ORAL	
cephalexin	*tablet*	*250 mg*	ORAL	
cephalexin	*tablet*	*500 mg*	ORAL	
FLUOROQUINOLONES				
BAXDELA	TABLET	450 MG	ORAL	PA; QL
ciprofloxacin	*suspension; microcapsule reconstituted*	*250 mg/5 ml*	ORAL	
ciprofloxacin	*suspension; microcapsule reconstituted*	*500 mg/5 ml*	ORAL	
ciprofloxacin hcl	*tablet*	*100 mg*	ORAL	
ciprofloxacin hcl	*tablet*	*250 mg*	ORAL	
ciprofloxacin hcl	*tablet*	*500 mg*	ORAL	
ciprofloxacin hcl	*tablet*	*750 mg*	ORAL	
levofloxacin	solution; oral	250 mg/10 ml	ORAL	
levofloxacin	*tablet*	*250 mg*	ORAL	
levofloxacin	*tablet*	*500 mg*	ORAL	
levofloxacin	*tablet*	*750 mg*	ORAL	
levofloxacin	*vial (ml)*	*25 mg/ml*	IV	ST
moxifloxacin hcl	*tablet*	*400 mg*	ORAL	
ofloxacin	*tablet*	*300 mg*	ORAL	
ofloxacin	*tablet*	*400 mg*	ORAL	
HIV/AIDS THERAPY				
ABACAVIR	SOLUTION; ORAL	20 MG/ML	ORAL	SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ABACAVIR	TABLET	300 MG	ORAL	SP
ABACAVIR-LAMIVUDINE	TABLET	600-300 MG	ORAL	SP
APTIVUS	CAPSULE	250 MG	ORAL	SP
ATAZANAVIR SULFATE	CAPSULE	150 MG	ORAL	SP
ATAZANAVIR SULFATE	CAPSULE	200 MG	ORAL	SP
ATAZANAVIR SULFATE	CAPSULE	300 MG	ORAL	SP
BIKTARVY	TABLET	30-120-15	ORAL	SP
BIKTARVY	TABLET	50-200-25	ORAL	SP
CIMDUO	TABLET	300-300 MG	ORAL	SP
DARUNAVIR	TABLET	600 MG	ORAL	SP
DARUNAVIR	TABLET	800 MG	ORAL	SP
DESCOVY	TABLET	120 MG-15 MG	ORAL	SP
DESCOVY	TABLET	200 MG-25 MG	ORAL	SP
DIDANOSINE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	250 MG	ORAL	SP
DIDANOSINE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	400 MG	ORAL	SP
DOVATO	TABLET	50 MG-300 MG	ORAL	SP
EDURANT	TABLET	25 MG	ORAL	SP
EFAVIRENZ	CAPSULE	50 MG	ORAL	SP
EFAVIRENZ	CAPSULE	200 MG	ORAL	SP
EFAVIRENZ	TABLET	600 MG	ORAL	SP
EFAVIRENZ-EMTRIC-TENOFOV DISOP	TABLET	600-200 MG	ORAL	SP
EFAVIRENZ-LAMIVU-TENOFOV DISOP	TABLET	400-300 MG	ORAL	SP
EFAVIRENZ-LAMIVU-TENOFOV DISOP	TABLET	600-300 MG	ORAL	SP
EMTRICITABINE	CAPSULE	200 MG	ORAL	SP
EMTRICITABINE-TENOFOVIR DISOP	TABLET	100-150 MG	ORAL	SP
EMTRICITABINE-TENOFOVIR DISOP	TABLET	133-200 MG	ORAL	SP
EMTRICITABINE-TENOFOVIR DISOP	TABLET	167-250 MG	ORAL	SP
emtricitabine-tenofovir disop	*tablet*	*200-300 mg*	ORAL	ACA; SP
EMTRIVA	SOLUTION; ORAL	10 MG/ML	ORAL	SP
ETRAVIRINE	TABLET	100 MG	ORAL	SP
ETRAVIRINE	TABLET	200 MG	ORAL	SP
FOSAMPRENAVIR CALCIUM	TABLET	700 MG	ORAL	SP
FUZEON	VIAL (EA)	90 MG	SC	QL; SP
GENVOYA	TABLET	150-200-10	ORAL	SP
INTELENCE	TABLET	25 MG	ORAL	SP
ISENTRESS	POWDER IN PACKET (EA)	100 MG	ORAL	SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ISENTRESS	TABLET	400 MG	ORAL	SP
ISENTRESS	TABLET; CHEWABLE	25 MG	ORAL	SP
ISENTRESS	TABLET; CHEWABLE	100 MG	ORAL	SP
ISENTRESS HD	TABLET	600 MG	ORAL	SP
JULUCA	TABLET	50 MG-25 MG	ORAL	SP
LAMIVUDINE	SOLUTION; ORAL	10 MG/ML	ORAL	SP
LAMIVUDINE	TABLET	150 MG	ORAL	SP
LAMIVUDINE	TABLET	300 MG	ORAL	SP
LAMIVUDINE-ZIDOVUDINE	TABLET	150-300 MG	ORAL	SP
LOPINAVIR-RITONAVIR	SOLUTION; ORAL	400-100/5	ORAL	SP
LOPINAVIR-RITONAVIR	TABLET	100 MG-25 MG	ORAL	SP
LOPINAVIR-RITONAVIR	TABLET	200 MG-50 MG	ORAL	SP
MARAVIROC	TABLET	150 MG	ORAL	SP
MARAVIROC	TABLET	300 MG	ORAL	SP
NEVIRAPINE	SUSPENSION; ORAL (FINAL DOSE FORM)	50 MG/5 ML	ORAL	SP
NEVIRAPINE	TABLET	200 MG	ORAL	SP
NEVIRAPINE ER	TABLET; EXTENDED RELEASE 24 HR	100 MG	ORAL	SP
NEVIRAPINE ER	TABLET; EXTENDED RELEASE 24 HR	400 MG	ORAL	SP
ODEFSEY	TABLET	200-25-25	ORAL	SP
PREZISTA	SUSPENSION; ORAL (FINAL DOSE FORM)	100 MG/ML	ORAL	SP
PREZISTA	TABLET	75 MG	ORAL	SP
PREZISTA	TABLET	150 MG	ORAL	SP
REYATAZ	POWDER IN PACKET (EA)	50 MG	ORAL	SP
RITONAVIR	TABLET	100 MG	ORAL	SP
SELZENTRY	SOLUTION; ORAL	20 MG/ML	ORAL	SP
STAVUDINE	CAPSULE	40 MG	ORAL	SP
SYMTUZA	TABLET	800-150 MG	ORAL	SP
TENOFOVIR DISOPROXIL FUMARATE	TABLET	300 MG	ORAL	SP
TIVICAY	TABLET	25 MG	ORAL	PA; SP
TIVICAY	TABLET	50 MG	ORAL	PA; SP
TIVICAY PD	TABLET FOR SUSPENSION	5 MG	ORAL	PA; SP
TRIUMEQ	TABLET	600-50-300	ORAL	SP
VIRACEPT	TABLET	250 MG	ORAL	SP
VIRACEPT	TABLET	625 MG	ORAL	SP
VIREAD	POWDER (GRAM)	40 MG/SCOOP	ORAL	SP
VIREAD	TABLET	150 MG	ORAL	SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
VIREAD	TABLET	200 MG	ORAL	SP
VIREAD	TABLET	250 MG	ORAL	SP
ZIDOVUDINE	CAPSULE	100 MG	ORAL	SP
ZIDOVUDINE	SYRUP	10 MG/ML	ORAL	SP
ZIDOVUDINE	TABLET	300 MG	ORAL	SP
MISC ANTIINFECTIVES				
ARIKAYCE	VIAL; NEBULIZER (ML)	590 MG/8.4	INH	LA; PA; SP
CAYSTON	VIAL; NEBULIZER (ML)	75 MG/ML	INH	LA; PA; QL; SP
clindamycin hcl	*capsule*	*75 mg*	ORAL	
clindamycin hcl	*capsule*	*150 mg*	ORAL	
clindamycin hcl	*capsule*	*300 mg*	ORAL	
clindamycin palmitate hcl	*solution; reconstituted; oral*	*75 mg/5 ml*	ORAL	
clindamycin pediatric	*solution; reconstituted; oral*	*75 mg/5 ml*	ORAL	
DALVANCE	VIAL (EA)	500 MG	IV	ST
dapsone	*tablet*	*25 mg*	ORAL	
dapsone	*tablet*	*100 mg*	ORAL	
KITABIS PAK	AMPUL FOR NEBULIZATION (ML)	300 MG/5 ML	INH	PA; QL; SP
linezolid	*suspension; reconstituted; oral (ml)*	*100 mg/5 ml*	ORAL	PA
linezolid	*tablet*	*600 mg*	ORAL	PA
neomycin sulfate	*tablet*	*500 mg*	ORAL	
ORBACTIV	VIAL (EA)	400 MG	IV	ST
TOBI PODHALER	CAPSULE; WITH INHALATION DEVICE	28 MG	INH	PA; QL; SP
TOBRAMYCIN SULFATE	AMPUL FOR NEBULIZATION (ML)	300 MG/4 ML	INH	PA; QL; SP
TOBRAMYCIN SULFATE	AMPUL FOR NEBULIZATION (ML)	300 MG/5 ML	INH	PA; QL; SP
tobramycin sulfate	vial (ea)	1.2 g	INJ	PA
tobramycin sulfate	vial (ml)	10 mg/ml	INJ	PA
tobramycin sulfate	vial (ml)	40 mg/ml	INJ	PA
XIFAXAN	TABLET	200 MG	ORAL	PA; QL
XIFAXAN	TABLET	550 MG	ORAL	PA; QL
MISC ANTIVIRALS				
acyclovir	*capsule*	*200 mg*	ORAL	
acyclovir	*suspension; oral (final dose form)*	*200 mg/5 ml*	ORAL	
acyclovir	*tablet*	*400 mg*	ORAL	
acyclovir	*tablet*	*800 mg*	ORAL	
adefovir dipivoxil	tablet	10 mg	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
amantadine hcl	*capsule*	*100 mg*	ORAL	
amantadine hcl	*solution; oral*	*50 mg/5 ml*	ORAL	
amantadine hcl	*tablet*	*100 mg*	ORAL	
BARACLUDE	SOLUTION; ORAL	0.05 MG/ML	ORAL	PA
beyfortus	*syringe (ml)*	*50 mg/0.5 ml*	IM	ACA
beyfortus	*syringe (ml)*	*100 mg/ml*	IM	ACA
entecavir	tablet	0.5 mg	ORAL	PA
entecavir	tablet	1 mg	ORAL	PA
EPCLUSA	PELLETS IN PACKET (EA)	150-37.5 MG	ORAL	PA; QL; SP
EPCLUSA	PELLETS IN PACKET (EA)	200 MG-50 MG	ORAL	PA; QL; SP
EPCLUSA	TABLET	200 MG-50 MG	ORAL	PA; QL; SP
EPCLUSA	TABLET	400-100 MG	ORAL	PA; QL; SP
famciclovir	*tablet*	*125 mg*	ORAL	QL
famciclovir	*tablet*	*250 mg*	ORAL	QL
famciclovir	*tablet*	*500 mg*	ORAL	QL
foscarnet sodium	plastic bag; injection (ml)	24 mg/ml	IV	
ganciclovir sodium	vial (ml)	500 mg/10 ml	IV	
HARVONI	PELLETS IN PACKET (EA)	33.75-150	ORAL	PA; QL; SP
HARVONI	PELLETS IN PACKET (EA)	45 MG-200 MG	ORAL	PA; QL; SP
HARVONI	TABLET	45 MG-200 MG	ORAL	PA; QL; SP
HARVONI	TABLET	90 MG-400 MG	ORAL	PA; QL; SP
LAGEVRIO (EUA)	CAPSULE	200 MG	ORAL	QL
lamivudine	tablet	100 mg	ORAL	
oseltamivir phosphate	*capsule*	*30 mg*	ORAL	QL
oseltamivir phosphate	*capsule*	*45 mg*	ORAL	QL
oseltamivir phosphate	*capsule*	*75 mg*	ORAL	QL
oseltamivir phosphate	*suspension; reconstituted; oral (ml)*	*6 mg/ml*	ORAL	QL
PAXLOVID	TABLET; DOSE PACK	150-100 MG	ORAL	QL
PAXLOVID	TABLET; DOSE PACK	300-100 MG	ORAL	QL
PREVYMIS	TABLET	240 MG	ORAL	QL
PREVYMIS	TABLET	480 MG	ORAL	QL
ribavirin	vial; nebulizer (ea)	6 g	INH	PA
rimantadine hcl	tablet	100 mg	ORAL	
valacyclovir	*tablet*	*500 mg*	ORAL	QL
valacyclovir	*tablet*	*1000 mg*	ORAL	QL
valganciclovir hcl	solution; reconstituted; oral	50 mg/ml	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
valganciclovir hcl	tablet	450 mg	ORAL	
VEMLIDY	TABLET	25 MG	ORAL	PA
VOSEVI	TABLET	400-100 MG	ORAL	PA; QL; SP
ZEPATIER	TABLET	50 MG-100 MG	ORAL	PA; QL; SP
PENICILLINS				
amoxicillin	*capsule*	*250 mg*	ORAL	
amoxicillin	*capsule*	*500 mg*	ORAL	
amoxicillin	*suspension; reconstituted; oral (ml)*	*125 mg/5 ml*	ORAL	
amoxicillin	*suspension; reconstituted; oral (ml)*	*200 mg/5 ml*	ORAL	
amoxicillin	*suspension; reconstituted; oral (ml)*	*250 mg/5 ml*	ORAL	
amoxicillin	*suspension; reconstituted; oral (ml)*	*400 mg/5 ml*	ORAL	
amoxicillin	*tablet*	*500 mg*	ORAL	
amoxicillin	*tablet*	*875 mg*	ORAL	
amoxicillin	*tablet; chewable*	*125 mg*	ORAL	
amoxicillin	*tablet; chewable*	*250 mg*	ORAL	
amoxicillin-clavulanate pot er	tablet; extended release 12 hr	1000-62.5	ORAL	
amoxicillin-clavulanate potass	*suspension; reconstituted; oral (ml)*	*200-28.5/5*	ORAL	
amoxicillin-clavulanate potass	*suspension; reconstituted; oral (ml)*	*250-62.5/5*	ORAL	
amoxicillin-clavulanate potass	*suspension; reconstituted; oral (ml)*	*400-57 mg/5*	ORAL	
amoxicillin-clavulanate potass	*suspension; reconstituted; oral (ml)*	*600-42.9/5*	ORAL	
amoxicillin-clavulanate potass	*tablet*	*250-125 mg*	ORAL	
amoxicillin-clavulanate potass	*tablet*	*500-125 mg*	ORAL	
amoxicillin-clavulanate potass	*tablet*	*875-125 mg*	ORAL	
amoxicillin-clavulanate potass	tablet; chewable	200-28.5 mg	ORAL	
amoxicillin-clavulanate potass	tablet; chewable	400-57 mg	ORAL	
ampicillin trihydrate	*capsule*	*500 mg*	ORAL	
AUGMENTIN	SUSPENSION; RECONSTITUTED; ORAL (ML)	125-31.25/	ORAL	
dicloxacillin sodium	*capsule*	*250 mg*	ORAL	
dicloxacillin sodium	*capsule*	*500 mg*	ORAL	
penicillin v potassium	*solution; reconstituted; oral*	*125 mg/5 ml*	ORAL	
penicillin v potassium	*solution; reconstituted; oral*	*250 mg/5 ml*	ORAL	
penicillin v potassium	*tablet*	*250 mg*	ORAL	
penicillin v potassium	*tablet*	*500 mg*	ORAL	
SECOND GENERATION CEPHALOSPORINS				
cefaclor	*capsule*	*250 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
cefaclor	*capsule*	*500 mg*	ORAL	
cefaclor	*suspension; reconstituted; oral (ml)*	*125 mg/5 ml*	ORAL	
cefaclor	*suspension; reconstituted; oral (ml)*	*250 mg/5 ml*	ORAL	
cefaclor	*suspension; reconstituted; oral (ml)*	*375 mg/5 ml*	ORAL	
cefaclor er	*tablet; extended release 12 hr*	*500 mg*	ORAL	
cefpodoxime proxetil	*suspension; reconstituted; oral (ml)*	*50 mg/5 ml*	ORAL	
cefpodoxime proxetil	*suspension; reconstituted; oral (ml)*	*100 mg/5 ml*	ORAL	
cefpodoxime proxetil	*tablet*	*100 mg*	ORAL	
cefpodoxime proxetil	*tablet*	*200 mg*	ORAL	
cefprozil	*suspension; reconstituted; oral (ml)*	*125 mg/5 ml*	ORAL	
cefprozil	*suspension; reconstituted; oral (ml)*	*250 mg/5 ml*	ORAL	
cefprozil	*tablet*	*250 mg*	ORAL	
cefprozil	*tablet*	*500 mg*	ORAL	
cefuroxime axetil	*tablet*	*250 mg*	ORAL	
cefuroxime axetil	*tablet*	*500 mg*	ORAL	
SULFA'S & RELATED AGENTS				
sulfadiazine	*tablet*	*500 mg*	ORAL	
sulfamethoxazole-trimethoprim	*suspension; oral (final dose form)*	*200-40 mg/5*	ORAL	
sulfamethoxazole-trimethoprim	*suspension; oral (final dose form)*	*800-160/20*	ORAL	
sulfamethoxazole-trimethoprim	*tablet*	*400 mg-80 mg*	ORAL	
sulfamethoxazole-trimethoprim	*tablet*	*800-160 mg*	ORAL	
sulfatrim	*suspension; oral (final dose form)*	*200-40 mg/5*	ORAL	
TETRACYCLINES				
avidoxy	*tablet*	*100 mg*	ORAL	
demeclocycline hcl	tablet	150 mg	ORAL	
demeclocycline hcl	tablet	300 mg	ORAL	
doxycycline hyclate	*capsule*	*50 mg*	ORAL	
doxycycline hyclate	*capsule*	*100 mg*	ORAL	
doxycycline hyclate	*tablet*	*20 mg*	ORAL	
doxycycline hyclate	tablet	50 mg	ORAL	ST
doxycycline hyclate	*tablet*	*75 mg*	ORAL	ST
doxycycline hyclate	*tablet*	*100 mg*	ORAL	
doxycycline hyclate	*tablet*	*150 mg*	ORAL	ST
doxycycline hyclate	*tablet; enteric coated*	*50 mg*	ORAL	ST
doxycycline hyclate	*tablet; enteric coated*	*75 mg*	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
doxycycline hyclate	*tablet; enteric coated*	*100 mg*	ORAL	ST
doxycycline hyclate	*tablet; enteric coated*	*150 mg*	ORAL	ST
doxycycline ir-dr	capsule; immediate; delay release; biphase	40 mg	ORAL	ST
doxycycline hyclate	tablet; enteric coated	200 mg	ORAL	ST
doxycycline monohydrate	*capsule*	*50 mg*	ORAL	
doxycycline monohydrate	*capsule*	*75 mg*	ORAL	
doxycycline monohydrate	*capsule*	*100 mg*	ORAL	
doxycycline monohydrate	*capsule*	*150 mg*	ORAL	ST
doxycycline monohydrate	*suspension; reconstituted; oral (ml)*	*25 mg/5 ml*	ORAL	
doxycycline monohydrate	*tablet*	*50 mg*	ORAL	
doxycycline monohydrate	*tablet*	*75 mg*	ORAL	
doxycycline monohydrate	*tablet*	*100 mg*	ORAL	
doxycycline monohydrate	*tablet*	*150 mg*	ORAL	
minocycline hcl	*capsule*	*50 mg*	ORAL	
minocycline hcl	*capsule*	*75 mg*	ORAL	
minocycline hcl	*capsule*	*100 mg*	ORAL	
minocycline hcl	*tablet*	*50 mg*	ORAL	
minocycline hcl	*tablet*	*75 mg*	ORAL	
minocycline hcl	*tablet*	*100 mg*	ORAL	
minocycline hcl er	tablet; extended release 24 hr	45 mg	ORAL	ST
minocycline hcl er	tablet; extended release 24 hr	55 mg	ORAL	ST
minocycline hcl er	tablet; extended release 24 hr	65 mg	ORAL	ST
minocycline hcl er	tablet; extended release 24 hr	80 mg	ORAL	ST
minocycline hcl er	tablet; extended release 24 hr	90 mg	ORAL	ST
minocycline hcl er	tablet; extended release 24 hr	105 mg	ORAL	ST
minocycline hcl er	tablet; extended release 24 hr	115 mg	ORAL	ST
minocycline hcl er	tablet; extended release 24 hr	135 mg	ORAL	ST
mondoxyne nl	*capsule*	*75 mg*	ORAL	
mondoxyne nl	*capsule*	*100 mg*	ORAL	
morgidox	*capsule*	*100 mg*	ORAL	
tetracycline hcl	capsule	250 mg	ORAL	
tetracycline hcl	capsule	500 mg	ORAL	
tetracycline hcl	tablet	250 mg	ORAL	ST
tetracycline hcl	tablet	500 mg	ORAL	ST

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
THIRD GENERATION CEPHALOSPORINS				
cefdinir	*capsule*	*300 mg*	ORAL	
cefdinir	*suspension; reconstituted; oral (ml)*	*125 mg/5 ml*	ORAL	
cefdinir	*suspension; reconstituted; oral (ml)*	*250 mg/5 ml*	ORAL	
cefditoren pivoxil	tablet	400 mg	ORAL	
cefixime	*capsule*	*400 mg*	ORAL	
cefixime	*suspension; reconstituted; oral (ml)*	*100 mg/5 ml*	ORAL	
cefixime	*suspension; reconstituted; oral (ml)*	*200 mg/5 ml*	ORAL	
URINARY TRACT AGENTS				
fosfomycin tromethamine	packet (ea)	3 g	ORAL	
methenamine hippurate	*tablet*	*1 g*	ORAL	
methenamine mandelate	tablet	500 mg	ORAL	
methenamine mandelate	tablet	1 g	ORAL	
nitrofurantoin	*capsule*	*25 mg*	ORAL	
nitrofurantoin	*capsule*	*50 mg*	ORAL	
nitrofurantoin	*capsule*	*100 mg*	ORAL	
nitrofurantoin	suspension; oral (final dose form)	25 mg/5 ml	ORAL	
nitrofurantoin mono-macro	*capsule*	*100 mg*	ORAL	
trimethoprim	*tablet*	*100 mg*	ORAL	
VANCOMYCIN				
vancomycin hcl	capsule	125 mg	ORAL	QL
vancomycin hcl	capsule	250 mg	ORAL	QL
vancomycin hcl	solution; reconstituted; oral	25 mg/ml	ORAL	QL
vancomycin hcl	solution; reconstituted; oral	50 mg/ml	ORAL	QL
ANTINEOPLASTIC & IMMUNOSUPPRESSANT DRUGS				
ADJUNCTIVE AGENTS				
KEPIVANCE	VIAL (EA)	5.16 MG	IV	PA; SP
leucovorin calcium	*tablet*	*5 mg*	ORAL	
leucovorin calcium	tablet	10 mg	ORAL	
leucovorin calcium	tablet	15 mg	ORAL	
leucovorin calcium	*tablet*	*25 mg*	ORAL	
MESNEX	TABLET	400 MG	ORAL	
VISTOGARD	GRANULES IN PACKET (EA)	10 G	ORAL	PA; SP
VORAXAZE	VIAL (EA)	1000 UNIT	IV	PA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ALKYLATING AGENTS				
BENDAMUSTINE HCL	VIAL (EA)	25 MG	IV	PA; SP
BENDAMUSTINE HCL	VIAL (EA)	100 MG	IV	PA; SP
busulfan	vial (ml)	60 mg/10 ml	IV	
carboplatin	vial (ml)	10 mg/ml	IV	PA
carmustine	vial (ea)	100 mg	IV	PA
CYCLOPHOSPHAMIDE	CAPSULE	25 MG	ORAL	
CYCLOPHOSPHAMIDE	CAPSULE	50 MG	ORAL	
GLEOSTINE	CAPSULE	10 MG	ORAL	PA
GLEOSTINE	CAPSULE	40 MG	ORAL	
GLEOSTINE	CAPSULE	100 MG	ORAL	
LEUKERAN	TABLET	2 MG	ORAL	PA
melphalan hcl	vial (ea)	50 mg	IV	PA
MYLERAN	TABLET	2 MG	ORAL	PA
oxaliplatin	vial (ea)	50 mg	IV	
oxaliplatin	vial (ea)	100 mg	IV	
TEMODAR	VIAL (EA)	100 MG	IV	PA; SP
TEMOZOLOMIDE	CAPSULE	5 MG	ORAL	PA; SP
TEMOZOLOMIDE	CAPSULE	20 MG	ORAL	PA; SP
TEMOZOLOMIDE	CAPSULE	100 MG	ORAL	PA; SP
TEMOZOLOMIDE	CAPSULE	140 MG	ORAL	PA; SP
TEMOZOLOMIDE	CAPSULE	180 MG	ORAL	PA; SP
TEMOZOLOMIDE	CAPSULE	250 MG	ORAL	PA; SP
thiotepa	vial (ea)	15 mg	INJ	PA
thiotepa	vial (ea)	100 mg	INJ	PA
ANTIANDROGENS				
ABIRATERONE ACETATE	TABLET	250 MG	ORAL	PA; SP
ABIRATERONE ACETATE	TABLET	500 MG	ORAL	PA; SP
BICALUTAMIDE	TABLET	50 MG	ORAL	
ERLEADA	TABLET	60 MG	ORAL	PA; SP
ERLEADA	TABLET	240 MG	ORAL	PA; SP
NILUTAMIDE	TABLET	150 MG	ORAL	PA
NUBEQA	TABLET	300 MG	ORAL	LA; PA; SP
XTANDI	CAPSULE	40 MG	ORAL	PA; SP
XTANDI	TABLET	40 MG	ORAL	PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
XTANDI	TABLET	80 MG	ORAL	PA; SP
ANTIESTROGENS				
ANASTROZOLE	TABLET	1 MG	ORAL	
EXEMESTANE	TABLET	25 MG	ORAL	
LETROZOLE	TABLET	2.5 MG	ORAL	
ORSERDU	TABLET	86 MG	ORAL	PA; SP
ORSERDU	TABLET	345 MG	ORAL	PA; SP
TAMOXIFEN CITRATE	TABLET	10 MG	ORAL	
TAMOXIFEN CITRATE	TABLET	20 MG	ORAL	
TOREMIFENE CITRATE	TABLET	60 MG	ORAL	PA
ANTIMETABOLITES				
AZACITIDINE	VIAL (EA)	100 MG	INJ	SP
CAPECITABINE	TABLET	150 MG	ORAL	PA; SP
CAPECITABINE	TABLET	500 MG	ORAL	PA; SP
clofarabine	vial (ml)	20 mg/20 ml	IV	
floxuridine	vial (ea)	500 mg	INJ	
gemcitabine hcl	vial (ea)	200 mg	IV	
gemcitabine hcl	vial (ea)	1 g	IV	
gemcitabine hcl	vial (ea)	2 g	IV	
MERCAPTOPURINE	TABLET	50 MG	ORAL	
METHOTREXATE	TABLET	2.5 MG	ORAL	
methotrexate	*vial (ea)*	*1 g*	INJ	
methotrexate	*vial (ml)*	*25 mg/ml*	INJ	
METHOTREXATE SODIUM	TABLET	2.5 MG	ORAL	
methotrexate sodium	*vial (ea)*	*1 g*	INJ	
methotrexate sodium	*vial (ml)*	*25 mg/ml*	INJ	PA
NELARABINE	VIAL (ML)	250 MG/50 ML	IV	SP
PRALATREXATE	VIAL (ML)	20 MG/ML (1)	IV	PA; SP
PRALATREXATE	VIAL (ML)	40 MG/2 ML	IV	PA; SP
PURIXAN	SUSPENSION; ORAL (FINAL DOSE FORM)	20 MG/ML	ORAL	PA; SP
HORMONES				
megestrol acetate	suspension; oral (final dose form)	400 mg/10 ml	ORAL	
megestrol acetate	*suspension; oral (final dose form)*	*625 mg/5 ml*	ORAL	
MEGESTROL ACETATE	TABLET	20 MG	ORAL	
MEGESTROL ACETATE	TABLET	40 MG	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
IMMUNOSUPPRESSANT DRUGS				
AZATHIOPRINE	TABLET	50 MG	ORAL	SP
AZATHIOPRINE	TABLET	75 MG	ORAL	SP
AZATHIOPRINE	TABLET	100 MG	ORAL	SP
CYCLOSPORINE	CAPSULE	25 MG	ORAL	SP
CYCLOSPORINE	CAPSULE	50 MG	ORAL	SP
CYCLOSPORINE	CAPSULE	100 MG	ORAL	SP
CYCLOSPORINE	SOLUTION; ORAL	100 MG/ML	ORAL	SP
ENSPRYNG	SYRINGE (ML)	120 MG/ML	SC	PA; SP
EVEROLIMUS	TABLET	0.25 MG	ORAL	PA; SP
EVEROLIMUS	TABLET	0.5 MG	ORAL	PA; SP
EVEROLIMUS	TABLET	0.75 MG	ORAL	PA; SP
EVEROLIMUS	TABLET	1 MG	ORAL	PA; SP
GENGRAF	CAPSULE	25 MG	ORAL	SP
GENGRAF	CAPSULE	100 MG	ORAL	SP
GENGRAF	SOLUTION; ORAL	100 MG/ML	ORAL	SP
LUPKINIS	CAPSULE	7.9 MG	ORAL	PA; QL; SP
MYCOPHENOLATE MOFETIL	CAPSULE	250 MG	ORAL	SP
MYCOPHENOLATE MOFETIL	SUSPENSION; RECONSTITUTED; ORAL (ML)	200 MG/ML	ORAL	SP
MYCOPHENOLATE MOFETIL	TABLET	500 MG	ORAL	SP
MYCOPHENOLIC ACID	TABLET; ENTERIC COATED	180 MG	ORAL	SP
MYCOPHENOLIC ACID	TABLET; ENTERIC COATED	360 MG	ORAL	SP
PROGRAF	GRANULES IN PACKET (EA)	0.2 MG	ORAL	SP
PROGRAF	GRANULES IN PACKET (EA)	1 MG	ORAL	SP
SANDIMMUNE	SOLUTION; ORAL	100 MG/ML	ORAL	SP
SIROLIMUS	SOLUTION; ORAL	1 MG/ML	ORAL	SP
SIROLIMUS	TABLET	0.5 MG	ORAL	SP
SIROLIMUS	TABLET	1 MG	ORAL	SP
SIROLIMUS	TABLET	2 MG	ORAL	SP
TACROLIMUS	CAPSULE	0.5 MG	ORAL	SP
TACROLIMUS	CAPSULE	1 MG	ORAL	SP
TACROLIMUS	CAPSULE	5 MG	ORAL	SP
MISC ANTINEOPLASTIC DRUGS				
ALECENSA	CAPSULE	150 MG	ORAL	PA; SP
ALUNBRIG	TABLET	30 MG	ORAL	PA; SP

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ALUNBRIG	TABLET	90 MG	ORAL	PA; SP
ALUNBRIG	TABLET	180 MG	ORAL	PA; SP
ALUNBRIG	TABLET; DOSE PACK	90 MG-180 MG	ORAL	PA; SP
arsenic trioxide	vial (ml)	10 mg/10 ml	IV	PA
arsenic trioxide	vial (ml)	12 mg/6 ml	IV	PA
BALVERSA	TABLET	3 MG	ORAL	LA; PA; SP
BALVERSA	TABLET	4 MG	ORAL	LA; PA; SP
BALVERSA	TABLET	5 MG	ORAL	LA; PA; SP
BEXAROTENE	CAPSULE	75 MG	ORAL	PA; SP
BEXAROTENE	GEL (GRAM)	1%	TOPICAL	PA; SP
BOSULIF	TABLET	100 MG	ORAL	PA; SP
BOSULIF	TABLET	400 MG	ORAL	PA; SP
BOSULIF	TABLET	500 MG	ORAL	PA; SP
BRUKINSA	CAPSULE	80 MG	ORAL	LA; PA; SP
CABOMETYX	TABLET	20 MG	ORAL	LA; PA; SP
CABOMETYX	TABLET	40 MG	ORAL	LA; PA; SP
CABOMETYX	TABLET	60 MG	ORAL	LA; PA; SP
CALQUENCE	TABLET	100 MG	ORAL	LA; PA; SP
CAPRELSA	TABLET	100 MG	ORAL	LA; PA; SP
CAPRELSA	TABLET	300 MG	ORAL	LA; PA; SP
cladribine	vial (ml)	10 mg/10 ml	IV	PA
COMETRIQ	CAPSULE	60 MG/DAY	ORAL	PA; SP
COMETRIQ	CAPSULE	100 MG/DAY	ORAL	PA; SP
COMETRIQ	CAPSULE	140 MG/DAY	ORAL	PA; SP
COTELLIC	TABLET	20 MG	ORAL	LA; PA; SP
dactinomycin	vial (ea)	0.5 mg	IV	
doxorubicin hcl	vial (ea)	10 mg	IV	
doxorubicin hcl	vial (ea)	50 mg	IV	
doxorubicin hcl	vial (ml)	2 mg/ml	IV	
doxorubicin hcl	vial (ml)	10 mg/5 ml	IV	PA
doxorubicin hcl	vial (ml)	20 mg/10 ml	IV	
doxorubicin hcl	vial (ml)	50 mg/25 ml	IV	
DROXIA	CAPSULE	200 MG	ORAL	
DROXIA	CAPSULE	300 MG	ORAL	
DROXIA	CAPSULE	400 MG	ORAL	
EMCYT	CAPSULE	140 MG	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ERIBULIN MESYLATE	VIAL (ML)	1 MG/2 ML	IV	PA; SP
ERIVEDGE	CAPSULE	150 MG	ORAL	PA; SP
ERLOTINIB HCL	TABLET	25 MG	ORAL	PA; SP
ERLOTINIB HCL	TABLET	100 MG	ORAL	PA; SP
ERLOTINIB HCL	TABLET	150 MG	ORAL	PA; SP
ETOPOSIDE	CAPSULE	50 MG	ORAL	
EVEROLIMUS	TABLET	2.5 MG	ORAL	PA; SP
EVEROLIMUS	TABLET	5 MG	ORAL	PA; SP
EVEROLIMUS	TABLET	7.5 MG	ORAL	PA; SP
EVEROLIMUS	TABLET	10 MG	ORAL	PA; SP
EVEROLIMUS	TABLET FOR SUSPENSION	2 MG	ORAL	PA; SP
EVEROLIMUS	TABLET FOR SUSPENSION	3 MG	ORAL	PA; SP
EVEROLIMUS	TABLET FOR SUSPENSION	5 MG	ORAL	PA; SP
EXKIVITY	CAPSULE	40 MG	ORAL	PA; SP
GAVRETO	CAPSULE	100 MG	ORAL	LA; PA; SP
GEFITINIB	TABLET	250 MG	ORAL	PA; SP
GILOTRIF	TABLET	20 MG	ORAL	PA; SP
GILOTRIF	TABLET	30 MG	ORAL	PA; SP
GILOTRIF	TABLET	40 MG	ORAL	PA; SP
HYCAMTIN	CAPSULE	0.25 MG	ORAL	PA; SP
HYCAMTIN	CAPSULE	1 MG	ORAL	PA; SP
HYDROXYUREA	CAPSULE	500 MG	ORAL	
ICLUSIG	TABLET	10 MG	ORAL	PA; SP
ICLUSIG	TABLET	15 MG	ORAL	PA; SP
ICLUSIG	TABLET	30 MG	ORAL	PA; SP
ICLUSIG	TABLET	45 MG	ORAL	PA; SP
idarubicin hcl	vial (ml)	1 mg/ml	ORAL	
IDHIFA	TABLET	50 MG	ORAL	LA; PA; SP
IDHIFA	TABLET	100 MG	ORAL	LA; PA; SP
IMATINIB MESYLATE	TABLET	100 MG	ORAL	PA; SP
IMATINIB MESYLATE	TABLET	400 MG	ORAL	PA; SP
IMBRUVICA	CAPSULE	70 MG	ORAL	SP; ST
IMBRUVICA	CAPSULE	140 MG	ORAL	SP; ST
IMBRUVICA	SUSPENSION; ORAL (FINAL DOSE FORM)	70 MG/ML	ORAL	SP; ST
IMBRUVICA	TABLET	140 MG	ORAL	SP; ST
IMBRUVICA	TABLET	280 MG	ORAL	SP; ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
IMBRUVICA	TABLET	420 MG	ORAL	SP; ST
INLYTA	TABLET	1 MG	ORAL	PA; SP
INLYTA	TABLET	5 MG	ORAL	PA; SP
irinotecan hcl	vial (ml)	40 mg/2 ml	IV	
irinotecan hcl	vial (ml)	100 mg/5 ml	IV	
irinotecan hcl	vial (ml)	300 mg/15 ml	IV	
irinotecan hcl	vial (ml)	500 mg/25 ml	IV	
JAKAFI	TABLET	5 MG	ORAL	SP; ST
JAKAFI	TABLET	10 MG	ORAL	SP; ST
JAKAFI	TABLET	15 MG	ORAL	SP; ST
JAKAFI	TABLET	20 MG	ORAL	SP; ST
JAKAFI	TABLET	25 MG	ORAL	SP; ST
KISQALI	TABLET	200 MG/DAY	ORAL	PA; SP
KISQALI	TABLET	400 MG/DAY	ORAL	PA; SP
KISQALI	TABLET	600 MG/DAY	ORAL	PA; SP
KISQALI FEMARA CO-PACK	TABLET	200-2.5 MG	ORAL	PA; SP
KISQALI FEMARA CO-PACK	TABLET	400-2.5 MG	ORAL	PA; SP
KISQALI FEMARA CO-PACK	TABLET	600-2.5 MG	ORAL	PA; SP
LAPATINIB	TABLET	250 MG	ORAL	PA; SP
LENALIDOMIDE	CAPSULE	2.5 MG	ORAL	PA; SP
LENALIDOMIDE	CAPSULE	5 MG	ORAL	PA; SP
LENALIDOMIDE	CAPSULE	10 MG	ORAL	PA; SP
LENALIDOMIDE	CAPSULE	15 MG	ORAL	PA; SP
LENALIDOMIDE	CAPSULE	20 MG	ORAL	PA; SP
LENALIDOMIDE	CAPSULE	25 MG	ORAL	PA; SP
LENVIMA	CAPSULE	4 MG	ORAL	PA; SP
LENVIMA	CAPSULE	8 MG/DAY	ORAL	PA; SP
LENVIMA	CAPSULE	10 MG/DAY	ORAL	PA; SP
LENVIMA	CAPSULE	12 MG/DAY	ORAL	PA; SP
LENVIMA	CAPSULE	14 MG/DAY	ORAL	PA; SP
LENVIMA	CAPSULE	18 MG/DAY	ORAL	PA; SP
LENVIMA	CAPSULE	20 MG/DAY	ORAL	PA; SP
LENVIMA	CAPSULE	24 MG/DAY	ORAL	PA; SP
LEUPROLIDE ACETATE	KIT	1 MG/0.2 ML	SC	PA; SP
LONSURF	TABLET	15-6.14 MG	ORAL	PA; SP
LONSURF	TABLET	20-8.19 MG	ORAL	PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
LORBRENA	TABLET	25 MG	ORAL	PA; SP
LORBRENA	TABLET	100 MG	ORAL	PA; SP
LYNPARZA	TABLET	100 MG	ORAL	PA; SP
LYNPARZA	TABLET	150 MG	ORAL	PA; SP
LYSODREN	TABLET	500 MG	ORAL	PA; SP
LYTGOBI	TABLET	12 MG/DAY	ORAL	LA; PA; SP
LYTGOBI	TABLET	16 MG/DAY	ORAL	LA; PA; SP
LYTGOBI	TABLET	20 MG/DAY	ORAL	LA; PA; SP
MATULANE	CAPSULE	50 MG	ORAL	PA; SP
MEKINIST	TABLET	0.5 MG	ORAL	PA; SP
MEKINIST	TABLET	2 MG	ORAL	PA; SP
mitomycin	vial (ea)	5 mg	IV	
mitomycin	vial (ea)	20 mg	IV	PA
mitomycin	vial (ea)	40 mg	IV	
NERLYNX	TABLET	40 MG	ORAL	LA; PA; SP
NINLARO	CAPSULE	2.3 MG	ORAL	PA; SP
NINLARO	CAPSULE	3 MG	ORAL	PA; SP
NINLARO	CAPSULE	4 MG	ORAL	PA; SP
OCTREOTIDE ACETATE	AMPUL (ML)	50 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	AMPUL (ML)	100 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	AMPUL (ML)	500 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	SYRINGE (ML)	50 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	SYRINGE (ML)	100 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	SYRINGE (ML)	500 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	VIAL (ML)	50 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	VIAL (ML)	100 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	VIAL (ML)	200 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	VIAL (ML)	500 MCG/ML	INJ	PA; SP
OCTREOTIDE ACETATE	VIAL (ML)	1000 MCG/ML	INJ	PA; SP
ODOMZO	CAPSULE	200 MG	ORAL	LA; PA; SP
PACLITAXEL PROTEIN-BOUND	VIAL (EA)	100 MG	IV	SP
PAZOPANIB HCL	TABLET	200 MG	ORAL	PA; SP
PEMAZYRE	TABLET	4.5 MG	ORAL	LA; PA; SP
PEMAZYRE	TABLET	9 MG	ORAL	LA; PA; SP
PEMAZYRE	TABLET	13.5 MG	ORAL	LA; PA; SP
PIQRAY	TABLET	200 MG/DAY	ORAL	PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
PIQRAY	TABLET	250 MG/DAY	ORAL	PA; SP
PIQRAY	TABLET	300 MG/DAY	ORAL	PA; SP
POMALYST	CAPSULE	1 MG	ORAL	LA; PA; SP
POMALYST	CAPSULE	2 MG	ORAL	LA; PA; SP
POMALYST	CAPSULE	3 MG	ORAL	LA; PA; SP
POMALYST	CAPSULE	4 MG	ORAL	LA; PA; SP
REVLIMID	CAPSULE	2.5 MG	ORAL	LA; PA; SP
REVLIMID	CAPSULE	5 MG	ORAL	LA; PA; SP
REVLIMID	CAPSULE	10 MG	ORAL	LA; PA; SP
REVLIMID	CAPSULE	15 MG	ORAL	LA; PA; SP
REVLIMID	CAPSULE	20 MG	ORAL	LA; PA; SP
REVLIMID	CAPSULE	25 MG	ORAL	LA; PA; SP
ROZLYTREK	CAPSULE	100 MG	ORAL	LA; PA; SP
ROZLYTREK	CAPSULE	200 MG	ORAL	LA; PA; SP
ROZLYTREK	PELLETS IN PACKET (EA)	50 MG	ORAL	LA; PA; SP
RYDAPT	CAPSULE	25 MG	ORAL	PA; SP
SCEMBLIX	TABLET	20 MG	ORAL	PA; SP
SCEMBLIX	TABLET	40 MG	ORAL	PA; SP
SIGNIFOR	AMPUL (ML)	0.3 MG/ML	SC	PA; SP
SIGNIFOR	AMPUL (ML)	0.6 MG/ML	SC	PA; SP
SIGNIFOR	AMPUL (ML)	0.9 MG/ML	SC	PA; SP
SORAFENIB	TABLET	200 MG	ORAL	PA; SP
SPRYCEL	TABLET	20 MG	ORAL	PA; SP
SPRYCEL	TABLET	50 MG	ORAL	PA; SP
SPRYCEL	TABLET	70 MG	ORAL	PA; SP
SPRYCEL	TABLET	80 MG	ORAL	PA; SP
SPRYCEL	TABLET	100 MG	ORAL	PA; SP
SPRYCEL	TABLET	140 MG	ORAL	PA; SP
STIVARGA	TABLET	40 MG	ORAL	PA; SP
SUNITINIB MALATE	CAPSULE	12.5 MG	ORAL	PA; SP
SUNITINIB MALATE	CAPSULE	25 MG	ORAL	PA; SP
SUNITINIB MALATE	CAPSULE	37.5 MG	ORAL	PA; SP
SUNITINIB MALATE	CAPSULE	50 MG	ORAL	PA; SP
TABRECTA	TABLET	150 MG	ORAL	PA; SP
TABRECTA	TABLET	200 MG	ORAL	PA; SP
TAFINLAR	CAPSULE	50 MG	ORAL	PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
TAFINLAR	CAPSULE	75 MG	ORAL	PA; SP
TAGRISSO	TABLET	40 MG	ORAL	LA; PA; SP
TAGRISSO	TABLET	80 MG	ORAL	LA; PA; SP
TALZENNA	CAPSULE	0.1 MG	ORAL	PA; SP
TALZENNA	CAPSULE	0.25 MG	ORAL	PA; SP
TALZENNA	CAPSULE	0.35 MG	ORAL	PA; SP
TALZENNA	CAPSULE	0.5 MG	ORAL	PA; SP
TALZENNA	CAPSULE	0.75 MG	ORAL	PA; SP
TALZENNA	CAPSULE	1 MG	ORAL	PA; SP
TASIGNA	CAPSULE	50 MG	ORAL	PA; SP
TASIGNA	CAPSULE	150 MG	ORAL	PA; SP
TASIGNA	CAPSULE	200 MG	ORAL	PA; SP
TEMSIROLIMUS	VIAL (ML)	FDN 30 MG/3	IV	PA; SP
THALOMID	CAPSULE	50 MG	ORAL	PA; SP
THALOMID	CAPSULE	100 MG	ORAL	PA; SP
THALOMID	CAPSULE	150 MG	ORAL	PA; SP
THALOMID	CAPSULE	200 MG	ORAL	PA; SP
TIBSOVO	TABLET	250 MG	ORAL	PA; SP
TOPOTECAN HCL	VIAL (EA)	4 MG	IV	PA; SP
TOPOTECAN HCL	VIAL (ML)	4 MG/4 ML	IV	PA; SP
TRETINOIN	CAPSULE	10 MG	ORAL	PA
VENCLEXTA	TABLET	10 MG	ORAL	LA; PA; SP
VENCLEXTA	TABLET	50 MG	ORAL	LA; PA; SP
VENCLEXTA	TABLET	100 MG	ORAL	LA; PA; SP
VENCLEXTA STARTING PACK	TABLET; DOSE PACK	10-50-100	ORAL	PA; SP
VERZENIO	TABLET	50 MG	ORAL	LA; PA; SP
VERZENIO	TABLET	100 MG	ORAL	LA; PA; SP
VERZENIO	TABLET	150 MG	ORAL	LA; PA; SP
VERZENIO	TABLET	200 MG	ORAL	LA; PA; SP
VIJOICE	TABLET	50 MG	ORAL	PA; QL; SP
VIJOICE	TABLET	125 MG	ORAL	PA; QL; SP
VIJOICE	TABLET	250 MG/DAY	ORAL	PA; QL; SP
vinorelbine tartrate	vial (ml)	10 mg/ml	IV	
vinorelbine tartrate	vial (ml)	50 mg/5 ml	IV	
VITRAKVI	CAPSULE	25 MG	ORAL	LA; PA; SP
VITRAKVI	CAPSULE	100 MG	ORAL	LA; PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
VITRAKVI	SOLUTION; ORAL	20 MG/ML	ORAL	LA; PA; SP
VIZIMPRO	TABLET	15 MG	ORAL	PA; SP
VIZIMPRO	TABLET	30 MG	ORAL	PA; SP
VIZIMPRO	TABLET	45 MG	ORAL	PA; SP
XALKORI	CAPSULE	200 MG	ORAL	PA; SP
XALKORI	CAPSULE	250 MG	ORAL	PA; SP
XALKORI	PELLETS IN DISPENSING CAPSULE	20 MG	ORAL	PA; SP
XALKORI	PELLETS IN DISPENSING CAPSULE	50 MG	ORAL	PA; SP
XALKORI	PELLETS IN DISPENSING CAPSULE	150 MG	ORAL	PA; SP
XERMELO	TABLET	250 MG	ORAL	LA; PA; SP
XOSPATA	TABLET	40 MG	ORAL	LA; PA; SP
ZELBORAF	TABLET	240 MG	ORAL	PA; SP
ZEVALIN	KIT	3.2 MG/2 ML	IV	PA
ZOLINZA	CAPSULE	100 MG	ORAL	PA; SP
ZYDELIG	TABLET	100 MG	ORAL	PA; SP
ZYDELIG	TABLET	150 MG	ORAL	PA; SP
ZYKADIA	TABLET	150 MG	ORAL	PA; SP
AUTONOMIC & CNS DRUGS, NEUROLOGY & PSYCH				
ANTICONVULSANTS				
carbamazepine	suspension; oral (final dose form)	100 mg/5 ml	ORAL	
carbamazepine	*tablet*	*200 mg*	ORAL	
carbamazepine	*tablet; chewable*	*100 mg*	ORAL	
carbamazepine er	capsule; extended release multiphase 12hr	100 mg	ORAL	
carbamazepine er	capsule; extended release multiphase 12hr	200 mg	ORAL	
carbamazepine er	capsule; extended release multiphase 12hr	300 mg	ORAL	
carbamazepine er	*tablet; extended release 12 hr*	*100 mg*	ORAL	
carbamazepine er	tablet; extended release 12 hr	200 mg	ORAL	
carbamazepine er	tablet; extended release 12 hr	400 mg	ORAL	
clobazam	suspension; oral (final dose form)	2.5 mg/ml	ORAL	PA
clobazam	tablet	10 mg	ORAL	PA
clobazam	tablet	20 mg	ORAL	PA
clonazepam	*tablet*	*0.5 mg*	ORAL	
clonazepam	*tablet*	*1 mg*	ORAL	
clonazepam	*tablet*	*2 mg*	ORAL	
clonazepam	*tablet; disintegrating*	*0.125 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
clonazepam	*tablet; disintegrating*	*0.25 mg*	ORAL	
clonazepam	*tablet; disintegrating*	*0.5 mg*	ORAL	
clonazepam	*tablet; disintegrating*	*1 mg*	ORAL	
clonazepam	*tablet; disintegrating*	*2 mg*	ORAL	
DIACOMIT	CAPSULE	250 MG	ORAL	PA; SP
DIACOMIT	CAPSULE	500 MG	ORAL	PA; SP
DIACOMIT	POWDER IN PACKET (EA)	250 MG	ORAL	PA; SP
DIACOMIT	POWDER IN PACKET (EA)	500 MG	ORAL	PA; SP
diazepam	*kit*	*2.5 mg*	RECTAL	
diazepam	kit	5-7.5-10 mg	RECTAL	
diazepam	kit	12.5-15-20	RECTAL	
DILANTIN	CAPSULE	30 MG	ORAL	
divalproex sodium	capsule; delayed release sprinkle	125 mg	ORAL	
divalproex sodium	*tablet; enteric coated*	*125 mg*	ORAL	
divalproex sodium	*tablet; enteric coated*	*250 mg*	ORAL	
divalproex sodium	*tablet; enteric coated*	*500 mg*	ORAL	
divalproex sodium er	*tablet; extended release 24 hr*	*250 mg*	ORAL	
divalproex sodium er	*tablet; extended release 24 hr*	*500 mg*	ORAL	
EPIDIOLEX	SOLUTION; ORAL	100 MG/ML	ORAL	LA; PA; SP
epitol	tablet	200 mg	ORAL	
ethosuximide	capsule	250 mg	ORAL	
ethosuximide	solution; oral	250 mg/5 ml	ORAL	
felbamate	suspension; oral (final dose form)	600 mg/5 ml	ORAL	
felbamate	tablet	400 mg	ORAL	
felbamate	tablet	600 mg	ORAL	
FYCOMPA	SUSPENSION; ORAL (FINAL DOSE FORM)	0.5 MG/ML	ORAL	
FYCOMPA	TABLET	2 MG	ORAL	
FYCOMPA	TABLET	4 MG	ORAL	
FYCOMPA	TABLET	6 MG	ORAL	
FYCOMPA	TABLET	8 MG	ORAL	
FYCOMPA	TABLET	10 MG	ORAL	
FYCOMPA	TABLET	12 MG	ORAL	
gabapentin	*capsule*	*100 mg*	ORAL	
gabapentin	*capsule*	*300 mg*	ORAL	
gabapentin	*capsule*	*400 mg*	ORAL	
gabapentin	*solution; oral*	*250 mg/5 ml*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
gabapentin	*solution; oral*	*300 mg/6 ml*	ORAL	
gabapentin	*tablet*	*600 mg*	ORAL	
gabapentin	*tablet*	*800 mg*	ORAL	
gabapentin er	tablet; extended release 24 hr	300 mg	ORAL	ST
gabapentin er	tablet; extended release 24 hr	600 mg	ORAL	ST
lacosamide	solution; oral	10 mg/ml	ORAL	
lacosamide	tablet	50 mg	ORAL	
lacosamide	tablet	100 mg	ORAL	
lacosamide	tablet	150 mg	ORAL	
lacosamide	tablet	200 mg	ORAL	
lamotrigine	*tablet*	*25 mg*	ORAL	
lamotrigine	*tablet*	*100 mg*	ORAL	
lamotrigine	*tablet*	*150 mg*	ORAL	
lamotrigine	*tablet*	*200 mg*	ORAL	
lamotrigine	tablet; chewable dispersible	5 mg	ORAL	
lamotrigine	tablet; chewable dispersible	25 mg	ORAL	
lamotrigine	tablet; extended release 24 hr	25 mg	ORAL	
lamotrigine	tablet; extended release 24 hr	50 mg	ORAL	
lamotrigine	tablet; extended release 24 hr	100 mg	ORAL	
lamotrigine	tablet; extended release 24 hr	200 mg	ORAL	
lamotrigine	tablet; extended release 24 hr	250 mg	ORAL	
lamotrigine	tablet; extended release 24 hr	300 mg	ORAL	
lamotrigine (blue)	tablet; dose pack	25 mg (35)	ORAL	
lamotrigine (green)	tablet; dose pack	25 (84)-100	ORAL	
lamotrigine (orange)	tablet; dose pack	25 (42)-100	ORAL	
lamotrigine odt	tablet; disintegrating	25 mg	ORAL	
lamotrigine odt	tablet; disintegrating	50 mg	ORAL	
lamotrigine odt	tablet; disintegrating	100 mg	ORAL	
lamotrigine odt	tablet; disintegrating	200 mg	ORAL	
lamotrigine odt	tablet; disintegrating; dose pack	25 (21)-50	ORAL	
lamotrigine odt	tablet; disintegrating; dose pack	25-50-100	ORAL	
lamotrigine odt	tablet; disintegrating; dose pack	50 (42)-100	ORAL	
levetiracetam	*solution; oral*	*100 mg/ml*	ORAL	
levetiracetam	*solution; oral*	*500 mg/5 ml*	ORAL	
levetiracetam	*tablet*	*250 mg*	ORAL	
levetiracetam	*tablet*	*500 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
levetiracetam	*tablet*	*750 mg*	ORAL	
levetiracetam	*tablet*	*1000 mg*	ORAL	
levetiracetam	*tablet; extended release 24 hr*	*500 mg*	ORAL	
levetiracetam	*tablet; extended release 24 hr*	*750 mg*	ORAL	
methsuximide	capsule	300 mg	ORAL	
NAYZILAM	SPRAY; NON-AEROSOL (EA)	5 MG/SPRAY	NASAL	PA
oxcarbazepine	suspension; oral (final dose form)	300 mg/5 ml	ORAL	
oxcarbazepine	*tablet*	*150 mg*	ORAL	
oxcarbazepine	*tablet*	*300 mg*	ORAL	
oxcarbazepine	*tablet*	*600 mg*	ORAL	
phenobarbital	*elixir*	*20 mg/5 ml*	ORAL	
phenobarbital	*tablet*	*15 mg*	ORAL	
phenobarbital	*tablet*	*16.2 mg*	ORAL	
phenobarbital	*tablet*	*30 mg*	ORAL	
phenobarbital	*tablet*	*32.4 mg*	ORAL	
phenobarbital	*tablet*	*60 mg*	ORAL	
phenobarbital	*tablet*	*64.8 mg*	ORAL	
phenobarbital	*tablet*	*97.2 mg*	ORAL	
phenobarbital	*tablet*	*100 mg*	ORAL	
phenytoin	*suspension; oral (final dose form)*	*125 mg/5 ml*	ORAL	
phenytoin	*tablet; chewable*	*50 mg*	ORAL	
phenytoin sodium	*capsule*	*100 mg*	ORAL	
phenytoin sodium	*capsule*	*200 mg*	ORAL	
phenytoin sodium	*capsule*	*300 mg*	ORAL	
pregabalin	*capsule*	*25 mg*	ORAL	
pregabalin	*capsule*	*50 mg*	ORAL	
pregabalin	*capsule*	*75 mg*	ORAL	
pregabalin	*capsule*	*100 mg*	ORAL	
pregabalin	*capsule*	*150 mg*	ORAL	
pregabalin	*capsule*	*200 mg*	ORAL	
pregabalin	*capsule*	*225 mg*	ORAL	
pregabalin	*capsule*	*300 mg*	ORAL	
pregabalin	*solution; oral*	*20 mg/ml*	ORAL	
pregabalin er	*tablet; extended release 24 hr*	*82.5 mg*	ORAL	ST
pregabalin er	*tablet; extended release 24 hr*	*165 mg*	ORAL	ST
pregabalin er	*tablet; extended release 24 hr*	*330 mg*	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
primidone	*tablet*	*50 mg*	ORAL	
primidone	*tablet*	*250 mg*	ORAL	
roweepra	*tablet*	*500 mg*	ORAL	
rufinamide	suspension; oral (final dose form)	40 mg/ml	ORAL	PA
rufinamide	tablet	200 mg	ORAL	PA
rufinamide	tablet	400 mg	ORAL	PA
subvenite	tablet	25 mg	ORAL	
subvenite	tablet	100 mg	ORAL	
subvenite	tablet	150 mg	ORAL	
subvenite	tablet	200 mg	ORAL	
subvenite	tablet; dose pack	25 mg (35)	ORAL	
subvenite	tablet; dose pack	25 (42)-100	ORAL	
subvenite	tablet; dose pack	25 (84)-100	ORAL	
tiagabine hcl	tablet	2 mg	ORAL	
tiagabine hcl	tablet	4 mg	ORAL	
tiagabine hcl	tablet	12 mg	ORAL	
tiagabine hcl	tablet	16 mg	ORAL	
topiramate	*capsule; sprinkle*	*15 mg*	ORAL	
topiramate	*capsule; sprinkle*	*25 mg*	ORAL	
topiramate	*tablet*	*25 mg*	ORAL	
topiramate	*tablet*	*50 mg*	ORAL	
topiramate	*tablet*	*100 mg*	ORAL	
topiramate	*tablet*	*200 mg*	ORAL	
topiramate er	capsule; ext release 24 hr	25 mg	ORAL	ST
topiramate er	capsule; ext release 24 hr	50 mg	ORAL	ST
topiramate er	capsule; ext release 24 hr	100 mg	ORAL	ST
topiramate er	capsule; ext release 24 hr	200 mg	ORAL	ST
topiramate er	capsule sprinkle; extended release 24 hr	25 mg	ORAL	ST
topiramate er	capsule sprinkle; extended release 24 hr	50 mg	ORAL	ST
topiramate er	capsule sprinkle; extended release 24 hr	100 mg	ORAL	ST
topiramate er	capsule sprinkle; extended release 24 hr	150 mg	ORAL	ST
topiramate er	capsule sprinkle; extended release 24 hr	200 mg	ORAL	ST
valproic acid	*capsule*	*250 mg*	ORAL	
valproic acid	*solution; oral*	*250 mg/5 ml*	ORAL	
valproic acid	*solution; oral*	*500 mg/10 ml*	ORAL	
VIGABATRIN	POWDER IN PACKET (EA)	500 MG	ORAL	LA; PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
VIGABATRIN	TABLET	500 MG	ORAL	LA; PA; SP
VIGADRONE	POWDER IN PACKET (EA)	500 MG	ORAL	PA; SP
VIGADRONE	TABLET	500 MG	ORAL	PA; SP
VIGPODER	POWDER IN PACKET (EA)	500 MG	ORAL	PA; SP
zonisamide	*capsule*	*25 mg*	ORAL	
zonisamide	*capsule*	*50 mg*	ORAL	
zonisamide	*capsule*	*100 mg*	ORAL	
ANTIPARKINSONISM AGENTS				
APOMORPHINE HCL	CARTRIDGE (ML)	10 MG/ML	SC	PA; SP
benztropine mesylate	*tablet*	*0.5 mg*	ORAL	
benztropine mesylate	*tablet*	*1 mg*	ORAL	
benztropine mesylate	*tablet*	*2 mg*	ORAL	
bromocriptine mesylate	capsule	5 mg	ORAL	
bromocriptine mesylate	tablet	2.5 mg	ORAL	
carbidopa	*tablet*	*25 mg*	ORAL	PA
carbidopa/levodopa	*tablet*	*10 mg-100 mg*	ORAL	
carbidopa/levodopa	*tablet*	*25 mg-100 mg*	ORAL	
carbidopa/levodopa	*tablet*	*25 mg-250 mg*	ORAL	
carbidopa/levodopa	tablet; disintegrating	10 mg-100 mg	ORAL	
carbidopa/levodopa	tablet; disintegrating	25 mg-100 mg	ORAL	
carbidopa/levodopa	tablet; disintegrating	25 mg-250 mg	ORAL	
carbidopa-levodopa er	*tablet; extended release*	*25 mg-100 mg*	ORAL	
carbidopa-levodopa er	*tablet; extended release*	*50 mg-200 mg*	ORAL	
carbidopa-levodopa-entacapone	tablet	12.5-50 mg	ORAL	
carbidopa-levodopa-entacapone	tablet	18.75-75 mg	ORAL	
carbidopa-levodopa-entacapone	tablet	25-100-200	ORAL	
carbidopa-levodopa-entacapone	tablet	31.25-125	ORAL	
carbidopa-levodopa-entacapone	tablet	37.5-150 mg	ORAL	
carbidopa-levodopa-entacapone	tablet	50-200-200	ORAL	
entacapone	tablet	200 mg	ORAL	
INBRIJA	CAPSULE; WITH INHALATION DEVICE	42 MG	INH	PA; SP
pramipexole di-hcl	*tablet*	*0.125 mg*	ORAL	
pramipexole di-hcl	*tablet*	*0.25 mg*	ORAL	
pramipexole di-hcl	*tablet*	*0.5 mg*	ORAL	
pramipexole di-hcl	*tablet*	*0.75 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
pramipexole di-hcl	*tablet*	*1 mg*	ORAL	
pramipexole di-hcl	*tablet*	*1.5 mg*	ORAL	
pramipexole er	tablet; extended release 24 hr	0.375 mg	ORAL	
pramipexole er	tablet; extended release 24 hr	0.75 mg	ORAL	
pramipexole er	tablet; extended release 24 hr	1.5 mg	ORAL	
pramipexole er	tablet; extended release 24 hr	2.25 mg	ORAL	
pramipexole er	tablet; extended release 24 hr	3 mg	ORAL	
pramipexole er	tablet; extended release 24 hr	3.75 mg	ORAL	
pramipexole er	tablet; extended release 24 hr	4.5 mg	ORAL	
rasagiline mesylate	tablet	0.5 mg	ORAL	
rasagiline mesylate	tablet	1 mg	ORAL	
ropinirole hcl	*tablet*	*0.25 mg*	ORAL	
ropinirole hcl	*tablet*	*0.5 mg*	ORAL	
ropinirole hcl	*tablet*	*1 mg*	ORAL	
ropinirole hcl	*tablet*	*2 mg*	ORAL	
ropinirole hcl	*tablet*	*3 mg*	ORAL	
ropinirole hcl	*tablet*	*4 mg*	ORAL	
ropinirole hcl	*tablet*	*5 mg*	ORAL	
ropinirole hcl	*tablet; extended release 24 hr*	*2 mg*	ORAL	
ropinirole hcl	*tablet; extended release 24 hr*	*4 mg*	ORAL	
ropinirole hcl	*tablet; extended release 24 hr*	*6 mg*	ORAL	
ropinirole hcl	*tablet; extended release 24 hr*	*8 mg*	ORAL	
ropinirole hcl	*tablet; extended release 24 hr*	*12 mg*	ORAL	
selegiline hcl	*capsule*	*5 mg*	ORAL	
selegiline hcl	*tablet*	*5 mg*	ORAL	
tolcapone	tablet	100 mg	ORAL	PA
trihexyphenidyl hcl	*solution; oral*	*2 mg/5 ml*	ORAL	
trihexyphenidyl hcl	*tablet*	*2 mg*	ORAL	
trihexyphenidyl hcl	*tablet*	*5 mg*	ORAL	
ANXIOLYTICS				
alprazolam	*tablet*	*0.25 mg*	ORAL	
alprazolam	*tablet*	*0.5 mg*	ORAL	
alprazolam	*tablet*	*1 mg*	ORAL	
alprazolam	*tablet*	*2 mg*	ORAL	
alprazolam er	*tablet; extended release 24 hr*	*0.5 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
alprazolam er	*tablet; extended release 24 hr*	*1 mg*	ORAL	
alprazolam er	*tablet; extended release 24 hr*	*2 mg*	ORAL	
alprazolam er	*tablet; extended release 24 hr*	*3 mg*	ORAL	
alprazolam intensol	*concentrate; oral*	*1 mg/ml*	ORAL	
alprazolam odt	*tablet; disintegrating*	*0.25 mg*	ORAL	
alprazolam odt	*tablet; disintegrating*	*0.5 mg*	ORAL	
alprazolam odt	*tablet; disintegrating*	*1 mg*	ORAL	
alprazolam odt	*tablet; disintegrating*	*2 mg*	ORAL	
alprazolam xr	*tablet; extended release 24 hr*	*0.5 mg*	ORAL	
alprazolam xr	*tablet; extended release 24 hr*	*1 mg*	ORAL	
alprazolam xr	*tablet; extended release 24 hr*	*2 mg*	ORAL	
alprazolam xr	*tablet; extended release 24 hr*	*3 mg*	ORAL	
buspirone hcl	*tablet*	*5 mg*	ORAL	
buspirone hcl	*tablet*	*7.5 mg*	ORAL	
buspirone hcl	*tablet*	*10 mg*	ORAL	
buspirone hcl	*tablet*	*15 mg*	ORAL	
buspirone hcl	*tablet*	*30 mg*	ORAL	
chlordiazepoxide hcl	*capsule*	*5 mg*	ORAL	
chlordiazepoxide hcl	*capsule*	*10 mg*	ORAL	
chlordiazepoxide hcl	*capsule*	*25 mg*	ORAL	
clorazepate dipotassium	*tablet*	*3.75 mg*	ORAL	
clorazepate dipotassium	*tablet*	*7.5 mg*	ORAL	
clorazepate dipotassium	*tablet*	*15 mg*	ORAL	
diazepam	*concentrate; oral*	*5 mg/ml*	ORAL	
diazepam	*solution; oral*	*5 mg/5 ml*	ORAL	
diazepam	*tablet*	*2 mg*	ORAL	
diazepam	*tablet*	*5 mg*	ORAL	
diazepam	*tablet*	*10 mg*	ORAL	
lorazepam	*cartridge (ml)*	*2 mg/ml*	INJ	
lorazepam	*concentrate; oral*	*2 mg/ml*	ORAL	
lorazepam	*tablet*	*0.5 mg*	ORAL	
lorazepam	*tablet*	*1 mg*	ORAL	
lorazepam	*tablet*	*2 mg*	ORAL	
lorazepam intensol	*concentrate; oral*	*2 mg/ml*	ORAL	
midazolam hcl	*syrup*	*2 mg/ml*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
BUTYROPHENONES				
haloperidol	*tablet*	*0.5 mg*	ORAL	
haloperidol	*tablet*	*1 mg*	ORAL	
haloperidol	*tablet*	*2 mg*	ORAL	
haloperidol	*tablet*	*5 mg*	ORAL	
haloperidol	*tablet*	*10 mg*	ORAL	
haloperidol	*tablet*	*20 mg*	ORAL	
haloperidol lactate	*concentrate; oral*	*2 mg/ml*	ORAL	
COMBINATION NARCOTIC /ANALGESICS				
acetaminophen w/ butalbital	*tablet*	*50 mg-325 mg*	ORAL	
acetaminophen w/ codeine	*solution; oral*	*120-12 mg/5*	ORAL	
acetaminophen w/ codeine	*tablet*	*300 mg-15 mg*	ORAL	
acetaminophen w/ codeine	*tablet*	*300 mg-30 mg*	ORAL	
acetaminophen w/ codeine	*tablet*	*300 mg-60 mg*	ORAL	
apap-caffeine-dihydrocodeine	capsule	320.5-30 mg	ORAL	
asa-butalb-caff-cod	*capsule*	*30-50-325*	ORAL	
ascomp with codeine	*capsule*	*30-50-325*	ORAL	
butalbital compound	*capsule*	*50-325-40*	ORAL	
butalbital w/ acetaminophen	tablet	50 mg-300 mg	ORAL	
butalbital w/ acetaminophen	*tablet*	*50 mg-325 mg*	ORAL	
butalbital/apap/caffeine	*capsule*	*50-300-40*	ORAL	
butalbital/apap/caffeine	*capsule*	*50-325-40*	ORAL	
butalbital/apap/caffeine	*tablet*	*50-325-40*	ORAL	
butalbital/caff/apap/codeine	capsule	50-300-30	ORAL	
butalbital/caff/apap/codeine	*capsule*	*50-325-30*	ORAL	
butalbital-asp-caffeine	*capsule*	*50-325-40*	ORAL	
butalbital-asp-caffeine	tablet	50-325-40	ORAL	
endocet	*tablet*	*2.5-325 mg*	ORAL	
endocet	*tablet*	*5 mg-325 mg*	ORAL	
endocet	*tablet*	*7.5-325 mg*	ORAL	
endocet	*tablet*	*10 mg-325 mg*	ORAL	
hydrocodone bit-ibuprofen	*tablet*	*5 mg-200 mg*	ORAL	
hydrocodone bit-ibuprofen	*tablet*	*7.5-200 mg*	ORAL	
hydrocodone bit-ibuprofen	*tablet*	*10 mg-200 mg*	ORAL	
hydrocodone w/ acetaminophen	solution; oral	7.5-325/15	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
hydrocodone w/ acetaminophen	solution; oral	10-325/15	ORAL	
hydrocodone w/ acetaminophen	*tablet*	*5 mg-300 mg*	ORAL	
hydrocodone w/ acetaminophen	*tablet*	*5 mg-325 mg*	ORAL	
hydrocodone w/ acetaminophen	*tablet*	*7.5-300 mg*	ORAL	
hydrocodone w/ acetaminophen	*tablet*	*7.5-325 mg*	ORAL	
hydrocodone w/ acetaminophen	*tablet*	*10 mg-300 mg*	ORAL	
hydrocodone w/ acetaminophen	*tablet*	*10 mg-325 mg*	ORAL	
oxycodone w/ acetaminophen	*solution; oral*	*5-325/5 ml*	ORAL	
oxycodone w/ acetaminophen	solution; oral	10-300 mg/5	ORAL	
oxycodone w/ acetaminophen	tablet	2.5-300 mg	ORAL	
oxycodone w/ acetaminophen	*tablet*	*2.5-325 mg*	ORAL	
oxycodone w/ acetaminophen	tablet	5 mg-300 mg	ORAL	
oxycodone w/ acetaminophen	*tablet*	*5 mg-325 mg*	ORAL	
oxycodone w/ acetaminophen	tablet	7.5-300 mg	ORAL	
oxycodone w/ acetaminophen	*tablet*	*7.5-325 mg*	ORAL	
oxycodone w/ acetaminophen	tablet	10 mg-300 mg	ORAL	
oxycodone w/ acetaminophen	*tablet*	*10 mg-325 mg*	ORAL	
prolate	tablet	5 mg-300 mg	ORAL	
prolate	tablet	7.5-300 mg	ORAL	
prolate	tablet	10 mg-300 mg	ORAL	
tencon	tablet	50 mg-325 mg	ORAL	
HEADACHE THERAPY				
AIMOVIG AUTOINJECTOR	AUTO-INJECTOR (ML)	70 MG/ML	SC	PA; QL
AIMOVIG AUTOINJECTOR	AUTO-INJECTOR (ML)	140 MG/ML	SC	PA; QL
AJOVY	SYRINGE (ML)	225 MG/1.5	SC	PA; QL
AJOVY AUTOINJECTOR	AUTO-INJECTOR (ML)	225 MG/1.5	SC	PA; QL
almotriptan malate	tablet	6.25 mg	ORAL	QL
almotriptan malate	tablet	12.5 mg	ORAL	QL
dihydroergotamine mesylate	ampul (ml)	1 mg/ml	INJ	
eletriptan hbr	tablet	20 mg	ORAL	QL
eletriptan hbr	tablet	40 mg	ORAL	QL
EMGALITY	PEN INJECTOR (ML)	120 MG/ML	SC	PA; QL
EMGALITY SYRINGE	SYRINGE (ML)	120 MG/ML	SC	PA; QL
EMGALITY SYRINGE	SYRINGE (ML)	300 MG/3 ML	SC	PA; QL
ergotamine-caffeine	tablet	1 mg-100 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
frovatriptan succinate	tablet	2.5 mg	ORAL	QL
migergot	suppository; rectal	2-100 mg	RECTAL	
naratriptan hcl	*tablet*	*1 mg*	ORAL	QL
naratriptan hcl	*tablet*	*2.5 mg*	ORAL	QL
NURTEC ODT	TABLET; DISINTEGRATING	75 MG	ORAL	PA; QL
QULIPTA	TABLET	10 MG	ORAL	PA; QL
QULIPTA	TABLET	30 MG	ORAL	PA; QL
QULIPTA	TABLET	60 MG	ORAL	PA; QL
rizatriptan	*tablet*	*5 mg*	ORAL	QL
rizatriptan	*tablet*	*10 mg*	ORAL	QL
rizatriptan	*tablet; disintegrating*	*5 mg*	ORAL	QL
rizatriptan	*tablet; disintegrating*	*10 mg*	ORAL	QL
sumatriptan	spray; non-aerosol (ea)	5 mg	NASAL	QL
sumatriptan	spray; non-aerosol (ea)	20 mg	NASAL	QL
sumatriptan succinate	cartridge (ml)	4 mg/0.5 ml	SC	QL
sumatriptan succinate	cartridge (ml)	6 mg/0.5 ml	SC	QL
sumatriptan succinate	pen injector (ml)	4 mg/0.5 ml	SC	QL
sumatriptan succinate	pen injector (ml)	6 mg/0.5 ml	SC	QL
sumatriptan succinate	*tablet*	*25 mg*	ORAL	QL
sumatriptan succinate	*tablet*	*50 mg*	ORAL	QL
sumatriptan succinate	*tablet*	*100 mg*	ORAL	QL
sumatriptan succinate	*vial (ml)*	*6 mg/0.5 ml*	SC	QL
sumatriptan succ-naproxen sod	tablet	85 mg-500 mg	ORAL	QL; ST
UBRELVY	TABLET	50 MG	ORAL	PA; QL
UBRELVY	TABLET	100 MG	ORAL	PA; QL
zolmitriptan	spray; non-aerosol (ea)	5 mg	NASAL	QL; ST
zolmitriptan	*tablet*	*2.5 mg*	ORAL	QL
zolmitriptan	*tablet*	*5 mg*	ORAL	QL
zolmitriptan odt	tablet; disintegrating	2.5 mg	ORAL	QL
zolmitriptan odt	tablet; disintegrating	5 mg	ORAL	QL
ZOMIG	SPRAY; NON-AEROSOL (EA)	2.5 MG	NASAL	QL; ST
HYPNOTIC AGENTS				
doxepin hcl	tablet	3 mg	ORAL	PA; QL
doxepin hcl	tablet	6 mg	ORAL	PA; QL
estazolam	tablet	1 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
estazolam	tablet	2 mg	ORAL	
eszopiclone	*tablet*	*1 mg*	ORAL	QL
eszopiclone	*tablet*	*2 mg*	ORAL	QL
eszopiclone	*tablet*	*3 mg*	ORAL	QL
flurazepam	capsule	15 mg	ORAL	
flurazepam	capsule	30 mg	ORAL	
ramelteon	tablet	8 mg	ORAL	QL
triazolam	*tablet*	*0.125 mg*	ORAL	
triazolam	*tablet*	*0.25 mg*	ORAL	
zaleplon	*capsule*	*5 mg*	ORAL	QL
zaleplon	*capsule*	*10 mg*	ORAL	QL
zolpidem tartrate	*tablet*	*5 mg*	ORAL	QL
zolpidem tartrate	*tablet*	*10 mg*	ORAL	QL
zolpidem tartrate	tablet; sublingual	1.75 mg	SL	QL
zolpidem tartrate	tablet; sublingual	3.5 mg	SL	QL
zolpidem tartrate er	*tablet; extended release multiphase*	*6.25 mg*	ORAL	QL
zolpidem tartrate er	*tablet; extended release multiphase*	*12.5 mg*	ORAL	QL
MAO INHIBITORS				
phenelzine sulfate	*tablet*	*15 mg*	ORAL	
tranylcypromine sulfate	tablet	10 mg	ORAL	
MISC ANALGESICS				
butorphanol tartrate	*aerosol; spray (ml)*	*10 mg/ml*	NASAL	QL
butorphanol tartrate	*vial (ml)*	*1 mg/ml*	INJ	
butorphanol tartrate	*vial (ml)*	*2 mg/ml*	INJ	
tramadol hcl	*tablet*	*50 mg*	ORAL	QL
tramadol hcl er	*tablet; extended release 24 hr*	*100 mg*	ORAL	QL; ST
tramadol hcl er	*tablet; extended release 24 hr*	*200 mg*	ORAL	QL; ST
tramadol hcl er	*tablet; extended release 24 hr*	*300 mg*	ORAL	QL; ST
tramadol hcl er	*tablet; extended release multiphase 24 hr*	*100 mg*	ORAL	QL; ST
tramadol hcl er	*tablet; extended release multiphase 24 hr*	*200 mg*	ORAL	QL; ST
tramadol hcl er	*tablet; extended release multiphase 24 hr*	*300 mg*	ORAL	QL; ST
tramadol hcl-acetaminophen	*tablet*	*37.5-325 mg*	ORAL	QL
MISC ANTIDEPRESSANTS				
amitriptyline/chlordiazepoxide	tablet	12.5 mg-5 mg	ORAL	
amitriptyline/chlordiazepoxide	tablet	25 mg-10 mg	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
amitriptyline-perphenazine	tablet	2 mg-10 mg	ORAL	
amitriptyline-perphenazine	tablet	2 mg-25 mg	ORAL	
amitriptyline-perphenazine	tablet	4 mg-10 mg	ORAL	
amitriptyline-perphenazine	tablet	4 mg-25 mg	ORAL	
amitriptyline-perphenazine	tablet	4 mg-50 mg	ORAL	
bupropion hcl	*tablet*	*75 mg*	ORAL	
bupropion hcl	*tablet*	*100 mg*	ORAL	
bupropion sr	*tablet; sustained-release 12 hr*	*100 mg*	ORAL	
bupropion sr	*tablet; sustained-release 12 hr*	*150 mg*	ORAL	
bupropion sr	*tablet; sustained-release 12 hr*	*200 mg*	ORAL	
bupropion xl	*tablet; extended release 24 hr*	*150 mg*	ORAL	
bupropion xl	*tablet; extended release 24 hr*	*300 mg*	ORAL	
desvenlafaxine succinate er	*tablet; extended release 24 hr*	*25 mg*	ORAL	ST
desvenlafaxine succinate er	*tablet; extended release 24 hr*	*50 mg*	ORAL	ST
desvenlafaxine succinate er	*tablet; extended release 24 hr*	*100 mg*	ORAL	ST
duloxetine hcl	*capsule; delayed release (enteric coated)*	*20 mg*	ORAL	
duloxetine hcl	*capsule; delayed release (enteric coated)*	*30 mg*	ORAL	
duloxetine hcl	capsule; delayed release (enteric coated)	40 mg	ORAL	ST
duloxetine hcl	*capsule; delayed release (enteric coated)*	*60 mg*	ORAL	
FETZIMA	CAPSULE; EXTENDED RELEASE 24HR	20 MG	ORAL	ST
FETZIMA	CAPSULE; EXTENDED RELEASE 24HR	40 MG	ORAL	ST
FETZIMA	CAPSULE; EXTENDED RELEASE 24HR	80 MG	ORAL	ST
FETZIMA	CAPSULE; EXTENDED RELEASE 24HR	120 MG	ORAL	ST
FETZIMA	CAPSULE; EXTENDED RELEASE 24 HR DOSE PACK	20 MG-40 MG	ORAL	ST
mirtazapine	*tablet*	*7.5 mg*	ORAL	
mirtazapine	*tablet*	*15 mg*	ORAL	
mirtazapine	*tablet*	*30 mg*	ORAL	
mirtazapine	*tablet*	*45 mg*	ORAL	
mirtazapine	*tablet; disintegrating*	*15 mg*	ORAL	
mirtazapine	*tablet; disintegrating*	*30 mg*	ORAL	
mirtazapine	*tablet; disintegrating*	*45 mg*	ORAL	
trazodone hcl	*tablet*	*50 mg*	ORAL	
trazodone hcl	*tablet*	*100 mg*	ORAL	
trazodone hcl	*tablet*	*150 mg*	ORAL	
trazodone hcl	*tablet*	*300 mg*	ORAL	
venlafaxine hcl	*tablet*	*25 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
venlafaxine hcl	*tablet*	*37.5 mg*	ORAL	
venlafaxine hcl	*tablet*	*50 mg*	ORAL	
venlafaxine hcl	*tablet*	*75 mg*	ORAL	
venlafaxine hcl	*tablet*	*100 mg*	ORAL	
venlafaxine hcl er	*capsule; ext release 24 hr*	*37.5 mg*	ORAL	
venlafaxine hcl er	*capsule; ext release 24 hr*	*75 mg*	ORAL	
venlafaxine hcl er	*capsule; ext release 24 hr*	*150 mg*	ORAL	
venlafaxine hcl er	tablet; extended release 24 hr	37.5 mg	ORAL	ST
venlafaxine hcl er	tablet; extended release 24 hr	75 mg	ORAL	ST
venlafaxine hcl er	tablet; extended release 24 hr	150 mg	ORAL	ST
venlafaxine hcl er	tablet; extended release 24 hr	225 mg	ORAL	ST
ZURZUVAE	CAPSULE	20 MG	ORAL	PA; SP
ZURZUVAE	CAPSULE	25 MG	ORAL	PA; SP
ZURZUVAE	CAPSULE	30 MG	ORAL	PA; SP
MISC ANTIPSYCHOTICS				
ABILIFY ASIMTUFII	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	720 MG/2.4	IM	
ABILIFY ASIMTUFII	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	960 MG/3.2	IM	
aripiprazole	solution; oral	1 mg/ml	ORAL	
aripiprazole	*tablet*	*2 mg*	ORAL	
aripiprazole	*tablet*	*5 mg*	ORAL	
aripiprazole	*tablet*	*10 mg*	ORAL	
aripiprazole	*tablet*	*15 mg*	ORAL	
aripiprazole	*tablet*	*20 mg*	ORAL	
aripiprazole	*tablet*	*30 mg*	ORAL	
aripiprazole odt	*tablet; disintegrating*	*10 mg*	ORAL	
aripiprazole odt	*tablet; disintegrating*	*15 mg*	ORAL	
ARISTADA	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	441 MG/1.6	IM	PA
ARISTADA	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	662 MG/2.4	IM	PA
ARISTADA	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	882 MG/3.2	IM	PA
ARISTADA	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	1064 MG/3.9	IM	PA
asenapine maleate	tablet; sublingual	2.5 mg	SL	
asenapine maleate	tablet; sublingual	5 mg	SL	
asenapine maleate	tablet; sublingual	10 mg	SL	
clozapine	tablet	25 mg	ORAL	
clozapine	tablet	50 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
clozapine	tablet	100 mg	ORAL	
clozapine	tablet	200 mg	ORAL	
clozapine odt	tablet; disintegrating	12.5 mg	ORAL	
clozapine odt	tablet; disintegrating	25 mg	ORAL	
clozapine odt	tablet; disintegrating	100 mg	ORAL	
clozapine odt	tablet; disintegrating	150 mg	ORAL	
clozapine odt	tablet; disintegrating	200 mg	ORAL	
loxapine succinate	*capsule*	*5 mg*	ORAL	
loxapine succinate	*capsule*	*10 mg*	ORAL	
loxapine succinate	*capsule*	*25 mg*	ORAL	
loxapine succinate	*capsule*	*50 mg*	ORAL	
lurasidone hcl	tablet	20 mg	ORAL	
lurasidone hcl	tablet	40 mg	ORAL	
lurasidone hcl	tablet	60 mg	ORAL	
lurasidone hcl	tablet	80 mg	ORAL	
lurasidone hcl	tablet	120 mg	ORAL	
molindone hcl	tablet	5 mg	ORAL	
molindone hcl	tablet	10 mg	ORAL	
molindone hcl	tablet	25 mg	ORAL	
olanzapine	*tablet*	*2.5 mg*	ORAL	
olanzapine	*tablet*	*5 mg*	ORAL	
olanzapine	*tablet*	*7.5 mg*	ORAL	
olanzapine	*tablet*	*10 mg*	ORAL	
olanzapine	*tablet*	*15 mg*	ORAL	
olanzapine	*tablet*	*20 mg*	ORAL	
olanzapine odt	*tablet; disintegrating*	*5 mg*	ORAL	
olanzapine odt	*tablet; disintegrating*	*10 mg*	ORAL	
olanzapine odt	*tablet; disintegrating*	*15 mg*	ORAL	
olanzapine odt	*tablet; disintegrating*	*20 mg*	ORAL	
olanzapine-fluoxetine hcl	capsule	3 mg-25 mg	ORAL	
olanzapine-fluoxetine hcl	capsule	6 mg-25 mg	ORAL	
olanzapine-fluoxetine hcl	capsule	6 mg-50 mg	ORAL	
olanzapine-fluoxetine hcl	capsule	12 mg-25 mg	ORAL	
olanzapine-fluoxetine hcl	capsule	12 mg-50 mg	ORAL	
paliperidone er	tablet; extended release 24 hr	1.5 mg	ORAL	
paliperidone er	tablet; extended release 24 hr	3 mg	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
paliperidone er	tablet; extended release 24 hr	6 mg	ORAL	
paliperidone er	tablet; extended release 24 hr	9 mg	ORAL	
pimozide	*tablet*	*1 mg*	ORAL	
pimozide	*tablet*	*2 mg*	ORAL	
quetiapine fumarate	*tablet*	*25 mg*	ORAL	
quetiapine fumarate	*tablet*	*50 mg*	ORAL	
quetiapine fumarate	*tablet*	*100 mg*	ORAL	
quetiapine fumarate	*tablet*	*200 mg*	ORAL	
quetiapine fumarate	*tablet*	*300 mg*	ORAL	
quetiapine fumarate	*tablet*	*400 mg*	ORAL	
quetiapine fumarate er	*tablet; extended release 24 hr*	*50 mg*	ORAL	
quetiapine fumarate er	*tablet; extended release 24 hr*	*150 mg*	ORAL	
quetiapine fumarate er	*tablet; extended release 24 hr*	*200 mg*	ORAL	
quetiapine fumarate er	*tablet; extended release 24 hr*	*300 mg*	ORAL	
quetiapine fumarate er	*tablet; extended release 24 hr*	*400 mg*	ORAL	
risperidone	*solution; oral*	*1 mg/ml*	ORAL	
risperidone	*tablet*	*0.25 mg*	ORAL	
risperidone	*tablet*	*0.5 mg*	ORAL	
risperidone	*tablet*	*1 mg*	ORAL	
risperidone	*tablet*	*2 mg*	ORAL	
risperidone	*tablet*	*3 mg*	ORAL	
risperidone	*tablet*	*4 mg*	ORAL	
risperidone er	vial (ea)	12.5 mg/2 ml	IM	
risperidone er	vial (ea)	25 mg/2 ml	IM	
risperidone er	vial (ea)	37.5 mg/2 ml	IM	
risperidone er	vial (ea)	50 mg/2 ml	IM	
risperidone odt	tablet; disintegrating	0.25 mg	ORAL	
risperidone odt	tablet; disintegrating	0.5 mg	ORAL	
risperidone odt	tablet; disintegrating	1 mg	ORAL	
risperidone odt	tablet; disintegrating	2 mg	ORAL	
risperidone odt	tablet; disintegrating	3 mg	ORAL	
risperidone odt	tablet; disintegrating	4 mg	ORAL	
RYKINDO	VIAL (EA)	25 MG/2 ML	IM	
RYKINDO	VIAL (EA)	37.5 MG/2 ML	IM	
RYKINDO	VIAL (EA)	50 MG/2 ML	IM	
thiothixene	capsule	1 mg	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
thiothixene	capsule	2 mg	ORAL	
thiothixene	capsule	5 mg	ORAL	
thiothixene	capsule	10 mg	ORAL	
UZEDY	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	50 MG/0.14	SC	
UZEDY	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	75 MG/0.21	SC	
UZEDY	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	100 MG/0.28	SC	
UZEDY	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	125 MG/0.35	SC	
UZEDY	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	150 MG/0.42	SC	
UZEDY	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	200 MG/0.56	SC	
UZEDY	SUSPENSION; EXTENDED RELEASE SYRINGE (ML)	250 MG/0.7	SC	
ziprasidone hcl	*capsule*	*20 mg*	ORAL	
ziprasidone hcl	*capsule*	*40 mg*	ORAL	
ziprasidone hcl	*capsule*	*60 mg*	ORAL	
ziprasidone hcl	*capsule*	*80 mg*	ORAL	
MISC NEUROLOGICAL THERAPY				
AUSTEDO	TABLET	6 MG	ORAL	LA; PA; SP
AUSTEDO	TABLET	9 MG	ORAL	LA; PA; SP
AUSTEDO	TABLET	12 MG	ORAL	LA; PA; SP
AUSTEDO XR	TABLET; EXTENDED RELEASE 24 HR	6 MG	ORAL	PA; SP
AUSTEDO XR	TABLET; EXTENDED RELEASE 24 HR	12 MG	ORAL	PA; SP
AUSTEDO XR	TABLET; EXTENDED RELEASE 24 HR	24 MG	ORAL	PA; SP
AUSTEDO XR TITRATION KT (WK 1-4)	TABLET; EXTENDED RELEASE 24 HR DOSE PACK	6-12-24 MG	ORAL	PA; SP
DALFAMPRIDINE ER	TABLET; EXTENDED RELEASE 12 HR	10 MG	ORAL	PA; QL; SP
DICHLORPHENAMIDE	TABLET	50 MG	ORAL	PA; SP
donepezil hcl	*tablet*	*5 mg*	ORAL	
donepezil hcl	*tablet*	*10 mg*	ORAL	
donepezil hcl	*tablet*	*23 mg*	ORAL	ST
donepezil hcl	*tablet; disintegrating*	*5 mg*	ORAL	
donepezil hcl	*tablet; disintegrating*	*10 mg*	ORAL	
FIRDAPSE	TABLET	10 MG	ORAL	LA; PA; SP
galantamine	solution; oral	4 mg/ml	ORAL	
galantamine	tablet	4 mg	ORAL	
galantamine	tablet	8 mg	ORAL	
galantamine	tablet	12 mg	ORAL	
galantamine er	capsule; extended release pellets 24 hr	8 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
galantamine er	capsule; extended release pellets 24 hr	16 mg	ORAL	
galantamine er	capsule; extended release pellets 24 hr	24 mg	ORAL	
memantine hcl	*solution; oral*	*2 mg/ml*	ORAL	
memantine hcl	*tablet*	*5 mg*	ORAL	
memantine hcl	*tablet*	*10 mg*	ORAL	
memantine hcl er	*capsule sprinkle; extended release 24 hr*	*7 mg*	ORAL	
memantine hcl er	*capsule sprinkle; extended release 24 hr*	*14 mg*	ORAL	
memantine hcl er	*capsule sprinkle; extended release 24 hr*	*21 mg*	ORAL	
memantine hcl er	*capsule sprinkle; extended release 24 hr*	*28 mg*	ORAL	
NUEDEXTA	CAPSULE	20 MG-10 MG	ORAL	PA
ORMALVI	TABLET	50 MG	ORAL	PA; SP
rivastigmine	capsule	1.5 mg	ORAL	
rivastigmine	capsule	3 mg	ORAL	
rivastigmine	capsule	4.5 mg	ORAL	
rivastigmine	capsule	6 mg	ORAL	
rivastigmine	patch; transdermal 24 hours	4.6 mg/24 hr	TRANSDERM	
rivastigmine	patch; transdermal 24 hours	9.5 mg/24 hr	TRANSDERM	
rivastigmine	patch; transdermal 24 hours	13.3 mg/24 hr	TRANSDERM	
TETRABENAZINE	TABLET	12.5 MG	ORAL	PA; SP
TETRABENAZINE	TABLET	25 MG	ORAL	PA; SP
ZEPOSIA	CAPSULE	0.92 MG	ORAL	PA; QL; SP
ZEPOSIA	CAPSULE; DOSE PACK	0.23-0.46	ORAL	PA; QL; SP
ZEPOSIA	CAPSULE; DOSE PACK	0.46-0.92	ORAL	PA; QL; SP
MISC PSYCHOTHERAPEUTIC AGENTS				
amphetamine sulfate	*tablet*	*5 mg*	ORAL	ST
amphetamine sulfate	*tablet*	*10 mg*	ORAL	ST
armodafinil	*tablet*	*50 mg*	ORAL	PA; QL
armodafinil	*tablet*	*150 mg*	ORAL	PA; QL
armodafinil	*tablet*	*200 mg*	ORAL	PA; QL
armodafinil	*tablet*	*250 mg*	ORAL	PA; QL
atomoxetine hcl	*capsule*	*10 mg*	ORAL	ST
atomoxetine hcl	*capsule*	*18 mg*	ORAL	ST
atomoxetine hcl	*capsule*	*25 mg*	ORAL	ST
atomoxetine hcl	*capsule*	*40 mg*	ORAL	ST
atomoxetine hcl	*capsule*	*60 mg*	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
atomoxetine hcl	*capsule*	*80 mg*	ORAL	ST
atomoxetine hcl	*capsule*	*100 mg*	ORAL	ST
AZSTARYS	CAPSULE	26.1-5.2 MG	ORAL	ST
AZSTARYS	CAPSULE	39.2-7.8 MG	ORAL	ST
AZSTARYS	CAPSULE	52.3-10.4	ORAL	ST
clonidine hcl er	*tablet; extended release 12 hr*	*0.1 mg*	ORAL	ST
dexmethylphenidate hcl	*tablet*	*2.5 mg*	ORAL	ST
dexmethylphenidate hcl	*tablet*	*5 mg*	ORAL	ST
dexmethylphenidate hcl	*tablet*	*10 mg*	ORAL	ST
dexmethylphenidate hcl er	*capsule; extended release biphasic 50-50*	*5 mg*	ORAL	ST
dexmethylphenidate hcl er	*capsule; extended release biphasic 50-50*	*10 mg*	ORAL	ST
dexmethylphenidate hcl er	*capsule; extended release biphasic 50-50*	*15 mg*	ORAL	ST
dexmethylphenidate hcl er	*capsule; extended release biphasic 50-50*	*20 mg*	ORAL	ST
dexmethylphenidate hcl er	*capsule; extended release biphasic 50-50*	*25 mg*	ORAL	ST
dexmethylphenidate hcl er	*capsule; extended release biphasic 50-50*	*30 mg*	ORAL	ST
dexmethylphenidate hcl er	*capsule; extended release biphasic 50-50*	*35 mg*	ORAL	ST
dexmethylphenidate hcl er	*capsule; extended release biphasic 50-50*	*40 mg*	ORAL	ST
dextroamphetamine sulfate	solution; oral	5 mg/5 ml	ORAL	ST
dextroamphetamine sulfate	tablet	2.5 mg	ORAL	ST
dextroamphetamine sulfate	tablet	5 mg	ORAL	ST
dextroamphetamine sulfate	tablet	7.5 mg	ORAL	ST
dextroamphetamine sulfate	tablet	10 mg	ORAL	ST
dextroamphetamine sulfate	tablet	15 mg	ORAL	ST
dextroamphetamine sulfate	tablet	20 mg	ORAL	ST
dextroamphetamine sulfate	tablet	30 mg	ORAL	ST
dextroamphetamine sulfate er	capsule; extended release	5 mg	ORAL	ST
dextroamphetamine sulfate er	capsule; extended release	10 mg	ORAL	ST
dextroamphetamine sulfate er	capsule; extended release	15 mg	ORAL	ST
dextroamphetamine-amphet er	*capsule; ext release 24 hr*	*5 mg*	ORAL	ST
dextroamphetamine-amphet er	*capsule; ext release 24 hr*	*10 mg*	ORAL	ST
dextroamphetamine-amphet er	*capsule; ext release 24 hr*	*15 mg*	ORAL	ST
dextroamphetamine-amphet er	*capsule; ext release 24 hr*	*20 mg*	ORAL	ST
dextroamphetamine-amphet er	*capsule; ext release 24 hr*	*25 mg*	ORAL	ST
dextroamphetamine-amphet er	*capsule; ext release 24 hr*	*30 mg*	ORAL	ST
dextroamphetamine-amphet er	capsule; extended release triphasic 24 hr	12.5 mg	ORAL	ST
dextroamphetamine-amphet er	capsule; extended release triphasic 24 hr	25 mg	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
dextroamphetamine-amphet er	capsule; extended release triphasic 24 hr	37.5 mg	ORAL	ST
dextroamphetamine-amphet er	capsule; extended release triphasic 24 hr	50 mg	ORAL	ST
dextroamphetamine-amphetamine	*tablet*	*5 mg*	ORAL	ST
dextroamphetamine-amphetamine	*tablet*	*7.5 mg*	ORAL	ST
dextroamphetamine-amphetamine	*tablet*	*10 mg*	ORAL	ST
dextroamphetamine-amphetamine	*tablet*	*12.5 mg*	ORAL	ST
dextroamphetamine-amphetamine	*tablet*	*15 mg*	ORAL	ST
dextroamphetamine-amphetamine	*tablet*	*20 mg*	ORAL	ST
dextroamphetamine-amphetamine	*tablet*	*30 mg*	ORAL	ST
ergoloid mesylates	tablet	1 mg	ORAL	
guanfacine hcl er	*tablet; extended release 24 hr*	*1 mg*	ORAL	ST
guanfacine hcl er	*tablet; extended release 24 hr*	*2 mg*	ORAL	ST
guanfacine hcl er	*tablet; extended release 24 hr*	*3 mg*	ORAL	ST
guanfacine hcl er	*tablet; extended release 24 hr*	*4 mg*	ORAL	ST
lisdexamfetamine dimesylate	capsule	10 mg	ORAL	ST
lisdexamfetamine dimesylate	capsule	20 mg	ORAL	ST
lisdexamfetamine dimesylate	capsule	30 mg	ORAL	ST
lisdexamfetamine dimesylate	capsule	40 mg	ORAL	ST
lisdexamfetamine dimesylate	capsule	50 mg	ORAL	ST
lisdexamfetamine dimesylate	capsule	60 mg	ORAL	ST
lisdexamfetamine dimesylate	capsule	70 mg	ORAL	ST
lisdexamfetamine dimesylate	tablet; chewable	10 mg	ORAL	ST
lisdexamfetamine dimesylate	tablet; chewable	20 mg	ORAL	ST
lisdexamfetamine dimesylate	tablet; chewable	30 mg	ORAL	ST
lisdexamfetamine dimesylate	tablet; chewable	40 mg	ORAL	ST
lisdexamfetamine dimesylate	tablet; chewable	50 mg	ORAL	ST
lisdexamfetamine dimesylate	tablet; chewable	60 mg	ORAL	ST
lithium carbonate	*capsule*	*150 mg*	ORAL	
lithium carbonate	*capsule*	*300 mg*	ORAL	
lithium carbonate	*capsule*	*600 mg*	ORAL	
lithium carbonate	*tablet*	*300 mg*	ORAL	
lithium carbonate	*tablet; extended release*	*300 mg*	ORAL	
lithium carbonate	*tablet; extended release*	*450 mg*	ORAL	
lithium citrate	solution; oral	8 meq/5 ml	ORAL	
LUMRYZ	PACKET; EXTENDED RELEASE GRANULES	4.5 G	ORAL	SP; ST
LUMRYZ	PACKET; EXTENDED RELEASE GRANULES	6 G	ORAL	SP; ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
LUMRYZ	PACKET; EXTENDED RELEASE GRANULES	7.5 G	ORAL	SP; ST
LUMRYZ	PACKET; EXTENDED RELEASE GRANULES	9 G	ORAL	SP; ST
methamphetamine hcl	tablet	5 mg	ORAL	ST
methylphenidate	patch; transdermal 24 hours	10 mg/9 hr	TRANSDERM	ST
methylphenidate	patch; transdermal 24 hours	15 mg/9 hr	TRANSDERM	ST
methylphenidate	patch; transdermal 24 hours	20 mg/9 hr	TRANSDERM	ST
methylphenidate	patch; transdermal 24 hours	30 mg/9 hr	TRANSDERM	ST
methylphenidate er	*capsule; er sprinkle; biphasic 40-60*	*10 mg*	ORAL	ST
methylphenidate er	*capsule; er sprinkle; biphasic 40-60*	*15 mg*	ORAL	ST
methylphenidate er	*capsule; er sprinkle; biphasic 40-60*	*20 mg*	ORAL	ST
methylphenidate er	*capsule; er sprinkle; biphasic 40-60*	*30 mg*	ORAL	ST
methylphenidate er	*capsule; er sprinkle; biphasic 40-60*	*40 mg*	ORAL	ST
methylphenidate er	*capsule; er sprinkle; biphasic 40-60*	*50 mg*	ORAL	ST
methylphenidate er	*capsule; er sprinkle; biphasic 40-60*	*60 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 30-70*	*10 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 30-70*	*20 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 30-70*	*30 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 30-70*	*40 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 30-70*	*50 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 30-70*	*60 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 50-50*	*10 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 50-50*	*20 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 50-50*	*30 mg*	ORAL	ST
methylphenidate er	*capsule; extended release biphasic 50-50*	*40 mg*	ORAL	ST
methylphenidate er	*tablet; extended release*	*10 mg*	ORAL	ST
methylphenidate er	*tablet; extended release*	*20 mg*	ORAL	ST
methylphenidate er	*tablet; extended release 24 hr*	*18 mg*	ORAL	ST
methylphenidate er	*tablet; extended release 24 hr*	*27 mg*	ORAL	ST
methylphenidate er	*tablet; extended release 24 hr*	*36 mg*	ORAL	ST
methylphenidate er	*tablet; extended release 24 hr*	*54 mg*	ORAL	ST
methylphenidate hcl	*solution; oral*	*5 mg/5 ml*	ORAL	ST
methylphenidate hcl	*solution; oral*	*10 mg/5 ml*	ORAL	ST
methylphenidate hcl	*tablet*	*5 mg*	ORAL	ST
methylphenidate hcl	*tablet*	*10 mg*	ORAL	ST
methylphenidate hcl	*tablet*	*20 mg*	ORAL	ST
methylphenidate hcl	tablet; chewable	2.5 mg	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
methylphenidate hcl	tablet; chewable	5 mg	ORAL	ST
methylphenidate hcl	tablet; chewable	10 mg	ORAL	ST
methylphenidate hcl cd	*capsule; extended release biphasic 30-70*	*10 mg*	ORAL	ST
methylphenidate hcl cd	*capsule; extended release biphasic 30-70*	*20 mg*	ORAL	ST
methylphenidate hcl cd	*capsule; extended release biphasic 30-70*	*30 mg*	ORAL	ST
methylphenidate hcl cd	*capsule; extended release biphasic 30-70*	*40 mg*	ORAL	ST
methylphenidate hcl cd	*capsule; extended release biphasic 30-70*	*50 mg*	ORAL	ST
methylphenidate hcl cd	*capsule; extended release biphasic 30-70*	*60 mg*	ORAL	ST
methylphenidate la	*capsule; extended release biphasic 50-50*	*10 mg*	ORAL	ST
methylphenidate la	*capsule; extended release biphasic 50-50*	*20 mg*	ORAL	ST
methylphenidate la	*capsule; extended release biphasic 50-50*	*30 mg*	ORAL	ST
methylphenidate la	*capsule; extended release biphasic 50-50*	*40 mg*	ORAL	ST
methylphenidate la	*capsule; extended release biphasic 50-50*	*60 mg*	ORAL	ST
modafinil	*tablet*	*100 mg*	ORAL	QL; ST
modafinil	*tablet*	*200 mg*	ORAL	QL; ST
procentra	solution; oral	5 mg/5 ml	ORAL	ST
SODIUM OXYBATE	SOLUTION; ORAL	500 MG/ML	ORAL	LA; SP; ST
SUNOSI	TABLET	75 MG	ORAL	QL; ST
SUNOSI	TABLET	150 MG	ORAL	QL; ST
VYVANSE	TABLET; CHEWABLE	10 MG	ORAL	ST
VYVANSE	TABLET; CHEWABLE	20 MG	ORAL	ST
VYVANSE	TABLET; CHEWABLE	30 MG	ORAL	ST
VYVANSE	TABLET; CHEWABLE	40 MG	ORAL	ST
VYVANSE	TABLET; CHEWABLE	50 MG	ORAL	ST
VYVANSE	TABLET; CHEWABLE	60 MG	ORAL	ST
XYWAV	SOLUTION; ORAL	0.5 G/ML	ORAL	LA; SP; ST
zenzedi	tablet	5 mg	ORAL	ST
zenzedi	tablet	10 mg	ORAL	ST
MUSCLE RELAXANTS & ANTISPASMODIC AGENTS				
baclofen	*suspension; oral (final dose form)*	*25 mg/5 ml*	ORAL	
baclofen	*tablet*	*5 mg*	ORAL	
baclofen	*tablet*	*10 mg*	ORAL	
baclofen	*tablet*	*20 mg*	ORAL	
chlorzoxazone	*tablet*	*375 mg*	ORAL	
chlorzoxazone	*tablet*	*500 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
chlorzoxazone	*tablet*	*750 mg*	ORAL	
cyclobenzaprine hcl	capsule; ext release 24 hr	15 mg	ORAL	PA
cyclobenzaprine hcl	*capsule; ext release 24 hr*	*30 mg*	ORAL	PA
cyclobenzaprine hcl	*tablet*	*5 mg*	ORAL	
cyclobenzaprine hcl	tablet	7.5 mg	ORAL	
cyclobenzaprine hcl	*tablet*	*10 mg*	ORAL	
dantrolene sodium	capsule	25 mg	ORAL	
dantrolene sodium	capsule	50 mg	ORAL	
dantrolene sodium	capsule	100 mg	ORAL	
metaxalone	tablet	400 mg	ORAL	
metaxalone	tablet	800 mg	ORAL	
methocarbamol	*tablet*	*500 mg*	ORAL	
methocarbamol	*tablet*	*750 mg*	ORAL	
orphenadrine-aspirin-caffeine	tablet	25-385-30	ORAL	
orphenadrine citrate	*tablet; extended release*	*100 mg*	ORAL	
orphengesic forte	tablet	50-770-60	ORAL	
tizanidine hcl	*tablet*	*2 mg*	ORAL	
tizanidine hcl	*tablet*	*4 mg*	ORAL	
MYASTHENIA GRAVIS				
neostigmine-sterile water	syringe (ml)	5 mg/5 ml	INJ	
pyridostigmine bromide	*solution; oral*	*60 mg/5 ml*	ORAL	
pyridostigmine bromide	*tablet*	*60 mg*	ORAL	
pyridostigmine bromide er	*tablet; extended release*	*180 mg*	ORAL	
NARCOTIC ANTAGONISTS				
buprenorphine-naloxone	film; medicated (ea)	2 mg-0.5 mg	SL	
buprenorphine-naloxone	film; medicated (ea)	4 mg-1 mg	SL	
buprenorphine-naloxone	film; medicated (ea)	8 mg-2 mg	SL	
buprenorphine-naloxone	film; medicated (ea)	12 mg-3 mg	SL	
buprenorphine-naloxone	tablet; sublingual	2 mg-0.5 mg	SL	
buprenorphine-naloxone	tablet; sublingual	8 mg-2 mg	SL	
KLOXXADO	SPRAY; NON-AEROSOL (EA)	8 MG	NASAL	QL
naloxone hcl	*cartridge (ml)*	*0.4 mg/ml*	INJ	
naloxone hcl	*spray; non-aerosol (ea)*	*4 mg*	NASAL	QL
naloxone hcl	*syringe (ml)*	*1 mg/ml*	INJ	
naloxone hcl	*vial (ml)*	*0.4 mg/ml*	INJ	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
naltrexone hydrochloride	*tablet*	*50 mg*	ORAL	
REXTOVY	SPRAY; NON-AEROSOL (EA)	4 MG	NASAL	QL
ZUBSOLV	TABLET; SUBLINGUAL	0.7-0.18 MG	SL	
ZUBSOLV	TABLET; SUBLINGUAL	1.4-0.36 MG	SL	
ZUBSOLV	TABLET; SUBLINGUAL	2.9-0.71 MG	SL	
ZUBSOLV	TABLET; SUBLINGUAL	5.7-1.4 MG	SL	
ZUBSOLV	TABLET; SUBLINGUAL	8.6-2.1 MG	SL	
ZUBSOLV	TABLET; SUBLINGUAL	11.4-2.9 MG	SL	
NARCOTICS				
BELBUCA	FILM; MEDICATED (EA)	75 MCG	BUCCAL	QL; ST
BELBUCA	FILM; MEDICATED (EA)	150 MCG	BUCCAL	QL; ST
BELBUCA	FILM; MEDICATED (EA)	300 MCG	BUCCAL	QL; ST
BELBUCA	FILM; MEDICATED (EA)	450 MCG	BUCCAL	QL; ST
BELBUCA	FILM; MEDICATED (EA)	600 MCG	BUCCAL	QL; ST
BELBUCA	FILM; MEDICATED (EA)	750 MCG	BUCCAL	QL; ST
BELBUCA	FILM; MEDICATED (EA)	900 MCG	BUCCAL	QL; ST
buprenorphine	patch; transdermal weekly	5 mcg/hr	TRANSDERM	ST
buprenorphine	patch; transdermal weekly	7.5 mcg/hr	TRANSDERM	ST
buprenorphine	patch; transdermal weekly	10 mcg/hr	TRANSDERM	ST
buprenorphine	patch; transdermal weekly	15 mcg/hr	TRANSDERM	ST
buprenorphine	patch; transdermal weekly	20 mcg/hr	TRANSDERM	ST
buprenorphine hydrochloride	*tablet; sublingual*	*2 mg*	SL	
buprenorphine hydrochloride	*tablet; sublingual*	*8 mg*	SL	
codeine sulfate	*tablet*	*15 mg*	ORAL	
codeine sulfate	*tablet*	*30 mg*	ORAL	
codeine sulfate	*tablet*	*60 mg*	ORAL	
diskets	*tablet; soluble*	*40 mg*	ORAL	ST
fentanyl	patch; transdermal 72 hours	12 mcg/hr	TRANSDERM	QL; ST
fentanyl	patch; transdermal 72 hours	25 mcg/hr	TRANSDERM	QL; ST
fentanyl	patch; transdermal 72 hours	37.5 mcg/hr	TRANSDERM	QL; ST
fentanyl	patch; transdermal 72 hours	50 mcg/hr	TRANSDERM	QL; ST
fentanyl	patch; transdermal 72 hours	62.5 mcg/hr	TRANSDERM	QL; ST
fentanyl	patch; transdermal 72 hours	75 mcg/hr	TRANSDERM	QL; ST
fentanyl	patch; transdermal 72 hours	87.5 mcg/hr	TRANSDERM	QL; ST
fentanyl	patch; transdermal 72 hours	100 mcg/hr	TRANSDERM	QL; ST

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
fentanyl citrate	lozenge on a handle	200 mcg	BUCCAL	QL; ST
fentanyl citrate	lozenge on a handle	400 mcg	BUCCAL	QL; ST
fentanyl citrate	lozenge on a handle	600 mcg	BUCCAL	QL; ST
fentanyl citrate	lozenge on a handle	800 mcg	BUCCAL	QL; ST
fentanyl citrate	lozenge on a handle	1200 mcg	BUCCAL	QL; ST
fentanyl citrate	lozenge on a handle	1600 mcg	BUCCAL	QL; ST
fentanyl citrate	prefilled pump reservoir	2500 mcg/50	IV	
fentanyl citrate	syringe (ml)	100 mcg/2 ml	IV	
hydrocodone bitartrate er	capsule; oral only; extended release 12hr	10 mg	ORAL	QL; ST
hydrocodone bitartrate er	capsule; oral only; extended release 12hr	15 mg	ORAL	QL; ST
hydrocodone bitartrate er	capsule; oral only; extended release 12hr	20 mg	ORAL	QL; ST
hydrocodone bitartrate er	capsule; oral only; extended release 12hr	30 mg	ORAL	QL; ST
hydrocodone bitartrate er	capsule; oral only; extended release 12hr	40 mg	ORAL	QL; ST
hydrocodone bitartrate er	capsule; oral only; extended release 12hr	50 mg	ORAL	QL; ST
hydrocodone bitartrate er	tablet; oral only; extended release 24 hr	20 mg	ORAL	QL; ST
hydrocodone bitartrate er	tablet; oral only; extended release 24 hr	30 mg	ORAL	QL; ST
hydrocodone bitartrate er	tablet; oral only; extended release 24 hr	40 mg	ORAL	QL; ST
hydrocodone bitartrate er	tablet; oral only; extended release 24 hr	60 mg	ORAL	QL; ST
hydrocodone bitartrate er	tablet; oral only; extended release 24 hr	80 mg	ORAL	QL; ST
hydrocodone bitartrate er	tablet; oral only; extended release 24 hr	100 mg	ORAL	QL; ST
hydrocodone bitartrate er	tablet; oral only; extended release 24 hr	120 mg	ORAL	QL; ST
hydromorphone er	*tablet; extended release 24 hr*	*8 mg*	ORAL	QL; ST
hydromorphone er	*tablet; extended release 24 hr*	*12 mg*	ORAL	QL; ST
hydromorphone er	*tablet; extended release 24 hr*	*16 mg*	ORAL	QL; ST
hydromorphone er	*tablet; extended release 24 hr*	*32 mg*	ORAL	QL; ST
hydromorphone hcl	*liquid (ml)*	*1 mg/ml*	ORAL	
hydromorphone hcl	syringe (ml)	0.5 mg/0.5 ml	INJ	
hydromorphone hcl	syringe (ml)	1 mg/ml	INJ	
hydromorphone hcl	*suppository; rectal*	*3 mg*	RECTAL	
hydromorphone hcl	*tablet*	*2 mg*	ORAL	
hydromorphone hcl	*tablet*	*4 mg*	ORAL	
hydromorphone hcl	*tablet*	*8 mg*	ORAL	
levorphanol tartrate	tablet	2 mg	ORAL	
levorphanol tartrate	tablet	3 mg	ORAL	
methadone hcl	concentrate; oral	10 mg/ml	ORAL	ST
methadone hcl	*solution; oral*	*5 mg/5 ml*	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
methadone hcl	*solution; oral*	*10 mg/5 ml*	ORAL	ST
methadone hcl	syringe (ml)	10 mg/ml	IV	ST
methadone hcl	*tablet*	*5 mg*	ORAL	ST
methadone hcl	*tablet*	*10 mg*	ORAL	ST
methadone hcl	*tablet; soluble*	*40 mg*	ORAL	ST
methadose	*concentrate; oral*	*10 mg/ml*	ORAL	ST
methadose	*tablet; soluble*	*40 mg*	ORAL	ST
morphine sulfate	*solution; oral*	*10 mg/5 ml*	ORAL	
morphine sulfate	*solution; oral*	*20 mg/5 ml*	ORAL	
morphine sulfate	*solution; oral*	*100 mg/5 ml*	ORAL	
morphine sulfate	*suppository; rectal*	*5 mg*	RECTAL	
morphine sulfate	*suppository; rectal*	*10 mg*	RECTAL	
morphine sulfate	*suppository; rectal*	*20 mg*	RECTAL	
morphine sulfate	*suppository; rectal*	*30 mg*	RECTAL	
morphine sulfate	*tablet*	*15 mg*	ORAL	
morphine sulfate	*tablet*	*30 mg*	ORAL	
morphine sulfate er	capsule; extended release multiphase 24hr	30 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release multiphase 24hr	45 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release multiphase 24hr	60 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release multiphase 24hr	75 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release multiphase 24hr	90 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release multiphase 24hr	120 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release pellets	10 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release pellets	20 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release pellets	30 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release pellets	50 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release pellets	60 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release pellets	80 mg	ORAL	QL; ST
morphine sulfate er	capsule; extended release pellets	100 mg	ORAL	QL; ST
morphine sulfate er	*tablet; extended release*	*15 mg*	ORAL	QL; ST
morphine sulfate er	*tablet; extended release*	*30 mg*	ORAL	QL; ST
morphine sulfate er	*tablet; extended release*	*60 mg*	ORAL	QL; ST
morphine sulfate er	*tablet; extended release*	*100 mg*	ORAL	QL; ST
morphine sulfate er	*tablet; extended release*	*200 mg*	ORAL	QL; ST
morphine sulfate-0.9% nacl	patient controlled analgesia syringe	30 mg/30 ml	IV	
morphine sulfate-0.9% nacl	patient controlled analgesia syringe	50 mg/50 ml	IV	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
morphine sulfate-0.9% nacl	plastic bag; injection (ml)	1 mg/ml	IV	
morphine sulfate-0.9% nacl	syringe (ml)	1 mg/ml	IV	
morphine sulfate-0.9% nacl	syringe (ml)	2 mg/2 ml	IV	
morphine sulfate-0.9% nacl	syringe (ml)	5 mg/5 ml	IV	
oxycodone hcl	*capsule*	*5 mg*	ORAL	
oxycodone hcl	*concentrate; oral*	*20 mg/ml*	ORAL	
oxycodone hcl	*solution; oral*	*5 mg/5 ml*	ORAL	
oxycodone hcl	*tablet*	*5 mg*	ORAL	
oxycodone hcl	*tablet*	*10 mg*	ORAL	
oxycodone hcl	*tablet*	*15 mg*	ORAL	
oxycodone hcl	*tablet*	*20 mg*	ORAL	
oxycodone hcl	*tablet*	*30 mg*	ORAL	
OXYCONTIN	TABLET; ORAL ONLY; EXTENDED RELEASE 12 HR	10 MG	ORAL	QL; ST
OXYCONTIN	TABLET; ORAL ONLY; EXTENDED RELEASE 12 HR	15 MG	ORAL	QL; ST
OXYCONTIN	TABLET; ORAL ONLY; EXTENDED RELEASE 12 HR	20 MG	ORAL	QL; ST
OXYCONTIN	TABLET; ORAL ONLY; EXTENDED RELEASE 12 HR	30 MG	ORAL	QL; ST
OXYCONTIN	TABLET; ORAL ONLY; EXTENDED RELEASE 12 HR	40 MG	ORAL	QL; ST
OXYCONTIN	TABLET; ORAL ONLY; EXTENDED RELEASE 12 HR	60 MG	ORAL	QL; ST
OXYCONTIN	TABLET; ORAL ONLY; EXTENDED RELEASE 12 HR	80 MG	ORAL	QL; ST
oxymorphone hcl	tablet	5 mg	ORAL	
oxymorphone hcl	tablet	10 mg	ORAL	
oxymorphone hcl er	tablet; extended release 12 hr	5 mg	ORAL	QL; ST
oxymorphone hcl er	tablet; extended release 12 hr	7.5 mg	ORAL	QL; ST
oxymorphone hcl er	tablet; extended release 12 hr	10 mg	ORAL	QL; ST
oxymorphone hcl er	tablet; extended release 12 hr	15 mg	ORAL	QL; ST
oxymorphone hcl er	tablet; extended release 12 hr	20 mg	ORAL	QL; ST
oxymorphone hcl er	tablet; extended release 12 hr	30 mg	ORAL	QL; ST
oxymorphone hcl er	tablet; extended release 12 hr	40 mg	ORAL	QL; ST
NSAIDS				
diclofenac potassium	capsule	25 mg	ORAL	
diclofenac potassium	powder in packet (ea)	50 mg	ORAL	QL; ST
diclofenac potassium	tablet	25 mg	ORAL	ST
diclofenac potassium	*tablet*	*50 mg*	ORAL	
diclofenac sodium	*drops*	*1.5%*	TOPICAL	QL
diclofenac sodium	solution in metered-dose pump (gram)	20 mg/g (2%)	TOPICAL	QL; ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
diclofenac sodium	*tablet; enteric coated*	*25 mg*	ORAL	
diclofenac sodium	*tablet; enteric coated*	*50 mg*	ORAL	
diclofenac sodium	*tablet; enteric coated*	*75 mg*	ORAL	
diclofenac sodium	*tablet; extended release 24 hr*	*100 mg*	ORAL	
diclofenac sodium-misoprostol	tablet; immediate; delay release; biphase	50 mg-200	ORAL	
diclofenac sodium-misoprostol	tablet; immediate; delay release; biphase	75 mg-200	ORAL	
etodolac	*capsule*	*200 mg*	ORAL	
etodolac	*capsule*	*300 mg*	ORAL	
etodolac	*tablet*	*400 mg*	ORAL	
etodolac	*tablet*	*500 mg*	ORAL	
etodolac er	*tablet; extended release 24 hr*	*400 mg*	ORAL	
etodolac er	*tablet; extended release 24 hr*	*500 mg*	ORAL	
etodolac er	*tablet; extended release 24 hr*	*600 mg*	ORAL	
fenoprofen calcium	capsule	400 mg	ORAL	ST
fenoprofen calcium	tablet	600 mg	ORAL	ST
FLECTOR	PATCH; TRANSDERMAL 12 HOURS	1.3%	TRANSDERM	PA; QL
flurbiprofen	*tablet*	*100 mg*	ORAL	
ibu	*tablet*	*400 mg*	ORAL	
ibu	*tablet*	*600 mg*	ORAL	
ibu	*tablet*	*800 mg*	ORAL	
ibuprofen	*tablet*	*400 mg*	ORAL	
ibuprofen	*tablet*	*600 mg*	ORAL	
ibuprofen	*tablet*	*800 mg*	ORAL	
ibuprofen-famotidine	tablet	800-26.6 mg	ORAL	ST
indomethacin	*capsule*	*25 mg*	ORAL	
indomethacin	*capsule*	*50 mg*	ORAL	
indomethacin	*capsule; extended release*	*75 mg*	ORAL	
indomethacin	suspension; oral (final dose form)	25 mg/5 ml	ORAL	ST
ketoprofen	*capsule*	*25 mg*	ORAL	ST
ketoprofen	*capsule*	*50 mg*	ORAL	
ketoprofen	*capsule*	*75 mg*	ORAL	
ketoprofen	*capsule; extended release pellets 24 hr*	*200 mg*	ORAL	ST
ketorolac tromethamine	*tablet*	*10 mg*	ORAL	QL
kiprofen	capsule	25 mg	ORAL	ST
LICART	PATCH; TRANSDERMAL 24 HOURS	1.3%	TRANSDERM	QL; ST
lofena	*tablet*	*25 mg*	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
meclofenamate sodium	capsule	50 mg	ORAL	
meclofenamate sodium	capsule	100 mg	ORAL	
mefenamic acid	capsule	250 mg	ORAL	
meloxicam	*capsule*	*5 mg*	ORAL	QL; ST
meloxicam	capsule	10 mg	ORAL	QL; ST
meloxicam	*tablet*	*7.5 mg*	ORAL	QL
meloxicam	*tablet*	*15 mg*	ORAL	QL
nabumetone	*tablet*	*500 mg*	ORAL	
nabumetone	*tablet*	*750 mg*	ORAL	
naproxen	*suspension; oral (final dose form)*	*125 mg/5 ml*	ORAL	ST
naproxen	*tablet*	*250 mg*	ORAL	
naproxen	*tablet*	*375 mg*	ORAL	
naproxen	*tablet*	*500 mg*	ORAL	
naproxen	tablet; enteric coated	375 mg	ORAL	
naproxen	tablet; enteric coated	500 mg	ORAL	
naproxen sodium	*tablet*	*275 mg*	ORAL	
naproxen sodium	*tablet*	*550 mg*	ORAL	
naproxen sodium er	tablet; extended release multiphase 24 hr	375 mg	ORAL	ST
naproxen sodium er	tablet; extended release multiphase 24 hr	500 mg	ORAL	ST
naproxen sodium er	tablet; extended release multiphase 24 hr	750 mg	ORAL	ST
naproxen-esomeprazole mag	tablet; immediate; delay release; biphase	375 mg-20 mg	ORAL	ST
naproxen-esomeprazole mag	tablet; immediate; delay release; biphase	500 mg-20 mg	ORAL	ST
oxaprozin	*tablet*	*600 mg*	ORAL	
piroxicam	*capsule*	*10 mg*	ORAL	
piroxicam	*capsule*	*20 mg*	ORAL	
sulindac	*tablet*	*150 mg*	ORAL	
sulindac	*tablet*	*200 mg*	ORAL	
tolmetin sodium	capsule	400 mg	ORAL	ST
NSAIDS- SPECIFIC COX-II INHIBITORS				
celecoxib	*capsule*	*50 mg*	ORAL	
celecoxib	*capsule*	*100 mg*	ORAL	
celecoxib	*capsule*	*200 mg*	ORAL	
celecoxib	*capsule*	*400 mg*	ORAL	
PHENOTHIAZINES				
chlorpromazine hcl	concentrate; oral	30 mg/ml	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
chlorpromazine hcl	concentrate; oral	100 mg/ml	ORAL	
chlorpromazine hcl	tablet	10 mg	ORAL	
chlorpromazine hcl	tablet	25 mg	ORAL	
chlorpromazine hcl	tablet	50 mg	ORAL	
chlorpromazine hcl	tablet	100 mg	ORAL	
chlorpromazine hcl	tablet	200 mg	ORAL	
fluphenazine decanoate	vial (ml)	25 mg/ml	INJ	
fluphenazine hcl	concentrate; oral	5 mg/ml	ORAL	
fluphenazine hcl	elixir	2.5 mg/5 ml	ORAL	
fluphenazine hcl	tablet	1 mg	ORAL	
fluphenazine hcl	tablet	2.5 mg	ORAL	
fluphenazine hcl	tablet	5 mg	ORAL	
fluphenazine hcl	tablet	10 mg	ORAL	
perphenazine	*tablet*	*2 mg*	ORAL	
perphenazine	*tablet*	*4 mg*	ORAL	
perphenazine	*tablet*	*8 mg*	ORAL	
perphenazine	*tablet*	*16 mg*	ORAL	
thioridazine hcl	tablet	10 mg	ORAL	
thioridazine hcl	tablet	25 mg	ORAL	
thioridazine hcl	tablet	50 mg	ORAL	
thioridazine hcl	tablet	100 mg	ORAL	
trifluoperazine hcl	*tablet*	*1 mg*	ORAL	
trifluoperazine hcl	*tablet*	*2 mg*	ORAL	
trifluoperazine hcl	*tablet*	*5 mg*	ORAL	
trifluoperazine hcl	*tablet*	*10 mg*	ORAL	
SALICYLATES				
aspirin	*tablet; chewable*	*81 mg*	ORAL	ACA
aspirin ec	*tablet; enteric coated*	*81 mg*	ORAL	ACA
children's aspirin	*tablet; chewable*	*81 mg*	ORAL	ACA
diflunisal	tablet	500 mg	ORAL	
ecotrin	*tablet; enteric coated*	*81 mg*	ORAL	ACA
low dose aspirin	*tablet; enteric coated*	*81 mg*	ORAL	ACA
salsalate	*tablet*	*500 mg*	ORAL	
salsalate	*tablet*	*750 mg*	ORAL	
st. joseph aspirin	*tablet; chewable*	*81 mg*	ORAL	ACA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
SELECTIVE SEROTONIN REUPTAKE INHIBITORS				
citalopram hbr	*solution; oral*	*10 mg/5 ml*	ORAL	
citalopram hbr	*tablet*	*10 mg*	ORAL	
citalopram hbr	*tablet*	*20 mg*	ORAL	
citalopram hbr	*tablet*	*40 mg*	ORAL	
escitalopram oxalate	*solution; oral*	*5 mg/5 ml*	ORAL	ST
escitalopram oxalate	*tablet*	*5 mg*	ORAL	
escitalopram oxalate	*tablet*	*10 mg*	ORAL	
escitalopram oxalate	*tablet*	*20 mg*	ORAL	
fluoxetine dr	*capsule; delayed release (enteric coated)*	*90 mg*	ORAL	ST
fluoxetine hcl	*capsule*	*10 mg*	ORAL	
fluoxetine hcl	*capsule*	*20 mg*	ORAL	
fluoxetine hcl	*capsule*	*40 mg*	ORAL	
fluoxetine hcl	*solution; oral*	*20 mg/5 ml*	ORAL	
fluoxetine hcl	*tablet*	*10 mg*	ORAL	ST
fluoxetine hcl	*tablet*	*20 mg*	ORAL	ST
fluoxetine hcl	*tablet*	*60 mg*	ORAL	ST
fluvoxamine maleate	*capsule; ext release 24 hr*	*100 mg*	ORAL	ST
fluvoxamine maleate	*capsule; ext release 24 hr*	*150 mg*	ORAL	ST
fluvoxamine maleate	*tablet*	*25 mg*	ORAL	
fluvoxamine maleate	*tablet*	*50 mg*	ORAL	
fluvoxamine maleate	*tablet*	*100 mg*	ORAL	
paroxetine er	*tablet; extended release 24 hr*	*12.5 mg*	ORAL	ST
paroxetine er	*tablet; extended release 24 hr*	*25 mg*	ORAL	ST
paroxetine er	*tablet; extended release 24 hr*	*37.5 mg*	ORAL	ST
paroxetine hcl	*suspension; oral (final dose form)*	*10 mg/5 ml*	ORAL	ST
paroxetine hcl	*tablet*	*10 mg*	ORAL	
paroxetine hcl	*tablet*	*20 mg*	ORAL	
paroxetine hcl	*tablet*	*30 mg*	ORAL	
paroxetine hcl	*tablet*	*40 mg*	ORAL	
paroxetine mesylate	capsule	7.5 mg	ORAL	ST
sertraline hcl	*concentrate; oral*	*20 mg/ml*	ORAL	
sertraline hcl	*tablet*	*25 mg*	ORAL	
sertraline hcl	*tablet*	*50 mg*	ORAL	
sertraline hcl	*tablet*	*100 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
vilazodone hcl	tablet	10 mg	ORAL	ST
vilazodone hcl	tablet	20 mg	ORAL	ST
vilazodone hcl	tablet	40 mg	ORAL	ST
TRICYCLICS				
amitriptyline hcl	*tablet*	*10 mg*	ORAL	
amitriptyline hcl	*tablet*	*25 mg*	ORAL	
amitriptyline hcl	*tablet*	*50 mg*	ORAL	
amitriptyline hcl	*tablet*	*75 mg*	ORAL	
amitriptyline hcl	*tablet*	*100 mg*	ORAL	
amitriptyline hcl	*tablet*	*150 mg*	ORAL	
amoxapine	tablet	25 mg	ORAL	
amoxapine	tablet	50 mg	ORAL	
amoxapine	tablet	100 mg	ORAL	
amoxapine	tablet	150 mg	ORAL	
clomipramine hcl	*capsule*	*25 mg*	ORAL	
clomipramine hcl	*capsule*	*50 mg*	ORAL	
clomipramine hcl	*capsule*	*75 mg*	ORAL	
desipramine hcl	*tablet*	*10 mg*	ORAL	
desipramine hcl	*tablet*	*25 mg*	ORAL	
desipramine hcl	*tablet*	*50 mg*	ORAL	
desipramine hcl	*tablet*	*75 mg*	ORAL	
desipramine hcl	*tablet*	*100 mg*	ORAL	
desipramine hcl	*tablet*	*150 mg*	ORAL	
doxepin hcl	*capsule*	*10 mg*	ORAL	
doxepin hcl	*capsule*	*25 mg*	ORAL	
doxepin hcl	*capsule*	*50 mg*	ORAL	
doxepin hcl	*capsule*	*75 mg*	ORAL	
doxepin hcl	*capsule*	*100 mg*	ORAL	
doxepin hcl	*capsule*	*150 mg*	ORAL	
doxepin hcl	*concentrate; oral*	*10 mg/ml*	ORAL	
imipramine hcl	*tablet*	*10 mg*	ORAL	
imipramine hcl	*tablet*	*25 mg*	ORAL	
imipramine hcl	*tablet*	*50 mg*	ORAL	
imipramine pamoate	capsule	75 mg	ORAL	
imipramine pamoate	capsule	100 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
imipramine pamoate	capsule	125 mg	ORAL	
imipramine pamoate	capsule	150 mg	ORAL	
nortriptyline hcl	*capsule*	*10 mg*	ORAL	
nortriptyline hcl	*capsule*	*25 mg*	ORAL	
nortriptyline hcl	*capsule*	*50 mg*	ORAL	
nortriptyline hcl	*capsule*	*75 mg*	ORAL	
nortriptyline hcl	*solution; oral*	*10 mg/5 ml*	ORAL	
protriptyline hcl	tablet	5 mg	ORAL	
protriptyline hcl	tablet	10 mg	ORAL	
trimipramine maleate	capsule	25 mg	ORAL	
trimipramine maleate	capsule	50 mg	ORAL	
trimipramine maleate	capsule	100 mg	ORAL	
CARDIOVASCULAR, HYPERTENSION & LIPIDS				
ACE INHIBITORS				
benazepril hcl	*tablet*	*5 mg*	ORAL	
benazepril hcl	*tablet*	*10 mg*	ORAL	
benazepril hcl	*tablet*	*20 mg*	ORAL	
benazepril hcl	*tablet*	*40 mg*	ORAL	
captopril	*tablet*	*12.5 mg*	ORAL	
captopril	*tablet*	*25 mg*	ORAL	
captopril	*tablet*	*50 mg*	ORAL	
captopril	*tablet*	*100 mg*	ORAL	
enalapril maleate	solution; oral	1 mg/ml	ORAL	
enalapril maleate	*tablet*	*2.5 mg*	ORAL	
enalapril maleate	*tablet*	*5 mg*	ORAL	
enalapril maleate	*tablet*	*10 mg*	ORAL	
enalapril maleate	*tablet*	*20 mg*	ORAL	
fosinopril sodium	*tablet*	*10 mg*	ORAL	
fosinopril sodium	*tablet*	*20 mg*	ORAL	
fosinopril sodium	*tablet*	*40 mg*	ORAL	
lisinopril	*tablet*	*2.5 mg*	ORAL	
lisinopril	*tablet*	*5 mg*	ORAL	
lisinopril	*tablet*	*10 mg*	ORAL	
lisinopril	*tablet*	*20 mg*	ORAL	
lisinopril	*tablet*	*30 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
lisinopril	*tablet*	*40 mg*	ORAL	
moexipril hcl	*tablet*	*7.5 mg*	ORAL	
moexipril hcl	*tablet*	*15 mg*	ORAL	
perindopril erbumine	tablet	2 mg	ORAL	
perindopril erbumine	tablet	4 mg	ORAL	
perindopril erbumine	tablet	8 mg	ORAL	
quinapril	*tablet*	*5 mg*	ORAL	
quinapril	*tablet*	*10 mg*	ORAL	
quinapril	*tablet*	*20 mg*	ORAL	
quinapril	*tablet*	*40 mg*	ORAL	
ramipril	*capsule*	*1.25 mg*	ORAL	
ramipril	*capsule*	*2.5 mg*	ORAL	
ramipril	*capsule*	*5 mg*	ORAL	
ramipril	*capsule*	*10 mg*	ORAL	
trandolapril	*tablet*	*1 mg*	ORAL	
trandolapril	*tablet*	*2 mg*	ORAL	
trandolapril	*tablet*	*4 mg*	ORAL	
ADRENERGIC ANTAGONISTS & RELATED DRUGS				
clonidine hcl	patch; transdermal weekly	0.1 mg/24 hr	TRANSDERM	QL
clonidine hcl	patch; transdermal weekly	0.2 mg/24 hr	TRANSDERM	QL
clonidine hcl	patch; transdermal weekly	0.3 mg/24 hr	TRANSDERM	QL
clonidine hcl	*tablet*	*0.1 mg*	ORAL	
clonidine hcl	*tablet*	*0.2 mg*	ORAL	
clonidine hcl	*tablet*	*0.3 mg*	ORAL	
doxazosin mesylate	*tablet*	*1 mg*	ORAL	QL
doxazosin mesylate	*tablet*	*2 mg*	ORAL	QL
doxazosin mesylate	*tablet*	*4 mg*	ORAL	QL
doxazosin mesylate	*tablet*	*8 mg*	ORAL	QL
guanfacine hcl	*tablet*	*1 mg*	ORAL	
guanfacine hcl	*tablet*	*2 mg*	ORAL	
methyldopa	*tablet*	*250 mg*	ORAL	
methyldopa	*tablet*	*500 mg*	ORAL	
prazosin hcl	*capsule*	*1 mg*	ORAL	
prazosin hcl	*capsule*	*2 mg*	ORAL	
prazosin hcl	*capsule*	*5 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
terazosin hcl	*capsule*	*1 mg*	ORAL	QL
terazosin hcl	*capsule*	*2 mg*	ORAL	QL
terazosin hcl	*capsule*	*5 mg*	ORAL	QL
terazosin hcl	*capsule*	*10 mg*	ORAL	QL
AGENTS FOR PHEOCHROMOCYTOMA				
metyrosine	capsule	250 mg	ORAL	PA
phenoxybenzamine hcl	capsule	10 mg	ORAL	PA
ANGIOTENSIN II RECEPTOR BLOCKERS & RENIN INHIBITOR				
aliskiren	tablet	150 mg	ORAL	
aliskiren	tablet	300 mg	ORAL	
candesartan cilexetil	*tablet*	*4 mg*	ORAL	
candesartan cilexetil	*tablet*	*8 mg*	ORAL	
candesartan cilexetil	*tablet*	*16 mg*	ORAL	
candesartan cilexetil	*tablet*	*32 mg*	ORAL	
candesartan-hydrochlorothiazid	*tablet*	*16-12.5 mg*	ORAL	
candesartan-hydrochlorothiazid	*tablet*	*32-12.5 mg*	ORAL	
candesartan-hydrochlorothiazid	*tablet*	*32 mg-25 mg*	ORAL	
eprosartan mesylate	tablet	600 mg	ORAL	
irbesartan	*tablet*	*75 mg*	ORAL	
irbesartan	*tablet*	*150 mg*	ORAL	
irbesartan	*tablet*	*300 mg*	ORAL	
irbesartan-hydrochlorothiazide	*tablet*	*150-12.5 mg*	ORAL	
irbesartan-hydrochlorothiazide	*tablet*	*300-12.5 mg*	ORAL	
losartan potassium	*tablet*	*25 mg*	ORAL	
losartan potassium	*tablet*	*50 mg*	ORAL	
losartan potassium	*tablet*	*100 mg*	ORAL	
losartan-hydrochlorothiazide	*tablet*	*50-12.5 mg*	ORAL	
losartan-hydrochlorothiazide	*tablet*	*100-12.5 mg*	ORAL	
losartan-hydrochlorothiazide	*tablet*	*100 mg-25 mg*	ORAL	
olmesartan medoxomil	*tablet*	*5 mg*	ORAL	
olmesartan medoxomil	*tablet*	*20 mg*	ORAL	
olmesartan medoxomil	*tablet*	*40 mg*	ORAL	
olmesartan-hydrochlorothiazide	*tablet*	*20-12.5 mg*	ORAL	
olmesartan-hydrochlorothiazide	*tablet*	*40-12.5 mg*	ORAL	
olmesartan-hydrochlorothiazide	*tablet*	*40 mg-25 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
TEKTURNA HCT	TABLET	300 MG-25 MG	ORAL	
telmisartan	*tablet*	*20 mg*	ORAL	
telmisartan	*tablet*	*40 mg*	ORAL	
telmisartan	*tablet*	*80 mg*	ORAL	
telmisartan-hydrochlorothiazid	*tablet*	*40-12.5 mg*	ORAL	
telmisartan-hydrochlorothiazid	*tablet*	*80-12.5 mg*	ORAL	
telmisartan-hydrochlorothiazid	*tablet*	*80 mg-25 mg*	ORAL	
valsartan	*tablet*	*40 mg*	ORAL	
valsartan	*tablet*	*80 mg*	ORAL	
valsartan	*tablet*	*160 mg*	ORAL	
valsartan	*tablet*	*320 mg*	ORAL	
valsartan-hydrochlorothiazide	*tablet*	*80-12.5 mg*	ORAL	
valsartan-hydrochlorothiazide	*tablet*	*160-12.5 mg*	ORAL	
valsartan-hydrochlorothiazide	*tablet*	*160 mg-25 mg*	ORAL	
valsartan-hydrochlorothiazide	*tablet*	*320-12.5 mg*	ORAL	
valsartan-hydrochlorothiazide	*tablet*	*320 mg-25 mg*	ORAL	
ANTIARRHYTHMIC AGENTS				
amiodarone hcl	*tablet*	*100 mg*	ORAL	
amiodarone hcl	*tablet*	*200 mg*	ORAL	
amiodarone hcl	*tablet*	*400 mg*	ORAL	
bretylium tosylate	vial (ml)	50 mg/ml	INJ	
dofetilide	capsule	125 mcg	ORAL	
dofetilide	capsule	250 mcg	ORAL	
dofetilide	capsule	500 mcg	ORAL	
flecainide acetate	*tablet*	*50 mg*	ORAL	
flecainide acetate	*tablet*	*100 mg*	ORAL	
flecainide acetate	*tablet*	*150 mg*	ORAL	
mexiletine hcl	*capsule*	*150 mg*	ORAL	
mexiletine hcl	*capsule*	*200 mg*	ORAL	
mexiletine hcl	capsule	250 mg	ORAL	
MULTAQ	TABLET	400 MG	ORAL	
pacerone	tablet	100 mg	ORAL	
pacerone	tablet	200 mg	ORAL	
pacerone	tablet	400 mg	ORAL	
procainamide hcl	vial (ml)	100 mg/ml	INJ	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
procainamide hcl	vial (ml)	500 mg/ml	INJ	
propafenone hcl	*tablet*	*150 mg*	ORAL	
propafenone hcl	*tablet*	*225 mg*	ORAL	
propafenone hcl	*tablet*	*300 mg*	ORAL	
propafenone hcl er	capsule; extended release 12 hr	225 mg	ORAL	
propafenone hcl er	capsule; extended release 12 hr	325 mg	ORAL	
propafenone hcl er	capsule; extended release 12 hr	425 mg	ORAL	
quinidine gluconate	tablet; extended release	324 mg	ORAL	
quinidine sulfate	tablet	200 mg	ORAL	
quinidine sulfate	tablet	300 mg	ORAL	
sorine	tablet	120 mg	ORAL	
sotalol	*tablet*	*80 mg*	ORAL	
sotalol	*tablet*	*120 mg*	ORAL	
sotalol	*tablet*	*160 mg*	ORAL	
sotalol	*tablet*	*240 mg*	ORAL	
sotalol af	*tablet*	*80 mg*	ORAL	
sotalol af	*tablet*	*120 mg*	ORAL	
sotalol af	*tablet*	*160 mg*	ORAL	
SOTYLIZE	SOLUTION; ORAL	5 MG/ML	ORAL	
ANTICOAGULANTS				
dabigatran etexilate	capsule	75 mg	ORAL	PA
dabigatran etexilate	capsule	110 mg	ORAL	PA
dabigatran etexilate	capsule	150 mg	ORAL	PA
ELIQUIS	TABLET	2.5 MG	ORAL	PA
ELIQUIS	TABLET	5 MG	ORAL	PA
ELIQUIS	TABLET; DOSE PACK	5 MG (74)	ORAL	PA
jantoven	*tablet*	*1 mg*	ORAL	
jantoven	*tablet*	*2 mg*	ORAL	
jantoven	*tablet*	*2.5 mg*	ORAL	
jantoven	*tablet*	*3 mg*	ORAL	
jantoven	*tablet*	*4 mg*	ORAL	
jantoven	*tablet*	*5 mg*	ORAL	
jantoven	*tablet*	*6 mg*	ORAL	
jantoven	*tablet*	*7.5 mg*	ORAL	
jantoven	*tablet*	*10 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
warfarin sodium	*tablet*	*1 mg*	ORAL	
warfarin sodium	*tablet*	*2 mg*	ORAL	
warfarin sodium	*tablet*	*2.5 mg*	ORAL	
warfarin sodium	*tablet*	*3 mg*	ORAL	
warfarin sodium	*tablet*	*4 mg*	ORAL	
warfarin sodium	*tablet*	*5 mg*	ORAL	
warfarin sodium	*tablet*	*6 mg*	ORAL	
warfarin sodium	*tablet*	*7.5 mg*	ORAL	
warfarin sodium	*tablet*	*10 mg*	ORAL	
XARELTO	SUSPENSION; RECONSTITUTED; ORAL (ML)	1 MG/ML	ORAL	PA
XARELTO	TABLET	2.5 MG	ORAL	PA
XARELTO	TABLET	10 MG	ORAL	PA
XARELTO	TABLET	15 MG	ORAL	PA
XARELTO	TABLET	20 MG	ORAL	PA
XARELTO	TABLET; DOSE PACK	15 MG-20 MG	ORAL	PA
ANTIPLATELET DRUGS				
aspirin-dipyridamole er	capsule; extended release multiphase 12hr	25 mg-200 mg	ORAL	
BRILINTA	TABLET	60 MG	ORAL	
BRILINTA	TABLET	90 MG	ORAL	
cilostazol	*tablet*	*50 mg*	ORAL	
cilostazol	*tablet*	*100 mg*	ORAL	
clopidogrel	*tablet*	*75 mg*	ORAL	
clopidogrel	tablet	300 mg	ORAL	
dipyridamole	tablet	25 mg	ORAL	
dipyridamole	tablet	50 mg	ORAL	
dipyridamole	tablet	75 mg	ORAL	
prasugrel hcl	*tablet*	*5 mg*	ORAL	
prasugrel hcl	*tablet*	*10 mg*	ORAL	
BETA BLOCKERS				
acebutolol hcl	*capsule*	*200 mg*	ORAL	
acebutolol hcl	*capsule*	*400 mg*	ORAL	
atenolol	*tablet*	*25 mg*	ORAL	
atenolol	*tablet*	*50 mg*	ORAL	
atenolol	*tablet*	*100 mg*	ORAL	
betaxolol hcl	*tablet*	*10 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
betaxolol hcl	*tablet*	*20 mg*	ORAL	
bisoprolol fumarate	*tablet*	*5 mg*	ORAL	
bisoprolol fumarate	*tablet*	*10 mg*	ORAL	
carvedilol	*tablet*	*3.125 mg*	ORAL	
carvedilol	*tablet*	*6.25 mg*	ORAL	
carvedilol	*tablet*	*12.5 mg*	ORAL	
carvedilol	*tablet*	*25 mg*	ORAL	
carvedilol er	capsule; extended release multiphase 24hr	10 mg	ORAL	
carvedilol er	capsule; extended release multiphase 24hr	20 mg	ORAL	
carvedilol er	capsule; extended release multiphase 24hr	40 mg	ORAL	
carvedilol er	capsule; extended release multiphase 24hr	80 mg	ORAL	
labetalol hcl	*tablet*	*100 mg*	ORAL	
labetalol hcl	*tablet*	*200 mg*	ORAL	
labetalol hcl	*tablet*	*300 mg*	ORAL	
metoprolol succinate	*tablet; extended release 24 hr*	*25 mg*	ORAL	
metoprolol succinate	*tablet; extended release 24 hr*	*50 mg*	ORAL	
metoprolol succinate	*tablet; extended release 24 hr*	*100 mg*	ORAL	
metoprolol succinate	*tablet; extended release 24 hr*	*200 mg*	ORAL	
metoprolol tartrate	*tablet*	*25 mg*	ORAL	
metoprolol tartrate	*tablet*	*37.5 mg*	ORAL	
metoprolol tartrate	*tablet*	*50 mg*	ORAL	
metoprolol tartrate	*tablet*	*75 mg*	ORAL	
metoprolol tartrate	*tablet*	*100 mg*	ORAL	
nadolol	*tablet*	*20 mg*	ORAL	
nadolol	*tablet*	*40 mg*	ORAL	
nadolol	tablet	80 mg	ORAL	
nebivolol hcl	*tablet*	*2.5 mg*	ORAL	
nebivolol hcl	*tablet*	*5 mg*	ORAL	
nebivolol hcl	*tablet*	*10 mg*	ORAL	
nebivolol hcl	*tablet*	*20 mg*	ORAL	
pindolol	*tablet*	*5 mg*	ORAL	
pindolol	*tablet*	*10 mg*	ORAL	
propranolol hcl	*solution; oral*	*20 mg/5 ml*	ORAL	
propranolol hcl	*solution; oral*	*40 mg/5 ml*	ORAL	
propranolol hcl	*tablet*	*10 mg*	ORAL	
propranolol hcl	*tablet*	*20 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
propranolol hcl	*tablet*	*40 mg*	ORAL	
propranolol hcl	*tablet*	*60 mg*	ORAL	
propranolol hcl	*tablet*	*80 mg*	ORAL	
propranolol hcl er	*capsule; extended release 24hr*	*60 mg*	ORAL	
propranolol hcl er	*capsule; extended release 24hr*	*80 mg*	ORAL	
propranolol hcl er	*capsule; extended release 24hr*	*120 mg*	ORAL	
propranolol hcl er	*capsule; extended release 24hr*	*160 mg*	ORAL	
timolol maleate	*tablet*	*5 mg*	ORAL	
timolol maleate	*tablet*	*10 mg*	ORAL	
timolol maleate	*tablet*	*20 mg*	ORAL	
CALCIUM CHANNEL BLOCKERS/DIHYDROPYRIDINES				
amlodipine besylate	*tablet*	*2.5 mg*	ORAL	
amlodipine besylate	*tablet*	*5 mg*	ORAL	
amlodipine besylate	*tablet*	*10 mg*	ORAL	
felodipine er	*tablet; extended release 24 hr*	*2.5 mg*	ORAL	
felodipine er	*tablet; extended release 24 hr*	*5 mg*	ORAL	
felodipine er	*tablet; extended release 24 hr*	*10 mg*	ORAL	
isradipine	capsule	2.5 mg	ORAL	
isradipine	capsule	5 mg	ORAL	
nicardipine hcl	capsule	20 mg	ORAL	
nicardipine hcl	capsule	30 mg	ORAL	
nifedipine er	*tablet; extended release*	*30 mg*	ORAL	
nifedipine er	*tablet; extended release*	*60 mg*	ORAL	
nifedipine er	*tablet; extended release*	*90 mg*	ORAL	
nifedipine er	*tablet; extended release 24 hr*	*30 mg*	ORAL	
nifedipine er	*tablet; extended release 24 hr*	*60 mg*	ORAL	
nifedipine er	*tablet; extended release 24 hr*	*90 mg*	ORAL	
nisoldipine	tablet; extended release 24 hr	8.5 mg	ORAL	
nisoldipine	tablet; extended release 24 hr	17 mg	ORAL	
nisoldipine	tablet; extended release 24 hr	20 mg	ORAL	
nisoldipine	tablet; extended release 24 hr	25.5 mg	ORAL	
nisoldipine	tablet; extended release 24 hr	30 mg	ORAL	
nisoldipine	tablet; extended release 24 hr	34 mg	ORAL	
nisoldipine	tablet; extended release 24 hr	40 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
CALCIUM CHANNEL BLOCKERS/NON-DIHYDROPYRIDINES				
cartia xt	*capsule; ext release 24 hr*	*120 mg*	ORAL	
cartia xt	*capsule; ext release 24 hr*	*180 mg*	ORAL	
cartia xt	*capsule; ext release 24 hr*	*240 mg*	ORAL	
cartia xt	*capsule; ext release 24 hr*	*300 mg*	ORAL	
diltiazem 24hr er (cd)	*capsule; ext release 24 hr*	*120 mg*	ORAL	
diltiazem 24hr er (cd)	*capsule; ext release 24 hr*	*180 mg*	ORAL	
diltiazem 24hr er (cd)	*capsule; ext release 24 hr*	*240 mg*	ORAL	
diltiazem 24hr er (cd)	*capsule; ext release 24 hr*	*300 mg*	ORAL	
diltiazem 24hr er (cd)	*capsule; ext release 24 hr*	*360 mg*	ORAL	
diltiazem 24hr er (la)	*tablet; extended release 24 hr*	*120 mg*	ORAL	
diltiazem 24hr er (la)	*tablet; extended release 24 hr*	*180 mg*	ORAL	
diltiazem 24hr er (la)	*tablet; extended release 24 hr*	*240 mg*	ORAL	
diltiazem 24hr er (la)	*tablet; extended release 24 hr*	*300 mg*	ORAL	
diltiazem 24hr er (la)	*tablet; extended release 24 hr*	*360 mg*	ORAL	
diltiazem 24hr er (la)	*tablet; extended release 24 hr*	*420 mg*	ORAL	
diltiazem 24hr er (xr)	*capsule; extended-release 24hr degradable*	*120 mg*	ORAL	
diltiazem 24hr er (xr)	*capsule; extended-release 24hr degradable*	*180 mg*	ORAL	
diltiazem 24hr er (xr)	*capsule; extended-release 24hr degradable*	*240 mg*	ORAL	
diltiazem er	*capsule; extended release 12 hr*	*60 mg*	ORAL	
diltiazem er	*capsule; extended release 12 hr*	*90 mg*	ORAL	
diltiazem er	*capsule; extended release 12 hr*	*120 mg*	ORAL	
diltiazem er	*capsule; extended release 24hr*	*180 mg*	ORAL	
diltiazem er	*capsule; extended release 24hr*	*240 mg*	ORAL	
diltiazem er	*capsule; extended release 24hr*	*300 mg*	ORAL	
diltiazem er	*capsule; extended release 24hr*	*360 mg*	ORAL	
diltiazem er	*capsule; extended release 24hr*	*420 mg*	ORAL	
diltiazem hcl	*tablet*	*30 mg*	ORAL	
diltiazem hcl	*tablet*	*60 mg*	ORAL	
diltiazem hcl	*tablet*	*90 mg*	ORAL	
diltiazem hcl	*tablet*	*120 mg*	ORAL	
dilt-xr	*capsule; extended-release 24hr degradable*	*120 mg*	ORAL	
dilt-xr	*capsule; extended-release 24hr degradable*	*180 mg*	ORAL	
dilt-xr	*capsule; extended-release 24hr degradable*	*240 mg*	ORAL	
matzim la	*tablet; extended release 24 hr*	*180 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
matzim la	*tablet; extended release 24 hr*	*240 mg*	ORAL	
matzim la	*tablet; extended release 24 hr*	*300 mg*	ORAL	
matzim la	*tablet; extended release 24 hr*	*360 mg*	ORAL	
matzim la	*tablet; extended release 24 hr*	*420 mg*	ORAL	
nimodipine	capsule	30 mg	ORAL	
taztia xt	*capsule; extended release 24hr*	*120 mg*	ORAL	
taztia xt	*capsule; extended release 24hr*	*180 mg*	ORAL	
taztia xt	*capsule; extended release 24hr*	*240 mg*	ORAL	
taztia xt	*capsule; extended release 24hr*	*300 mg*	ORAL	
tiadylt er	*capsule; extended release 24hr*	*120 mg*	ORAL	
tiadylt er	*capsule; extended release 24hr*	*180 mg*	ORAL	
tiadylt er	*capsule; extended release 24hr*	*240 mg*	ORAL	
tiadylt er	*capsule; extended release 24hr*	*300 mg*	ORAL	
tiadylt er	*capsule; extended release 24hr*	*360 mg*	ORAL	
tiadylt er	*capsule; extended release 24hr*	*420 mg*	ORAL	
verapamil er	*capsule; extended release pellets 24 hr*	*120 mg*	ORAL	
verapamil er	*capsule; extended release pellets 24 hr*	*180 mg*	ORAL	
verapamil er	*capsule; extended release pellets 24 hr*	*240 mg*	ORAL	
verapamil er	*capsule; extended release pellets 24 hr*	*360 mg*	ORAL	
verapamil er	*tablet; extended release*	*120 mg*	ORAL	
verapamil er	*tablet; extended release*	*180 mg*	ORAL	
verapamil er	*tablet; extended release*	*240 mg*	ORAL	
verapamil er pm	capsule; 24hr extended release pellet ct	100 mg	ORAL	
verapamil er pm	*capsule; 24hr extended release pellet ct*	*200 mg*	ORAL	
verapamil er pm	*capsule; 24hr extended release pellet ct*	*300 mg*	ORAL	
verapamil hcl	*tablet*	*40 mg*	ORAL	
verapamil hcl	*tablet*	*80 mg*	ORAL	
verapamil hcl	*tablet*	*120 mg*	ORAL	
CARDIAC GLYCOSIDES				
digoxin	*solution; oral*	*50 mcg/ml*	ORAL	
digoxin	*tablet*	*62.5 mcg*	ORAL	
digoxin	*tablet*	*125 mcg*	ORAL	
digoxin	*tablet*	*250 mcg*	ORAL	
HEMOSTATICS				
aminocaproic acid	solution; oral	250 mg/ml	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
aminocaproic acid	tablet	500 mg	ORAL	
aminocaproic acid	tablet	1000 mg	ORAL	
DOPTELET	TABLET	20 MG	ORAL	LA; PA; QL; SP
PROMACTA	POWDER IN PACKET (EA)	12.5 MG	ORAL	LA; PA; SP
PROMACTA	POWDER IN PACKET (EA)	25 MG	ORAL	LA; PA; SP
PROMACTA	TABLET	12.5 MG	ORAL	LA; PA; SP
PROMACTA	TABLET	25 MG	ORAL	LA; PA; SP
PROMACTA	TABLET	50 MG	ORAL	LA; PA; SP
PROMACTA	TABLET	75 MG	ORAL	LA; PA; SP
tranexamic acid-nacl	intravenous solution; piggyback (ml)	1000 mg/100	IV	
HEPARIN				
ENOXAPARIN SODIUM	SYRINGE (ML)	30 MG/0.3 ML	SC	SP
ENOXAPARIN SODIUM	SYRINGE (ML)	40 MG/0.4 ML	SC	SP
ENOXAPARIN SODIUM	SYRINGE (ML)	60 MG/0.6 ML	SC	SP
ENOXAPARIN SODIUM	SYRINGE (ML)	80 MG/0.8 ML	SC	SP
ENOXAPARIN SODIUM	SYRINGE (ML)	100 MG/ML	SC	SP
ENOXAPARIN SODIUM	SYRINGE (ML)	120 MG/0.8 ML	SC	SP
ENOXAPARIN SODIUM	SYRINGE (ML)	150 MG/ML	SC	SP
ENOXAPARIN SODIUM	VIAL (ML)	300 MG/3 ML	SC	SP
FONDAPARINUX SODIUM	SYRINGE (ML)	2.5 MG/0.5	SC	SP
FONDAPARINUX SODIUM	SYRINGE (ML)	5 MG/0.4 ML	SC	SP
FONDAPARINUX SODIUM	SYRINGE (ML)	7.5 MG/0.6	SC	SP
FONDAPARINUX SODIUM	SYRINGE (ML)	10 MG/0.8 ML	SC	SP
FRAGMIN	SYRINGE (ML)	2500/0.2 ML	SC	SP
FRAGMIN	SYRINGE (ML)	5000/0.2 ML	SC	SP
FRAGMIN	SYRINGE (ML)	7500/0.3 ML	SC	SP
FRAGMIN	SYRINGE (ML)	10000/ML	SC	SP
FRAGMIN	SYRINGE (ML)	12500/0.5	SC	SP
FRAGMIN	SYRINGE (ML)	15000/0.6	SC	SP
FRAGMIN	SYRINGE (ML)	18000/0.72	SC	SP
FRAGMIN	VIAL (ML)	10000/4 ML	SC	SP
FRAGMIN	VIAL (ML)	25000/ML	SC	SP
heparin lock flush	*syringe (ml)*	*1 unit/ml*	IV	
heparin lock flush	*syringe (ml)*	*10 unit/ml*	IV	
heparin lock flush	*syringe (ml)*	*100/ml (1)*	IV	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
heparin lock flush	*syringe (ml)*	*200/2 ml*	IV	
heparin lock flush	*syringe (ml)*	*300/3 ml*	IV	
heparin lock flush	*syringe (ml)*	*500/5 ml*	IV	
heparin lock flush	*syringe (ml)*	*1000/10 ml*	IV	
heparin lock flush	*vial (ml)*	*10 unit/ml*	IV	
heparin lock flush	*vial (ml)*	*100/ml*	IV	
heparin lock flush	*vial (ml)*	*100/ml (1)*	IV	
heparin sodium	*cartridge (ml)*	*5000/0.5 ml*	INJ	
heparin sodium	*cartridge (ml)*	*5000/ml (1)*	INJ	
heparin sodium	*syringe (ml)*	*5000/ml*	INJ	
heparin sodium	*vial (ml)*	*1000/ml*	INJ	
heparin sodium	*vial (ml)*	*5000/0.5 ml*	INJ	
heparin sodium	*vial (ml)*	*5000/ml*	INJ	
heparin sodium	*vial (ml)*	*10000/ml*	INJ	
heparin sodium	*vial (ml)*	*20000/ml*	INJ	
heparin sodium in 0.45% nacl	*intravenous solution*	*25000/250*	IV	
heparin sodium in 0.45% nacl	*intravenous solution*	*25000/500*	IV	
heparin sodium in 0.9% nacl	*intravenous solution*	*1000/500 ml*	IV	
heparin sodium in 0.9% nacl	*intravenous solution*	*2k/1000 ml*	IV	
heparin sodium in 5% dextrose	*intravenous solution*	*20k/500 ml*	IV	
heparin sodium in 5% dextrose	*intravenous solution*	*25000/250*	IV	
heparin sodium in 5% dextrose	*intravenous solution*	*25000/500*	IV	
LIPID/CHOLESTEROL LOWERING AGENTS				
amlodipine-atorvastatin	tablet	2.5 mg-10 mg	ORAL	QL
amlodipine-atorvastatin	tablet	2.5 mg-20 mg	ORAL	QL
amlodipine-atorvastatin	tablet	2.5 mg-40 mg	ORAL	QL
amlodipine-atorvastatin	tablet	5 mg-10 mg	ORAL	QL
amlodipine-atorvastatin	tablet	5 mg-20 mg	ORAL	QL
amlodipine-atorvastatin	tablet	5 mg-40 mg	ORAL	QL
amlodipine-atorvastatin	tablet	5 mg-80 mg	ORAL	QL
amlodipine-atorvastatin	tablet	10 mg-10 mg	ORAL	QL
amlodipine-atorvastatin	tablet	10 mg-20 mg	ORAL	QL
amlodipine-atorvastatin	tablet	10 mg-40 mg	ORAL	QL
amlodipine-atorvastatin	tablet	10 mg-80 mg	ORAL	QL
atorvastatin calcium	*tablet*	*10 mg*	ORAL	ACA; QL

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
atorvastatin calcium	*tablet*	*20 mg*	ORAL	ACA; QL
atorvastatin calcium	*tablet*	*40 mg*	ORAL	QL
atorvastatin calcium	*tablet*	*80 mg*	ORAL	QL
cholestyramine	*powder (gram)*	*4 g*	ORAL	
cholestyramine	powder in packet (ea)	4 g	ORAL	
cholestyramine light	*powder (gram)*	*4 g*	ORAL	
cholestyramine light	powder in packet (ea)	4 g	ORAL	
colesevelam hcl	powder in packet (ea)	3.75 g	ORAL	
colesevelam hcl	tablet	625 mg	ORAL	
colestipol hcl	*granules (gram)*	*5 g*	ORAL	
colestipol hcl	*packet (ea)*	*5 g*	ORAL	
colestipol hcl	*tablet*	*1 g*	ORAL	
ezetimibe	*tablet*	*10 mg*	ORAL	
ezetimibe-simvastatin	*tablet*	*10 mg-10 mg*	ORAL	QL
ezetimibe-simvastatin	*tablet*	*10 mg-20 mg*	ORAL	QL
ezetimibe-simvastatin	*tablet*	*10 mg-40 mg*	ORAL	QL
ezetimibe-simvastatin	*tablet*	*10 mg-80 mg*	ORAL	QL
fenofibrate	*capsule*	*43 mg*	ORAL	
fenofibrate	*capsule*	*67 mg*	ORAL	
fenofibrate	*capsule*	*130 mg*	ORAL	
fenofibrate	*capsule*	*134 mg*	ORAL	
fenofibrate	*capsule*	*200 mg*	ORAL	
fenofibrate	tablet	40 mg	ORAL	ST
fenofibrate	*tablet*	*48 mg*	ORAL	
fenofibrate	*tablet*	*54 mg*	ORAL	
fenofibrate	tablet	120 mg	ORAL	ST
fenofibrate	*tablet*	*145 mg*	ORAL	
fenofibrate	*tablet*	*160 mg*	ORAL	
fenofibric acid	*capsule; delayed release (enteric coated)*	*45 mg*	ORAL	
fenofibric acid	*capsule; delayed release (enteric coated)*	*135 mg*	ORAL	
fenofibric acid	*tablet*	*35 mg*	ORAL	
fenofibric acid	*tablet*	*105 mg*	ORAL	
fluvastatin er	*tablet; extended release 24 hr*	*80 mg*	ORAL	ACA; QL
fluvastatin sodium	*capsule*	*20 mg*	ORAL	ACA; QL
fluvastatin sodium	*capsule*	*40 mg*	ORAL	ACA; QL
gemfibrozil	*tablet*	*600 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
icosapent ethyl	capsule	0.5 gram	ORAL	PA
icosapent ethyl	capsule	1 g	ORAL	PA
JUXTAPID	CAPSULE	5 MG	ORAL	LA; PA; SP
JUXTAPID	CAPSULE	10 MG	ORAL	LA; PA; SP
JUXTAPID	CAPSULE	20 MG	ORAL	LA; PA; SP
JUXTAPID	CAPSULE	30 MG	ORAL	LA; PA; SP
lovastatin	*tablet*	*10 mg*	ORAL	ACA; QL
lovastatin	*tablet*	*20 mg*	ORAL	ACA; QL
lovastatin	*tablet*	*40 mg*	ORAL	ACA; QL
NEXLETOL	TABLET	180 MG	ORAL	PA
NEXLIZET	TABLET	180 MG-10 MG	ORAL	PA
omega-3 acid ethyl esters	*capsule*	*1 g*	ORAL	PA
pitavastatin calcium	*tablet*	*1 mg*	ORAL	ACA; QL
pitavastatin calcium	*tablet*	*2 mg*	ORAL	ACA; QL
pitavastatin calcium	*tablet*	*4 mg*	ORAL	ACA; QL
pravastatin sodium	*tablet*	*10 mg*	ORAL	ACA; QL
pravastatin sodium	*tablet*	*20 mg*	ORAL	ACA; QL
pravastatin sodium	*tablet*	*40 mg*	ORAL	ACA; QL
pravastatin sodium	*tablet*	*80 mg*	ORAL	ACA; QL
prevalite	*powder (gram)*	*4 g*	ORAL	
prevalite	powder in packet (ea)	4 g	ORAL	
REPATHA PUSHTRONEX	WEARABLE INJECTOR	420 MG/3.5	SC	PA; QL
REPATHA SURECLICK	PEN INJECTOR (ML)	140 MG/ML	SC	PA; QL
REPATHA SYRINGE	SYRINGE (ML)	140 MG/ML	SC	PA; QL
rosuvastatin calcium	*tablet*	*5 mg*	ORAL	ACA; QL
rosuvastatin calcium	*tablet*	*10 mg*	ORAL	ACA; QL
rosuvastatin calcium	*tablet*	*20 mg*	ORAL	QL
rosuvastatin calcium	*tablet*	*40 mg*	ORAL	QL
simvastatin	*tablet*	*5 mg*	ORAL	ACA; QL
simvastatin	*tablet*	*10 mg*	ORAL	ACA; QL
simvastatin	*tablet*	*20 mg*	ORAL	ACA; QL
simvastatin	*tablet*	*40 mg*	ORAL	ACA; QL
simvastatin	*tablet*	*80 mg*	ORAL	QL
LONG ACTING NITRATES				
isosorbide dinitrate	*tablet*	*5 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
isosorbide dinitrate	*tablet*	*10 mg*	ORAL	
isosorbide dinitrate	*tablet*	*20 mg*	ORAL	
isosorbide dinitrate	*tablet*	*30 mg*	ORAL	
isosorbide dinitrate	*tablet*	*40 mg*	ORAL	
isosorbide mononitrate	*tablet*	*10 mg*	ORAL	
isosorbide mononitrate	*tablet*	*20 mg*	ORAL	
isosorbide mononitrate	*tablet; extended release 24 hr*	*30 mg*	ORAL	
isosorbide mononitrate	*tablet; extended release 24 hr*	*60 mg*	ORAL	
isosorbide mononitrate	*tablet; extended release 24 hr*	*120 mg*	ORAL	
nitro-bid	*ointment (gram)*	*2%*	TRANSDERM	
nitroglycerin	*patch; transdermal 24 hours*	*0.1 mg/hr*	TRANSDERM	
nitroglycerin	*patch; transdermal 24 hours*	*0.2 mg/hr*	TRANSDERM	
nitroglycerin	*patch; transdermal 24 hours*	*0.4 mg/hr*	TRANSDERM	
nitroglycerin	*patch; transdermal 24 hours*	*0.6 mg/hr*	TRANSDERM	
nitro-time	*capsule; extended release*	*2.5 mg*	ORAL	
nitro-time	*capsule; extended release*	*6.5 mg*	ORAL	
nitro-time	*capsule; extended release*	*9 mg*	ORAL	
MISC CARDIOVASCULAR AGENTS				
ENTRESTO	TABLET	24 MG-26 MG	ORAL	
ENTRESTO	TABLET	49 MG-51 MG	ORAL	
ENTRESTO	TABLET	97 MG-103 MG	ORAL	
ranolazine er	*tablet; extended release 12 hr*	*500 mg*	ORAL	
ranolazine er	*tablet; extended release 12 hr*	*1000 mg*	ORAL	
VERQUVO	TABLET	2.5 MG	ORAL	PA
VERQUVO	TABLET	5 MG	ORAL	PA
VERQUVO	TABLET	10 MG	ORAL	PA
VYNDAMAX	CAPSULE	61 MG	ORAL	PA; SP
VYNDAQEL	CAPSULE	20 MG	ORAL	PA; SP
MISC COAGULATION AGENTS				
OBIZUR	VIAL (EA)	500 (+/-)	IV	PA; SP
pentoxifylline	*tablet; extended release*	*400 mg*	ORAL	
TAVALISSE	TABLET	100 MG	ORAL	LA; PA; QL; SP
TAVALISSE	TABLET	150 MG	ORAL	LA; PA; QL; SP
XYNTHA SOLOFUSE	SYRINGE (EA)	250 (+/-)	IV	PA; SP
XYNTHA SOLOFUSE	SYRINGE (EA)	500 (+/-)	IV	PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
XYNTHA SOLOFUSE	SYRINGE (EA)	1000 (+/-)	IV	PA; SP
XYNTHA SOLOFUSE	SYRINGE (EA)	2000 (+/-)	IV	PA; SP
XYNTHA SOLOFUSE	SYRINGE (EA)	3000 (+/-)	IV	PA; SP
OTHER ANTIHYPERTENSIVE COMBINATIONS				
amlodipine besylate-benazepril	*capsule*	*2.5 mg-10 mg*	ORAL	
amlodipine besylate-benazepril	*capsule*	*5 mg-10 mg*	ORAL	
amlodipine besylate-benazepril	*capsule*	*5 mg-20 mg*	ORAL	
amlodipine besylate-benazepril	*capsule*	*5 mg-40 mg*	ORAL	
amlodipine besylate-benazepril	*capsule*	*10 mg-20 mg*	ORAL	
amlodipine besylate-benazepril	*capsule*	*10 mg-40 mg*	ORAL	
amlodipine-olmesartan	*tablet*	*5 mg-20 mg*	ORAL	
amlodipine-olmesartan	*tablet*	*5 mg-40 mg*	ORAL	
amlodipine-olmesartan	*tablet*	*10 mg-20 mg*	ORAL	
amlodipine-olmesartan	*tablet*	*10 mg-40 mg*	ORAL	
amlodipine-valsartan	*tablet*	*5 mg-160 mg*	ORAL	
amlodipine-valsartan	*tablet*	*5 mg-320 mg*	ORAL	
amlodipine-valsartan	*tablet*	*10 mg-160 mg*	ORAL	
amlodipine-valsartan	*tablet*	*10 mg-320 mg*	ORAL	
amlodipine-valsartan-hctz	tablet	5-160-12.5	ORAL	
amlodipine-valsartan-hctz	tablet	5-160-25 mg	ORAL	
amlodipine-valsartan-hctz	tablet	10-160-25	ORAL	
amlodipine-valsartan-hctz	tablet	10 mg-160 mg	ORAL	
amlodipine-valsartan-hctz	tablet	10-320-25	ORAL	
atenolol w/ chlorthalidone	*tablet*	*50 mg-25 mg*	ORAL	
atenolol w/ chlorthalidone	*tablet*	*100 mg-25 mg*	ORAL	
benazepril hcl-hctz	*tablet*	*5-6.25 mg*	ORAL	
benazepril hcl-hctz	*tablet*	*10-12.5 mg*	ORAL	
benazepril hcl-hctz	*tablet*	*20-12.5 mg*	ORAL	
benazepril hcl-hctz	*tablet*	*20 mg-25 mg*	ORAL	
bisoprolol fumarate/hctz	*tablet*	*2.5-6.25 mg*	ORAL	
bisoprolol fumarate/hctz	*tablet*	*5-6.25 mg*	ORAL	
bisoprolol fumarate/hctz	*tablet*	*10-6.25 mg*	ORAL	
captopril/hydrochlorothiazide	tablet	25 mg-15 mg	ORAL	
captopril/hydrochlorothiazide	tablet	25 mg-25 mg	ORAL	
captopril/hydrochlorothiazide	tablet	50 mg-15 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
captopril/hydrochlorothiazide	tablet	50 mg-25 mg	ORAL	
enalapril maleate/hctz	*tablet*	*5 mg-12.5 mg*	ORAL	
enalapril maleate/hctz	*tablet*	*10 mg-25 mg*	ORAL	
fosinopril-hydrochlorothiazide	*tablet*	*10-12.5 mg*	ORAL	
fosinopril-hydrochlorothiazide	*tablet*	*20-12.5 mg*	ORAL	
lisinopril-hctz	*tablet*	*10-12.5 mg*	ORAL	
lisinopril-hctz	*tablet*	*20-12.5 mg*	ORAL	
lisinopril-hctz	*tablet*	*20 mg-25 mg*	ORAL	
methyldopa/hydrochlorothiazide	tablet	250 mg-15 mg	ORAL	
methyldopa/hydrochlorothiazide	tablet	250 mg-25 mg	ORAL	
metoprolol-hydrochlorothiazide	*tablet*	*50 mg-25 mg*	ORAL	
metoprolol-hydrochlorothiazide	*tablet*	*100 mg-25 mg*	ORAL	
metoprolol-hydrochlorothiazide	*tablet*	*100 mg-50 mg*	ORAL	
olmesartan-amlodipine-hctz	tablet	20-5-12.5	ORAL	
olmesartan-amlodipine-hctz	tablet	40-5-12.5	ORAL	
olmesartan-amlodipine-hctz	tablet	40-5-25 mg	ORAL	
olmesartan-amlodipine-hctz	tablet	40-10-12.5	ORAL	
olmesartan-amlodipine-hctz	tablet	40-10-25 mg	ORAL	
propranolol hcl-hctz	*tablet*	*40 mg-25 mg*	ORAL	
propranolol hcl-hctz	*tablet*	*80 mg-25 mg*	ORAL	
quinapril-hydrochlorothiazide	*tablet*	*10-12.5 mg*	ORAL	
quinapril-hydrochlorothiazide	*tablet*	*20-12.5 mg*	ORAL	
quinapril-hydrochlorothiazide	*tablet*	*20 mg-25 mg*	ORAL	
telmisartan-amlodipine	tablet	40 mg-5 mg	ORAL	
telmisartan-amlodipine	tablet	40 mg-10 mg	ORAL	
telmisartan-amlodipine	tablet	80 mg-5 mg	ORAL	
telmisartan-amlodipine	tablet	80 mg-10 mg	ORAL	
trandolapril-verapamil	tablet; immed and extend rel biphase 24hr	1 mg-240 mg	ORAL	
trandolapril-verapamil	tablet; immed and extend rel biphase 24hr	2 mg-180 mg	ORAL	
trandolapril-verapamil	tablet; immed and extend rel biphase 24hr	2 mg-240 mg	ORAL	
trandolapril-verapamil	tablet; immed and extend rel biphase 24hr	4 mg-240 mg	ORAL	
RAPID ACTING NITRATES				
nitroglycerin	spray; non-aerosol (gram)	400 mcg/spr	TRANSLINGUAL	
nitroglycerin	*tablet; sublingual*	*0.3 mg*	SL	
nitroglycerin	*tablet; sublingual*	*0.4 mg*	SL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
nitroglycerin	*tablet; sublingual*	*0.6 mg*	SL	
THIAZIDE & RELATED DIURETICS				
amiloride hcl	*tablet*	*5 mg*	ORAL	
amiloride hcl w/ hctz	*tablet*	*5 mg-50 mg*	ORAL	
bumetanide	*tablet*	*0.5 mg*	ORAL	
bumetanide	*tablet*	*1 mg*	ORAL	
bumetanide	*tablet*	*2 mg*	ORAL	
chlorthalidone	*tablet*	*25 mg*	ORAL	
chlorthalidone	*tablet*	*50 mg*	ORAL	
eplerenone	*tablet*	*25 mg*	ORAL	
eplerenone	*tablet*	*50 mg*	ORAL	
ethacrynic acid	*tablet*	*25 mg*	ORAL	
furosemide	*solution; oral*	*10 mg/ml*	ORAL	
furosemide	*solution; oral*	*40 mg/5 ml*	ORAL	
furosemide	*tablet*	*20 mg*	ORAL	
furosemide	*tablet*	*40 mg*	ORAL	
furosemide	*tablet*	*80 mg*	ORAL	
hydrochlorothiazide	*capsule*	*12.5 mg*	ORAL	
hydrochlorothiazide	*tablet*	*12.5 mg*	ORAL	
hydrochlorothiazide	*tablet*	*25 mg*	ORAL	
hydrochlorothiazide	*tablet*	*50 mg*	ORAL	
indapamide	*tablet*	*1.25 mg*	ORAL	
indapamide	*tablet*	*2.5 mg*	ORAL	
KERENDIA	TABLET	10 MG	ORAL	PA; QL
KERENDIA	TABLET	20 MG	ORAL	PA; QL
metolazone	*tablet*	*2.5 mg*	ORAL	
metolazone	*tablet*	*5 mg*	ORAL	
metolazone	*tablet*	*10 mg*	ORAL	
spironolactone	*suspension; oral (final dose form)*	*25 mg/5 ml*	ORAL	
spironolactone	*tablet*	*25 mg*	ORAL	
spironolactone	*tablet*	*50 mg*	ORAL	
spironolactone	*tablet*	*100 mg*	ORAL	
spironolactone w/ hctz	*tablet*	*25 mg-25 mg*	ORAL	
torsemide	*tablet*	*5 mg*	ORAL	
torsemide	*tablet*	*10 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
torsemide	*tablet*	*20 mg*	ORAL	
torsemide	*tablet*	*100 mg*	ORAL	
triamterene	*capsule*	*50 mg*	ORAL	
triamterene	*capsule*	*100 mg*	ORAL	
triamterene w/ hctz	*capsule*	*37.5-25 mg*	ORAL	
triamterene w/ hctz	*tablet*	*37.5-25 mg*	ORAL	
triamterene w/ hctz	*tablet*	*75 mg-50 mg*	ORAL	
VASODILATORS				
EPOPROSTENOL SODIUM	VIAL (EA)	0.5 MG	IV	PA; SP
EPOPROSTENOL SODIUM	VIAL (EA)	1.5 MG	IV	PA; SP
hydralazine hcl	*tablet*	*10 mg*	ORAL	
hydralazine hcl	*tablet*	*25 mg*	ORAL	
hydralazine hcl	*tablet*	*50 mg*	ORAL	
hydralazine hcl	*tablet*	*100 mg*	ORAL	
isosorbide dinit-hydralazine	tablet	20-37.5 mg	ORAL	
minoxidil	*tablet*	*2.5 mg*	ORAL	
minoxidil	*tablet*	*10 mg*	ORAL	
TREPROSTINIL	VIAL (ML)	1 MG/ML	INJ	PA; SP
TREPROSTINIL	VIAL (ML)	2.5 MG/ML	INJ	PA; SP
TREPROSTINIL	VIAL (ML)	5 MG/ML	INJ	PA; SP
TREPROSTINIL	VIAL (ML)	10 MG/ML	INJ	PA; SP
UPTRAVI	TABLET	200 MCG	ORAL	LA; PA; QL; SP
UPTRAVI	TABLET	400 MCG	ORAL	LA; PA; QL; SP
UPTRAVI	TABLET	600 MCG	ORAL	LA; PA; QL; SP
UPTRAVI	TABLET	800 MCG	ORAL	LA; PA; QL; SP
UPTRAVI	TABLET	1000 MCG	ORAL	LA; PA; QL; SP
UPTRAVI	TABLET	1200 MCG	ORAL	LA; PA; QL; SP
UPTRAVI	TABLET	1400 MCG	ORAL	LA; PA; QL; SP
UPTRAVI	TABLET	1600 MCG	ORAL	LA; PA; QL; SP
UPTRAVI	TABLET; DOSE PACK	200-800 MCG	ORAL	LA; PA; QL; SP
VITAMIN K				
phytonadione	*ampul (ml)*	*10 mg/ml*	INJ	
PHYTONADIONE	SYRINGE (ML)	1 MG/0.5 ML	INJ	
phytonadione	*tablet*	*5 mg*	ORAL	QL
vitamin k	ampul (ml)	1 mg/0.5 ml	INJ	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
vitamin k	ampul (ml)	10 mg/ml	INJ	
DERMATOLOGICALS/TOPICAL THERAPY				
ANTIPSORIATIC / ANTISEBORRHEIC				
acitretin	capsule	10 mg	ORAL	
acitretin	capsule	17.5 mg	ORAL	
acitretin	capsule	25 mg	ORAL	
calcipotriene	cream (gram)	0.005%	TOPICAL	QL
calcipotriene	ointment (gram)	0.005%	TOPICAL	QL
calcipotriene	solution; non-oral	0.005%	TOPICAL	QL
calcipotriene-betamethasone	ointment (gram)	0.005-0.064	TOPICAL	QL; ST
calcipotriene-betamethasone	suspension; topical (gram)	0.005-0.064	TOPICAL	QL
calcitriol	*ointment (gram)*	*3 mcg/g*	TOPICAL	
hc pramoxine	cream (gram)	2.5%-1%	TOPICAL	ST
selenium sulfide	*lotion (ml)*	*2.5%*	TOPICAL	
selenium sulfide	*shampoo*	*2.25%*	TOPICAL	
selenium sulfide	*shampoo*	*2.3%*	TOPICAL	
SKYRIZI	SYRINGE (ML)	150 MG/ML	SC	PA; QL; SP
SKYRIZI PEN	PEN INJECTOR (ML)	150 MG/ML	SC	PA; QL; SP
sodium sulfacetamide	cleanser (ml)	10%	TOPICAL	
sodium sulfacetamide	cleanser; gel (ml)	10%	TOPICAL	
sodium sulfacetamide	shampoo	9.8%	TOPICAL	
sodium sulfacetamide	shampoo	10%	TOPICAL	
SOTYKTU	TABLET	6 MG	ORAL	PA; QL; SP
STELARA	SYRINGE (ML)	45 MG/0.5 ML	SC	PA; QL; SP
STELARA	SYRINGE (ML)	90 MG/ML	SC	PA; QL; SP
STELARA	VIAL (ML)	45 MG/0.5 ML	SC	PA; QL; SP
TALTZ AUTOINJECTOR	AUTO-INJECTOR (ML)	80 MG/ML	SC	PA; QL; SP
TALTZ AUTOINJECTOR (2 PACK)	AUTO-INJECTOR (ML)	80 MG/ML	SC	PA; QL; SP
TALTZ AUTOINJECTOR (3 PACK)	AUTO-INJECTOR (ML)	80 MG/ML	SC	PA; QL; SP
TALTZ SYRINGE	SYRINGE (ML)	80 MG/ML	SC	PA; QL; SP
TREMFYA	AUTO-INJECTOR (ML)	100 MG/ML	SC	PA; QL; SP
TREMFYA	SYRINGE (ML)	100 MG/ML	SC	PA; QL; SP
BURN THERAPY				
silver sulfadiazine	*cream (gram)*	*1%*	TOPICAL	
ssd	*cream (gram)*	*1%*	TOPICAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
MISC DERMATOLOGICALS				
ADBRY	SYRINGE (ML)	150 MG/ML	SC	PA; QL; SP
CIBINQO	TABLET	50 MG	ORAL	PA; QL; SP
CIBINQO	TABLET	100 MG	ORAL	PA; QL; SP
CIBINQO	TABLET	200 MG	ORAL	PA; QL; SP
diclofenac sodium	gel (gram)	3%	TOPICAL	PA; QL
doxepin hcl	*cream (gram)*	*5%*	TOPICAL	QL; ST
DUPIXENT	SYRINGE (ML)	200 MG/1.14	SC	PA; QL; SP
DUPIXENT	SYRINGE (ML)	300 MG/2 ML	SC	PA; QL; SP
DUPIXENT PEN	PEN INJECTOR (ML)	200 MG/1.14	SC	PA; QL; SP
DUPIXENT PEN	PEN INJECTOR (ML)	300 MG/2 ML	SC	PA; QL; SP
EUCRISA	OINTMENT (GRAM)	2%	TOPICAL	PA; QL
fluorouracil	cream (gram)	5%	TOPICAL	
fluorouracil	solution; non-oral	2%	TOPICAL	
fluorouracil	solution; non-oral	5%	TOPICAL	
methoxsalen	capsule; liquid-filled; rapid release	10 mg	ORAL	
methyl salicylate	liquid (ml)	str n/a	TOPICAL	
methyl salicylate	oil (ml)	str n/a	MISC	
pimecrolimus	cream (gram)	1%	TOPICAL	QL; ST
podofilox	gel (gram)	0.5%	TOPICAL	QL; ST
podofilox	*solution; non-oral*	*0.5%*	TOPICAL	
prudoxin	*cream (gram)*	*5%*	TOPICAL	QL; ST
REGRANEX	GEL (GRAM)	0.01%	TOPICAL	QL
tacrolimus	ointment (gram)	0.03%	TOPICAL	QL; ST
tacrolimus	ointment (gram)	0.1%	TOPICAL	QL; ST
VALCHLOR	GEL (GRAM)	0.016%	TOPICAL	PA; SP
wintergreen	oil (ml)	str n/a	MISC	
THERAPY FOR ACNE				
10-1	cleanser (gram)	10%-1%	TOPICAL	ST
accutane	capsule	10 mg	ORAL	
accutane	capsule	20 mg	ORAL	
accutane	capsule	30 mg	ORAL	
accutane	capsule	40 mg	ORAL	
adapalene	cream (gram)	0.1%	TOPICAL	PA
adapalene	gel (gram)	0.1%	TOPICAL	PA

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
adapalene	gel (gram)	0.3%	TOPICAL	PA
adapalene	gel with pump (gram)	0.3%	TOPICAL	PA
adapalene	solution; non-oral	0.1%	TOPICAL	PA
adapalene	swab; medicated	0.1%	TOPICAL	PA
adapalene-benzoyl peroxide	gel with pump (gram)	0.1%-2.5%	TOPICAL	
adapalene-benzoyl peroxide	gel with pump (gram)	0.3%-2.5%	TOPICAL	
amnesteem	capsule	10 mg	ORAL	
amnesteem	capsule	20 mg	ORAL	
amnesteem	capsule	40 mg	ORAL	
avar	cleanser (gram)	10-5% (w/w)	TOPICAL	
azelaic acid	gel (gram)	15%	TOPICAL	PA
benzepro	towelette (ea)	6%	TOPICAL	
benzoyl peroxide	foam (gram)	9.8%	TOPICAL	
claravis	capsule	10 mg	ORAL	
claravis	capsule	20 mg	ORAL	
claravis	capsule	30 mg	ORAL	
claravis	capsule	40 mg	ORAL	
clindacin	*foam (gram)*	*1%*	TOPICAL	QL
clindacin etz	*swab; medicated*	*1%*	TOPICAL	
clindacin p	*swab; medicated*	*1%*	TOPICAL	
clindamycin phosphate	foam (gram)	1%	TOPICAL	QL
clindamycin phosphate	*gel (gram)*	*1%*	TOPICAL	QL
clindamycin phosphate	gel; once daily	1%	TOPICAL	QL; ST
clindamycin phosphate	*lotion (ml)*	*1%*	TOPICAL	QL
clindamycin phosphate	*solution; non-oral*	*1%*	TOPICAL	QL
clindamycin phosphate	*swab; medicated*	*1%*	TOPICAL	
clindamycin phos-tretinoin	gel (gram)	1.2-0.025%	TOPICAL	
clindamycin-benzoyl peroxide	gel (gram)	1%-5%	TOPICAL	
clindamycin-benzoyl peroxide	gel (gram)	1.2 (1)%-5%	TOPICAL	
clindamycin-benzoyl peroxide	gel with pump (gram)	1%-5%	TOPICAL	
clindamycin-benzoyl peroxide	gel with pump (gram)	1.2%-2.5%	TOPICAL	
clindamycin-benzoyl peroxide	gel with pump (gram)	1.2%-3.75%	TOPICAL	
dapsone	gel (gram)	5%	TOPICAL	
dapsone	gel with pump (gram)	7.5%	TOPICAL	
ery	*swab; medicated*	*2%*	TOPICAL	
erygel	*gel (gram)*	*2%*	TOPICAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
erythromycin	*gel (gram)*	*2%*	TOPICAL	
erythromycin	*solution; non-oral*	*2%*	TOPICAL	
erythromycin-benzoyl peroxide	gel (gram)	3%-5%	TOPICAL	
FINACEA	FOAM (GRAM)	15%	TOPICAL	PA
isotretinoin	capsule	10 mg	ORAL	
isotretinoin	capsule	20 mg	ORAL	
isotretinoin	capsule	25 mg	ORAL	
isotretinoin	capsule	30 mg	ORAL	
isotretinoin	capsule	35 mg	ORAL	
isotretinoin	capsule	40 mg	ORAL	
ivermectin	cream (gram)	1%	TOPICAL	QL
metronidazole	*cream (gram)*	*0.75%*	TOPICAL	
metronidazole	*gel (gram)*	*0.75%*	TOPICAL	
metronidazole	gel (gram)	1%	TOPICAL	
metronidazole	gel with pump (gram)	1%	TOPICAL	
metronidazole	lotion (ml)	0.75%	TOPICAL	
neuac	gel (gram)	1.2 (1)%-5%	TOPICAL	
rosadan	*cream (gram)*	*0.75%*	TOPICAL	
rosadan	*gel (gram)*	*0.75%*	TOPICAL	
rosula	pads; medicated (ea)	10%-5%	TOPICAL	
sodium sulfacetamide/sulfur	cleanser (gram)	9%-4%	TOPICAL	
sodium sulfacetamide/sulfur	cleanser (gram)	9%-4.5%	TOPICAL	
sodium sulfacetamide/sulfur	cleanser (gram)	9.8%-4.8%	TOPICAL	
sodium sulfacetamide/sulfur	cleanser (gram)	10%-2%	TOPICAL	
sodium sulfacetamide/sulfur	*cleanser (gram)*	*10-5% (w/w)*	TOPICAL	
sodium sulfacetamide/sulfur	cleanser (ml)	9%-4%	TOPICAL	
sodium sulfacetamide/sulfur	cream (gram)	9.8%-4.8%	TOPICAL	
sodium sulfacetamide/sulfur	cream (gram)	10%-2%	TOPICAL	
sodium sulfacetamide/sulfur	cream (gram)	10-5% (w/w)	TOPICAL	
sodium sulfacetamide/sulfur	lotion (gram)	9.8%-4.8%	TOPICAL	
sodium sulfacetamide/sulfur	lotion (gram)	10-5% (w/v)	TOPICAL	
sodium sulfacetamide/sulfur	lotion (gram)	10-5% (w/w)	TOPICAL	
sodium sulfacetamide/sulfur	pads; medicated (ea)	9.8%-4.8%	TOPICAL	
sodium sulfacetamide/sulfur	pads; medicated (ea)	10%-4%	TOPICAL	
sodium sulfacetamide/sulfur	suspension; topical (gram)	10-5% (w/w)	TOPICAL	
sodium sulfacetamide/sulfur	suspension; topical (ml)	8%-4%	TOPICAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ss 10-2	cleanser (gram)	10%-2%	TOPICAL	
sss 10-5	cream (gram)	10-5% (w/w)	TOPICAL	
sss 10-5	foam (gram)	10%-5%	TOPICAL	
sulfacetamide sodium-sulfur	*cleanser (gram)*	*10-5% (w/w)*	TOPICAL	
sulfacetamide sodium-sulfur	lotion (gram)	10-5% (w/w)	TOPICAL	
sulfacleanse 8/4	suspension; topical (ml)	8%-4%	TOPICAL	ST
tazarotene	cream (gram)	0.1%	TOPICAL	PA
tazarotene	gel (gram)	0.05%	TOPICAL	PA
tazarotene	gel (gram)	0.1%	TOPICAL	PA
tretinoin	cream (gram)	0.025%	TOPICAL	PA
tretinoin	cream (gram)	0.05%	TOPICAL	PA
tretinoin	cream (gram)	0.1%	TOPICAL	PA
tretinoin	gel (gram)	0.01%	TOPICAL	PA
tretinoin	gel (gram)	0.025%	TOPICAL	PA
tretinoin	gel (gram)	0.05%	TOPICAL	PA
tretinoin microsphere	gel (gram)	0.04%	TOPICAL	PA
tretinoin microsphere	gel (gram)	0.1%	TOPICAL	PA
tretinoin microsphere	gel with pump (gram)	0.04%	TOPICAL	PA
tretinoin microsphere	gel with pump (gram)	0.08%	TOPICAL	PA
tretinoin microsphere	gel with pump (gram)	0.1%	TOPICAL	PA
zenatane	capsule	10 mg	ORAL	
zenatane	capsule	20 mg	ORAL	
zenatane	capsule	30 mg	ORAL	
zenatane	capsule	40 mg	ORAL	
TOPICAL ANESTHETICS				
dermacinrx lidocan	*adhesive patch; medicated*	*5%*	TOPICAL	ST
lidocaine	*adhesive patch; medicated*	*5%*	TOPICAL	ST
lidocaine	*ointment (gram)*	*5%*	TOPICAL	QL
lidocaine hcl	*solution; non-oral*	*40 mg/ml*	MUCOUS MEMBRANE	
lidocaine hcl	*solution; oral*	*2%*	MUCOUS MEMBRANE	
lidocaine hcl	*solution; oral*	*4%*	TOPICAL	
lidocaine-hc	*cream (gram)*	*3%-0.5%*	TOPICAL	
lidocaine-prilocaine	*cream (gram)*	*2.5%-2.5%*	TOPICAL	QL
lidocaine-prilocaine	*kit*	*2.5%-2.5%*	TOPICAL	
lidocan iii	adhesive patch; medicated	5%	TOPICAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
lidocan iv	adhesive patch; medicated	5%	TOPICAL	ST
lidocan v	adhesive patch; medicated	5%	TOPICAL	ST
lidocort	cream (gram)	3%-0.5%	TOPICAL	
tridacaine	adhesive patch; medicated	5%	TOPICAL	ST
ZTLIDO	ADHESIVE PATCH; MEDICATED	1.8%	TOPICAL	ST
TOPICAL ANTIBACTERIALS				
gentamicin sulfate	*cream (gram)*	*0.1%*	TOPICAL	QL
gentamicin sulfate	*ointment (gram)*	*0.1%*	TOPICAL	QL
iodine	solution; non-oral	5%-10%	TOPICAL	
lugol's	solution; non-oral	5%-10%	TOPICAL	
mafenide acetate	packet (ea)	50 g	TOPICAL	
mupirocin	cream (gram)	2%	TOPICAL	QL; ST
mupirocin	*ointment (gram)*	*2%*	TOPICAL	QL
sulfacetamide sodium	suspension; topical (ml)	10%	TOPICAL	
SULFAMYLON	CREAM (GRAM)	8.5%	TOPICAL	
TOPICAL ANTIFUNGALS				
ciclodan	*cream (gram)*	*0.77%*	TOPICAL	QL
ciclopirox	*cream (gram)*	*0.77%*	TOPICAL	QL
ciclopirox	*gel (gram)*	*0.77%*	TOPICAL	QL
ciclopirox	*shampoo*	*1%*	TOPICAL	QL
ciclopirox	*suspension; topical (ml)*	*0.77%*	TOPICAL	QL
clotrimazole/betamethasone	*cream (gram)*	*1%-0.05%*	TOPICAL	QL
clotrimazole/betamethasone	lotion (ml)	1%-0.05%	TOPICAL	QL
econazole nitrate	*cream (gram)*	*1%*	TOPICAL	QL
ketoconazole	*cream (gram)*	*2%*	TOPICAL	QL
ketoconazole	*foam (gram)*	*2%*	TOPICAL	QL; ST
ketoconazole	*shampoo*	*2%*	TOPICAL	QL
ketodan	*combination package (gram)*	*2%*	TOPICAL	ST
ketodan	*foam (gram)*	*2%*	TOPICAL	QL; ST
klayesta	powder (gram)	100000/g	TOPICAL	QL
naftifine hcl	cream (gram)	1%	TOPICAL	QL
naftifine hcl	cream (gram)	2%	TOPICAL	QL
naftifine hcl	gel (gram)	2%	TOPICAL	QL
nyamyc	*powder (gram)*	*100000/g*	TOPICAL	QL
nystatin	*cream (gram)*	*100000/g*	TOPICAL	QL

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
nystatin	*ointment (gram)*	*100000/g*	TOPICAL	QL
nystatin	*powder (gram)*	*100000/g*	TOPICAL	QL
nystatin w/ triamcinolone	*cream (gram)*	*100000-0.1*	TOPICAL	QL
nystatin w/ triamcinolone	*ointment (gram)*	*100000-0.1*	TOPICAL	QL
nystop	*powder (gram)*	*100000/g*	TOPICAL	QL
oxiconazole nitrate	cream (gram)	1%	TOPICAL	QL
tavaborole	solution with applicator (ml)	5%	TOPICAL	ST
TOPICAL ANTIVIRALS				
acyclovir	cream (gram)	5%	TOPICAL	PA; QL
acyclovir	*ointment (gram)*	*5%*	TOPICAL	PA; QL
penciclovir	cream (gram)	1%	TOPICAL	
TOPICAL CORTICOSTEROIDS HIGH POTENCY				
amcinonide	cream (gram)	0.1%	TOPICAL	ST
amcinonide	ointment (gram)	0.1%	TOPICAL	ST
apexicon e	cream (gram)	0.05%	TOPICAL	ST
betamethasone dipropionate	*cream (gram)*	*0.05%*	TOPICAL	
betamethasone dipropionate	*gel (gram)*	*0.05%*	TOPICAL	
betamethasone dipropionate	*lotion (ml)*	*0.05%*	TOPICAL	
betamethasone dipropionate	*ointment (gram)*	*0.05%*	TOPICAL	
betamethasone valerate	*ointment (gram)*	*0.1%*	TOPICAL	
desoximetasone	*cream (gram)*	*0.25%*	TOPICAL	ST
desoximetasone	*gel (gram)*	*0.05%*	TOPICAL	ST
desoximetasone	*ointment (gram)*	*0.25%*	TOPICAL	ST
desoximetasone	*spray; non-aerosol (ml)*	*0.25%*	TOPICAL	ST
diflorasone diacetate	cream (gram)	0.05%	TOPICAL	QL; ST
fluocinonide	*cream (gram)*	*0.05%*	TOPICAL	QL
fluocinonide	*cream (gram)*	*0.1%*	TOPICAL	QL; ST
fluocinonide	*gel (gram)*	*0.05%*	TOPICAL	QL
fluocinonide	*ointment (gram)*	*0.05%*	TOPICAL	QL
fluocinonide	*solution; non-oral*	*0.05%*	TOPICAL	QL
fluocinonide-e	*cream (gram)*	*0.05%*	TOPICAL	QL
halcinonide	cream (gram)	0.1%	TOPICAL	ST
triamcinolone acetonide	*cream (gram)*	*0.5%*	TOPICAL	
triamcinolone acetonide	*ointment (gram)*	*0.5%*	TOPICAL	
triderm	*cream (gram)*	*0.5%*	TOPICAL	ST

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
TOPICAL CORTICOSTEROIDS LOW POTENCY				
alclometasone dipropionate	*cream (gram)*	*0.05%*	TOPICAL	
alclometasone dipropionate	*ointment (gram)*	*0.05%*	TOPICAL	
desonide	*cream (gram)*	*0.05%*	TOPICAL	
desonide	gel (gram)	0.05%	TOPICAL	ST
desonide	lotion (ml)	0.05%	TOPICAL	ST
desonide	*ointment (gram)*	*0.05%*	TOPICAL	
fluocinolone acetonide	*cream (gram)*	*0.01%*	TOPICAL	
fluocinolone acetonide	*oil (ml)*	*0.01%*	TOPICAL	
fluocinolone acetonide	*solution; non-oral*	*0.01%*	TOPICAL	
hydrocortisone	*cream (gram)*	*2.5%*	TOPICAL	
hydrocortisone	lotion (ml)	2%	TOPICAL	
hydrocortisone	*lotion (ml)*	*2.5%*	TOPICAL	
hydrocortisone	*ointment (gram)*	*2.5%*	TOPICAL	
scalacort	*lotion (ml)*	*2%*	TOPICAL	
TOPICAL CORTICOSTEROIDS MEDIUM POTENCY				
beser	*lotion (ml)*	*0.05%*	TOPICAL	ST
betamethasone valerate	*cream (gram)*	*0.1%*	TOPICAL	
betamethasone valerate	foam (gram)	0.12%	TOPICAL	ST
betamethasone valerate	*lotion (ml)*	*0.1%*	TOPICAL	
clocortolone pivalate	cream (gram)	0.1%	TOPICAL	
desoximetasone	cream (gram)	0.05%	TOPICAL	ST
desoximetasone	*ointment (gram)*	*0.05%*	TOPICAL	ST
fluocinolone acetonide	*cream (gram)*	*0.025%*	TOPICAL	
fluocinolone acetonide	*ointment (gram)*	*0.025%*	TOPICAL	
flurandrenolide	cream (gram)	0.05%	TOPICAL	QL; ST
flurandrenolide	lotion (ml)	0.05%	TOPICAL	QL; ST
flurandrenolide	ointment (gram)	0.05%	TOPICAL	QL; ST
fluticasone propionate	*cream (gram)*	*0.05%*	TOPICAL	
fluticasone propionate	*lotion (ml)*	*0.05%*	TOPICAL	ST
fluticasone propionate	*ointment (gram)*	*0.005%*	TOPICAL	
hydrocortisone butyrate	*cream (gram)*	*0.1%*	TOPICAL	QL
hydrocortisone butyrate	*lotion (ml)*	*0.1%*	TOPICAL	QL; ST
hydrocortisone butyrate	*ointment (gram)*	*0.1%*	TOPICAL	QL; ST
hydrocortisone butyrate	*solution; non-oral*	*0.1%*	TOPICAL	QL; ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
hydrocortisone valerate	cream (gram)	0.2%	TOPICAL	
hydrocortisone valerate	ointment (gram)	0.2%	TOPICAL	
mometasone furoate	*cream (gram)*	*0.1%*	TOPICAL	
mometasone furoate	*ointment (gram)*	*0.1%*	TOPICAL	
mometasone furoate	*solution; non-oral*	*0.1%*	TOPICAL	
prednicarbate	*cream (gram)*	*0.1%*	TOPICAL	
prednicarbate	*ointment (gram)*	*0.1%*	TOPICAL	
triamcinolone acetonide	*aerosol (gram)*	*0.147 mg/g*	TOPICAL	QL; ST
triamcinolone acetonide	*cream (gram)*	*0.025%*	TOPICAL	
triamcinolone acetonide	*cream (gram)*	*0.1%*	TOPICAL	
triamcinolone acetonide	*lotion (ml)*	*0.025%*	TOPICAL	
triamcinolone acetonide	*lotion (ml)*	*0.1%*	TOPICAL	
triamcinolone acetonide	*ointment (gram)*	*0.025%*	TOPICAL	
triamcinolone acetonide	ointment (gram)	0.05%	TOPICAL	ST
triamcinolone acetonide	*ointment (gram)*	*0.1%*	TOPICAL	
triderm	*cream (gram)*	*0.1%*	TOPICAL	
TOPICAL CORTICOSTEROIDS VERY HIGH POTENCY				
betamethasone dipropionate	*ointment (gram)*	*0.05%*	TOPICAL	
clobetasol e	cream (gram)	0.05%	TOPICAL	QL
clobetasol emulsion	foam (gram)	0.05%	TOPICAL	QL; ST
clobetasol propionate	*cream (gram)*	*0.05%*	TOPICAL	QL
clobetasol propionate	cream (gram)	0.05%	TOPICAL	QL
clobetasol propionate	foam (gram)	0.05%	TOPICAL	QL; ST
clobetasol propionate	*gel (gram)*	*0.05%*	TOPICAL	QL
clobetasol propionate	lotion (ml)	0.05%	TOPICAL	QL; ST
clobetasol propionate	*ointment (gram)*	*0.05%*	TOPICAL	QL
clobetasol propionate	*shampoo*	*0.05%*	TOPICAL	QL; ST
clobetasol propionate	*solution; non-oral*	*0.05%*	TOPICAL	QL
clobetasol propionate	*spray; non-aerosol (ml)*	*0.05%*	TOPICAL	QL; ST
clodan	*shampoo*	*0.05%*	TOPICAL	QL; ST
diflorasone diacetate	ointment (gram)	0.05%	TOPICAL	QL; ST
halobetasol propionate	*cream (gram)*	*0.05%*	TOPICAL	
halobetasol propionate	*ointment (gram)*	*0.05%*	TOPICAL	
tovet emollient	foam (gram)	0.05%	TOPICAL	QL; ST

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
TOPICAL ENZYMES				
SANTYL	OINTMENT (GRAM)	250 UNIT/G	TOPICAL	QL
TOPICAL SCABICIDES / PEDICULICIDES				
crotan	lotion (gram)	10%	TOPICAL	
malathion	lotion (ml)	0.5%	TOPICAL	
permethrin	*cream (gram)*	*5%*	TOPICAL	
spinosad	suspension; topical (ml)	0.9%	TOPICAL	
DIAGNOSTICS & MISC AGENTS				
IRRIGATING SOLUTIONS				
lactated ringers	solution; irrigation	str n/a	IRRIGATION	
neomycin-polymyxin b	ampul (ml)	40-200k/ml	IRRIGATION	
neomycin-polymyxin b	vial (ml)	40-200k/ml	IRRIGATION	
ringers	solution; irrigation	str n/a	IRRIGATION	
tis-u-sol	solution; irrigation	800-40/100	IRRIGATION	
MISC AGENTS				
acamprosate calcium	tablet; enteric coated	333 mg	ORAL	
acetic acid	*solution; irrigation*	*0.25%*	IRRIGATION	
anagrelide hydrochloride	*capsule*	*0.5 mg*	ORAL	
anagrelide hydrochloride	*capsule*	*1 mg*	ORAL	
caffeine citrated	solution; oral	60 mg/3 ml	ORAL	
CARBAGLU	TABLET; DISPERSIBLE	200 MG	ORAL	LA; PA; SP
CARGLUMIC ACID	TABLET; DISPERSIBLE	200 MG	ORAL	PA; SP
cevimeline hcl	capsule	30 mg	ORAL	
CHEMET	CAPSULE	100 MG	ORAL	PA
DEFERASIROX	GRANULES IN PACKET (EA)	90 MG	ORAL	PA; SP
DEFERASIROX	GRANULES IN PACKET (EA)	180 MG	ORAL	PA; SP
DEFERASIROX	GRANULES IN PACKET (EA)	360 MG	ORAL	PA; SP
DEFERASIROX	TABLET	90 MG	ORAL	PA; SP
DEFERASIROX	TABLET	180 MG	ORAL	PA; SP
DEFERASIROX	TABLET	360 MG	ORAL	PA; SP
DEFERASIROX	TABLET; DISPERSIBLE	125 MG	ORAL	PA; SP
DEFERASIROX	TABLET; DISPERSIBLE	250 MG	ORAL	PA; SP
DEFERASIROX	TABLET; DISPERSIBLE	500 MG	ORAL	PA; SP
DEFERIPRONE	TABLET	500 MG	ORAL	PA; SP
DEFERIPRONE (3 TIMES A DAY)	TABLET	1000 MG	ORAL	PA; SP

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
disulfiram	*tablet*	*250 mg*	ORAL	
disulfiram	*tablet*	*500 mg*	ORAL	
EMPAVELI	VIAL (ML)	1080 MG/20	SC	PA; SP
FABHALTA	CAPSULE	200 MG	ORAL	PA; SP
FERRIPROX	SOLUTION; ORAL	100 MG/ML	ORAL	PA; SP
FERRIPROX (2 TIMES A DAY)	TABLET; MODIFIED RELEASE	1000 MG	ORAL	PA; SP
INCRELEX	VIAL (ML)	10 MG/ML	SC	LA; PA; SP
levocarnitine	*solution; oral*	*100 mg/ml*	ORAL	
levocarnitine	*tablet*	*330 mg*	ORAL	
levocarnitine sf	*solution; oral*	*100 mg/ml*	ORAL	
midodrine hcl	*tablet*	*2.5 mg*	ORAL	
midodrine hcl	*tablet*	*5 mg*	ORAL	
midodrine hcl	*tablet*	*10 mg*	ORAL	
NITISINONE	CAPSULE	2 MG	ORAL	LA; PA; SP
NITISINONE	CAPSULE	5 MG	ORAL	LA; PA; SP
NITISINONE	CAPSULE	10 MG	ORAL	LA; PA; SP
NITISINONE	CAPSULE	20 MG	ORAL	LA; PA; SP
NITYR	TABLET	2 MG	ORAL	LA; PA; SP
NITYR	TABLET	5 MG	ORAL	LA; PA; SP
NITYR	TABLET	10 MG	ORAL	LA; PA; SP
PHEBURANE	GRANULES (GRAM)	483 MG/G	ORAL	PA; SP
pilocarpine hcl	*tablet*	*5 mg*	ORAL	
PROLASTIN C	VIAL (EA)	1000 MG/20	IV	LA; PA; SP
riluzole	tablet	50 mg	ORAL	PA
risedronate sodium	*tablet*	*30 mg*	ORAL	QL
sodium chloride	*intravenous solution*	*0.9%*	IV	
sodium chloride	*piggyback with threaded port (ml)*	*str n/a*	IV	
sodium chloride	*piggyback with vial port (non-threaded)*	*str n/a*	IV	
sodium chloride	*solution; irrigation*	*0.9%*	IRRIGATION	
sodium chloride	*syringe (ml)*	*0.9%*	INJ	
sodium chloride	*vial (ml)*	*0.9%*	INJ	
sodium phenylbutyrate	powder (gram)	0.94 g/g	ORAL	PA
sodium phenylbutyrate	tablet	500 mg	ORAL	PA
TIOPRONIN	TABLET	100 MG	ORAL	PA; SP
TIOPRONIN	TABLET; ENTERIC COATED	100 MG	ORAL	PA; SP
TIOPRONIN	TABLET; ENTERIC COATED	300 MG	ORAL	PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
trientine hcl	capsule	250 mg	ORAL	PA
water	*solution; irrigation*	*str n/a*	IRRIGATION	
XURIDEN	GRANULES IN PACKET (EA)	2 G	ORAL	PA; SP
ZOLEDRONIC ACID	INTRAVENOUS SOLUTION; PIGGYBACK (ML)	5 MG/100 ML	IV	PA; SP
ZOLEDRONIC ACID	IV SOLUTION; PIGGYBACK; BOTTLE (ML)	5 MG/100 ML	IV	PA; SP
SMOKING DETERRENTS				
bupropion sr	*tablet; extended release 12 hr*	*150 mg*	ORAL	ACA; QL
nicorette	*gum*	*4 mg*	BUCCAL	ACA; QL
nicotine	*lozenge*	*2 mg*	BUCCAL	ACA; QL
nicotine	*lozenge*	*4 mg*	BUCCAL	ACA; QL
nicotine	*mini lozenge*	*2 mg*	BUCCAL	ACA; QL
nicotine	*mini lozenge*	*4 mg*	BUCCAL	ACA; QL
nicotine	*patch; transdermal 24 hours*	*7 mg/24 hr*	TRANSDERM	ACA; QL
nicotine	*patch; transdermal 24 hours*	*14 mg/24 hr*	TRANSDERM	ACA; QL
nicotine	*patch; transdermal 24 hours*	*21 mg/24 hr*	TRANSDERM	ACA; QL
nicotine	*patch; transdermal daily; sequential*	*21-14-7 mg*	TRANSDERM	ACA; QL
nicotine gum	*gum*	*2 mg*	BUCCAL	ACA; QL
nicotine gum	*gum*	*4 mg*	BUCCAL	ACA; QL
quit 2	*gum*	*2 mg*	BUCCAL	ACA; QL
quit 2	*lozenge*	*2 mg*	BUCCAL	ACA; QL
quit 4	*gum*	*4 mg*	BUCCAL	ACA; QL
quit 4	*lozenge*	*4 mg*	BUCCAL	ACA; QL
stop smoking aid	*lozenge*	*2 mg*	BUCCAL	ACA; QL
stop smoking aid	*lozenge*	*4 mg*	BUCCAL	ACA; QL
varenicline tartrate	*tablet*	*0.5 mg*	ORAL	ACA; QL
varenicline tartrate	*tablet*	*1 mg*	ORAL	ACA; QL
varenicline tartrate	*tablet; dose pack*	*0.5 (11)-1*	ORAL	ACA; QL
EAR, NOSE & THROAT MEDICATIONS				
MISC AGENTS				
azelastine hcl	*aerosol; spray with pump (ml)*	*137 mcg*	NASAL	QL
chlorhexidine gluconate	*mouthwash*	*0.12%*	MUCOUS MEMBRANE	
denta 5000 plus	*cream (gram)*	*1.1%*	DENTAL	
denta 5000 plus sensitive	paste (ml)	1.1%-5%	DENTAL	
dentagel	*gel (gram)*	*1.1%*	DENTAL	
ipratropium bromide	*aerosol; spray (ml)*	*21 mcg*	NASAL	QL

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ipratropium bromide	*aerosol; spray (ml)*	*42 mcg*	NASAL	QL
kourzeq	paste (gram)	0.1%	DENTAL	
olopatadine hcl	aerosol; spray with pump (gram)	0.6%	NASAL	QL
oralone	*paste (gram)*	*0.1%*	DENTAL	
periogard	*mouthwash*	*0.12%*	MUCOUS MEMBRANE	
pilocarpine hcl	*tablet*	*7.5 mg*	ORAL	
sf	*gel (gram)*	*1.1%*	DENTAL	
sf 5000 plus	*cream (gram)*	*1.1%*	DENTAL	
sodium fluoride	*cream (gram)*	*1.1%*	DENTAL	
sodium fluoride	*gel (gram)*	*1.1%*	DENTAL	
sodium fluoride	*paste (ml)*	*1.1%*	DENTAL	
sodium fluoride	*solution; non-oral*	*0.2%*	DENTAL	
sodium fluoride 5000 plus	*cream (gram)*	*1.1%*	DENTAL	
sodium fluoride enamel protect	*paste (ml)*	*1.1%-5%*	DENTAL	
sodium fluoride sensitive	*paste (ml)*	*1.1%-5%*	DENTAL	
triamcinolone acetonide	*paste (gram)*	*0.1%*	DENTAL	
MISC OTIC PREPARATIONS				
acetic acid	*solution; non-oral*	*2%*	OTIC (EAR)	
acetic acid/hydrocortisone	drops	1%-2%	OTIC (EAR)	
ciprofloxacin hcl	dropperette; single-use drop dispenser	0.2%	OTIC (EAR)	
flac otic oil	*drops*	*0.01%*	OTIC (EAR)	
fluocinolone acetonide oil	*drops*	*0.01%*	OTIC (EAR)	
ofloxacin	*drops*	*0.3%*	OTIC (EAR)	
OTIC STEROID / ANTIBIOTIC				
ciprofloxacin-dexamethasone	suspension; drops (final dosage form) (ml)	0.3%-0.1%	OTIC (EAR)	
neomycin/polymyxin/hc	*solution; non-oral*	*3.5-10k-1*	OTIC (EAR)	
neomycin/polymyxin/hc	*suspension; drops (final dosage form) (ml)*	*3.5-10k-1*	OTIC (EAR)	
ENDOCRINE/DIABETES				
ADRENAL HORMONES				
cortisone acetate	*tablet*	*25 mg*	ORAL	
DEFLAZACORT	SUSPENSION; ORAL (FINAL DOSE FORM)	22.75 MG/ML	ORAL	PA; SP
DEFLAZACORT	TABLET	6 MG	ORAL	PA; SP
DEFLAZACORT	TABLET	18 MG	ORAL	PA; SP
DEFLAZACORT	TABLET	30 MG	ORAL	PA; SP
DEFLAZACORT	TABLET	36 MG	ORAL	PA; SP

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
dexabliss	tablet; dose pack	1.5 mg (39)	ORAL	PA
dexamethasone	*drops*	*1 mg/ml*	ORAL	
dexamethasone	*elixir*	*0.5 mg/5 ml*	ORAL	
dexamethasone	*solution; oral*	*0.5 mg/5 ml*	ORAL	
dexamethasone	*tablet*	*0.5 mg*	ORAL	
dexamethasone	*tablet*	*0.75 mg*	ORAL	
dexamethasone	*tablet*	*1 mg*	ORAL	
dexamethasone	*tablet*	*1.5 mg*	ORAL	
dexamethasone	*tablet*	*2 mg*	ORAL	
dexamethasone	*tablet*	*4 mg*	ORAL	
dexamethasone	*tablet*	*6 mg*	ORAL	
dexamethasone	tablet; dose pack	1.5 mg (21)	ORAL	PA
dexamethasone	tablet; dose pack	1.5 mg (35)	ORAL	PA
dexamethasone	tablet; dose pack	1.5 mg (51)	ORAL	PA
fludrocortisone acetate	*tablet*	*0.1 mg*	ORAL	
hydrocortisone	*tablet*	*5 mg*	ORAL	
hydrocortisone	*tablet*	*10 mg*	ORAL	
hydrocortisone	*tablet*	*20 mg*	ORAL	
methylprednisolone	*tablet*	*4 mg*	ORAL	
methylprednisolone	*tablet*	*8 mg*	ORAL	
methylprednisolone	*tablet*	*16 mg*	ORAL	
methylprednisolone	*tablet*	*32 mg*	ORAL	
methylprednisolone	*tablet; dose pack*	*4 mg*	ORAL	
millipred	*tablet*	*5 mg*	ORAL	
millipred	*tablet; dose pack*	*5 mg (21)*	ORAL	
millipred	*tablet; dose pack*	*5 mg (48)*	ORAL	
prednisolone	*solution; oral*	*15 mg/5 ml*	ORAL	
prednisolone	*tablet*	*5 mg*	ORAL	
prednisolone sodium phos odt	*tablet; disintegrating*	*10 mg*	ORAL	
prednisolone sodium phos odt	*tablet; disintegrating*	*15 mg*	ORAL	
prednisolone sodium phos odt	*tablet; disintegrating*	*30 mg*	ORAL	
prednisolone sodium phosphate	*solution; oral*	*5 mg/5 ml*	ORAL	
prednisolone sodium phosphate	solution; oral	10 mg/5 ml	ORAL	
prednisolone sodium phosphate	*solution; oral*	*15 mg/5 ml*	ORAL	
prednisolone sodium phosphate	solution; oral	20 mg/5 ml	ORAL	
prednisolone sodium phosphate	*solution; oral*	*25 mg/5 ml*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
prednisone	*concentrate; oral*	*5 mg/ml*	ORAL	
prednisone	*solution; oral*	*5 mg/5 ml*	ORAL	
prednisone	*tablet*	*1 mg*	ORAL	
prednisone	*tablet*	*2.5 mg*	ORAL	
prednisone	*tablet*	*5 mg*	ORAL	
prednisone	*tablet*	*10 mg*	ORAL	
prednisone	*tablet*	*20 mg*	ORAL	
prednisone	*tablet*	*50 mg*	ORAL	
prednisone	*tablet; dose pack*	*5 mg*	ORAL	
prednisone	*tablet; dose pack*	*10 mg*	ORAL	
ANDROGENS				
ANDRODERM	PATCH; TRANSDERMAL 24 HOURS	2 MG/24 HR	TRANSDERM	PA; QL
ANDRODERM	PATCH; TRANSDERMAL 24 HOURS	4 MG/24 HR	TRANSDERM	PA; QL
danazol	capsule	50 mg	ORAL	
danazol	capsule	100 mg	ORAL	
danazol	capsule	200 mg	ORAL	
METHITEST	TABLET	10 MG	ORAL	PA
methyltestosterone	*capsule*	*10 mg*	ORAL	
oxandrolone	tablet	2.5 mg	ORAL	PA
oxandrolone	tablet	10 mg	ORAL	PA
testosterone	gel (gram)	50 mg (1%)	TRANSDERM	PA; QL
testosterone	gel in metered-dose pump	10 mg (2%)	TRANSDERM	PA; QL
testosterone	gel in metered-dose pump	12.5/1.25 g	TRANSDERM	PA; QL
testosterone	gel in metered-dose pump	20.25/1.25	TRANSDERM	PA; QL
testosterone	gel in packet (gram)	1.25 g-1.62	TRANSDERM	PA; QL
testosterone	gel in packet (gram)	2.5 g-1.62%	TRANSDERM	PA; QL
testosterone	gel in packet (gram)	25 mg (1%)	TRANSDERM	PA; QL
testosterone	gel in packet (gram)	50 mg (1%)	TRANSDERM	PA; QL
testosterone	solution in metered-dose pump with appl.	30 mg/1.5 ml	TRANSDERM	PA; QL
testosterone cypionate	*vial (ml)*	*100 mg/ml*	IM	PA
testosterone cypionate	*vial (ml)*	*200 mg/ml*	IM	PA
testosterone enanthate	*vial (ml)*	*200 mg/ml*	IM	PA
XYOSTED	AUTO-INJECTOR (ML)	50 MG/0.5 ML	SC	PA; QL
XYOSTED	AUTO-INJECTOR (ML)	75 MG/0.5 ML	SC	PA; QL
XYOSTED	AUTO-INJECTOR (ML)	100 MG/0.5	SC	PA; QL

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ANTITHYROID AGENTS				
methimazole	*tablet*	*5 mg*	ORAL	
methimazole	*tablet*	*10 mg*	ORAL	
potassium iodide	solution; oral	1 g/ml	ORAL	
propylthiouracil	tablet	50 mg	ORAL	
BLOOD GLUCOSE MONITORING DEVICES & SUPPLIES				
FREESTYLE INSULINX	STRIP	STR N/A	MISC	
FREESTYLE INSULINX TEST STRIPS	STRIP	STR N/A	MISC	
FREESTYLE LITE STRIPS	STRIP	STR N/A	MISC	
FREESTYLE LITE TEST STRIPS	STRIP	STR N/A	MISC	ST
FREESTYLE PRECISION NEO	STRIP	STR N/A	MISC	ST
FREESTYLE TEST STRIPS	STRIP	STR N/A	MISC	
ONE TOUCH ULTRA TEST STRIPS	STRIP	STR N/A	MISC	
ONE TOUCH VERIO	STRIP	STR N/A	MISC	
PRECISION XTRA	STRIP	STR N/A	MISC	
GLUCOSE ELEVATING AGENTS				
BAQSIMI	SPRAY; NON-AEROSOL (EA)	3 MG	NASAL	QL
diazoxide	suspension; oral (final dose form)	50 mg/ml	ORAL	
glucagon emergency kit	vial (ea)	1 mg	INJ	QL
GVOKE	VIAL (ML)	1 MG/0.2 ML	SC	PA; QL
GVOKE HYPOPEN	AUTO-INJECTOR (ML)	0.5 MG/0.1	SC	PA; QL
GVOKE HYPOPEN	AUTO-INJECTOR (ML)	1 MG/0.2 ML	SC	PA; QL
GVOKE SYRINGE	SYRINGE (ML)	1 MG/0.2 ML	SC	QL
GONADOTROPIN & RELATED AGENTS				
ORILISSA	TABLET	150 MG	ORAL	QL; ST
ORILISSA	TABLET	200 MG	ORAL	QL; ST
INSULIN SYRINGES/MISC DURABLE MEDICAL EQU				
ACE AEROSOL CLOUD ENHANCER	SPACER (EA)	STR N/A	MISC	
AEROCHAMBER	SPACER (EA)	STR N/A	MISC	
AEROCHAMBER PLUS	SPACER (EA)	STR N/A	MISC	
AEROCHAMBER Z-STAT PLUS	SPACER (EA)	STR N/A	MISC	
AEROTRACH PLUS	SPACER (EA)	STR N/A	MISC	
AEROVENT PLUS	SPACER (EA)	STR N/A	MISC	
AUTOJECT 2	INSULIN PEN (EA)	STR N/A	SC	
AUTOPEN	INSULIN PEN (EA)	STR N/A	SC	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
AUTOSOFT 30	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
AUTOSOFT 90	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
AUTOSOFT XC	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
BD INTEGRA NEEDLE	NEEDLE; DISPOSABLE	23 G X 1''	MISC	
BD MICROTAINER LANCET	EACH	30 GAUGE	MISC	
BD NANO PEN NEEDLE	NEEDLE; DISPOSABLE	32 G X 5/32''	MISC	
B-D NEEDLES	NEEDLE; DISPOSABLE	30 G X 1/2''	MISC	
BREATHERITE	SPACER (EA)	STR N/A	MISC	
CEQUR SIMPLICITY	EACH	2 UNIT	MISC	
COMPACT SPACE CHAMBER	SPACER (EA)	STR N/A	MISC	
DEXCOM G6 RECEIVER	EACH	STR N/A	MISC	QL; ST
DEXCOM G6 SENSOR	EACH	STR N/A	MISC	QL; ST
DEXCOM G6 TRANSMITTER	EACH	STR N/A	MISC	QL; ST
DEXCOM G7 RECEIVER	EACH	STR N/A	MISC	QL; ST
DEXCOM G7 SENSOR	EACH	STR N/A	MISC	QL; ST
EASIVENT	SPACER (EA)	STR N/A	MISC	
EUA PATIENT ASSESSMENT	MISC	STR N/A	MISC	
FLEXICHAMBER	SPACER (EA)	STR N/A	MISC	
FREESTYLE CONTROL SOLUTION	EACH	STR N/A	MISC	
FREESTYLE FREEDOM	KIT	STR N/A	MISC	
FREESTYLE FREEDOM LITE	KIT	STR N/A	MISC	
FREESTYLE INSULINX	EACH	STR N/A	MISC	
FREESTYLE LIBRE 2 READER	EACH	STR N/A	MISC	ST
FREESTYLE LIBRE 2 SENSOR	KIT	STR N/A	MISC	QL; ST
FREESTYLE LIBRE 3 READER	EACH	STR N/A	MISC	QL; ST
FREESTYLE LIBRE 3 SENSOR	EACH	STR N/A	MISC	QL; ST
FREESTYLE LIBRE READER	EACH	STR N/A	MISC	ST
FREESTYLE LIBRE SENSOR	KIT	STR N/A	MISC	QL; ST
FREESTYLE LITE METER	KIT	STR N/A	MISC	
ILET INFUSION-CONTACT DETACH	COMBINATION PACKAGE (EA)	STR N/A	MISC	
ILET INFUSION KIT-INSET	COMBINATION PACKAGE (EA)	STR N/A	MISC	
ILET INSULIN PUMP	EACH	STR N/A	MISC	QL
LANCET	EACH		MISC	
LANCING DEVICE	EACH	STR N/A	MISC	
LITEAIRE	SPACER (EA)	STR N/A	MISC	
MEDISENSE	COMBINATION PACKAGE (EA)	STR N/A	MISC	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
MEDISENSE GLUCOSE KETONE CONTR	COMBINATION PACKAGE (EA)	STR N/A	MISC	
MEDTRONIC EXT INFUSION SET	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
MICROCHAMBER	SPACER (EA)	STR N/A	MISC	
MICROSPACER	SPACER (EA)	STR N/A	MISC	
MINIMED	EACH	STR N/A	MISC	
MINIMED MIO ADVANCE	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
MINIMED QUICK SET	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
MINIMED SILHOUETTE	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
MINIMED SURE T	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
OMNIPOD 5 G6 INTRO KIT (GEN 5)	EACH	STR N/A	SC	QL
OMNIPOD 5 G6 PODS (GEN 5)	CARTRIDGE (EA)	STR N/A	SC	QL
OMNIPOD CLASSIC PODS (GEN 3)	CARTRIDGE (EA)	STR N/A	SC	QL
OMNIPOD DASH INTRO KIT (GEN 4)	EACH	STR N/A	SC	QL
OMNIPOD DASH PODS (GEN 4)	CARTRIDGE (EA)	STR N/A	SC	QL
OMNIPOD GO PODS	CARTRIDGE (EA)	STR N/A	SC	QL
ONE TOUCH ULTRA 2	EACH	STR N/A	MISC	
ONE TOUCH ULTRA CONTROL SOLN	EACH	STR N/A	MISC	
ONE TOUCH VERIO	EACH	STR N/A	MISC	
ONETOUCH VERIO FLEX	EACH	STR N/A	MISC	
ONETOUCH VERIO REFLECT	EACH	STR N/A	MISC	
OPTICHAMBER DIAMOND	SPACER (EA)	STR N/A	MISC	
POCKET CHAMBER	SPACER (EA)	STR N/A	MISC	
PRECISION XTRA	EACH	STR N/A	MISC	
PRECISION XTRA KETONE-GLUCOSE	KIT	STR N/A	MISC	
PRIMEAIRE	SPACER (EA)	STR N/A	MISC	
PROCHAMBER	SPACER (EA)	STR N/A	MISC	
RITEFLO	SPACER (EA)	STR N/A	MISC	
SILHOUETTE	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
SPACE CHAMBER	SPACER (EA)	STR N/A	MISC	
T:FLEX	CARTRIDGE (EA)	STR N/A	SC	
T:SLIM X2	CARTRIDGE (EA)	STR N/A	SC	
TANDEM MOBI CARTRIDGE	CARTRIDGE (EA)	STR N/A	SC	
TRUSTEEL INFUSION SET	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
VARISOFT INFUSION SET	INFUSION SETS-PARAPHERNALIA	STR N/A	MISC	
VGO 20	EACH	STR N/A	MISC	
VGO 30	EACH	STR N/A	MISC	

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VGO 40	EACH	STR N/A	MISC	
VORTEX	SPACER (EA)	STR N/A	MISC	
INSULIN THERAPY				
HUMALOG	CARTRIDGE (ML)	100/ML	SC	
HUMALOG	INSULIN PEN (ML)	100/ML	SC	
HUMALOG	INSULIN PEN (ML)	200/ML (3)	SC	
HUMALOG	VIAL (ML)	100/ML	SC	
HUMALOG JUNIOR KWIKPEN	INSULIN PEN; HALF-UNIT (ML)	100/ML	SC	
HUMALOG MIX 50-50	INSULIN PEN (ML)	50-50/ML	SC	
HUMALOG MIX 50-50	VIAL (ML)	50-50/ML	SC	
HUMALOG MIX 75-25	INSULIN PEN (ML)	75-25/ML	SC	
HUMALOG MIX 75-25	VIAL (ML)	75-25/ML	SC	
HUMALOG TEMPO PEN U-100	INSULIN PEN; SENSOR (ML)	100/ML	SC	ST
HUMULIN 70/30 KWIKPEN	INSULIN PEN (ML)	70-30/ML	SC	
HUMULIN 70-30	VIAL (ML)	70-30/ML	SC	
HUMULIN N	VIAL (ML)	100/ML	SC	
HUMULIN N KWIKPEN	INSULIN PEN (ML)	100/ML (3)	SC	
HUMULIN R	VIAL (ML)	100/ML	INJ	
HUMULIN R	VIAL (ML)	500/ML	SC	
HUMULIN R U-500 KWIKPEN	INSULIN PEN (ML)	500/ML (3)	SC	
INSULIN LISPRO	VIAL (ML)	100/ML	SC	
INSULIN LISPRO JUNIOR KWIKPEN	INSULIN PEN; HALF-UNIT (ML)	100/ML	SC	
INSULIN LISPRO KWIKPEN U-100	INSULIN PEN (ML)	100/ML	SC	
INSULIN LISPRO PROTAMINE MIX	INSULIN PEN (ML)	75-25/ML	SC	
LYUMJEV	VIAL (ML)	100/ML	SC	
LYUMJEV KWIKPEN U-100	INSULIN PEN (ML)	100/ML	SC	
LYUMJEV KWIKPEN U-200	INSULIN PEN (ML)	200/ML (3)	SC	
LYUMJEV TEMPO PEN U-100	INSULIN PEN; SENSOR (ML)	100/ML	SC	ST
SEMGLEE (YFGN)	VIAL (ML)	100/ML	SC	
SEMGLEE (YFGN) PEN	INSULIN PEN (ML)	100/ML (3)	SC	
SOLIQUA 100-33	INSULIN PEN (ML)	100-33/ML	SC	QL
TOUJEO MAX SOLOSTAR	INSULIN PEN (ML)	300/ML (3)	SC	
TOUJEO SOLOSTAR	INSULIN PEN (ML)	300/ML	SC	
TRESIBA	VIAL (ML)	100/ML	SC	
TRESIBA FLEXTOUCH U-100	INSULIN PEN (ML)	100/ML (3)	SC	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
TRESIBA FLEXTOUCH U-200	INSULIN PEN (ML)	200/ML (3)	SC	
MISC AGENTS				
cabergoline	*tablet*	*0.5 mg*	ORAL	QL
calcitonin-salmon	*aerosol; spray with pump (ml)*	*200/spray*	NASAL	
calcitonin-salmon	*vial (ml)*	*200/ml*	INJ	
calcitriol	*ampul (ml)*	*1 mcg/ml*	IV	
calcitriol	*capsule*	*0.25 mcg*	ORAL	
calcitriol	*capsule*	*0.5 mcg*	ORAL	
calcitriol	*solution; oral*	*1 mcg/ml*	ORAL	
calcitriol	vial (ml)	1 mcg/ml	IV	
CERDELGA	CAPSULE	84 MG	ORAL	PA; QL; SP
cinacalcet hcl	tablet	30 mg	ORAL	ST
cinacalcet hcl	tablet	60 mg	ORAL	ST
cinacalcet hcl	tablet	90 mg	ORAL	ST
desmopressin acetate	aerosol; spray with pump (ml)	10/spray	NASAL	PA
DESMOPRESSIN ACETATE	AEROSOL; SPRAY WITH PUMP (EA)	150/SPRAY	NASAL	PA
desmopressin acetate	*tablet*	*0.1 mg*	ORAL	
desmopressin acetate	*tablet*	*0.2 mg*	ORAL	
DESMOPRESSIN ACETATE	VIAL (ML)	4 MCG/ML	INJ	PA; SP
doxercalciferol	capsule	0.5 mcg	ORAL	ST
doxercalciferol	capsule	1 mcg	ORAL	ST
doxercalciferol	capsule	2.5 mcg	ORAL	ST
JAVYGTOR	POWDER IN PACKET (EA)	100 MG	ORAL	PA; SP
JAVYGTOR	POWDER IN PACKET (EA)	500 MG	ORAL	PA; SP
JAVYGTOR	TABLET; SOLUBLE	100 MG	ORAL	PA; SP
MIFEPRISTONE	TABLET	300 MG	ORAL	PA; SP
MIGLUSTAT	CAPSULE	100 MG	ORAL	LA; PA; QL; SP
MYALEPT	VIAL (EA)	FNL 5 MG/ML	SC	LA; PA; SP
PALYNZIQ	SYRINGE (ML)	2.5 MG/0.5	SC	LA; PA; QL; SP
PALYNZIQ	SYRINGE (ML)	10 MG/0.5 ML	SC	LA; PA; QL; SP
PALYNZIQ	SYRINGE (ML)	20 MG/ML	SC	LA; PA; QL; SP
paricalcitol	capsule	1 mcg	ORAL	ST
paricalcitol	capsule	2 mcg	ORAL	ST
paricalcitol	capsule	4 mcg	ORAL	ST
paricalcitol	vial (ml)	2 mcg/ml	IV	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
paricalcitol	vial (ml)	5 mcg/ml	IV	
SAPROPTERIN DIHYDROCHLORIDE	POWDER IN PACKET (EA)	100 MG	ORAL	PA; SP
SAPROPTERIN DIHYDROCHLORIDE	POWDER IN PACKET (EA)	500 MG	ORAL	PA; SP
SAPROPTERIN DIHYDROCHLORIDE	TABLET; SOLUBLE	100 MG	ORAL	PA; SP
SOMAVERT	VIAL (EA)	10 MG	SC	PA; SP
SOMAVERT	VIAL (EA)	15 MG	SC	PA; SP
SOMAVERT	VIAL (EA)	20 MG	SC	PA; SP
SOMAVERT	VIAL (EA)	25 MG	SC	PA; SP
SOMAVERT	VIAL (EA)	30 MG	SC	PA; SP
STRENSIQ	VIAL (ML)	18 MG/0.45 ML	SC	LA; PA; SP
STRENSIQ	VIAL (ML)	28 MG/0.7 ML	SC	LA; PA; SP
STRENSIQ	VIAL (ML)	40 MG/ML	SC	LA; PA; SP
STRENSIQ	VIAL (ML)	80 MG/0.8 ML	SC	LA; PA; SP
SYNAREL	AEROSOL; SPRAY (ML)	2 MG/ML	NASAL	PA
TOLVAPTAN	TABLET	15 MG	ORAL	LA; PA; QL; SP
TOLVAPTAN	TABLET	30 MG	ORAL	LA; PA; QL; SP
ZOLEDRONIC ACID	IV SOLUTION; PIGGYBACK; BOTTLE (ML)	4 MG/100 ML	IV	SP
ZOLEDRONIC ACID	VIAL (ML)	4 MG/5 ML	IV	PA; SP
NON-INSULIN HYPOGLYCEMIC AGENTS				
acarbose	*tablet*	*25 mg*	ORAL	
acarbose	*tablet*	*50 mg*	ORAL	
acarbose	*tablet*	*100 mg*	ORAL	
BYDUREON BCISE	AUTO-INJECTOR (ML)	2 MG/0.85 ML	SC	QL; ST
BYETTA	PEN INJECTOR (ML)	5 MCG/0.02	SC	QL; ST
BYETTA	PEN INJECTOR (ML)	10 MCG/0.04	SC	QL; ST
FARXIGA	TABLET	5 MG	ORAL	QL; ST
FARXIGA	TABLET	10 MG	ORAL	QL; ST
glimepiride	*tablet*	*1 mg*	ORAL	
glimepiride	*tablet*	*2 mg*	ORAL	
glimepiride	*tablet*	*4 mg*	ORAL	
glipizide	*tablet*	*5 mg*	ORAL	
glipizide	*tablet*	*10 mg*	ORAL	
glipizide er	*tablet; extended release 24 hr*	*2.5 mg*	ORAL	
glipizide er	*tablet; extended release 24 hr*	*5 mg*	ORAL	
glipizide er	*tablet; extended release 24 hr*	*10 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
glipizide xl	*tablet; extended release 24 hr*	*2.5 mg*	ORAL	
glipizide xl	*tablet; extended release 24 hr*	*5 mg*	ORAL	
glipizide xl	*tablet; extended release 24 hr*	*10 mg*	ORAL	
glipizide-metformin	*tablet*	*2.5-250 mg*	ORAL	
glipizide-metformin	*tablet*	*2.5-500 mg*	ORAL	
glipizide-metformin	*tablet*	*5 mg-500 mg*	ORAL	
glyburide	*tablet*	*1.25 mg*	ORAL	
glyburide	*tablet*	*2.5 mg*	ORAL	
glyburide	*tablet*	*5 mg*	ORAL	
glyburide micronized	tablet	1.5 mg	ORAL	
glyburide micronized	*tablet*	*3 mg*	ORAL	
glyburide micronized	*tablet*	*6 mg*	ORAL	
glyburide-metformin hcl	*tablet*	*1.25-250 mg*	ORAL	
glyburide-metformin hcl	*tablet*	*2.5-500 mg*	ORAL	
glyburide-metformin hcl	*tablet*	*5 mg-500 mg*	ORAL	
GLYXAMBI	TABLET	10 MG-5 MG	ORAL	QL; ST
GLYXAMBI	TABLET	25 MG-5 MG	ORAL	QL; ST
JANUMET	TABLET	50 MG-500 MG	ORAL	QL; ST
JANUMET	TABLET	50-1000 MG	ORAL	QL; ST
JANUMET XR	TABLET; EXTENDED RELEASE MULTIPHASE 24 HR	50 MG-500 MG	ORAL	QL; ST
JANUMET XR	TABLET; EXTENDED RELEASE MULTIPHASE 24 HR	50-1000 MG	ORAL	QL; ST
JANUMET XR	TABLET; EXTENDED RELEASE MULTIPHASE 24 HR	100-1000 MG	ORAL	QL; ST
JANUVIA	TABLET	25 MG	ORAL	QL; ST
JANUVIA	TABLET	50 MG	ORAL	QL; ST
JANUVIA	TABLET	100 MG	ORAL	QL; ST
JARDIANCE	TABLET	10 MG	ORAL	QL; ST
JARDIANCE	TABLET	25 MG	ORAL	QL; ST
metformin hcl	solution; oral	500 mg/5 ml	ORAL	ST
metformin hcl	*tablet*	*500 mg*	ORAL	
metformin hcl	*tablet*	*850 mg*	ORAL	
metformin hcl	*tablet*	*1000 mg*	ORAL	
metformin hcl er	*tablet, extended release 24 hr*	*500 mg*	ORAL	QL
metformin hcl er	*tablet; extended release 24 hr*	*750 mg*	ORAL	QL
miglitol	*tablet*	*25 mg*	ORAL	
miglitol	*tablet*	*50 mg*	ORAL	
miglitol	*tablet*	*100 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
MOUNJARO	PEN INJECTOR (ML)	2.5 MG/0.5	SC	QL; ST
MOUNJARO	PEN INJECTOR (ML)	5 MG/0.5 ML	SC	QL; ST
MOUNJARO	PEN INJECTOR (ML)	7.5 MG/0.5	SC	QL; ST
MOUNJARO	PEN INJECTOR (ML)	10 MG/0.5 ML	SC	QL; ST
MOUNJARO	PEN INJECTOR (ML)	12.5 MG/0.5	SC	QL; ST
MOUNJARO	PEN INJECTOR (ML)	15 MG/0.5 ML	SC	QL; ST
nateglinide	*tablet*	*60 mg*	ORAL	
nateglinide	*tablet*	*120 mg*	ORAL	
OZEMPIC	PEN INJECTOR (ML)	0.25 OR 0.5	SC	QL; ST
OZEMPIC	PEN INJECTOR (ML)	1/0.75 (3)	SC	QL; ST
OZEMPIC	PEN INJECTOR (ML)	2 MG/0.75 ML	SC	QL; ST
pioglitazone hcl	*tablet*	*15 mg*	ORAL	QL
pioglitazone hcl	*tablet*	*30 mg*	ORAL	QL
pioglitazone hcl	*tablet*	*45 mg*	ORAL	QL
pioglitazone-glimepiride	tablet	30 mg-2 mg	ORAL	QL
pioglitazone-glimepiride	tablet	30 mg-4 mg	ORAL	QL
pioglitazone-metformin	tablet	15 mg-500 mg	ORAL	QL
pioglitazone-metformin	tablet	15 mg-850 mg	ORAL	QL
repaglinide	*tablet*	*0.5 mg*	ORAL	
repaglinide	*tablet*	*1 mg*	ORAL	
repaglinide	*tablet*	*2 mg*	ORAL	
RYBELSUS	TABLET	3 MG	ORAL	QL; ST
RYBELSUS	TABLET	7 MG	ORAL	QL; ST
RYBELSUS	TABLET	14 MG	ORAL	QL; ST
saxagliptin hcl	tablet	2.5 mg	ORAL	QL; ST
saxagliptin hcl	tablet	5 mg	ORAL	QL; ST
saxagliptin-metformin er	tablet; extended release multiphase 24 hr	2.5-1000 mg	ORAL	QL; ST
saxagliptin-metformin er	tablet; extended release multiphase 24 hr	5 mg-500 mg	ORAL	QL; ST
saxagliptin-metformin er	tablet; extended release multiphase 24 hr	5 mg-1000 mg	ORAL	QL; ST
SEGLUROMET	TABLET	2.5-500 MG	ORAL	QL; ST
SEGLUROMET	TABLET	2.5-1000 MG	ORAL	QL; ST
SEGLUROMET	TABLET	7.5-500 MG	ORAL	QL; ST
SEGLUROMET	TABLET	7.5-1000 MG	ORAL	QL; ST
STEGLATRO	TABLET	5 MG	ORAL	QL; ST
STEGLATRO	TABLET	15 MG	ORAL	QL; ST
SYMLINPEN 60	PEN INJECTOR (ML)	1500/1.5 ML	SC	QL; ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
SYMLINPEN 120	PEN INJECTOR (ML)	2700/2.7 ML	SC	QL; ST
SYNJARDY	TABLET	5 MG-500 MG	ORAL	QL; ST
SYNJARDY	TABLET	5 MG-1000 MG	ORAL	QL; ST
SYNJARDY	TABLET	12.5-500 MG	ORAL	QL; ST
SYNJARDY	TABLET	12.5-1000	ORAL	QL; ST
SYNJARDY XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	5 MG-1000 MG	ORAL	QL; ST
SYNJARDY XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	10-1000 MG	ORAL	QL; ST
SYNJARDY XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	12.5-1000	ORAL	QL; ST
SYNJARDY XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	25-1000 MG	ORAL	QL; ST
TRIJARDY XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	5-2.5-1000	ORAL	ST
TRIJARDY XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	10-5-1000	ORAL	ST
TRIJARDY XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	12.5-2.5 MG	ORAL	ST
TRIJARDY XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	25-5-1000	ORAL	ST
TRULICITY	PEN INJECTOR (ML)	0.75 MG/0.5	SC	QL; ST
TRULICITY	PEN INJECTOR (ML)	1.5 MG/0.5	SC	QL; ST
TRULICITY	PEN INJECTOR (ML)	3 MG/0.5 ML	SC	QL; ST
TRULICITY	PEN INJECTOR (ML)	4.5 MG/0.5	SC	QL; ST
XIGDUO XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	2.5-1000 MG	ORAL	QL; ST
XIGDUO XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	5 MG-500 MG	ORAL	QL; ST
XIGDUO XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	5 MG-1000 MG	ORAL	QL; ST
XIGDUO XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	10 MG-500 MG	ORAL	QL; ST
XIGDUO XR	TABLET; IMMED AND EXTEND REL BIPHASE 24HR	10-1000 MG	ORAL	QL; ST
THYROID HORMONES				
adthyza	tablet	15 mg	ORAL	
adthyza	tablet	30 mg	ORAL	
adthyza	tablet	60 mg	ORAL	
adthyza	tablet	90 mg	ORAL	
adthyza	tablet	120 mg	ORAL	
ARMOUR THYROID	TABLET	15 MG	ORAL	
ARMOUR THYROID	TABLET	30 MG	ORAL	
ARMOUR THYROID	TABLET	60 MG	ORAL	
ARMOUR THYROID	TABLET	90 MG	ORAL	
ARMOUR THYROID	TABLET	120 MG	ORAL	
ARMOUR THYROID	TABLET	180 MG	ORAL	
ARMOUR THYROID	TABLET	240 MG	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ARMOUR THYROID	TABLET	300 MG	ORAL	
euthyrox	*tablet*	*25 mcg*	ORAL	
euthyrox	*tablet*	*50 mcg*	ORAL	
euthyrox	*tablet*	*75 mcg*	ORAL	
euthyrox	*tablet*	*88 mcg*	ORAL	
euthyrox	*tablet*	*100 mcg*	ORAL	
euthyrox	*tablet*	*112 mcg*	ORAL	
euthyrox	*tablet*	*125 mcg*	ORAL	
euthyrox	*tablet*	*137 mcg*	ORAL	
euthyrox	*tablet*	*150 mcg*	ORAL	
euthyrox	*tablet*	*175 mcg*	ORAL	
euthyrox	*tablet*	*200 mcg*	ORAL	
levo-t	*tablet*	*25 mcg*	ORAL	
levo-t	*tablet*	*50 mcg*	ORAL	
levo-t	*tablet*	*75 mcg*	ORAL	
levo-t	*tablet*	*88 mcg*	ORAL	
levo-t	*tablet*	*100 mcg*	ORAL	
levo-t	*tablet*	*112 mcg*	ORAL	
levo-t	*tablet*	*125 mcg*	ORAL	
levo-t	*tablet*	*137 mcg*	ORAL	
levo-t	*tablet*	*150 mcg*	ORAL	
levo-t	*tablet*	*175 mcg*	ORAL	
levo-t	*tablet*	*200 mcg*	ORAL	
levo-t	*tablet*	*300 mcg*	ORAL	
levothyroxine sodium	*tablet*	*25 mcg*	ORAL	
levothyroxine sodium	*tablet*	*50 mcg*	ORAL	
levothyroxine sodium	*tablet*	*75 mcg*	ORAL	
levothyroxine sodium	*tablet*	*88 mcg*	ORAL	
levothyroxine sodium	*tablet*	*100 mcg*	ORAL	
levothyroxine sodium	*tablet*	*112 mcg*	ORAL	
levothyroxine sodium	*tablet*	*125 mcg*	ORAL	
levothyroxine sodium	*tablet*	*137 mcg*	ORAL	
levothyroxine sodium	*tablet*	*150 mcg*	ORAL	
levothyroxine sodium	*tablet*	*175 mcg*	ORAL	
levothyroxine sodium	*tablet*	*200 mcg*	ORAL	
levothyroxine sodium	*tablet*	*300 mcg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
levoxyl	*tablet*	*25 mcg*	ORAL	
levoxyl	*tablet*	*50 mcg*	ORAL	
levoxyl	*tablet*	*75 mcg*	ORAL	
levoxyl	*tablet*	*88 mcg*	ORAL	
levoxyl	*tablet*	*100 mcg*	ORAL	
levoxyl	*tablet*	*112 mcg*	ORAL	
levoxyl	*tablet*	*125 mcg*	ORAL	
levoxyl	*tablet*	*137 mcg*	ORAL	
levoxyl	*tablet*	*150 mcg*	ORAL	
levoxyl	*tablet*	*175 mcg*	ORAL	
levoxyl	*tablet*	*200 mcg*	ORAL	
liothyronine sodium	*tablet*	*5 mcg*	ORAL	
liothyronine sodium	*tablet*	*25 mcg*	ORAL	
liothyronine sodium	*tablet*	*50 mcg*	ORAL	
niva thyroid	*tablet*	*15 mg*	ORAL	
niva thyroid	*tablet*	*30 mg*	ORAL	
niva thyroid	*tablet*	*60 mg*	ORAL	
niva thyroid	*tablet*	*90 mg*	ORAL	
niva thyroid	*tablet*	*120 mg*	ORAL	
np thyroid	*tablet*	*15 mg*	ORAL	
np thyroid	*tablet*	*30 mg*	ORAL	
np thyroid	*tablet*	*60 mg*	ORAL	
np thyroid	*tablet*	*90 mg*	ORAL	
np thyroid	*tablet*	*120 mg*	ORAL	
thyroid	*tablet*	*15 mg*	ORAL	
thyroid	*tablet*	*30 mg*	ORAL	
thyroid	*tablet*	*60 mg*	ORAL	
thyroid	*tablet*	*90 mg*	ORAL	
thyroid	*tablet*	*120 mg*	ORAL	
unithroid	*tablet*	*25 mcg*	ORAL	
unithroid	*tablet*	*50 mcg*	ORAL	
unithroid	*tablet*	*75 mcg*	ORAL	
unithroid	*tablet*	*88 mcg*	ORAL	
unithroid	*tablet*	*100 mcg*	ORAL	
unithroid	*tablet*	*112 mcg*	ORAL	
unithroid	*tablet*	*125 mcg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
unithroid	*tablet*	*137 mcg*	ORAL	
unithroid	*tablet*	*150 mcg*	ORAL	
unithroid	*tablet*	*175 mcg*	ORAL	
unithroid	*tablet*	*200 mcg*	ORAL	
unithroid	*tablet*	*300 mcg*	ORAL	
GASTROENTEROLOGY				
ANTIDIARRHEALS				
belladonna & opium	suppository; rectal	30-16.2 mg	RECTAL	
belladonna & opium	suppository; rectal	60-16.2 mg	RECTAL	
diphenoxylate w/ atropine	*liquid (ml)*	*2.5-0.025/5*	ORAL	
diphenoxylate w/ atropine	*tablet*	*2.5-0.025 mg*	ORAL	
opium	*tincture*	*10 mg/ml*	ORAL	
ANTISPASMODICS				
anaspaz	*tablet; disintegrating*	*0.125 mg*	ORAL	
dicyclomine hcl	*capsule*	*10 mg*	ORAL	
dicyclomine hcl	*solution; oral*	*10 mg/5 ml*	ORAL	
dicyclomine hcl	*tablet*	*20 mg*	ORAL	
ed-spaz	*tablet; disintegrating*	*0.125 mg*	ORAL	
glycopyrrolate	solution; oral	1 mg/5 ml	ORAL	
glycopyrrolate	*tablet*	*1 mg*	ORAL	
glycopyrrolate	*tablet*	*2 mg*	ORAL	
hyoscyamine sulfate	*drops*	*0.125 mg/ml*	ORAL	
hyoscyamine sulfate	*elixir*	*125 mcg/5 ml*	ORAL	
hyoscyamine sulfate	*tablet*	*0.125 mg*	ORAL	
hyoscyamine sulfate	*tablet; extended release 12 hr*	*0.375 mg*	ORAL	
hyoscyamine sulfate	*tablet; sublingual*	*0.125 mg*	SL	
hyoscyamine sulfate	*tablet; disintegrating*	*0.125 mg*	ORAL	
hyosyne	*drops*	*0.125 mg/ml*	ORAL	
hyosyne	*elixir*	*125 mcg/5 ml*	ORAL	
oscimin	*tablet*	*0.125 mg*	ORAL	
oscimin sl	*tablet; sublingual*	*0.125 mg*	SL	
symax	*tablet; disintegrating*	*0.125 mg*	ORAL	
symax-sl	*tablet; sublingual*	*0.125 mg*	SL	
symax-sr	*tablet; extended release 12 hr*	*0.375 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ANTIVERTIGO & ANTIEMETIC AGENTS				
aprepitant	capsule	40 mg	ORAL	PA; QL
aprepitant	capsule	80 mg	ORAL	PA; QL
aprepitant	capsule	125 mg	ORAL	PA; QL
aprepitant	capsule; dose pack	125 mg-80 mg	ORAL	PA; QL
CINVANTI	VIAL (ML)	130 MG/18 ML	IV	PA
compro	*suppository; rectal*	*25 mg*	RECTAL	
doxylamine succ-pyridoxine hcl	tablet; enteric coated	10 mg-10 mg	ORAL	QL
dronabinol	capsule	2.5 mg	ORAL	PA
dronabinol	capsule	5 mg	ORAL	PA
dronabinol	capsule	10 mg	ORAL	PA
granisetron hcl	tablet	1 mg	ORAL	QL
ondansetron hcl	*solution; oral*	*4 mg/5 ml*	ORAL	QL
ondansetron hcl	*tablet*	*4 mg*	ORAL	QL
ondansetron hcl	*tablet*	*8 mg*	ORAL	QL
ondansetron odt	*tablet; disintegrating*	*4 mg*	ORAL	QL
ondansetron odt	*tablet; disintegrating*	*8 mg*	ORAL	QL
palonosetron hcl	syringe (ml)	0.25 mg/5 ml	IV	
palonosetron hcl	vial (ml)	0.25 mg/5 ml	IV	
prochlorperazine maleate	*suppository; rectal*	*25 mg*	RECTAL	
prochlorperazine maleate	*tablet*	*5 mg*	ORAL	
prochlorperazine maleate	*tablet*	*10 mg*	ORAL	
scopolamine	*patch; transdermal 3 day*	*1 mg/3 day*	TRANSDERM	
trimethobenzamide hcl	capsule	300 mg	ORAL	
VARUBI	TABLET	90 MG	ORAL	PA; QL
BILE ACIDS				
CHENODAL	TABLET	250 MG	ORAL	LA; PA; SP
CHOLBAM	CAPSULE	50 MG	ORAL	PA; QL; SP
CHOLBAM	CAPSULE	250 MG	ORAL	PA; SP
ursodiol	capsule	200 mg	ORAL	
ursodiol	capsule	300 mg	ORAL	
ursodiol	capsule	400 mg	ORAL	
ursodiol	tablet	250 mg	ORAL	
ursodiol	tablet	500 mg	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
BOWEL EVACUANTS				
clearlax	*powder (gram)*	*17 g/dose*	ORAL	ACA
gavilax	*powder (gram)*	*17 g/dose*	ORAL	ACA
gavilyte-c	*solution; reconstituted; oral*	*240-22.72 g*	ORAL	ACA
gavilyte-g	*solution; reconstituted; oral*	*236-22.74 g*	ORAL	ACA
gavilyte-n	*solution; reconstituted; oral*	*420 g*	ORAL	ACA
gentlelax	*powder (gram)*	*17 g/dose*	ORAL	ACA
laxative peg 3350	*powder (gram)*	*17 g/dose*	ORAL	ACA
natura-lax	*powder (gram)*	*17 g/dose*	ORAL	ACA
peg 3350-electrolyte	*solution; reconstituted; oral*	*236-22.74 g*	ORAL	ACA
peg 3350-electrolyte	*solution; reconstituted; oral*	*420 g*	ORAL	ACA
peg3350-sod sul-nacl-kcl-asb-c	*powder in packet (ea)*	*7.5-2.691 g*	ORAL	ACA
polyethylene glycol	*powder (gram)*	*17 g/dose*	ORAL	ACA
powderlax	*powder (gram)*	*17 g/dose*	ORAL	ACA
purelax	*powder (gram)*	*17 g/dose*	ORAL	ACA
smoothlax	*powder (gram)*	*17 g/dose*	ORAL	ACA
sod sulf-potass sulf-mag sulf	*solution; reconstituted; oral*	*17.5-3.13 g*	ORAL	ACA
COMBINATION ANTICHOLINERGICS				
atropine sulfate	*syringe (ml)*	*0.25 mg/5 ml*	IV	
atropine sulfate	*syringe (ml)*	*0.1 mg/ml*	INJ	
atropine sulfate	*syringe (ml)*	*0.8 mg/2 ml*	IV	
atropine sulfate	*vial (ml)*	*0.4 mg/ml*	INJ	
atropine sulfate	*vial (ml)*	*0.4 mg/ml*	IV	
atropine sulfate	*vial (ml)*	*1 mg/ml*	IV	
clidinium w/ chlordiazepoxide	capsule	5 mg-2.5 mg	ORAL	
phenobarbital-hyosc-atrop-scop	elixir	16.2 mg/5 ml	ORAL	
phenobarbital-hyosc-atrop-scop	tablet	16.2 mg	ORAL	
phenohytro	elixir	16.2 mg/5 ml	ORAL	
phenohytro	tablet	16.2 mg	ORAL	
DIGESTIVE ENZYMES				
CREON	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	3-9.5-15K	ORAL	PA
CREON	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	6K-19K-30K	ORAL	PA
CREON	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	12K-38K-60	ORAL	PA
CREON	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	24-76-120K	ORAL	PA
CREON	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	36K-114K	ORAL	PA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
PANCREAZE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	2.6K-8.8K	ORAL	PA
PANCREAZE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	4.2K-14.2K	ORAL	PA
PANCREAZE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	10.5-35.5K	ORAL	PA
PANCREAZE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	16.8-56.8K	ORAL	PA
PANCREAZE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	21K-54.7K	ORAL	PA
PANCREAZE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	37K-97.3K	ORAL	PA
SUCRAID	SOLUTION; ORAL	8500/ML	ORAL	PA; SP
VIOKACE	TABLET	10.4-39.2K	ORAL	
VIOKACE	TABLET	20.9-78.3K	ORAL	
ZENPEP	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	3-10-14K	ORAL	PA
ZENPEP	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	5K-17K-24K	ORAL	PA
ZENPEP	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	10-32-42K	ORAL	PA
ZENPEP	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	15-47-63K	ORAL	PA
ZENPEP	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	20-63-84K	ORAL	PA
ZENPEP	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	25-79-105K	ORAL	PA
ZENPEP	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	40-126-168	ORAL	PA
ZENPEP	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	60K-189.6K	ORAL	PA
H2 ANTAGONISTS				
cimetidine	*solution; oral*	*300 mg/5 ml*	ORAL	
cimetidine	*tablet*	*300 mg*	ORAL	
cimetidine	*tablet*	*400 mg*	ORAL	
cimetidine	*tablet*	*800 mg*	ORAL	
famotidine	*tablet*	*40 mg*	ORAL	
nizatidine	*capsule*	*150 mg*	ORAL	
nizatidine	*capsule*	*300 mg*	ORAL	
MISC AGENTS				
lanthanum carbonate	tablet; chewable	500 mg	ORAL	QL
lanthanum carbonate	tablet; chewable	750 mg	ORAL	QL
lanthanum carbonate	tablet; chewable	1000 mg	ORAL	QL
LOKELMA	POWDER IN PACKET (EA)	5 G	ORAL	QL
LOKELMA	POWDER IN PACKET (EA)	10 G	ORAL	QL
sevelamer carbonate	powder in packet (ea)	0.8 g	ORAL	QL
sevelamer carbonate	powder in packet (ea)	2.4 g	ORAL	QL
sevelamer carbonate	tablet	800 mg	ORAL	QL
sevelamer hcl	tablet	400 mg	ORAL	QL

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
sevelamer hcl	tablet	800 mg	ORAL	QL
sodium polystyrene sulfonate	powder (gram)	str n/a	ORAL	
sps	enema (ml)	30 g/120 ml	RECTAL	
sps	suspension; oral (final dose form)	15 g/60 ml	ORAL	
VELPHORO	TABLET; CHEWABLE	500 MG IRON	ORAL	QL
VELTASSA	POWDER IN PACKET (EA)	8.4 GRAM	ORAL	QL
VELTASSA	POWDER IN PACKET (EA)	16.8 GRAM	ORAL	QL
VELTASSA	POWDER IN PACKET (EA)	25.2 GRAM	ORAL	QL
MISC GASTROINTESTINAL AGENTS				
alosetron hcl	tablet	0.5 mg	ORAL	
alosetron hcl	tablet	1 mg	ORAL	
alvimopan	capsule	12 mg	ORAL	
anucort-hc	suppository; rectal	25 mg	RECTAL	
balsalazide disodium	capsule	750 mg	ORAL	
BETAINE ANHYDROUS	POWDER (GRAM)	1 G/SCOOP	ORAL	PA; SP
bisacodyl	*tablet; enteric coated*	*5 mg*	ORAL	ACA
budesonide	aerosol; foam with applicator (gram)	2 mg	RECTAL	
budesonide ec	capsule; delayed; and extended release	3 mg	ORAL	
budesonide er	tablet; delayed and extended release	9 mg	ORAL	
citrate of magnesia	*solution; oral*	*str n/a*	ORAL	ACA
citroma	*solution; oral*	*str n/a*	ORAL	ACA
constulose	*solution; oral*	*10 g/15 ml*	ORAL	
cromolyn sodium	concentrate; oral	20 mg/ml	ORAL	
dulcolax	*suspension; oral (final dose form)*	*400 mg/5 ml*	ORAL	ACA
enulose	*solution; oral*	*10 g/15 ml*	ORAL	
generlac	*solution; oral*	*10 g/15 ml*	ORAL	
gentle laxative	*tablet; enteric coated*	*5 mg*	ORAL	ACA
hc pramoxine	cream with applicator	1%-1%	RECTAL	
hc pramoxine	cream with applicator	2.5%-1%	RECTAL	ST
hc pramoxine	cream with applicator	2.5-1% (4g)	RECTAL	ST
hemmorex-hc	suppository; rectal	25 mg	RECTAL	
hemmorex-hc	suppository; rectal	30 mg	RECTAL	
hydrocortisone	*cream with perineal applicator*	*1%*	TOPICAL	
hydrocortisone	*cream with perineal applicator*	*2.5%*	TOPICAL	
hydrocortisone	enema (ml)	100 mg/60 ml	RECTAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
hydrocortisone acetate	suppository; rectal	25 mg	RECTAL	
hydrocortisone acetate	suppository; rectal	30 mg	RECTAL	
lactulose	*packet (ea)*	*10 g*	ORAL	
lactulose	*solution; oral*	*10 g/15 ml*	ORAL	
lactulose	*solution; oral*	*20 g/30 ml*	ORAL	
laxative	*tablet; enteric coated*	*5 mg*	ORAL	ACA
lidocaine-hc	*cream (gram)*	*3%-0.5%*	RECTAL	
lidocaine-hc	*cream with applicator*	*3%-0.5%*	RECTAL	
lidocaine-hc	gel with applicator (gram)	0.55%-2.8%	RECTAL	
lidocaine-hc	kit	2%-2% (7 g)	RECTAL	
lidocaine-hc	kit	2.5-3% (7 g)	RECTAL	
lidocaine-hc	kit	3%-0.5%	RECTAL	
lidocaine-hc	kit	3%-1% (7 g)	RECTAL	
LINZESS	CAPSULE	72 MCG	ORAL	QL
LINZESS	CAPSULE	145 MCG	ORAL	QL
LINZESS	CAPSULE	290 MCG	ORAL	QL
lubiprostone	capsule	8 mcg	ORAL	QL
lubiprostone	capsule	24 mcg	ORAL	QL
magnesium citrate	*solution; oral*	*str n/a*	ORAL	ACA
mesalamine	enema (ml)	4 g/60 ml	RECTAL	
mesalamine	enema kit	4 g/60 ml	RECTAL	
mesalamine	suppository; rectal	1000 mg	RECTAL	
mesalamine	tablet; enteric coated	800 mg	ORAL	
mesalamine	tablet; enteric coated	1.2 g	ORAL	
mesalamine dr	capsule (with delayed release tablets)	400 mg	ORAL	
mesalamine er	capsule; ext release 24 hr	0.375 g	ORAL	
mesalamine er	capsule; extended release	500 mg	ORAL	
metoclopramide hcl	*solution; oral*	*5 mg/5 ml*	ORAL	
metoclopramide hcl	*solution; oral*	*10 mg/10 ml*	ORAL	
metoclopramide hcl	*tablet*	*5 mg*	ORAL	
metoclopramide hcl	*tablet*	*10 mg*	ORAL	
milk of magnesia	*suspension; oral (final dose form)*	*400 mg/5 ml*	ORAL	ACA
milk of magnesia	*suspension; oral (final dose form)*	*2400 mg/10*	ORAL	ACA
MOVANTIK	TABLET	12.5 MG	ORAL	QL
MOVANTIK	TABLET	25 MG	ORAL	QL
nitroglycerin	ointment (gram)	0.4% (w/w)	RECTAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
OCALIVA	TABLET	5 MG	ORAL	LA; PA; QL; SP
OCALIVA	TABLET	10 MG	ORAL	LA; PA; QL; SP
OMVOH PEN	PEN INJECTOR (ML)	100 MG/ML	SC	PA; QL; SP
onelax magnesium citrate	*solution; oral*	*str n/a*	ORAL	ACA
oral saline laxative	*liquid (ml)*	*7.2-2.7/15*	ORAL	ACA
PENTASA	CAPSULE; EXTENDED RELEASE	250 MG	ORAL	
phosphate laxative	*liquid (ml)*	*7.2-2.7/15*	ORAL	ACA
pramoxine hcl w/ hydrocortisone	cream with applicator	2.5%-1%	RECTAL	ST
procto-med hc	*cream with perineal applicator*	*2.5%*	TOPICAL	
proctosol-hc	*cream with perineal applicator*	*2.5%*	TOPICAL	
proctozone-hc	*cream with perineal applicator*	*2.5%*	TOPICAL	
RELISTOR	SYRINGE (ML)	8 MG/0.4 ML	SC	ST
RELISTOR	SYRINGE (ML)	12 MG/0.6 ML	SC	ST
RELISTOR	TABLET	150 MG	ORAL	ST
RELISTOR	VIAL (ML)	12 MG/0.6 ML	SC	ST
SKYRIZI ON-BODY	WEARABLE INJECTOR	180 MG/1.2	SC	PA; QL; SP
SKYRIZI ON-BODY	WEARABLE INJECTOR	360 MG/2.4	SC	PA; QL; SP
sulfasalazine	*tablet*	*500 mg*	ORAL	
sulfasalazine dr	*tablet; enteric coated*	*500 mg*	ORAL	
SYMPROIC	TABLET	0.2 MG	ORAL	PA
TRULANCE	TABLET	3 MG	ORAL	PA
VIBERZI	TABLET	75 MG	ORAL	
VIBERZI	TABLET	100 MG	ORAL	
women's gentle laxative	*tablet; enteric coated*	*5 mg*	ORAL	ACA
OTHER ULCER THERAPY				
bismuth-metronidazole-tetracyc	capsule	125-125 mg	ORAL	ST
lansoprazol-amoxicil-clarithro	combination package (ea)	30-500-500	ORAL	QL
sucralfate	suspension; oral (final dose form)	1 g/10 ml	ORAL	
sucralfate	*tablet*	*1 g*	ORAL	
PROSTAGLANDINS				
misoprostol	*tablet*	*100 mcg*	ORAL	
misoprostol	*tablet*	*200 mcg*	ORAL	
PROTON PUMP INHIBITORS				
dexlansoprazole dr	capsule; delayed release; biphasic	30 mg	ORAL	QL; ST
dexlansoprazole dr	capsule; delayed release; biphasic	60 mg	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
esomeprazole magnesium	*capsule; delayed release (enteric coated)*	*40 mg*	ORAL	
esomeprazole magnesium	susp for recon; delayed rel. in a packet	10 mg	ORAL	QL; ST
esomeprazole magnesium	susp for recon; delayed rel. in a packet	20 mg	ORAL	QL; ST
esomeprazole magnesium	susp for recon; delayed rel. in a packet	40 mg	ORAL	ST
lansoprazole	*capsule; delayed release (enteric coated)*	*15 mg*	ORAL	QL
lansoprazole	*capsule; delayed release (enteric coated)*	*30 mg*	ORAL	
lansoprazole	tablet; disintegrating; delayed release	15 mg	ORAL	QL; ST
lansoprazole	tablet; disintegrating; delayed release	30 mg	ORAL	ST
omeprazole	*capsule; delayed release (enteric coated)*	*10 mg*	ORAL	QL
omeprazole	*capsule; delayed release (enteric coated)*	*20 mg*	ORAL	QL
omeprazole	*capsule; delayed release (enteric coated)*	*40 mg*	ORAL	
omeprazole-sodium bicarbonate	capsule	20 mg-1.1 g	ORAL	QL; ST
omeprazole-sodium bicarbonate	capsule	40 mg-1.1 g	ORAL	ST
omeprazole-sodium bicarbonate	packet (ea)	20-1680 mg	ORAL	QL; ST
omeprazole-sodium bicarbonate	packet (ea)	40-1680 mg	ORAL	ST
pantoprazole sodium	granules delayed release for susp packet	40 mg	ORAL	ST
pantoprazole sodium	*tablet; enteric coated*	*20 mg*	ORAL	QL
pantoprazole sodium	*tablet; enteric coated*	*40 mg*	ORAL	
rabeprazole sodium	*tablet; enteric coated*	*20 mg*	ORAL	
IMMUNOLOGY, VACCINES & BIOTECHNOLOGY				
ERYTHROID STIMULANTS				
PROCRIT	VIAL (ML)	2000/ML	INJ	PA; SP
PROCRIT	VIAL (ML)	3000/ML	INJ	PA; SP
PROCRIT	VIAL (ML)	4000/ML	INJ	PA; SP
PROCRIT	VIAL (ML)	10000/ML	INJ	PA; SP
PROCRIT	VIAL (ML)	20000/ML	INJ	PA; SP
PROCRIT	VIAL (ML)	20000/2 ML	INJ	PA; SP
PROCRIT	VIAL (ML)	40000/ML	INJ	PA; SP
RETACRIT	VIAL (ML)	2000/ML	INJ	PA; SP
RETACRIT	VIAL (ML)	3000/ML	INJ	PA; SP
RETACRIT	VIAL (ML)	4000/ML	INJ	PA; SP
RETACRIT	VIAL (ML)	10000/ML	INJ	PA; SP
RETACRIT	VIAL (ML)	20000/ML	INJ	PA; SP
RETACRIT	VIAL (ML)	20000/2 ML	INJ	PA; SP
RETACRIT	VIAL (ML)	40000/ML	INJ	PA; SP

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
GROWTH HORMONES				
EGRIFTA SV	VIAL (EA)	2 MG	SC	PA; SP
GENOTROPIN	CARTRIDGE (EA)	5 MG/ML	SC	PA; SP
GENOTROPIN	CARTRIDGE (EA)	12 MG/ML	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	0.2 MG/0.25	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	0.4 MG/0.25	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	0.6 MG/0.25	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	0.8 MG/0.25	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	1 MG/0.25 ML	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	1.2 MG/0.25	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	1.4 MG/0.25	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	1.6 MG/0.25	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	1.8 MG/0.25	SC	PA; SP
GENOTROPIN	SYRINGE (EA)	2 MG/0.25 ML	SC	PA; SP
NGENLA	PEN INJECTOR (ML)	24 MG/1.2 ML	SC	PA; SP
NGENLA	PEN INJECTOR (ML)	60 MG/1.2 ML	SC	PA; SP
OMNITROPE	CARTRIDGE (ML)	5 MG/1.5 ML	SC	PA; SP
OMNITROPE	CARTRIDGE (ML)	10 MG/1.5 ML	SC	PA; SP
OMNITROPE	VIAL (EA)	5.8 MG	SC	PA; SP
SEROSTIM	VIAL (EA)	4 MG	SC	PA; SP
SEROSTIM	VIAL (EA)	5 MG	SC	PA; SP
SEROSTIM	VIAL (EA)	6 MG	SC	PA; SP
INTERFERONS				
AVONEX ADMINISTRATION PACK	SYRINGE KIT (EA)	30 MCG/0.5 ML	IM	PA; QL; SP
AVONEX PEN	PEN INJECTOR KIT (EA)	30 MCG/0.5 ML	IM	PA; QL; SP
BAFIERTAM	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	95 MG	ORAL	PA; QL; SP
BETASERON	KIT	0.3 MG	SC	PA; QL; SP
DIMETHYL FUMARATE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	120 MG	ORAL	PA; QL; SP
DIMETHYL FUMARATE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	240 MG	ORAL	PA; QL; SP
DIMETHYL FUMARATE	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	120-240 MG	ORAL	PA; QL; SP
FINGOLIMOD	CAPSULE	0.5 MG	ORAL	PA; QL; SP
GLATIRAMER ACETATE	SYRINGE (ML)	20 MG/ML	SC	PA; QL; SP
GLATIRAMER ACETATE	SYRINGE (ML)	40 MG/ML	SC	PA; QL; SP
GLATOPA	SYRINGE (ML)	20 MG/ML	SC	PA; QL; SP
GLATOPA	SYRINGE (ML)	40 MG/ML	SC	PA; QL; SP

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
KESIMPTA PEN	PEN INJECTOR (ML)	20 MG/0.4 ML	SC	PA; QL; SP
MAYZENT	TABLET	0.25 MG	ORAL	PA; QL; SP
MAYZENT	TABLET	1 MG	ORAL	PA; QL; SP
MAYZENT	TABLET	2 MG	ORAL	PA; QL; SP
MAYZENT	TABLET; DOSE PACK	0.25 MG (7)	ORAL	PA; QL; SP
MAYZENT	TABLET; DOSE PACK	0.25 MG (12)	ORAL	PA; QL; SP
PEGASYS	VIAL (ML)	180 MCG/ML	SC	PA; SP
PLEGRIDY	PEN INJECTOR (ML)	63-94 MCG	SC	PA; QL; SP
PLEGRIDY	PEN INJECTOR (ML)	125 MCG/0.5	SC	PA; QL; SP
PLEGRIDY	SYRINGE (ML)	63-94 MCG	SC	PA; QL; SP
PLEGRIDY	SYRINGE (ML)	125 MCG/0.5	IM	PA; QL; SP
PLEGRIDY	SYRINGE (ML)	125 MCG/0.5	SC	PA; QL; SP
PONVORY	TABLET	20 MG	ORAL	PA; QL; SP
PONVORY	TABLET; DOSE PACK	2 MG-10 MG	ORAL	PA; QL; SP
REBIF	SYRINGE (ML)	8.8-22 (6)	SC	PA; QL; SP
REBIF	SYRINGE (ML)	22 MCG/0.5 ML	SC	PA; QL; SP
REBIF	SYRINGE (ML)	44 MCG/0.5 ML	SC	PA; QL; SP
REBIF REBIDOSE	PEN INJECTOR (ML)	8.8-22 (6)	SC	PA; QL; SP
REBIF REBIDOSE	PEN INJECTOR (ML)	22 MCG/0.5 ML	SC	PA; QL; SP
REBIF REBIDOSE	PEN INJECTOR (ML)	44 MCG/0.5 ML	SC	PA; QL; SP
RIBAVIRIN	CAPSULE	200 MG	ORAL	SP; ST
RIBAVIRIN	TABLET	200 MG	ORAL	SP; ST
TERIFLUNOMIDE	TABLET	7 MG	ORAL	PA; QL; SP
TERIFLUNOMIDE	TABLET	14 MG	ORAL	PA; QL; SP
VUMERITY	CAPSULE; DELAYED RELEASE (ENTERIC COATED)	231 MG	ORAL	PA; QL; SP
INTERLEUKINS				
ACTIMMUNE	VIAL (ML)	100 MCG/0.5	SC	PA; SP
ALFERON N	VIAL (ML)	5 MM UNIT/ML	INJ	
imiquimod	cream in metered-dose pump	3.75%	TOPICAL	
imiquimod	cream in packet (ea)	3.75%	TOPICAL	
imiquimod	*cream in packet (ea)*	*5%*	TOPICAL	
MYELOID STIMULANTS				
FULPHILA	SYRINGE (ML)	6 MG/0.6 ML	SC	PA; QL; SP
LEUKINE	VIAL (EA)	250 MCG	INJ	PA; SP
NIVESTYM	SYRINGE (ML)	300 MCG/0.5	SC	PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
NIVESTYM	SYRINGE (ML)	480 MCG/0.8	SC	PA; SP
NIVESTYM	VIAL (ML)	300 MCG/ML	INJ	PA; SP
NIVESTYM	VIAL (ML)	480 MCG/1.6	INJ	PA; SP
PLERIXAFOR	VIAL (ML)	24 MG/1.2 ML	SC	SP
ZIEXTENZO	SYRINGE (ML)	6 MG/0.6 ML	SC	PA; QL; SP
VACCINES & MISC IMMUNOLOGICALS				
abrysvo	*vial (ea)*	*120 mcg/0.5*	IM	ACA
ACAM2000 (NATIONAL STOCKPILE)	VIAL (EA)	1-5 X 10EXP8	INJ	
acthib	*vial (ea)*	*10 mcg/0.5*	IM	ACA
adacel	*syringe (ml)*	*2-2.5-5/0.5*	IM	ACA
adacel	*vial (ml)*	*2-2.5-5/0.5*	IM	ACA
afluria quad 2023-2024	*vial (ml)*	*60 mcg/0.5 ml*	IM	ACA
afluria quad 2023-24 (3yr up)	*syringe (ml)*	*60 mcg/0.5 ml*	IM	ACA
arexvy	*kit*	*120 mcg/0.5*	IM	ACA
bexsero	*syringe (ml)*	*50-50/0.5*	IM	ACA
boostrix	*syringe (ml)*	*2.5-8-5/0.5*	IM	ACA
boostrix	*vial (ml)*	*2.5-8-5/0.5*	IM	ACA
comirnaty 2023-2024	*syringe (ml)*	*30 mcg/0.3*	IM	ACA
comirnaty 2023-2024	*vial (ml)*	*30 mcg/0.3*	IM	ACA
CYTOGAM	VIAL (ML)	50 MG/ML	IV	PA; SP
daptacel	*vial (ml)*	*15-10-5/0.5*	IM	ACA
dengvaxia	*vial (ea)*	*10exp4.5-6*	SC	ACA
engerix-b	*syringe (ml)*	*10 mcg/0.5*	IM	ACA
engerix-b	*syringe (ml)*	*20 mcg/ml*	IM	ACA
engerix-b	*vial (ml)*	*20 mcg/ml*	IM	ACA
fluad quad 2023-2024	*syringe (ml)*	*60 mcg/0.5 ml*	IM	ACA
fluarix quad 2023-2024	*syringe (ml)*	*60 mcg/0.5 ml*	IM	ACA
flublok quad 2023-2024	*syringe (ml)*	*180 mcg/0.5*	IM	ACA
flucelvax quad 2023-2024	*syringe (ml)*	*60 mcg/0.5 ml*	IM	ACA
flucelvax quad 2023-2024	*vial (ml)*	*60 mcg/0.5 ml*	IM	ACA
flulaval quad 2023-2024	*syringe (ml)*	*60 mcg/0.5 ml*	IM	ACA
flumist quad 2023-2024	*nasal spray syringe (ea)*	*10e6.5-7.5*	NASAL	ACA
fluzone high-dose quad 2023-24	*syringe (ml)*	*240 mcg/0.7*	IM	ACA
fluzone quad 2023-2024	*syringe (ml)*	*60 mcg/0.5 ml*	IM	ACA
fluzone quad 2023-2024	*vial (ml)*	*60 mcg/0.5 ml*	IM	ACA

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
GAMASTAN	VIAL (ML)	15%-18%	IM	PA; SP
gardasil 9	*syringe (ml)*	*0.5 ml*	IM	ACA
gardasil 9	*vial (ml)*	*0.5 ml*	IM	ACA
GRASTEK	TABLET; SUBLINGUAL	2800 UNIT	SL	PA
havrix	*syringe (ml)*	*720/0.5 ml*	IM	ACA
havrix	*syringe (ml)*	*1440/ml*	IM	ACA
heplisav-b	*syringe (ml)*	*20 mcg/0.5*	IM	ACA
hiberix	*vial (ea)*	*10 mcg/0.5*	IM	ACA
infanrix	*syringe (ml)*	*25-58-10*	IM	ACA
ipol	*vial (ml)*	*40-8-32*	INJ	ACA
IXCHIQ	VIAL (EA)	1000 TCID	IM	
JYNNEOS	VIAL (ML)	0.5 X 10EXP8	SC	
JYNNEOS (NATIONAL STOCKPILE)	VIAL (ML)	0.5 X 10EXP8	SC	
kinrix	*syringe (ml)*	*25-25-10*	IM	ACA
menquadfi	*vial (ml)*	*10 mcg/0.5*	IM	ACA
menveo a-c-y-w-135-dip	*kit*	*10-5/0.5 ml*	IM	ACA
menveo a-c-y-w-135-dip	*vial (ml)*	*10-5/0.5 ml*	IM	ACA
m-m-r ii vaccine w/ diluent	*vial (ea)*	*12500/0.5*	SC	ACA
moderna covid 23-24 (6m-11y) eua	*vial (ml)*	*25 mcg/0.25*	IM	ACA
novavax covid 2023-2024 (eua)	*vial (ml)*	*5 mcg/0.5 ml*	IM	ACA
ODACTRA	TABLET; SUBLINGUAL	12 SQ-HDM	SL	PA
ORALAIR	TABLET; SUBLINGUAL	300 IR	SL	PA; SP
pediarix	*syringe (ml)*	*10-25-25*	IM	ACA
pedvaxhib	*vial (ml)*	*7.5 mcg/0.5*	IM	ACA
prenbraya	*kit*	*5-120/0.5*	IM	ACA
pentacel	*kit*	*15-48-5-62*	IM	ACA
pfizer covid 2023-24 (6m-4y) eua	*vial (ml)*	*3 mcg/0.3 ml*	IM	ACA
pfizer covid 2023-24 (5-11y) eua	*vial (ml)*	*10 mcg/0.3*	IM	ACA
pneumovax 23	*syringe (ml)*	*25 mcg/0.5*	INJ	ACA
pneumovax 23	*vial (ml)*	*25 mcg/0.5*	INJ	ACA
prehevbrio	*vial (ml)*	*10 mcg/ml*	IM	ACA
prevnar 20	*syringe (ml)*	*0.5 ml*	IM	ACA
priorix	*vial (ea)*	*3.4-4.2*	SC	ACA
proquad	*vial (ea)*	*3-4.3-3*	SC	ACA
quadracel dtap-ipv	*syringe (ml)*	*15-48-5-62*	IM	ACA
quadracel dtap-ipv	*vial (ml)*	*15-20-20*	IM	ACA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
quadracel dtap-ipv	*vial (ml)*	*15-48-5-62*	IM	ACA
RAGWITEK	TABLET; SUBLINGUAL	12 UNIT	SL	PA
recombivax hb	*syringe (ml)*	*5 mcg/0.5 ml*	IM	ACA
recombivax hb	*syringe (ml)*	*10 mcg/ml*	IM	ACA
recombivax hb	*vial (ml)*	*5 mcg/0.5 ml*	IM	ACA
recombivax hb	*vial (ml)*	*10 mcg/ml*	IM	ACA
recombivax hb	*vial (ml)*	*40 mcg/ml*	IM	ACA
rotarix	*suspension; oral (final dose form)*	*10e6/1.5 ml*	ORAL	ACA
rotateq	*solution; oral*	*2 ml*	ORAL	ACA
shingrix	*kit*	*50 mcg/0.5*	IM	ACA
spikevax 2023-2024	*syringe (ml)*	*50 mcg/0.5*	IM	ACA
spikevax 2023-2024	*vial (ml)*	*50 mcg/0.5*	IM	ACA
tenivac	*syringe (ml)*	*5-2/0.5 ml*	IM	ACA
tenivac	*vial (ml)*	*5-2/0.5 ml*	IM	ACA
tetanus diphtheria toxoids	*vial (ml)*	*2-2 lf/0.5*	IM	ACA
THYMOGLOBULIN	VIAL (EA)	25 MG	IV	PA; SP
TICE BCG	VIAL (EA)	50 MG	INTRAVESICAL	
trumenba	*syringe (ml)*	*120 mcg/0.5*	IM	ACA
twinrix	*syringe (ml)*	*720-20/ml*	IM	ACA
vaqta	*syringe (ml)*	*25/0.5 ml*	IM	ACA
vaqta	*syringe (ml)*	*50 unit/ml*	IM	ACA
vaqta	*vial (ml)*	*25/0.5 ml*	IM	ACA
vaqta	*vial (ml)*	*50 unit/ml*	IM	ACA
varivax vaccine	*vial (ea)*	*1350 unit*	SC	ACA
vaxelis	*syringe (ml)*	*15-5-10*	IM	ACA
vaxelis	*vial (ml)*	*15-5-10*	IM	ACA
vaxneuvance	*syringe (ml)*	*0.5 ml*	IM	ACA
MUSCULOSKELETAL & RHEUMATOLOGY				
GOUT THERAPY				
allopurinol	*tablet*	*100 mg*	ORAL	
allopurinol	*tablet*	*300 mg*	ORAL	
colchicine	capsule	0.6 mg	ORAL	ST
colchicine	*tablet*	*0.6 mg*	ORAL	
febuxostat	tablet	40 mg	ORAL	ST
febuxostat	tablet	80 mg	ORAL	ST

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
probenecid	*tablet*	*500 mg*	ORAL	
probenecid w/ colchicine	*tablet*	*500-0.5 mg*	ORAL	
MISC RHEUMATOLOGICAL AGENTS				
ACTEMRA	SYRINGE (ML)	162 MG/0.9	SC	PA; QL; SP
ACTEMRA ACTPEN	PEN INJECTOR (ML)	162 MG/0.9	SC	PA; QL; SP
ADALIMUMAB-ADAZ (CF)	SYRINGE (ML)	40 MG/0.4 ML	SC	PA; QL; SP
ADALIMUMAB-ADAZ (CF) PEN	PEN INJECTOR (ML)	40 MG/0.4 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF)	SYRINGE KIT (EA)	10 MG/0.2 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF)	SYRINGE KIT (EA)	20 MG/0.4 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF)	SYRINGE KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF)	SYRINGE KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF) PEN CROHNS	PEN INJECTOR KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF) PEN CROHNS	PEN INJECTOR KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF) PEN PS-UV	PEN INJECTOR KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF) PEN PS-UV	PEN INJECTOR KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF) PEN	PEN INJECTOR KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
ADALIMUMAB-ADBM (CF) PEN	PEN INJECTOR KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
BENLYSTA	AUTO-INJECTOR (ML)	200 MG/ML	SC	PA; QL; SP
BENLYSTA	SYRINGE (ML)	200 MG/ML	SC	PA; QL; SP
CYLTEZO (CF)	SYRINGE KIT (EA)	10 MG/0.2 ML	SC	PA; QL; SP
CYLTEZO (CF)	SYRINGE KIT (EA)	20 MG/0.4 ML	SC	PA; QL; SP
CYLTEZO (CF)	SYRINGE KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
CYLTEZO (CF)	SYRINGE KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
CYLTEZO (CF) PEN	PEN INJECTOR KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
CYLTEZO (CF) PEN	PEN INJECTOR KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
CYLTEZO (CF) PEN CROHN'S-UC-HS	PEN INJECTOR KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
CYLTEZO (CF) PEN CROHN'S-UC-HS	PEN INJECTOR KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
CYLTEZO (CF) PEN PSORIASIS	PEN INJECTOR KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
CYLTEZO (CF) PEN PSORIASIS	PEN INJECTOR KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
ENBREL	CARTRIDGE (ML)	50 MG/ML (1)	SC	PA; QL; SP
ENBREL	PEN INJECTOR (ML)	50 MG/ML (1)	SC	PA; QL; SP
ENBREL	SYRINGE (ML)	25 MG/0.5 ML	SC	PA; QL; SP
ENBREL	SYRINGE (ML)	50 MG/ML (1)	SC	PA; QL; SP
ENBREL	VIAL (ML)	25 MG/0.5 ML	SC	PA; QL; SP
HUMIRA	PEN INJECTOR KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
HUMIRA	PEN INJECTOR KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
HUMIRA	PEN INJECTOR KIT (EA)	80 MG-40 MG	SC	PA; QL; SP
HUMIRA	PEN INJECTOR KIT (EA)	80 MG/0.8 ML	SC	PA; QL; SP
HUMIRA	SYRINGE KIT (EA)	10 MG/0.1 ML	SC	PA; QL; SP
HUMIRA	SYRINGE KIT (EA)	20 MG/0.2 ML	SC	PA; QL; SP
HUMIRA	SYRINGE KIT (EA)	40 MG/0.4 ML	SC	PA; QL; SP
HUMIRA	SYRINGE KIT (EA)	40 MG/0.8 ML	SC	PA; QL; SP
HUMIRA PEDIATRIC	PEN INJECTOR KIT (EA)	80 MG/0.8 ML	SC	PA; QL; SP
HUMIRA PEDIATRIC	SYRINGE KIT (EA)	80 MG-40 MG	SC	PA; QL; SP
HUMIRA PEDIATRIC	SYRINGE KIT (EA)	80 MG/0.8 ML	SC	PA; QL; SP
HYRIMOZ (CF)	SYRINGE (ML)	10 MG/0.1 ML	SC	PA; QL; SP
HYRIMOZ (CF)	SYRINGE (ML)	20 MG/0.2 ML	SC	PA; QL; SP
HYRIMOZ (CF)	SYRINGE (ML)	40 MG/0.4 ML	SC	PA; QL; SP
HYRIMOZ (CF) PEDIATRIC CROHN'S	SYRINGE (ML)	80 MG/0.8 ML	SC	PA; QL; SP
HYRIMOZ (CF) PEDIATRIC CROHN'S	SYRINGE (ML)	80 MG-40 MG	SC	PA; QL; SP
HYRIMOZ (CF) PEN	PEN INJECTOR (ML)	40 MG/0.4 ML	SC	PA; QL; SP
HYRIMOZ (CF) PEN	PEN INJECTOR (ML)	80 MG/0.8 ML	SC	PA; QL; SP
HYRIMOZ (CF) PEN CROHN-UC START	PEN INJECTOR (ML)	80 MG/0.8 ML	SC	PA; QL; SP
HYRIMOZ (CF) PEN PSORIASIS	PEN INJECTOR (ML)	80 MG-40 MG	SC	PA; QL; SP
leflunomide	*tablet*	*10 mg*	ORAL	QL
leflunomide	tablet	20 mg	ORAL	QL
OTEZLA	TABLET	30 MG	ORAL	PA; QL; SP
OTEZLA	TABLET; DOSE PACK	10-20-30 MG	ORAL	PA; QL; SP
penicillamine	capsule	250 mg	ORAL	PA
penicillamine	tablet	250 mg	ORAL	PA
RASUVO	AUTO-INJECTOR (ML)	7.5 MG/0.15	SC	ST
RASUVO	AUTO-INJECTOR (ML)	10 MG/0.2 ML	SC	ST
RASUVO	AUTO-INJECTOR (ML)	12.5/0.25	SC	ST
RASUVO	AUTO-INJECTOR (ML)	15 MG/0.3 ML	SC	ST
RASUVO	AUTO-INJECTOR (ML)	17.5/0.35	SC	ST
RASUVO	AUTO-INJECTOR (ML)	20 MG/0.4 ML	SC	ST
RASUVO	AUTO-INJECTOR (ML)	22.5/0.45	SC	ST
RASUVO	AUTO-INJECTOR (ML)	25 MG/0.5 ML	SC	ST
RASUVO	AUTO-INJECTOR (ML)	30 MG/0.6 ML	SC	ST
RIDAURA	CAPSULE	3 MG	ORAL	PA
RINVOQ	TABLET; EXTENDED RELEASE 24 HR	15 MG	ORAL	PA; QL; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
RINVOQ	TABLET; EXTENDED RELEASE 24 HR	30 MG	ORAL	PA; QL; SP
RINVOQ	TABLET; EXTENDED RELEASE 24 HR	45 MG	ORAL	PA; QL; SP
SAVELLA	TABLET	12.5 MG	ORAL	ST
SAVELLA	TABLET	25 MG	ORAL	ST
SAVELLA	TABLET	50 MG	ORAL	ST
SAVELLA	TABLET	100 MG	ORAL	ST
SAVELLA	TABLET; DOSE PACK	12.5-25-50	ORAL	ST
SIMPONI	PEN INJECTOR (ML)	100 MG/ML	SC	PA; QL; SP
SIMPONI	SYRINGE (ML)	100 MG/ML	SC	PA; QL; SP
XELJANZ	SOLUTION; ORAL	1 MG/ML	ORAL	PA; QL; SP
XELJANZ	TABLET	5 MG	ORAL	PA; QL; SP
XELJANZ	TABLET	10 MG	ORAL	PA; QL; SP
XELJANZ XR	TABLET; EXTENDED RELEASE 24 HR	11 MG	ORAL	PA; QL; SP
XELJANZ XR	TABLET; EXTENDED RELEASE 24 HR	22 MG	ORAL	PA; QL; SP
OSTEOPOROSIS THERAPY				
alendronate sodium	*solution; oral*	*70 mg/75 ml*	ORAL	QL
alendronate sodium	*tablet*	*5 mg*	ORAL	QL
alendronate sodium	*tablet*	*10 mg*	ORAL	QL
alendronate sodium	*tablet*	*35 mg*	ORAL	QL
alendronate sodium	*tablet*	*70 mg*	ORAL	QL
FORTEO	PEN INJECTOR (ML)	20 MCG/DOSE	SC	PA; QL; SP
IBANDRONATE SODIUM	SYRINGE (ML)	3 MG/3 ML	IV	PA; SP
ibandronate sodium	*tablet*	*150 mg*	ORAL	QL
IBANDRONATE SODIUM	VIAL (ML)	3 MG/3 ML	IV	PA; SP
raloxifene hcl	*tablet*	*60 mg*	ORAL	
risedronate sodium	*tablet*	*5 mg*	ORAL	QL
risedronate sodium	*tablet*	*35 mg*	ORAL	QL
risedronate sodium	*tablet*	*150 mg*	ORAL	QL
risedronate sodium dr	*tablet; enteric coated*	*35 mg*	ORAL	QL
TERIPARATIDE	PEN INJECTOR (ML)	20 MCG/DOSE	SC	PA; QL; SP
TYMLOS	PEN INJECTOR (ML)	80 MCG/DOSE	SC	PA; QL; SP
OBSTETRICS & GYNECOLOGY				
ABORTIFACIENTS				
mifepristone	*tablet*	*200 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
DIAPHRAGMS AND OTHER NON-ORAL CONTRACEPTIVES				
caya contoured	*diaphragm*	*65 mm-80 mm*	VAGINAL	ACA
eluryng	*ring; vaginal*	*0.12-0.015 mg*	VAGINAL	ACA
enilloring	*ring; vaginal*	*0.12-0.015 mg*	VAGINAL	ACA
etonogestrel-ethinyl estradiol	*ring; vaginal*	*0.12-0.015 mg*	VAGINAL	ACA
fc2 female condom	*each*	*str n/a*	MISC	ACA
femcap	*each*	*22 mm*	VAGINAL	ACA
haloette	*ring; vaginal*	*0.12-0.015 mg*	VAGINAL	ACA
kyleena	*intrauterine device*	*17.5 mcg/24 hr*	INTRAUTERINE	ACA; SP
mirena	*intrauterine device*	*21 mcg/24 hr*	INTRAUTERINE	ACA; SP
nexplanon	*implant (ea)*	*68 mg*	SC	ACA; SP
norelgestromin-eth estradiol	*patch; transdermal weekly*	*150-35/24 hr*	TRANSDERM	ACA
paragard t 380-a	*intrauterine device*	*380 sq mm*	INTRAUTERINE	ACA; SP
skyla	*intrauterine device*	*14 mcg/24 hr*	INTRAUTERINE	ACA; SP
trustex-ria	*each*	*str n/a*	MISC	ACA
vcf	*film; medicated (ea)*	*28%*	VAGINAL	ACA
vcf	*gel with prefilled applicator (gram)*	*4%*	VAGINAL	ACA
xulane	*patch; transdermal weekly*	*150-35/24 hr*	TRANSDERM	ACA
zafemy	*patch; transdermal weekly*	*150-35/24 hr*	TRANSDERM	ACA
ESTROGEN COMBINATIONS				
amabelz	tablet	0.5-0.1 mg	ORAL	
COMBIPATCH	PATCH; TRANSDERMAL SEMIWEEKLY	0.05-0.14/24	TRANSDERM	
COMBIPATCH	PATCH; TRANSDERMAL SEMIWEEKLY	0.05-0.25/24	TRANSDERM	
covaryx	tablet	1.25-2.5 mg	ORAL	
covaryx h.s.	tablet	0.625-1.25	ORAL	
DUAVEE	TABLET	0.45-20 MG	ORAL	
eemt	tablet	1.25-2.5 mg	ORAL	
eemt hs	tablet	0.625-1.25	ORAL	
estradiol-norethindrone acetat	*tablet*	*0.5-0.1 mg*	ORAL	
estradiol-norethindrone acetat	*tablet*	*1 mg-0.5 mg*	ORAL	
estrogen & methyltestosterone	tablet	0.625-1.25	ORAL	
estrogen & methyltestosterone	tablet	1.25-2.5 mg	ORAL	
fyavolv	*tablet*	*0.5 mg-2.5*	ORAL	
fyavolv	*tablet*	*1 mg-5 mcg*	ORAL	
jinteli	*tablet*	*1 mg-5 mcg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
mimvey	*tablet*	*1 mg-0.5 mg*	ORAL	
norethindrone-ethin estradiol	*tablet*	*0.5 mg-2.5*	ORAL	
norethindrone-ethin estradiol	*tablet*	*1 mg-5 mcg*	ORAL	
ESTROGENS				
DEPO-ESTRADIOL	VIAL (ML)	5 MG/ML	IM	
dotti	*patch; transdermal semiweekly*	*0.025 mg/24 hr*	TRANSDERM	QL
dotti	*patch; transdermal semiweekly*	*0.0375 mg/24 hr*	TRANSDERM	QL
dotti	*patch; transdermal semiweekly*	*0.05 mg/24 hr*	TRANSDERM	QL
dotti	*patch; transdermal semiweekly*	*0.075 mg/24 hr*	TRANSDERM	QL
dotti	*patch; transdermal semiweekly*	*0.1 mg/24 hr*	TRANSDERM	QL
estradiol	*cream with applicator*	*0.01%*	VAGINAL	
estradiol	gel in metered-dose pump	1.25 g	TRANSDERM	QL
estradiol	*gel in packet (ea)*	*0.25/0.25 g*	TRANSDERM	QL
estradiol	*gel in packet (ea)*	*0.5 mg/0.5 g*	TRANSDERM	QL
estradiol	*gel in packet (ea)*	*0.75/0.75 g*	TRANSDERM	QL
estradiol	*gel in packet (gram)*	*1 mg/gram*	TRANSDERM	QL
estradiol	*gel in packet (gram)*	*1.25/1.25 g*	TRANSDERM	QL
estradiol	*patch; transdermal semiweekly*	*0.025 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal semiweekly*	*0.0375 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal semiweekly*	*0.05 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal semiweekly*	*0.075 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal semiweekly*	*0.1 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal weekly*	*0.025 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal weekly*	*0.0375 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal weekly*	*0.05 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal weekly*	*0.06 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal weekly*	*0.075 mg/24 hr*	TRANSDERM	QL
estradiol	*patch; transdermal weekly*	*0.1 mg/24 hr*	TRANSDERM	QL
estradiol	tablet	10 mcg	VAGINAL	
estradiol	*tablet*	*0.5 mg*	ORAL	
estradiol	*tablet*	*1 mg*	ORAL	
estradiol	*tablet*	*2 mg*	ORAL	
estradiol valerate	vial (ml)	10 mg/ml	IM	
estradiol valerate	vial (ml)	20 mg/ml	IM	
estradiol valerate	vial (ml)	40 mg/ml	IM	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
lyllana	*patch; transdermal semiweekly*	*0.025 mg/24 hr*	TRANSDERM	QL
lyllana	*patch; transdermal semiweekly*	*0.0375 mg/24 hr*	TRANSDERM	QL
lyllana	*patch; transdermal semiweekly*	*0.05 mg/24 hr*	TRANSDERM	QL
lyllana	*patch; transdermal semiweekly*	*0.075 mg/24 hr*	TRANSDERM	QL
lyllana	*patch; transdermal semiweekly*	*0.1 mg/24 hr*	TRANSDERM	QL
PREMARIN	CREAM WITH APPLICATOR	0.625 MG/G	VAGINAL	
yuvafem	*tablet*	*10 mcg*	VAGINAL	
MONOPHASIC / BIPHASIC / TRIPHASIC AGENTS				
afirmelle	*tablet*	*0.1-0.02 mg*	ORAL	ACA
after pill	*tablet*	*1.5 mg*	ORAL	ACA; QL
altavera	*tablet*	*0.15-0.03*	ORAL	ACA
alyacen	*tablet*	*1 mg-35 mcg*	ORAL	ACA
alyacen	*tablet*	*7 days x 3*	ORAL	ACA
amethia	*tablet; dose pack; 3 months*	*150-30 (84)*	ORAL	ACA
amethyst	*tablet*	*90-20 mcg*	ORAL	ACA
apri	*tablet*	*0.15-0.03*	ORAL	ACA
aranelle	*tablet*	*7-9-5*	ORAL	ACA
ashlyna	*tablet; dose pack; 3 months*	*150-30 (84)*	ORAL	ACA
aubra	*tablet*	*0.1-0.02 mg*	ORAL	ACA
aubra eq	*tablet*	*0.1-0.02 mg*	ORAL	ACA
aurovela	*tablet*	*1 mg-20 mcg*	ORAL	ACA
aurovela	*tablet*	*1.5-0.03 mg*	ORAL	ACA
aurovela 24 fe	*tablet*	*1 mg-20 (24)*	ORAL	ACA
aurovela fe	*tablet*	*1 mg-20 (21)*	ORAL	ACA
aurovela fe	*tablet*	*1.5-30 (21)*	ORAL	ACA
aviane	*tablet*	*0.1-0.02 mg*	ORAL	ACA
ayuna	*tablet*	*0.15-0.03*	ORAL	ACA
azurette	*tablet*	*21-5 (28)*	ORAL	ACA
balziva	*tablet*	*0.4-0.035*	ORAL	ACA
blisovi 24 fe	*tablet*	*1 mg-20 (24)*	ORAL	ACA
blisovi fe	*tablet*	*1 mg-20 (21)*	ORAL	ACA
blisovi fe	*tablet*	*1.5-30 (21)*	ORAL	ACA
briellyn	*tablet*	*0.4-0.035*	ORAL	ACA
camrese	*tablet; dose pack; 3 months*	*150-30 (84)*	ORAL	ACA
camrese lo	*tablet; dose pack; 3 months*	*100-20 (84)*	ORAL	ACA

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
caziant	*tablet*	*7 days x 3*	ORAL	ACA
charlotte 24 fe	*tablet; chewable*	*1 mg-20 (24)*	ORAL	ACA
chateal	*tablet*	*0.15-0.03*	ORAL	ACA
chateal eq	*tablet*	*0.15-0.03*	ORAL	ACA
cryselle	*tablet*	*0.3-0.03 mg*	ORAL	ACA
curae	*tablet*	*1.5 mg*	ORAL	ACA; QL
cyred	*tablet*	*0.15-0.03*	ORAL	ACA
cyred eq	*tablet*	*0.15-0.03*	ORAL	ACA
dasetta	*tablet*	*1 mg-35 mcg*	ORAL	ACA
dasetta	*tablet*	*7 days x 3*	ORAL	ACA
daysee	*tablet; dose pack; 3 months*	*150-30 (84)*	ORAL	ACA
desogestr-eth estrad eth estra	*tablet*	*21-5 (28)*	ORAL	ACA
dolishale	*tablet*	*90-20 mcg*	ORAL	ACA
drospirenone-eth estra-levomef	*tablet*	*3-0.02 (24)*	ORAL	ACA
drospirenone-eth estra-levomef	*tablet*	*3-0.03 (21)*	ORAL	ACA
drospirenone-ethinyl estradiol	*tablet*	*0.02-3 (28)*	ORAL	ACA
drospirenone-ethinyl estradiol	*tablet*	*0.03 mg-3 mg*	ORAL	ACA
econtra ez	*tablet*	*1.5 mg*	ORAL	ACA; QL
econtra one-step	*tablet*	*1.5 mg*	ORAL	ACA; QL
elinest	*tablet*	*0.3-0.03 mg*	ORAL	ACA
ella	*tablet*	*30 mg*	ORAL	ACA; QL
enpresse	*tablet*	*6-5-10*	ORAL	ACA
enskyce	*tablet*	*0.15-0.03*	ORAL	ACA
estarylla	*tablet*	*0.25-0.035*	ORAL	ACA
ethynodiol-ethinyl estradiol	*tablet*	*1 mg-35 mcg*	ORAL	ACA
ethynodiol-ethinyl estradiol	*tablet*	*1 mg-50 mcg*	ORAL	ACA
falmina	*tablet*	*0.1-0.02 mg*	ORAL	ACA
finzala	*tablet; chewable*	*1 mg-20 (24)*	ORAL	ACA
gemmily	*capsule*	*1 mg-20 (24)*	ORAL	ACA
hailey	*tablet*	*1.5-0.03 mg*	ORAL	ACA
hailey fe	*tablet*	*1 mg-20 (21)*	ORAL	ACA
hailey fe	*tablet*	*1 mg-20 (24)*	ORAL	ACA
hailey fe	*tablet*	*1.5-30 (21)*	ORAL	ACA
her style	*tablet*	*1.5 mg*	ORAL	ACA; QL
iclevia	*tablet; dose pack; 3 months*	*0.15-0.03*	ORAL	ACA
isibloom	*tablet*	*0.15-0.03*	ORAL	ACA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
jaimiess	*tablet; dose pack; 3 months*	*150-30 (84)*	ORAL	ACA
jasmiel	*tablet*	*0.02-3 (28)*	ORAL	ACA
jolessa	*tablet; dose pack; 3 months*	*0.15-0.03*	ORAL	ACA
joyeaux	*tablet*	*0.1-0.02 mg*	ORAL	ACA
juleber	*tablet*	*0.15-0.03*	ORAL	ACA
junel	*tablet*	*1 mg-20 mcg*	ORAL	ACA
junel	*tablet*	*1.5-0.03 mg*	ORAL	ACA
junel fe	*tablet*	*1 mg-20 (21)*	ORAL	ACA
junel fe	*tablet*	*1 mg-20 (24)*	ORAL	ACA
junel fe	*tablet*	*1.5-30 (21)*	ORAL	ACA
kaitlib fe	*tablet; chewable*	*0.8-25 (24)*	ORAL	ACA
kalliga	*tablet*	*0.15-0.03*	ORAL	ACA
kariva	*tablet*	*21-5 (28)*	ORAL	ACA
kelnor 1-35	*tablet*	*1 mg-35 mcg*	ORAL	ACA
kelnor 1-50	*tablet*	*1 mg-50 mcg*	ORAL	ACA
kurvelo	*tablet*	*0.15-0.03*	ORAL	ACA
larin	*tablet*	*1 mg-20 mcg*	ORAL	ACA
larin	*tablet*	*1.5-0.03 mg*	ORAL	ACA
larin fe	*tablet*	*1 mg-20 (21)*	ORAL	ACA
larin fe	*tablet*	*1 mg-20 (24)*	ORAL	ACA
larin fe	*tablet*	*1.5-30 (21)*	ORAL	ACA
layolis fe	*tablet; chewable*	*0.8-25 (24)*	ORAL	ACA
leena	*tablet*	*7-9-5*	ORAL	ACA
lessina	*tablet*	*0.1-0.02 mg*	ORAL	ACA
levonest	*tablet*	*6-5-10*	ORAL	ACA
levonorgestrel	*tablet*	*1.5 mg*	ORAL	ACA; QL
levonorgestrel-eth estradiol	*tablet*	*0.1-0.02 mg*	ORAL	ACA
levonorgestrel-eth estradiol	*tablet*	*0.15-0.03*	ORAL	ACA
levonorgestrel-eth estradiol	*tablet*	*6-5-10*	ORAL	ACA
levonorgestrel-eth estradiol	*tablet*	*90-20 mcg*	ORAL	ACA
levonorgestrel-eth estradiol	*tablet; dose pack; 3 months*	*0.15-0.03*	ORAL	ACA
levonorg-eth estrad eth estrad	*tablet; dose pack; 3 months*	*0.15 mg (84)*	ORAL	ACA
levonorg-eth estrad eth estrad	*tablet; dose pack; 3 months*	*100-20 (84)*	ORAL	ACA
levonorg-eth estrad eth estrad	*tablet; dose pack; 3 months*	*150-30 (84)*	ORAL	ACA
levonorg-eth estrad-fe bisglyc	*tablet*	*0.1-0.02 mg*	ORAL	ACA
levora	*tablet*	*0.15-0.03*	ORAL	ACA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
lojaimiess	*tablet; dose pack; 3 months*	*100-20 (84)*	ORAL	ACA
loryna	*tablet*	*0.02-3 (28)*	ORAL	ACA
low-ogestrel	*tablet*	*0.3-0.03 mg*	ORAL	ACA
lo-zumandimine	*tablet*	*0.02-3 (28)*	ORAL	ACA
lutera	*tablet*	*0.1-0.02 mg*	ORAL	ACA
marlissa	*tablet*	*0.15-0.03*	ORAL	ACA
merzee	*capsule*	*1 mg-20 (24)*	ORAL	ACA
mibelas 24 fe	*tablet; chewable*	*1 mg-20 (24)*	ORAL	ACA
microgestin	*tablet*	*1 mg-20 mcg*	ORAL	ACA
microgestin	*tablet*	*1.5-0.03 mg*	ORAL	ACA
microgestin 24 fe	*tablet*	*1 mg-20 (24)*	ORAL	ACA
microgestin fe	*tablet*	*1 mg-20 (21)*	ORAL	ACA
microgestin fe	*tablet*	*1.5-30 (21)*	ORAL	ACA
mili	*tablet*	*0.25-0.035*	ORAL	ACA
mono-linyah	*tablet*	*0.25-0.035*	ORAL	ACA
my choice	*tablet*	*1.5 mg*	ORAL	ACA; QL
my way	*tablet*	*1.5 mg*	ORAL	ACA; QL
necon	*tablet*	*0.5-0.035*	ORAL	ACA
new day	*tablet*	*1.5 mg*	ORAL	ACA; QL
nikki	*tablet*	*0.02-3 (28)*	ORAL	ACA
norethindrone-e.estradiol-iron	*capsule*	*1 mg-20 (24)*	ORAL	ACA
norethindrone-e.estradiol-iron	*tablet*	*1 mg-20 (21)*	ORAL	ACA
norethindrone-e.estradiol-iron	*tablet*	*1.5-30 (21)*	ORAL	ACA
norethindrone-e.estradiol-iron	*tablet*	*5-7-9-7*	ORAL	ACA
norethindrone-e.estradiol-iron	*tablet; chewable*	*0.4-35 (21)*	ORAL	ACA
norethindrone-e.estradiol-iron	*tablet; chewable*	*0.8-25 (24)*	ORAL	ACA
norethindrone-e.estradiol-iron	*tablet; chewable*	*1 mg-20 (24)*	ORAL	ACA
norethindrone-ethin estradiol	*tablet*	*1 mg-20 mcg*	ORAL	ACA
norethindrone-ethin estradiol	*tablet*	*1.5-0.03 mg*	ORAL	ACA
norgestimate-ethinyl estradiol	*tablet*	*0.25-0.035*	ORAL	ACA
norgestimate-ethinyl estradiol	*tablet*	*7 days x3 28*	ORAL	ACA
norgestimate-ethinyl estradiol	*tablet*	*7 days x3 lo*	ORAL	ACA
nortrel	*tablet*	*0.5-0.035*	ORAL	ACA
nortrel	*tablet*	*1 mg-35 mcg*	ORAL	ACA
nortrel	*tablet*	*7 days x 3*	ORAL	ACA
nylia	*tablet*	*1 mg-35 mcg*	ORAL	ACA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
nylia	*tablet*	*7 days x 3*	ORAL	ACA
nymyo	*tablet*	*0.25-0.035*	ORAL	ACA
ocella	*tablet*	*0.03 mg-3 mg*	ORAL	ACA
opcicon one-step	*tablet*	*1.5 mg*	ORAL	ACA; QL
option 2	*tablet*	*1.5 mg*	ORAL	ACA; QL
philith	*tablet*	*0.4-0.035*	ORAL	ACA
pimtrea	*tablet*	*21-5 (28)*	ORAL	ACA
portia	*tablet*	*0.15-0.03*	ORAL	ACA
reclipsen	*tablet*	*0.15-0.03*	ORAL	ACA
rivelsa	*tablet; dose pack; 3 months*	*0.15 mg (84)*	ORAL	ACA
setlakin	*tablet; dose pack; 3 months*	*0.15-0.03*	ORAL	ACA
simliya	*tablet*	*21-5 (28)*	ORAL	ACA
simpesse	*tablet; dose pack; 3 months*	*150-30 (84)*	ORAL	ACA
sprintec	*tablet*	*0.25-0.035*	ORAL	ACA
sronyx	*tablet*	*0.1-0.02 mg*	ORAL	ACA
syeda	*tablet*	*0.03 mg-3 mg*	ORAL	ACA
tarina fe	*tablet*	*1 mg-20 (21)*	ORAL	ACA
tarina fe	*tablet*	*1 mg-20 (24)*	ORAL	ACA
taysofy	*capsule*	*1 mg-20 (24)*	ORAL	ACA
tilia fe	*tablet*	*5-7-9-7*	ORAL	ACA
tri-estarylla	*tablet*	*7 days x3 28*	ORAL	ACA
tri-legest fe	*tablet*	*5-7-9-7*	ORAL	ACA
tri-linyah	*tablet*	*7 days x3 28*	ORAL	ACA
tri-lo-estarylla	*tablet*	*7 days x3 lo*	ORAL	ACA
tri-lo-marzia	*tablet*	*7 days x3 lo*	ORAL	ACA
tri-lo-mili	*tablet*	*7 days x3 lo*	ORAL	ACA
tri-lo-sprintec	*tablet*	*7 days x3 lo*	ORAL	ACA
tri-mili	*tablet*	*7 days x3 28*	ORAL	ACA
tri-nymyo	*tablet*	*7 days x3 28*	ORAL	ACA
tri-sprintec	*tablet*	*7 days x3 28*	ORAL	ACA
trivora	*tablet*	*6-5-10*	ORAL	ACA
tri-vylibra	*tablet*	*7 days x3 28*	ORAL	ACA
tri-vylibra	*tablet*	*7 days x3 lo*	ORAL	ACA
turqoz	*tablet*	*0.3-0.03 mg*	ORAL	ACA
tydemy	*tablet*	*3-0.03 (21)*	ORAL	ACA
velivet	*tablet*	*7 days x 3*	ORAL	ACA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
vestura	*tablet*	*0.02-3 (28)*	ORAL	ACA
vienva	*tablet*	*0.1-0.02 mg*	ORAL	ACA
viorele	*tablet*	*21-5 (28)*	ORAL	ACA
volnea	*tablet*	*21-5 (28)*	ORAL	ACA
vyfemla	*tablet*	*0.4-0.035*	ORAL	ACA
vylibra	*tablet*	*0.25-0.035*	ORAL	ACA
wera	*tablet*	*0.5-0.035*	ORAL	ACA
wymzya fe	*tablet; chewable*	*0.4-35 (21)*	ORAL	ACA
zarah	*tablet*	*0.03 mg-3 mg*	ORAL	ACA
zovia	*tablet*	*1 mg-35 mcg*	ORAL	ACA
zumandimine	*tablet*	*0.03 mg-3 mg*	ORAL	ACA
OXYTOCICS				
methylergonovine maleate	tablet	0.2 mg	ORAL	QL; ST
PROGESTINS				
camila	*tablet*	*0.35 mg*	ORAL	ACA
deblitane	*tablet*	*0.35 mg*	ORAL	ACA
emzahh	*tablet*	*0.35 mg*	ORAL	ACA
errin	*tablet*	*0.35 mg*	ORAL	ACA
heather	*tablet*	*0.35 mg*	ORAL	ACA
incassia	*tablet*	*0.35 mg*	ORAL	ACA
jencycla	*tablet*	*0.35 mg*	ORAL	ACA
lyleq	*tablet*	*0.35 mg*	ORAL	ACA
lyza	*tablet*	*0.35 mg*	ORAL	ACA
medroxyprogesterone acetate	*syringe (ml)*	*150 mg/ml*	IM	ACA; QL
medroxyprogesterone acetate	*tablet*	*2.5 mg*	ORAL	
medroxyprogesterone acetate	*tablet*	*5 mg*	ORAL	
medroxyprogesterone acetate	*tablet*	*10 mg*	ORAL	
medroxyprogesterone acetate	*vial (ml)*	*150 mg/ml*	IM	ACA; QL
nora-be	*tablet*	*0.35 mg*	ORAL	ACA
norethindrone acetate	*tablet*	*0.35 mg*	ORAL	ACA
norethindrone acetate	*tablet*	*5 mg*	ORAL	
opill	*tablet*	*75 mcg*	ORAL	ACA
progesterone	*capsule*	*100 mg*	ORAL	PA
progesterone	*capsule*	*200 mg*	ORAL	PA
PROGESTERONE	VIAL (ML)	50 MG/ML	IM	PA; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
sharobel	*tablet*	*0.35 mg*	ORAL	ACA
tulana	*tablet*	*0.35 mg*	ORAL	ACA
SPECIALIZED OB/GYN DRUGS				
MYFEMBREE	TABLET	40-1-0.5 MG	ORAL	PA
ORIAHNN	CAP SEQ	300-1-0.5	ORAL	PA
tranexamic acid	tablet	650 mg	ORAL	
VAGINAL ANTIFUNGALS				
terconazole	*cream with applicator*	*0.4%*	VAGINAL	
terconazole	*cream with applicator*	*0.8%*	VAGINAL	
terconazole	*suppository; vaginal*	*80 mg*	VAGINAL	
VAGINAL CLEANSER /ANTIINFECTIVES				
clindamycin phosphate	*cream with applicator*	*2%*	VAGINAL	
fem ph	jelly with applicator (gram)	0.9-0.025%	VAGINAL	
metronidazole	*gel with applicator (gram)*	*0.75%*	VAGINAL	
TRIMO-SAN	JELLY WITH APPLICATOR (GRAM)	0.025-0.01	VAGINAL	
vandazole	gel with applicator (gram)	0.75%	VAGINAL	
OPHTHALMOLOGY				
ANTIBIOTICS				
AZASITE	DROPS	1%	OPHTH (EYE)	
bacitracin	*ointment (gram)*	*500 unit/g*	OPHTH (EYE)	
bacitracin/polymyxin	*ointment (gram)*	*500-10k/g*	OPHTH (EYE)	
ciprofloxacin hcl	*drops*	*0.3%*	OPHTH (EYE)	
erythromycin	*ointment (gram)*	*5 mg/gram*	OPHTH (EYE)	
gatifloxacin	*drops*	*0.5%*	OPHTH (EYE)	
gentamicin sulfate	*drops*	*0.3%*	OPHTH (EYE)	
levofloxacin	*drops*	*1.5%*	OPHTH (EYE)	
moxifloxacin hcl	*drops*	*0.5%*	OPHTH (EYE)	
moxifloxacin hcl	drops; viscous (ml)	0.5%	OPHTH (EYE)	
NATACYN	SUSPENSION; DROPS (FINAL DOSAGE FORM) (ML)	5%	OPHTH (EYE)	
neomycin/bacitracin/polymyxin	*ointment (gram)*	*3.5 mg-400*	OPHTH (EYE)	
neomycin/polymyxin/gramicidin	drops	1.75 mg-10k	OPHTH (EYE)	
neo-polycin	*ointment (gram)*	*3.5 mg-400*	OPHTH (EYE)	
ofloxacin	*drops*	*0.3%*	OPHTH (EYE)	
polycin	*ointment (gram)*	*500-10k/g*	OPHTH (EYE)	
polymyxin b sul-trimethoprim	*drops*	*10000-1/ml*	OPHTH (EYE)	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
tobramycin sulfate	*drops*	*0.3%*	OPHTH (EYE)	
ANTIVIRALS				
trifluridine	drops	1%	OPHTH (EYE)	
BETA-BLOCKERS				
betaxolol hcl	*drops*	*0.5%*	OPHTH (EYE)	
carteolol hcl	drops	1%	OPHTH (EYE)	
levobunolol hcl	drops	0.5%	OPHTH (EYE)	
timolol maleate	*dropperette; single-use drop dispenser*	*0.25%*	OPHTH (EYE)	
timolol maleate	*dropperette; single-use drop dispenser*	*0.5%*	OPHTH (EYE)	
timolol maleate	*drops*	*0.25%*	OPHTH (EYE)	
timolol maleate	*drops*	*0.5%*	OPHTH (EYE)	
timolol maleate	drops; once daily	0.5%	OPHTH (EYE)	
timolol maleate	*gel-forming solution*	*0.25%*	OPHTH (EYE)	
timolol maleate	gel-forming solution	0.5%	OPHTH (EYE)	
CHOLINESTERASE INHIBITOR MIOTICS				
PHOSPHOLINE IODIDE	DROPS	0.125%	OPHTH (EYE)	SP
CYCLOPLEGIC MYDRIATICS				
atropine sulfate	*drops*	*1%*	OPHTH (EYE)	
atropine sulfate	*ointment (gram)*	*1%*	OPHTH (EYE)	
cyclopentolate hcl	*drops*	*1%*	OPHTH (EYE)	
homatropaire	drops	5%	OPHTH (EYE)	
tropicamide	drops	0.5%	OPHTH (EYE)	
tropicamide	drops	1%	OPHTH (EYE)	
tropicamide-cyclopentolate-pe	drops	1%-1%-2.5%	OPHTH (EYE)	
DIRECT ACTING MIOTICS				
pilocarpine hcl	*drops*	*1%*	OPHTH (EYE)	
pilocarpine hcl	*drops*	*2%*	OPHTH (EYE)	
pilocarpine hcl	*drops*	*4%*	OPHTH (EYE)	
MISC OPHTHALMOLOGICS				
altacaine	*drops*	*0.5%*	OPHTH (EYE)	
azelastine hcl	*drops*	*0.05%*	OPHTH (EYE)	
bepotastine besilate	drops	1.5%	OPHTH (EYE)	
cromolyn sodium	*drops*	*4%*	OPHTH (EYE)	
cyclosporine	dropperette; single-use drop dispenser	0.05%	OPHTH (EYE)	PA; QL
CYSTARAN	DROPS	0.44%	OPHTH (EYE)	PA; SP

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epinastine hcl	*drops*	*0.05%*	OPHTH (EYE)	
OXERVATE	DROPS	0.002%	OPHTH (EYE)	PA; SP
proparacaine hcl	drops	0.5%	OPHTH (EYE)	
proparacaine-fluorescein	drops	0.5%-0.25%	OPHTH (EYE)	
RESTASIS MULTIDOSE	DROPS	0.05%	OPHTH (EYE)	PA; QL
tetracaine hcl	*drops*	*0.5%*	OPHTH (EYE)	
XDEMVY	DROPS	0.25%	OPHTH (EYE)	PA; QL; SP
XIIDRA	DROPPERETTE; SINGLE-USE DROP DISPENSER	5%	OPHTH (EYE)	PA; QL
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS				
bromfenac sodium	drops	0.07%	OPHTH (EYE)	
bromfenac sodium	drops	0.075%	OPHTH (EYE)	
bromfenac sodium	drops	0.09%	OPHTH (EYE)	
diclofenac sodium	*drops*	*0.1%*	OPHTH (EYE)	
flurbiprofen sodium	*drops*	*0.03%*	OPHTH (EYE)	
ketorolac tromethamine	*drops*	*0.4%*	OPHTH (EYE)	
ketorolac tromethamine	*drops*	*0.5%*	OPHTH (EYE)	
ORAL DRUGS FOR GLAUCOMA				
acetazolamide	*capsule; extended release*	*500 mg*	ORAL	
acetazolamide	*tablet*	*125 mg*	ORAL	
acetazolamide	*tablet*	*250 mg*	ORAL	
methazolamide	tablet	25 mg	ORAL	
methazolamide	tablet	50 mg	ORAL	
OTHER GLAUCOMA DRUGS				
bimatoprost	*drops*	*0.03%*	OPHTH (EYE)	ST
brimonidine tartrate-timolol	drops	0.2%-0.5%	OPHTH (EYE)	
brinzolamide	suspension; drops (final dosage form) (ml)	1%	OPHTH (EYE)	
dorzolamide hcl	*drops*	*2%*	OPHTH (EYE)	
dorzolamide-timolol	dropperette; single-use drop dispenser	2%-0.5%	OPHTH (EYE)	
dorzolamide-timolol	*drops*	*22.3-6.8/1*	OPHTH (EYE)	
latanoprost	*drops*	*0.005%*	OPHTH (EYE)	ST
miostat	vial (ml)	0.01%	INTRAOCULAR	
tafluprost	dropperette; single-use drop dispenser	0.0015%	OPHTH (EYE)	ST
travoprost	drops	0.004%	OPHTH (EYE)	ST
STEROID-ANTIBIOTIC COMBINATIONS				
neo/polymyxin/dexamethasone	*ointment (gram)*	*3.5-10k-0.1*	OPHTH (EYE)	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
neo/polymyxin/dexamethasone	*suspension; drops (final dosage form) (ml)*	*0.1%*	OPHTH (EYE)	
neomycin/bacitracin/poly/hc	*ointment (gram)*	*3.5-10k-1*	OPHTH (EYE)	
neomycin/polymyxin/hc	suspension; drops (final dosage form) (ml)	3.5-10k-10	OPHTH (EYE)	
neomycin-polymyxin-dexamethaso	*ointment (gram)*	*3.5-10k-0.1*	OPHTH (EYE)	
neo-polycin hc	*ointment (gram)*	*3.5-10k-1*	OPHTH (EYE)	
tobramycin-dexamethasone	*suspension; drops (final dosage form) (ml)*	*0.3%-0.1%*	OPHTH (EYE)	
STEROIDS				
dexamethasone sodium phosphate	*drops*	*0.1%*	OPHTH (EYE)	
difluprednate	drops	0.05%	OPHTH (EYE)	
EYSUVIS	SUSPENSION; DROPS (FINAL DOSAGE FORM) (ML)	0.25%	OPHTH (EYE)	PA; QL
fluorometholone	*suspension; drops (final dosage form) (ml)*	*0.1%*	OPHTH (EYE)	
loteprednol etabonate	drops; gel (gram)	0.5%	OPHTH (EYE)	
loteprednol etabonate	suspension; drops (final dosage form) (ml)	0.2%	OPHTH (EYE)	ST
loteprednol etabonate	suspension; drops (final dosage form) (ml)	0.5%	OPHTH (EYE)	
OZURDEX	IMPLANT (EA)	0.7 MG	INTRAOCULAR	PA; SP
prednisolone acetate	*suspension; drops (final dosage form) (ml)*	*1%*	OPHTH (EYE)	
prednisolone sodium phosphate	*drops*	*1%*	OPHTH (EYE)	
STEROID-SULFONAMIDE COMBINATIONS				
sulfacetamide w/ prednisolone	*drops*	*10%-0.23%*	OPHTH (EYE)	
SULFONAMIDES				
sulfacetamide sodium	*drops*	*10%*	OPHTH (EYE)	
sulfacetamide sodium	ointment (gram)	10%	OPHTH (EYE)	
SYMPATHOMIMETICS				
apraclonidine hcl	*drops*	*0.5%*	OPHTH (EYE)	
brimonidine tartrate	drops	0.1%	OPHTH (EYE)	
brimonidine tartrate	drops	0.15%	OPHTH (EYE)	
brimonidine tartrate	*drops*	*0.2%*	OPHTH (EYE)	
VASOCONSTRICTOR DECONGESTANTS				
phenylephrine hcl	drops	2.5%	OPHTH (EYE)	
phenylephrine hcl	drops	10%	OPHTH (EYE)	
RESPIRATORY, ALLERGY, COUGH & COLD				
ADRENERGICS				
epinephrine	auto-injector (ea)	0.15 mg/0.3	INJ	QL
epinephrine	auto-injector (ea)	0.3 mg/0.3	INJ	QL

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
SYMJEPI	SYRINGE (EA)	0.15 MG/0.3	INJ	QL
SYMJEPI	SYRINGE (EA)	0.3 MG/0.3	INJ	QL
ANTIHISTAMINES				
carbinoxamine	liquid (ml)	4 mg/5 ml	ORAL	
carbinoxamine	tablet	4 mg	ORAL	
carbinoxamine	tablet	6 mg	ORAL	ST
cetirizine hcl	*solution; oral*	*1 mg/ml*	ORAL	
clemastine fumarate	tablet	2.68 mg	ORAL	
cyproheptadine hcl	*syrup*	*2 mg/5 ml*	ORAL	
cyproheptadine hcl	*tablet*	*4 mg*	ORAL	
desloratadine	*tablet*	*5 mg*	ORAL	QL
desloratadine	*tablet; disintegrating*	*2.5 mg*	ORAL	QL
desloratadine	*tablet; disintegrating*	*5 mg*	ORAL	QL
hydroxyzine hcl	*solution; oral*	*10 mg/5 ml*	ORAL	
hydroxyzine hcl	*tablet*	*10 mg*	ORAL	
hydroxyzine hcl	*tablet*	*25 mg*	ORAL	
hydroxyzine hcl	*tablet*	*50 mg*	ORAL	
hydroxyzine hcl	*vial (ml)*	*25 mg/ml*	IM	
hydroxyzine pamoate	*capsule*	*25 mg*	ORAL	
hydroxyzine pamoate	*capsule*	*50 mg*	ORAL	
hydroxyzine pamoate	*capsule*	*100 mg*	ORAL	
promethazine hcl	suppository; rectal	12.5 mg	RECTAL	
promethazine hcl	suppository; rectal	25 mg	RECTAL	
promethazine hcl	*syrup*	*6.25 mg/5 ml*	ORAL	
promethazine hcl	*tablet*	*12.5 mg*	ORAL	
promethazine hcl	*tablet*	*25 mg*	ORAL	
promethazine hcl	*tablet*	*50 mg*	ORAL	
promethazine hcl	*vial (ml)*	*25 mg/ml*	INJ	
promethegan	suppository; rectal	12.5 mg	RECTAL	
promethegan	suppository; rectal	25 mg	RECTAL	
promethegan	suppository; rectal	50 mg	RECTAL	
ANTITUSSIVE COMBINATIONS				
benzonatate	*capsule*	*100 mg*	ORAL	
benzonatate	*capsule*	*150 mg*	ORAL	
benzonatate	*capsule*	*200 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
brompheniramine w/ pseudoephed	*syrup*	*2-30-10/5*	ORAL	
g tussin ac	*liquid (ml)*	*10-100 mg/5*	ORAL	
guaifenesin with codeine	*liquid (ml)*	*10-100 mg/5*	ORAL	
hydrocodone/homatropine	*syrup*	*5-1.5 mg/5*	ORAL	
hydrocodone/homatropine	*tablet*	*5 mg-1.5 mg*	ORAL	
hydrocodone-chlorpheniramine	*suspension; extended release 12 hr*	*10-8 mg/5 ml*	ORAL	
hydromet	*syrup*	*5-1.5 mg/5*	ORAL	
maxi-tuss ac	*liquid (ml)*	*10-100 mg/5*	ORAL	
promethazine w/ codeine	*syrup*	*6.25-10/5*	ORAL	
promethazine w/ dm	*syrup*	*6.25-15/5*	ORAL	
BETA AGONISTS INHALERS				
albuterol sulfate	*solution; non-oral*	*5 mg/ml*	INH	
albuterol sulfate	*vial; nebulizer (ea)*	*2.5 mg/0.5*	INH	
albuterol sulfate	*vial; nebulizer (ml)*	*0.63 mg/3 ml*	INH	
albuterol sulfate	*vial; nebulizer (ml)*	*1.25 mg/3 ml*	INH	
albuterol sulfate	*vial; nebulizer (ml)*	*2.5 mg/3 ml*	INH	
albuterol sulfate hfa	*hfa aerosol with adapter (gram)*	*90 mcg*	INH	QL
arformoterol tartrate	vial; nebulizer (ml)	15 mcg/2 ml	INH	QL
formoterol fumarate	vial; nebulizer (ml)	20 mcg/2 ml	INH	QL
levalbuterol hcl	*vial; nebulizer (ea)*	*1.25 mg/0.5*	INH	
levalbuterol hcl	*vial; nebulizer (ml)*	*0.31 mg/3 ml*	INH	
levalbuterol hcl	*vial; nebulizer (ml)*	*0.63 mg/3 ml*	INH	
levalbuterol hcl	*vial; nebulizer (ml)*	*1.25 mg/3 ml*	INH	
STRIVERDI RESPIMAT	MIST INHALER (GRAM)	2.5 MCG	INH	QL
BETA AGONISTS ORAL				
albuterol sulfate	*syrup*	*2 mg/5 ml*	ORAL	
albuterol sulfate	*tablet*	*2 mg*	ORAL	
albuterol sulfate	*tablet*	*4 mg*	ORAL	
albuterol sulfate	*tablet; extended release 12 hr*	*4 mg*	ORAL	
albuterol sulfate	*tablet; extended release 12 hr*	*8 mg*	ORAL	
terbutaline sulfate	tablet	2.5 mg	ORAL	
terbutaline sulfate	tablet	5 mg	ORAL	
DECONGESTANT / ANTIHISTAMINES				
promethazine vc	*syrup*	*5-6.25 mg/5*	ORAL	
r-tanna	*tablet*	*25-9 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
EXPECTORANT COMBINATIONS				
pe-guai	drops	20-1.5/ml	ORAL	
INHALED CORTICOSTEROIDS				
ARNUITY ELLIPTA	BLISTER; WITH INHALATION DEVICE	50 MCG	INH	QL
ARNUITY ELLIPTA	BLISTER; WITH INHALATION DEVICE	100 MCG	INH	QL
ARNUITY ELLIPTA	BLISTER; WITH INHALATION DEVICE	200 MCG	INH	QL
ASMANEX	AEROSOL POWDER; BREATH ACTIVATED (EA)	110 MCG (30)	INH	QL
ASMANEX	AEROSOL POWDER; BREATH ACTIVATED (EA)	220 MCG (14)	INH	QL
ASMANEX	AEROSOL POWDER; BREATH ACTIVATED (EA)	220 MCG (30)	INH	QL
ASMANEX	AEROSOL POWDER; BREATH ACTIVATED (EA)	220 MCG (60)	INH	QL
ASMANEX	AEROSOL POWDER; BREATH ACTIVATED (EA)	220 MCG (120)	INH	QL
ASMANEX HFA	HFA AEROSOL WITH ADAPTER (GRAM)	50 MCG	INH	QL
ASMANEX HFA	HFA AEROSOL WITH ADAPTER (GRAM)	100 MCG	INH	QL
ASMANEX HFA	HFA AEROSOL WITH ADAPTER (GRAM)	200 MCG	INH	QL
budesonide	ampul for nebulization (ml)	0.25 mg/2 ml	INH	QL
budesonide	ampul for nebulization (ml)	0.5 mg/2 ml	INH	QL
budesonide	ampul for nebulization (ml)	1 mg/2 ml	INH	QL
QVAR REDIHALER	HFA AEROSOL; BREATH ACTIVATED (GRAM)	40 MCG	INH	QL
QVAR REDIHALER	HFA AEROSOL; BREATH ACTIVATED (GRAM)	80 MCG	INH	QL
INTRANASAL STEROIDS				
azelastine-fluticasone	aerosol; spray with pump (gram)	137-50 mcg	NASAL	QL; ST
flunisolide	*aerosol; spray (ml)*	*25 mcg*	NASAL	QL; ST
fluticasone propionate	*spray; suspension*	*50 mcg*	NASAL	QL
mometasone furoate	*aerosol; spray with pump (gram)*	*50 mcg*	NASAL	QL; ST
MISC PULMONARY AGENTS				
acetylcysteine	vial (ml)	100 mg/ml	MISC	
acetylcysteine	vial (ml)	200 mg/ml	MISC	
ADEMPAS	TABLET	0.5 MG	ORAL	LA; PA; QL; SP
ADEMPAS	TABLET	1 MG	ORAL	LA; PA; QL; SP
ADEMPAS	TABLET	1.5 MG	ORAL	LA; PA; QL; SP
ADEMPAS	TABLET	2 MG	ORAL	LA; PA; QL; SP
ADEMPAS	TABLET	2.5 MG	ORAL	LA; PA; QL; SP
ADVAIR HFA	HFA AEROSOL WITH ADAPTER (GRAM)	45-21 MCG	INH	QL; ST
ADVAIR HFA	HFA AEROSOL WITH ADAPTER (GRAM)	115-21 MCG	INH	QL; ST
ADVAIR HFA	HFA AEROSOL WITH ADAPTER (GRAM)	230-21 MCG	INH	QL; ST

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
ALYQ	TABLET	20 MG	ORAL	PA; QL; SP
AMBRISENTAN	TABLET	5 MG	ORAL	LA; PA; QL; SP
AMBRISENTAN	TABLET	10 MG	ORAL	LA; PA; QL; SP
ANORO ELLIPTA	BLISTER; WITH INHALATION DEVICE	62.5-25 MCG	INH	QL
BOSENTAN	TABLET	62.5 MG	ORAL	PA; QL; SP
BOSENTAN	TABLET	125 MG	ORAL	PA; QL; SP
BREO ELLIPTA	BLISTER; WITH INHALATION DEVICE	50-25 MCG	INH	QL; ST
BREO ELLIPTA	BLISTER; WITH INHALATION DEVICE	100-25 MCG	INH	QL; ST
BREO ELLIPTA	BLISTER; WITH INHALATION DEVICE	200-25 MCG	INH	QL; ST
breyna	hfa aerosol with adapter (gram)	80-4.5 mcg	INH	QL; ST
breyna	hfa aerosol with adapter (gram)	160-4.5 mcg	INH	QL; ST
BREZTRI AEROSPHERE	HFA AEROSOL WITH ADAPTER (GRAM)	160-9-4.8	INH	QL
budesonide-formoterol fumarate	hfa aerosol with adapter (gram)	80-4.5 mcg	INH	QL; ST
budesonide-formoterol fumarate	hfa aerosol with adapter (gram)	160-4.5 mcg	INH	QL; ST
COMBIVENT RESPIMAT	MIST INHALER (GRAM)	20-100 MCG	INH	QL
cromolyn sodium	ampul for nebulization (ml)	20 mg/2 ml	INH	
DULERA	HFA AEROSOL WITH ADAPTER (GRAM)	50 MCG-5 MCG	INH	QL; ST
DULERA	HFA AEROSOL WITH ADAPTER (GRAM)	100-5 MCG	INH	QL; ST
DULERA	HFA AEROSOL WITH ADAPTER (GRAM)	200-5 MCG	INH	QL; ST
epinephrine	solution; non-oral	1 mg/ml	NASAL	
FASENRA PEN	AUTO-INJECTOR (ML)	30 MG/ML	SC	PA; QL; SP
fluticasone-salmeterol	blister; with inhalation device	100-50 mcg	INH	QL; ST
fluticasone-salmeterol	blister; with inhalation device	250-50 mcg	INH	QL; ST
fluticasone-salmeterol	blister; with inhalation device	500-50 mcg	INH	QL; ST
ICATIBANT	SYRINGE (ML)	30 MG/3 ML	SC	PA; QL; SP
ipratropium bromide	*solution; non-oral*	*0.2 mg/ml*	INH	
ipratropium-albuterol	*ampul for nebulization (ml)*	*0.5-3 mg/3*	INH	QL
KALYDECO	GRANULES IN PACKET (EA)	5.8 MG	ORAL	PA; QL; SP
KALYDECO	GRANULES IN PACKET (EA)	13.4 MG	ORAL	PA; QL; SP
KALYDECO	GRANULES IN PACKET (EA)	25 MG	ORAL	PA; QL; SP
KALYDECO	GRANULES IN PACKET (EA)	50 MG	ORAL	PA; QL; SP
KALYDECO	GRANULES IN PACKET (EA)	75 MG	ORAL	PA; QL; SP
KALYDECO	TABLET	150 MG	ORAL	PA; QL; SP
montelukast sodium	granules in packet (ea)	4 mg	ORAL	
montelukast sodium	*tablet*	*10 mg*	ORAL	
montelukast sodium	*tablet; chewable*	*4 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
montelukast sodium	*tablet; chewable*	*5 mg*	ORAL	
nebusal	*vial; nebulizer (ml)*	*3%*	INH	
NUCALA	SYRINGE (ML)	40 MG/0.4 ML	SC	LA; PA; QL; SP
NUCALA	SYRINGE (ML)	100 MG/ML	SC	LA; PA; QL; SP
NUCALA	VIAL (EA)	100 MG	SC	LA; PA; QL; SP
OFEV	CAPSULE	100 MG	ORAL	PA; QL; SP
OFEV	CAPSULE	150 MG	ORAL	PA; QL; SP
OPSUMIT	TABLET	10 MG	ORAL	LA; PA; QL; SP
ORKAMBI	GRANULES IN PACKET (EA)	75 MG-94 MG	ORAL	PA; QL; SP
ORKAMBI	GRANULES IN PACKET (EA)	100-125 MG	ORAL	PA; QL; SP
ORKAMBI	GRANULES IN PACKET (EA)	150-188 MG	ORAL	PA; QL; SP
ORKAMBI	TABLET	100-125 MG	ORAL	PA; QL; SP
ORKAMBI	TABLET	200-125 MG	ORAL	PA; QL; SP
PIRFENIDONE	CAPSULE	267 MG	ORAL	PA; QL; SP
PIRFENIDONE	TABLET	267 MG	ORAL	PA; QL; SP
PIRFENIDONE	TABLET	801 MG	ORAL	PA; QL; SP
pulmosal	vial; nebulizer (ml)	7%	INH	
PULMOZYME	SOLUTION; NON-ORAL	1 MG/ML	INH	PA; SP
roflumilast	tablet	250 mcg	ORAL	QL; ST
roflumilast	tablet	500 mcg	ORAL	ST
SAJAZIR	SYRINGE (ML)	30 MG/3 ML	SC	PA; QL; SP
SILDENAFIL CITRATE	SUSPENSION; RECONSTITUTED; ORAL (ML)	10 MG/ML	ORAL	PA; QL; SP
SILDENAFIL CITRATE	TABLET	20 MG	ORAL	PA; QL; SP
SILDENAFIL CITRATE	VIAL (ML)	10 MG/12.5	IV	SP
sodium chloride	*vial; nebulizer (ml)*	*0.9%*	INH	
sodium chloride	*vial; nebulizer (ml)*	*3%*	INH	
sodium chloride	*vial; nebulizer (ml)*	*7%*	INH	
sodium chloride	*vial; nebulizer (ml)*	*10%*	INH	
SPIRIVA RESPIMAT	MIST INHALER (GRAM)	1.25 MCG	INH	QL
SPIRIVA RESPIMAT	MIST INHALER (GRAM)	2.5 MCG	INH	QL
STIOLTO RESPIMAT	MIST INHALER (GRAM)	2.5-2.5 MCG	INH	QL
SYMDEKO	TABLET; SEQUENTIAL	50 MG-75 MG	ORAL	PA; QL; SP
SYMDEKO	TABLET; SEQUENTIAL	100-150 MG	ORAL	PA; QL; SP
TADALAFIL	TABLET	20 MG	ORAL	PA; QL; SP
TAKHZYRO	SYRINGE (ML)	150 MG/ML	SC	LA; PA; QL; SP
TAKHZYRO	SYRINGE (ML)	300 MG/2 ML	SC	LA; PA; QL; SP

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
TAKHZYRO	VIAL (ML)	300 MG/2 ML	SC	LA; PA; QL; SP
TEZSPIRE	PEN INJECTOR (ML)	210 MG/1.91	SC	PA; QL; SP
tiotropium bromide	capsule; with inhalation device	18 mcg	INH	
TRACLEER	TABLET FOR SUSPENSION	32 MG	ORAL	LA; PA; QL; SP
TRELEGY ELLIPTA	BLISTER; WITH INHALATION DEVICE	100-62.5	INH	QL
TRELEGY ELLIPTA	BLISTER; WITH INHALATION DEVICE	200-62.5	INH	QL
TRIKAFTA	GRANULES IN PACKET; SEQUENTIAL	80-40-60 MG	ORAL	PA; QL; SP
TRIKAFTA	GRANULES IN PACKET; SEQUENTIAL	100-50-75	ORAL	PA; QL; SP
TRIKAFTA	TABLET; SEQUENTIAL	50-25-37.5	ORAL	PA; QL; SP
TRIKAFTA	TABLET; SEQUENTIAL	100-50-75	ORAL	PA; QL; SP
TYVASO	AMPUL FOR NEBULIZATION (ML)	1.74 MG/2.9	INH	PA; SP
wixela inhub	blister; with inhalation device	100-50 mcg	INH	QL; ST
wixela inhub	blister; with inhalation device	250-50 mcg	INH	QL; ST
wixela inhub	blister; with inhalation device	500-50 mcg	INH	QL; ST
XOLAIR	SYRINGE (ML)	75 MG/0.5 ML	SC	LA; PA; QL; SP
XOLAIR	SYRINGE (ML)	150 MG/ML	SC	LA; PA; QL; SP
XOLAIR	SYRINGE (ML)	300 MG/2 ML	SC	LA; PA; QL; SP
YUPELRI	VIAL; NEBULIZER (ML)	175 MCG/3 ML	INH	QL
zafirlukast	*tablet*	*10 mg*	ORAL	
zafirlukast	*tablet*	*20 mg*	ORAL	
zileuton	tablet; extended release multiphase 12 hr	600 mg	ORAL	PA
XANTHINES				
theophylline anhydrous	elixir	80 mg/15 ml	ORAL	
theophylline anhydrous	solution; oral	80 mg/15 ml	ORAL	
theophylline er	tablet; extended release 12 hr	100 mg	ORAL	
theophylline er	tablet; extended release 12 hr	200 mg	ORAL	
theophylline er	*tablet; extended release 12 hr*	*300 mg*	ORAL	
theophylline er	*tablet; extended release 12 hr*	*450 mg*	ORAL	
theophylline er	*tablet; extended release 24 hr*	*400 mg*	ORAL	
theophylline er	*tablet; extended release 24 hr*	*600 mg*	ORAL	
UROLOGICALS				
ANTICHOLINERGICS & ANTISPASMODICS				
darifenacin er	*tablet; extended release 24 hr*	*7.5 mg*	ORAL	
darifenacin er	*tablet; extended release 24 hr*	*15 mg*	ORAL	
fesoterodine fumarate er	*tablet; extended release 24 hr*	*4 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
fesoterodine fumarate er	*tablet; extended release 24 hr*	*8 mg*	ORAL	
flavoxate hcl	tablet	100 mg	ORAL	
GELNIQUE	GEL IN PACKET (GRAM)	10%	TRANSDERM	QL; ST
mirabegron er	tablet; extended release 24 hr	25 mg	ORAL	
mirabegron er	tablet; extended release 24 hr	50 mg	ORAL	
MYRBETRIQ	SUSPENSION; EXTENDED RELEASE; RECON (ML)	8 MG/ML	ORAL	ST
oxybutynin chloride	*syrup*	*5 mg/5 ml*	ORAL	
oxybutynin chloride	*tablet*	*5 mg*	ORAL	
oxybutynin chloride er	*tablet; extended release 24 hr*	*5 mg*	ORAL	
oxybutynin chloride er	*tablet; extended release 24 hr*	*10 mg*	ORAL	
oxybutynin chloride er	*tablet; extended release 24 hr*	*15 mg*	ORAL	
solifenacin succinate	*tablet*	*5 mg*	ORAL	
solifenacin succinate	*tablet*	*10 mg*	ORAL	
tolterodine tartrate	*tablet*	*1 mg*	ORAL	
tolterodine tartrate	*tablet*	*2 mg*	ORAL	
tolterodine tartrate er	*capsule; ext release 24 hr*	*2 mg*	ORAL	
tolterodine tartrate er	*capsule; ext release 24 hr*	*4 mg*	ORAL	
trospium chloride	capsule; ext release 24 hr	60 mg	ORAL	
trospium chloride	*tablet*	*20 mg*	ORAL	
BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY				
alfuzosin hcl er	*tablet; extended release 24 hr*	*10 mg*	ORAL	
dutasteride	*capsule*	*0.5 mg*	ORAL	ST
dutasteride-tamsulosin	capsule; extended release multiphase 24hr	0.5-0.4 mg	ORAL	ST
finasteride	*tablet*	*5 mg*	ORAL	
silodosin	*capsule*	*4 mg*	ORAL	
silodosin	*capsule*	*8 mg*	ORAL	
tadalafil	tablet	2.5 mg	ORAL	QL; ST
tadalafil	tablet	5 mg	ORAL	QL; ST
tamsulosin hcl	*capsule*	*0.4 mg*	ORAL	
CHOLINERGIC STIMULANTS				
bethanechol chloride	*tablet*	*5 mg*	ORAL	
bethanechol chloride	*tablet*	*10 mg*	ORAL	
bethanechol chloride	*tablet*	*25 mg*	ORAL	
bethanechol chloride	*tablet*	*50 mg*	ORAL	

Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
MISC UROLOGICALS				
CYSTAGON	CAPSULE	50 MG	ORAL	LA; PA; SP
CYSTAGON	CAPSULE	150 MG	ORAL	LA; PA; SP
ELMIRON	CAPSULE	100 MG	ORAL	
K-PHOS ORIGINAL	TABLET; SOLUBLE	500 MG	ORAL	
me-naphos-mb-hyo 1	tablet	81.6-0.12 mg	ORAL	
oral citrate	solution; oral	640-490 mg	ORAL	
potassium citrate er	*tablet; extended release*	*5 meq*	ORAL	
potassium citrate er	*tablet; extended release*	*10 meq*	ORAL	
potassium citrate er	*tablet; extended release*	*15 meq*	ORAL	
RENACIDIN	SOLUTION; IRRIGATION	1.9806 G/30	IRRIGATION	
sildenafil citrate	tablet	25 mg	ORAL	QL
sildenafil citrate	tablet	50 mg	ORAL	QL
sildenafil citrate	tablet	100 mg	ORAL	QL
uretron d-s	tablet	81.6-10.8	ORAL	
urimar-t	tablet	120-10.8 mg	ORAL	
uro-458	tablet	81-0.12 mg	ORAL	
urogesic	tablet	81.6-0.12 mg	ORAL	
uro-mp	capsule	118-10-36	ORAL	
uro-sp	capsule	118-10-36	ORAL	
uryl	tablet	81.6-0.12 mg	ORAL	
URINARY ANESTHETICS				
phenazopyridine hcl	*tablet*	*100 mg*	ORAL	
phenazopyridine hcl	*tablet*	*200 mg*	ORAL	
VITAMINS, HEMATINICS & ELECTROLYTES				
OTHER ELECTROLYTES				
calcium acetate	*capsule*	*667 mg*	ORAL	QL
calcium acetate	*tablet*	*667 mg*	ORAL	QL
lugol's	solution; oral	5%	ORAL	
PHOSLYRA	SOLUTION; ORAL	667 MG/5 ML	ORAL	QL
strong iodine	solution; oral	5%	ORAL	
POTASSIUM				
effer-k	*tablet; effervescent*	*25 meq*	ORAL	
klor-con	packet (ea)	20 meq	ORAL	
klor-con	*tablet; extended release*	*8 meq*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
klor-con	*tablet; extended release*	*10 meq*	ORAL	
klor-con m	*tablet; ext release; particles/crystals*	*10 meq*	ORAL	
klor-con m	*tablet; ext release; particles/crystals*	*15 meq*	ORAL	
klor-con m	*tablet; ext release; particles/crystals*	*20 meq*	ORAL	
klor-con-ef	*tablet; effervescent*	*25 meq*	ORAL	
potassium chloride	*capsule; extended release*	*8 meq*	ORAL	
potassium chloride	*capsule; extended release*	*10 meq*	ORAL	
potassium chloride	liquid (ml)	20 meq/15 ml	ORAL	
potassium chloride	liquid (ml)	40 meq/15 ml	ORAL	
potassium chloride	packet (ea)	20 meq	ORAL	
potassium chloride	*tablet; ext release; particles/crystals*	*10 meq*	ORAL	
potassium chloride	*tablet; ext release; particles/crystals*	*15 meq*	ORAL	
potassium chloride	*tablet; ext release; particles/crystals*	*20 meq*	ORAL	
potassium chloride	*tablet; extended release*	*8 meq*	ORAL	
potassium chloride	*tablet; extended release*	*10 meq*	ORAL	
potassium chloride	*tablet; extended release*	*20 meq*	ORAL	
VITAMINS & HEMATINICS				
b complex formula #1	tablet	0.4 mg	ORAL	
b complex w/ vitamin c	*tablet*	*400 mcg*	ORAL	
balanced b-complex	*tablet*	*400 mcg*	ORAL	
bal-care dha	*combination package; tablet and dr cap*	*27-1-430 mg*	ORAL	
b-balanced	tablet	0.4 mg	ORAL	
b-complex	tablet	0.4 mg	ORAL	
b-complex & c	*tablet*	*400 mcg-500*	ORAL	
c-nate dha	*capsule*	*28-1-200 mg*	ORAL	
complete natal dha	*combination package (ea)*	*29-1-200 mg*	ORAL	
cyanocobalamin	spray; non-aerosol (ea)	500 mcg/spr	NASAL	QL; ST
cyanocobalamin	*vial (ml)*	*1000 mcg/ml*	INJ	
daily prenatal	*combination package (ea)*	*28-800-440*	ORAL	
dialyvite 800	*tablet*	*0.8 mg*	ORAL	
dodex	*vial (ml)*	*1000 mcg/ml*	INJ	
elite-ob	*tablet*	*50-1.25 mg*	ORAL	
ferocon	capsule	110-0.5 mg	ORAL	
fluoride	*tablet; chewable*	*0.25 (0.55)*	ORAL	ACA
fluoride	*tablet; chewable*	*0.5 (1.1) mg*	ORAL	ACA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
fluoride	*tablet; chewable*	*1 mg (2.2 mg)*	ORAL	ACA
folic acid	*tablet*	*0.4 mg*	ORAL	ACA
folic acid	*tablet*	*0.8 mg*	ORAL	ACA
folic acid	*tablet*	*1 mg*	ORAL	
folitab	tablet; extended release	105-500-0.8	ORAL	
folivane-ob	*capsule*	*85 mg-1 mg*	ORAL	
foltabs 800	tablet	115-0.8-10	ORAL	
full spectrum b	*tablet*	*0.8 mg*	ORAL	
hydroxocobalamin	*vial (ml)*	*1000 mcg/ml*	IM	
kobee	tablet	0.4 mg	ORAL	
ludent fluoride	*tablet; chewable*	*0.25 (0.55)*	ORAL	ACA
ludent fluoride	*tablet; chewable*	*0.5 (1.1) mg*	ORAL	ACA
ludent fluoride	*tablet; chewable*	*1 mg (2.2 mg)*	ORAL	ACA
m-natal plus	*tablet*	*27 mg-1 mg*	ORAL	
multivitamin with fluoride	*drops*	*0.25 mg/ml*	ORAL	ACA
multivitamin with fluoride	*drops*	*0.5 mg/ml*	ORAL	ACA
multivitamin with fluoride	*tablet; chewable*	*0.25 mg*	ORAL	ACA
multivitamin with fluoride	*tablet; chewable*	*0.5 mg*	ORAL	ACA
multivitamin with fluoride	*tablet; chewable*	*1 mg*	ORAL	ACA
mvc-fluoride	*tablet; chewable*	*0.25 mg*	ORAL	ACA
mvc-fluoride	*tablet; chewable*	*0.5 mg*	ORAL	ACA
mvc-fluoride	*tablet; chewable*	*1 mg*	ORAL	ACA
mynatal	*capsule*	*65 mg-1 mg*	ORAL	
mynatal	*tablet*	*90-50-1 mg*	ORAL	
mynatal plus	*tablet*	*65 mg-1 mg*	ORAL	
mynatal-z	*tablet*	*65 mg-1 mg*	ORAL	
newgen	*tablet*	*32 mg-1 mg*	ORAL	
pnv-dha	*capsule*	*27-1-300 mg*	ORAL	
pnv-dha + docusate	*capsule*	*27-1.25-55*	ORAL	
pnv-omega	*capsule*	*28-1-300 mg*	ORAL	
pnv-select	*tablet*	*27 mg-1 mg*	ORAL	
pr natal 400	*combination package (ea)*	*29-1-400 mg*	ORAL	
pr natal 400 ec	*combination package; tablet and dr cap*	*29-1-400 mg*	ORAL	
pr natal 430	*combination package (ea)*	*29-1-430 mg*	ORAL	
pr natal 430 ec	*combination package; tablet and dr cap*	*29-1-430 mg*	ORAL	
prena1 chew	*tablet chew; immed and delay rel; biphase*	*1.4 mg*	ORAL	

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
prena1 pearl	*capsule; immediate; delay release; biphase*	*30-1.4-200*	ORAL	
prena1 true	*combination package (ea)*	*30-1.4-300*	ORAL	
prenaissance	*capsule*	*29-1.25-55*	ORAL	
prenaissance plus	*capsule*	*28-1-50 mg*	ORAL	
prenatabs fa	*tablet*	*29 mg-1 mg*	ORAL	
prenatabs rx	*tablet*	*29 mg-1 mg*	ORAL	
prenatal	*tablet*	*27 mg-0.8 mg*	ORAL	
prenatal	*tablet*	*28 mg-0.8 mg*	ORAL	
prenatal complete	*tablet*	*14 mg-400*	ORAL	
prenatal formula	*tablet*	*28 mg-0.8 mg*	ORAL	
prenatal multi + dha	*capsule*	*27-0.8-250*	ORAL	
prenatal plus	*tablet*	*27 mg-1 mg*	ORAL	
prenatal plus	*tablet*	*29 mg-1 mg*	ORAL	
prenatal vitamin	*tablet*	*28 mg-0.8 mg*	ORAL	
prenatal-u	*capsule*	*106.5-1 mg*	ORAL	
prenavite	*tablet*	*28 mg-0.8 mg*	ORAL	
rena-vite	*tablet*	*0.8 mg*	ORAL	
se-natal 19	*tablet*	*29 mg-1 mg*	ORAL	
se-natal 19	*tablet; chewable*	*29 mg-1 mg*	ORAL	
sodium fluoride	*drops*	*0.5 mg/ml*	ORAL	ACA
sodium fluoride	*tablet; chewable*	*0.25 (0.55)*	ORAL	ACA
sodium fluoride	*tablet; chewable*	*0.5 (1.1) mg*	ORAL	ACA
sodium fluoride	*tablet; chewable*	*1 mg (2.2 mg)*	ORAL	ACA
stress formula vitamin + iron	tablet	500-400-18	ORAL	
stress formula vitamin + iron	tablet	500-400-27	ORAL	
super b complex	capsule	400-20-50	ORAL	
super b complex	*tablet*	*400 mcg*	ORAL	
super b complex-vitamin c	*tablet*	*400 mcg*	ORAL	
super b maxi complex	tablet	0.4 mg	ORAL	
super quints	tablet	0.4 mg	ORAL	
taron prenatal	*capsule*	*30-1.2-55*	ORAL	
taron-c dha	*capsule*	*35-1-200 mg*	ORAL	
trinatal rx 1	*tablet*	*60 mg-1 mg*	ORAL	
trinate	*tablet*	*28 mg-1 mg*	ORAL	
tri-vitamin with fluoride	*drops*	*0.25 mg/ml*	ORAL	ACA
tri-vitamin with fluoride	*drops*	*0.5 mg/ml*	ORAL	ACA

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Drug Name	Dosage Form	Strength	Route	Requirements/ Limits
tricon	capsule	110-0.5 mg	ORAL	
vitamin b complex with c	*tablet*	*400 mcg*	ORAL	
vitamin b-complex & c	*tablet*	*400 mcg-500*	ORAL	
vitamin d2	*capsule*	*1250 mcg*	ORAL	
vitamin d3	*capsule*	*25 mcg*	ORAL	
vitamin d3	*tablet*	*10 mcg*	ORAL	
vitamin d3	*tablet*	*25 mcg*	ORAL	
vitamin d3	*tablet; chewable*	*25 mcg*	ORAL	
vitamins a;c;d & fluoride	*drops*	*0.25 mg/ml*	ORAL	ACA
vitamins a;c;d & fluoride	*drops*	*0.5 mg/ml*	ORAL	ACA
wescap-c dha	*capsule*	*35-1-200 mg*	ORAL	
wescap-pn dha	*capsule*	*27-1-300 mg*	ORAL	
wesnatal dha complete	combination package (ea)	29-1-200 mg	ORAL	
wesnate dha	*capsule*	*28-1-200 mg*	ORAL	
westab plus	*tablet*	*27 mg-1 mg*	ORAL	
westgel dha	*capsule*	*31-1-200mg*	ORAL	
zatean-pn dha	*capsule*	*27-1-300 mg*	ORAL	
zatean-pn plus	*capsule*	*28-1-300 mg*	ORAL	
zingiber	*tablet*	*1.2-40-100*	ORAL	

EXCLUDED MEDICATIONS WITH COVERED ALTERNATIVES

The excluded medications shown below are not covered on the Express Scripts drug list. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price.

Take action to avoid paying full price. If you're currently using one of the excluded medications, please ask your doctor to consider writing you a new prescription for one of the following preferred alternatives. Additional covered alternatives may be available. Costs for covered alternatives may vary. Log on to express-scripts.com/covered to compare drug prices. Not all drugs listed are covered by all prescription plans; check your benefit materials for the specific drugs covered and the copayments for your plan. For specific questions about coverage, please call the number on your member ID card.

Drug Class	Excluded Medications	Preferred Alternatives
ANTIINFECTIVES		
Antibiotic Agents (Oral)	FIRVANQ, VANCOMYCIN 25 MG/ML SOLUTION	vancomycin capsules, vancomycin 50 mg/ml oral solution
	LIKMEZ	metronidazole tablets
	SIVEXTRO	linezolid
Antibiotic Agents for Urinary Tract Infections	NITROFURANTOIN 50 MG/5 ML SUSPENSION	nitrofurantoin 25 mg/5 ml suspension
Antifungal Agents (Oral)	TOLSURA	itraconazole
Antivirals (Oral)	SITAVIG, XERESE	acyclovir oral or cream, famciclovir, penciclovir cream, valacyclovir
Chagas Disease Agents	LAMPIT	BENZNIDAZOLE
AUTONOMIC & CENTRAL NERVOUS SYSTEM		
Alpha-2 Adrenergic Agonists (for Opioid Withdrawal)	LUCEMYRA	clonidine
Alzheimer's Agents	ADUHELM, LEQEMBI	No alternatives recommended
Amyotrophic Lateral Sclerosis (ALS) Agents	QALSODY, RELYVRIO	No alternatives recommended
Anticonvulsants	EPRONTIA	topiramate sprinkle capsules
	FINTEPLA	DIACOMIT, EPIDIOLEX
	MOTPOLY XR	lacosamide
	PRIMIDONE 125 MG TABLETS	primidone 50 mg or 250 mg tablets
	ZONISADE	zonisamide
Antimigraine Agents	ONZETRA XSAIL	sumatriptan nasal spray, zolmitriptan nasal spray
	VYEPTI	AIMOVIG, AJOVY, EMGALITY
	ZAVZPRET	NURTEC ODT, UBRELVY
Antiparkinsonism Agents	APOKYN	Coverage may be approved for the treatment of Parkinson's Disease under certain conditions.
	DHIVY	carbidopa/levodopa
	GOCOVRI ER, OSMOLEX ER	amantadine capsules, amantadine oral solution, amantadine tablets
	ONGENTYS	entacapone
	XADAGO, ZELAPAR	rasagiline, selegiline
Antipsychotics (Injectable)	INVEGA HAFYERA	risperidone er, RISPERDAL CONSTA, RYKINDO ER, UZEDY ER
Antipsychotics (Oral)	QUETIAPINE 150 MG TABLETS	quetiapine 50 mg or 100 mg
Antispasmotic Agents	BACLOFEN 15 MG TABLETS, BACLOFEN SOLUTION, LYVISPAH, OZOBAX, OZOBAX DS	baclofen suspension, baclofen 5 mg, 10 mg or 20 mg tablets
Anxiolytic Agents	LOREEV XR	lorazepam tablets
Cataplexy Treatment	SODIUM OXYBATE (by Amneal), XYREM	LUMRYZ ER, SODIUM OXYBATE (by Hikma), XYWAV

Drug Class	Excluded Medications	Preferred Alternatives
Central Nervous System Stimulants	DYANAVEL XR, XELSTRYM	dextroamphetamine er, dextroamphetamine/amphetamine er, lisdexamfetamine
	METHYLPHENIDATE ER 45 MG, 63 MG & 72 MG, QUILLICHEW ER, QUILLIVANT XR, RELEXXII ER	dexmethylphenidate er, methylphenidate cd, methylphenidate er, methylphenidate la, AZSTARYS
Duchenne Muscular Dystrophy (DMD) Agents	AGAMREE	prednisolone solution/syrup, prednisolone tablets, prednisone solution, prednisone tablets
	AMONDYS 45, EXONDYS 51, VILTEPSO, VYONDYS 53	No alternatives recommended
Friedreich's Ataxia Agents	SKYCLARYS	Coverage may be approved for the treatment of Friedrich's Ataxia under certain conditions.
Multiple Sclerosis Agents	BRIUMVI	KESIMPTA, OCREVUS
	EXTAVIA	AVONEX, BETASERON, PLEGRIDY, REBIF
	GILENYA, TASCENSO ODT	fingolimod, teriflunomide, BAFIERTAM, MAYZENT, PONVORY, VUMERITY
Narcotic Analgesics & Combinations	CONZIP, QDOLO, TRAMADOL 25 MG & 100 MG TABLETS, TRAMADOL ER CAPSULES, TRAMADOL SOLUTION	tramadol 50 mg tablets, tramadol er tablets
	NUCYNTA	hydrocodone/acetaminophen, morphine sulfate, oxycodone, tramadol, tramadol/acetaminophen
	NUCYNTA ER, OXYCODONE ER, XTAMPZA ER	hydrocodone bitartrate er, hydromorphone er, morphine sulfate er, oxymorphone hcl er, HYSINGLA ER, OXYCONTIN
	OXAYDO, ROXYBOND	oxycodone
	PRIMLEV, PROLATE SOLUTION	oxycodone/acetaminophen
	SEGLENTIS	tramadol tablets plus celecoxib
Narcotic Antagonists	ZIMHI	naloxone syringes
Rett Syndrome Agents	DAYBUE	No alternatives recommended
Sedative-Hypnotic Agents	DORAL, QUAZEPAM	estazolam, lorazepam
	ZOLPIDEM 7.5 MG CAPSULES	eszopiclone, zaleplon, zolpidem tablets
Selective Serotonin Reuptake Inhibitors (SSRIs) Antidepressants	CITALOPRAM CAPSULES, PEXEVA, SERTRALINE CAPSULES	citalopram tablets, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline tablets, vilazodone
Serotonin/Norepinephrine Reuptake Inhibitor Antidepressants	DRIZALMA SPRINKLE, VENLAFAXINE BESYLATE ER	desvenlafaxine er, duloxetine, venlafaxine hcl er, FETZIMA
Transmucosal Fentanyl Analgesics	FENTANYL CITRATE BUCCAL TABLETS, FENTORA	fentanyl citrate lozenges
Miscellaneous Antidepressants	APLENZIN, BUPROPION XL 450 MG, FORFIVO XL	bupropion xl 150 mg or 300 mg
	AUVELITY ER	bupropion, citalopram, duloxetine, paroxetine, sertraline, venlafaxine, FETZIMA
	SPRAVATO	olanzapine/fluoxetine, bupropion, desvenlafaxine er, duloxetine, escitalopram, mirtazapine, sertraline
CARDIOVASCULAR		
ACE Inhibitors	QBRELIS	lisinopril
Alpha-Adrenergic Agonists	CLONIDINE ER 0.17 MG, NEXICLON XR	clonidine patches, clonidine tablets
Angiotensin Receptor Blockers (ARBs) and Combinations	EDARBI	candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan
	EDARBYCLOR	candesartan/hydrochlorothiazide, irbesartan/hydrochlorothiazide, losartan/hydrochlorothiazide, olmesartan/hydrochlorothiazide, telmisartan/hydrochlorothiazide, valsartan/hydrochlorothiazide, chlorthalidone plus valsartan
	VALSARTAN SOLUTION	valsartan tablets
Anticoagulants	PRADAXA, SAVAYSA	dabigatran, ELIQUIS, XARELTO
Beta Blockers & Combinations	HEMANGEOL	propranolol solution
	INDERAL XL, INNOPRAN XL	propranolol er
	KAPSPARGO SPRINKLE	metoprolol succinate

Drug Class	Excluded Medications	Preferred Alternatives
Calcium Channel Blockers	CONJUPRI, LEVAMLODIPINE	amlodipine, felodipine er, nifedipine er, nisoldipine
	KATERZIA, NORLIQVA	amlodipine tablets
Diuretics	FUROSCIX, SOAANZ	bumetanide, furosemide, torsemide
	THALITONE	chlorthalidone
Fenofibrates	ANTARA, FENOFIBRATE CAPSULES (30 MG, 50 MG, 90 MG, 150 MG), LIPOFEN	fenofibrate capsules (43 mg, 67 mg, 130 mg, 134 mg, 200 mg), fenofibrate tablets, fenofibric acid
HMG & Cholesterol Inhibitor Combinations	ALTOPREV, ATORVALIQ, EZALLOR SPRINKLE	atorvastatin, fluvastatin er, lovastatin, pitavastatin, pravastatin, rosuvastatin, simvastatin tablets
	ROSUVASTATIN/EZETIMIBE	ezetimibe plus atorvastatin or rosuvastatin
PCSK9 & siRNA Inhibitors	LEQVIO, PRALUENT	REPATHA
Pulmonary Arterial Hypertension (PAH) Agents	LIQREV, TADLIQ	sildenafil oral suspension, sildenafil 20 mg tablets, tadalafil 20 mg tablets
Sodium Glucose Co-Transporter-1 and 2 Inhibitors	INPEFA	FARXIGA, JARDIANCE
Miscellaneous Cardiovascular Agents	ASPRUZYO SPRINKLE ER	ranolazine er
	CORLANOR	atenolol, bisoprolol, carvedilol, metoprolol succinate, metoprolol tartrate, propranolol
	LODOCO	colchicine
	NORPACE CR	amiodarone, quinidine sulfate, sotalol
DERMATOLOGICAL		
Agents for Hyperhydrosis	DRYSOL, QBREXZA	Over-the-Counter aluminum chloride containing products
Oral Agents for Acne	ABSORICA LD	isotretinoin capsules
	DORYX DR 80 MG, DORYX MPC, DOXYCYCLINE HYCLATE DR 80 MG	doxycycline hyclate, doxycycline monohydrate
	MINOCYCLINE BIPHASIC TABLETS, MINOCYCLINE ER CAPSULES, XIMINO	minocycline 24 hour er tablets
Rosacea Agents (Topical)	NORITATE	metronidazole
	ZILXI	azelaic acid, ivermectin, metronidazole, sodium sulfacetamide/sulfur, FINACEA FOAM
Topical Agents for Acne	CABTREO	adalapene, adalapene/benzoyl peroxide, benzoyl peroxide gel, clindamycin topical, clindamycin/benzoyl peroxide, tretinoin, tretinoin micro
	CLENIA PLUS, SULFACETAMIDE/SULFUR 8%-4% CLEANSER, SULFACETAMIDE/SULFUR 9%-4.25% SUSPENSION, ZMA CLEAR	sulfacetamide/sulfur 9%-4% cleanser, sulfacetamide/sulfur 8%-4% suspension
	FABIOR, TAZAROTENE FOAM	tazarotene cream, tretinoin
	WINLEVI	azelaic acid, clindamycin phosphate gel, clindamycin/tretinoin, dapsone, erythromycin gel, tretinoin
Topical Agents for Actinic Keratosis	CARAC, FLUOROURACIL 0.5% CREAM, KLISYRI, ZYCLARA	diclofenac 3% gel, fluorouracil 5% cream, fluorouracil 2% solution, imiquimod 5% cream
Topical Antifungals	ECOZA, ERTACZO, LULICONAZOLE, LUZU, OXISTAT LOTION, SULCONAZOLE, XOLEGEL	ciclopirox, clotrimazole, econazole, ketoconazole, naftifine, oxiconazole
	MICONAZOLE/ZINC OXIDE/PETROLATUM, VUSION	clotrimazole, ketoconazole, miconazole, nystatin
Topical Corticosteroids	IMPOYZ, LEXETTE, SERNIVO, ULTRAVATE, VERDESO FOAM	generic topical corticosteroids
Vitamin D Analogs (Topical)	CALCIPOTRIENE FOAM, SORILUX	calcipotriene, calcitriol
Miscellaneous Topical Dermatological Agents	ALCORTIN A	generic topical corticosteroids plus mupirocin
	CONDYLOX, VEREGEN	imiquimod 5% cream, podofilox solution
	LIDOCAINE/TETRACAINE, PLIAGLIS	lidocaine cream, lidocaine/prilocaine cream
	TAZORAC 0.05% CREAM	tazarotene 0.1% cream
	TRI-LUMA	fluocinolone acetonide, hydroquinone, tretinoin
DIABETES		
Biguanide Agents	METFORMIN 625 MG TABLETS	metformin 500 mg or 850 mg tablets

Drug Class	Excluded Medications	Preferred Alternatives
Blood Glucose Meters & Test Strips	ASCENSIA (CONTOUR), ONETOUCH SOLUTIONS STARTER KIT, ROCHE (ACCU-CHEK), TEMPO (WELCOME KIT, REFILL KIT, SMART BUTTON), TRIVIDIA (TRUETEST, TRUETRACK), ALL OTHER METERS & TEST STRIPS THAT ARE NOT LISTED AS PREFERRED	FREESTYLE KITS/METERS (FREESTYLE FREEDOM, FREESTYLE FREEDOM LITE, FREESTYLE INSULINX, FREESTYLE LITE) FREESTYLE TEST STRIPS (FREESTYLE, FREESTYLE INSULINX, FREESTYLE LITE, FREESTYLE PRECISION NEO) ONETOUCH KITS/METERS (ULTRA2, VERIO FLEX, VERIO REFLECT) ONETOUCH TEST STRIPS (ULTRA, VERIO) PRECISION XTRA METERS, TEST STRIPS
Diabetic Pen Needles & Syringes	PEN NEEDLES & SYRINGES BY: ARKRAY, HOME AIDE DIAGNOSTICS, HTL-STREFA, NOVO NORDISK, OWEN MUMFORD, PRODIGY DIABETES CARE, SIMPLE DIAGNOSTICS, TRIVIDIA (NIPRO DIAGNOSTICS), ULTIMED, ALL OTHER DIABETIC PEN NEEDLES & SYRINGES THAT ARE NOT LISTED AS PREFERRED	BD DIABETES PEN NEEDLES BD DIABETES SYRINGES
Diabetic Supply Kits	BIGFOOT UNITY PROGRAM KIT	DEXCOM G6 (RECEIVER, SENSOR, TRANSMITTER), DEXCOM G7 (RECEIVER, SENSOR), FREESTYLE LIBRE (READER, SENSOR)
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors & Combinations	ALOGLIPTIN, NESINA, SITAGLIPTIN, TRADJENTA, ZITUVIO	saxagliptin, JANUVIA
	ALOGLIPTIN/METFORMIN, JENTADUETO, JENTADUETO XR, KAZANO	saxagliptin/metformin, JANUMET, JANUMET XR
	ALOGLIPTAN/PIOGLITAZONE	pioglitazone plus saxagliptin or JANUVIA
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors/Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors Combinations	QTERN, STEGLUJAN	GLYXAMBI
Glucagon-Like Peptide-1 Agonists	VICTOZA	BYDUREON BCISE, BYETTA, OZEMPIC, TRULICITY
Glucose-Elevating Drugs	GLUCAGEN HYPOKIT, GLUCAGON EMERGENCY KIT (by Fresenius), ZEGALOGUE	glucagon emergency kit (by Amphastar), BAQSIMI, GVOKE
Insulin (Basal) and Glucagon-Like Peptide-1 (GLP-1) Agonist Combinations	XULTOPHY	SOLIQUA
Insulins	ADMELOG, AFREZZA, APIDRA, FIASP, INSULIN ASPART, NOVOLOG, RELION NOVOLOG	HUMALOG, HUMALOG TEMPO, INSULIN LISPRO, LYUMJEV, LYUMJEV TEMPO
	U-100: INSULIN DEGLUDEC, INSULIN GLARGINE, INSULIN GLARGINE-YFGN, LANTUS, LEVEMIR, REZVOGLAR U-200: INSULIN DEGLUDEC U-300: INSULIN GLARGINE	U-100: SEMGLEE (YFGN), TRESIBA U-200: TRESIBA U-300: TOUJEO
	INSULIN ASPART PROTAMINE, NOVOLOG MIX, RELION NOVOLOG MIX	HUMALOG MIX, INSULIN LISPRO PROTAMINE MIX
	NOVOLIN, NOVOLIN MIX, RELION NOVOLIN, RELION NOVOLIN MIX	HUMULIN, HUMULIN MIX
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors & Combinations	BRENZAVVY, DAPAGLIFLOZIN, INVOKANA	FARXIGA, JARDIANCE, STEGLATRO
	DAPAGLIFLOZIN/METFORMIN ER, INVOKAMET, INVOKAMET XR	SEGLUROMET, SYNJARDY, SYNJARDY XR, XIGDUO XR
Sulfonylurea Agents	GLIPIZIDE 2.5 MG TABLETS	glipizide 5 mg tablets
EAR/NOSE		
Nasal Steroids	BECONASE AQ, OMNARIS, QNASL, ZETONNA	flunisolide, fluticasone, mometasone, XHANCE
Otic Antibiotics & Combination Products	CETRAXAL	ciprofloxacin otic, ofloxacin otic
	CIPRO HC, CIPROFLOXACIN/FLUOCINOLONE OTIC	ciprofloxacin/dexamethasone otic
ENDOCRINE		
Cushing's Agents	ISTURISA	ketoconazole tablets, mifepristone 300 mg, SIGNIFOR
	RECORLEV	ketoconazole tablets
Gonadotropin-Releasing Hormone (GnRH) Analogs (for Central Precocious Puberty)	LUPRON DEPOT-PED, SUPPRELIN LA	FENSOLVI, TRIPTODUR
Growth Hormones	HUMATROPE, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN, SAIZEN, SAIZENPREP, ZOMACTON	GENOTROPIN, OMNITROPE
	SKYTROFA, SOGROYA	GENOTROPIN, OMNITROPE, NGENLA
Somatostatin Analogs	LANREOTIDE, SANDOSTATIN LAR DEPOT	SOMATULINE DEPOT
	SIGNIFOR LAR	For Acromegaly: SOMATULINE DEPOT For Cushing's Disease: SIGNIFOR

Drug Class	Excluded Medications	Preferred Alternatives
Testosterone Products	AVEED	testosterone cypionate, testosterone enanthate, XYOSTED
	KYZATREX, NATESTO, TLANDO	testosterone gel, testosterone solution, ANDRODERM PATCHES
Thyroid Replacement Therapy	ADTHYZA 16.25 MG, 32.5 MG, 65 MG, 97.5 MG, 130 MG	levothyroxine tablets, thyroid pork, ARMOUR THYROID
	LEVOTHYROXINE CAPSULES, THYQUIDITY, TIROSINT, TIROSINT-SOL	levothyroxine tablets
Miscellaneous Endocrine Agents	CORTROPHIN GEL	No alternatives recommended
GASTOINTESTINAL		
Antidiarrheal Agents	MYTESI	diphenoxylate/atropine, loperamide
Antiemetics (Oral)	AKYNZEO CAPSULES	granisetron, ondansetron, aprepitant, VARUBI TABLETS
	ANTIVERT, MECLIZINE 50 MG TABLETS	meclizine 25 mg tablets
	ANZEMET	granisetron, ondansetron
	BONJESTA	doxylamine/pyridoxine hcl
	EMEND POWDER PACKETS	aprepitant, VARUBI TABLETS
Bowel Evacuants	CLENPIQ, PLENVU, SUFLAVE, SUTAB	magnesium sulfate/potassium sulfate/sodium sulfate solution, peg 3350/ascorbic acid powder packets
Corticosteroids (Rectal Formulations)	CORTIFOAM	budesonide foam, hydrocortisone enema, UCERIS FOAM
Fecal Microbiota Agents	REBYOTA	Coverage may be approved for the prevention of recurrent Clostridioides difficile infection under certain conditions.
Gallstone Dissolution Agents	RELTONE	ursodiol
Gastroparesis Agents	GIMOTI	No alternatives recommended
Hemorrhoidal Preparations	HYDROCORTISONE/PRAMOXINE 25-18 MG SUPPOSITORIES	hydrocortisone ac suppositories, pramoxine/hydrocortisone cream
	PROCTOFOAM-HC	pramoxine/hydrocortisone cream
Inflammatory Bowel Agents	DIPENTUM	balsalazide disodium, mesalamine dr, mesalamine er, sulfasalazine, PENTASA 250 MG CAPSULES
Irritable Bowel Syndrome & Chronic Constipation Agents	IBSRELA, MOTEGRITY, ZELNORM	LINZESS, TRULANCE
Pancreatic Enzymes	PERTZYE	CREON, PANCREAZE, ZENPEP
Proton Pump Inhibitors	KONVOMEP, NEXIUM PACKETS, PRILOSEC SUSPENSION, RABEPRAZOLE DR SPRINKLE	dexlansoprazole, esomeprazole magnesium, lansoprazole, omeprazole, pantoprazole, rabeprazole
Miscellaneous Gastrointestinal Agents	DARTISLA ODT	glycopyrrolate tablets
HEMATOLOGICAL		
Antiplatelet Agents	ASPIRIN/OMEPRAZOLE DR, YOSPRALA DR	aspirin plus omeprazole, esomeprazole, lansoprazole, pantoprazole, rabeprazole
Erythropoiesis-Stimulating Agents	ARANESP, EPOGEN, MIRCERA	PROCRIT, RETACRIT
Factor Deficiency Agents & Related Products	IXINITY, RIXUBIS	BENEFIX
	NOVOSEVEN RT	SEVENFACT
	NUWIQ, RECOMBINATE	ADVATE, ADYNOVATE, AFSTYLA, ALTUVIIIO, ELOCTATE, ESPEROCT, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, XYNTHA, XYNTHA SOLOFUSE
	REBINYN	ALPROLIX, IDELVION
Granulocyte Colony Stimulating Factors	FYLNETRA, NEULASTA, NYVEPRIA, ROLVEDON, STIMUFEND, UDENYCA	FULPHILA, ZIEXTENZO
	GRANIX, NEUPOGEN, RELEUKO, ZARXIO	NIVESTYM
Hematopoietic & Thrombopoietic Agents	APHEXDA	plerixafor
Hypoxia-Inducible Factor Prolyl Hydroxylase Inhibitors	JESDUVROQ	PROCRIT, RETACRIT
Iron Replacement Agents	MONOFERRIC	sodium ferric gluconate complex, VENOFER
Sickle Cell Disease Agents	OXBRYTA	hydroxyurea, DROXIA
	SIKLOS	DROXIA
Thrombocytopenia Agents	ALVAIZ	NPLATE, PROMACTA
	MULPLETA	DOPTELET

Drug Class	Excluded Medications	Preferred Alternatives
HEPATITIS		
Hepatitis C	LEDIPASVIR/SOFOSBUVIR, MAVYRET, SOFOSBUVIR/VELPATASVIR, SOVALDI	EPCLUSA, HARVONI, VOSEVI, ZEPATIER
HIV		
Antiretrovirals Note: Current patients established on therapy are allowed to continue therapy.	COMPLERA	ODEFSEY
	DELSTRIGO	efavirenz/emtricitabine/tenofovir disoproxil fumarate, efavirenz/lamivudine/tenofovir disoproxil fumarate, BIKTARVY, GENVOYA, ODEFSEY, SYMFI, SYMFI LO, SYMTUZA, TRIUMEQ
	PIFELTRO	efavirenz, EDURANT
	PREZCOBIX	atazanavir, lopinavir/ritonavir, ritonavir, PREZISTA
	RUKOBIA ER	Coverage may be approved for the treatment of human immunodeficiency virus-1 infection in heavily treatment-experienced patients with multidrug-resistant infection.
	STRIBILD	BIKTARVY, GENVOYA
MUSCULOSKELETAL & RHEUMATOLOGY		
Gout Therapy	ALLOPURINOL 200 MG TABLETS	allopurinol 100 mg tablets
Muscle Relaxants & Antispasmodic Agents	METHOCARBAMOL 1,000 MG TABLETS	methocarbamol 500 mg tablets
Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	COXANTO, DICLOFENAC 35 MG CAPSULES, FENOPROFEN 200 MG CAPSULES, KETOROLAC NASAL SPRAY, OXAPROZIN 300 MG CAPSULES, RELAFEN DS, TIVORBEX, ZORVOLEX	generic oral nonsteroidal anti-inflammatory drugs
	ELYXYB	celecoxib
	MELOXICAM SUSPENSION	ibuprofen suspension, naproxen suspension
Topical Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	DICLOFENAC EPOLAMINE PATCHES	FLECTOR PATCHES, LICART PATCHES
OBSTETRICAL & GYNECOLOGICAL		
Combination Patches	CLIMARA PRO	COMBIPATCH
Contraceptives	LO LOESTRIN FE, NATAZIA, NEXTSTELLIS, TWIRLA, TYBLUME	generic oral, patch and ring contraceptives
	PHEXXI	Barrier methods of contraception, such as condoms, diaphragms, spermicides or sponges.
	SLYND	generic progestin-only oral contraceptives
Estrogen & Estrogen Modifiers for Vaginal Symptoms	ESTRING, IMVEXXY, INTRAROSA, OSPHENA	estradiol cream, estradiol vaginal inserts, PREMARIN CREAM
	FEMRING	estradiol cream, estradiol patches, estradiol tablets, estradiol vaginal inserts, PREMARIN CREAM
Estrogen/Progestin Combinations (Oral)	BIJUVA, PREMPHASE, PREMPRO	estradiol/norethindrone acetate, ethinyl estradiol/norethindrone acetate
Estrogens (Oral)	MENEST, PREMARIN TABLETS	estradiol tablets
Human Chorionic Gonadotropin Note: Product placement is subject to change throughout the year based upon changes in market dynamics.	CHORIONIC GONADOTROPIN 10,000 UNITS	NOVAREL, OVIDREL
Ovulatory Stimulants (Follitropins)	FOLLISTIM AQ	GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-JECT
Prenatal Vitamins	CITRANATAL, NATAL PNV, PREGENNA, TRINAZ	generic prenatal vitamins
Topical Estrogen Agents	ELESTRIN, EVAMIST	estradiol gel, estradiol patches
Vaginal Progesterones	CRINONE 4%	medroxyprogesterone, megestrol, norethindrone, progesterone
	ENDOMETRIN	CRINONE 8%
ONCOLOGY		
Acute Myeloid Leukemia (AML) Agents	ONUREG	Coverage may be approved for treatment of Acute Myeloid Leukemia under certain conditions.
	REZLIDHIA	TIBSOVO
	VANFLYTA	RYDAPT

Drug Class	Excluded Medications	Preferred Alternatives
B-Cell Lymphoma Agents	COLUMVI, EPKINLY	cyclophosphamide, cytarabine, dexamethasone, doxorubicin, prednisone, vincristine, KYMRIAH, RUXIENCE, YESCARTA
Bendamustine Agents	VIVIMUSTA	bendamustine, BENDEKA
Bevacizumab-Containing Agents	ALYMSYS, AVASTIN, VEGZELMA	ZIRABEV
BRAF Inhibitors	BRAFTOVI	TAFLINAR, ZELBORAF
Bruton Tyrosine Kinase Inhibitors	JAYPIRCA	For Mantle Cell Lymphoma: BRUKINSA, CALQUENCE For Chronic or Small Lymphocytic Leukemia: BRUKINSA, CALQUENCE, IMBRUVICA, VENCLEXTA
Cyclin-Dependent Kinase 4/6 Inhibitors	IBRANCE	KISQALI, VERZENIO
Docetaxel Agents	DOCIVYX	docetaxel
Interferons	BESREMI	hydroxyurea
Kinase Inhibitor of Vascular Endothelial Growth Factor Receptor	FRUZAQLA	LONSURF
Kinase Inhibitors	TRUQAP	anastrozole, exemestane, letrozole, tamoxifen, KISQALI, KISQALI FEMARA CO-PACK, VERZENIO
MEK Inhibitors	MEKTOVI	COTELLIC, MEKINIST
Multiple Myeloma Agents	XPOVIO	bortezomib, DARZALEX, KYPROLIS, POMALYST, REVLIMID, THALOMID
Myelodysplastic Syndrome Agents	INQOVI	decitabine
Myelofibrosis Agents	INREBIC, OJJAARA	JAKAFI
Non-Small Cell Lung Cancer Agents	AUGTYRO	ROZLYTREK
	KRAZATI	Coverage may be approved for the treatment of KRAS G12C-mutated non-small cell lung cancer.
	TEPMETKO	TABRECTA
PARP Inhibitors	RUBRACA, ZEJULA	LYNPARZA
Prostate Cancer Agents	AKEEGA	abiraterone plus LYNPARZA, TALZENNA plus XTANDI
	CAMCEVI, LEUPROLIDE DEPOT, TRELSTAR	ELIGARD, FIRMAGON, LUPRON DEPOT
	YONSA	abiraterone, XTANDI
Renal Cell Cancer Agents	FOTIVDA	CABOMETYX, INLYTA, LENVIMA
Rituximab-Containing Agents	RIABNI, RITUXAN, RITUXAN HYCELA, TRUXIMA	RUXIENCE
Trastuzumab-Containing Agents	HERCEPTIN, HERCEPTIN HYLECTA, HERZUMA, OGIVRI, ONTRUZANT	KANJINTI, TRAZIMERA
Tyrosine Kinase Inhibitors	QINLOCK	imatinib, pazopanib, sorafenib, sunitinib malate, SPRYCEL, STIVARGA, TASIGNA
OPHTHALMIC		
Antiglaucoma Agents (Beta-Adrenergic Blockers)	BETIMOL	timolol drops, betaxolol drops, carteolol drops, levobunolol drops
Antiglaucoma Agents (Ophthalmic Prostaglandins)	DURYSTA, IDOSE TR, IYUZEH, XELPROS	bimatoprost drops, latanoprost drops, tafluprost drops, travoprost drops
Antiglaucoma Agents (Other)	RHOPRESSA, ROCKLATAN	betaxolol drops, bimatoprost drops, dorzolamide/timolol drops, latanoprost drops, levobunolol drops, tafluprost drops, timolol drops, travoprost drops
Blepharoptosis Agents	UPNEEQ	No alternatives recommended
Ophthalmic Agents (Complement Protein C5 Inhibitors)	IZERVAY	Coverage may be approved for the treatment of Geographic Atrophy under certain conditions.
Ophthalmic Agents (Vascular Endothelial Growth Inhibitors)	EYLEA HD, VABYSMO	EYLEA
	LUCENTIS	BYOOVIZ, CIMERLI
	SUSVIMO	No alternatives recommended
Ophthalmic Agents (Other)	ATROPINE (PRESERVATIVE FREE) 1% EYE SINGLE USE DROPPERETTE	atropine 1% drops
	CYSTADROPS	CYSTARAN
	VERKAZIA	azelastine drops, bepotastine drops, cromolyn drops, epinastine drops, olopatadine drops
	VUITY	No alternatives recommended

Drug Class	Excluded Medications	Preferred Alternatives
Ophthalmic Anti-Allergic	ALOCRIL, ALOMIDE, ALREX, ZERVIATE	azelastine drops, bepotastine drops, cromolyn drops, epinastine drops, olopatadine drops
Ophthalmic Anti-Inflammatory	FLAREX, FML FORTE, MAXIDEX, PRED MILD	dexamethasone drops, difluprednate drops, fluoromethalone drops, loteprednol 0.5% drops, prednisolone drops
Ophthalmic Combinations	TOBRADEX ST, ZYLET	tobramycin/dexamethasone drops
Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	ACUVAIL, NEVANAC	bromfenac drops, diclofenac drops, ketorolac drops
Ophthalmic Quinolone Antibiotics	BESIVANCE, CILOXAN OINTMENT	ciprofloxacin drops, gatifloxacin drops, levofloxacin drops, moxifloxacin drops, ofloxacin drops
OSTEOARTHRITIS		
Hyaluronic Acid Derivatives	DUROLANE, GEL-ONE, GELSYN-3, GENVISC 850, HYALGAN, HYMOVIS, SUPARTZ FX, SYNOJOYNT, SYNVISC, SYNVISC-ONE, TRILURON, TRIVISC, VISCO-3	EUFLEXXA, MONOVISC, ORTHOVISC
RENAL		
Nephropathic Cystinosis Agents	PROCYSBI	CYSTAGON
Nephropathy Agents	FILSPARI	benazepril, candesartan, irbesartan, lisinopril, losartan, ramipril, valsartan
Nocturnal Polyuria Agents	NOCTIVA	desmopressin tablets
Overactive Bladder Agents	OXYBUTYNIN 2.5 MG, VESICARE LS	oxybutynin er, oxybutynin solution, oxybutynin 5 mg tablets, MYRBETRIQ ER
Phosphate Binders	FOSRENOL POWDER PACKETS, XPHOZAH	calcium acetate, lanthanum, sevelamer carbonate, sevelamer hcl, VELPHORO
Miscellaneous Urologicals	URIMAR-T CAPSULES, URNEVA	uro mp, uro sp
RESPIRATORY		
Epinephrine Auto-Injector Systems	AUVI-Q, EPINEPHRINE AUTO-INJECTOR (by A-S Medication, Amneal Pharma, Avkare), EPIPEN, EPIPEN JR	epinephrine auto-injector (by Mylan, Teva)
Idiopathic Pulmonary Fibrosis Agents	PIRFENIDONE 534 MG TABLETS	pirfenidone, OFEV
Immunological Agents for Asthma	CINQAIR	DUPIXENT, FASENRA, NUCALA, TEZSPIRE, XOLAIR
Long-Acting Beta Agonist Inhalers	SEREVENT DISKUS	STRIVERDI RESPIMAT
Long-Acting Muscarinic Antagonist Inhalers	INCRUSE ELLIPTA, TUDORZA PRESSAIR	tiotropium inhaler, SPIRIVA HANDIHALER, SPIRIVA RESPIMAT
Long-Acting Muscarinic Antagonist/Long-Acting Beta-Agonist Combination Inhalers	BEVESPI AEROSPHERE, DUAKLIR PRESSAIR	ANORO ELLIPTA, STIOLTO RESPIMAT
Pulmonary Anti-Inflammatory Inhalers	ALVESCO, ARMONAIR DIGIHALER, FLOVENT DISKUS, FLOVENT HFA, FLUTICASONE PROPIONATE DISKUS, FLUTICASONE PROPIONATE HFA, PULMICORT FLEXHALER	ARNUITY ELLIPTA, ASMANEX HFA, ASMANEX TWISTHALER, QVAR REDIHALER
Pulmonary Anti-Inflammatory/Beta-Agonist Combination Inhalers	AIRDUO RESPICLICK, FLUTICASONE/SALMETEROL DPI (by A-S Medication, Teva), FLUTICASONE/SALMETROL HFA, FLUTICASONE/VILANTEROL	budesonide/formoterol, fluticasone/salmeterol dpi (by Hikma, Prasco, Proficient Rx), ADVAIR HFA, BREO ELLIPTA, DULERA
Short-Acting Beta2-Agonist Inhalers	ALBUTEROL SULFATE HFA (BY A-S Medication, Prasco), LEVALBUTEROL HFA, PROAIR DIGIHALER, PROAIR RESPICLICK, VENTOLIN HFA, XOPENEX HFA	albuterol sulfate hfa (by AHP, Cipla, Civica, Exelan, Lupin, Perrigo, Sandoz, Teva & West-Ward)
MISCELLANEOUS AGENTS		
Allergen Immunotherapy	PALFORZIA	Coverage may be approved for treatment of Peanut Allergy under certain conditions.
Benign Prostatic Hyperplasia Agents	ENTADFI	finasteride 5 mg plus tadalafil 5 mg
Botulinum Toxin Products	BOTOX	DYSPORT, MYOBLOC Migraine: AIMOVIG, AJOVY, EMGALITY, QULIPTA Hyperhidrosis: Over-the-Counter aluminum chloride containing products
	DAXXIFY, XEOMIN	DYSPORT, MYOBLOC
Enzyme Replacement Therapy – Fabry Disease	FABRAZYME	ELFABRIO
Eosinophilic Esophagitis Agents	EOHILIA	budesonide suspension made into a slurry or suspension and swallowed (not inhaled)
Gaucher Disease Agents	ELELYSO, VPRIV	CEREZYME
Glucocorticoids	ALKINDI SPRINKLE	hydrocortisone tablets
	HEMADY	dexamethasone tablets

Drug Class	Excluded Medications	Preferred Alternatives
Hereditary Angioedema	BERINERT	CINRYZE, RUCONEST
Immune Globulins	CUTAQUIG	SC: GAMMAGARD LIQUID, GAMUNEX-C, XEMBIFY
	GAMMAKED	IV: GAMMAGARD LIQUID, GAMMAGARD S-D, GAMUNEX-C SC: GAMMAGARD LIQUID, GAMUNEX-C, XEMBIFY
Immunosuppressant Agents	ENVARSUS XR	tacrolimus
	JYLAMVO, XATMEP	methotrexate tablets
	OTREXUP	RASUVO
Inflammatory Conditions Agents	SOVUNA	hydroxychloroquine tablets
Infused TNF Antagonists	AVSOLA, INFLIXIMAB, REMICADE, RENFLEXIS	INFLECTRA
Metabolic Agents	RAVICTI	sodium phenylbutyrate, PHEBURANE
	RIVFLOZA	Coverage may be approved for the treatment of Primary Hyperoxaluria Type 1 under certain conditions.
Myasthenia Gravis Agents	RYSTIGGO	Coverage may be approved for the treatment of generalized myasthenia gravis.
	ZILBRYSQ	SOLIRIS
Neuromyelitis Optica Spectrum Disorder Agents	UPLIZNA	ENSPRYNG
Osteoporosis (Bone Modifiers)	EVENITY, PROLIA	alendronate, ibandronate, risedronate, zoledronic acid, FORTEO, TYMLOS
Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis	AMVUTTRA, ONPATTRO, WAINUA	Coverage may be approved for treatment of Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR) under certain conditions.
Potassium Replacement Agents	POKONZA	potassium chloride
Vasculitis Agents	TAVNEOS	azathioprine, methotrexate, mycophenolate, RUXIENCE
Wilson's Disease Agents	CUVRIOR, TRIENTENE 500 MG CAPSULES	trientene 250 mg capsules

Effective Date: 8/1/2024

Drug Prior Authorization List

Why do some drugs require prior authorization?
Prior authorization is a tool to ensure the appropriate use of certain drugs and allows us to determine if a drug meets the medical necessity requirements of your policy.

What if my drug isn't listed?
The drug prior authorization list only includes drugs that are covered under the formulary. Drugs that are not covered (i.e., non-formulary drugs) are not listed, but they would also require a prior authorization as an exception to the formulary. Please call the number on the back of your insurance card if you are unsure if your drug is covered and/or requires a prior authorization.

Who makes the prior authorization decisions?
Physicians, nurses, and pharmacists at your health plan or at one of our partners, Express Scripts (ESI), Care Continuum (CCUM), or eviCore. The prior authorization list to follow specifies who will perform the review and make the authorization decision.

Why am I sometimes asked to use a different drug than my doctor prescribed?
If you go to the pharmacy to have your prescription filled before getting prior authorization when required, your pharmacist may tell you about other medications that may be equally effective but don't require prior authorization. If this occurs, contact your doctor to ask about changing the prescription to the other drug. If your doctor approves, the pharmacy can immediately fill the prescription.

What information is used by the physician or pharmacist in the decision-making process?
Medical records describing the patient's condition and prior treatments, FDA approved labeling for the requested treatment, published and peer-reviewed scientific literature, and/or evidence-based guidelines.

Where can I obtain a copy of the prior authorization or step therapy criteria?

- For drugs reviewed by Express Scripts or Care Continuum, please call 1-800-475-1954 to speak with a prior authorization specialist for more detailed information.
- For drugs reviewed by eviCore, please go to https://www.evicore.com/provider/clinical-guidelines. Click on Medical Oncology or Radiation Oncology, and search for "WPS Health Plan" or "WPS Health Insurance".
- Please confirm Gene Therapy coverage with WPS Customer Service using the number on the member's insurance card.

For *WPS Powered by Auxiant Groups using the AETNA Network:*

- Drugs under the Pharmacy Benefit (P) will require prior authorization through Express Scripts, eviCore, or WPS, as indicated.
- Drugs under the Medical Benefit (M) do not require a prior authorization, but a medical necessity review is highly recommended prior to drugs being administered. Please fax medical notes to American Health Holdings (AHH) at 608-273-4554.

For WPS Powered by Auxiant Groups with alternate Pharmacy and/or Medical Benefit vendors:

- For groups that do not use Express Scripts (ESI) through WPS for their Pharmacy Benefits (P), refer to the other Pharmacy Benefit Manager.
- For groups that do not use Care Continuum or eviCore for prior authorization reviews under their Medical Benefits (M) , please use iExchange (https://www.wpshealth.com/resources/provider-resources/iexchange/overview.shtml) or download and fax the Prior Authorization and Referral Request Form (https://www.wpshealth.com/resources/files/30652-wps-prior-auth-referral.pdf) to 1-608-226-4777.

Effective Date: 8/1/2024 ** If using a PBM other than Express Scripts (ESI) through WPS, refer to the other PBM

Description	Alt Descriptions	Benefit Type P = Pharmacy** M = Medical	HCPCS Code	Reviewer ESI, CCUM, eviCore ☎: 1-800-475-1954 WPS ☎: 1-800-333-5003	Drug Comments MH/SUD = mental health/ substance use disorder
5-fluorouracil - topical	5FU CREAM, EFUDEX, CARAC, FLUOROPLEX	P	J3490	eviCore (option 3)	Oncology
5-fluorouracil- injection	5FU, ADRUCIL	M	J9190	eviCore (option 3)	Oncology
abacavir/dolutegravir/lamivudi	TRIUMEQ PD	P	J8499	ESI (option 1)	
abaloparatide	TYMLOS	P	J3490	ESI (option 1)	
abatacept	ORENCIA CLICKJECT	P	J0129	ESI (option 1)	
abatacept/maltose	ORENCIA	P	J0129	ESI (option 1)	
abemaciclib - oral	VERZENIO	P	J8999	eviCore (option 3)	Oncology
abiraterone acetate	ABIRATERONE ACETATE	P	J8999	eviCore (option 3)	Oncology
abiraterone acetate - oral	YONSA (NOT INTERCHANGEABLE WITH ZYTIGA)	P	J8999	eviCore (option 3)	Oncology
abiraterone acetate - oral	ZYTIGA (NOT INTERCHANGEABLE WITH YONSA)	P	J8999	eviCore (option 3)	Oncology
abobotulinumtoxin a	DYSPORT	M	J0586	CCUM (option 2)	
abrocitinib	CIBINQO	P	J8499	ESI (option 1)	
acalabrutinib - oral	CALQUENCE	P	J8999	eviCore (option 3)	Oncology
adagrasib - oral	KRAZATI	P	J8999	eviCore (option 3)	Oncology
adalimumab	HUMIRA, HUMIRA PEDIATRIC	P	J0135	ESI (option 1)	
adalimumab-aacf (biosimilar)	IDACIO	P	Q5131	ESI (option 1)	
adalimumab-aaty (biosimilar)	YUFLYMA	P	J3490 J3590 C9399	ESI (option 1)	
adalimumab-adaz (biosimilar)	ADALIMUMAB-ADAZ, HYRIMOZ	P	J3490 J3590 C9399	ESI (option 1)	
adalimumab-adbm (biosimilar)	CYLTEZO	P	J3490 J3590 C9399	ESI (option 1)	
adalimumab-afzb (biosimilar)	ABRILADA	P	Q5132	ESI (option 1)	
adalimumab-aqvh (biosimilar)	YUSIMRY	P	J3490 J3590 C9399	ESI (option 1)	
adalimumab-bwwd (biosimilar)	HADLIMA	P	J3490 J3590 C9399	ESI (option 1)	

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ADAMTS13 recombinant-krhn	ADZYNMA	M	J7171 C9167	CCUM (option 2)	
adapalene	ADAPALENE	P	J3490	ESI (option 1)	
adapalene/benzoyl peroxide	EPIDUO	P	J3490	ESI (option 1)	
ado-trastuzumab emtansine	KADCYLA	M	J9354	eviCore (option 3)	Oncology
aducanumab-avwa	ADUHELM	M	J0172	CCUM (option 2)	MH/SUD
afamelanotide acetate	SCENESSE	M	J7352	CCUM (option 2)	
afatinib - oral	GILOTRIF	P	J8999	eviCore (option 3)	Oncology
aflibercept (HD)	EYLEA (HD)	M	J0177 J0178 C9161	CCUM (option 2)	
agalsidase beta	FABRAZYME	M	J0180	CCUM (option 2)	
albiglutide	TANZEUM	P	J3490	ESI (option 1)	
albuterol inhaler	PROVENTIL HFA	P	J3490	ESI (option 1)	
aldesleukin	PROLEUKIN, INTERLEUKIN-2	M	J9015	eviCore (option 3)	Oncology
alectinib - oral	ALECENSA	P	J8999	eviCore (option 3)	Oncology
alemtuzumab	LEMTRADA	M	J0202	CCUM (option 2)	
alendronate	BINOSTO	P	J8499	ESI (option 1)	
alendronate/vitamin d	FOSAMAX plus D	P	J8499	ESI (option 1)	
alglucosidase alfa	LUMIZYME	M	J0221	CCUM (option 2)	
alglucosidase alfa	MYOZYME	P	J0220	ESI (option 1)	
alirocumab	PRALUENT	P	J3590	ESI (option 1)	
alitretinoin	PANRETIN	P	J3490	ESI (option 1)	
all-trans retinoic acid - oral	VESANOID, ATRA, TRETINOIN	P	J8999	eviCore (option 3)	Oncology
alogliptin	ALOGLIPTIN	P	J8499	ESI (option 1)	
alogliptin	NESINA	P	J8499	ESI (option 1)	
alogliptin/metformin	ALOGLIPTIN/ METFORMIN	P	J8499	ESI (option 1)	
alogliptin/metformin	KAZANO	P	J8499	ESI (option 1)	
alogliptin/pioglitazone	ALOGLIPTIN/ PIOGLITASONE	P	J8499	ESI (option 1)	
alogliptin/pioglitazone	OSENI	P	J8499	ESI (option 1)	

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alpelisib	PIQRAY	P	J8999	eviCore (option 3)	Oncology
alpelisib	VIJOICE	P	J8499	ESI (option 1)	
alpha1-proteinase inhibitor	ARALAST NP, PROLASTIN-C, ZEMAIRA	M	J0256	CCUM (option 2)	
alpha1-proteinase inhibitor	GLASSIA	M	J0257	CCUM (option 2)	
altretamine	HEXALEN	P	J8999	ESI (option 1)	Oncology
amantadine hcl	GOCOVRI	P	J8499 G9033	ESI (option 1)	
ambrisentan	AMBRISENTAN	P	J8499	ESI (option 1)	
ambrisentan	LETAIRIS	P	J8499	ESI (option 1)	
amifampridine	RUZURGI	P	J8499	ESI (option 1)	
amifampridine phosphate	FIRDAPSE	P	J8499	ESI (option 1)	
amifostine	ETHYOL	M	J0207	eviCore (option 3)	Oncology
amikacin liposomal/neb.accessr	ARIKAYCE	P	J3490	ESI (option 1)	
amivantamab-vmjw	RYBREVANT	M	J9061	eviCore (option 3)	Oncology
amphetamine/ dextroamphetamine	MYDAYIS	P	J8499	ESI (option 1)	MH/SUD
anakinra	KINERET	P	J3590	ESI (option 1)	
anifrolumab-fnia	SAPHNELO	M	J0491	CCUM (option 2)	
antihem.fviii, sin-chn, b-dm tru	AFSTYLA	M	J7210	CCUM (option 2)	
antihemo.fviii, full length peg	ADYNOVATE	M	J7207	CCUM (option 2)	
antihemoph.fviii rec, fc fusion	ELOCTATE	M	J7205	CCUM (option 2)	
antihemoph.fviii, b-domain del	XYNTHA SOLOFUSE	P	J7185 J7192	ESI (option 1)	
antihemoph.fviii, hek b-delete	NUWIQ	M	J7209	CCUM (option 2)	
antihemophil.fviii, full length	ADVATE H	P	J7185 J7192	ESI (option 1)	
antihemophil.fviii, full length	ADVATE L	P	J7185 J7192	ESI (option 1)	
antihemophil.fviii, full length	ADVATE M	P	J7185 J7192	ESI (option 1)	
antihemophil.fviii, full length	ADVATE SH	P	J7185 J7192	ESI (option 1)	
antihemophil.fviii, full length	ADVATE UH	P	J7185 J7192	ESI (option 1)	
antihemophil.fviii, full length	ADVATE	M	J7192	CCUM (option 2)	

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antihemophilic factor (human)	HEMOFIL M	M	J7190	CCUM (option 2)	
antihemophilic factor (human)	KOATE	M	J7190	CCUM (option 2)	
antihemophilic factor (recombinant)	HELIXATE FS	M	J7192	CCUM (option 2)	
antihemophilic factor (recombinant)	KOGENATE FS	M	J7192	CCUM (option 2)	
antihemophilic factor (recombinant)	KOVALTRY	M	J7211	CCUM (option 2)	
antihemophilic factor (recombinant)	NOVOEIGHT	M	J7182	CCUM (option 2)	
antihemophilic factor (recombinant)	RECOMBINATE	M	J7192	CCUM (option 2)	
antihemophilic factor (recombinant)	XYNTHA	M	J7185	CCUM (option 2)	
antihemophilic factor, human	HEMOFIL-M	P	J7190	ESI (option 1)	
antihemophilic factor, human	KOATE-DVI	P	J7190 J7191	ESI (option 1)	
antihemophilic factor/ahf/factorviii	MONOCLATE-P	P	J7191	ESI (option 1)	
antihemophilic factor/vwf	ALPHANATE	M	J7186	CCUM (option 2)	
antihemophilic factor/vwf	HUMATE-P	M	J7187	CCUM (option 2)	
antihemophilic factor/vwf	WILATE	M	J7183	CCUM (option 2)	
antihemophilic fviii,rec porc	OBIZUR	P	J7188	ESI (option 1)	
anti-inhibitor coagulant comp.	FEIBA NF, FEIBA VH IMMUNO	P	J7198	ESI (option 1)	
anti-inhibitor coagulant comp.	FEIBA	M	J7198	CCUM (option 2)	
anti-thymocyte globulin,rabbit	THYMOGLOBULIN	P	J7511	ESI (option 1)	
apalutamide - oral	ERLEADA	P	J8999	eviCore (option 3)	Oncology
apixaban	ELIQUIS	P	J8499	ESI (option 1)	
apomorphine hcl	APOMORPHINE HCL	P	J0364	ESI (option 1)	
apomorphine hcl	KYNMOBI, APOKYN	P	J0364	ESI (option 1)	
apremilast	OTEZLA	P	J3590	ESI (option 1)	

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aprepitant - IV	APONVIE	M	C9145	CCUM (option 2)	
aprepitant - IV	CINVANTI	M	C9463 J0185	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
aprepitant - oral	APREPITANT	P	J8501	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
aprepitant - oral	EMEND	P	J8501	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
armodafinil	NUVIGIL	P	J8499	ESI (option 1)	MH/SUD
arsenic trioxide	TRISENOX	M	J9017	eviCore (option 3)	Oncology
asciminib - oral	SCEMBLIX	P	J8999	eviCore (option 3)	Oncology
asfotase alfa	STRENSIQ	P	J3490 J3590	ESI (option 1)	
asparaginase erwinia chrysanthemi (recombinant)-rywn	RYLAZE	M	J9021	eviCore (option 3)	Oncology
atezolizumab	TECENTRIQ	M	J9022	eviCore (option 3)	Oncology
atogepant	QULIPTA	P	J8499	ESI (option 1)	
atorvastatin/ezetimibe	LIPTRUZET	P	J8499	ESI (option 1)	
auranofin (gold)	RIDAURA	P	J8499	ESI (option 1)	
avacincaptad pegol	IZERVAY	M	J2782 C9162	CCUM (option 2)	
avacopan	TAVNEOS	P	J8499	ESI (option 1)	
avalglucosidase alfa-ngpt	NEXVIAZYME	M	J0219	CCUM (option 2)	
avapritinib - oral	AYVAKIT	P	J8999	eviCore (option 3)	Oncology
avatrombopag maleate	DOPTELET	P	J8499	ESI (option 1)	
avelumab	BAVENCIO	M	J9023	eviCore (option 3)	Oncology
axicabtagene ciloleucel	YESCARTA	M	Q2041	eviCore (option 3)	Oncology - CAR-T therapy
axitinib - oral	INLYTA	P	J8999	eviCore (option 3)	Oncology
azacitidine	VIDAZA	M	J9025	eviCore (option 3)	Oncology
azacitidine - oral	ONUREG	P	J8999	eviCore (option 3)	Oncology
azelaic acid	AZELEX	P	J3490	ESI (option 1)	
azelaic acid	FINACEA	P	J3490	ESI (option 1)	

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azelastine	ASTEPRO	P	J3490	ESI (option 1)	
azelastine/fluticasone	DYMISTA	P	J3490	ESI (option 1)	
azilsartan	EDARBI	P	J8499	ESI (option 1)	
azilsartan/chlorthalidone	EDARBYCLOR	P	J8499	ESI (option 1)	
aztreonam lysine (inhalation)	CAYSTON	P	J3490	ESI (option 1)	
baricitinib	OLUMIANT	P	J8499	ESI (option 1)	
bcg	THERACYS, TICE	M	J9030	eviCore (option 3)	Oncology
beclomethasone nasal	BECONASE AQ	P	J3490	ESI (option 1)	
beclomethasone nasal	QNASL HFA	P	J3490	ESI (option 1)	
belantamab mafodotin-blmf	BLENREP	M	J9037	eviCore (option 3)	Oncology
belatacept	NULOJIX	M	J0485	CCUM (option 2)	
belimumab	BENLYSTA	P	J0490	ESI (option 1)	
belimumab	BENLYSTA IV	M	J0490	CCUM (option 2)	
belinostat	BELEODAQ	M	J9032	eviCore (option 3)	Oncology
belumosudil mesylate	REZUROCK	P	J8499	ESI (option 1)	
belzutifan - oral	WELIREG	P	J8999	eviCore (option 3)	Oncology
bendamustine hcl	BELRAPZO, BENDEKA, TREANDA, VIVIMUSTA	M	J9033 J9034 J9036 J9056	eviCore (option 3)	Oncology
bendamustine hcl (Apotex)	BENDAMUSTINE	M	J9058	eviCore (option 3)	Oncology
bendamustine hcl (Baxter)	BENDAMUSTINE	M	J9059	eviCore (option 3)	Oncology
bendamustine hcl (Vivimusta)	BENDAMUSTINE	M	J9056	eviCore (option 3)	Oncology
benralizumab	FASENRA	M	J0517	CCUM (option 2)	
benralizumab	FASENRA PEN	P	J0517 C9466	ESI (option 1)	
beremagene geperpavec-svdt	VYJUVEK	M	J3401	CCUM (option 2)	Gene Therapy
berotralstat hydrochloride	ORLADEYO	P	J8499	ESI (option 1)	
betaine	BETAINE ANHYDROUS	P	J8499	ESI (option 1)	
betaine	CYSTADANE	P	J8499	ESI (option 1)	
betibeglogene autotemcel	ZYNTEGLO	M	J3393	CCUM (option 2)	Gene Therapy

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betrixaban	BEVYXXA	P	J8499	ESI (option 1)	
bevacizumab	AVASTIN	M	C9257 J9035	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
bevacizumab-adcd	VEGZELMA	M	Q5129	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
bevacizumab-awwb	MVASI	M	Q5107	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
bevacizumab-bvzr	ZIRABEV	M	Q5118	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
bevacizumab-maly	ALYMSYS	M	Q5126	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
bevacizumab-tnjn	AVZIVI	M	C9399 J3490 J3590 J9999	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
bexarotene	BEXAROTENE	P	J8999	eviCore (option 3)	Oncology
bexarotene - oral	TARGRETIN	P	J8999	eviCore (option 3)	Oncology
bexarotene - topical	TARGRETIN GEL	P	J3490	eviCore (option 3)	
bicalutamide - oral	CASODEX	P	J8999	ESI (option 1)	
bimatoprost	DURYSTA	M	J7351	CCUM (option 2)	
bimatoprost	LUMIGAN	P	J3490	ESI (option 1)	
binimetinib - oral	MEKTOVI	P	J8999	eviCore (option 3)	Oncology
bleomycin	BLENOXANE	M	J9040	eviCore (option 3)	Oncology
blinatumomab	BLINCYTO	M	J9039	eviCore (option 3)	Oncology
blood glucose test strip	ACCU-CHECK, ADVOCATE, BREEZE, CONTOUR, EMBRACE, PRECISION, TRUETEST, TRUETRACK, UNISTRIP, VICTORY	P	J3490	ESI (option 1)	
bortezomib	VELCADE	M	J9041 J9044	eviCore (option 3)	Oncology
bortezomib (dr. reddy's)	BORTEZOMIB (DR. REDDY'S)	M	J9046	eviCore (option 3)	Oncology
bortezomib (fresenius kabi)	BORTEZOMIB (FRESENIUS KABI)	M	J9048	eviCore (option 3)	Oncology
bortezomib (hospira)	BORTEZOMIB (HOSPIRA)	M	J9049	eviCore (option 3)	Oncology

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bortezomib (maia)	BORTEZOMIB (MAIA)	M	J9051	eviCore (option 3)	Oncology
bosentan	BOSENTAN	P	J8499	ESI (option 1)	
bosentan	TRACLEER	P	J8499	ESI (option 1)	
bosutinib - oral	BOSULIF	P	J8999	eviCore (option 3)	Oncology
brentuximab vedotin	ADCETRIS	M	J9042	eviCore (option 3)	Oncology
brexanolone	ZULRESSO	M	J1632	CCUM (option 2)	
brexucabtagene autoleucel	TECARTUS	M	C9073 Q2053	eviCore (option 3)	Oncology - CAR-T therapy
brigatinib - oral	ALUNBRIG	P	J8999	eviCore (option 3)	Oncology
brivaracetam	BRIVIACT	P	J8499	ESI (option 1)	
brodalumab	SILIQ	P	J3590	ESI (option 1)	
brolucizumab-dbll	BEOVU	M	J0179	CCUM (option 2)	
budesonide	TARPEYO	P	J8499	ESI (option 1)	
bupropion	APLENZIN, FORFIVO XL	P	J8499	ESI (option 1)	MH/SUD
burosumab-twza	CRYSVITA	M	J0584	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
busulfan - oral	MYLERAN, BUSULFEX	P	J8510	eviCore (option 3)	Oncology
c1 esterase inhibitor	CINRYZE	M	J0598	CCUM (option 2)	
c1 esterase inhibitor	BERINERT	M	J0597	CCUM (option 2)	
c1 esterase inhibitor	HAEGARDA	M	J0599	CCUM (option 2)	
c1 esterase inhibitor, recomb	RUCONEST	M	J0596	CCUM (option 2)	
cabazitaxel	JEVTANA	M	J9043	eviCore (option 3)	Oncology
cabazitaxel	CABAZITAXEL	M	J9064	eviCore (option 3)	Oncology
cabotegravir	APRETUDE	M	J0739	CCUM (option 2)	
cabotegravir/rilpivirine extended-release injection	CABENUVA	M	J0741	CCUM (option 2)	
cabozantinib - oral	CABOMETYX, COMETRIQ	P	J8999	eviCore (option 3)	Oncology
calaspargase pegol-mknl	ASPARLAS	P	J9118	eviCore (option 3)	Oncology
canagliflozin	INVOKANA	P	J8499	ESI (option 1)	

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canagliflozin/metformin	INVOKAMET (XR)	P	J8499	ESI (option 1)	
canakinumab	ILARIS	M	J0638	CCUM (option 2)	
cannabidiol (cbd)	EPIDIOLEX	P	J8499	ESI (option 1)	
cantharidin	YCANTH	M	C9399	CCUM (option 2)	
capecitabine - oral	XELODA	P	J8520 J8521	eviCore (option 3)	Oncology
capivasertib	TRUQAP	P	J8999	eviCore (option 3)	
caplacizumab-yhdp	CABLIVI	M	C9047	CCUM (option 2)	
capmatinib - oral	TABRECTA	P	J8999	eviCore (option 3)	Oncology
carboplatin	CARBOPLATIN	M	J9045	eviCore (option 3)	Oncology
carboplatin	PARAPLATIN	M	J9045	eviCore (option 3)	Oncology
carfilzomib	KYPROLIS	M	J9047	eviCore (option 3)	Oncology
carglumic acid	CARBAGLU	P	J8499	ESI (option 1)	
carglumic acid	CARGLUMIC ACID	P	J8499	ESI (option 1)	
carmustine	BICNU, BCNU	M	J9050	eviCore (option 3)	Oncology
carmustine	CARMUSTINE NOT EQUIV TO J9050	M	J9052	eviCore (option 3)	Oncology
carmustine in polifeprosan 20	GLIADEL	M	C9399	eviCore (option 3)	Oncology
casimersen	AMONDYS 45	M	J1426 C9075	CCUM (option 2)	
casirivimab/imdevimab	CASIRIVIMAB-IMDEVIMAB (EUA)	P	Q0240 Q0243 Q0244	ESI (option 1)	
casirivimab/imdevimab	REGEN-COV (EUA)	P	Q0240 Q0243 Q0244	ESI (option 1)	
celecoxib	CELEBREX	P	J8499	ESI (option 1)	
cemiplimab-rwlc	LIBTAYO	M	J9119	eviCore (option 3)	Oncology
cenegermin-bkbj	OXERVATE	P	J3490	ESI (option 1)	
cenobamate	XCOPRI	P	J8499	ESI (option 1)	
ceritinib - oral	ZYKADIA	P	J8999	eviCore (option 3)	Oncology
cerliponase alfa	BRINEURA	M	J0567 C9014	CCUM (option 2)	
certolizumab pegol	CIMZIA	P	J0717	ESI (option 1)	

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cetrorelix	CETROTIDE	P	J3490	WPS	
cetuximab	ERBITUX	M	J9055	eviCore (option 3)	Oncology
chenodiol	CHENODAL	P	J8499	ESI (option 1)	
chlorambucil - oral	LEUKERAN	P	J8999 S0172	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
cholic acid	CHOLBAM	P	J8499	ESI (option 1)	
chorionic gonadotropin	CHOREX	P	J0725	WPS	
chorionic gonadotropin	OVIDREL	P	J0725	WPS	
chorionic gonadotropin	PREGNYL	P	J0725	WPS	
ciclesonide inhalation	ALVESCO	P	J3490	ESI (option 1)	
ciclesonide nasal	OMNARIS, ZETONNA	P	J3490	ESI (option 1)	
ciclopirox	CICLODAN	P	J3490	ESI (option 1)	
ciclopirox	PENLAC	P	J3490	ESI (option 1)	
ciltacabtagene autoleucel	CARVYKTI	M	C9098 Q2056	eviCore (option 3)	Oncology - CAR-T therapy
cipaglucosidase alfa-atga	POMBILITI	M	J1203	CCUM (option 2)	
ciprofloxacin otic	CETRAXAL	P	J3490	ESI (option 1)	
cisplatin	PLATINOL	M	J9060	eviCore (option 3)	Oncology
cladribine	CLADRIBINE	M	J9065	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
cladribine	LEUSTATIN	M	J9065	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
cladribine	MAVENCLAD	M	J8499	ESI (option 1)	
clindamycin/tretinoin	VELTIN, ZIANA	P	J3490	ESI (option 1)	
clobazam	ONFI, SYMPAZAN	P	J3490	ESI (option 1)	
clofarabine	CLOLAR	M	J9027	eviCore (option 3)	Oncology
clomiphene citrate	CLOMID	P	J8499	WPS	
clomiphene citrate	SEROPHENE	P	J8499	WPS	
coagulation factor ix (recombinant)	IXINITY	M	J7195 J7213	CCUM (option 2)	

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coagulation factor viia, recomb	NOVOSEVEN	P	J7189	ESI (option 1)	
coagulation factor viia, recombinant	NOVOSEVEN RT	M	J7189	CCUM (option 2)	
coagulation factor x	COAGADEX	M	J7175	CCUM (option 2)	
coagulation viia, recomb-jncw	SEVENFACT	M	J7212	CCUM (option 2)	
cobimetinib - oral	COTELLIC	P	J8999	eviCore (option 3)	Oncology
collagenase clostridium hist.	XIAFLEX	M	J0775	CCUM (option 2)	
copanlisib	ALIQOPA	M	J9057	eviCore (option 3)	Oncology
corticotropin	CORTROPHIN	P	J0800 J0802	ESI (option 1)	
corticotropin	H.P. ACTHAR GEL	P	J0800 J0801	CCUM (option 2)	
crisaborole	EUCRISA	P	J3490	ESI (option 1)	
crizanlizumab-tmca	ADAKVEO	M	J0791	CCUM (option 2)	
crizotinib - oral	XALKORI	P	J8999	eviCore (option 3)	Oncology
cyclophosphamide - inj	CYTOXAN, ENDOXAN-ASTA	M	J9070	eviCore (option 3)	Oncology
cyclophosphamide - inj	CYCLOPHOSPHAMIDE - INJ, NOT OTHERWISE SPECIFIED, 5 MG	M	J9075	eviCore (option 3)	Oncology
cyclophosphamide - inj (auromedic)	CYCLOPHOSPHAMIDE - INJ (AUROMEDICS) 10 MG	M	J9071	eviCore (option 3)	Oncology
cyclophosphamide - inj (dr reddy's)	CYCLOPHOSPHAMIDE - INJ (DR REDDY'S) 10 MG	M	J9072	eviCore (option 3)	Oncology
cyclophosphamide - inj (ingenus)	CYCLOPHOSPHAMIDE - INJ (INGENUS) 5 MG	M	J9073	eviCore (option 3)	Oncology
cyclophosphamide - inj (sandoz)	CYCLOPHOSPHAMIDE - INJ (SANDOZ), 5 MG	M	J9074	eviCore (option 3)	Oncology
cysteamine bitartrate	CYSTAGON	P	J8499	ESI (option 1)	
cysteamine bitartrate	PROCYSBI	P	J8499	ESI (option 1)	
cysteamine hcl	CYSTADROPS	P	J8499	ESI (option 1)	
cysteamine hcl	CYSTARAN	P	J8499	ESI (option 1)	
cytarabine	ARA-C	M	J9100	eviCore (option 3)	Oncology
cytarabine-liposome	DEPOCYT	M	J9098	eviCore (option 3)	Oncology

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cytomegalovirus immune globuln	CYTOGAM	P	J0850	ESI (option 1)	
dabrafenib - oral	TAFINLAR	P	J8999	eviCore (option 3)	Oncology
dacarbazine	DTIC-DOME	M	J9130	eviCore (option 3)	Oncology
daclatasvir	DAKLINZA	P	J8499	ESI (option 1)	
dacomitinib - oral	VIZIMPRO	P	J8999	eviCore (option 3)	Oncology
dactinomycin	COSMEGEN, ACTINOMYCIN	M	J9120	eviCore (option 3)	Oncology
dalbavancin hcl	DALVANCE	P	C9443	ESI (option 1)	
dalfampridine	AMPYRA	P	J8499	ESI (option 1)	
dalfampridine	DALFAMPRIDINE ER	P	J8499	ESI (option 1)	
dapagliflozin	FARXIGA	P	J8499	ESI (option 1)	
dapagliflozin/metformin	XIGDUO XR	P	J8499	ESI (option 1)	
dapagliflozin/saxagliptin	QTERN	P	J8499	ESI (option 1)	
daprodustat	JESDUVROQ	P	J0889	ESI (option 1)	
daratumumab	DARZALEX	M	J9145	eviCore (option 3)	Oncology
daratumumab and hyaluronidase-fihj	DARZALEX FASPRO	M	J9144	eviCore (option 3)	Oncology
darbepoetin alfa	ARANESP	P	J0881 J0882	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
darifenacin	ENABLEX	P	J8499	ESI (option 1)	
darolutamide - oral	NUBEQA	P	J8999	eviCore (option 3)	Oncology
dasatinib - oral	SPRYCEL	P	J8999	eviCore (option 3)	Oncology
daunorubicin	CERUBIDINE	M	J9150	eviCore (option 3)	Oncology
daunorubicin/cytarabine lipos	VYXEOS LIPOSOME	M	J9153	eviCore (option 3)	Oncology
daxibotulinumtoxinA-lanm	DAXXIFY	M	J0589 C9160	CCUM (option 2)	
decitabine	DACOGEN	M	J0894	eviCore (option 3)	Oncology
decitabine (sun pharma)	DECITABINE (SUN PHARMA)	M	J0893	eviCore (option 3)	Oncology
decitabine and cedazuridine - oral	INQOVI	P	J8999	eviCore (option 3)	Oncology
deferasirox	DEFERASIROX	P	J8499	ESI (option 1)	

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deferasirox	EXJADE	P	J8499	ESI (option 1)	
deferasirox	JADENU, JADENU SPRINKLE	P	J8499	ESI (option 1)	
deferiprone	DEFERIPRONE	P	J8499	ESI (option 1)	
deferiprone	FERRIPROX	P	J8499	ESI (option 1)	
deflazacort	EMFLAZA	P	J8499	ESI (option 1)	
degarelix	FIRMAGON	M	J9155	eviCore (option 3)	Oncology
delafloxacin	BAXDELA	P	J8499	ESI (option 1)	
delandistrogene moxeparvovec-rokl	ELEVIDYS	M	J1413	CCUM (option 2)	Gene Therapy
denosumab	PROLIA, XGEVA	M	J0897	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
denosumab-bbdz	WYOST	M	C9399 J3490 J3590 J9999	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
desmopressin acetate	DDAVP, NOCTIVA	P	J8499	ESI (option 1)	
desmopressin acetate	DESMOPRESSIN ACETATE	P	J8499	ESI (option 1)	
desvenlafaxine	DESVENLAFAXINE ER	P	J8499	ESI (option 1)	MH/SUD
desvenlafaxine	KHEDEZLA	P	J8499	ESI (option 1)	MH/SUD
deucravacitinib	SOTYKTU	P	J8499	ESI (option 1)	
deutetrabenazine	AUSTEDO	P	J8499	ESI (option 1)	
dexamethasone	OZURDEX	P	J7312	WPS	
dexlansoprazole	DEXILANT	P	J8499	ESI (option 1)	
dextranomer/hyaluronate/nacl	DEFLUX SOLESTA	P	L8605	ESI (option 1)	
dextroamphetamine	ZENZEDI	P	J8499	ESI (option 1)	MH/SUD
dichlorphenamide	KEVEYIS	P	J8499	ESI (option 1)	
diclofenac	ZIPSOR, ZORVOLEX	P	J8499	ESI (option 1)	
diclofenac patch	FLECTOR PATCH	P	J3490	ESI (option 1)	
diclofenac topical	PENNSAID, VOLTAREN GEL	P	J3490	ESI (option 1)	
dimercaprol	BAL	M	J0470	WPS	
dimethyl fumarate	DIMETHYL FUMARATE	P	J8499	ESI (option 1)	

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dimethyl fumarate	TECFIDERA	P	J8499	ESI (option 1)	
dinutuximab	UNITUXIN	M	J1246	eviCore (option 3)	Oncology
diroximel fumarate	VUMERITY	P	J8499	ESI (option 1)	
docetaxel	TAXOTERE	M	J9171	eviCore (option 3)	Oncology
docetaxel (ingenus)	DOCETAXEL NOT EQUIV TO J9171	M	J9172	eviCore (option 3)	Oncology
dolasetron mesylate	ANZEMET	P	J8597	eviCore (option 3)	Oncology
dornase alfa	PULMOZYME	P	J7639	ESI (option 1)	
dostarlimab-gxly	JEMPERLI	M	J9272	eviCore (option 3)	Oncology
doxepin	DOXEPIN	P	J8499	ESI (option 1)	
doxorubicin hcl	ADRIAMYCIN	M	J9000	eviCore (option 3)	Oncology
doxorubicin hcl (liposomal)	DOXIL, DOXORUBICIN HCL (LIPOSOMAL) NOT OTHERWISE SPECIFIED	M	Q2050	eviCore (option 3)	Oncology
doxycycline	ACTICLATE, ADOXA, ALODOX, AVIDOXY, DORYX, ORACEA	P	J8499	ESI (option 1)	
droxidopa	DROXIDOPA	P	J8499	ESI (option 1)	
droxidopa	NORTHERA	P	J8499	ESI (option 1)	
dulaglutide	TRULICITY	P	J3490	ESI (option 1)	
dupilumab	DUPIXENT, DUPIXENT PEN	P	J3590	ESI (option 1)	
durvalumab	IMFINZI	M	J9173	eviCore (option 3)	Oncology
duvelisib - oral	COPIKTRA	P	J8999	eviCore (option 3)	Oncology
ecallantide	KALBITOR	M	J1290	CCUM (option 2)	
eculizumab	SOLIRIS	M	J1300	CCUM (option 2)	
edaravone	RADICAVA	M	J1301	CCUM (option 2)	
edaravone	RADICAVA ORS	M	J1301 C9493	ESI (option 1)	
efbemalenograstim alfa-vuxw (biosimilar)	RYZNEUTA	P	J9361	eviCore (option 3)	
efgartigimod alfa and hyaluronidase-qvfc	VYVGART HYTRULO	M	J9334	CCUM (option 2)	

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efgartigimod alfa-fcab	VYVGART	M	J9332	CCUM (option 2)	
eflapegrastim-xnst	ROLVEDON	M	J1449	eviCore (option 3)	Oncology
elacestrant	ORSERDU	P	J9999	eviCore (option 3)	Oncology
elagolix	ORILISSA	P	J8499	ESI (option 1)	
elapegademase-lvlr	REVCOVI	M	C9399	CCUM (option 2)	
elbasvir/grazoprevir	ZEPATIER	P	J8499	ESI (option 1)	
eletriptan hydrobromide	RELPAX	P	J8499	ESI (option 1)	
elexacaftor/tezacaftor/ivacaft	TRIKAFTA	P	J8499	ESI (option 1)	
eliglustat tartrate	CERDELGA	P	J8499	ESI (option 1)	
elivaldogene autotemcel	SKYSONA	M	J3490 J3590 C9399	CCUM (option 2)	Gene Therapy
elosulfase alfa	VIMIZIM	M	J1322	CCUM (option 2)	
elotuzumab	EMPLICITI	M	J9176	eviCore (option 3)	Oncology
elranatamab-bcmm	ELREXFIO	M	J1323 C9165	eviCore (option 3)	Oncology
eltrombopag olamine	PROMACTA	P	J8499	ESI (option 1)	
emapalumab-lzsg	GAMIFANT	M	J9210	CCUM (option 2)	
emicizumab-kxwh	HEMLIBRA	M	J7170	CCUM (option 2)	
empagliflozin	JARDIANCE	P	J8499	ESI (option 1)	
empagliflozin /metformin	SYNJARDY (XR)	P	J8499	ESI (option 1)	
empagliflozin/linagliptin	GLYXAMBI	P	J8499	ESI (option 1)	
enasidenib - oral	IDHIFA	P	J8999	eviCore (option 3)	Oncology
encorafenib - oral	BRAFTOVI	P	J8999	eviCore (option 3)	Oncology
enfortumab vedotin-ejfv	PADCEV	M	J9177	eviCore (option 3)	Oncology
entecavir	BARACLUDE	P	J8499	ESI (option 1)	
entecavir	ENTECAVIR	P	J8499	ESI (option 1)	
entrectinib - oral	ROZLYTREK	P	J8999	eviCore (option 3)	Oncology
enzalutamide - oral	XTANDI	P	J8999	eviCore (option 3)	Oncology
epcoritamab-bysp	EPKINLY	M	J9321 C9155	eviCore (option 3)	Oncology

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epirubicin	ELLENCE	M	J9178	eviCore (option 3)	Oncology
eplontersen	WAINUA	M	C9399 J3490 J3590	CCUM (option 2)	
epoetin alfa	EPOGEN, PROCRIT	P	J0885	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
epoetin alfa-epbx	RETACRIT	P	Q5105 Q5106*	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
epoprostenol sodium	VELETRI	P	J1325	ESI (option 1)	
epoprostenol sodium (glycine)	EPOPROSTENOL SODIUM	P	J1325	ESI (option 1)	
epoprostenol sodium (glycine)	FLOLAN	M	J1325	CCUM (option 2)	
epoprostenol sodium	VELETRI	M	J1325	CCUM (option 2)	
eprosartan/hctz	TEVETEN HCT	P	J8499	ESI (option 1)	
eptinezumab-jjmr	VYEPTI	M	J3032	CCUM (option 2)	
erdafitinib-oral	BALVERSA	P	J8999	eviCore (option 3)	Oncology
erenumab-aooe	AIMOVIG	P	J3590	ESI (option 1)	
eribulin mesylate	HALAVEN	M	J9179	eviCore (option 3)	Oncology
erlotinib - oral	TARCEVA	P	J8999	eviCore (option 3)	Oncology
erlotinib hcl	ERLOTINIB HCL	P	J8999	eviCore (option 3)	Oncology
ertugliflozin	STEGLATRO	P	J8499	ESI (option 1)	
ertugliflozin/metformin	SEGLUROMET	P	J8499	ESI (option 1)	
ertugliflozin/sitagliptin	STEGLUJAN	P	J8499	ESI (option 1)	
esketamine	SPRAVATO	M	S0013	CCUM (option 2)	MH/SUD
estradiol gel	ESTROGEL	P	J3490	ESI (option 1)	
estramustine - oral	EMCYT	P	J8999	eviCore (option 3)	Oncology
eszopiclone	LUNESTA	P	J8499	ESI (option 1)	MH/SUD
etanercept	ENBREL	P	J1438	ESI (option 1)	
etelcalcetide hydrochloride	PARSABIV	P	J0606	WPS	
eteplirsen	EXONDYS 51	M	J1428	CCUM (option 2)	
etoposide - inj	TOPOSAR, VEPESID, ETOPOPHOS	M	J9181	eviCore (option 3)	Oncology

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etoposide - oral	TOPOSAR	P	J8560	eviCore (option 3)	Oncology
etranacogene dezaparvovec	HEMGENIX	M	J1411	CCUM (option 2)	Gene Therapy
everolimus - oral	AFINITOR, AFINITOR DISPERZ, ZORTRESS	P	J8999	eviCore (option 3)	
evinacumab-dgnb	EVKEEZA	M	J1305	CCUM (option 2)	
evolocumab	REPATHA	P	J3590	ESI (option 1)	
exagamglogene autotemcel	CASGEVY	M	J3490 J3590 C9399	CCUM (option 2)	Gene Therapy
exemestane - oral	AROMASIN	P	J8999 S0156	eviCore (option 3)	Oncology
exenatide	BYDUREON, BYDUREON BCISE, BYETTA	P	J3490	ESI (option 1)	
factor ix cplx(pcc)no4, 3factor	PROFILNINE, PROFILNINE SD	M	J7194	CCUM (option 2)	
factor ix human rec, pegylated	REBINYN	M	J7203	CCUM (option 2)	
factor ix human recombinant	BENEFIX	M	J7195	CCUM (option 2)	
factor ix human recombinant	RIXUBIS	M	J7200	CCUM (option 2)	
factor ix rec, fc fusion protn	ALPROLIX	M	J7201	CCUM (option 2)	
factor ix recom, albumin fusion	IDELVION	M	J7199 J7202	CCUM (option 2)	
factor ix	ALPHANINE SD, MONONINE	M	J7193	CCUM (option 2)	
factor VIII, recombinant human with VWF fusion	ALTUVIIIO	M	J7214	CCUM (option 2)	
factor xiii a-subunit, recomb	TRETTEN	M	J7181	CCUM (option 2)	
factor xiii	CORIFACT	M	J7180	CCUM (option 2)	
fam-trastuzumab deruxtecan-nxki	ENHERTU	M	J9358	eviCore (option 3)	Oncology
faricimab-svoa	VABYSMO	M	J2777	CCUM (option 2)	
febuxostat	ULORIC	P	J8499	ESI (option 1)	
fecal microbiota, live	VOWST	P	J1440	ESI (option 1)	
fedratinib - oral	INREBIC	P	J8999	eviCore (option 3)	Oncology
fenfluramine hcl	FINTEPLA	P	J8499	ESI (option 1)	
fentanyl	LAZANDA	P	J3490	ESI (option 1)	
fentanyl buccal	FENTORA, ONSOLIS	P	J8499	ESI (option 1)	

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fentanyl lozenge	ACTIQ	P	J8499	ESI (option 1)	
fentanyl sublingual	ABSTRAL, SUBSYS	P	J8499	ESI (option 1)	
ferric maltol	ACCRUFER	P	J8499	ESI (option 1)	
fesoteridine	TOVIAZ	P	J8499	ESI (option 1)	
fibrinogen	FIBRYGA	P	J7177	ESI (option 1)	
fibrinogen concentrate (human)	RIASTAP	M	J7178	CCUM (option 2)	
fibrinogen	FIBRYGA	M	J7177	CCUM (option 2)	
fidanacogene elaparvovec	BEQVEZ	M	J3490 J3590 C9399	CCUM (option 2)	Gene Therapy
filgrastim	NEUPOGEN	P	J1442	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
filgrastim-aafi	NIVESTYM	P	Q5110	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
filgrastim-ayow	RELEUKO	P	C9096 Q5125	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
filgrastim-sndz	ZARXIO	P	Q5101	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
finerenone	KERENDIA	P	J8499	ESI (option 1)	
fingolimod hcl	FINGOLIMOD	P	J8499	ESI (option 1)	
fingolimod hcl	GILENYA	P	J8499	ESI (option 1)	
floxuridine	FUDR	M	J9200	eviCore (option 3)	Oncology
fludarabine phosphate	FLUDARA, OFORTA	M	J9185	eviCore (option 3)	Oncology
fluocinolone acetonide	ILUVIEN	M	J7313	WPS	
fluocinolone acetonide	RETISERT	M	J7311	ESI (option 1)	
fluocinolone acetonide	YUTIQ	M	J7314	WPS	
fluoxetine	SARAFEM	P	J8499	ESI (option 1)	MH/SUD
fluoxymesterone - oral	ANDROXY	P	J8499	eviCore (option 3)	Oncology
flutamide - oral	EULEXIN	P	J8999	eviCore (option 3)	Oncology
fluticasone nasal	VERAMYST	P	J3490	ESI (option 1)	

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folinic acid	LEUCOVORIN - ORAL	P	J8499	ESI (option 1)	
follistim	FOLLISTIM	P	S0128 S0126	WPS	
follitropin alfa	GONAL	P	S0126	WPS	
fosaprepitant	EMEND	M	J1453	eviCore (option 3)	Oncology
fosaprepitant	FOCINVEZ	M	J1434	eviCore (option 3)	Oncology
fosaprepitant (teva)	FOSAPREPITANT (TEVA)	M	J1456	eviCore (option 3)	Oncology
fosdenopterin	NULIBRY	M	C9399	CCUM (option 2)	
fosnetupitant/palonosetron	AKYNZEO	M	J1454	eviCore (option 3)	Oncology
fostamatinib disodium	TAVALISSE	P	J8499	ESI (option 1)	
fostemsavir tromethamine	RUKOBIA	P	J8499	ESI (option 1)	
fremanezumab-vfrm	AJOVY	P	J3031	ESI (option 1)	
frovatriptan succinate	FROVA	P	J8499	ESI (option 1)	
fruquintinib	FRUZAQLA	P	J8999	eviCore (option 3)	
fulvestrant	FASLODEX	M	J9395	eviCore (option 3)	Oncology
fulvestrant (fresenius kabi)	FULVESTRANT (FRESENIUS KABI)	M	J9394	eviCore (option 3)	Oncology
fulvestrant (teva)	FULVESTRANT (TEVA)	M	J9393	eviCore (option 3)	Oncology
futibatinib - oral	LYTGOBI	P	J8999	eviCore (option 3)	Oncology
fviii rec, b-dom delet peg-aucl	JIVI	M	J7208	CCUM (option 2)	
fviii rec, b-dom trunc peg-exei	ESPEROCT	M	J7204	CCUM (option 2)	
gabapentin	HORIZANT	P	J8499	ESI (option 1)	
galcanezumab	EMGALITY	P	J8499	ESI (option 1)	
galsulfase	NAGLAZYME	M	J1458	CCUM (option 2)	
ganaxolone	ZTALMY	P	J8499	ESI (option 1)	
ganirelix acetate	ANTAGON	P	S0132	WPS	
ganirelix acetate	GANIRELIX ACETATE	P	S0132	WPS	
gefitinib - oral	IRESSA	P	J8565	eviCore (option 3)	Oncology
gemcitabine	GEMZAR	M	J9201	eviCore (option 3)	Oncology
gemcitabine hcl	GEMCITABINE NOT EQUIV TO J9201	M	J9196	eviCore (option 3)	Oncology

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gemcitabine hcl in nacl	INFUGEM	M	J9198	eviCore (option 3)	Oncology
gemtuzumab ozogamicin	MYLOTARG	M	J9203	eviCore (option 3)	Oncology
gilteritinib - oral	XOSPATA	P	J8999	eviCore (option 3)	Oncology
givosiran sodium	GIVLAARI	P	J0223 C9056	ESI (option 1)	
glasdegib - oral	DAURISMO	P	J8999	eviCore (option 3)	Oncology
glatiramer acetate	COPAXONE	P	J3490	ESI (option 1)	
glatiramer acetate	GLATIRAMER ACETATE, GLATOPA	P	J1595	ESI (option 1)	
glecaprevir/pibrentasvir	MAVYRET	P	J8499	ESI (option 1)	
glofitamab-gxbm	COLUMVI	M	J9286	eviCore (option 3)	Oncology
glucagon	GVOKE	P	J1610	ESI (option 1)	
glucarpidase	VORAXAZE	P	C9293	ESI (option 1)	
glutamine	ENDARI	P	J8499	ESI (option 1)	
glycerol phenylbutyrate	RAVICTI	P	J8499	ESI (option 1)	
golimumab	SIMPONI	P	J3590	ESI (option 1)	
golimumab	SIMPONI ARIA	M	J1602	CCUM (option 2)	
golodirsen	VYONDYS 53	M	J1429	CCUM (option 2)	
gonadorelin	FACTREL	M	J1620	WPS	
gonadorelin	LUTREPULSE	M	J1620	WPS	
gonadotropin	CHORIONIC GONADOTROPIN	P	J0725	WPS	
gonadotropin	UROFOLLITROPIN	P	J3355	WPS	
goserelin acetate implant	ZOLADEX	M	J9202	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
gr pol-orc/sw ver/rye/kent/tim	ORALAIR	P	J8499	ESI (option 1)	
granisetron - subcutaneous	SUSTOL	M	J1627	eviCore (option 3)	Oncology
granisetron - transdermal	SANCUSO	P	J3490	eviCore (option 3)	
grass pollen-perennial rye,std	STANDARD RYE GRASS POLLEN	P	J8499	ESI (option 1)	
grass pollen-timothy, standard	GRASTEK	P	J8499	ESI (option 1)	
guselkumab	TREMFYA	P	J1628	ESI (option 1)	

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hemin	PANHEMATIN	M	J1640	CCUM (option 2)	
histrelin acetate	SUPPRELIN LA, VANTAS	M	J9226	CCUM (option 2)	
histrelin implant	VANTAS	M	J9225	eviCore (option 3)	Oncology
ibalizumab-uiy	TROGARZO	M	J1746	CCUM (option 2)	
ibandronate sodium	IBANDRONATE SODIUM	P	J8499	ESI (option 1)	
ibandronate sodium	BONIVA	M	J1740	CCUM (option 2)	
ibrutinib - oral	IMBRUVICA	P	J8999	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
icatibant acetate	FIRAZYR, SAJAZIR	P	J1744	ESI (option 1)	
icatibant acetate	ICATIBANT	P	J1744	ESI (option 1)	
idarubicin hcl - inj	IDAMYCIN	M	J9211	eviCore (option 3)	Oncology
idecabtagene vicleucel	ABECMA	M	C9081 Q2055	eviCore (option 3)	Oncology - CAR-T therapy
idelalisib - oral	ZYDELIG	P	J8999	eviCore (option 3)	Oncology
idursulfase	ELAPRASE	M	J1743	CCUM (option 2)	
ifosfamide	IFEX, MITOXANA	M	J9208	eviCore (option 3)	Oncology
igg/hyaluronidase, recombinant	HYQVIA	P	J1575	ESI (option 1)	
iloprost tromethamine	VENTAVIS	P	Q4074	ESI (option 1)	
imatinib - oral	GLEEVEC	P	J8999 S0088	eviCore (option 3)	Oncology
imatinib mesylate	IMATINIB MESYLATE	P	S0088	ESI (option 1)	
imetelstat	RYTELO	M	J3490 J9999 C9399	CCUM (option 2)	
imiglucerase	CEREZYME	M	J1786	CCUM (option 2)	
imiquimod	ZYCLARA	P	J3490	ESI (option 1)	
imm glob g (igg)/sorb/iga 0-50	FLEBOGAMMA	M	J1572	CCUM (option 2)	
imm glob sc/scig/igsc	VIVAGLOBIN	P	J1562	ESI (option 1)	
immun glob g(igg)/gly/iga 0-50	GAMMAPLEX	M	J1557	CCUM (option 2)	
immun glob g(igg)/gly/iga ov50	CUVITRU	M	J1555	CCUM (option 2)	
immun glob g(igg)/gly/iga ov50	BIVIGAM	M	J1556	CCUM (option 2)	

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immun glob g(igg)/gly/iga ov50	GAMMAGARD LIQUID	M	J1569	CCUM (option 2)	
immun glob g(igg)/pro/iga 0-50	PRIVIGEN	M	J1459	CCUM (option 2)	
immun glob g(igg)/pro/iga 0-50	HIZENTRA	M	J1559	CCUM (option 2)	
immun glob g(igg)-hipp/maltose	CUTAQUIG	M	J1551	CCUM (option 2)	
immun glob g(igg)-ifas/glycine	PANZYGA	M	J1576 J1599	CCUM (option 2)	
immun glob g/gly/gluc/iga 0-50	GAMMAGARD S-D	M	J1566	CCUM (option 2)	
immun glob g/sorb/gly/iga 0-50	GAMUNEX-C	M	J1561	CCUM (option 2)	
immun globg(igg)/malt/iga ov50	OCTAGAM	M	J1568	CCUM (option 2)	
immune globul g (igg)/glycine	GAMASTAN, GAMASTAN S-D	P	J1460 J1560	ESI (option 1)	
immune globul g/gly/iga avg 46	GAMUNEX-C	P	J1561	ESI (option 1)	
immune globul g/gly/iga avg 46	GAMMAKED	M	J1561	CCUM (option 2)	
immune globulin, gamma(igg)klhw	XEMBIFY	M	J1558	CCUM (option 2)	
immune globulin, gamma(igg)slra	ASCENIV	M	J1554	CCUM (option 2)	
inclisiran	LEQVIO	M	J1306	CCUM (option 2)	
incobotulinumtoxin a	XEOMIN	M	J0588	CCUM (option 2)	
inebilizumab-cdon	UPLIZNA	M	J1823	CCUM (option 2)	
infigratinib - oral	TRUSELTIQ	P	J8999	eviCore (option 3)	Oncology
infliximab	REMICADE	M	J1745	CCUM (option 2)	
infliximab-abda	RENFLEXIS	M	Q5104	CCUM (option 2)	
infliximab-axxq	AVSOLA	M	Q5121	CCUM (option 2)	
infliximab-dyyb	INFLECTRA, ZYMFENTRA	M	J1748 Q5103	CCUM (option 2)	
inotersen sodium	TEGSEDI	M	C9399	CCUM (option 2)	
inotuzumab ozogamicin	BESPONSA	M	J9229	eviCore (option 3)	Oncology
insulin	NOVOLIN	P	J3490	ESI (option 1)	
insulin aspart	NOVOLOG	P	J3490	ESI (option 1)	
insulin glulisine	APIDRA	P	J3490	ESI (option 1)	

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interferon alfa-2b	INTRON A	P	J9214	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
interferon beta-1a	AVONEX ADMINISTRATION PACK, AVONEX PEN	P	J1826	ESI (option 1)	
interferon beta-1a/albumin	REBIF, REBIF REBIDOSE	P	J1826 Q3028	ESI (option 1)	
interferon beta-1b	BETASERON, EXTAVIA	P	J1830	ESI (option 1)	
interferon gamma-1b, recomb.	ACTIMMUNE	P	J9216	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
interferon, alfa-2b, recombinant	INTRON A	M	J9214	eviCore (option 3)	Oncology
interferon, gamma-1b	ACTIMMUNE	M	J9216	eviCore (option 3)	Oncology
ipilumumab	YERVOY	M	J9228	eviCore (option 3)	Oncology
iptacopan	FABHALTA	P	J8499	ESI (option 1)	
irinotecan	CAMPTOSAR	M	J9206	eviCore (option 3)	Oncology
irinotecan liposome	ONIVYDE	M	J9205	eviCore (option 3)	Oncology
isatuximab-irfc	SARCLISA	M	J9227	eviCore (option 3)	Oncology
istradefylline	NOURIANZ	P	J8499	ESI (option 1)	
ivacaftor	KALYDECO	P	J8499	ESI (option 1)	
ivosidenib - oral	TIBSOVO	P	J8999	eviCore (option 3)	Oncology
ixabepilone	IXEMPRA	M	J9207	eviCore (option 3)	Oncology
ixazomib - oral	NINLARO	P	J8999	eviCore (option 3)	Oncology
ixekizumab	TALTZ AUTOINJECTOR, TALTZ SYRINGE	P	J3590	ESI (option 1)	
ketorolac ophthalmic	ACUVAIL	P	J3490	ESI (option 1)	
ketorolac tromethamine	SPRIX	P	C9399	ESI (option 1)	
kit prep of ga-68/gozetotide	ILLUCCIX	M	A9596	eviCore (option 3)	Radiation Oncology
lacosamide	VIMPAT	P	J8499	ESI (option 1)	
lamiditan succinate	REYVOW	P	J8499	ESI (option 1)	
lanadelumab-flyo	TAKHZYRO	P	J0593	ESI (option 1)	
lanreotide	SOMATULINE DEPOT	M	J1930	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)

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lanreotide (cipla)	LANREOTIDE (CIPLA)	M	J1932	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
lapatinib - oral	TYKERB	P	J8999	eviCore (option 3)	Oncology
laronidase	ALDURAZYME	M	J1931	CCUM (option 2)	
larotrectinib - oral	VITRAKVI	P	J8999	eviCore (option 3)	Oncology
ledipasvir/sofosbuvir	HARVONI	P	J8499	ESI (option 1)	
ledipasvir/sofosbuvir	LEDIPASVIR-SOFOSBUVIR	P	J8499	ESI (option 1)	
lemborexant	DAYVIGO	P	J8499	ESI (option 1)	
lenacapavir	SUNLENCA	P	J1961	ESI (option 1)	
lenalidomide	LENALIDOMIDE	P	J8999	eviCore (option 3)	Oncology
lenalidomide - oral	REVLIMID	P	J8999	eviCore (option 3)	Oncology
lenvatinib - oral	LENVIMA	P	J8999	eviCore (option 3)	Oncology
lesinurad	ZURAMPIC	P	J8499	ESI (option 1)	
leucovorin - inj	LEUCOVORIN	M	J0640	eviCore (option 3)	Oncology
leucovorin - oral	LEUCOVORIN - ORAL	P	J8999	eviCore (option 3)	Oncology
leuprolide acetate	ELIGARD, FENSOLVI, LUPRON DEPOT, LUPRON, LEUPROLIDE ACETATE	M	J1950 J1951 J9217 J9218	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
leuprolide acetate	LEUPROLIDE ACETATE (infertility only)	M	J1950 J9219 J9217 J9218	WPS	
leuprolide acetate	LUPRON (infertility only)	M	J1950 J9219 J9217 J9218	WPS	
leuprolide acetate (lutrate)	LEUPROLIDE ACETATE (LUTRATE)	M	J1954	eviCore (option 3)	Oncology
leuprolide acetate/norethindrone	LUPANETA PACK	M	J1950	CCUM (option 2)	
leuprolide mesylate	CAMCEVI	M	J1952	eviCore (option 3)	Oncology
levalbuterol inhaler	XOPENEX HFA	P	J3490	ESI (option 1)	
levodopa	INBRIJA	P	J8499	ESI (option 1)	
levoketoconazole	RECORLEV	P	J8499	ESI (option 1)	
levoleucovorin	FUSILEV	M	J0641	eviCore (option 3)	Oncology
levoleucovorin	KHAPZORY	M	J0642	eviCore (option 3)	Oncology

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levomilnacipran	FETZIMA	P	J8499	ESI (option 1)	MH/SUD
lifileucel	AMTAGVI	M	C9399 J3490 J3590 J9999	eviCore (option 3)	Oncology - CAR-T therapy
lifitegrast	XIIDRA	P	J3490	ESI (option 1)	
linagliptin	TRADJENTA	P	J8499	ESI (option 1)	
linagliptin/metformin	JENTADUETO (XR)	P	J8499	ESI (option 1)	
liposome-encapsulated combination of daunorubicin and cytarabine	VYXEOS	M	J9153	eviCore (option 3)	Oncology
liraglutide	VICTOZA	P	J3490	ESI (option 1)	
lisdexamfetamine	VYVANSE	P	J8499	ESI (option 1)	MH/SUD
lisocabtagene maraleucel	BREYANZI	M	C9076 Q2054	eviCore (option 3)	Oncology - CAR-T therapy
lixisenatide	ADLYXIN	P	J3490	ESI (option 1)	
lomitapide mesylate	JUXTAPID	P	J8499	ESI (option 1)	
lomustine - oral	GLEOSTINE, CEENU	P	S0178	eviCore (option 3)	Oncology
lonafarnib	ZOKINVY	P	J8499	ESI (option 1)	
lonapegsomatropin-tcgd	SKYTROFA	P	J3490	ESI (option 1)	
loncastuximab tesirine-lpyl	ZYNLONTA	M	J9359	eviCore (option 3)	Oncology
lorlatinib - oral	LORBRENA	P	J8999	eviCore (option 3)	Oncology
lovotibeglogene autotemcel	LYFGENIA	M	J3394	CCUM (option 2)	Gene Therapy
lumacaftor/ivacaftor	ORKAMBI	P	J8499	ESI (option 1)	
lumasiran sodium	OXLUMO	P	J0224 C9074	ESI (option 1)	
lumateperone	CAPLYTA	P	J8499	ESI (option 1)	
lurbinectedin	ZEPZELCA	M	J9223	eviCore (option 3)	Oncology
luspatercept-aamt	REBLOZYL	P	J0896	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
lusutrombopag	MULPLETA	P	J8499	ESI (option 1)	
lutetium lu 177 dotatate	LUTATHERA	M	C9031 A9513	eviCore (option 3)	Radiation Oncology

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lutetium lu 177 vipivotide tetraxetan	PLUVICTO	M	A9607	eviCore (option 3)	Radiation Oncology
lutropin	LUVERIS	P	J3490	WPS	
lymphocyte ig, antithymocyt, equ	ATGAM	M	J7504	CCUM (option 2)	
macitentan	OPSUMIT	P	J8499	ESI (option 1)	
maralixibat	LIVMARLI	P	J3490	ESI (option 1)	
margetuximab-cmkb	MARGENZA	M	J9353	eviCore (option 3)	Oncology
maribavir	LIVTENCITY	P	J8499	ESI (option 1)	
mavacamten	CAMZYOS	P	J8499	ESI (option 1)	
mecasermin	INCRELEX	P	J2170	ESI (option 1)	
mechlorethamine - topical	VALCHLOR	P	J9999	eviCore (option 3)	Oncology
melphalan flufenamide hcl	PEPAXTO	M	C9080	eviCore (option 3)	Oncology
melphalan hcl - inj	EVOMELA	M	J9246	eviCore (option 3)	Oncology
melphalan hcl - inj	HEPZATO KIT	M	J9248	eviCore (option 3)	Oncology
melphalan hcl - inj (apotex)	MELPHALAN	M	J9249	eviCore (option 3)	Oncology
melphalan hcl - nos inj	ALKERAN	M	J9245	eviCore (option 3)	Oncology
menotropins	MENOPUR	P	S0122	WPS	
menotropins	PERGONAL	P	S0122	WPS	
mepolizumab	NUCALA	M	J2182	CCUM (option 2)	
mercaptopurine	PURIXAN	P	S0108	ESI (option 1)	
mesalamine delayed release	ASACOL HD, DELZICOL	P	J8499	ESI (option 1)	
mesna	MESNEX	M	J9209	eviCore (option 3)	Oncology
metformin	RIOMET	P	J8499	ESI (option 1)	
metformin er	GLUMETZA	P	J8499	ESI (option 1)	
methotrexate sodium	FOLEX, METHOTREXATE	M	J9250 J9260	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
methotrexate sodium (accord)	METHOTREXATE NOT EQUIV TO J9250 OR J9260	M	J9255	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
methotrexate/pf	OTREXUP, RASUVO, REDITREX	P	J9250	ESI (option 1)	

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methoxy peg-epoetin beta	MIRCERA	P	J0887 J0888	ESI (option 1)	
methylphenidate	QUILLICHEW, QUILLIVANT XR	P	J8499	ESI (option 1)	MH/SUD
methylphenidate hcl	ADHANSIA XR	P	J8499	ESI (option 1)	MH/SUD
methylphenidate patch	DAYTRANA	P	J3490	ESI (option 1)	MH/SUD
methyltestosterone	ANDROID, METHITEST, TESTRED	P	J8499	ESI (option 1)	
metreleptin	MYALEPT	P	J3490	ESI (option 1)	
midostaurin - oral	RYDAPT	P	J8999	eviCore (option 3)	Oncology
mifepristone	KORLYM	P	S0190	ESI (option 1)	
migalastat hcl	GALAFOLD	P	J8499	ESI (option 1)	
miglustat	MIGLUSTAT	P	J1202	ESI (option 1)	
miglustat	ZAVESCA	P	J1202	ESI (option 1)	
milnacipran	SAVELLA	P	J8499	ESI (option 1)	
minocycline	SOLODYN, XIMINO	P	J8499	ESI (option 1)	
minocycline hcl microspheres	ARESTIN	P	J8499	ESI (option 1)	
mipomersen	KYNAMRO	P	J3490	ESI (option 1)	
mirabegron	MYRBETRIQ	P	J8499	ESI (option 1)	
mirikizumab-mrkz	OMVOH	P	J2267 C9168	ESI (option 1)	
mirvetuximab soravtansine-gynx	ELAHERE	M	J9063 C9146	eviCore (option 3)	Oncology
mitapivat sulfate	PYRUKYND	P	J8499	ESI (option 1)	
mite, d.farinae-d.pteronyssinus	ODACTRA	P	J8499	ESI (option 1)	
mitomycin	JELMYTO	M	J9281	eviCore (option 3)	Oncology
mitomycin	MITOMYCIN-STERILE WATER	M	J3490	ESI (option 1)	
mitomycin	MUTAMYCIN	M	J9280	eviCore (option 3)	Oncology
mitotane - oral	LYSODREN	P	J8999	eviCore (option 3)	Oncology
mitoxantrone hcl	NOVANTRONE	M	J9293	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
mobocertinib - oral	EXKIVITY	P	J8999	eviCore (option 3)	Oncology
mogamulizumab-kpkc	POTELIGEO	M	J9204	eviCore (option 3)	Oncology

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momelotinib	OJJAARA	M	C9399 J3490 J3590 J9999	eviCore (option 3)	Oncology
mometasone furoate	SINUVA	P	C9122 J7402	ESI (option 1)	
monomethyl fumarate	BAFIERTAM	P	J8499	ESI (option 1)	
mosunetuzumab-axgb	LUNSUMIO	M	J9350	eviCore (option 3)	Oncology
motixafortide	APHEXDA	M	J2277	CCUM (option 2)	
moxetumomab pasudotox-tdfk	LUMOXITI	M	J9313	eviCore (option 3)	Oncology
nabilone	CESAMET	P	J8499	ESI (option 1)	
nadofaragen firadenovec-vncg	ADSTILADRIN	M	J9029	eviCore (option 3)	Oncology
naldemedine	SYMPROIC	P	J8499	ESI (option 1)	
naloxone auto injector	EVZIO	P	J3490	ESI (option 1)	MH/SUD
nandrolone decanoate	DECA-DURABOLIN	M	J2320	WPS	
naproxen + esomeprazole	VIMOVO	P	J8499	ESI (option 1)	
natalizumab	TYSABRI	M	J2323	CCUM (option 2)	
natalizumab (biosimilar)	TYRUKO	M	Q5134	CCUM (option 2)	
naxitamab-gqgk	DANYELZA	M	J9348	eviCore (option 3)	Oncology
necitumumab	PORTRAZZA	M	J9295	eviCore (option 3)	Oncology
nelarabine	ARRANON	M	J9261	eviCore (option 3)	Oncology
neratinib - oral	NERLYNX	P	J8999	eviCore (option 3)	Oncology
netupitant/palonosetron - oral	AKYNZEO	P	J8655	eviCore (option 3)	Oncology
nilotinib - oral	TASIGNA	P	J8999	eviCore (option 3)	Oncology
nilutamide	NILANDRON	P	J8999	eviCore (option 3)	Oncology
nilutamide	NILUTAMIDE	P	J8999	eviCore (option 3)	Oncology
nintedanib esylate	OFEV	P	J8499	ESI (option 1)	
niraparib - oral	ZEJULA	P	J8999	eviCore (option 3)	Oncology
niraparib and abiraterone acetate	AKEEGA	P	J8999	eviCore (option 3)	Oncology
nirogacestat	OGSIVEO	P	J8999	eviCore (option 3)	
nitisinone	NITISINONE	P	J8499	ESI (option 1)	

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nitisinone	NITYR, ORFADIN	P	J8499	ESI (option 1)	
nivolumab	OPDIVO	M	J9299	eviCore (option 3)	Oncology
nivolumab and relatlimab-rmbw	OPDUALAG	M	J9298	eviCore (option 3)	Oncology
nusinersen	SPINRAZA	M	J2326	CCUM (option 2)	
obeticholic acid	OCALIVA	P	J8499	ESI (option 1)	
obinutuzumab	GAZYVA	M	J9301	eviCore (option 3)	Oncology
ocrelizumab	OCREVUS	M	J2350	CCUM (option 2)	
octreotide acetate	BYNFEZIA, MYCAPSSA	P	J3490	ESI (option 1)	
octreotide acetate	OCTREOTIDE ACETATE	P	J3490	ESI (option 1)	
octreotide acetate, mi-spheres	SANDOSTATIN LAR	M	J2353	CCUM (option 2)	
octreotide depot	SANDOSTATIN	M	J2353	eviCore (option 3)	Oncology
octreotide non-depot	SANDOSTATIN	M	J2354	eviCore (option 3)	Oncology
ofatumumab	ARZERRA	M	J9302	eviCore (option 3)	Oncology
ofatumumab	KESIMPTA PEN	P	J9302	eviCore (option 3)	Oncology
olaparib - oral	LYNPARZA	P	J8999	eviCore (option 3)	Oncology
olipudase alfa-rpcp	XENPOZYME	M	J0218	CCUM (option 2)	
olsalazine	DIPENTUM	P	J8499	ESI (option 1)	
olutasidenib - oral	REZLIDHIA	P	J8999	eviCore (option 3)	Oncology
omacetaxine	SYNRIBO	M	J9262	eviCore (option 3)	Oncology
omalizumab	XOLAIR	M	J2357	CCUM (option 2)	
ombita/paritap/riton/dasabuvir	VIEKIRA PAK, VIEKIRA XR	P	J8499	ESI (option 1)	
ombitasvir, paritaprevir and ritonavir	TECHNIVIE	P	J8499	ESI (option 1)	
omeprazole packets	PRILOSEC PACKETS	P	J8499	ESI (option 1)	
omeprazole/sodium bicarb	ZEGERID PACKETS	P	J8499	ESI (option 1)	
omidubicel-onlv	OMISURGE	M	J3490 J3590 C9399	CCUM (option 2)	
omidubicel-onlv	OMISIRGE	M	J3490 J3590 C9399	CCUM (option 2)	

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onabotulinumtoxin a	BOTOX	M	J0585	CCUM (option 2)	
onasemnogene abeparvovec-xioi	ZOLGENSMA	M	J3399	CCUM (option 2)	Gene Therapy
ondansetron	ZUPLENZ	P	S0119 Q0162	ESI (option 1)	
opicapone	ONGENTYS	P	J8499	ESI (option 1)	
oritavancin diphosphate	KIMYRSA	P	J2406 C9444	ESI (option 1)	
oritavancin diphosphate	ORBACTIV	P	J2407	ESI (option 1)	
osilodrostat phosphate	ISTURISA	P	J8499	ESI (option 1)	
osimertinib - oral	TAGRISSO	P	J8999	eviCore (option 3)	Oncology
oxaliplatin	ELOXATIN	M	J9263	eviCore (option 3)	Oncology
oxandrolone	OXANDRIN	P	J8499	ESI (option 1)	
oxandrolone	OXANDROLONE	P	J8499	ESI (option 1)	
oxcarbazepine	OXTELLAR XR	P	J8499	ESI (option 1)	
oxybutynin	OXYTROL	P	J3490	ESI (option 1)	
oxybutynin gel	GELNIQUE	P	J3490	ESI (option 1)	
oxymetholone	ANADROL	P	J8499	ESI (option 1)	
ozanimod hydrochloride	ZEPOSIA	P	J8499	ESI (option 1)	
paclitaxel	NOV-ONXOL, TAXOL	M	J9267	eviCore (option 3)	Oncology
paclitaxel (albumin-bound)	ABRAXANE	M	J9264	eviCore (option 3)	Oncology
paclitaxel (albumin-bound)	PACLITAXEL	M	J9258 J9259	eviCore (option 3)	Oncology
paclitaxel (albumin-bound)	PACLITAXEL NOT EQUIV TO J9264	M	J9264	eviCore (option 3)	Oncology
pacritinib - oral	VONJO	P	J8999	eviCore (option 3)	Oncology
palbociclib - oral	IBRANCE	P	J8999	eviCore (option 3)	Oncology
palifermin	KEPIVANCE	P	J2425	ESI (option 1)	
palivizumab	SYNAGIS	M	90378	CCUM (option 2)	
palonosetron	ALOXI	M	J2469	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
palonosetron, not equivalent to J2469	AVYXA	M	J2468	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)

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pamidronate disodium	AREDIA	M	J2430	eviCore (option 3)	Oncology
pancrelipase dr	PANCREAZE, PERTYZE, ULTRESA	P	J8499	ESI (option 1)	
panitumumab	VECTIBIX	M	J9303	eviCore (option 3)	Oncology
panobinostat lactate	FARYDAK	P	J8999	eviCore (option 3)	Oncology
pantoprazole suspension	PROTONIX SUSP	P	J8499	ESI (option 1)	
parathyroid hormone	NATPARA	P	J3490	ESI (option 1)	
paroxetine	BRISDELLE, PEXEVA	P	J8499	ESI (option 1)	MH/SUD
pasireotide diaspartate	SIGNIFOR	P	J2502	ESI (option 1)	
pasireotide pamoate	SIGNIFOR LAR	M	J2502 C9454	CCUM (option 2)	
patisiran sodium, lipid complex	ONPATTRO	M	J0222	CCUM (option 2)	
pazopanib - oral	VOTRIENT	P	J8999	eviCore (option 3)	Oncology
peanut allergen powder-dnfp	PALFORZIA	P	J8499	ESI (option 1)	
pegademase bovine	ADAGEN	P	J2504	ESI (option 1)	
pegaspargase	ONCASPAR	M	J9266	eviCore (option 3)	Oncology
pegcetacoplan	EMPAVELI	P	C9151	ESI (option 1)	
pegcetacoplan (ophthalmic)	SYFOVRE	M	J2781	CCUM (option 2)	
pegfilgrastim	NEULASTA	P	J2506	eviCore (option 3)	
pegfilgrastim-apgf	NYVEPRIA	P	Q5122	eviCore (option 3)	
pegfilgrastim-bmez	ZIEXTENZO	P	Q5120 C9058	eviCore (option 3)	
pegfilgrastim-cbqv	UDENYCA	P	Q5111	eviCore (option 3)	
pegfilgrastim-fpgk	STIMUFEND	P	Q5127	eviCore (option 3)	Oncology
pegfilgrastim-jmdb	FULPHILA	P	Q5108	eviCore (option 3)	
pegfilgrastim-pbbk	FYLNETRA	P	Q5130	eviCore (option 3)	Oncology
peginterferon alfa-2a	PEGASYS PROCLICK	P	J9213 S0145	ESI (option 1)	
peginterferon alfa-2b	SYLATRON	P	S0148	ESI (option 1)	
peginterferon beta-1a	PLEGRIDY	P	Q3028	ESI (option 1)	
peginterferon, alfa-2a	PEGASYS	M	J3590	eviCore (option 3)	Oncology
peginterferon, alfa-2b	PEGINTRON	M	S0148	eviCore (option 3)	Oncology

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pegloticase	KRYSTEXXA	M	J2507	CCUM (option 2)	
pegunigalsidase alfa	ELFABRIO	M	J2508	CCUM (option 2)	
pegvaliase-pqpz	PALYNZIQ	P	J3490	ESI (option 1)	
pegvisomant	SOMAVERT	P	J3490	ESI (option 1)	
pembrolizumab	KEYTRUDA	M	J9271	eviCore (option 3)	Oncology
pemetrexed	ALIMTA, PEMETREXED NOT OTHERWISE SPECIFIED	M	J9305	eviCore (option 3)	Oncology
pemetrexed	PEMETREXED NOT EQUIV TO J9305	M	J9294 J9296 J9297 J9314 J9322 J9323 J9324	eviCore (option 3)	Oncology
pemetrexed	PEMRYDI RTU	M	J9324	eviCore (option 3)	Oncology
pemetrexed	PEMFEXY	M	J9304	eviCore (option 3)	Oncology
pemigatinib - oral	PEMAZYRE	P	J8999	eviCore (option 3)	Oncology
pemivibart	PEMGARDA (EUA)	M	M0224 Q0224	WPS	
pentostatin	NIPENT	M	J9268	eviCore (option 3)	Oncology
perrenial rye grass pollen allergen	STANDARD RYE GRASS POLLEN	P	J8499	ESI (option 1)	
pertuzumab	PERJETA	M	J9306	eviCore (option 3)	Oncology
pertuzumab / trastuzumab / hyaluronidase-zzxf	PHESGO	M	J9316	eviCore (option 3)	Oncology
pexidartinib - oral	TURALIO	P	J8999	eviCore (option 3)	Oncology
phenoxybenzamine hcl	DIBENZYLINE	P	J8499	ESI (option 1)	
phenoxybenzamine hcl	PHENOXYBENZAMINE HCL	P	J8499	ESI (option 1)	
pimavanserin tartrate	NUPLAZID	P	J8499	ESI (option 1)	MH/SUD
pirfenidone	ESBRIET	P	J8499	ESI (option 1)	
pirfenidone	PIRFENIDONE	P	J8499	ESI (option 1)	
pirtobrutinib	JAYPIRCA	M	J8999	eviCore (option 3)	Oncology
pitolisant hcl	WAKIX	P	J8499	ESI (option 1)	MH/SUD
plasminogen, human-tvmh	RYPLAZIM	M	J2998	CCUM (option 2)	

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plecanatide	TRULANCE	P	J8499	ESI (option 1)	
plerixafor	MOZOBIL	P	J2562	ESI (option 1)	
polatuzumab vedotin-piiq	POLIVY	M	J9309	eviCore (option 3)	Oncology
polidocanol inj foam	VARITHENA	M	J3490	WPS	
pomalidomide - oral	POMALYST	P	J8999	eviCore (option 3)	Oncology
ponatinib - oral	ICLUSIG	P	J8999	eviCore (option 3)	Oncology
ponesimod	PONVORY	P	J8499	ESI (option 1)	
porfimer sodium	PHOTOFRIN	M	J9600	eviCore (option 3)	Oncology
pozelimab-bbfg	VEOPOZ	M	J9376	CCUM (option 2)	
pralatrexate	FOLOTYN	M	J9307	eviCore (option 3)	Oncology
pralsetinib - oral	GAVRETO	P	J8999	eviCore (option 3)	Oncology
procarbazine hydrochloride	MATULANE	P	J8999 S0182	eviCore (option 3)	Oncology
progesterone	CRINONE 8% GEL	P	J2675	WPS	
progesterone	PROCHIEVE 8% GEL	P	J3490	WPS	
progesterone	PROGESTERONE INJ	P	J2675	WPS	
progesterone	PROGESTERONE ORAL (PA req < 45 years old)	P	J8499	WPS	
progesterone vaginal	ENDOMETRIN INSERT	P	J3490	WPS	
propranolol	HEMANGEOL	P	J8999	ESI (option 1)	
protein c, human	CEPROTIN	M	J2724	CCUM (option 2)	
prothrombin complex concentrate (human)	BALFAXAR	M	J7165 C9159	CCUM (option 2)	
pyrimethamine	DARAPRIM	P	J8499	ESI (option 1)	
pyrimethamine	PYRIMETHAMINE	P	J8499	ESI (option 1)	
quizartinib dihydrochloride	VANFLYTA	P	J8999	eviCore (option 3)	
radium-223 dichloride	XOFIGO	M	A9606	eviCore (option 3)	Radiation Oncology
ramelteon	ROZEREM	P	J8499	ESI (option 1)	
ramucirumab	CYRAMZA	M	J9308	eviCore (option 3)	Oncology

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ranibizumab	LUCENTIS	M	J2778	CCUM (option 2)	
ranibizumab intravitreal implant	SUSVIMO IMPLNT AND INSERT TOOL	M	C9093 J2779	WPS	
ranibizumab-eqrn	CIMERLI	M	Q5128	CCUM (option 2)	
ranibizumab-nuna	BYOOVIZ	M	Q5124	CCUM (option 2)	
rasburicase	ELITEK	M	J2783	eviCore (option 3)	Oncology
ravulizumab-cwvz	ULTOMIRIS	M	J1303	CCUM (option 2)	
regorafenib - oral	STIVARGA	P	J8999	eviCore (option 3)	Oncology
relugolix - oral	ORGOVYX	P	J8999	eviCore (option 3)	Oncology
remdesivir	VEKLURY	M	J0248	CCUM (option 2)	
remimazolam	BYFAVO	P	J8499	ESI (option 1)	
repotrectinib	AUGTYRO	P	J8999	eviCore (option 3)	
reslizumab	CINQAIR	M	J2786	CCUM (option 2)	
retifanlimab-dlwr	ZYNYZ	M	J9345	eviCore (option 3)	Oncology
rezafungin	REZZAYO	M	J0349	CCUM (option 2)	
ribavirin	COPEGUS, MODERIBA, REBETOL, RIBAPAK, RIBASPHERE, RIBATAB, VIRAZOLE	P	J8499	ESI (option 1)	
ribociclib - oral	KISQALI	P	J8999	eviCore (option 3)	Oncology
ribociclib succinate/letrozole	KISQALI FEMARA CO-PACK	P	J8999	ESI (option 1)	Oncology
riboflavin 5'-phosphate (ophthalmic)	PHOTREXA	M	J2787	WPS	
rilonacept	ARCALYST	P	J2793	ESI (option 1)	
rimabotulinumtoxin b	MYOBLOC	M	J0587	CCUM (option 2)	
rimegepant	NURTEC ODT	P	J3490	ESI (option 1)	
riociguat	ADEMPAS	P	J8499	ESI (option 1)	
ripretinib - oral	QINLOCK	P	J8999	eviCore (option 3)	Oncology
risankizumab-rzaa	SKYRIZI, SKYRIZI ON-BODY, SKYRIZI PEN	P	J2327	ESI (option 1)	
risdiplam	EVRYSDI	P	J3490	ESI (option 1)	

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risedronate/calcium	ACTONEL w/CALCIUM	P	J8499	ESI (option 1)	
rituximab	RITUXAN	M	J9310 J9312	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
rituximab and hyaluronidase human	RITUXAN HYCELA	M	J9311	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
rituximab-abbs	TRUXIMA	M	Q5115	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
rituximab-arrx	RIABNI	M	Q5123	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
rituximab-pvvr	RUXIENCE	M	Q5119	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
rolapitant - oral	VARUBI	P	J8670	eviCore (option 3)	Oncology
romidepsin (lypohilized)	ISTODAX	M	J9319	eviCore (option 3)	Oncology
romidepsin (non-lyophilized)	ROMIDEPSIN, NON-LYOPHILIZED	M	J9318	eviCore (option 3)	Oncology
romiplostim	NPLATE	M	J2796	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
romosozumab	EVENITY	M	J3111	CCUM (option 2)	
ropeginterferon alfa-2b-njft	BESREMI	M	J9999 C9399	eviCore (option 3)	Oncology
rosuvastatin	EZALLOR SPRINKLE	P	J8499	ESI (option 1)	
rozanolixizumab-noli	RYSTIGGO	M	J9333	CCUM (option 2)	
rucaparib - oral	RUBRACA	P	J8999	eviCore (option 3)	Oncology
rufinamide	BANZEL	P	J8499	ESI (option 1)	
ruxolitinib - oral	JAKAFI	P	J8999	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
sacituzumab govitecan-hziy	TRODELVY	M	J9317	eviCore (option 3)	Oncology
sacrosidase	SUCRAID	P	J8499	ESI (option 1)	
safinamide	XADAGO	P	J8499	ESI (option 1)	
sapropterin dihydrochloride	JAVYGTOR, KUVAN	P	J8499	ESI (option 1)	
sapropterin dihydrochloride	SAPROPTERIN DIHYDROCHLORIDE	P	J8499	ESI (option 1)	

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sargramostim	LEUKINE	P	J2820	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
sarilumab	KEVZARA	P	J3590	ESI (option 1)	
satralizumab-mwge	ENSPRYNG	P	J3590	ESI (option 1)	
saxagliptin	ONGLYZA	P	J8499	ESI (option 1)	
saxagliptin/metformin	KOMBIGLYZE XR	P	J8499	ESI (option 1)	
sebelipase alfa	KANUMA	M	J2840	CCUM (option 2)	
secukinumab	COSENTYX, COSENTYX SYRINGE (SC Only)	P	C9166	ESI (option 1)	
secukinumab	COSENTYX (IV Only)	M	J3247 C9166	ESI (option 1)	
selexipag	UPTRAVI	P	J8499	ESI (option 1)	
selinexor - oral	XPOVIO	P	J8999	eviCore (option 3)	Oncology
selpercatinib - oral	RETEVMO	P	J8999	eviCore (option 3)	Oncology
selumetinib - oral	KOSELUGO	P	J8999	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
semaglutide	OZEMPIC	P	J3490	ESI (option 1)	
semaglutide	RYBELSUS	P	J8499	ESI (option 1)	
serdexmethylphenidate and dexmethylphenidate	AZSTARYS	P	J8499	ESI (option 1)	MH/SUD
setmelanotide acetate	IMCIVREE	P	J8499	ESI (option 1)	
short ragweed pollen (inj)	RAGWITEK	P	J8499	ESI (option 1)	
short ragweed pollen (sl tablet)	SHORT RAGWEED	P	J8499	ESI (option 1)	
sildenafil citrate	REVATIO	P	J8499 S0090	ESI (option 1)	
sildenafil citrate	SILDENAFIL CITRATE	P	J8499 S0090	ESI (option 1)	
siltuximab	SYLVANT	M	J2860	eviCore (option 3)	Oncology
simeprevir	OLYSIO	P	J8499	ESI (option 1)	
siponimod	MAYZENT	P	J3590	ESI (option 1)	
sipuleucel-t	PROVENGE	M	Q2043	eviCore (option 3)	Oncology

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sirolimus protein-bound particles for injectable suspension (albumin bound)	FYARRO	M	J9331	eviCore (option 3)	Oncology
sitagliptin	JANUVIA	P	J8499	ESI (option 1)	
sitagliptin/metformin	JANUMET (XR)	P	J8499	ESI (option 1)	
sod phenylbutyrat/taurursodiol	RELYVRIO	P	J3490	ESI (option 1)	
sodium oxybate	XYREM, LUMRYZ	P	J8499	ESI (option 1)	MH/SUD
sodium phenylbutyrate	OLPRUVA	P	J3490	ESI (option 1)	
sodium thiosulfate injection	PEDMARK, HOPE	M	J0208 J0209	eviCore (option 3)	Oncology
sodium, calcium, mag, pot oxybate	XYWAV	P	J8499	ESI (option 1)	MH/SUD
sofosbuvir	SOVALDI	P	J8499	ESI (option 1)	
sofosbuvir/velpatas/voxilaprev	VOSEVI	P	J8499	ESI (option 1)	
sofosbuvir/velpatasvir	EPCLUSA	P	J8499	ESI (option 1)	
sofosbuvir/velpatasvir	SOFOSBUVIR-VELPATASVIR	P	J8499	ESI (option 1)	
solifenacin	VESICARE	P	J8499	ESI (option 1)	
somatropin	GENOTROPIN, HUMATROPE, NORDITROPIN, NORDITROPIN FLEXPRO, NORDITROPIN NORDIFLEX, NUTROPIN, NUTROPIN AQ, OMNITROPE, SAIZEN, SAIZENPREP, SEROSTIM, TEV-TROPIN, ZOMACTON, ZORBTIVE	P	J2941	ESI (option 1)	
sonidegib - oral	ODOMZO	P	J8999	eviCore (option 3)	Oncology
sorafenib tosylate	SORAFENIB	P	J8999	eviCore (option 3)	Oncology
sorafenib tosylate - oral	NEXAVAR	P	J8999	eviCore (option 3)	Oncology
sotorasib - oral	LUMAKRAS	P	J8999	eviCore (option 3)	Oncology
spesolimab-sbzo	SPEVIGO	M	J1747	CCUM (option 2)	
stiripentol	DIACOMIT	P	J8499	ESI (option 1)	
streptozocin	ZANOSAR	M	J9320	eviCore (option 3)	Oncology

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sucralfate malate, polymerized	PROTHELIAL	P	J3490	ESI (option 1)	
sucralfate malate, polymerized	SILATRIX	P	J3490	ESI (option 1)	
sumatriptan injection	SUMAVEL	P	J3490	ESI (option 1)	
sumatriptan/naproxen sodium	TREXIMET	P	J8499	ESI (option 1)	
sunitinib - oral	SUTENT	P	J8999	eviCore (option 3)	Oncology
sunitinib malate	SUNITINIB MALATE	P	J8999	eviCore (option 3)	Oncology
sutimlimab – jome	ENJAYMO	M	J1302	CCUM (option 2)	
suvorexant	BELSOMRA	P	J8499	ESI (option 1)	MH/SUD
tacrolimus	TACROLIMUS	P	J8999	ESI (option 1)	
tadalafil	ADCIRCA, ALYQ, CIALIS, TADLIQ	P	J8499	ESI (option 1)	
tadalafil	TADALAFIL	P	J8499	ESI (option 1)	
tafamidis meglumine	VYNDAQEL, VYNADMAX	P	J3490	ESI (option 1)	
tafasitamab-cxix	MONJUVI	M	J9349	eviCore (option 3)	Oncology
tafluprost ophthalmic	ZIOPTIN	P	J3490	ESI (option 1)	
tagraxofusp-erzs	ELZONRIS	M	J9269	eviCore (option 3)	Oncology
talazoparib - oral	TALZENNA	P	J8999	eviCore (option 3)	Oncology
taliglucerase alfa	ELELYSO	M	J3060	CCUM (option 2)	
talimogene laherparepvec	IMLYGIC	M	J9325	eviCore (option 3)	Oncology
talquetamab-tgvs	TALVEY	M	J3055 C9163	eviCore (option 3)	Oncology
tapinarof	VTAMA	P	C9399	ESI (option 1)	
tarlatamab-dlle	IMDRELLTRA	M	J3490 C9399	eviCore (option 3)	Oncology
tasimelteon	HETLIOZ LQ	P	J8499	ESI (option 1)	
tazarotene	TAZORAC	P	J3490	ESI (option 1)	
tazemetostat - oral	TAZVERIK	P	J8999	eviCore (option 3)	Oncology
tbo-filgrastim	GRANIX	M	J1447	eviCore (option 3)	Oncology
tebentafusp-tebn	KIMMTRAK	M	J9274	eviCore (option 3)	Oncology
teclistamab-cqyv	TECVAYLI	M	J9380 C9148	eviCore (option 3)	Oncology
teduglutide	GATTEX	P	J3490	ESI (option 1)	

Description	Alt Descriptions	Benefit Type P = Pharmacy** M = Medical	HCPCS Code	Reviewer ESI, CCUM, eviCore ☎: 1-800-475-1954 WPS ☎: 1-800-333-5003	Drug Comments MH/SUD = mental health/ substance use disorder
telotristat ethyl - oral	XERMELO	P	J8499	eviCore (option 3)	Oncology
temozolomide	TEMOZOLOMIDE	P	J8700	ESI (option 1)	
temozolomide - inj	TEMODAR	M	J9328	eviCore (option 3)	Oncology
temozolomide - oral	TEMODAR	P	J8700	eviCore (option 3)	Oncology
temsirolimus	TORISEL	M	J9330	eviCore (option 3)	Oncology
tenapanor	IBSRELA	P	J8499	ESI (option 1)	
teniposide	VUMON	M	Q2017	eviCore (option 3)	Oncology
tenofovir alafenamide	VEMLIDY	P	J8499	ESI (option 1)	
teplizumab-mzwv	TZIELD	M	J9381	CCUM (option 2)	
tepotinib - oral	TEPMETKO	P	J8999	eviCore (option 3)	Oncology
teprotumumab-trbw	TEPEZZA	M	J3241	CCUM (option 2)	
teriflunomide	AUBAGIO	P	J8499	ESI (option 1)	
teriparatide	FORTEO	P	J3110	ESI (option 1)	
teriparatide	TERIPARATIDE	P	J3110	ESI (option 1)	
tesamorelin acetate	EGRIFTA, EGRIFTA SV	P	J3490	ESI (option 1)	
testosterone	ANDRODERM, ANDROGEL, AXIRON, FORTESTA, STRIANT, TESTIM	P	J3490	ESI (option 1)	
testosterone cypionate	TESTOSTERONE CYPIONATE (office-administered)	M	J1060 J1070 J1071 J1080	WPS	
testosterone cypionate	TESTOSTERONE CYPIONATE (self-administered)	M	J1060 J1070 J1071 J1080	ESI (option 1)	
testosterone enanthate	TESTOSTERONE ENANTHATE (office-administered)	M	J3121	WPS	
testosterone enanthate	TESTOSTERONE ENANTHATE (self-administered)	M	J3121	ESI (option 1)	
testosterone gel	TESTOSTERONE GEL	P	J3490	ESI (option 1)	
testosterone gel	VOGELXO	P	J3490	ESI (option 1)	
testosterone nasal gel	NATESTO	P	J3490	ESI (option 1)	
testosterone pellets	TESTOPEL	M	S0189	WPS	

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testosterone undecanoate	AVEED	M	J3145	WPS	
tetrabenazine	TETRABENAZINE	P	J8499	ESI (option 1)	
tetrabenazine	XENAZINE	P	J8499	ESI (option 1)	
tezacaftor/ivacaftor	SYMDEKO	P	J8499	ESI (option 1)	
tezepelumab-ekko	TEZSPIRE	M	J2356	CCUM (option 2)	
thalidomide - oral	THALOMID	P	J8999	see comments	ESI - Non-Oncology (option 1) eviCore - Oncology (option 3)
thioguanine	TABLOID	P	J8999	eviCore (option 3)	Oncology
thiotepa	THIOPLEX	M	J9340	eviCore (option 3)	Oncology
thyrotropin alfa	THYROGEN	P	J3240	ESI (option 1)	
tildrakizumab	ILUMYA	M	J3245	CCUM (option 2)	
timolol ophthalmic	ISTALOL	P	J3490	ESI (option 1)	
timothy grass pollen allergen	STANDARDIZED TIMOTHY GRASS	P	J8499	ESI (option 1)	
tiopronin	THIOLA, THIOLA EC	P	J8499	ESI (option 1)	
tirbanibulin	KLISYRI	P	J3490	ESI (option 1)	
tirzepatide	MOUNJARO	P	J3490	ESI (option 1)	
tisagenlecleucel	KYMRIAH	M	Q2042	eviCore (option 3)	Oncology - CAR-T therapy
tisotumab vedotin-tftv	TIVDAK	M	J9273	eviCore (option 3)	Oncology
tivozanib - oral	FOTIVDA	P	J8999	eviCore (option 3)	Oncology
tixagevimab and cilgavimab	EVUSHELD	M	Q0220	CCUM (option 2)	
tobramycin/nebulizer	BETHKIS, KITABIS PAK, TOBI	P	J3490	ESI (option 1)	
tobramycin/nebulizer	TOBRAMYCIN	P	J3490	ESI (option 1)	
tobramycin/nebulizer	TOBRAMYCIN	P	J3490	ESI (option 1)	
tocilizumab	ACTEMRA	P	J3262	ESI (option 1)	
tocilizumab	ACTEMRA (IV-ONLY)	M	J3262	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
tocilizumab-aazg (biosimilar)	TYENNE (IV-ONLY)	M	J3490 J9999 C9399	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)

Description	Alt Descriptions	Benefit Type P = Pharmacy** M = Medical	HCPCS Code	Reviewer ESI, CCUM, eviCore ☎: 1-800-475-1954 WPS ☎: 1-800-333-5003	Drug Comments MH/SUD = mental health/ substance use disorder
tocilizumab-bavi (biosimilar)	TOFIDENCE (IV-ONLY)	M	Q5133	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
tofacitinib citrate	XELJANZ, XELJANZ XR	P	J8499	ESI (option 1)	
tofersen	QALSODY	M	J1304 C9157	CCUM (option 2)	
tolvaptan	JYNARQUE, SAMSCA	P	J8499	ESI (option 1)	
tolvaptan	TOLVAPTAN	P	J8499	ESI (option 1)	
topotecan - inj	HYCAMTIN	M	J9351	eviCore (option 3)	Oncology
topotecan - oral	HYCAMTIN	P	J8705	eviCore (option 3)	Oncology
toremifene citrate - oral	FARESTON	P	J8999	eviCore (option 3)	Oncology
toripalimab-tpzi	LOQTORZ	M	J3263	eviCore (option 3)	Oncology
trabectedin	YONDELIS	M	J9352	eviCore (option 3)	Oncology
tralokinumab-ldrm	ADBRY	P	J3590	ESI (option 1)	
trametinib - oral	MEKINIST	P	J8999	eviCore (option 3)	Oncology
trastuzumab	HERCEPTIN	M	J9355	eviCore (option 3)	Oncology
trastuzumab and hyaluronidase-oysk	HERCEPTIN HYLECTA	M	J9356	eviCore (option 3)	Oncology
trastuzumab-anns	KANJINTI	M	Q5117	eviCore (option 3)	Oncology
trastuzumab-dkst	OGIVRI	M	Q5114	eviCore (option 3)	Oncology
trastuzumab-dttb	ONTRUZANT	M	Q5112	eviCore (option 3)	Oncology
trastuzumab-pkrb	HERZUMA	M	Q5113	eviCore (option 3)	Oncology
trastuzumab-qyyp	TRAZIMERA	M	Q5116	eviCore (option 3)	Oncology
travoprost implant	IDOSE TR IMPLANT	M	J7355	CCUM (option 2)	
tremelimumab-actl	IMJUDO	M	J9347 C9147	eviCore (option 3)	Oncology
treprostinil	REMODULIN	M	J3285	CCUM (option 2)	
treprostinil	TYVASO, TYVASO DPI	P	J3285	ESI (option 1)	
treprostinil diolamine	ORENITRAM ER	P	J3285	ESI (option 1)	
treprostinil sodium	TREPROSTINIL	P	J3285	ESI (option 1)	
tretinoin	ATRALIN GEL, AVITA, RENOVA, RETIN-A, TRETIN-X	P	J3490 S0117	ESI (option 1)	

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tretinoin	TRETINOIN	P	J3490 S0117	ESI (option 1)	
triamcinolone acetonide, suprachoroidal	XIPERE	M	J3299 C9092	WPS	
trientine hcl	CLOVIQUE, SYPRINE	P	J8499	ESI (option 1)	
trientine hcl	TRIENTINE HCL	P	J8499	ESI (option 1)	
trifluridine/tipiracil - oral	LONSURF	P	J8999	eviCore (option 3)	Oncology
triheptanoin	DOJOLVI	P	J8499	ESI (option 1)	
trilaciclib	COSELA	M	J1448	eviCore (option 3)	Oncology
triptorelin	TRIPTODUR	M	J3316	CCUM (option 2)	
triptorelin pamoate	TRELSTAR	M	J3315	eviCore (option 3)	Oncology
tucatinib - oral	TUKYSA	P	J8999	eviCore (option 3)	Oncology
ublituximab	BRIUMVI	M	J2329	CCUM (option 2)	
ubrogepant	UBRELVY	P	J8499	ESI (option 1)	
umbralisib - oral	UKONIQ	P	J8999	eviCore (option 3)	Oncology
upadacitinib	RINVOQ	P	J8499	ESI (option 1)	
uridine triacetate	VISTOGARD, XURIDEN	P	J8499	ESI (option 1)	
urofollitropin	BRAVELLE	P	J3355	WPS	
urofollitropin	FERTINEX	P	J3355	WPS	
ustekinumab	STELARA	P	J3357 J3358 C9487	ESI (option 1)	
ustekinumab-auub (biosimilar)	WEZLANA (SC Only)	P	Q5137	ESI (option 1)	
ustekinumab-auub (biosimilar)	WEZLANA (IV Only)	M	Q5138	ESI (option 1)	
valbenazine tosylate	INGREZZA, INGREZZA INITIATION PACK	P	J8499	ESI (option 1)	
valoctocogene roxaparvovec-rvox	ROCTAVIAN	M	J1412	CCUM (option 2)	Gene Therapy
valrubicin	VALSTAR	M	J9357	eviCore (option 3)	Oncology
vandetanib	VANDETANIB	P	J8999	eviCore (option 3)	Oncology
vandetanib - oral	CAPRELSA	P	J8999	eviCore (option 3)	Oncology
vedolizumab	ENTYVIO	M	J3380	CCUM (option 2)	

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velaglucerase alfa	VPRIV	M	J3385	CCUM (option 2)	
velmanase alfa	LAMZEDE	M	J0217	CCUM (option 2)	
vemurafenib - oral	ZELBORAF	P	J8999	eviCore (option 3)	Oncology
venetoclax - oral	VENCLEXTA, VENCLEXTA STARTING PACK	P	J8999	eviCore (option 3)	Oncology
vericiguat	VERQUVO	P	J8499	ESI (option 1)	
verteporfin	VISUDYNE	P	J3396	ESI (option 1)	
vestronidase alfa-vjbk	MEPSEVII	M	J3397	CCUM (option 2)	
vibegron	GEMTESA	P	J8499	ESI (option 1)	
vigabatrin	SABRIL, VIGADRONE	P	J8499	ESI (option 1)	
vigabatrin	VIGABATRIN	P	J8499	ESI (option 1)	
vilazodone	VIIBRYD	P	J8499	ESI (option 1)	MH/SUD
viloxazine	QELBREE	P	J8499	ESI (option 1)	
viltolarsen	VILTEPSO	M	J1427	CCUM (option 2)	
vinblastine sulfate	VELBAN	M	J9360	eviCore (option 3)	Oncology
vincristine sulfate	ONCOVIN, VINCASAR PFS	M	J9370	eviCore (option 3)	Oncology
vincristine sulfate liposome	MARQIBO	M	J9371	eviCore (option 3)	Oncology
vinorelbine tartrate	NAVELBINE	M	J9390	eviCore (option 3)	Oncology
vismodegib - oral	ERIVEDGE	P	J8999	eviCore (option 3)	Oncology
voclosporin	LUPKYNIS	P	J8499	ESI (option 1)	
von willebrand factor	VONVENDI	M	J7179	CCUM (option 2)	
voretigene neparvovec-rzyl	LUXTURNA	M	J3398	CCUM (option 2)	Gene Therapy
vorinostat - oral	ZOLINZA	P	J8999	eviCore (option 3)	Oncology
vortioxetine	TRINTELLIX	P	J8499	ESI (option 1)	MH/SUD
vosoritide	VOXZOGO	P	J3490	ESI (option 1)	
voxelotor	OXBRYTA	P	J8499	ESI (option 1)	
vutrisiran	AMVUTTRA	M	J0225	CCUM (option 2)	
weed pollen-short ragweed	SHORT RAGWEED	P	J8499	ESI (option 1)	

Effective Date: 8/1/2024 ** If using a PBM other than Express Scripts (ESI) through WPS, refer to the other PBM

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yttrium 90 ibritumomab tiuxetan	ZEVALIN	M	A9543	eviCore (option 3)	Radiation Oncology
zanubrutinib - oral	BRUKINSA	P	J8999	eviCore (option 3)	Oncology
ziconotide	PRIALT	M	J2278	WPS	
zivafibercept	ZALTRAP	M	J9400	eviCore (option 3)	Oncology
zoledronic acid	ZOLEDRONIC ACID	M	J3489	see comments	CCUM - Non-Oncology (option 2) eviCore - Oncology (option 3)
zoledronic acid/mannitol-water	RECLAST	M	J3489	CCUM (option 2)	
zolpidem	EDLUAR	P	J8499	ESI (option 1)	MH/SUD
zolpidem spray	ZOLPIMIST	P	J8499	ESI (option 1)	MH/SUD
zolpidem sublingual	INTERMEZZO	P	J8499	ESI (option 1)	MH/SUD
zuranolone	ZURZUVAE	P	J8499	ESI (option 1)	MH/SUD

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Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services. Teladoc service is optional for WPS large and self-funded groups. If you are group leader for a large or self-funded group, check your plan or talk to an agent for more information on adding this great benefit for your employees. Health plans are underwritten by the Wisconsin Physicians Service Insurance Corporation and WPS Health Plan, Inc.

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Notice of privacy practices

Nonpublic Personal Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to the privacy practices of Wisconsin Physicians Service Insurance Corporation and The EPIC Life Insurance Company (collectively, "WPS"). It is effective on November 1, 2015 and will remain in effect until we replace it.

Our Rights and Responsibilities

WPS is required by law to maintain the privacy of your Protected Health Information ("PHI"), and to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. WPS is also required to notify you of any breach of your unsecured PHI.

WPS reserves the right to revise this notice at any time and to apply the revised terms to any PHI already in our possession and any PHI we may later receive. We will promptly redistribute this notice whenever material changes are made to its terms. You may request a copy of this notice at any time.

Uses and Disclosures of Protected Health Information

Here are a few examples of how WPS routinely uses and discloses your PHI. Please note that HIPAA permits these types of disclosures without your authorization.

Treatment. We may use your PHI and share it with your health care provider to manage the treatment you receive. Example: Your doctor sends us information about your medical history and diagnosis so we can prior authorize an upcoming surgery.

Payment. We may use and disclose your PHI to pay for your covered benefits. Example: We review your PHI to determine whether claims associated with a recent hospital visit are eligible for payment under your health plan.

Health Care Operations. We may use and disclose your PHI in connection with the administrative, financial, legal, and quality improvement activities that are necessary to run our business and to support the core functions of treatment and payment. Example: We may use your PHI to conduct quality assessment and improvement activities designed to enhance the efficiency, effectiveness, and performance of our services and improve customer satisfaction.

Business Associates. We may disclose your PHI to our business associates to provide necessary services to WPS, if such business associates have agreed in writing to protect the confidentiality of your PHI.

Plan Sponsors. If you are covered under a group health plan, we may disclose your eligibility, enrollment, and disenrollment information to the plan sponsor. We may disclose your PHI to the plan sponsor to permit the plan sponsor to perform certain administrative functions on behalf of the plan, but only if the plan sponsor agrees in writing to use the PHI appropriately and to protect it as required by law.

Persons Involved With Your Care. We may disclose your relevant PHI to family members, close friends, or others that you identify as being involved in decisions about your health care or payment for your health care. Before doing so, we will provide you with an opportunity to object to such uses or disclosures. If you are deceased or otherwise unavailable due to incapacity or an emergency, we will disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest.

Disasters and Medical Emergencies. We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. We may use or disclose your name, location, and general condition or death to notify or assist in the notification of a person involved in your care.

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Health-Related Benefits and Services. We may use and disclose your PHI to contact you about treatment alternatives, appointment reminders, or other health-related benefits and services that may be of interest to you.

Required Disclosures. We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services if necessary for an investigation being conducted by the Secretary; and upon request, to you or to individuals authorized by you, such as your personal representative.

Other Uses or Disclosures Permitted or Required by Law. We may also use or disclose your PHI:

- As required by state or federal law;
- For public health activities including reporting related to disease and vital statistics; abuse, neglect, or domestic violence; FDA oversight, and work-related illnesses or injuries;
- To personal representatives;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, funeral directors, and organ procurement organizations;
- To avert a serious and imminent threat of harm;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To certain specialized government functions such as the military, prisons, etc.; and
- As authorized by state worker's compensation laws.

Written Authorization. Unless you give us your written authorization, we will not use or disclose your PHI for purposes other than those described in this notice. We will not sell your PHI, or use or disclose your PHI for marketing purposes, or use or disclose your psychotherapy notes except as permitted by law, unless we have received your written authorization. If you give us written authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

State Law. State law may provide additional protection for specific medical conditions or PHI. For example, state law may prohibit us from disclosing or using information related to HIV/AIDS, mental health, alcohol or substance abuse and genetic information without your authorization. In these situations, we will follow the requirements of the applicable state law.

Your Rights

Inspect and Copy. With certain exceptions, you have the right to inspect or copy the PHI that we maintain on you. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we may charge you a reasonable, cost-based fee for staff time to locate and copy your PHI, and postage if you want the copies mailed to you. If we deny your request to access and inspect your information, you may request a review of the denial.

Amendment. You have the right to request that we amend the PHI that we maintain on you. Your request must be in writing and must provide a reason to support the requested amendment. We may deny your request to amend PHI if: (a) we did not create it and the originator remains available; (b) it is accurate and complete; (c) it is not part of the information that we maintain; or (d) it is not part of the information that you would be permitted to inspect and copy. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended.

Confidential Communications. You have the right to request that we contact you in a specific way or send mail to a different address.

Notice of privacy practices

Nonpublic Personal Information Privacy Practices

We will accommodate your request if (a) it is reasonable; (b) it specifies the alternative address or method of contact you would like us to use; (c) it clearly states that disclosure of the PHI to which your request pertains could endanger you; and (d) it continues to permit us to collect premiums and pay claims under your health plan. Please note that unless you requested confidential communications, an explanation of benefits (EOB) will be issued to the policyholder for all health care services you receive. EOBs typically identify the person who received care, the health care provider, and the type of care obtained. EOBs also include information about the amount charged and the amount covered by your health plan.

Request Restrictions. You have the right to request restrictions on how we use or disclose PHI about you for treatment, payment or health care operations. You also have the right to request restrictions on how we disclose PHI to someone who may be involved in your care or payment for your care, like a family member or friend. Except in the case of a disclosure to a health care provider when you have already paid for your care, we are not required to agree to these restrictions. If we do, we will abide by our agreement (except in an emergency). Your restriction request must be made to us in writing. A person authorized to make such an agreement on our behalf must sign any agreement to restrictions. We will not agree to restrictions on uses or disclosures that are legally required, or which are necessary for us to administer our business.

Disclosure Accounting. You have the right to receive an accounting of the disclosures we have made of your PHI. This accounting will not include disclosures made for treatment, payment, health care operations, to law enforcement or corrections personnel, pursuant to your authorization, directly to you, or for certain other activities. Your request for an accounting must be made in writing to us and must state a time period of six years or less for which you would like to receive the accounting. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Breach Notification. You have the right to be notified by us if there is a breach of your unsecured PHI.

Copy of Notice. You have the right to receive a paper copy of this notice upon request, even if you have received it electronically. Please contact us using the information listed at the end of this notice to submit your request.

Protection of PHI. WPS is committed to ensuring that your PHI is protected from unauthorized use or disclosure. We have implemented strong security measures and processes to keep oral, written and electronic PHI secure across our organization. For example, any employee or contractor who accesses your PHI must comply with all of our information security requirements including, but not limited to signing confidentiality agreements, completing annual information security training and using encryption when transmitting data to any external party.

Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure this person has this authority and can act for you before we take action.

Questions and Complaints

If you believe that WPS may have violated your privacy rights, or if you disagree with a decision we made regarding one of the individual rights provided to you under this notice, you may submit a complaint to us using the contact information provided at the end of this notice. You also may submit a written complaint to the Secretary of the U.S. Department of Health and Human Services. Office of Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201.

We will not retaliate against you in any way if you choose to file a complaint regarding our privacy practices.

Notice of privacy practices

Nonpublic Personal Information Privacy Practices

Wisconsin Physicians Service Insurance Corporation and The EPIC Life Insurance Company (collectively, "WPS"), are committed to protecting the confidential information of our customers. We at WPS value our relationship with you and take the protection of your personal information very seriously. This notice explains the types of information we collect, how we collect it, to whom we may disclose it, and how we keep it confidential and secure.

Information We May Collect. WPS may collect and use nonpublic personal information about you from the following sources:

- Information we receive from you on applications and other forms that are provided to us, such as your name, address, social security number, date of birth, marital status, dependent information, employment information, and medical history;
- Information about your transactions with us, our affiliates and others, such as health care claims, medical history, eligibility information, payment information, and service request, appeal and grievance information;
- Information we receive from consumer reporting agencies, employers and insurance companies, such as credit history, creditworthiness, and information verifying employment history or insurance coverage.

Information We May Disclose. WPS does not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. We share nonpublic personal information only to the extent necessary for us to take care of our customers' claims and other transactions involving our products and services.

When necessary, we share a customer's nonpublic personal information with our affiliates and disclose it to health care providers, other insurers, third party administrators, payors, vendors, consultants, government authorities, and their respective agents. These parties are required to keep nonpublic personal information confidential as required by law.

WPS does not share nonpublic personal information with other companies for those companies' marketing purposes. WPS may disclose nonpublic personal information to companies that perform marketing services on behalf of WPS or to companies with which we have joint marketing agreements. These companies are required by law to keep your nonpublic personal information confidential.

Confidentiality and Security. At WPS, we restrict access to nonpublic personal information to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards to protect nonpublic personal information against unauthorized access and use. These safeguards comply with federal regulations on the protection of nonpublic personal information.

WPS will amend this notice as necessary and appropriate to protect nonpublic personal information about our customers.

Contact Information. For additional information regarding this notice or our privacy practices in general, please contact us in one of the following ways:

- Call the toll-free Customer Service number on your WPS ID card.
- Contact the WPS Privacy Officer
  Write to us: WPS Health Solutions, Privacy Office, 1717 W. Broadway, P.O. Box 8190, Madison, WI 53708-8190;
  Email us at: WPSprivacyofficer@wpsic.com; or
  Call us at: 1-608-977-7500

You can also find detailed guidance about your health information privacy rights online at hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

WPS Powered By Auxiant WPS HEALTH INSURANCE

20928-009-2312

Certificate of Coverage – Preferred Provider Plan
for
Medical College of Wisconsin Affiliated Hospitals

Wisconsin Physicians Service Insurance Corporation
1717 West Broadway
P.O. Box 8190
Madison, Wisconsin 53708-8190

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NON-PREFERRED PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-preferred provider for a covered health care service, benefit payments to such non-preferred providers are not based upon the amount billed. The basis of your benefit payment will be determined according to your Schedule of Benefits and the usual and customary charge, as determined by us. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND CO-PAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-preferred providers may bill you for any amount up to the billed charge after we have paid our portion of the bill. Preferred providers have agreed to accept discounted payment for covered health care services with no additional billing to you other than co-payment, coinsurance and deductible amounts. You may obtain further information about the preferred status of health care providers and information on out-of-pocket expenses by calling the Customer Service toll-free telephone number on your identification card or visiting our website at wpshealth.com.

This certificate is not the contract of insurance. It is merely evidence of insurance provided under the group medical insurance policy (hereinafter called "group policy" or "policy") issued by WPS to the group policyholder (hereinafter called "group policyholder" or "policyholder"). This certificate describes the essential features of such insurance. This certificate replaces and supersedes any certificates and endorsements we issued to you prior to the effective date of this certificate.

You are responsible for choosing your preferred provider from our most recent Preferred Provider Directory. The preferred providers and all other health care providers are independent contractors and are not employed by WPS. WPS merely provides benefits for covered expenses in accordance with the group policy. WPS does not provide health care services. WPS does not warrant or guarantee the quality of the health care services provided by any preferred provider or any other health care provider. WPS is not liable or responsible in any way for the provision of such health care services by any preferred provider or any other health care provider. Please see subsection "Your Relationship with Your Physician, Hospital or Other Health Care Provider" of this certificate.

The insurance described in this certificate limits charges for covered expenses to the amounts we determine as being reasonable. This amount may be less than the amount billed. Please see the definition of "charge" in section "DEFINITIONS." If you would like more information, please contact our Customer Service Department by calling the telephone number shown on your WPS identification card.

This certificate does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your agent or the Federally-Facilitated Marketplace, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

In performing its obligations under the policy, WPS is acting only as a health insurer with respect to the policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), or any other federal or state law.

The group policy is issued by WPS and delivered to the policyholder in Wisconsin. All terms, conditions, and provisions of the group policy, including, but not limited to, all exclusions and coverage limitations contained in the group policy, are governed by the laws of Wisconsin. All benefits are provided in accordance with the terms, conditions, and provisions of the group policy, any endorsements attached to this certificate, your completed application for this insurance, and applicable laws and regulations.

Wisconsin Physicians Service Insurance Corporation

Wendy J. Perkins
President and Chief Executive Officer

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SCHEDULE OF BENEFITS

Unless otherwise stated in the policy, all health care services are subject to the annual deductible amounts, copayments, coinsurance, and out-of-pocket limit stated below and all other exclusions and limitations described in the policy (e.g., medical necessity, prior authorization requirements, visit limits, step therapy, etc.).

You and your health care provider must obtain prior authorization before receiving certain health care services. Failure to obtain our prior authorization will result in no benefits being paid. Refer to the "OBTAINING SERVICES" section of the policy for information about our prior authorization requirements.

Deductible		
The annual deductible amount applies each policy year. Charges for covered expenses directly provided to you must add up to this deductible amount before benefits are payable for other charges for covered expenses, unless specifically stated otherwise below. Charges for covered expenses for health care services applied by us to satisfy the annual deductible amount for preferred providers will also be used to satisfy the annual deductible amount for non-preferred providers and vice versa. Medical services and supplies provided by a non-preferred provider but performed at a preferred facility will be paid subject to the applicable preferred provider deductible except as stated in subsection "OBTAINING SERVICES / Non- Preferred Provider Benefits."		
	Preferred Providers	Non-Preferred Providers
Per Covered Person	$300	$900
Per Family	$900	$2,700
Office Visit Copayment		
The copayment amount applies to the charge for each office visit. The copayment does not apply to: (1) related health care services provided during the home or office visit; or (2) charges billed by a facility for an office visit.		
	Preferred Providers	Non-Preferred Providers
Primary care physician	$20	$25
Specialty physician	$35	$45
Chiropractor	$20	$25
Psychologist, psychiatrist, or a health care provider licensed to provide non-residential treatment of nervous or mental disorders, alcoholism or drug abuse	$20	$25
Convenient Care Clinic	$20	$25
Preventive	Not Applicable	$25
Telehealth visits through our approved telehealth service provider	$10	Not Applicable

Coinsurance		
Coinsurance is the amount you pay for a covered service as stated below, unless specifically stated otherwise in the policy.		
	Preferred Providers	Non-Preferred Providers
Coinsurance	10%	30%
Annual Out-of-Pocket Limit		
This is the out-of-pocket amount that you are required to pay each policy year for covered health care services provided by a preferred provider or non-preferred provider. Any of the following costs will count towards your annual out-of-pocket limit: (1) your deductible; and (2) coinsurance amounts you pay for covered expenses associated with health care services provided by a preferred provider or non-preferred provider. Charges for covered expenses for health care services applied by us to satisfy the annual deductible and coinsurance out-of-pocket limit for preferred providers will also be used to satisfy the annual out-of-pocket limit for non-preferred providers and vice versa. Radiology, pathology, anesthesia, and emergency room services provided by a non-preferred provider but performed at a preferred facility will be paid subject to applicable preferred provider out-of-pocket limit. Medical services and supplies provided by a non-preferred provider but performed at a preferred facility will be paid subject to the applicable preferred provider out-of-network limit except as stated in section "OBTAINING SERVICES / Non- Preferred Provider Benefits."		
	Preferred Providers	Non-Preferred Providers
Per Covered Person	$800	$2,400
Per Family	$2,400	$7,200
Maximum Annual Out-of-Pocket Limit		
This is the maximum out-of-pocket amount that you are required to pay each policy year for covered health care services provided by a preferred provider or non-preferred provider. Any of the following costs will count towards your annual out-of-pocket limit: (1) your deductible; (2) copayments; and (3) coinsurance amounts you pay for covered expenses associated with health care services provided by a preferred provider or non-preferred provider. Charges for covered expenses for health care services applied by us to satisfy the annual deductible and coinsurance out-of-pocket limit for preferred providers will also be used to satisfy the annual out-of-pocket limit for non-preferred providers and vice versa. Radiology, pathology, anesthesia, and emergency room services provided by a non-preferred provider but performed at a preferred facility will be paid subject to applicable preferred provider out-of-pocket limit. Medical services and supplies provided by a non-preferred provider but performed at a preferred facility will be paid subject to the applicable preferred provider out-of-network limit except as stated in section "OBTAINING SERVICES / Non- Preferred Provider Benefits."		
	Preferred Providers	Non-Preferred Providers
Per Covered Person	$7,350	$7,350
Per Family	$14,700	$14,700
Covered Expenses – Excluding Prescription Legend Drugs Dispensed by a Pharmacy		
We'll pay benefits for charges for the following covered expenses, subject to the applicable deductible, copayment and out-of-pocket limits stated above.		
	The Amount You Pay for Services Provided by Preferred Providers	The Amount You Pay for Services Provided by Non-Preferred Providers
Ambulance Services	Deductible and Coinsurance	Preferred Provider Deductible and Coinsurance
Autism Services	Deductible and Coinsurance	Deductible and Coinsurance

Behavioral Health Services (treatment of alcoholism, drug abuse and nervous or mental disorders) Inpatient Services Office Visits Transitional Treatment	 Deductible and Coinsurance Copayment, then 0% Deductible and Coinsurance	 Deductible and Coinsurance Copayment, then 0% Deductible and Coinsurance
Breastfeeding Equipment	You have no cost sharing responsibility	Deductible and Coinsurance
Contraceptives	You have no cost sharing responsibility	Deductible and Coinsurance
Diagnostic X-Ray and Laboratory Services – outpatient (excluding services in a hospital emergency room)	Coinsurance	Coinsurance
Emergency Medical Care	Payable subject to applicable preferred provider deductible and coinsurance	
Emergency Room – visit charge only	Deductible and Coinsurance	Preferred Provider Deductible and Coinsurance
Emergency Room Services	Coinsurance	Preferred Provider Coinsurance
Hospital Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	You have no cost sharing responsibility	You have no cost sharing responsibility
Injections (other than injections billed as a surgical procedure) - outpatient	Coinsurance	Deductible and Coinsurance
Kidney Disease Treatment	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional Counseling	You have no cost sharing responsibility	Deductible and Coinsurance
Office Visits – visit charge only	Copayment, then 0%	Copayment, then 0%
Preventive Care Services- Office Visit Diagnostic Services	 You have no cost sharing responsibility You have no cost sharing responsibility	 Copayment, then 0% Deductible and Coinsurance
Sterilization Procedures – Female	You have no cost sharing responsibility	Deductible and Coinsurance
Sterilization Procedures – Male	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth Visits through our approved telehealth service provider	Copayment, then 0%	Not Covered
Temporomandibular Joint Disorders (TMJ)	Deductible and Coinsurance	Deductible and Coinsurance
Therapy Visits – Office Setting Outpatient Hospital Setting	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Transplants Services Inpatient Services All Other Services	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Urgent Care-visit charge only Copayment could be higher depending on the specialty of the physician providing treatment	Copayment, then 0%	Deductible and Coinsurance

All Other Health Care Services	Deductible and Coinsurance	Deductible and Coinsurance
Prescription Legend Drug Coverage		
The following provisions apply when covered drugs or covered supplies are dispensed by a preferred pharmacy. Covered drugs or covered supplies dispensed by non-preferred pharmacy are limited to the amount that would have been payable if dispensed by a preferred pharmacy.		
	Preferred Pharmacy	
Copayments: *Copayments applied as follows: 1-30-day supply = one copayment 31-60-day supply = two copayments 61-90-day supply = three copayments	Dispensed by a Pharmacy* Generic - $10 Preferred Brand-Name - $20 Brand-Name – $30 Specialty – $40	Dispensed by Home Delivery Generic - $20 Preferred Brand-Name - $40 Brand-Name - $60 Specialty – $40
Coinsurance (after copayments)	0%	
Preventive Drugs – as defined in policy	0%	
Expanded Preventive Drugs	0%	

GENERAL INFORMATION

How Group Coverage Works

WPS has issued a group policy to your employer, who we call the "policyholder." The group policy (the "policy") forms a contract between us and your employer under which we provide health insurance coverage for certain employees. This certificate describes the health insurance benefits you are entitled to receive. We provide the benefits described in this certificate under the terms, conditions and provisions of the group policy.

Any employee to whom we issue this certificate is a "covered employee." Any person that is eligible and approved to receive health insurance coverage under this certificate, including the covered employee, is a "covered person." For example, if a covered employee is issued limited family or family coverage under the group policy, the covered employee and his/her eligible dependents that we have approved for coverage are all covered persons. Subject to the group policy, each covered person is insured for the coverage described in this certificate. Please see subsection "Entire Contract."

General Description of Coverage

This certificate describes two benefit levels. One benefit level applies when you receive covered health care services provided from a preferred provider. The other benefit level applies when you receive covered health care services from a non-preferred provider.

Coverage is subject to all terms, conditions and provisions of the policy. This certificate replaces and supersedes any certificates we issued to the policyholder before the effective date of the policy and any written or oral representations that we or our representatives made.

Your Choice of Health Care Providers Affects Your Benefits

Preferred providers are health care providers who are part of the preferred provider network shown on your WPS identification card. See section "DEFINITIONS" for more information.

If you use a preferred provider, covered charges will be payable under the policy based on that provider's agreement with WPS, subject to any deductible, coinsurance, and copayment provisions. If there is a difference between the amount we pay and the amount the preferred provider bills, you are not responsible for that amount.

Non-preferred providers are health care providers who have not agreed to participate in the health care network shown on your WPS identification card.

If you use a non-preferred provider, covered charges will be payable under the policy up to the maximum out-of-network allowable fee as defined in section "DEFINITIONS." If there is a difference between the amount we pay and the amount the non-preferred provider bills, you are responsible for that amount.

How to Use This Certificate

This certificate, including its Schedule of Benefits and all endorsements, should be read carefully and completely by you. The provisions of this certificate are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear or full understanding of your coverage under the policy.

Each term used in this certificate has a special meaning. These terms are defined for you in section "DEFINITIONS." By understanding these definitions, you will have a better understanding of your coverage under the policy.

Changes to the Policy

We reserve the right to change, interpret, modify, remove or add benefits, or terminate the policy, at our sole discretion, subject to the notice requirements stated in subsection "Waiver and Change." When a change occurs, a new certificate or endorsement for this certificate will be made available to each covered employee online. That means your coverage under the policy will change to the extent described in the new certificate or endorsement, as of the effective date of that new certificate or endorsement. No person or entity other than WPS has the authority to make oral changes or amendments to the policy.

Covered Expenses

The policy only provides benefits for certain health care services. Just because a physician has performed or prescribed a health care service does not mean that it will be covered under the policy. Likewise, just because a health care service is the only available health care service for your illness or injury does not mean that the health care service will be covered under the policy. We have the sole and exclusive right to interpret and apply the policy's provisions and to make factual determinations. This means, for example, we also have the sole and exclusive right to determine whether benefits are payable for a particular health care service.

In certain circumstances for purposes of overall cost savings or efficiency, we may at our sole discretion, pay benefits for health care services: (1) at the preferred provider level of benefits for a health care service provided by a non-preferred provider; or (2) that are not covered under the policy, to the limited extent provided in subsection "Alternate Care." The fact that we provide such coverage in one case shall not require us to do so in any other case, regardless of any similarities between the two.

We may, at our sole discretion, arrange for other persons or entities to provide administrative services in regard to the policy, including claims processing and utilization review management services. We may also, at our sole discretion, authorize other persons or entities to exercise discretionary authority with regard to the policy. The identity of these persons or entities and the nature of the services they provide to us may be changed at any time without prior notice to or approval from you. By accepting this certificate, you agree to cooperate fully with those persons or entities in the performance of their responsibilities.

OBTAINING SERVICES

Preferred Provider Benefits

1. Unless otherwise stated in the Policy, the preferred provider benefits shown in your Schedule of Benefits are payable when health care services are received from any of the following:

a. A preferred provider;

b. A non-preferred provider if you are receiving covered emergency medical care; You will not incur any greater costs than if the covered service had been provided by a preferred provider;

c. A radiologist, pathologist, or anesthesiologist who is on staff at a preferred hospital, or performed at a preferred hospital, or ordered by a preferred provider;

d. A non-preferred provider if you are receiving air ambulance services

Charges for covered expenses received from a non-preferred provider are limited to the amounts which are determined as being the maximum allowable fee.

2. Preferred providers are not permitted to bill you for any medically necessary covered expenses above the maximum allowable fee. Health care services you receive from preferred providers are only subject to your cost sharing. Please see section "PAYMENT OF BENEFITS" for additional information about the costs you are responsible for under the Policy.

3. Non-preferred providers may bill you for the difference between the amount billed and the amount that we determine to be the maximum out-of-network allowable fee, as shown in paragraph C., below, even if the services are applied to your participating provider benefits under paragraph 1., above, except as stated in Paragraph 4. below.

4. Non-preferred providers providing (a) emergency medical care, (b) air ambulance services, or (c) a radiologist, pathologist, anesthesiologist, neonatologist, assistant surgeon, hospitalist, intensivist, or emergency room health care practitioner who is on staff at a participating hospital are not permitted to bill you for any covered expenses above the qualifying payment amount. Such health care services are only subject to your preferred provider cost sharing amount. Please see section "PAYMENT OF BENEFITS" for additional information about the costs you are responsible for under the Policy.

Non-Preferred Provider Benefits

1. If you receive health care services from a non-preferred provider, benefits are limited to the maximum out-of-network allowable fee and you will be responsible for paying any difference between that amount and the charge billed. For example, if the non-preferred provider's charge is $1,000 and the maximum out-of-network allowable fee is $700, you will be responsible for paying the remaining balance of $300 in addition to any applicable cost sharing amounts.

2. If you receive covered: (a) emergency medical care, (b) air ambulance services, or (c) health care services at a preferred facility, from a non-preferred provider, benefits are limited to the qualifying payment amount. You will not incur any greater costs than if the covered service had been provided by a preferred provider.

3. If you sign the non-preferred provider's No Surprises Act notice and consent form, benefits will be subject to paragraph 1. Above for the health care services described in the form. Exception: The notice and consent form will not apply to the following ancillary services provided by a non-preferred provider at a preferred facility: (a) health care services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; (b) health care services provided by assistant surgeons, hospitalists, and intensivists; (c) diagnostic services, including radiology and laboratory services; and (d) health care services provided by a non-preferred provider when a preferred provider is unavailable at the preferred facility.

Prior Authorization

You are required to obtain prior authorization before you receive certain health care services, such as pain management, spinal surgery, new technologies (may be considered experimental/ investigational/ unproven), non-emergency ambulance, high-cost durable medical equipment, certain high-technology imaging, or procedures that could potentially be considered cosmetic. You can find a current list of health care providers and health care services for which prior authorization is required on our website at wpshealth.com. Please refer to this website often, as it may change from time to time at our sole discretion.

1. How to Request a Prior Authorization.

Your health care provider can start the prior authorization process by calling our Customer Service Department at 1-800-223-6048 or by downloading a printable Prior Authorization Form from our website as wpshealth.com. After the health care provider faxes or mails the prior authorization request, we suggest that you call Customer Service to verify that it has been received. Please allow up to 15 business days for the review process.

Although your health care provider should initiate the prior authorization process, it is **your** responsibility to ensure that:

a. the prior authorization request form is obtained and completed in consultation with your health care provider;

b. the prior authorization request is submitted to and received by us;

c. the prior authorization request is approved by us before you obtain the applicable health care services.

After we review your request, we will send a written response to you and/or the health care provider who submitted the request. Our benefit determination(s) will be based upon the information available to us at the time we receive your request.

If we approve your request, our prior authorization will only be valid for: (a) the covered person for whom the prior authorization was made; (b) the health care services specified in the prior authorization and approved by us; and (c) the specific period of time and service location approved by us.

A standing authorization is subject to the same prior authorization requirements stated above. If we approve a standing authorization, you may request that the designated specialist provide primary care services, as long as your health care provider agrees.

2. Consequences for Failing to Obtain a Prior Authorization.

Failure to comply with the prior authorization process outlined in this subsection will initially result in no benefits being paid under the policy. If, however, a health care service is denied solely because you did not obtain our prior authorization, you can request that we review and reconsider the denial of benefits by following the Claim Appeal Procedure outlined in the policy. If you prove to us that the health care service would have been covered under your policy if you had followed the prior authorization process, we will overturn the prior authorization penalty and reprocess the affected claim(s) in accordance with your standard benefits.

3. Health Care Services That Do Not Require a Prior Authorization.

You do <u>not</u> need a prior authorization from us or any other person to obtain emergency care or urgent care at an emergency or urgent care facility.

Coding Errors

In some cases, we may deny a claim if we determine that the health care provider or its agent did not use the appropriate billing code to identify the health care service provided to you. We follow the coding guidelines of the Center for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS) and the International Class of Diseases and Related Health Problems 10th Edition (ICD-10).

DEFINITIONS

In this certificate, the following terms shall mean:

Activities of Daily Living (ADL): the following, whether performed with or without assistance:

1. Bathing which is the cleansing of the body in either a tub or shower or by sponge bath;

2. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;

3. Toileting which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;

4. Mobility, which is to move from one place to another, with or without assistance of equipment;

5. Eating, which is getting nourishment into the body by any means other than intravenous; and

6. Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

Ambulance Services: ground and air transportation: (1) to the nearest hospital where emergency health care services can be provided; (2) provided by a licensed ambulance service using its licensed and/or certified vehicle, helicopter, or plane which is designed, equipped, and used to transport you when you are sick or injured; and (3) which is staffed by emergency medical technicians, paramedics, or other certified medical professionals.

Behavioral Health Services: health care services for the treatment of alcoholism, drug abuse and nervous or mental disorders.

Benefits: your right to payment for covered health care services that are available under the policy. Your right to benefits is subject to the terms, conditions, limitations and exclusions of the policy, including this certificate, the Schedule of Benefits and any attached endorsements.

Bone Anchored Hearing Aid (BAHA): a surgically implantable system for treatment of hearing loss that works through direct bone conduction.

Calendar Year: the period of time that starts with your applicable effective date of coverage shown in our records, as determined by us, and ends on December 31st of such year. Each following calendar year shall start on January 1st of that year and end on December 31st of that same year.

Certificate: the certificate of coverage that is issued to covered employees summarizing the terms, conditions, and limitations of their group health care coverage.

Certified Nurse Midwife: a person who is a registered nurse and is certified to practice as a nurse midwife by the American College of Nurse Midwives and by either Wisconsin or by the state in which he/she practices.

Charge: an amount for a health care service directly provided to you by a health care provider that is reasonable, as determined by us, when taking into consideration, among other factors (including national sources) determined by us: (a) amounts charged by health care providers for similar health care services when provided in the same geographical area; (b) our methodology guidelines; (c) pricing guidelines of any third party responsible for pricing a claim; and (d) the negotiated rate determined by us in accordance with the applicable contract between us and a preferred provider. The term "area" means a county or other geographical area which we determine is appropriate to obtain a representative cross section of such amounts. For example, in some cases the "area" may be an entire state. In some cases the amount we determine as reasonable may be less than the amount billed. Charges are incurred on the date you receive the health care service.

As required by Section Ins 3.60, Wis. Admin. Code, as amended, upon written or oral request from you for our charge for a health care service and if you provide us with the appropriate billing code that identifies the health care service (for example, CPT codes, ICD-10 codes or hospital revenue codes) and the health care provider's estimated fee for that health care service, we will provide you with any of the following:

1. a description of our specific methodology, including, but not limited to, the following:

a. the source of the data used, such as our claims experience, an expert panel of health care providers, or other sources;

b. the frequency of updating such data;

c. the geographic area used;

d. if applicable, the percentile used by us in determining the charge; and

e. any supplemental information used by us in determining the charge.

2. The amount allowable by us under our guidelines for determination of the reasonable portion of the amount billed by the health care provider for a specific health care service provided to you in the geographic area where you received the health care service. That may be in the form of a range of payments or maximum payment.

Child/Children: any of the following:

1. A natural, biological child of a covered employee.

2. A step-child of a covered employee.

3. A legally adopted child or a child placed for adoption with the covered employee.

4. A child under the covered employee's (or his/her spouse's) legal guardianship as ordered by a court. To be initially eligible for coverage, the child must be under the age of 18 and you must have sole and permanent guardianship of both the child and his/her estate.

5. A child who is considered an alternate recipient under a qualified medical child support order.

6. The child of a covered employee's domestic partner provided that:

a. the domestic partner is enrolled as a covered person under the policy; and

b. the domestic partner is the biological parent or has a court-appointed legal relationship with the child (i.e. through adoption).

Cochlear Implant: any implantable instrument or device that is designed to enhance hearing.

Confinement/Confined: the period starting with your admission on an inpatient basis to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends with your discharge from the same hospital or other facility.

Convenient Care Clinic: a medical clinic that: (1) is located in a retail store, supermarket, pharmacy or other non-traditional, convenient, and accessible setting; and (2) provides covered health care services performed by nurse practitioners, physician assistants, or physicians acting within the scope of their respective licenses.

Copayment: the portion of the charge for a covered expense that you are required to pay to the health care provider for a certain health care service covered under the policy. Copayments are a specific dollar amount. Please note that for covered health care services, you are responsible for paying the lesser of the following: (1) the applicable copayment; or (2) the covered expense.

Cosmetic Treatment: any health care service used solely to: (1) change or improve your physical appearance or self-esteem; or (2) treat a condition that causes no functional impairment or threat to your health.

Cost Sharing: Your share of costs for health care services covered under the Policy that you must pay out of your own pocket limited to copayments, deductibles, and coinsurance. Other costs, including your premiums, amounts you pay for non-covered health care services, and amounts you pay that exceed the maximum allowable fee are not considered cost sharing.

Covered Dependent: a dependent who meets all of the following requirements: (1) he/she is eligible for coverage under the policy; (2) he/she has properly enrolled for coverage under the policy; and (3) he/she is approved by us for coverage under the policy.

Covered Employee: an eligible employee who has properly enrolled and been approved by us for coverage under the policy.

Covered Expenses: any charge, or any portion thereof, that is eligible for full or partial payment under the policy.

Covered Person: a covered employee and/or his/her covered dependent(s).

Custodial Care: health care services given to you if: (1) you do not require the technical skills of a registered nurse at all times; (2) you need assistance to perform one or more activities of daily living; and (3) the health care services you require are not likely to improve your physical and/or mental condition. Health care services may still be considered custodial care, as determined by us, even if: (1) you are under the care of a physician; (2) the physician prescribes health care services to support and maintain your physical and/or mental condition; or (3) health care services are being directly provided to you by a registered nurse or licensed practical nurse, a physical, occupational, or speech therapist, or a physician.

Deductible: the amount that you are required to pay for covered expenses in a policy year before benefits are payable under the policy.

Dependent: an individual who falls into one or more of the five categories below and who is not on active military duty for longer than 30 days:

1. A covered employee's legal spouse.

2. A covered employee's child, under the age of 26.

3. A covered employee's child who is a full-time student returning from military duty as defined in the policy.

4. A covered employee's child over age 26 if all of the following criteria are met:

- **a.** the child's coverage under the policy began before he/she reached age 26;
- **b.** the child is incapable of self-sustaining employment because of intellectual disability or physical handicap;
- **c.** the child is chiefly dependent upon the covered employee for support and maintenance;
- **d.** the child's incapacity existed before he/she reached age 26; and
- **e.** the covered employee's family coverage remains in force under the policy.

5. A natural child of a covered employee's child if the covered employee's child is under 18 years old.

6. If shown in the policyholder's current application for coverage as being applicable, a covered employee's domestic partner, provided all of the following conditions are met:

- **a.** the covered employee and his/her partner are in a committed relationship (relationship of mutual support, caring and commitment and intend to remain in such a relationship in the immediate future);
- **b.** each partner is 18 years of age or older;
- **c.** neither partner is married or legally separated in marriage, or has been a party to an action or proceeding for divorce or annulment within six months of registration, or, if one has been married, at least six months have lapsed since the date of the judgment terminating the marriage;
- **d.** each partner is competent to contract;
- **e.** neither partner is currently registered in another domestic partnership, and if either party has been in such a registered relationship, at least six months have lapsed since the effective date of termination of that registered relationship;
- **f.** there are no blood ties between the covered employee and his/her partner closer than that permitted for marriage or for domestic partner registration;

g. the covered employee and his/her partner live together (i.e., occupy the same dwelling unit as a single non-profit housekeeping unit and have a relationship which is of permanent and domestic character);

h. the relationship of the covered employee and his/her partner is not merely temporary, social, political, commercial or economic in nature (i.e., there must be mutual financial interdependency);

i. the covered employee has registered his/her partner as a domestic partner with the policyholder and WPS by providing proof that, for at least the six month period immediately preceding the date of registration, the covered employee either:

(1) had obtained a domestic partnership certificate from the city, county or state of residence or from any other city, county or state offering the ability to register a domestic partnership; or

(2) has any three of the following with respect to the domestic partner:

(a) joint lease, mortgage or deed;

(b) joint ownership of a vehicle;

(c) joint ownership of checking account (demand deposit) or credit account;

(d) designation of the domestic partner as a beneficiary of the covered employee's will;

(e) designation of the domestic partner as a beneficiary for the covered employee's life insurance or retirement benefits;

(f) designation of the partner as holding power of attorney for health care; or

(g) shared household expenses.

Developmental Delay: any disease or condition that interrupts or delays the sequence and rate of normal growth and development in any functional area and is expected to continue for an extended period of time or for a lifetime. Functional areas include, but are not limited to, cognitive development, physical development, communication (including speech and hearing), social/emotional development, and adaptive skills. Developmental delays can occur even in the absence of a documented identifiable precipitating cause or established diagnosis. Developmental delays may or may not be congenital (present from birth).

Durable Medical Equipment: an item that we determine meets all of the following requirements: (1) it can withstand repeated use; (2) it is primarily used to serve a medical purpose with respect to an illness or injury; (3) it is generally not useful to a person in the absence of an illness or injury; (4) it is appropriate for use in your home; (5) it is prescribed by a physician; and (6) it is medically necessary. Durable medical equipment includes, but is not limited to: wheelchairs; oxygen equipment (including oxygen); and hospital-type beds.

Eligible Employee: a person who is either (1) employed by the policyholder on a permanent, full-time basis (or part-time basis, if applicable) for the required number of hours per week as shown in the policyholder's current WPS application for coverage; or (2) identified by the policyholder as an employee that must be covered pursuant to the Patient Protection and Affordable Care Act.

Emergency Medical Care: health care services to treat your medical emergency.

Emergency Room Visit: a meeting between you and a physician or other health care provider that: (1) occurs at the hospital emergency room or any other facility charge as an extension of the hospital emergency room; (2) includes only the charges for the emergency room fee billed by the hospital for use of the hospital emergency room.

Enrollment Date: the effective date of coverage under the policy or the first day of the probationary period, if any, as shown in the policyholder's current application for coverage whichever is the earlier. A late enrollee's enrollment date will always be his/her effective date of coverage under the policy.

Enrollment Period: for new entrants, enrollment period is the period beginning immediately following an eligible employee's enrollment date through the 31st day immediately following the end of his/her probationary period, if any. For additions to, or changes in, coverage, the enrollment period is stated in section "EFFECTIVE DATE."

Experimental/Investigational/Unproven: as determined by our Corporate Medical Director, any health care service or facility that meets at least one of the following criteria:

1. It is not currently recognized as accepted medical practice;

2. It was not recognized as accepted medical practice at the time the charges were incurred;

3. It has not been approved by the United States Food and Drug Administration upon completion of Phase III clinical investigation;

4. It is being used in a way that is not approved by the United States Food and Drug Administration (FDA) or listed in the FDA-approved labeling (i.e. off-label use except for off-label uses that are accepted medical practice);

5. It has not successfully completed all phases of clinical trials, unless required by law;

6. It is based upon or similar to a treatment protocol used in on-going clinical trials;

7. Prevailing peer-reviewed medical literature in the United States has failed to demonstrate that it is safe and effective for your condition;

8. There is not enough scientific evidence to demonstrate or make a convincing argument that (a) it can measure or alter the sought after changes to your illness or injury or (b) such measurement or alteration will affect your health outcome; or support conclusions concerning the effect of the drug, device, procedure, service or treatment on health outcomes.

9. It is associated with a Category III CPT code developed by the American Medical Association.

The above list is not all-inclusive.

A health care service or facility may be considered experimental/investigational/unproven even if the health care provider has performed, prescribed, recommended, ordered, or approved it, or if it is the only available procedure or treatment for the condition.

The following are covered under the policy as described in subsection "Prescription Legend Drugs": (1) investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended; and (2) drugs which by law require a written prescription used in the treatment of cancer that may not currently have FDA's approval for that specific diagnosis but are listed in recognized off-label drug usage publications as appropriate treatment for that diagnosis.

The determination of whether a health care service is experimental or investigative shall be made by us in our sole and absolute discretion. In any dispute arising as a result of our determination, such determination shall be upheld if the decision is based on any credible evidence. In any event, if the decision is reversed, the limit of our liability under the policy or on any other basis shall be to provide policy benefits only and neither compensatory nor punitive damages, nor attorney's fees, nor other costs of any kind shall be awarded in connection therewith or as a consequence thereof.

Family Coverage: coverage that applies to a covered employee and his/her covered dependents. When referred to in this certificate, family coverage also includes limited family coverage.

Full-Time Student: a child in regular full-time attendance at an accredited secondary school, accredited vocational school, accredited technical school, accredited adult education school, accredited college or accredited university. Such school must provide a schedule of scholastic courses and its principal activity must be to provide an academic education. An apprenticeship program is not considered an accredited school, college or university for this purpose. Full-time student status generally requires that the student take 12 or more credits per semester; however, the exact number of credits per semester depends on the manner in which the school defines regular full-time status for its general student body; this may vary if the school has trimesters, quarters, or another type of schedule for its general student body. Proof of enrollment, course load and attendance is required upon our request. Full-time student status includes any regular school vacation period (summer, semester break, etc.).

Full-Time Student Returning From Military Duty: an adult child of a covered employee who meets the following criteria:

1. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education; and

2. The child was under the age of 27 when called to federal active duty; and

3. Within 12 months after returning from federal active duty, the child returned to an institution of higher education on a full-time basis, regardless of age.

The adult child must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a full-time student; or (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. The adult child continues to be a full-time student during periods of vacation or between term periods established by the school.

Functional Impairment: a significant and documented deviation, loss, or loss of use of any body structure or body function that results in a person's inability to regularly perform one or more activity of daily living or an instrumental activity of daily living such as using transportation, shopping or handling finances.

Genetic Testing: examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Geographical Service Area: the region in which your plan is available, as determined by us.

Group Policy/Policy: the group medical insurance policy issued by us to the employer known as the group policyholder. In it, we agree to insure certain members of the group policyholder for future health care services covered by the policy through benefit payments, subject to the terms, conditions and provisions of the policy.

Habilitative Services: health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include, but are not limited to, therapy for a child who isn't walking or talking at the expected age. These health care services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Provider: any physician, hospital, pharmacy, clinic, skilled nursing facility, surgical center or other person, institution or other entity licensed by the state in which he/she/it is located to provide health care services.

Health Care Services: diagnosis, treatment, services, procedures, drugs, medicines, devices, or supplies directly provided to you by a health care provider acting within the lawful scope of his/her/its license.

Hearing Aid: any externally wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except its batteries and cords.

Home Care: health care services provided directly to you in your home under a written plan that meets the following criteria: (1) the plan is developed by your attending physician; (2) the plan is approved by your attending physician in writing; (3) the plan is reviewed by your attending physician every two months (or less frequently if your physician believes and we agree that less frequent reviews are enough); and (4) home care is provided or coordinated by a home health agency or certified rehabilitation agency that is licensed by the Wisconsin Department of Health Services or certified by Medicare.

Hospice Care: health care services that are: (1) provided to a covered person whose life expectancy, as certified by a physician, is six consecutive months or less; (2) available on an intermittent basis with on-call health care services available on a 24-hour basis; and (3) provided by a licensed hospice care provider approved by us. Hospice care includes services intended primarily to provide pain relief, symptom management, and medical support services. Hospice care may be provided at hospice facilities or in your place of residence.

Hospital: a facility providing 24-hour continuous service to a confined covered person. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of licensed physicians and surgeons must provide or supervise its services. It must provide general hospital and major surgical facilities and services. A hospital also includes a specialty hospital approved by us and licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short term treatment for patients who have specified medical conditions. A hospital does not include, as determined by us: (1) a convalescent or extended care facility unit within or affiliated with the hospital; (2) a clinic; (3) a nursing, rest or convalescent home; (4) an extended care facility; (5) a facility operated mainly for care of the aged; (6) a facility operated mainly for treatment of nervous or mental disorders, drug abuse or alcoholism; (7) sub-acute care center; or (8) a health resort, spa or sanitarium.

Illness: a physical illness, alcoholism, drug abuse, or a nervous or mental disorder.

Implantable Hearing Device: any implantable instrument or device that is designed to enhance hearing, including cochlear implants and bone anchored hearing devices.

Incidental/Inclusive: a procedure or service is incidental/inclusive if it is integral to the performance of another health care service or if it can be performed at the same time as another health care service without adding significant time or effort to the other health care service.

Infertility: the inability or diminished ability to produce offspring including, but not limited to, a couple's failure to achieve pregnancy after at least 12 consecutive months of unprotected sexual intercourse or a woman's repeated failures to carry a pregnancy to fetal viability. Repeated failures to carry a pregnancy to fetal viability means three consecutive documented spontaneous abortions in the first or second trimester. Such inability must be documented by a health care provider.

Infertility or Fertility Treatment: a health care service that is intended to: (1) promote or preserve fertility; or (2) achieve and maintain a condition of pregnancy.

For purposes of this definition, infertility or fertility treatment includes, but is not limited to:

1. Fertility tests and drugs;

2. Tests and exams done to prepare for or follow through with induced conception;

3. Surgical reversal of a sterilized state that was a result of a previous surgery;

4. Sperm enhancement procedures;

5. Direct attempts to cause or maintain pregnancy by any means including, but not limited to:

- **a.** hormone therapy or drugs;
- **b.** artificial insemination;
- **c.** in vitro fertilization;

d. GIFT or ZIFT;

e. embryo transfer; and

f. freezing or storage of embryo, eggs, or semen; and

6. Evaluation and treatment of repeated failures to carry a pregnancy to fetal viability when not pregnant.

Late Enrollee: an eligible employee, or eligible dependent of an eligible employee, who does not request coverage under the policy during an enrollment period during which the person is entitled to enroll for coverage under the policy and who subsequently requests coverage under the policy.

A late enrollee does not include:

1. A person who:

a. was covered under creditable prior coverage at the time the person was eligible to enroll; and

b. states, at the time of enrollment, that coverage under another health benefit plan was the reason for declining enrollment; and

c. has lost coverage under creditable prior coverage, either voluntarily or involuntarily; and

d. requests enrollment within 31 days after the voluntary or involuntary loss of his/her creditable prior coverage; or

e. requests enrollment under the policy within 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus; or

f. requests enrollment under the policy within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, has been determined; or

2. A person who is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during an open enrollment period; or

3. A person who a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made.

Injury: bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes. An accident caused by chewing resulting in damage to your teeth is not considered an injury.

Limited Family Coverage: coverage that applies to: (1) a covered employee and his/her eligible spouse who is a covered dependent; or (2) a covered employee and his/her dependent children who are covered dependents.

Maintenance Care: health care services provided to you after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. Such care promotes optimal function in the absence of significant symptoms.

Medical Emergency: a medical condition that involves acute and abnormal symptoms of such severity (including severe pain) to lead a prudent sensible person who possesses an average knowledge of health and medicine would reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

1. Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;

2. Serious impairment to the person's bodily functions; or

3. Serious dysfunction of one or more of the person's body organs or parts.

Medically Necessary: a health care service or facility that we determine to be:

1. Consistent with and appropriate for the diagnosis or treatment of your illness or injury;

2. Commonly and customarily recognized and generally accepted by the medical profession in the United States as appropriate and standard care for the condition being evaluated or treated;

3. Substantiated by the clinical documentation;

4. The most appropriate and cost effective level of care that can safely be provided to you. Appropriate and cost effective does not necessarily mean the least expensive;

5. Proven to be useful or likely to be successful, yield additional information, or improve clinical outcome; and

6. Not primarily for the convenience or preference of the covered person, his/her family, or any health care provider.

A health care service or facility may not be considered medically necessary even if the health care provider has performed, prescribed, recommended, ordered, or approved the service, or if the service is the only available procedure or treatment for your condition.

Medical Services: health care services recognized by a physician to treat your illness or injury.

Medical Supplies: items that we determine to be: (1) used primarily to treat an illness or injury; (2) generally not useful to a person in the absence of an illness or injury; (3) the most appropriate item that can be safely provided to you and accomplish the desired end result in the most economical manner; and (4) not primarily for the patient's comfort or convenience; and (5) prescribed by a physician.

Miscellaneous Hospital Expenses: regular hospital costs (including take-home drug expenses) that we cover under the policy for treatment of an illness or injury requiring either: (1) inpatient hospitalization; or (2) outpatient health care services at a hospital. For outpatient health care services, miscellaneous hospital expenses include charges for: (1) use of the hospital's emergency room; and (2) emergency medical care provided to you at the hospital. Miscellaneous hospital expenses do not include room and board, nursing services, and ambulance services.

Nervous or Mental Disorders: clinically significant psychological syndromes that: (1) are associated with distress, dysfunction or physical illness; and (2) represent a dysfunctional response to a situation or event that exposes you to an increased risk of pain, suffering, conflict, physical illness or death. Behavior problems, learning disabilities or developmental delays are not nervous or mental disorders.

New Entrant: an eligible employee, or eligible dependent of an eligible employee, who:

1. Becomes part of the employer group after the commencement of the employer's initial enrollment period with us under the policy. A new entrant must enroll for coverage under the policy within 31 days immediately following the end of his/her probationary period;

2. Is a spouse or dependent child who a court orders be covered under the policy and who requests enrollment under the policy;

3. Failed to request coverage under the policy during an enrollment period, during which the person was entitled to enroll under the policy, if the person:

a. was covered under creditable prior coverage at the time of enrollment; and

b. loses his/her creditable prior coverage, either voluntarily or involuntarily; and

c. requests enrollment under the policy within 31 days immediately following the voluntary or involuntary loss of his/her creditable prior coverage; or

d. requests enrollment under the policy within 60 days after the loss of eligibility for Medicaid, including BadgerCare Plus; or

e. requests enrollment under the policy within 60 days after eligibility for premium assistance subsidy under Medicaid, including BadgerCare Plus, has been determined; and

f. states, at the time of enrollment, that coverage under another health benefit plan was the reason for declining enrollment; or

4. Is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during an open enrollment period.

Non-Preferred Provider: a health care provider that has not entered into a written agreement with the health care network selected by the policyholder or covered person.

Nurse Practitioner: a person who is licensed as a registered nurse under Chapter 441, Wisconsin Statutes, as amended, or the laws and regulations of another state and who satisfies any of the following:

1. Is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates;

2. Holds a master's degree in nursing from an accredited school of nursing;

3. Prior to March 31, 1990, has successfully completed a formal one-year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care, includes at least four months of classroom instruction and a component of supervised clinical practice, and awards a degree, diploma or certificate to individuals who successfully complete the program; or

4. Has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but that does not meet the requirements of 3. above, and has performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately before July 1, 1978.

Obesity: a body mass index (BMI) of 30 or greater. BMI is calculated by dividing your weight in kilograms by the square of your height in meters.

Office Visit: either of the following:

1. For health care services other than behavioral health services, a meeting between you and a physician or other health care provider that: (a) occurs at the provider's office, a medical clinic, convenient care clinic, an ambulatory surgical center, a free-standing urgent care center, skilled nursing facility, the outpatient department of a hospital, other than a hospital's emergency room, or in your home; and (b) includes you receiving medical evaluation and health management services (as defined in the latest edition of Physician's Current Procedural Terminology or as determined by us) or manipulations by a physician, other than services related to physical therapy.

2. For behavioral health services, a meeting between you and a licensed psychiatrist, a licensed or certified psychologist, or a health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse that: (a) occurs in the provider's office, a medical clinic, a free-standing urgent care center, skilled nursing facility, outpatient treatment facility, the outpatient department of a hospital, other than a hospital's emergency room, or in your home; and (b) involves you receiving psychotherapy, psychiatric diagnostic interviews, medication management, electro-shock therapy, behavioral counseling, or neuropsychological testing.

Oral Surgery: surgical services performed within the oral cavity.

Physical Illness: a disturbance in a function, structure or system of the human body that causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of health status or of the function, structure or system of the human body. Physical illness includes pregnancy and complications of pregnancy. Physical illness does not include alcoholism, drug abuse, or a nervous or mental disorder.

Physician: a person who:

1. Received one of the following degrees in medicine from an accredited college or university: Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O); Doctor of Dental Surgery (D.D.S); Doctor of Dental Medicine (D.D.M.); Doctor of Surgical Chiropody (D.S.C.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Optometry (O.D.); or Doctor of Chiropractic (D.C.);

2. Is a medical doctor or surgeon licensed by the state in which he/she is located; and

3. Practices medicine within the lawful scope of his/her license.

When we are required by law to cover the health care services of any other licensed medical professional under the policy, a physician also includes such other licensed medical professional who:

1. Is licensed by the state in which he/she is located;

2. Is acting within the lawful scope of his/her license; and

3, Provides a health care service that we determine to be a covered expense under the policy.

Placed For Adoption: any of the following:

1. The Wisconsin Department of Children and Families, a county department under Wis. Stat § 48.57(1)(e) or (hm), or a child welfare agency licensed under § 48.60 places a child in a covered employee's home for adoption and enters into an agreement under § 48.63 (3) (b) 4. Or § 48.833 (1) or (2) with the covered employee;

2. The Wisconsin Department of Children and Families, a county department under Wis. Stat. § 48.57 (1) (e) or (hm), or a child welfare agency under § 48.837(1r) places, or a court under § 48.837 (4)(d) or (6)(b) orders, a child placed in a covered employee's home for adoption;

3. A sending agency, as defined in Wis. Stat. § 48.988 (2)(d), places a child in a covered employee's home under § 48.988 for adoption, or a public child placing agency, as defined in § 48.99 (2)(r), or a private child placing agency, as defined in § 48.99 (2)(p), of a sending state, as defined in § 48.99 (2)(w), places a child in the covered employee's home under § 48.99 as a preliminary step to a possible adoption, and the covered employee takes physical custody of the child at any location within the United States;

4. The person bringing the child into this state has complied with Wis. Stat. § 48.98, and the covered employee takes physical custody of the child at any location within the United States; or

5. A court of a foreign jurisdiction appoints a covered employee as guardian of a child who is a citizen of that jurisdiction, and the child arrives in the covered employee's home for the purpose of adoption by the covered employee under Wis. Stat. § 48.839.

Policy Year: the period of 12 consecutive months intervening between any two consecutive occurrences of the policy year date. The policy year date is July 1.

Preferred Facility: a hospital or ambulatory surgery center that has entered into a written agreement with us to provide covered services to you as of the date upon which the services are provided. A hospital's or ambulatory surgery center's participation status may change from time to time. Please refer to our on-line directory or contact us for a listing of preferred facilities.

Preferred Physician/ Hospital/ Provider: a physician, hospital, or other health care provider that has entered into a written agreement with the health care provider network shown on your WPS identification card as of the date upon which the services are provided. The Preferred Provider Directory is available online at wpshealth.com or by request from WPS. A health care provider's preferred status may change from time to time so you should check it frequently. You may be required to pay a larger portion of the cost of a covered health care service if you see a non-preferred provider.

Preventive Care Services: health care services that are designed to: (1) evaluate or assess health and well-being, (2) screen for possible detection of unrevealed illness, (3) improve health, or (4) extend life expectancy, and that are not for the diagnosis or treatment of an illness or injury.

Primary Care Physician: a physician who directly provides or coordinates a range of health care services for a patient. A primary care physician's primary practice is Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics. A physician assistant, nurse practitioner, or certified nurse midwife may also act as a primary care physician.

Prior Authorization: written approval that you must receive from us before you receive certain health care services. Each prior authorization will state the type and extent of the treatment or other health care services that we have authorized.

Psychologist: a person who: (1) has received a doctoral degree in psychology from an accredited college or university; (2) is licensed by the state in which he/she is located; and (3) provides health care services while he/she is acting within the lawful scope of his/her license. A doctoral degree in psychology means a Doctor of Philosophy (Ph. D) or Doctor of Psychology (Psy. D) degree that involves the application of principles of the practice of psychology that is recognized by the American Psychological Association.

Reconstructive Surgery: surgery performed on abnormal structures of the body caused by: (1) congenital defects; (2) development abnormalities; (3) trauma; (4) infection; (5) tumors; or (6) disease. The presence of a psychological condition alone will not entitle you to coverage for reconstructive surgery.

Rehabilitative Services: health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Qualifying Payment Amount: the amount of reimbursement allowed for a covered health care service provided by a health care practitioner who is a non-participating provider for emergency medical care, air ambulance, or health care services provided while the covered person is receiving treatment at a participating provider facility. This amount will be determined in compliance with 42 U.S.C. 300gg et.seq.

Services: hospital services, surgical services, maternity services, medical services or any other service directly provided to you by a health care provider, as determined by us.

Single Coverage: coverage that applies only to a covered employee.

Skilled Nursing Care: health care services that: (1) are furnished pursuant to a physician's orders; (2) require the skills of professional personnel such as a registered nurse or a licensed practical nurse; and (3) provided either directly by or under the direct supervision of such professional personnel.

Skilled Nursing Facility: an institution or a designated part of one, including but not limited to, a sub-acute or rehabilitation facility that:

1. Is operating pursuant to state and federal law;

2. Is under the full time supervision of a physician or registered nurse;

3. Provides services seven days a week, 24 hours a day, including skilled nursing care and therapies for the recovery of health or physical strength;

4. Is not a place primarily for custodial or maintenance care;

5. Requires compensation from its patients;

6. Admits patients only upon a physician's orders;

7. Has an agreement to have a physician's services available when needed;

8. Maintains adequate records for all patients; and

9. Has a written transfer agreement with at least one hospital.

Sound Natural Teeth: teeth that: (1) are organic and formed by the natural development of the human body; (2) are not manufactured; (3) have not been extensively restored; (4) have not become extensively decayed or involved in periodontal disease; and (5) are not more susceptible to injury than whole organic teeth.

Specialty Physician: any physician whose primary practice is not one of the following: Family Practice, Internal Medicine, General Practice, Obstetrics/Gynecology and Pediatrics.

Supplies: medical supplies, durable medical equipment or other materials provided directly to you by a health care provider, as determined by us.

Supportive Care: health care services provided to a covered person whose recovery has slowed or ceased entirely so that only minimal rehabilitative gains can be demonstrated with continuation of such health care services.

Surgical Services: (1) an operative procedure performed by a physician that we recognize as treatment of an illness or injury; or (2) those services we identify as surgical services, including sterilization procedures and preoperative and postoperative care. Surgical services do not include: (1) the reversal of a sterilization procedure; (2) oral surgery; and (3) maternity services.

Telehealth: the delivery of health care services, the provision of health care information, and the transfer of medical data via telecommunications technologies, including but not limited to, telephone, interactive audio and video conferencing, and email. Telehealth does not include teleradiology.

Therapy Visit: a meeting between you and a physician, licensed physical, speech, or occupational therapist or any other health care provider approved by us that: (1) occurs in the provider's office, a medical clinic, convenient care clinic, free-standing urgent care center, skilled nursing facility, or the outpatient department of a hospital, other than a hospital's emergency room; and (2) involves you receiving physical, speech, occupational, or massage therapy.

Totally Disabled/Total Disability: being unable due to illness or injury to perform the essential functions of any job or, for dependents and retirees, to carry on most of the normal activities of a person of the same age and sex, as determined by us. You are not totally disabled if you are working on either a full-time or part-time basis for wage or profit for anyone, including working for yourself. To qualify as a totally disabled person, you must be under the regular care of a physician. We have the right to examine any covered person who claim that he/she is totally disabled as often as reasonably required for us to determine whether or not that person meets this definition. Such examinations may include, having health care providers or vocational experts examine that person.

Treatment: management and care directly provided to you by a physician or other health care provider for purposes of diagnosing, healing, curing, and/or combating an illness or injury, as determined by us.

Urgent Care: care received for an illness or injury with symptoms of sudden or recent onset that require medical care the same day.

Waiting Period: a period of time that must pass before an individual is eligible to be covered for benefits under the provisions of the policy.

We, Us, Our: Wisconsin Physicians Service Insurance Corporation.

Wisconsin Physicians Service Insurance Corporation: a service insurance corporation with its principal office in Monona, Wisconsin, organized and existing under Chapter 613 of the laws of Wisconsin.

WPS: Wisconsin Physicians Service Insurance Corporation.

You, Your: a covered person.

ELIGIBILITY

Eligible Employee

An eligible employee is a person who:

1. Appears on the policyholder's regular payroll records (excluding employees working on a temporary or substitute basis); and

2. Performs all of the duties of his/her principal occupation in his/her job with the policyholder for at least the minimum number of hours per week as shown in the policyholder's current WPS application for coverage; or

3. Is a sole proprietor, business owner, including the owner of a farm business, a partner of a partnership or a member of a limited liability company, if he/she is actively engaged in the policyholder's business on a full-time basis and is included as an employee under a health benefit plan of an employer; or

4. 1099 employees, if the policyholder elects to cover these employees as shown in the Employer's Group Application. These employees must meet the policy definition of full-time employees, work exclusively for the policyholder, and must work the entire year. Seasonal 1099 employees are not eligible for coverage.

An employee is eligible for coverage under the policy if he/she:

1. Is actively at work performing all of the duties of his/her principal occupation in his/her job with the policyholder and paid at least the minimum wage required by law for at least the minimum number of hours per week as shown in the policyholder's current WPS application for coverage;

2. Has completed his/her probationary period, if any, as shown in the policyholder's current WPS application for coverage; or

3. Is covered under any valid extension of coverage identified in section "WHEN COVERAGE ENDS."

Eligible Dependent

An eligible dependent is a person who is:

1. A covered employee's lawful spouse;

2. A covered employee's natural child, adopted child, child placed for adoption with the covered employee, step-child or legal ward who is less than 26 years of age;

3. A covered employee's child or step-child who is a full-time student as defined in the policy;

4. An unmarried natural child of a dependent child (as described in 2. above) until the dependent child is 18 years of age;

5. A covered employee's domestic partner provided all of the following conditions are met:

a. the covered employee and his/her partner must be in a committed relationship (relationship of mutual support, caring and commitment and intend to remain in such a relationship in the immediate future);

b. each partner must be financially responsible for each other's well-being and debts to third parties;

c. each partner must not be married or legally separated in marriage, and must not have been a party to an action or proceeding for divorce or annulment within six months of registration, or, if one has been married, at least six months have lapsed since the date of the judgment terminating the marriage;

d. neither partner is currently registered in another domestic partnership, and if either party has been in such a registered relationship, at least six months have lapsed since the effective date of termination of that registered relationship before registration of the current domestic partnership;

e. each partner must be 18 years of age or older and competent to contract;

f. the parties must not have blood ties closer than that permitted for marriage for one to qualify for domestic partner registration;

g. the parties must live together in the same dwelling unit as a single non-profit housekeeping unit and have a relationship which is of permanent and domestic character;

h. the relationship is not temporary, social, political, commercial or economic in nature;

i. the covered employee shall have had the relationship with the partner for at least six months;

j. a person may be registered in only one such partnership at a time; and

k. the covered employee must register his/her partner as a domestic partner with us providing proof that, for at least the six month period immediately preceding the date of registration, the covered employee had any three of the following with respect to the domestic partner:

(1) joint lease, mortgage or deed;

(2) joint ownership of a vehicle;

(3) joint ownership of checking account (demand deposit) or credit account;

(4) designation of the domestic partner as a beneficiary of the covered employee's will;

(5) designation of the domestic partner as a beneficiary for the covered employee's life insurance or retirement benefits;

(6) designation of the partner as holding power of attorney for health care; or

(7) shared household expenses.

If the employee has obtained a domestic partnership certificate from the city, county or state of residence or from any other city, county or state offering the ability to register a domestic partnership, they are not required to show proof of these items.

6. a covered employee's designated partner's child provided that:

a. the domestic partner is a member under the policy;

b. the domestic partner is the biological parent or has a court-appointed legal relationship with the child (i.e. adoption); and

c. the child is under age 26.

In the case of a child placed for adoption with the covered employee, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended.

A person is not an eligible dependent if he/she is:

1. Covered under the policy as a covered employee;

2. On active duty with the military service, including national guard or reserves, other than for duty of less than 30 days; or

3. A child, and such child is no longer eligible if adopted or placed for adoption and insured under the adopting person's coverage in accordance with Section 632.896, Wisconsin Statutes, as amended.

No person shall be considered as an eligible dependent of more than one employee insured as a covered employee under the policy.

An unmarried dependent child who is over the age of 26 may remain insured as a dependent under the policy if he/she meets certain requirements, provided the covered employee's family coverage remains in force under the policy. The child must:

1. Be unable to support himself/herself with a job because of intellectual disability or physical handicap;

2. Have become totally disabled before he/she reaches the age of 26; and

3. Be principally supported by the covered employee.

Written proof of the child's totally disabling condition must be given to us within 31 days of the child attaining age 26. Failure to provide such proof to us within that 31-day period shall result in the termination of that dependent child's coverage in accordance with section "WHEN COVERAGE ENDS."

EFFECTIVE DATE

If application for coverage is properly made on our application form by an eligible employee and the required premium for his/her coverage is submitted to WPS, the effective date of single or family coverage to be issued under the policy for that eligible employee and his/her eligible dependents, if any, shall be determined by WPS as follows:

Initial Enrollees

An initial enrollee is an eligible employee and his/her eligible dependents, if any, who enrolls during the policyholder's initial enrollment period with WPS. An initial enrollee's effective date shall be the policy's effective date. The eligible employee must be actively at work with the policyholder on his/her effective date of coverage under the policy. However, if an otherwise eligible employee is not actively at work on the date his/her coverage would otherwise become effective under the policy, his/her coverage, including family coverage for his/her eligible dependents if he/she enrolled such persons, shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

New Entrants

A new entrant's effective date of coverage under the policy will be determined by us as follows:

An eligible employee and/or his/her eligible dependents shall become insured as indicated in the policyholder's current application for coverage if they apply for single or family coverage under the policy within 31 days after: (1) the completion of the eligible employee's probationary period, if any, as shown in the policyholder's current application for coverage; or (2) the date the dependent becomes eligible, provided the employee has applied for family coverage under the policy. The application must be received by WPS within 31 days following the end of the enrollment period. However, if the application is received by us more than 31 days after his/her enrollment period ends, that employee and/or his/her dependents, if any, are late enrollees. Please see subsection "Late Enrollees" below.

If a covered employee waives coverage for his/her eligible dependents because those dependents are not living in the United States as of his/her effective date of coverage, those dependents will be considered new entrants provided the covered employee applies for coverage under the policy within 31 days of the dependent(s) becoming resident legal aliens. If the covered employee does not apply within that 31-day period, those dependents will be considered late enrollees. Please see subsection "Late Enrollees" below.

However, if an otherwise eligible employee is not actively at work with the policyholder for any reason, other than for any health reason, on the date his/her coverage would otherwise become effective under the policy, his/her single or family coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

Late Enrollees

A late enrollee (as defined in section "DEFINITIONS") may make written application to us only during the annual enrollment period. See subsection "Annual Enrollment Period."

A late enrollee must apply using our application form and pay the required premium for single or family coverage.

However, if an otherwise eligible employee is not actively at work with the policyholder for any reason, other than for any health reason, on the date his/her coverage would otherwise become effective under the policy, his/her single or family coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

Change in Marital Status

1. Changing From Single Coverage to Family Coverage Due to Marriage.

If a covered employee has single coverage and wishes to change to family coverage to add an eligible spouse due to his/her marriage, the covered employee must apply to us for coverage within the 31-day enrollment period following the date of his/her marriage. The application must be received by us within 31 days following the end of the enrollment period. The effective date of family coverage will be the date of the marriage. If the application is received by us more than 31 days after his/her enrollment period ends, the eligible spouse is a late enrollee. Please see subsection "Late Enrollees" above.

2. Applying For Coverage Due to Marriage.

If an eligible employee wishes to apply for family coverage to add himself/herself and eligible dependent(s) due to his/her marriage, the eligible employee and/or eligible dependents must apply to us within the 31-day enrollment period following the date of his/her marriage. The application must be received by us within 31 days following the end of the enrollment period. The effective date of family coverage will be the date of the marriage. If the application is received by us more than 31 days after his/her enrollment period ends, the eligible employee and his/her eligible dependents are late enrollees. Please see subsection "Late Enrollees" above.

Adding a Newborn Natural Child

1. Adding Newborn Natural Children to Existing Family Coverage.

If a covered employee has family coverage, coverage is provided for his/her newborn natural child from the moment of that child's birth. We request that the covered employee notify us about the child's birth.

2. Changing From Single Coverage to Family Coverage to Add Newborn Natural Children.

If a covered employee has single coverage, coverage is provided for his/her newborn natural child from the moment of that child's birth and for the next 60 days of that child's life immediately following that child's date of birth. Prior to the end of that 60-day period, the covered employee must apply for family coverage as described below. If the covered employee fails to apply for family coverage as stated below, coverage for his/her newborn natural child shall terminate at the end of that child's 60-day period.

If a covered employee wishes to change to family coverage to add his/her newborn natural child, he/she must apply to us for coverage during either of the following enrollment periods: (a) within the first 60 days after the birth of his/her natural child; or (b) within one year after the birth of his/her natural child and pay all required past-due premiums and in addition pay interest on such premium payments at a rate of 5 1/2% per year. The application must be received by us within 31 days following the end of the enrollment period. The effective date for such family coverage will be the date of that child's birth. If the application is received by us more than 31 days after his/her enrollment period ends, his/her newborn natural child is a late enrollee. Please see subsection "Late Enrollees" above.

3. Applying For Coverage Due to the Birth of a Newborn Child.

If an eligible employee wishes to apply for family coverage to add himself/herself and his/her other eligible dependents due to the birth of his/her natural child, the eligible employee and/or his/her eligible dependents must apply to us within the 31-day enrollment period following the birth of the newborn natural child. The application must be received by us within 31 days following the end of the enrollment period. The effective date of family coverage shall be the date of birth of the newborn natural child. If the application is received by us more than 31 days after his/her enrollment period ends, the eligible employee and/or his/her eligible dependents are late enrollees. Please see subsection "Late Enrollees" above.

Adoption

1. Changing from Single to Family Coverage to Add a New Eligible Dependent Because of Adoption.

If a covered employee has single coverage and wishes to change to family coverage to add a new eligible dependent because of his/her adoption of a child or a child placed for adoption, the covered employee must apply to us for coverage within the 60-day enrollment period following the date of such adoption or placement for adoption. The application must be received by us within 31 days following the end of the enrollment period. In the case of a child placed for adoption with you, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended. If the covered employee applies to us within that 60-day enrollment period and we receive the application as stated above, the effective date for such family coverage will be: (a) on the date a court makes a final order granting adoption of the child by the covered employee; or (b) on the date that the child is placed for adoption with the covered employee, whichever occurs first. If the application is received by us more than 31 days after his/her enrollment period ends, his/her new dependent is a late enrollee. Please see subsection "Late Enrollees" above.

If adoption of a child who is placed for adoption with the covered employee is not finalized, the child's coverage will terminate when the child's adoptive placement with the covered employee terminates.

2. Applying for Coverage Due to Adoption.

If an eligible employee wishes to apply for family coverage to add himself/herself and his/her other eligible dependents due to the adoption or placement for adoption of a child with the eligible employee, the eligible employee and/or his/her eligible dependents must apply to us within the 31-day enrollment period following the adoption or placement for adoption of the child. The application must be received by us within 31 days following the end of the enrollment period. The effective date of family coverage shall be on the date a court makes a final order granting adoption of the child by the eligible employee or on the date that the child is placed for adoption with the eligible employee, whichever occurs first. If the application is received by us more than 31 days after his/her enrollment period ends, the eligible employee and/or his/her eligible dependents are late enrollees. Please see subsection “Late Enrollees” above.

Changing From Single to Family Coverage or Adding a Dependent Due to a Court Order

To the extent required by Section 632.897 (10) (am), Wisconsin Statutes, as amended, if a court orders a covered employee with single or family coverage to provide coverage for health care expenses for his/her dependent child, that covered employee will be issued family coverage to include that child effective as of the date that court order is issued unless another coverage date is contained in that order, provided that child is eligible as a dependent for coverage under the policy as determined by us. Written application for that child's coverage must be made by either the covered employee, the child's other parent, the department, or the county child support agency under Section 59.53 (5), Wisconsin Statutes, as amended, using our application form. The completed form, a copy of the court order and the appropriate premium for his/her coverage must be submitted to us within 31 days after the court order is issued to the covered employee. As long as the covered employee is eligible for family coverage under the policy, that child's coverage will continue under the policy until the date that court order is no longer in effect or the date that child has coverage under another group policy or individual policy that provides comparable health care coverage, as applicable, unless that child's coverage ends sooner in accordance with the section "WHEN COVERAGE ENDS.” The covered employee must notify us in writing about that court order ending and/or that other coverage becoming effective for that child as soon as reasonably possible after the covered employee becomes aware of that fact. If application is submitted to us after the 31-day period ends, the eligible dependent is a late enrollee. Please see subsection “Late Enrollees” above.

Adding a Domestic Partner

If a covered employee has single coverage and wishes to change to family coverage to add an eligible domestic partner and his/her domestic partner’s eligible dependent children, if any, the covered employee must apply for coverage within 31 days of the date the covered employee registers such partner as a domestic partner with the policyholder. The date of family coverage will be the date of registration. If application is submitted to the policyholder after that 31-day period ends, the domestic partner and the domestic partner’s eligible children, if any, are late enrollees. Please see subsection "Late Enrollees" above.

Annual Enrollment Period

Each year an employee will have an enrollment period in which he/she and his/her dependents who did not enroll under the policy when first eligible can enroll under the policy.

If an employee or dependent does not request enrollment during the annual enrollment period, he/she must wait to enroll for coverage during the next annual enrollment period unless he/she becomes eligible for special enrollment.

The annual enrollment period is the 45-day period preceding the anniversary date of the policy.

Reinstatement of All Coverage

If a covered employee’s coverage ends due to termination of employment, leave of absence, or lay-off, and he/she later returns to active work, he/she must meet the waiting period for a new employee. However, the waiting period requirement does not apply if his/her coverage ends due to leave of absence or lay-off and he/she returns to active work within 182 days from the day his/her leave of absence of lay-off began.

PAYMENT OF BENEFITS

Any payment of benefits is subject to: (1) the applicable deductible amount; (2) coinsurance; (3) the applicable copayment amount; (4) your out-of-pocket limit; (5) exclusions; (6) our prior authorization requirements (7) all other limitations shown in the Schedule of Benefits; and (8) all other terms, conditions and provisions of the policy.

Deductible Amounts

Each year, you are required to pay a certain amount of charges out-of-pocket before most benefits are payable under the policy. These out-of-pocket amounts are called deductibles.

Your deductible amounts are shown in the Schedule of Benefits. No benefits are payable under the policy for charges used to satisfy your deductible amount.

After you reach your applicable deductible amount, most charges for covered expenses will still be subject to any copayment and/or coinsurance amounts shown in your Schedule of Benefits.

The annual deductible amount does not apply to charges for covered expenses incurred for health care services used to treat your covered injury during the first 90 days following the date of your injury.

The preferred provider and non-preferred provider deductibles are separate. However, charges for health care services provided by a non-preferred provider and paid at the preferred provider level of benefits shall be applied to the preferred provider annual deductible amount shown in the Schedule of Benefits.

Coinsurance

Coinsurance is your share of the costs of a covered health care service, calculated as a percent of the covered expense. After you satisfy your deductible, you will only be responsible for the copayment amount and coinsurance percentage shown in the Schedule of Benefits. The coinsurance percentage, if any, applies unless you have reached your out-of-pocket limit. See subsection “Out-of-Pocket Limits” for additional information on your out-of-pocket limit.

Copayments

A copayment is the fixed amount you pay for a covered health care service, usually when you receive the service. As set forth below and if shown in your Schedule of Benefits, the copayment amount will vary by the type of service. You may also have a copayment when you get a prescription filled. See subsection “Prescription Legend Drugs” for information about prescription copayments.

If you receive a health care service at a hospital-based outpatient clinic or location, your bill may show two separate charges – one for the health care provider and one for the facility. The copayment only applies to the charge billed by the health care provider. Facility charges are subject to the applicable annual deductible and coinsurance amounts of the policy.

Out-of-Pocket Limits

1. Annual Out-of-Pocket Limit.

The annual out-of-pocket limit is shown in the Schedule of Benefits.

After the applicable annual deductible and coinsurance out-of-pocket limit is reached, benefits are payable at 100% of the charges for covered expenses, unless specifically stated otherwise in the policy, you incur during the remainder of the policy year, subject to any applicable copayment amounts, maximum out-of-pocket limit and all other terms, conditions and provisions of the policy.

2. Maximum Annual Out-of-Pocket Limit.
The maximum annual out-of-pocket limit is shown in the Schedule of Benefits.

Any of the following costs will count towards your maximum annual out-of-pocket limit: (a) the deductible; (b) copayments; and (c) coinsurance amounts.

After your maximum annual out-of-pocket limit is reached, we will pay 100% of the charges for covered health care services you receive from a preferred provider during the remainder of the policy year, subject to all other terms, conditions and provisions of the policy.

In determining whether you've reached your out-of-pocket limit, the following amounts will not count:

1. Amounts you pay for non-covered health care services; and

2. Amounts you pay that exceed our determination of the charges.

Charges for health care services provided by a non-preferred provider and paid at the preferred provider level of benefits shall be applied to the preferred provider out-of-pocket limit shown in the Schedule of Benefits.

Continuity of Care

To the limited extent required by Wis. Stat. § 609.24 and Wis. Admin. Code § Ins 9.35, we will provide benefits at the preferred provider level for health care services received from any provider if we represented during the most recent open enrollment period that the provider was or would be a preferred provider. This provision does not apply when: (1) the provider no longer practices within the area in which we are authorized to do business; or (2) the provider's participation with us is terminated because of his/her misconduct.

This subsection does not in any way expand or provide greater coverage of any health care provider's health care services beyond what we determine to be the minimum "continuity of care" requirements set forth in Wis. Stat. §m609.24 and Wis. Admin. Code § Ins 9.35. If you have any questions, please do not hesitate to contact our Customer Service Department at the telephone number shown on your WPS identification card.

COVERED EXPENSES

Health care services described in this section are covered expenses as long as they are:

1. Medically necessary;

2. Ordered by a physician for a covered illness, covered injury, or for preventive care;

3. Provided by any health care provider licensed to provide a health care service covered under the policy.

If the health care service is not listed in this section, that health care service is not covered and no benefits are payable under the policy.

Please note that any of the health care services listed below may be subject to a prior authorization requirement. Please see section "OBTAINING SERVICES" for detailed information about our prior authorization requirements.

Benefits are not payable for maintenance care, custodial care, supportive care, or any health care service to which an exclusion applies. Please see section "EXCLUSIONS AND LIMITATIONS" for detailed information about the policy's exclusions.

All benefits are subject to the deductible and coinsurance amounts, copayment amounts, out-of-pocket limits and all other provisions stated in the Schedule of Benefits.

Acupuncture Therapy

Acupuncture therapy for adults (members 18 and over) for: (1) postoperative nausea and vomiting, (2) nausea and vomiting due to anti-neoplastic agents, and (3) postoperative dental pain.

Alcoholism Treatment

See subsection "Behavioral Health Services" for benefits for alcoholism treatment.

Allergy Testing and Treatment

Therapy and testing for treatment of allergies.

Alternative Care

If your attending physician advises you to consider alternative care for a covered illness or injury that includes health care services not covered under the policy, your attending physician should contact us so we can discuss it with him/her. We, in our sole discretion, will consider paying such non-covered health care services as long as they are medically necessary to treat your illness or injury.

We may consider an alternative care plan if the alternative care is not subject to an exclusion of the policy and we find that:

1. The recommended alternative care offers a medical therapeutic value equal to or greater than the current treatment or confinement;

2. The current treatment or confinement is covered under the policy;

3. The current treatment or confinement may be changed without jeopardizing your health; and

4. The charges incurred for health care services provided under the alternative care plan will be less than those charges for health care services provided under the current treatment or confinement plan.

We will make each alternative care coverage determination on a case by case basis and no decision will set any precedent for future claims. Payment of benefits, if any, shall be determined by us.

Any alternate care decision must be approved by you, the attending physician, and us before such alternate care begins.

Ambulance Services

Ambulance services used to transport you when you are sick or injured:

1. From your home or the scene of an accident or medical emergency to a hospital;

2. Between hospitals;

3. Between a hospital and a skilled nursing facility; or

4. From a hospital or a skilled nursing facility to your home.

5. To and from your home for covered hospice care services.

Your ambulance services benefits include coverage of any emergency medical care directly provided to you during your ambulance transport. In other words, if the ambulance service bills emergency medical care along with transport services, benefits are payable as stated in this subsection. If, however, the ambulance service bills emergency medical care separate from the transport services, benefits shall be payable as stated elsewhere in the applicable provisions of the policy.

Ambulance transports must be made to the closest local facility that can provide health care services appropriate for your illness or injury, as determined by us. If none of these facilities are located in your local area, you are covered for transports to the closest facility outside your local area.

Benefits are not payable for ambulance services:

1. When you can use another type of transportation without endangering your health;

2. When ambulance services are used solely for the personal convenience or preference of you, a family member, physician, or other health care provider; and

3. When ambulance services are provided by anyone other than a licensed ambulance service.

Anesthesia Services

Anesthesia services provided in connection with other health care services covered under the policy.

Autism Services

1. Definitions.

The following definitions apply to this subsection only:

Autism Spectrum Disorder: any of the following: (a) autism disorder; (b) Asperger's syndrome; or (c) pervasive developmental disorder not otherwise specified.

Behavior Analyst: a person who is certified by the Behavior Analyst Certification Board, Inc., or successor organization, as a board-certified behavior analyst and has been granted a license under Wis. Stat. 440.312 to engage in the practice of behavior analysis.

Behavioral: interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

Efficacious Treatment or Efficacious Strategy: treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive-level services; or to improve the condition of a covered person with autism spectrum disorder.

Evidence-Based Therapy: therapy that is based upon medical and scientific evidence and is determined to be an effective treatment or strategy and is prescribed to improve your condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within your treatment plan.

Intensive-Level Service: evidenced-based behavioral therapies that are directly based on, and related to, your therapeutic goals and skills as prescribed by a physician familiar with you. Intensive level service may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, your therapeutic goals and skills, and is concomitant with evidence-based behavioral therapy.

Non-intensive-Level Services: evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

Practice of Behavior Analysis: the design, implementation, and evaluation of systematic instructional and environmental modifications to produce socially significant improvements in human behavior, including the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis, including interventions based on scientific research and the direct observation and measurement of behavior and environment. Practice of behavior analysis does not include psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, marriage counseling, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities.

Qualified Intensive-Level Professional: an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in Wis. Admin. Code DHS 35.03 (9g), and who has completed at least 2,080 hours of training, education and experience including all of the following:

a. 1,500 hours supervised training involving direct one-on-one work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;

b. supervised experience with all of the following:

(1) working with families as part of a treatment team and ensuring treatment compliance;

(2) treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;

(3) treating individuals with autism spectrum disorders with a variety of behavioral challenges;

(4) treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and

(5) designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

c. academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

Qualified Intensive-Level Provider: an individual identified in Wis. Stat. § 632.895 (12m) (b) 1. to 4, respectively, acting within the scope of a currently valid state-issued license for psychiatry, psychology or behavior analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy, who provides evidence-based behavioral therapy in accordance with this section and Wis. Admin. Code INS 3.36 and Wis. Stat. § 632.895 (12m) (a) 3. and who has completed at least 2,080 hours of training, education and experience which includes all of the following:

a. 1,500 hours supervised training involving direct one-on-one work with individuals with autism spectrum disorders using evidence-based, efficacious therapy models;

b. supervised experience with all of the following:

(1) working with families as the primary provider and ensuring treatment compliance;

(2) treating individuals with autism spectrum disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;

(3) treating individuals with autism spectrum disorders with a variety of behavioral challenges;

(4) treating individuals with autism spectrum disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and

(5) designing and implementing progressive treatment programs for individuals with autism spectrum disorders.

c. academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of evidence-based therapy models consistent with best practice and research on effectiveness for individuals with autism spectrum disorders.

Qualified Paraprofessional: an individual working under the active supervision of a qualified supervising provider, qualified intensive-level provider or qualified provider and who complies with all of the following:

a. is at least 18 years of age;

b. obtains a high school diploma;

c. completes a criminal background check;

d. obtains at least 20 hours of training that includes subjects related to autism, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid;

e. obtains at least 10 hours of training in the use of behavioral evidence-based therapy including the direct application of training techniques with an individual who has autism spectrum disorder present; and

f. receives regular, scheduled oversight by a qualified provider in implementing the treatment plan for you.

Qualified Professional: a professional working under the supervision of an outpatient mental health clinic certified under Wis. Stat. § 51.038, acting within the scope of a currently valid state-issued license and providing evidence-based therapy in accordance with Wis. Admin Code INS 3.36.

Qualified Provider: an individual identified under Wis. Stat. § 632.895 (12m) (b) 1. to 4., acting within the scope of a currently valid state-issued license for psychiatry, psychology, behavior analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy and who provides evidence-based therapy in accordance with Wis. Admin Code INS 3.36.

Qualified Supervising Provider: a qualified intensive-level provider and who has completed at least 4,160 hours of experience as a supervisor of less experienced providers, professionals and paraprofessionals.

Qualified Therapist: a speech-language pathologist or occupational therapist acting within the scope of a currently valid state issued license and who provides evidence-based therapy in accordance with Wis. Admin Code INS 3.36.

Supervision of an Outpatient Mental Health Clinic: an individual who meets the requirements of a qualified supervising provider and who periodically reviews all treatment plans developed by qualified professionals for covered persons with autism spectrum disorder.

Waiver Program: services provided by the Wisconsin Department of Health Services through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services.

2. Benefits.

Benefits are payable for charges for covered expenses as described in this subsection for covered persons who have a verified diagnosis of autism spectrum disorder made by a diagnostician skilled in testing and in the use of empirically-validated tools specific for autism spectrum disorders. Services must be prescribed by a physician and provided by any of the following who are qualified to provide intensive level services or non-intensive-level services: (a) a qualified intensive-level provider; (b) a qualified paraprofessional under the supervision of a qualified supervising provider; (c) a qualified intensive-level professional; or (d) a qualified therapist. Your progress must be assessed and documented throughout your course of treatment.

The benefits under this subsection do not include benefits for durable medical equipment and prescription legend drugs. For coverage of durable medical equipment and prescription legend drugs, see subsection "Durable Medical Equipment" and subsection "Prescription Legend Drugs."

Benefits are payable for the following:

a. Intensive-Level Services. Benefits are payable for charges for intensive-level services that meet all of the following requirements:

(1) the majority of such services are provided to you when your parent or legal guardian is present and engaged;

(2) the services are based upon a treatment plan developed by an individual who at least meets the requirements of a qualified intensive-level provider or a qualified intensive-level professional that includes at least 20 hours per week over a six-month period of time of intensive-level evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that you be present and engaged in the intervention. We may request and review your treatment plan and the summary of progress on a periodic basis;

(3) the services are implemented by qualified providers, qualified professionals, qualified therapists or qualified paraprofessionals;

(4) the services are provided in an environment most conducive to achieving the goals of your treatment plan;

(5) the services implement identified therapeutic goals by the team including training and consultation, participation in team meetings and active involvement of your family; and

(6) the services are provided by a qualified intensive-level provider or qualified intensive-level professional who directly observes you at least once every two months.

Benefits are also payable for intensive-level services provided by a qualified therapist if all of the following requirements are met:

(1) the services are rendered concomitant with intensive-level evidence-based behavioral therapy;

(2) the qualified therapist provides evidence-based therapy to a covered person who has a primary diagnosis of autism spectrum disorder;

(3) you are actively receiving behavioral therapy from a qualified intensive-level provider or qualified intensive-level professional; and

(4) the qualified therapist develops and implements a treatment plan consistent with his/her license.

b. **Non-intensive-Level Services.** Benefits are payable for charges for non-intensive-level evidence-based therapy services provided to you by someone who is at least a qualified provider, qualified professional, qualified therapist or qualified paraprofessional in either of the following situations:

(1) after the completion of intensive-level services, provided that such non-intensive level services are designed to sustain and maximize gains made during intensive-level services treatment; or

(2) to you if you have not and will not receive intensive-level services but for whom non-intensive-level services will improve his/her condition.

All non-intensive level services must:

(1) be based upon a treatment plan developed by an individual who is at least a qualified provider, a qualified professional or qualified therapist that includes specific evidence-based therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that you be present and engaged in the intervention. We may request and review your treatment plan and the summary of progress on a periodic basis;

(2) be implemented by a person who is at least a qualified provider, qualified professional, qualified therapist or qualified paraprofessional;

(3) be provided in the environment most conducive to achieving the goals of your treatment plan; and

(4) implement identified therapeutic goals developed by the team including training and consultation, participation in team meetings and active involvement of your family.

c. **Transition from Intensive-Level Services to Non-intensive-Level Services.** We will provide you, or your authorized representative, with notice regarding any change in the level of treatment covered under the policy. The notice will explain the reason for the transition which may include any of the following:

(1) you no longer require intensive-level services as supported by documentation from a qualified intensive-level provider, qualified intensive-level professional or a qualified supervising provider; or

(2) you no longer receive evidence-based therapy for at least 20 hours per week over a six month period of time.

You or your representative should promptly notify us if you qualify for intensive-level services but are unable to receive them for an extended period of time. The notification must indicate the specific reason or reasons you or your family or care giver is unable to comply with an intensive-level service treatment plan. Reasons for requesting an interruption of intensive-level services for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason that we determine to be acceptable. We will not deny intensive-level services to you for failing to maintain at least 20 hours per week of evidence based behavioral therapy over a six-month period when: (1) you notify us as stated above; or (2) you or your authorized representative can document that you failed to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

3. Exclusions.

This subsection is not subject to the exclusions in section "EXCLUSIONS AND LIMITATIONS." This subsection is subject to the following exclusions. The policy provides no benefits for:

a. acupuncture;

b. animal-based therapy including hippotherapy;

c. auditory integration training;

d. chelation therapy;

e. child care fees;

f. cranial sacral therapy;

g. hyperbaric oxygen therapy;

h. custodial or respite care;

i. special diets or supplements;

j. travel time by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals;

k. therapy, treatment or services when provided to a covered person who is residing in a residential treatment center, inpatient treatment or day treatment facility;

l. costs for the facility or location or for the use of a facility or location when treatment, therapy or services are provided outside of your home;

m. claims that have been determined by us to be fraudulent; and

n. treatment provided by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals for treatment provided to their own children.

Behavioral Health Services

1. Definitions.

The following definitions apply to this subsection only:

Collateral: a member of your immediate family.

Day Treatment Programs: nonresidential programs for alcohol and drug-dependent covered persons and for treatment of nervous or mental disorders that are operated by certified inpatient and outpatient Alcohol and Other Drug Abuse (AODA) facilities that provide case management, counseling, medical care and therapies on a routine basis for a scheduled part of a day and a scheduled number of days per week; also known as partial hospitalization.

Hospital: (a) a hospital licensed under Wis. Stat. §50.35; (b) an approved private treatment facility as defined in Wis. Stat. §51.45 (2) (b); or (c) an approved public treatment facility as defined in Wis. Stat. §51.45 (2)(c).

Inpatient Hospital Services: services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to a covered person who is a bed patient in the hospital. However this definition shall not include those inpatient hospital services for detoxification of drug addiction or alcohol dependency. Please see subsection "Hospital Services."

Licensed Mental Health Professional: a clinical social worker licensed under Wis. Stat. §457.08, a marriage and family therapist licensed under §457.10, or a professional counselor licensed under §457.12.

Outpatient Services: nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse problems directly provided to a covered person and, if for the purpose of enhancing his/her treatment, a collateral by any of the following: (a) a program in an outpatient treatment facility, if both the program and facility are approved by the Department of Health Services and established and maintained according to rules promulgated under Wis. Stat. s. 51.42 (7)(b); (b) a licensed physician who has completed a residency in psychiatry, in an outpatient treatment facility or the physician's office; (c) a psychologist licensed or certified by the state in which he/she is located; (d) a licensed mental health professional practicing within the scope of his/her license under Wis. Stat. Chapter 457 and applicable rules; or (e) a health care provider licensed to provide nonresidential services for the treatment of nervous or mental disorders, alcoholism or drug abuse within the scope of that license.

Residential Treatment Programs: therapeutic programs for treatment of nervous or mental disorders and alcohol and drug-dependent covered persons, including therapeutic communities and transitional facilities.

Transitional Treatment: services for the treatment of nervous or mental disorders, alcoholism or drug abuse that are directly provided to you in a less restrictive manner than inpatient hospital services but in a more intensive manner than outpatient services, if both the program and the facility are approved by the Department of Health Services as defined in the Wis. Admin. Code INS 3.37.

Transitional treatments are services provided by a health care provider and certified by the Department of Health Services for each of the following (except h.) below:

a. mental health services for covered adults in a day treatment program;

b. mental health services for covered children and adolescents in a day treatment program;

c. services for covered persons with chronic mental illness provided through a community support program;

d. residential treatment programs for treatment of a covered person's nervous or mental disorders and for alcohol or drug-dependent covered persons or both;

e. services for alcoholism and other drug problems provided in a day treatment program;

f. intensive outpatient programs for narcotic treatment services for opiate addiction and for treatment of nervous or mental disorders;

g. coordinated emergency mental health services which are provided by a licensed mental health professional for covered persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided; and

h. out-of-state services and programs that are substantially similar to a. through g. above if the provider is in compliance with similar requirements of the state in which the health care provider is located.

The criteria that we use to determine if a transitional treatment is medically necessary and covered under the policy include, but are not limited to, whether:

a. the transitional treatment is certified by the Department of Health Services;

b. the transitional treatment meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;

c. the specific diagnosis is consistent with the symptoms;

d. the transitional treatment is standard medical practice and appropriate for the specific diagnosis;

e. the transitional treatment plan is focused for the specific diagnosis; and

f. the multidisciplinary team running the transitional treatment is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider's program is located or the service is provided.

We will need the following information from the health care provider to help us determine the medical necessity of a transitional treatment:

a. a summary of the development of your illness and previous treatment;

b. a well-defined treatment plan listing treatment objections, goals and duration of the care provided under the transitional treatment program; and

c. a list of credentials for the staff who participated in the transitional treatment program or service, unless the program or service is certified by the Department of Health Services.

2. Benefits.

We'll pay benefits for charges for covered expenses you incur for inpatient hospital services, outpatient services and transitional treatment that you receive each calendar year.

No benefits are payable for charges for outpatient services provided to or received by a covered person as a collateral of a patient when those outpatient services do not enhance the outpatient treatment of another covered person who is also insured under the policy.

Blood and Blood Plasma

Whole blood; plasma; and blood products, including platelets.

Cardiac Rehabilitation Services

Cardiac rehabilitation services limited to the following:

1. Phase I, while you are confined as an inpatient in a hospital;

2. Phase II, while you are an outpatient receiving services in a facility with a facility-approved cardiac rehabilitation program.

Benefits are not payable for behavioral or vocational counseling. No other benefits for outpatient cardiac rehabilitation services are available under the policy.

Chiropractic Services

Spinal manipulations and diagnostic tests provided by a chiropractor.

For therapy benefits, please see subsection "Therapy Services."

Clinical Trials

1. Definitions.

The following definitions apply to this subsection only:

Life-Threatening Condition: any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualifying Clinical Trial: a clinical trial that meets the definition of an "approved clinical trial" under Section 2709(d) (1) of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act.

Routine Patient Care Costs: costs associated with any of the following:

a. health care services that are typically covered under the policy absent a clinical trial;

b. covered health care services required solely for the provision of the trial health care service and clinically appropriate monitoring of the effects of the health care service trial;

c. reasonable and necessary health care services used to diagnose and treat complications arising from your participation in a qualifying clinical trial; or

d. covered health care services needed for reasonable and necessary care arising from the provision of a trial health care service.

Routine patient care costs do not include costs associated with:

a. experimental/investigational/unproven health care services with the exception of: (1) certain Category B devices; (2) certain promising interventions for patients with terminal illnesses; and (3) other health care services that meet specified criteria in accordance with our medical policy guidelines;

b. health care services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

c. health care services provided by the research sponsors at no charge to any person enrolled in the trial; or

d. health care services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

2. Benefits.

Routine patient care costs that you incur while participating in a qualifying clinical trial for the treatment of cancer or other life-threatening conditions.

Benefits are available only when you are eligible to participate in an approved clinical trial according to trial protocol.

Contraceptives for Birth Control

Devices or medications used as contraceptives that require a prescription or intervention by a physician or other licensed health care provider, including related health care services. Examples include:

1. Intrauterine devices (IUD);

2. Subdermal contraceptive implants;

3. Injections of medication for birth control; and

4. Contraceptive devices obtained directly from your physician.

For coverage of additional contraceptives, including, but not limited to, oral contraceptives, contraceptive patches, diaphragms and contraceptive vaginal rings, see subsection "Prescription Legend Drugs."

Dental Services

Dental services, limited to the following:

1. Dental repair or replacement of your sound natural teeth due to an injury, provided treatment begins within six months of the injury.

2. Extraction of teeth: (a) to prepare the jaw for radiation treatment of neoplastic disease; or (b) in preparation for a covered transplant;

3. Sealants on existing teeth to prepare the jaw for chemotherapy treatment of neoplastic disease; and

4. Hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to you in a hospital or ambulatory surgery center if you:

a. are a child under the age of five;

b. have a chronic disability that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is likely to continue indefinitely; and (3) results in substantial functional limitations in one or more of the following area of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency; or

c. have a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes Treatment

Installation and use of an insulin infusion pump, and all other equipment and supplies used in the treatment of diabetes, excluding insulin. For coverage of insulin, see subsection "Prescription Legend Drugs and Supplies."

Benefits for insulin syringes and needles, lancets, diabetic test strips, alcohol pads, dextrose (tablets and gel), auto injector, auto blood sampler, and glucose control solution are only covered under this subsection when they are dispensed by a health care provider other than a pharmacy. When such disposable supplies are dispensed by a pharmacy, benefits are payable according to subsection "Prescription Legend Drugs and Supplies."

This benefit is limited to the purchase of one insulin infusion pump per covered person per calendar year, provided the replacement is medically necessary as determined by us. We'll also pay benefits for charges for diabetic self-management education programs, but only if we determine that the program is medically necessary.

Diagnostic Services

Diagnostic x-rays, radiology and laboratory services directly provided to you for radiology and lab tests related to a covered physical illness or injury. Charges for computer-aided detection are not payable under the policy (except for screening mammogram interpretation).

Drug Abuse Treatment

See subsection "Behavioral Health Services" for benefits for drug abuse treatment.

Durable Medical Equipment

Rental of or, at our option, purchase of durable medical equipment, subject to the following:

1. The durable medical equipment must be prescribed by a physician and needed in the treatment of an illness or injury.

2. If the durable medical equipment is purchased, benefits will be payable for subsequent repairs necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be payable subject to approval by us. Subsequent repairs due to abuse or misuse, as determined by us, are not covered.

3. Benefits will be limited to the standard models, as determined by us.

4. We will pay benefits for only one of the following: a manual wheelchair, a motorized wheelchair, or a motorized scooter, as determined by us.

Benefits are also payable for the rental or purchase of breastfeeding equipment in conjunction with each birth.

We do not cover: (1) rental fees that are more than the purchase price; (2) routine periodic maintenance, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of one month rental billed every six months; (3) replacement of equipment unless we determine that it is medically necessary; and (4) replacement of batteries.

Genetic Services

Genetic services, limited to the following:

1. Genetic counseling provided to you by a physician, a licensed or Master's trained genetic counselor or a medical geneticist. When genetic counseling is provided by a preferred provider, benefits are payable at 100% of the charges, without application of the applicable annual deductible amount. Genetic counseling includes evaluation for BRCA testing for a female covered person whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations.

2. Amniocentesis during pregnancy;

3. Chorionic villus sampling for genetic and non-genetic testing during pregnancy;

4. Identification of infectious agents such as influenza and hepatitis. Panel testing for multiple agents is not covered unless your physician provides a justification for including each test in the panel;

5. Compatibility testing for a covered person who has been approved by us for a covered transplant;

6. Cystic fibrosis and spinal muscular atrophy testing as recommended by the American College of Medical Genetics;

7. Molecular testing of pathological specimens. Such testing does not include any testing of blood, except testing for the diagnosis of leukemia, lymphoma, or platelet abnormalities. Molecular testing as part of a genetic panel analysis requires our prior authorization;

8. BRCA testing for a female covered person whose family history is associated with an increased risk for harmful BRCA1 and BRCA2 gene mutations. When such testing is provided by a preferred provider, benefits are payable at 100% of the charges, without application of the applicable annual deductible amount; and

9. All other genetic testing, provided you receive our prior authorization. We will authorize genetic testing if your physician shows that the results of such testing will directly impact your future treatment. Your physician must describe how and why, based on the results for the genetic testing results, your individual treatment plan would be different than your current or expected treatment plan based on a clinical assessment without genetic testing. Upon request, your physician must submit information regarding the genetic testing's clinical validity and clinical utility. Genetic testing that we consider experimental/investigational/unproven will not be covered.

Health and Behavior Assessments

Health and behavior assessments and reassessments, diagnostic interviews and neuropsychological testing provided by a psychologist to treat a physical illness or injury. However, subsequent treatment of that medical condition by a psychologist will not be covered under the policy.

Hearing Aids and Implantable Hearing Devices

1. One hearing aid, per ear, per child every three years;

2. Implantable hearing devices;

3. Treatment related to hearing aids and implantable hearing devices covered under this subsection, including procedures for the implantation of implantable hearing devices.

This subsection applies only to children under the age of 18. Such hearing aids and implantable hearing devices must be prescribed by a physician or an audiologist in accordance with accepted professional medical or audiological standards.

The child must be certified as deaf or hearing impaired by a physician or audiologist.

Home Care Services

1. Covered Services.

This subsection applies only if charges for home care services are not covered elsewhere under the policy. We'll pay benefits for charges for the following home care services, subject to paragraph 2. below:

a. part-time or intermittent home nursing care by or under supervision of a registered nurse;

b. part-time or intermittent home health aide services that: (1) are part of the home care plan; (2) consist solely of care for the patient; and (3) are supervised by a registered nurse or medical social worker;

c. physical or occupational therapy or speech-language pathology or respiratory care;

d. medical supplies, drugs and medications prescribed by a physician; laboratory services by or on behalf of a hospital if needed under the home care plan. These items are covered to the extent they would be if you had been hospitalized;

e. nutrition counseling provided or supervised by a registered or certified dietician; and

f. evaluation of the need for a home care plan by a registered nurse, physician extender or medical social worker. Your attending physician must request or approve this evaluation.

2. Limits on Home Care.

Home care is covered if ordered by a physician and determined by us to be medically necessary. We cover home safety evaluations, evaluations for a home treatment program, and/or initial visit(s) to evaluate you for an independent treatment plan. For all other home care to be determined medically necessary, you must be confined to your home due to an illness or injury or because leaving your home would be contraindicated. Examples of home care include, but are not limited to, IV administration, or wound care.

Benefits are limited to 100 home care visits in any 12-month period per covered person. Each visit by a person to provide services under a home care plan, or for evaluating your need, or for developing a home care plan counts as one home care visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.

The maximum weekly benefit payable for home care won't be more than the benefits payable for the total weekly charges for skilled nursing care available in a licensed skilled nursing facility, as determined by us.

If home care is covered under two or more health insurance contracts, coverage is payable under only one of them, except as stated in section "COORDINATION OF BENEFITS."

Home Intravenous (IV) Therapy or Infusion Therapy

Intravenous (IV) therapy/infusion therapy performed in your home if prescribed by a physician. Home IV therapy or home infusion therapy includes, but is not limited to: (1) injections (intra-muscular, subcutaneous, continuous subcutaneous); (2) Total Parenteral Nutrition (TPN); and (3) antibiotic therapy.

Hospice Care

Hospice care services provided to you if you are terminally ill: (1) if your health condition would otherwise require your confinement in a hospital or a skilled nursing facility; and (2) hospice care is a cost-effective alternative, as determined by us.

Covered expenses for hospice care shall include:

1. Room and board at a hospice facility while you are receiving acute care to alleviate physical symptoms of your terminal illness;

2. Physician and nursing care; and

3. Services provided to you at your place of residence.

Room and board for residential care at a hospice facility is not covered.

We'll pay benefits for charges for covered expenses for hospice care services provided to you during the initial six-month period immediately following the diagnosis of a terminal illness. Coverage for hospice care services after the initial six-month period will be extended by us under the policy beyond the initial six month period; provided, a physician certifies in writing that you are terminally ill.

Hospital Services

Hospital services as shown below. This subsection does not include services for: (1) covered transplants; or (2) treatment of alcoholism, drug abuse or nervous or mental disorders, except for inpatient hospital services for detoxification of drug addiction or alcohol dependency. Please see subsections “Behavioral Health Services” and “Transplants.”

1. Inpatient Hospital Services.

Benefits are payable for the following inpatient hospital services for a physical illness or injury:

a. charges for room and board;

b. charges for nursing services;

c. charges for miscellaneous hospital expenses; and

d. charges for intensive care unit room and board.

If you are confined in a hospital other than a preferred hospital as an inpatient due to a medical emergency, we reserve the right to coordinate your transfer to a preferred hospital once you are stable and can be safely moved to that preferred hospital.

2. Outpatient Hospital Services.

Benefits are payable for miscellaneous hospital expenses for a physical illness or injury received by you while you are not confined in a hospital. These don't include charges for outpatient physical, speech, occupational or respiratory therapy.

3. Facility Fees.

Benefits are payable for facility fees charged by the hospital for office visits and for urgent care visits.

Kidney Disease Treatment

Dialysis treatment, including any related medical supplies and laboratory services provided during dialysis and billed by the outpatient department of a hospital or by the dialysis center.

Kidney transplantation services are payable under the organ transplant benefit in subsection “Transplants.”

Mastectomy Treatment

A covered person who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy and who elects breast reconstruction, will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Breast prostheses; and

4. Treatment of physical complications for all stages of mastectomy, including lymphedemas.

Maternity Services

Maternity services include:

1. Global maternity charge. The global maternity charge is a unique procedure billed by a physician that includes prenatal care, delivery, and one postpartum care visit. Examples of health care services for this procedure may include the prenatal physical examinations, recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis. Monthly visits up to 28 weeks, biweekly visits to 36 weeks, and weekly visits until delivery are included.

2. Hospital charges for vaginal or cesarean section delivery.

3. Exams and testing that are billed separately from the global maternity fee.

4. Health care services for miscarriages.

5. Health care services related to an abortion provided the abortion procedure for the termination of a mother's pregnancy is: (a) considered a life-threatening complication of the mother's existing physical illness; or (b) due to a lethal fetal anomaly; and (c) the abortion procedure is permitted by, and performed in accordance with, law. "Lethal fetal anomaly" is defined as an anomaly which predictably results in fetal demise either in utero or shortly (within 72 hours) after delivery.

Maternity services are payable when provided by a: (1) hospital; (2) physician; (3) certified nurse midwife in a clinic or hospital.

With respect to confinements for pregnancy, the policy shall not limit the length of stay to less than: (1) 48 hours for a normal birth; and (2) 96 hours for a cesarean delivery. However, you are free to leave the hospital earlier if the decision to shorten the stay is the mutual decision of the physician and mother.

Medical Services

Medical services for a physical illness or injury, including second opinions. Services must be provided: (1) in a hospital; (2) in a physician's office; (3) in an urgent care center; (4) in a surgical care center; (5) in a convenient care clinic; or (6) in your home. These services do not include health care services, including home care services covered under subsection "Home Care Services," covered elsewhere under the policy.

Health and behavior interventions billed with a medical diagnosis are also payable.

Telehealth shall be payable only if services are provided through a telehealth provider approved by us and shown in the Schedule of Benefits as being payable under the policy. For information about approved telehealth providers, visit wpshealth.com or call the Customer Service telephone number shown on your identification card.

Advance care planning office consultations limited to one initial consultation and two follow-up consultations.

Medical Supplies

Medical supplies prescribed by a physician. Medical supplies include, but are not limited to, the following:

1. Strapping and crutches;

2. Initial pair of eyeglasses or external contact lenses: (a) for aphakia; (b) for keratoconus; and (c) following cataract surgery;

3. Elastic stockings or supports when prescribed by a physician and required in the treatment of an illness or injury. We may establish reasonable limits on the number of pairs allowed per covered person per calendar year;

4. Ostomy supplies limited to the following:

a. pouches, face plates and belts;

b. irrigation sleeves, bags and ostomy irrigation catheters;

c. skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above;

5. Enteral therapy (tube feeding) supplies if prescribed by a physician and determined by us as being appropriate for your medical condition. This does not include enteral formula, food, food supplements or vitamins; and

6. Disposable supplies, tubings and masks for the effective use of covered durable medical equipment.

Nutritional Counseling

Nutritional counseling that is: (1) for treatment of an illness or injury; and (2) provided by a physician, dietician or nutritionist licensed in the state where the counseling is provided to you. Nutritional counseling billed as educational services will not be covered.

Orthotics

Orthotics is defined as custom-made rigid or semi-rigid supportive devices used to (1) support, align, prevent, or correct deformities; (2) improve the function of movable parts of the body; or (3) limit or stop motion of a weak or diseased body part.

Covered orthotics (including fittings, adjustments and repairs) prescribed by a health care provider include, but are not limited to:

1. Casts and splints;

2. Orthopedic braces, including necessary adjustments to shoes to accommodate braces.

3. Cervical collars;

4. Orthotics to support the foot when custom-molded to fit the covered person;

5. Corsets (back and special surgical); and

6. Diabetic shoes when medically necessary.

Benefits will be limited to standard devices as determined by us. Orthotics may be replaced once per calendar year per covered person when medically necessary. Additional replacements will be allowed: (1) if you are under age 19 and due to rapid growth; or (2) if the orthotic is damaged and cannot be repaired.

The Policy does not cover: (1) routine periodic maintenance, such as testing and cleaning; (2) over-the-counter orthotics to support the foot; and (3) repairs due to abuse or misuse as determined by us.

Pain Management Treatment

Pain management treatment including injections and other procedures to manage your pain related to an illness or injury. Pain management includes, but is not limited to, the following:

1. Medial branch neuroablation (denervation) of the facet joint nerves, limited to one treatment per calendar year regardless of location;

2. Facet joint injections and medial branch nerve blocks, limited to a maximum of four per calendar year regardless of location, type, or level;

3. Sacroiliac joint injections, limited to one per calendar year;

4. Artificial cervical disc replacement; and

5. Epidural injections, including selective nerve root blocks, limited to three injections per calendar year regardless of location, type or level.

Please note that many pain management services are considered experimental/investigational/unproven and therefore are not covered under the policy.

Prescription Legend Drugs and Supplies

1. Definitions.

The following definitions apply to this subsection only:

Brand-Name Drug(s): a prescription legend drug sold by the pharmaceutical company or other legal entity holding the original United States patent for that prescription legend drug. For purposes of the policy, we may classify a brand-name drug as a generic drug if we determine that its price is comparable to the price of its generic equivalent.

Copayment: the amount you are required to pay for each prescription order or refill of a covered drug or covered supply. Your copayment amounts are shown in the Schedule of Benefits. You must pay this amount toward the purchase price charged by the provider for that covered drug or covered supply. The copayment applies to each separate prescription order or refill of a covered drug or covered supply. If the preferred pharmacy's charge is less than the copayment, you will be responsible for the lesser amount.

Expanded Preventive Drug(s): any drug on our Expanded Preventive Drug List, as determined by us. Expanded preventive drugs may include those prescription legend drugs the Internal Revenue Service has indicated are taken to prevent exacerbation of a chronic condition or the development of a secondary condition.

Generic Drug(s): a prescription legend drug, whether identified by its chemical, proprietary, or non-proprietary name, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA. For purposes of the policy, we may classify a generic drug as a brand-name drug if we determine that the generic drug's price is comparable to the price of its brand-name equivalent. The term generic drug shall also include over-the-counter drugs that we determine to be covered drugs.

Home Delivery: a preferred pharmacy contracted with us or our delegate to dispense extended supplies of maintenance medications (typically greater than a 30-34 day supply).

Preferred Drug(s): any generic or brand-name drug named on our list of preferred drugs which is available at wpshealth.com. This list may change from time to time.

Preferred Pharmacy: a pharmacy that has contracted with us to be a preferred pharmacy and that bills us directly for the charges you incur for covered drugs.

Prescription Legend Drug: any medicine, including investigational drugs used to treat the HIV virus as described in Wis. Stat. §632.895(9) whose label is required to contain the following wording: "Caution: Federal Law prohibits dispensing without prescription" or similar wording. Prescription legend drugs shall include insulin and other exceptions as designated by us.

Prescription Order: a written, electronic, or other lawful request for the preparation and administration of a prescription legend drug made by a physician or other provider with the authority to prescribe a drug for you.

Preventive Drugs: drugs that we are required by law to define as preventive drugs, including, but not limited to: (a) aspirin for the prevention of cardiovascular disease (age 50-59) and after 12 weeks of gestation in women who are at high risk for preeclampsia; (b) fluoride supplements if you are older than six months but younger than 17 years old; (c) folic acid for women planning or capable of pregnancy; (d) oral contraceptives, contraceptive patches, contraceptive devices (e.g., diaphragms, sponges, gel and female condoms) and contraceptive vaginal rings for birth control; (e) nicotine replacements (e.g., patches and gum) and covered drugs used for smoking cessation if you are age 18 and over; (f) risk reducing medications, such as tamoxifen or raloxifene, for women who are at increased risk for breast cancer and at low risk for adverse medication effects; (g) low/moderate dose statins for ages 40-75 with at least one cardiovascular disease risk factor and a 10-year calculated risk of at least 10%; (h) immunizations; (i) bowel preparations related to a preventive colonoscopy; and (j) Preexposure prophylaxis (PrEP) for covered person at high risk of HIV acquisition. This definition of preventive drugs may change during the course of the year.

Specialty Drugs: prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost. To determine if a drug is a specialty drug and if that specialty drug requires our prior authorization, visit our website at wpshealth.com or call the telephone number shown on your identification card.

Specialty Pharmacy: a pharmacy contracted with us or our delegate and designated by us to dispense specialty drugs. To inquire as to pharmacies that are currently participating as specialty pharmacies, you should contact us by calling the telephone number shown on your identification card.

2. Covered Drugs and Supplies.

We'll pay benefits as stated in the Schedule of Benefits for any of the following drugs, including refills, when they are medically necessary to treat your covered illness or injury and dispensed to you by a preferred pharmacy:

a. any prescription legend drug not otherwise excluded or otherwise limited under the policy;

b. any medicine a preferred pharmacy compounds as long as it contains at least one prescription legend drug that is not excluded under the policy, provided it is not considered experimental/investigative/unproven or not medically necessary;

c. preventive drugs that can only be obtained from a pharmacy pursuant to a prescription order;

d. specialty drugs;

e. injectable insulin;

f. prescription legend drugs that are FDA-approved for the treatment of HIV infection or an illness or medical condition arising from, or related to, HIV;

g. an immunization that is not excluded elsewhere in the policy;

h. oral chemotherapy drugs; and

i. phase 3 experimental / investigational / unproven drugs that are FDA approved, administered according to protocol, and required by statute to be covered

We'll pay benefits as stated in the Schedule of Benefits for any of the following disposable diabetic supplies when they are medically necessary and dispensed to you by a preferred pharmacy:

a. insulin syringes and needles;

b. lancets;

c. diabetic test strips;

d. alcohol pads;

e. dextrose (tablets and gel);

f. auto injector;

g. auto blood sampler;

h. blood glucose monitor; and

h. glucose control solution.

Our prior authorization is required for certain prescription drugs administered by a health care provider other than a pharmacy, including, but not limited to: (a) a physician's office; (b) the outpatient department of a hospital; (c) a dialysis facility; (d) a licensed skilled nursing facility; or (e) a home health agency. If you do not receive our authorization before receiving such drugs, benefits may not be payable under the policy. Even if we grant prior authorization, benefits for any specialty drug that is purchased from a provider other than a preferred pharmacy shall be limited to what we would have paid if the specialty drug was purchased from a preferred pharmacy. However, we may, at our discretion, allow initial does(s) of a drug to be provided by a health care provider, other than a pharmacy, to allow you appropriate time to establish alternative sources. Initial doses approved by us shall not be limited to the amount we would have paid if the drug was purchased from a pharmacy.

Benefits for covered drugs and supplies dispensed by a non-preferred pharmacy are payable as follows. In this situation, you must pay for the covered drugs or supplies up front. Then you must send us a claim for reimbursement. Your claim must include written proof of payment and enough detail to allow us to process the claim. After we receive your claim and supporting documentation, we will determine if benefits are payable for the requested drug or supply. If so, we will pay you the benefit amount that we would have paid had you purchased the covered drug or supply from a preferred pharmacy. You are liable for the copayment or deductible and any difference between our benefit payment and the price you paid for the covered drug or supply.

You will have no copayment for any preventive drug as defined in paragraph 1. above. All other covered drugs and supplies are subject to the copayment or deductible amounts listed in your Schedule of Benefits. If the preferred pharmacy's charge is less than the copayment, you will only be responsible for the charge amount. Otherwise, you must pay the copayment amount for each separate prescription order or refill of a covered drug or covered supply.

We, at our sole discretion, may cover drugs or supplies that vary from the benefits described in the policy if there is an advantage to both you and us.

3. Limitations.

a. **Limitations on Covered Drugs and Supplies Provided by a Pharmacy.** No drug will be covered under the policy unless we determine that: you have a valid prescription order for the drug; the charge for the drug is equal to or more than the copayment for it; and the drug is not administered at the time and place of the provider dispensing it under the prescription order (except for immunizations). In addition, the following limitations apply to all prescription drug benefits provided by the policy:

(1) **Step Therapy.** If there is more than one prescription legend drug that has been determined to be safe and effective for the treatment of your illness or injury, we may only provide benefits for the less expensive prescription legend drug. Alternatively, we may require you to try the less expensive prescription legend drug(s) before benefits are payable for any other alternative prescription legend drug(s).

(2) **Prior Authorization.** At our discretion, certain drugs, including all specialty drugs, require prior authorization from us before being eligible for coverage under the policy. To determine whether a drug requires our prior authorization, visit wpshealth.com or call the telephone number shown on your identification card.

If a drug requires prior authorization, your provider must contact us or our designee to supply the information needed, such as copies of all corresponding medical records and reports for your illness or injury.

After receiving the required information, we (or our designee) will determine if the drug is covered under the policy and notify you of our coverage determination. If we determine that the treatment is not a covered drug, is not medically necessary, or is experimental / investigational / unproven, no benefits will be payable for that drug.

(3) **Use of Brand-Name Drugs When Equivalent Generic Drugs Are Available.** If you obtain a brand-name drug and we determine that an equivalent generic drug is available, you must pay the difference in cost between the equivalent generic drug and the brand-name drug plus the brand-name drug copayment and/or deductible amount. Except as stated below, this limitation applies regardless of medical necessity or your physician's instructions, including any instruction that you use only the brand-name drug.

For preventive drugs as defined in paragraph 1. above, coverage is also limited to generic drugs when a generic equivalent is available, with the exception of preventive contraceptive methods. If your physician submits proof to us that it is medically necessary for you to use a brand-name preventive contraceptive method instead of its generic equivalent preventive contraceptive method, we will cover the brand-name preventive drug in full and you will not be charged.

We will cover a brand-name drug if substitution of an equivalent generic drug is prohibited by law.

(4) **Quantity Limits.** The following quantity limits apply to all prescription legend drug benefits under this subsection. At our discretion, we may enforce additional quantity limits on specific drugs to ensure the appropriate amounts are dispensed. Please note that in certain circumstances, we may approve a partial amount (*i.e.* less than a 30-day supply) of a specialty drug until we (or our designee) determine you are tolerating the specialty drug. In this case, your financial responsibility will be prorated.

Item	*Quantity Limit*
Prescription Legend Drugs or Supplies Dispensed by a Pharmacy	34-90 day supply per fill or refill
Prescription Legend Drugs or Supplies, other than Specialty Drugs, dispensed by a Home Delivery Pharmacy	90-day supply per fill or refill
Covered Drugs used for Tobacco Cessation	180-day supply of nicotine replacement treatment (*e.g.*, patches or gum) per covered person per 365-day period; and 180-day supply of another type of covered tobacco cessation drug (*e.g.*, varenicline or bupropion) per covered person per 365-day period
Specialty drugs	30-day supply per fill or refill, except as noted above
Disposable Diabetic Supplies	No limit
Oral Contraceptives	90-day supply

(5) **Miscellaneous.** Age, gender or other edits may be enforced to ensure appropriate prescribing. Copayment or coinsurance applies to each cycle of hormone replacement therapy.

b. **Limitations on Covered Drugs and Supplies Provided by a Provider Other than a Pharmacy.** If we determine a prescription legend drug can safely be administered in a lower-cost place of service (including by self-administration), benefits for such prescription legend drugs shall be payable up to the amount we would have paid if the prescription legend drug was purchased from and administered by a provider in that lower-cost place of service (or self-administered). However we may, at our discretion, allow initial dose(s) of a drug to be administered by a health care provider in a higher-cost place of service to allow you appropriate time to establish alternative sources. Initial doses approved by us shall not be limited to the amount we would have paid if the drug was purchased and administered in the lower-cost place of service (including self-administration).

4. **Exclusions.**

The policy provides no benefits for any of the following:

a. administration of a covered drug by injection or other means other than covered immunizations;

b. devices, appliances or durable equipment, except for covered supplies;

c. refills of covered drugs that exceed the number the prescription order calls for;

d. refills of covered drugs after one year from the date of the prescription order;

e. covered drugs usually not charged for by the provider; or a covered drug for which the provider's actual charge billed for the covered drug is less than the copayment;

f. covered drugs for which benefits are paid elsewhere under the policy;

g. covered drugs completely administered at the time and place of the provider who dispenses the drugs under the prescription orders, except for immunizations and drugs for which you receive our prior authorization;

h. anabolic steroids, unless we determine that they are being used for accepted medical purposes and eligible for coverage under the policy;

i. progesterone or similar drugs in any compounded dosage form, except for the purpose of maintaining a pregnancy under the appropriate standard of care guidelines;

j. costs related to the mailing, sending or delivery of prescription legend drugs;

k. prescription or refill of drugs, medicines, medications or supplies that are lost, stolen, spilled, spoiled, damaged, or otherwise rendered unusable;

l. any drug or medicine that is available in prescription strength without a prescription, except as determined by us;

m. more than one prescription for the same covered supply, covered drug or therapeutic equivalent medication prescribed by one or more providers until you have used at least 75% of the previous retail prescription. If the covered supply, drug or therapeutic equivalent medication is dispensed by a home delivery pharmacy, then you must have used at least 60% of the previous prescription;

n. charges properly covered by another insurance, government program, or manufacturer promotion (e.g. coupon or rebate);

o. any drug used for weight control or whose primary use is weight control, regardless of why the drug is being prescribed to you;

p. any compounded drug that is substantially like a commercially available product;

q. any drug used for sexual dysfunction or to enhance sexual activity, regardless of why the drug is being prescribed to you;

r. any drug delivered to or received from a destination outside of the United States;

s. any drug for which prior authorization or step therapy is required, as determined by us, and not obtained; and

t. drugs and medicines not covered under the policy. Please see section "EXCLUSIONS AND LIMITATIONS."

Preventive Care Services

Preventive care services ordered by a physician. Covered preventive care services include:

1. Routine immunizations including, but not limited to, those recommended by the Advisory Committee on Immunization Practices: influenza/flu, diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; haemophilus influenza B; meningitis, hepatitis A; hepatitis B; varicella; pneumococcal; meningococcal; rotavirus; human papillomavirus; and herpes zoster. Immunizations for travel purposes are not covered.

2. Preventive services including, but not limited to, those recommended by the United States Preventive Services Task Force with an A or B rating:

a. routine medical exams, including eye exams, hearing exams, pelvic exams, pap smears, and any related routine diagnostic services, other than routine mammograms and colorectal cancer screening. Pelvic exams and pap smears are covered under this paragraph when directly provided to you by a physician, certified nurse midwife or a nurse practitioner.

b. routine medical exams, including eye exams, hearing exams, and any related routine diagnostic services, other than routine eye exams, directly provided to a dependent child in connection with well-baby care.

c. one routine mammogram of a female covered person per calendar year. Mammograms must be performed by or under the direction of a physician, certified nurse midwife or licensed nurse practitioner.

d. blood lead tests.

e. preventive screenings including, but not limited to:

(1) screening for abdominal aortic aneurysm;

(2) screening and behavioral counseling to reduce alcohol misuse, as determined by us;

(3) screening for chlamydial infection;

(4) screening for gonorrhea;

(5) screening for congenital hypothyroidism in newborns;

(6) screening for hearing loss in newborns;

(7) screening for Hepatitis B and C;

(8) screening for high blood pressure;

(9) screening for HIV;

(10) screening for iron deficiency anemia in asymptomatic pregnant women;

(11) screening for lipid disorders;

(12) screening for major depressive disorders in children and adolescents;

(13) screening for phenylketonuria in newborns;

(14) screening for RH incompatibility;

(15) screening for osteoporosis;

(16) screening for sickle cell disease in newborns;

(17) screening for syphilis;

(18) screening for type 2 diabetes;

(19) screening for visual impairment in children under age five;

(20) screening for depression in adults;

(21) screening for bacteriura;

(22) screening for cervical cancer;

(23) screening and behavioral counseling for obesity, as determined by us.

(24) screening for gestational diabetes in pregnant women who are between 24 and 28 weeks of gestation and at the first prenatal visit if the woman is identified to be at high risk for diabetes;

(25) high risk human papillomavirus DNA testing in female covered persons with normal cytology results. Screening should begin at age 30 and should occur no more frequently than every three years;

(26) screening for lung cancer with low-dose computed tomography in adults aged 55 to 80 who have a 30 pack-year smoking history and currently smoke or have quit smoking within the last 15 years;

(27) screening for colorectal cancer, including fecal occult blood testing, limited to one routine sigmoidoscopy or colonoscopy, including related health care services, every five years, in accordance with the most current guidelines of the United States Preventive Services Task Force. Any additional routine sigmoidoscopies or colonoscopies performed within that five year period shall be payable subject to applicable deductible and coinsurance provisions. Exception: A preventive colonoscopy conducted by a preferred provider after an abnormal/positive non-invasive stool-based screening test or direct visualization screening test (e.g. sigmoidoscopy, CT colonography) for colorectal cancer will be treated as a preventive care service without cost sharing;

f. behavioral interventions to promote breast feeding; comprehensive lactation support and counseling by a trained health care provider during pregnancy and/or in the postpartum period;

g. annual counseling on sexually transmitted infections;

h. counseling for tobacco use;

i. prophylactic ocular topical medication for newborns against gonococcal ophthalmia neonatorum;

j. annual screening and counseling for female covered persons for interpersonal and domestic violence;

k. healthy diet and physical activity counseling to prevent cardiovascular disease;

l. behavioral counseling for skin cancer

Some laboratory and diagnostic studies may be subject to a deductible and/or coinsurance if determined not to be part of a routine preventive or screening examination. When you have a symptom or history of an illness or injury, laboratory and diagnostic studies related to that illness or injury are no longer considered part of a routine preventive or screening examination.

Prosthetics

Prosthetic devices and supplies, including the fitting of such devices, that replace all or part of: (1) an absent body part (including contiguous tissue); or (2) the function of a permanently inoperative or malfunctioning body part. Benefits are limited to one purchase no sooner than every three years of each type of the standard model, as determined by us. Prosthetic devices include, but are not limited to, artificial limbs, eyes, and larynx. We will also cover replacement or repairs if we determine that they are medically necessary. The policy does not cover dental prosthetics.

Radiation Therapy and Chemotherapy Services

Radiation therapy and chemotherapy services. Benefits are also payable for charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in conjunction with radiation therapy and chemotherapy services.

Skilled Nursing Care in a Skilled Nursing Facility

Skilled nursing care you receive while confined in a skilled nursing facility if: (1) you are admitted to a skilled nursing facility within 24 hours after discharge from a hospital or ambulatory surgical center; and (2) you are admitted for continued treatment of the same illness or injury treated in the hospital.

We'll pay benefits for such skilled nursing care provided to you at that facility for up to 30 days of confinement. The 30-day limit stated in this subsection will be reduced by any charges for such days of confinement that are applied to the applicable deductible amounts.

Benefits are payable only for the skilled nursing care that continues to treat the same illness or injury for which you were treated at the hospital prior to your admission to that skilled nursing facility. Benefits are only payable for skilled nursing care which is certified as medically necessary by your attending physician every seven days. If health care services can be provided at a lower level of care (e.g. home care or outpatient therapy), skilled nursing care during a skilled nursing facility confinement will not be covered.

No benefits are payable for domiciliary care, maintenance care, supportive care, custodial care, care that is available at no cost to you or care provided under a governmental health care program (other than a program provided under Wis. Stat. Chapter 49).

Surgical Services

Surgical services stated below. This subsection does not include surgical services for: (1) covered transplants; (2) pain management procedures; or (3) behavioral health services. Please see subsections “Behavioral Health Services,” “Transplants,” and “Pain Management Treatment.”

Covered surgical services include, but are not limited to:

1. Operative and cutting procedures;

2. Endoscopic examinations, such as: (a) arthroscopy; (b) bronchoscopy; (c) colonoscopy or sigmoidoscopy, unless specifically covered elsewhere under the policy; or (d) laparoscopy; and

3. Other invasive procedures such as: (a) angiogram; (b) arteriogram; or (c) tap or puncture of brain or spine.

4. Bariatric surgery for weight reduction, provided you meet all criteria established by us.

The following surgical services are covered when provided in a physician’s office, hospital, or licensed surgical center:

1. Surgical services, other than reconstructive surgery and oral surgery.

2. Reconstructive surgery for the treatment of the following:

- **a.** a congenital illness or anomaly that results in a functional impairment;
- **b.** an abnormality resulting from an injury; and
- **c.** an abnormality resulting from infection or other disease of the involved body part, if such surgery occurs within 12 months of being diagnosed of the abnormality.

3. Oral surgery, including related consultation, x-rays and anesthesia, limited to the following procedures:

- **a.** surgical removal of impacted, sound natural unerupted teeth;
- **b.** excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

c. surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;

d. apicoectomy (excision of the apex of the tooth root);

e. root canal therapy, if performed simultaneously with an apicoectomy;

f. excision of exostosis (bony outgrowth) of the jaws and hard palate;

g. frenotomy (incision of the membrane connecting the tongue to the floor of the mouth);

h. incision and drainage of cellulitis (tissue inflammation) of the mouth;

i. incision of accessory sinuses, salivary glands or ducts;

j. gingivectomy (excision of gum tissue to eliminate infection), but not including restoration of gum tissue or soft tissue Allograft;

k. alveolectomy; and

l. orthognathic surgery.

4. Sterilization procedures. Please note that reversal of a sterilization procedure is not covered under the policy.

5. Tissue transplants (e.g. arteries or veins, corneas, heart valves, skin) placed in the body to aid the function of a body organ or replace tissue lost due to illness or injury.

6. Removal of breast implants due to association with Anaplastic Large Cell Lymphoma.

Benefits are not payable for incidental or inclusive surgical procedures which are performed at the same setting as a major covered surgical procedure, which is the primary procedure. Incidental or inclusive surgical procedures are one or more surgical procedures performed through the same incision or operative approach as the primary surgical procedure with the highest charge as determined by us and which, in our opinion, are not clearly identified and/or do not add significant time or complexity to the surgical session. Benefits payable for incidental surgical procedures are limited to the charge for the primary surgical procedure with the highest charge, as determined by us. No additional benefits are payable for those incidental surgical procedures. For example, the removal of an appendix during the same operative session in which a hysterectomy is performed is an incidental surgical procedure (i.e., benefits are payable for the hysterectomy, but not for the removal of the appendix).

Telemedicine

1. Definition of Telemedicine: the delivery of clinical health care services via telecommunications technologies including but not limited to telephone and interactive audio video conferencing.

2. Covered Telemedicine Services:

a) Telemedicine services provided by a physician to a covered person via interactive audio-visual telecommunication to treat a covered illness physical illness, nervous or mental disorder, alcoholism or drug abuse, or injury.

b) Telephone and interactive audio and video conferencing provided by our approved telehealth service providers. Visit https://wpshealth.com/resources/customer-resources/telehealth.shtml or call the Customer Service telephone number shown on your identification card for additional information about this benefit.

3. Telemedicine Exclusions:

a) Transmission fees.

b) Website charges for online patient education material.

Temporomandibular Joint Disorders (TMJ)

Diagnostic procedures and medically necessary surgical and non-surgical treatment for the correction of temporomandibular disorders if all of the following apply:

1. The condition is caused by congenital, developmental or acquired deformity, disease or injury;

2. Under the accepted standards of the profession of the health care provider providing the service, the procedure is reasonable and appropriate for the diagnosis or treatment of the condition; and

3. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Non-surgical treatment includes coverage for prescribed intraoral splint therapy devices.

Benefits are not payable for cosmetic or elective orthodontic care, periodontic care or general dental care.

Therapy Services

Outpatient physical, massage, speech, respiratory and occupational therapy. Massage therapy is covered only when the therapy is billed by a chiropractor, physical therapist or occupational therapist.

The therapy must be: (a) ordered by a physician prior to the commencement of therapy for treatment of a physical illness or injury; and (b) expected to provide significant measurable gains that will improve your physical health within 60 days of the date on which such therapy begins. The therapy must be performed by: (a) a physician; (b) a licensed physical, speech, or occupational therapist; or (c) any other health care provider approved by us. The licensed therapist or other health care provider must be providing the therapy under the direction of your physician. If a license to perform such therapy is required by law, that therapist or other health care provider must: (a) be licensed by the state in which he/she is located; and (b) provide such therapy while he/she is acting within the lawful scope of his/her license. Physical therapy for your temporomandibular joint disorder is not covered under this paragraph.

Transplants

1. Definitions.

The following definitions apply to this subsection only:

Covered Transplant Drugs: immunosuppressant drugs prescribed by a physician when dispensed by a provider while you are not confined in a hospital. These drugs do not include high dose chemotherapy, except for high dose chemotherapy provided for a covered bone marrow transplant. This includes refills of immunosuppressant drugs.

Designated Transplant Facility: (a) a facility that has agreed to provide approved transplant services to covered persons pursuant to an agreement with a transplant provider network with which we have a contract; (b) a preferred provider when transplant services are provided while you are not confined in a hospital; or (c) any other health care provider approved by us. Designated transplant facilities are shown in the Schedule of Benefits as preferred providers.

Non-Designated Transplant Facility: a facility that does not have an agreement with the transplant provider network with which we have a contract. This may include facilities that are listed as preferred providers. Non-designated transplant facilities are shown in the Schedule of Benefits as non-preferred providers.

Organ and Tissue Acquisition: the harvesting, preparation, transportation, and storage of human organ and tissue that is transplanted to you. This includes related medical expenses of a living donor.

Transplant Services: approved health care services for which a prior authorization has been received and approved for transplants when ordered by a physician. Such services include, but are not limited to, hospital charges, physician's charges, organ and tissue procurement, tissue typing, and ancillary services.

2. Benefits.

All transplant services require prior authorization. If prior authorization is properly obtained, we'll pay benefits for charges for covered expenses you incur at a designated transplant facility or non-designated transplant facility as determined by us during the prior authorization process for an illness or injury. Transplant benefits are subject to any deductibles, coinsurance, maximum or limits shown in the Schedule of Benefits.

It is your responsibility to obtain a prior authorization for all transplant related services, including but not limited to the initial transplant evaluation. The transplant must meet our medical necessity criteria for such transplant and may not be experimental/investigational/unproven.

We will pay for approved transplant services, including but not limited to:

a. organ and tissue acquisition and transplantation, including any post-transplant complications, if you are the recipient; or

b. related medical care, including any post-harvesting complication, if you are a donor.

Covered expenses for transplant services include health care services for approved transplants when ordered by a physician. Health care services include, but are not limited to, hospital charges, physician charges, organ and tissue acquisition, tissue typing, and ancillary services. Covered transplant drugs are payable as described in subsection "Prescription Legend Drugs and Supplies."

Benefits are payable for the following approved transplants:

a. kidney;

b. kidney/pancreas;

c. liver;

d. heart;

e. heart/lung;

f. lung;

g. bone marrow (allogenic and autologous), when not considered to be experimental/investigational/unproven;

h. stem cell transplants, when not considered to be experimental/investigational/unproven;

i. small bowel transplantation; and

j. cornea.

k. any other transplant approved by us.

EXCLUSIONS AND LIMITATIONS

The policy provides no benefits for any of the following:

General Exclusions

1. Health care services that we determine are not medically necessary.

2. Health care services that we determine are experimental/investigational/unproven, except for investigational drugs used for the treatment of HIV infection as described in Wis. Stat. § 632.895 (9).

3. Health care services provided in connection with any injury or illness arising out of, or sustained in the course of, any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance. If you are covered by workers' compensation insurance, this exclusion applies regardless of whether benefits under worker's compensation laws or any similar laws have been claimed, paid, waived, or compromised.

4. Health care services furnished by the U.S. Veterans Administration, unless federal law designates the policy as the primary payer and the U.S. Veterans Administration as the secondary payer.

5. Health care services furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless such coverage under the policy is required by law.

6. Health care services covered by Medicare, if you have or are eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such health care services for which under applicable federal law the policy is the primary payer and Medicare is the secondary payer. Please also see section "COVERAGE WITH MEDICARE."

7. Health care services for any illness or injury caused by any military-related act or incident of declared or undeclared war, riots, or insurrection.

8. Health care services for any illness or injury you sustain: (a) while on active duty in the armed services of any country; or (b) as a result of you being on active duty in the armed services of any country.

9. Custodial care or rest care.

10. That portion of the amount billed for a health care service covered under the policy that exceeds our determination of the charge for such health care service.

11. General fitness programs, exercise programs, exercise equipment, personal trainers and health club memberships.

12 Medications for which the primary purpose is to preserve fertility.

13. Health care services provided while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in custody of law enforcement officials, except as required under Wis. Stat. § 609.65. This exclusion does not apply to covered persons on work-release.

14. Completion of claim forms or forms necessary for the return to work or school.

15. An appointment you did not attend.

16. Telehealth, except as specifically stated in subsection "Medical Services."

17. Health care services for which you have no obligation to pay or which are provided to you at no cost.

18. Health care services resulting or arising from complications of, or incidental to, any health care service not covered under the policy, except for complications of, or services incidental to, a covered employee's or his/her spouse's elective abortion.

19. Health care services requested by a third party for employment, licensing, insurance, marriage, adoption, travel, disability determinations, or court-ordered exams, other than as specifically stated in the policy or required by law.

20. Cranial banding or orthotic helmets, unless required after cranial surgery.

21. Private duty nursing.

22. Marriage counseling.

23. Reversal of sterilization.

24. Transportation or other travel costs associated with a health care service, except as specifically provided in subsection "Ambulance Services."

25. Bereavement counseling, unless provided as part of hospice coverage.

26. Health care services that are excluded elsewhere in the policy.

27. Health care services not specifically identified as being covered under the policy, except for those health care services approved by us subject to subsection "Alternative Care."

28. Health care services provided in connection with a health care service not covered under the policy.

29. Health care services provided when your coverage was not effective under the policy. Please see section "WHEN COVERAGE ENDS."

30. Health care services not provided by a physician or any of the health care providers listed in section "COVERED EXPENSES."

31. The following procedures and any related health care services:

a. injection of filling material (collagen) other than for incontinence;

b. salabrasion;

c. rhytidectomy (face lift);

d. dermabrasion;

e. chemical peel;

f. suction-assisted lipectomy (liposuction);

g. hair removal;

h. mastopexy;

i. augmentation mammoplasty (except for reconstruction associated with mastectomy);

j. correction of inverted nipples;

k. sclerotherapy for spider veins;

l. panniculectomy;

m. mastectomy for male gynecomastia;

n. botulinum toxin or similar products, unless you receive our prior authorization;

o. any modification to the anatomic structure of a body part that does not affect its function;

p. labioplasty; and

q. treatment of sialorrhea (drooling or excessive salivation).

32. Health care services provided at any nursing facility or convalescent home or charges billed by any place that's primarily for rest, for the aged or for drug abuse or alcoholism treatment, except as specifically stated in subsection “Behavioral Health Services.”

33. Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (b) in the cutting or trimming of toenails; or (c) in the non-operative partial removal of toenails. This exclusion does not apply to such health care services which are incidental to a covered illness or injury.

34. Health education; complementary, alternative or holistic medicine; or other programs with an objective to provide personal fulfillment.

35. Health care services that you receive not for the treatment of your own illness or injury, but in connection with the treatment of a collateral who is not a covered person under the policy.

36. Housekeeping, shopping, or meal preparation services.

37. Health care services provided in connection with: (a) any illness or injury caused by your engaging in an illegal occupation; or (b) any illness or injury caused by your commission of, or an attempt to commit, a felony.

38. Maintenance care or supportive care.

39. Health care services provided in connection with the temporomandibular joint or TMJ syndrome, except as specifically stated in subsection “Temporomandibular Joint Disorder (TMJ).”

40. Health care services for which proof of claim isn't provided to us in accordance with subsection “Filing Claims.”

41. Health care services and prescription legend drugs provided in connection with alcoholism, drug abuse and nervous or mental disorders, except as specifically stated in the following subsections: (a) “Hospital Services" (limited to inpatient hospital services for detoxification of drug addiction or alcohol dependency);" (b) "Behavioral Health Services;” (c) "Nutritional Counseling;" (d) “Prescription Legend Drugs and Supplies;” and (e) “Skilled Nursing Care in a Skilled Nursing Facility.”

42. Health care services not for or related to an illness or injury, other than as specifically stated in the policy.

43. Sales tax or any other tax, levy, or assessment by any federal or state agency or a local political subdivision.

44. Costs associated with indirect services provided by health care providers such as: creating standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; reviewing quality assurance data; transporting lab specimens; physician concierge payments; translating claim forms or other records; and after-hours charges.

45. Treatment of weak, strained, flat, unstable or unbalanced feet except as specifically stated otherwise in section Covered Expenses / Orthotics.

46. Health care services for treatment of sexual dysfunction, including impotence, regardless of the cause of the dysfunction. This includes: (a) surgical services; (b) devices; (c) drugs for, or used in connection with, sexual dysfunction; (d) penile implants; (e) sex therapy; and (f) the treatment of Peyronie's disease.

47. Health care services not supported by information contained in your medical records or from other relevant sources.

48. Health care services provided for your convenience or for the convenience of a physician, hospital, or other health care provider.

49. Baseline neuropsychological testing, for example, impact testing.

50. Magnetic sphincter augmentation (Linx® System); transoral incisionless fundoplication procedures.

51. Health care services that are for purposes of educational, occupational or athletic enhancement.

52. Storage of blood tissue, cells, or any other body fluids.

53. Salivary hormone testing.

54. Prolotherapy.

55. Platelet-rich plasma.

56. Coma stimulation programs.

57. In lab polysomnogram (PSG), unless a home sleep study is determined by us to not be medically appropriate.

Cosmetic Treatment Exclusion

Health care services that we determine to be cosmetic treatment.

Dental Services Exclusions

1. The care and treatment of teeth, gums, or alveolar process including dentures, appliances, or supplies used in such care or treatment.

2. Injuries or damage to teeth (natural or otherwise) that result from or are caused by the chewing of food or similar substances.

3. Dental implants or other implant related procedures, except as specifically stated in subsection "Dental Services."

4. Tooth extraction of any kind, except as specifically stated in subsection "Dental Services."

Drug Exclusions

1. Non-legend vitamins, minerals, and supplements even if prescribed by a physician, except as specifically stated in subsection "Prescription Legend Drugs."

2. Retinoids, Minoxidil, Rogaine, or their medical equivalent in the topical application form.

3. Medications, drugs, or hormones to stimulate human biological growth, unless there is a laboratory-confirmed physician's diagnosis of your growth hormone deficiency.

Durable Medical Equipment, Medical Supplies and Prosthesis Exclusions

1. Modifications to your vehicle, home or property including, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, chair lifts, grab bars, raised toilet seats, commodes, or ramps.

2. Medical supplies and durable medical equipment for your comfort, personal hygiene, or convenience including, but not limited to, physical fitness equipment, physician's equipment, disposable supplies (other than colostomy supplies, enteral therapy supplies and/or urinary catheters and supplies), or self-help devices not medical in nature.

3. Environmental items including, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

4. Wigs, toupees, hairpieces, cranial prosthesis, hair implants, or transplants or hair weaving.

5. Replacement of batteries and routine periodic maintenance of durable medical equipment, except for periodic maintenance for oxygen concentrators under a maintenance agreement which consists of one month rental billed every six months.

6. Rental fees for durable medical equipment that are more than the purchase price.

7. Durable medical equipment or prosthetics that we determine to have special features.

8. Continuous passive motion (CPM) devices and mechanical stretching devices.

9. Repairs due to abuse or misuse.

10. Home devices such as:

- **a.** home spinal traction devices or standers;
- **b.** home INR (international normalized ration blood test) monitors;
- **c.** home phototherapy for dermatological conditions;
- **d.** cold therapy (application of low temperatures for the skin) including, but not limited to, cold packs, ice packs, cryotherapy.

11. Light boxes for behavioral health conditions.

12. Car seats.

Genetic Counseling, Studies, and Testing Exclusions

1. Genetic counseling, studies and testing other than the coverage that is specifically provided in subsection "Genetic Services."

2. Genetic testing for the purposes of confirming a suspected diagnosis of a disorder that can be diagnosed based on clinical evaluations alone.

3. Genetic testing for conditions which cannot be altered by treatment or prevented by specific interventions.

4. Genetic testing solely for the purpose of informing the care or management of your family members.

5. Genetic counseling performed by the laboratory that performed the genetic test.

Hearing Services Exclusions

1. Augmentation communication devices and related instruction or therapy.

2. Hearing protection equipment.

Hospital Services Exclusion

Hospital stays if care could be provided in a less acute setting.

Infertility Exclusions

1. Health care services associated with expenses for infertility or fertility treatment, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to health care services required to treat or correct underlying causes of infertility.

2. Direct attempts to achieve pregnancy or increase chances of achieving pregnancy by any means.

3. Evaluation and treatment of habitual abortions (three consecutive documented spontaneous abortions in the first or second trimesters) when not pregnant.

4. Any laparoscopic procedure during which an ovum is manipulated for the purpose of fertility treatment even if the laparoscopic procedure includes other purposes.

Maternity Exclusions

1. Birthing classes, including Lamaze classes.

2. Abortion procedures, except as specifically stated in subsection “Maternity Services.”

3. Home births.

Reconstructive Surgery Exclusions

Reconstructive surgery, except as stated in subsection “Surgical Services.”

Rehabilitation/Rehabilitative Services Exclusions

1. Vocational or industrial rehabilitation including work hardening programs.

2. Cardiac rehabilitation beyond Phase II.

3. Sports hardening and rehabilitation.

4. Health care services used in educational or vocational training or testing.

5. Health clubs or health spas, aerobic and strength conditioning, functional capacity exams, physical performance testing, and all related material and products for these programs.

6. Long-term therapy and maintenance therapy.

Therapy Exclusions

1. Massage therapy or aquatic therapy, except as specifically stated in subsection "Therapy Services."

2. Hypnosis.

3. Sex therapy.

4. Chelation therapy, except in the treatment of heavy metal poisoning.

5. Health care services for holistic or homeopathic medicine or other programs that are not accepted medical practice, as determined by us, including, but not limited to, aromatherapy, herbal medicine, naturopathy, and reflexology.

6. Biofeedback, except for fecal/urinary incontinence.

7. Health care services by an athletic trainer.

8. Therapy services such as recreational therapy (other than recreational therapy included as part of a treatment program received during an inpatient hospital confinement for treatment of nervous or mental disorders, alcoholism or drug abuse), educational therapy, physical fitness, or exercise programs, except as specifically stated in subsection "Cardiac Rehabilitation Services" and "Therapy Services."

9. Photodynamic therapy and laser therapy for the treatment of acne.

Transplant Exclusions

1. Transplants considered by us to be experimental, investigational, or unproven.

2. Expenses related to the purchase of any organ.

3. Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, except as specifically stated in subsection "Transplants."

4. Lodging expenses, including meals, unless such expenses are covered under the global fee agreement of your transplant network.

Vision Services Exclusions

1. Vision therapy;

2. Orthoptic therapy and pleoptic therapy (eye exercise);

3. Preparation, fitting or purchase of eye glasses or contact lenses, except as specifically stated in the policy;

4. Correction of visual acuity or refractive errors by any means, except as specifically stated in the policy;

5. Implantable accommodating lenses to improve vision following cataract surgery;

Weight Control Exclusions

Health care services provided in connection with a diagnosis of obesity, morbid obesity, weight control, or weight reduction, regardless of whether such services are prescribed by a physician or associated with an illness or injury. Services excluded under this provision include, but are not limited to:

1. Wiring of the jaw;

2. Liposuction;

3. Drugs;

4. Weight loss programs, unless benefits are provided elsewhere in the policy;

5. Physical fitness or exercise programs or equipment, unless benefits are provided elsewhere in the policy; and

6. Bone densitometry (DEXA, DXA) scans.

Preventive/Wellness Care Exclusion

Immunizations for travel purposes.

COORDINATION OF BENEFITS (COB)

Applicability

1. This section applies when you have health care coverage under more than one plan. “Plan” and “this plan” are defined below.

2. If this section applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

a. shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

b. may be reduced when, under the order of benefit determination rules, another plan determines its benefits first. This reduction is described in subsection “Effect on the Benefits of This Plan.”

Definitions

The following definitions apply to this section only:

1. **Allowable Expense:** a health care service or expense, including deductibles and copayments, that is covered at least in part by one or more plans covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided shall be considered both an allowable expense and a benefit paid.

2. **Claim Determination Period:** a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this section or a similar provision takes effect.

3. **Custodial Parent:** a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

4. **Plan:** any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Individual or group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

   b. Coverage under a governmental plan or coverage that is required or provided by law.. It does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

   c. Medical expense benefits coverage in group, group-type and individual automobile "no-fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis are included.

   Each contract or other arrangement for coverage under a., b. or c. above is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

5. **Primary Plan/Secondary Plan:** Subsection "Order of Benefit Determination Rules" states whether this plan is a primary plan or secondary plan as to another plan covering the person.

   When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

   When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

   When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan or plans.

6. **This Plan:** the part of the policy that provides benefits for health care expenses.

Order of Benefit Determination Rules

1. **General.**

   When there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan, unless:

   a. the other plan is automobile medical expense benefit coverage or has rules coordinating its benefits with those of this plan; and

   b. both those rules and this plan's rules described in 2. below require that this plan's benefits be determined before those of the other plan.

2. Rules.

This plan determines its order of benefits using the first of the following rules which applies:

a. **Non-dependent/Dependent.** The benefits of the plan which covers the person as an employee, member or subscriber are determined before those of the plan which covers the person as a dependent of an employee, member or subscriber.

b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in 2. c. below, when this plan and another plan cover the same child as a dependent of different persons, called "parents":

(1) the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in that calendar year; but

(2) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rules described in (1) but instead has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits.

c. **Dependent Child/Separated or Divorced Parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the plan of the parent with custody of the child;

(2) then, the plan of the spouse of the parent with custody of the child; and

(3) finally, the plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to 2. b. above.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. **Active/Inactive Employee.** The benefits of a plan which covers a person as an employee who is neither laid-off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule d. is ignored. If a dependent is a Medicare beneficiary and if, under the Social Security Act of 1965 as amended, Medicare is secondary to the plan covering the person as a dependent of an active employee, the federal Medicare regulations shall supersede this paragraph d.

e. **Continuation Coverage.**

(1) If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

(a) first, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber;

(b) second, the benefits under the continuation coverage.

(2) If the other plan does not have the rule described in subparagraph (1), and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

g. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of This Plan

1. When This Subsection Applies.

This subsection applies when, in accordance with subsection "Order of Benefit Determination Rules," this plan is a secondary plan as to one or more other plans. In that event the benefits of this plan may be reduced under this subsection. Such other plan or plans are referred to as "the other plans" in 2. below.

2. Reduction in This Plan's Benefits.

The benefits of this plan will be reduced when the sum of the following exceeds the allowable expenses in a claim determination period:

a. the benefits that would be payable for the allowable expenses under this plan in the absence of this section; and

b. the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made. Under this provision, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Right to Receive and Release Needed Information

We have the right to decide which facts we need to apply these COB rules. We may get needed facts from or give them to any other organization or person without your consent but only as needed to apply these COB rules. Medical records remain confidential as provided by law. Each person claiming benefits under this plan must give us any facts we need to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this section, we may recover the excess from one or more of:

1. The persons we paid or for whom we paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coverage with Medicare

The policy will coordinate benefits with Medicare in accordance with federal law.

If you are eligible for Medicare benefits, but do not enroll in them, the policy will coordinate benefits as if you were covered by Medicare. For example, if you are eligible to enroll in Medicare Part B but fail to do so, we will still determine benefits that are payable under the policy as if you had Medicare Part B coverage and Medicare paid Part B benefits, even if Medicare didn't pay any Part B benefits. You will be responsible for all covered expenses that would have been covered by Medicare.

WHEN COVERAGE ENDS

General Rules

We may terminate your coverage under the policy on the earliest of the following dates:

1. The date the policy terminates.

2. The day immediately following the last day of the calendar month in which you die.

3. The day immediately following the last day of the calendar month for which the premium required for your coverage has been paid to us in accordance with the policy.

4. The date you enter into military service, other than for duty of less than 30 days.

5. The day immediately following the last day of the calendar month in which the covered employee's employment terminates**.**

6. The day immediately following the last day of the calendar month in which we determine the covered employee is not within the class of employees eligible for coverage under the policy or is not actively at work. However, the employee's coverage under the policy may continue if:

a. he/she is granted an approved leave of absence protected by the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), or any workers' compensation leave of absence. In this case, the covered employee's coverage will continue until the day immediately following the last day of the calendar month in which we determine the covered employee fails to return to work from that leave of absence;

b. he/she is granted a leave of absence under the policyholder's established leave of absence policy. In this case, the covered employee's coverage will continue no longer than three consecutive

months following the date on which his/her coverage would have otherwise ended, unless a later date is specifically stated in the employer's leave of absence policy. Such leave of absence policy and any supporting documentation must be provided to us upon our request;

c. the covered employee is subject to a collective bargaining agreement. In this case, the covered employee's coverage will continue as stated in that agreement if that agreement has termination dates other than as stated in a. or b. above. Such collective bargaining agreement and any supporting documentation must be provided to us upon our request.

The policyholder must continue to pay the required premiums during any period of continued coverage stated in this paragraph 6.

7. The day immediately following the last day of the calendar month in which a covered employee requests that his/her coverage terminate under the policy.

8. For a covered employee's covered dependent, the date the covered employee's coverage terminates.

9. For a covered employee's spouse or domestic partner who is a covered person: (a) the day immediately following the last day of the calendar month the covered employee's spouse is no longer married to the covered employee due to divorce or annulment; or (b) the day immediately following the last day of the calendar month the domestic partner no longer meets the requirements stated in the definition of "dependent."

10. For a child who is a covered dependent, the earliest of the following dates, as determined by us:

a. the day immediately following the last day of the calendar month in which the child reaches age 26, unless he/she is a full-time student returning from military duty or a disabled dependent as defined in the policy;

b. for step-children, the day immediately following the last day of the calendar month the covered employee's spouse is no longer married to the covered employee due to divorce or annulment.

A full-time student who attains the limiting age while covered under the policy will remain eligible for benefits until the day immediately following the last day of the calendar month in which the child ceases to be a full-time student as defined in the policy.

11. For a child of a covered dependent child, the date the dependent child reaches age 18.

12. For a child of a domestic partner, the date the domestic partner's coverage ends under the policy.

If a dependent has attained the limiting age while covered under the policy and continues coverage as a full-time student, he/she may continue coverage if he/she ceases to be a full-time student due to a medically necessary leave of absence. In order to continue coverage, we must receive written documentation and certification of the medical necessity of the leave of absence from his/her attending physician. The date on which he/she ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which coverage continuation begins.

Coverage shall continue for that full-time student until the earliest of the following dates:

1. He/she advises us that he/she does not intend to return to school full-time;

2. He/she becomes employed full time;

3. He/she obtains other health care coverage;

4 He/she marries and is eligible for coverage under his/her spouse's health coverage;

5. The date coverage of the subscriber through whom he/she has dependent coverage under the policy is discontinued or not renewed; or

6. One year following the date his/her continuation coverage began and he/she has not returned to school on a full-time basis.

If you have family coverage under the policy, a dependent child who is intellectually disabled or physically handicapped may continue coverage under your family coverage beyond the limiting age as set forth in subsection "Eligible Dependent."

It is the covered employee's responsibility to notify us of his/her child losing dependent status. If he/she does not so notify us, the covered employee shall be responsible for any claim payments made during the period of time the dependent was not eligible for coverage under the policy.

Special Rules for Full-Time Students Returning from Military Duty

A full-time student returning from military duty may continue coverage if he/she ceases to be a full-time student due to a medically necessary leave of absence. In order to continue coverage, we must receive written documentation and certification of the medical necessity of the leave of absence from his/her attending physician. The date on which he/she ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which coverage continuation begins.

Coverage shall continue for a full-time student returning from military duty on a medically necessary leave of absence until the earliest of the following dates:

1. He/she advises us that he/she does not intend to return to school full-time;

2. He/she becomes employed full time;

3. He/she obtains other health care coverage;

4 He/she marries and is eligible for coverage under his/her spouse's health coverage;

5. The date coverage of the subscriber through whom he/she has dependent coverage under the policy is discontinued or not renewed; or

6. One year following the date his/her continuation coverage began and he/she has not returned to school on a full-time basis.

It is the covered employee's responsibility to notify us of his/her child losing dependent status. If he/she does not so notify us, the covered employee shall be responsible for any claim payments made on behalf of the child while he/she was not eligible for coverage under the policy.

Special Rules for Disabled Children

If you have family coverage under the policy, a child who is: (1) incapable of self-sustaining employment because of intellectual disability or physical impairment; and (2) chiefly dependent upon the covered employee for support and maintenance, may continue coverage under your family coverage beyond the limiting age as set forth in the definition of dependent.

Written proof of a child's disability must be given to us within 31 days after the child turns age 26. Failure to provide such proof within that 31-day period shall result in the termination of that child's coverage. After the child turns 28, we may request poof of disability annually.

It is the covered employee's responsibility to notify us of his/her child no longer qualifies as a dependent due to his/her intellectual disability or physical impairment. If he/she does not so notify us, the covered employee shall be responsible for any claim payments made on behalf of the child during the period of time he/she was not eligible for coverage under the policy.

Extension of Benefits

This subsection only applies when (1) the policy is not replaced by another group health insurance policy, group health plan, or self-insured group health benefits plan; and (2) we determine that Wis. Admin. Code §§ Ins 6.51 (6) and (7) require that we provide an extension of coverage.

On the date the policy ends for all covered persons, benefits will continue for each covered person who, on the date the policy ends, is:

1. Totally disabled; or

2. Confined in a hospital.

An extension of benefits provided under this subsection shall end on the earliest of the following dates:

1. The day you are no longer totally disabled or no longer confined in a hospital;

2. The day on which 12 consecutive months have passed since the date the policy ended; or

3. The day on which coverage for the condition(s) causing your total disability or confinement is provided under similar coverage, other than temporary coverage required by Wis. Admin. Code § Ins 6.51 (7m) (b) under another group health plan.

This extension of benefits doesn't provide coverage for dental services, uncomplicated pregnancies or for any injury or illness other than the covered illness or injury causing the covered employee's total disability, the dependent's confinement, or the dependent's total disability.

CONTINUATION COVERAGE PRIVILEGE

Wisconsin Law

In certain cases you may be eligible to continue coverage that would otherwise end under section "WHEN COVERAGE ENDS" in accordance with Wis. Stat. § 632.897. Those who are eligible to purchase continuation coverage are: (1) covered employees who are no longer eligible for coverage under the policy through the policyholder, except if their employment is terminated for misconduct; or (2) a covered employee's spouse or dependent who is no longer eligible for coverage under the policy through the policyholder due to divorce, annulment or death of the covered employee. In either case, you must be covered under the policy through the policyholder for at least three consecutive months immediately prior to the termination date of your coverage in order to qualify for continuation coverage.

Within five days of the policyholder's receiving notice to end your coverage or notice that you are eligible under (1) or (2) above, the policyholder must notify you of:

1. Your option to continue your coverage under this subsection;

2. The monthly premium amount you must pay to continue your coverage. The premium amount for continuation coverage will be at the premium rate that we require for such coverage;

3. The manner in which and the place to which you must make premium payments; and

4. The time by which you must pay the premiums required for continuation coverage.

If you are eligible to purchase continuation coverage under Wis. Stat. § 632.897 and timely elect to continue your coverage and pay to the policyholder the required premium within 30 days after receiving the notice described above from the policyholder, the policyholder must notify us of your election of continuation coverage as soon as

reasonably possible in the manner required by us. Your continuation coverage under the policy may be continued until the earliest of the following dates:

1. The date you become eligible for other similar group health care coverage or the same coverage under the policy;

2. For a covered employee's spouse, the date the covered employee is no longer eligible for coverage under the policy;

3. The date the policy terminates;

4. The date you move out of Wisconsin;

5. The end of the last coverage period for which you paid the required premium; or

6. 18 consecutive months after you elect continuation coverage.

If any of the six events described above applies to a covered person with continuation coverage, the covered person whose continuation coverage terminated under the policy due to that event must give written notice of that event to the policyholder and us as soon as reasonably possible. The policyholder must also notify us of that event as soon as reasonably possible after becoming aware of that event.

The continuation coverage described above is made available by us only to the limited extent that we're required to provide such coverage under Wis. Stat. § 632.897. Nothing in this section provides, or shall be interpreted or construed to provide, any coverage in excess of, or in addition to, the continuation coverage required to be provided by us under Wis. Stat. § 632.897.

Federal Law

A covered person who is no longer eligible for coverage under the policy, such as a covered person whose employment ends with the policyholder, certain dependent children, or a divorced or surviving spouse and his/her children, may be eligible to purchase continuation coverage under the policy in accordance with the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended.

You must contact the policyholder within 60 days of a divorce or a child losing dependent status under the policy in order to be eligible for COBRA continuation. You have 60 days following the termination date to elect to continue coverage under COBRA.

If you are eligible to purchase continuation coverage under COBRA, please see the policyholder for further information.

COVERAGE WITH MEDICARE

If covered charges are incurred by a covered person who is a Medicare beneficiary, we will determine the benefits payable under the policy using the following rules. The rules require Medicare to pay as the secondary payer (and the employer group health plan to pay as the primary payer) when:

1. The covered person (employee or the employee's spouse) is age 65 or older and is covered under an employer group health plan of an employer that employs at least 20 persons (including part time employees) for a minimum of 20 weeks during the current or preceding calendar year and has not elected to have Medicare as the sole source of medical protection.

2. The covered person is under age 65, is covered under an employer group health plan of an employer of at least 100 employees, as a result of the covered person's current employment status or that of a covered family member, and is receiving Medicare benefits due to a permanent and total disability. In this case, the employer must have at least 100 people actively employed 50 percent or more of the regular business days in the preceding calendar year.

A person with “current employment status” is an individual who is working as an employee, is the employer (including self-employed persons) or is an individual associated with the employer in a business relationship.

3. A covered person is covered under an employer group health plan, and has end-stage renal disease (ESRD). If an ESRD patient has health insurance coverage under an employer group health plan, Medicare is secondary for 30 months from entitlement to, or eligibility for, Medicare Part A based on ESRD.

GENERAL PROVISIONS

Your Relationship with Your Physician, Hospital or Other Health Care Provider

We won't interfere with the professional relationship you have with your physician, hospital or other health care provider. We do not require that you choose any particular physician, hospital, or other health care provider, although there may be different benefits payable under the policy depending on your choice of physician, hospital, or other health care provider. We do not guarantee the competence of any particular physician, hospital, other health care provider, nor can we guarantee their availability to provide services to you. You must choose the physician, hospital, or other health care provider you would like to see and you also must choose what health care services you wish to receive. We're not responsible for any injury, damage or expense (including attorneys' fees) you suffer as a result of any improper advice, action or omission on the part of any physician, hospital, or other health care provider, including, but not limited to, any preferred provider. We're obligated only to provide the benefits as specifically stated in the policy.

Physician, Hospital or Other Health Care Provider Reports

Physicians, hospitals and other health care providers must release medical records and other claim-related information to us so that we can determine what benefits are payable to you. By accepting coverage under the policy, you authorize and direct the following individuals and entities to release such medical records and information to us, as required by a particular situation and allowed by applicable laws:

1. Any physician who has diagnosed for, attended, treated, advised or provided health care services to you;

2. Any hospital in which you were treated or diagnosed;

3. Any other health care provider who has diagnosed, attended, treated, advised or provided services to you; and

4. Any other insurance company, service, or benefit plan that possesses information that we need to determine your benefits under the policy.

This is a condition of our providing coverage to you. It's also a continuing condition of our paying benefits.

Assignment of Benefits

This coverage is just for a covered employee and his/her covered dependents. Benefits may be assigned to the extent allowed by the Wisconsin insurance laws and regulations.

Subrogation

We have the right to subrogate against a third party or to seek reimbursement from you for the medical expenses necessarily incurred by you and related to an illness or injury caused by a third party. When you receive a benefit under the policy for an illness or injury, we are subrogated to your right to recover the reasonable value of the services provided for your illness or injury to the extent of the benefits we have provided under the policy.

Our subrogation rights include the right of recovery for any injury or illness a third party caused or is liable for. "Third party" claims are claims against any insurance company or any person or party that is in any way responsible for providing payment as a result of the illness or injury. These rights also include the right of recovery under uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, and any other applicable insurance. We may pursue our rights of subrogation against any party liable for your illness or injury or any party that has contracted to pay for your illness or injury. In the event you have or may recover for your Injury, we have the right to seek reimbursement from you for the actual cash value of any payments made by us to treat such illness or injury.

You or your attorney or other representative agree to cooperate with us in pursuit of these rights and shall:

1. Sign and deliver all necessary papers we reasonably request to protect or enforce our rights;

2. Do whatever else is necessary to protect or allow us to enforce our rights including joining us as a party as we may request when you have commenced a legal action to recover for a personal injury; and

3. Shall not do anything before or after our payment that would prejudice our rights.

Our right to subrogate shall not apply unless you have been made whole for loss of payments which you or any other person or organization is entitled to on account of illness or injury. You agree that you have been made whole by any settlement where your claim has been reduced because of your contributory negligence. You also agree that you have been made whole if you receive a settlement for less than the third party's insurance company's policy limits. If a dispute arises over the question of whether or not you have been made whole, we reserve the right to seek a judicial determination of whether or not you have been made whole.

We will not pay fees or costs associated with any claim or lawsuit without our express written consent. We reserve the right to independently pursue and recover paid benefits.

Limitation on Lawsuits and Legal Proceedings

By accepting coverage under the policy, you agree that you will not bring any legal action against us regarding benefits, claims submitted, the payment of benefits or any other matter concerning your coverage until the earlier of: (1) 60 days after we've received or waived the proof of claim described in subsection "Filing Claims" below; or (2) the date we deny payment of benefits for a claim. This provision does not apply if waiting will result in prejudice against you. However, the mere fact that you must wait until the earlier of the above dates does not alone constitute loss or injury.

By accepting coverage under the policy, you also agree that you will not bring any legal action against us more than three years after the time we require written proof of claim. Please see subsection "Filing Claims" below.

Severability

Any term, condition or provision of the policy that is prohibited by Wisconsin law shall be void and without force or effect. This, however, won't affect the validity and enforceability of any other remaining term, condition or provision of the policy. Such remaining terms, conditions or provisions shall be interpreted in a way that achieves the original intent of the parties as closely as possible.

Filing Claims

1. How to File a Claim.

After health care services are provided to you, either you or your health care provider must submit a claim to us in accordance with this subsection. The following information must be filed with us within 120 days after receiving a health care service:

a. claim forms (including the proper code for each health care service, date of each health care service, name of the health care provider, place of service and billed charges) received from the health care provider at the time of the health care service; and

b. proof of payment.

If you receive health care services in a country other than the United States, you will need to pay for the health care services upfront and then submit the claim to us for reimbursement. We will reimburse you for any covered expenses in U.S. currency. The reimbursement amount will be based on the U.S. equivalency rate that is in effect on the date you paid the claim or on the date of service if the date of payment is unknown.

2. Time Limit on Filing Claims.

If you do not file the required information within 120 days after receiving a health care service, benefits will be paid for covered expenses if:

a. it was not reasonably possible to provide the required information within such time; and

b. the required information is furnished as soon as possible and no later than one year following the initial 120-day period. The only exception to this rule is if you are legally incapacitated. If we do not receive written proof of claim required by us within that one-year and 120-day period and you are not legally incapacitated, no benefits are payable for that health care service under the policy.

3. How to Appeal a Claim Denial.

If a claim is denied, you may appeal the denial by filing a written grievance. Please refer to subsection "Our Internal Grievance Procedure" for more information.

Conformity with Applicable Laws and Regulations

On the effective date of the policy, any term, condition or provision that conflicts with any applicable laws and regulations shall automatically conform to the minimum requirements of such laws and regulations.

Entire Contract

The entire contract between you and us is made up of the policy, including the policyholder's group application, the policyholder's supplemental applications, if any, the certificate, Schedule of Benefits, any endorsements, your application, and any supplemental applications.

Waiver and Change

Only our Chief Executive Officer can execute a waiver or make a change to the policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of the policy in any way or extend the time for any premium payment. We may unilaterally change any provision of the policy if we send written notice to the policyholder at least 30 days in advance of that change. When the change reduces coverage provided under the policy, we must send written notice of the change to the policyholder at least 60 days before any such change takes effect.

Any change to the policy shall be made by an endorsement signed by our Chief Executive Officer. Each endorsement shall be binding on the policyholder, all covered persons, and us. No error by us, the policyholder, or any covered person shall: (1) invalidate coverage otherwise validly in force; (2) continue or reissue coverage validly terminated; or (3) cause us to issue coverage that otherwise would not be issued. If we discover any error, we may, at our sole discretion, make an equitable adjustment of coverage, payment of benefits, and/or premium.

Direct Payments and Recovery

1. Direct Payment of Benefits.

Unless otherwise specifically stated in the policy, we have the option of paying benefits either directly to the physician, hospital or other health care provider, or to you as described below in subsection "Claims Processing Procedure." Payments for covered expenses for which we're liable may be paid under another group or franchise plan or policy arranged through your employer, trustee, union or association. If so, we can discharge our liability by paying the organization that has made these payments. In either case, such payments shall fully discharge us from all further liability to the extent of benefits paid.

2. Recovery of Excess Payments.

If we pay more benefits than what we're liable to pay for under the policy, including, but not limited to, benefits paid in error by us, we can recover the excess benefit payments from any person, organization, physician, hospital or other health care provider that has received such excess benefit payments. We can also recover such excess benefit payments from any other insurance company, service plan or benefit plan that has received such excess benefit payments. If we cannot recover such excess benefit payments from any other source, we can also recover such excess benefits payments from you. When we request that you pay us an amount of the excess benefit payments, you agree to pay us such amount immediately upon our notification to you. We may, at our option, reduce any future benefit payments for which we are liable under the policy on other claims by the amount of the excess benefit payments, in order to recover such payments. We will reduce such benefits otherwise payable for such claims until the excess benefit payments are recovered by us.

Workers' Compensation

This certificate is not issued in lieu of nor does it affect any requirements for coverage by workers' compensation insurance. Health care services for injuries or illnesses that are job, employment, or work related, and for which benefits are provided or payable under any workers' compensation or occupational disease act or law, are excluded from coverage by us. If a covered person receives benefits under this certificate for charges that are later determined to be eligible for coverage under any workers' compensation insurance, workers' compensation act, or employer liability law, the covered person shall reimburse us in full to the extent that benefits were paid by us under the policy for such charges. We reserve the right to recover against you even though:

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the illness or injury was sustained in the course of or resulted from employment; or

3. The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

Written Notice

Written notice that we provide to an authorized representative of the policyholder shall be deemed notice to all affected covered persons and their covered dependents. This provision applies regardless of the notice's subject matter.

Claims Processing Procedure

1. Definitions.

Correctly filed claim: a claim that includes: (a) the completed claim forms that we require; (b) the actual itemized bill for each health care service; and (c) all other information that we need to determine our liability to pay benefits under the policy, including but not limited to, medical records and reports.

Incomplete claim: a correctly filed claim that requires additional information including, but not limited to, medical information, coordination of benefits questionnaire, or subrogation questionnaire.

Incorrectly filed claim: a claim that is filed but lacks information which enables us to determine what, if any, benefits are payable under the terms and conditions of the policy. Examples include, but are not limited to, claims missing procedure codes, diagnosis or dates of service.

Urgent claim: any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or in the opinion of a physician with actual knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Procedures.

Benefits payable under the policy will be paid after receipt of a correctly filed claim or prior authorization request. We will notify you of our decision on your claim as follows:

a. **Concurrent Care.** Prior to the end of any pre-authorized course of treatment, if benefits are reduced or terminated prior to the number of treatments or time period that we authorized. The notice will provide time for you to file a grievance and receive a decision on that grievance prior to the benefit being reduced or terminated. This will not apply if the benefit is reduced or terminated due to a benefit change or termination of the policy.

Request to extend a pre-authorized treatment that involves urgent care must be responded to within 24 hours or as soon as possible if, your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

b. **Pre-Service Claims.** A pre-service claim is any claim for a benefit under the policy that requires prior authorization before obtaining medical care. For prescription legend drugs, submission of a prescription to a pharmacy or pharmacist will not constitute a claim for benefits under the terms and conditions of the policy. Claims made after 4:00 PM will be logged in and handled on the next business day.

(1) **Urgent Pre-Service Claims.** Within 72 hours of receipt of an urgent pre-service claim or as soon as possible if your condition requires a shorter time frame. You or a health care professional with knowledge of your medical condition may submit the claim to us by telephone, electronic facsimile (i.e. fax) or mail.

If the claim is an incomplete claim or incorrectly filed claim, we will notify you of the specific information needed as soon as possible but no later than 24 hours after we receive your claim. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of our receipt of the additional information, we will give our decision on the claim. If you fail to provide the information requested by us, we will provide you with our decision on the claim based on the most current information that we have within 48 hours of the end of the period that you were given to provide the information.

If you fail to follow our procedure for prior authorization requests, we will notify you within 24 hours of our receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior approval or precertification.

(2) **Non-Urgent Pre-Service Claims.** Within 15 days of receipt of a non-urgent pre-service claim.

If the claim is an incomplete claim or incorrectly filed claim, we will notify you of a 15 day extension and the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information. Once we have received the additional information, we will make our decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 15-day period. For example, if our notification was sent to you on the fifth day of the first 15-day period, we would have a total of 25 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 75 days from the date we received the non-urgent pre-service claim.

If you fail to follow our procedure for prior authorization requests, we will notify you within five days of our receipt of the request. The notice will include the reason why the request failed and the proper process for obtaining prior authorization.

(3) **Experimental Treatment.** Within 5 business days of receipt of a correctly filed pre-service claim for experimental treatment.

If you file an incomplete claim, an incorrectly filed claim, or if you fail to follow our prior authorization procedure, we will notify you as indicated in paragraph (1) or (2) above, as applicable.

c. **Post-Service Claims.** A post-service claim is any claim for a benefit under the policy that is not a pre-service claim within 30 days of receipt of the claim.

If the claim is an incomplete claim or incorrectly filed claim, we may notify you of a 15 day extension and the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information. Once we have received the additional information, we will make our decision within the period of time equal to the 15-day extension in addition to the number of days remaining from the initial 30-day period. For example, if our notification was sent to you on the fifth day of the first 30-day period, we would have a total of 40 days to make a decision on your claim following the receipt of the additional information. Under no circumstances will the period for making a final determination on your claim exceed 90 days from the date we received the post-service claim.

If benefits are payable on charges for services covered under the policy, we'll pay such benefits directly to the hospital, physician or other health care provider providing such services, unless you have already paid the charges and submitted paid receipts therefore to us before we pay benefits. We will send you written notice of the benefits we paid on your behalf. If you have already paid the charges and are seeking reimbursement from us, payment of such benefits will be made directly to you.

If the claim is denied in whole or in part, you will receive a written notice from us explaining why the claim was denied and how you can file a grievance or request an independent external review. Please see Grievance Procedure and Independent External Review procedure below. If our denial or partial denial is based on (1) an internal rule, guideline, protocol or other similar criterion, or (2) the definition of medical necessary or experimental/investigational/unproven, you have the right to request, free of charge, a copy of all information relevant to your claim. Upon request we will also provide you with the meaning of your diagnosis code and/or procedure code.

Grievance/Complaint Procedure

1. Definitions.

Authorized Representative: a person designate to file a grievance on your behalf and/or to act for you. For purposes of your grievance, the authorized representative will be treated as if he/she is the covered person. We will send our written decision responding to the grievance to the authorized representative, not you. Our committee's written decision will contain personal information about you, including your confidential medical information, if any, that applies to the matter which is being grieved.

Complaint: an expression of dissatisfaction that is expressed to us verbally.

Expedited Grievance: means a grievance to which any of the following conditions apply:

a. The duration of the standard resolution process will result in serious jeopardy to your life or health or your ability to regain maximum function.

b. A physician with knowledge of your medical condition believes that you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

c. A physician with knowledge of your medical condition determines that the grievance shall be treated as an expedited grievance.

An expedited grievance may be submitted verbally or in writing.

Grievance: any dissatisfaction with us or our administration of your health benefit plan that you (or your authorized representative) express to us in writing. For example, you might file a grievance about our provision of services, our determination to reform or rescind a policy, our determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders, or our claims practices.

You/Your: you, as a covered person, your authorized representative or your physician (if your physician submitted the grievance that pertains to our denial of benefits or coverage for a prescription legend drug or durable medical equipment or a similar medical device).

2. Our Informal Complaint Procedure.

Situations might occasionally arise when you question or are unhappy with a claims decision made by us or some aspect of our policy administration, claims processing, or service that you received from us. For example, you may question why we made a claims decision or denied benefits for a claim submitted. We can resolve most of these questions without you having to file a grievance under this subsection. Therefore, before filing a grievance under this subsection, we urge you to speak with our Customer Service Department to try to resolve any problem, question, or concern that you have. Just call the telephone number on your identification card. A Customer Service representative will record your information and your proposed resolution and consider all information that we have about your policy's terms, conditions, and provisions. If necessary, he/she will then discuss the matter with a supervisor in our Customer Service Department.

We'll respond to your proposed resolution in writing by sending you a letter or an Explanation of Benefits that explains the actions we have taken to resolve the matter. If you are still unhappy after receiving our response, you have the right to file a grievance in writing with our Grievance/Appeal Committee in accordance with the procedure explained below.

3. Grievance Procedure for Grievances That Are Not Expedited Grievances.

a. To file a grievance, you should write down the concerns, issues, and comments you have about our services and mail, fax or deliver the written grievance along with copies of any supporting documents to our Grievance/Appeal Department at the address shown below:

WPS Health Insurance Grievance and Appeals Department
P. O. Box 7062
Madison, Wisconsin 53707-7062
Fax Number: (608) 327-6319

We cannot accept telephone requests for a grievance. Your grievance must be in writing. Please deliver, fax, or mail your grievance to us at the address shown above.

You have three years after you received our initial notice of denial or partial denial of your claim to file a grievance.

For example, if we denied benefits for your claim because we determined that a health care service provided to you was not "medically necessary" and/or "experimental" as those terms are defined in the policy, please send us all additional medical information (including copies of your health care provider(s)'s medical records) that shows why the health care service was medically necessary and/or not experimental under the policy.

Any grievance filed by your physician regarding a prescription legend drug or a durable medical equipment or other medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that's not covered under the policy.

b. We will acknowledge our receipt of your grievance by delivering, faxing, or mailing you an acknowledgment letter within five business days of our receipt of the grievance. If you don't receive this acknowledgement, please contact our Customer Service Department using the telephone number on your identification card.

c. As soon as reasonably possible after we receive your grievance, our Grievance/Appeal Department will review the grievance. Our Grievance/Appeal Department will review the information you provided and consider your proposed resolution in the context of any information we have available about the applicable terms, conditions, and provisions of the policy. If we agree with your proposed resolution, we'll tell you in writing by sending you a letter explaining our subsequent claims processing action or administrative action that resolves the matter to your satisfaction. If our Grievance/Appeal Department upholds the original claims processing or administrative decision that you challenged, the grievance will be automatically forwarded to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained further below. Under no circumstances will the time frame exceed the time periods discussed below.

You have the right to submit written questions to the person or persons responsible for making the determination that is the subject of your grievance. The responses to your questions will be considered in the Grievance Committee's review of your grievance.

For decisions regarding medical judgment, we will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. You have the right to request the identity of the health care professional whose advice we obtained in connection with the adverse benefit determination, regardless of whether we relied upon such advice in making our decision.
In general, the Grievance Committee will reach and issue its decision to you within 30 days. If, however, the Committee determines that it needs additional time to make its decision, the committee will mail you a written notice before the 30-day period has expired. This notice will explain that the Committee needs an extension of time to complete its review and make its decision and will indicate how much additional time we need, when the committee's decision is expected to be made, and the reason additional time is needed. The Committee then has an additional 30 days after the first 30-day period has expired (or within 60 days from the date we first received the grievance) to provide you with its written decision.

d. You have a right to appear in person or to participate by teleconference before the Grievance/Appeal Committee which meets at our offices in Madison, Wisconsin, and to present written or oral information to the committee and to submit written questions to the Committee. In the Committee's written decision to the grievance the Committee will respond to all of the written questions submitted to the Committee prior to or at that meeting. The Committee will notify you in writing of the time and place of the meeting at least seven calendar days before the meeting. Please remember that this meeting is not a trial where there are rules of evidence that are followed. Also, cross-examination of the Committee's members, its advisors, or WPS employees is not allowed. No transcript of the meeting is prepared, and sworn testimony is not taken by the Committee. The person's presentation to the Committee may be tape-recorded by the Committee. If you attend the meeting to present the reason(s) for the grievance, we expect and require each person who attends the meeting to follow and abide by the internal practices, rules and requirements established by the Committee to handle grievances effectively and efficiently in accordance with the applicable laws and regulations.

e. Within 30 (or 60) days after our receipt of the grievance, the Grievance/Appeal Committee will mail you a detailed decision letter containing all information required by law. The letter will be sent to the person who filed the grievance by regular mail unless that person's grievance asked the Committee to transmit its written decision by fax.

f. We will retain our records of the grievance for at least six years after we send you the Committee's letter providing written notification of its decision. You have the right to request a copy of documents, free of charge, relevant to your grievance by sending a written request to the address listed above.

g. If we continue to deny the payment, coverage, or service requested, or if you do not receive a timely decision, you may be entitled to request an independent external review.

4. Grievance Procedure for Grievances That Are Expedited Grievances.

a. To file an expedited grievance, you or your health care provider must submit the concerns, issues, and comments underlying your grievance to us via telephone, mail, email, or fax using the contact information below. If you contact us initially by phone, you will need to submit copies of any supporting documents via email, fax or mail:

WPS Health Insurance
Grievance and Appeals Department
P.O. Box 7062
Madison, Wisconsin 53707-7062
Phone: 920-490-6987 or 1-877-897-4123 (toll free)
Fax Number: (608) 327-6319

For example, if we denied benefits for your claim because we determined that a health care service provided to you was not "medically necessary" and/or "experimental" as those terms are defined in the policy, please send us all additional medical information, including sending us copies of your health care provider(s)'s medical records, that you believe shows that the health care service was medically necessary and/or not experimental under the policy. Any grievance filed by your physician regarding a prescription legend drug or durable medical equipment or a medical device should present medical evidence demonstrating the medical reason(s) why we should make an exception to cover and pay benefits for that prescription legend drug, or durable medical equipment or medical device that's not covered under the policy.

b. As soon as reasonably possible following our receipt of the expedited grievance, our Grievance/Appeal Department will review the expedited grievance. Our Grievance/Appeal Department will take the information along with your proposed resolution and review the matter, including considering all information that we have available and the policy's applicable terms, conditions, and provisions. If we agree with the proposed resolution of this matter, we'll contact you by phone or fax to explain our decision and then follow up with either a letter or an Explanation of Benefits form explaining how we resolved your grievance. If our Grievance/Appeal Department upholds our original claims processing decision or administrative decision that you disputed, the grievance will be automatically forwarded to our Grievance/Appeal Committee for its review and decision in accordance with the grievance procedure explained below. For decisions regarding medical judgment, we will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. You have the right to request the identity of the health care professional whose advice we obtained in connection with the adverse benefit determination, regardless of whether we relied upon such advice in making our decision.

c. As expeditiously as your health condition requires, but not later than 72 hours after our receipt of the expedited grievance, the Grievance/Appeal Department will contact you by phone or fax to explain the Grievance/Appeal Committee's rationale and decision. The Committee will then mail a detailed decision letter containing all information required by law. The letter will be mailed to the person who filed the expedited grievance using the United States Postal Service.

d. We will retain our records of the grievance for at least six years after we send you the committee's letter providing written notification of its decision.

e. You have the right to request a copy of documents, free of charge, relevant to your grievance by sending a written request to the address listed above.

f. If we continue to deny the payment, coverage, or service requested, or if you do not receive a timely decision, you may be entitled to request an independent external review.

Independent External Review

1. Definitions.

The following definitions apply to this subsection only:

Experimental Treatment Determination: a determination by WPS to which all of the following apply:

a. we have reviewed the proposed treatment;

b. based on the information provided, we have determined the treatment is experimental/ investigational/ unproven;

c. based on the information provided, we denied the treatment or payment for the treatment.

Adverse Determination: a determination by WPS to which all of the following apply:

a. we have reviewed admission to a health care facility, the availability of care, the continued stay or other treatment;

b. based on the information provided, the treatment does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

c. based on the information provided, we reduced, denied or terminated the treatment or payment of the treatment.

An adverse determination also includes the denial of a prior authorization request for health care services from a non-preferred provider. The right to an independent external review applies only when you feel the non-preferred provider's clinical expertise is medically necessary and the expertise is not available from a preferred provider.

Rescission of Coverage Determination: a determination by WPS to withdraw coverage under the policy back to your initial date of coverage, modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability.

2. Independent External Review Process.

You may be entitled to an independent external review by an Independent Review Organization (IRO) if you have received an experimental treatment determination, adverse determination or a rescission of coverage determination.

In general, you must complete all grievance/appeal options before requesting an independent external review. This includes waiting for our determination on your grievance/appeal. However, if we agree with you that the matter should proceed directly to independent review, or if you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize your life or health, you may ask to bypass our internal grievance process. In these situations, your request will be processed on an expedited basis.

If you or your authorized representative wish to file a request for an independent external review, your request must be submitted in writing to the address listed below and received within four months of the decision date of your grievance.

WPS Health Insurance
Attention: IRO Coordinator
P.O. Box 7062
Madison, WI 53707-7062
Fax: 608-327-6319

Your request for an independent external review must include:

a. your name, address and telephone number.

b. an explanation of why you believe that the treatment should be covered.

c. any additional information or documentation that supports your position.

d. if someone else is filing on your behalf, a statement signed by you authorizing that person to be your representative.

e. any other information requested by us.

Within five days of our receipt of your request, an accredited IRO will be assigned to your case through an unbiased random selection process. The assigned IRO will send you a notice of acceptance within one business day of receipt, advising you of your right to submit additional information within ten business days of your receipt of the notice from the IRO. The assigned IRO will also deliver a notice of the final external review decision in writing to you and WPS within 45 calendar days of their receipt of the request. Some of the information you provide to the IRO may be shared with appropriate regulatory authorities.

Unless your case involves the rescission of the policy, the IRO's decision is binding for both you and WPS. You are not responsible for costs associated with the independent external review.

You may resolve your problem by taking the steps outlined above. You may also contact the ***OFFICE OF THE COMMISSIONER OF INSURANCE,*** *a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the* ***OFFICE OF THE COMMISSIONER OF INSURANCE*** *by writing to:*

Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873
http://oci.wi.gov/

or you can call 1-800-236-8517 outside of Madison or (608) 266-0103 in Madison, and request a complaint form.