Hamaspik Medicare Select (HMO-DSNP)
y
Hamaspik Medicare Choice (HMO-DSNP)

Formulario 2025

(Lista de Medicamentos Cubiertos o "Lista de Medicamentos")

LEA CON ATENCIÓN: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

Identificación de Envío de Archivo de Formulario Aprobado por HPMS: 25014

Este formulario fue actualizado el 01/12/2025.

Para obtener información más reciente o resolver otras preguntas, comuníquese con nosotros llamando al 888-426-2774. (Usuarios TTY deben llamar al 711). Estamos disponible los 7 días a la semana, de 8:00 am a 8:00 pm, desde el 1 de octubre de 2024 al 31 de marzo de 2025; y de lunes a viernes desde las 8:00 am a 8:00 pm, desde el 1 abril de 2025 al 30 de septiembre de 2025.

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Nota:

Este documento está disponible de manera gratuita en español. Esta EOC está disponible en español. Por favor, llame a servicios para miembros.

La información también está disponible en formatos alternativos como imprenta grande y Braille. Llame a Servicios para Miembros a los números mencionados para obtener más información.

Los beneficios, primas, deducibles, y/o copagos/coaseguro podrían cambiar el 1 de enero de 2026.

Hamaspik Medicare Select y Hamaspik Medicare Choice son ambos un HMO D-SNP con un contrato de Medicare. La inscripción en un plan de Hamaspik Medicare Advantage depende de la renovación del contrato.

Nota para miembros existentes:

Este Formulario ha cambiado desde el año pasado. Revise este documento detenidamente para asegurarse de que siga incluyendo el medicamento que usted consume.

Cuando esta Lista de Medicamentos (Formulario) sugiere los términos “nosotros,” o “nuestro/a,” se refiere a Hamaspik, Inc. Cuando sugiere “plan” o “nuestro plan,” se refiere a Hamaspik Medicare Select y Hamaspik Medicare Choice.

Este documento incluye la Lista de Medicamentos (formulario) para nuestro plan cuya vigencia comienza a partir de 01/12/2025.

Por lo general, debe utilizar farmacias de la red para usar su beneficio de medicamentos recetados. Los beneficios, el formulario, la red de farmacia, y/o copagos/coaseguro podrían cambiar desde el 1 de enero de 2026 y de vez en cuando durante el año.

¿Qué es el formulario de Hamaspik Medicare Select y Hamaspik Medicare Choice?

En este documento, utilizamos los términos Lista de Medicamentos y formulario para referirnos a lo mismo. Un formulario es una lista de los medicamentos cubiertos que fueron seleccionados por Hamaspik Medicare Select y Hamaspik Medicare Choice, en consulta con un equipo de proveedores de atención médica, que representan las terapias por prescripción que se consideran necesarias como parte de un programa de tratamiento de calidad. Hamaspik Medicare Select y Hamaspik Medicare Choice generalmente cubrirán los medicamentos indicados en nuestro formulario siempre y cuando el medicamento sea médicamente necesario, se surta la receta en una farmacia de la red y se sigan las directrices de otros planes. Para obtener más información respecto cómo surtir sus recetas, consulte la Evidencia de Cobertura.

¿Puede cambiar el formulario?

La mayoría de los cambios en la cobertura de medicamentos se producen el 1 de enero, aunque podría añadir o eliminar medicamentos del formulario durante el año, o incluso añadir restricciones. Debemos seguir las normas de Medicare al momento de realizar tales cambios. Se publican actualizaciones al formulario mensualmente en nuestro sitio web: www.hamaspik.com.

Los cambios que pueden afectarlo este año: En la mayoría de los casos, se verá afectado por cambios en la cobertura durante el año:

- **Sustituciones inmediatas de ciertas versiones nuevas de medicamentos de marca y productos biológicos**

originales. Podemos eliminar inmediatamente un medicamento de nuestro formulario si lo reemplazamos con una determinada versión nueva del mismo medicamento que aparecerá con las mismas o menos restricciones. Cuando añadimos una nueva versión de un medicamento a nuestro formulario, podemos decidir mantener el medicamento de marca o producto biológico original en nuestro formulario, e inmediatamente añadir nuevas restricciones.

Podemos realizar estas modificaciones inmediatas sólo si añadimos una nueva versión genérica de un medicamento de marca o incorporamos determinadas versiones bioequivalentes nuevas de un producto biológico original que ya estaba en el formulario (por ejemplo, añadir un bioequivalente intercambiable que pueda sustituirse por un producto biológico original en una farmacia sin una nueva receta).

Si actualmente consume el medicamento de marca o producto biológico original, es posible que no le informemos con anticipación antes de un cambio inmediato, aunque más adelante podríamos entregarle información respecto a los cambios específicos que hayamos realizado.

Si realizamos dichos cambios, usted o su recetador pueden pedirnos que hagamos una excepción y sigamos cubriendo el medicamento que se está cambiando. Para obtener más información, consulte la sección a continuación denominada

"¿Cómo solicitar una excepción al Formulario de Hamaspik Medicare Select y Hamaspik Medicare Choice?"

Algunos de estos tipos de medicamentos podrían ser nuevos para usted. Para obtener más información, consulte la sección a continuación denominada "¿Cuáles son los productos biológicos y cómo se relacionan con los bioequivalentes?"

- **Medicamentos retirados del mercado.** Si el fabricante retira un medicamento de la venta o la Administración de Alimentos y Drogas (FDA) determina que debe retirarse por motivos de seguridad o efectividad, nosotros podríamos de inmediato eliminar el medicamento de nuestro formulario y dar aviso en instancias posteriores a los miembros que consumen el medicamento.

- **Otros cambios.** Podríamos realizar otros cambios que afecten a los miembros que actualmente consumen un medicamento. Por ejemplo, podemos eliminar un medicamento de marca del formulario al añadir un equivalente genérico o retirar un producto biológico original al incorporar un bioequivalente. También podemos aplicar nuevas restricciones al medicamento de marca o al producto biológico original. Podríamos realizar cambios en base a nuevas directrices clínicas. En caso de que eliminemos medicamentos de nuestro formulario, incorporemos autorización previa, límites de cantidad y/o restricciones de

terapia de pasos a un medicamento, debemos notificar a los miembros afectados del cambio al menos con 30 días de anticipación a que dicha modificación se haga efectiva. Como alternativa, cuando un miembro solicita un resurtido de un medicamento, podrían recibir un suministro de 30 días del medicamento y la respectiva notificación del cambio.

Si realizamos otros cambios, usted o su recetador pueden pedirnos que hagamos una excepción en su nombre y sigamos cubriendo el medicamento que usted consume. La notificación que le entreguemos también incluirá la información sobre cómo solicitar una excepción, y puede encontrar información en la sección a continuación denominada: "¿Cómo solicitar una excepción al Formulario de Hamaspik Medicare Select y Hamaspik Medicare Choice?"

Cambios que no le afectarán si actualmente toma el medicamento. Por lo general, si usted consume un medicamento de nuestro formulario 2025 que tenía cobertura al comienzo del año, no descontinuaremos o reduciremos la cobertura del medicamento durante el año de cobertura, salvo en lo descrito anteriormente. Esto significa que estos medicamentos permanecerán disponibles al mismo reparto de costo y sin restricciones para aquellos miembros que los consuman por el resto del año de cobertura. Este año no recibirá notificación directa sobre cambios que no le afecten. Sin embargo, el 1 de enero del próximo año, dichos cambios le afectarían y es importante verificar el formulario para el nuevo año de beneficio respecto a cualquier cambio en los medicamentos.

El formulario adjunto está vigente desde el 01/12/2025. Para obtener información actualizada acerca de los medicamentos cubiertos por Hamaspik Medicare Select y Hamaspik Medicare Choice, comuníquese con nosotros. Nuestra información de contacto aparece en la parte frontal y última página.

¿De qué manera utilizo el Formulario?

Hay dos formas de encontrar su medicamento dentro del formulario:

Condición médica

El formulario comienza en la página 17. Los medicamentos en este formulario se agrupan en categorías dependiendo del tipo de condiciones médicas a las que acostumbran tratar. Por ejemplo, los medicamentos utilizados para tratar una condición cardíaca se agrupan en la categoría: "Agentes cardiovasculares". Si sabe para qué se usa su medicamento, busque el nombre de la categoría en la lista que comienza en la página 17. Luego busque bajo el nombre de categoría para su medicamento.

Listado alfabético

Si no tiene la certeza respecto a en qué categoría buscar, debe buscar su medicamento en el Índice que comienza en la página 297. El Índice proporciona un listado alfabético de todos los medicamentos que se incluyen en este documento. Tanto los medicamentos de marca como los genéricos aparecen en el Índice. Busque en el Índice y encuentre su medicamento. Junto a su medicamento, verá el número de página en el cual puede encontrar información de cobertura. Consulte la página indicada en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Hamaspik Medicare Select y Hamaspik Medicare Choice cubren los medicamentos de marca y los medicamentos genéricos. Un medicamento genérico está aprobado por la FDA por tener los mismos ingredientes activos que el medicamento de marca. Por lo general, los medicamentos genéricos funcionan tan bien como el medicamento de marca y tienen un costo más bajo. Hay sustitutos de medicamentos genéricos disponibles para muchos medicamentos de marca. Los medicamentos genéricos por lo general pueden sustituirse por medicamentos de marca en la farmacia sin la necesidad de una nueva receta, dependiendo de las leyes estatales.

¿Cuáles son los productos biológicos originales y cómo se relacionan con los bioequivalentes?

En el formulario, cuando nos referimos a medicamentos, esto podría implicar un medicamento o un producto biológico. Los productos biológicos son medicamentos que tienen mayor complejidad que los fármacos habituales. Dado que los productos biológicos tienen mayor complejidad que los fármacos habituales, en lugar de tener un formato genérico, tienen alternativas que se llaman bioequivalentes. Por lo general, los bioequivalentes funcionan tan bien como el producto biológico original y tienen un costo más bajo. Hay alternativas bioequivalentes para algunos productos biológicos originales. Algunos bioequivalentes son bioequivalentes intercambiables y, dependiendo de las leyes estatales, podrían sustituirse por el producto biológico original en la farmacia sin necesidad de una nueva receta, tal como los medicamentos genéricos pueden sustituirse por medicamentos de marca.

- Para conocer los tipos de medicamentos, consulte la Evidencia de Cobertura, Capítulo 5, Sección 3.1, “La Lista de Medicamentos le indica qué medicamentos de la Parte D tienen cobertura.”

¿Existe alguna restricción a mi cobertura?

Algunos medicamentos cubiertos podrían tener requerimientos adicionales o límites de cobertura. Estos requerimientos y límites podrían contemplar:

- **Autorización Previa:** Hamaspik Medicare Select o Hamaspik Medicare Choice requiere que usted [o su recetador] obtengan autorización previa para ciertos medicamentos. Esto significa que usted deberá obtener aprobación de Hamaspik Medicare Select o Hamaspik Medicare Choice antes de surtir sus recetas. Si no obtiene aprobación, es probable que no demos cobertura al medicamento.

- **Límites de cantidad:** Hamaspik Medicare Select o Hamaspik Medicare Choice limitan la cantidad del medicamento al que damos cobertura. Por ejemplo, Hamaspik Medicare Select o Hamaspik Medicare Choice proporcionan 3 unidades cada 28 días por receta para Ozempic. Esto podría ser además de un suministro de un mes o de tres meses.

- **Terapia de pasos:** En algunos casos, Hamaspik Medicare Select o Hamaspik Medicare Choice requiere que usted primero intente con ciertos medicamentos para tratar su condición médica antes de cubrir otro medicamento para dicha

condición. Por ejemplo, si un Medicamento A y un Medicamento B tratan su condición médica, Hamaspik Medicare Select o Hamaspik Medicare Choice podrían no cubrir el Medicamento B a menos que pruebe primero el Medicamento A. Si el medicamento A no le funciona, entonces cubriremos el Medicamento B.

Puede averiguar si su medicamento tiene cualquier requerimiento o límite adicional buscando en el formulario que comienza en la página 17. También puede obtener más información sobre las restricciones aplicadas a los medicamentos cubiertos específicos visitando nuestro sitio web. Publicamos documentos en línea que explican nuestra autorización previa y las restricciones de terapia de pasos. También puede pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la última fecha de actualización del formulario, aparece en la parte frontal y última página.

Usted puede solicitar a Hamaspik Medicare Select o Hamaspik Medicare Choice que realicen una excepción a estas restricciones o límites o que faciliten una lista de otros medicamentos similares que puedan tratar su condición de salud. Consulte la sección "¿Cómo solicitar una excepción al formulario de Hamaspik Medicare Select y Hamaspik Medicare Choice?" en la siguiente página para obtener información sobre cómo solicitar una excepción.

¿Qué son los medicamentos de venta libre (OTC)?

Los medicamentos de venta libre son medicamentos sin receta que normalmente no están cubiertos por un Plan de Medicamentos Recetados de Medicare. Nuestro plan también cubre ciertos

medicamentos de venta libre como beneficio complementario. (Este beneficio es aparte de su cobertura para medicamentos recetados de Medicare y se describe en el Capítulo 4 de su Evidencia de Cobertura). Algunos medicamentos recetados de venta libre son menos costosos que los medicamentos recetados y funcionan igual de bien. Para más información, llame a Servicios para Miembros. El costo de estos medicamentos de venta libre no se contabilizará hacia los costos totales por medicamentos de la Parte D.

¿Qué ocurre si mi medicamento no figura en el Formulario?

Si su medicamento no se incluye en este formulario (lista de medicamentos cubiertos), primero debe contactar a Servicios para Miembros y preguntar si su medicamento tiene cobertura. Nuestra información de contacto, junto con la última fecha de actualización del formulario, aparece en la parte frontal y última página.

Si usted se entera de que Hamaspik Medicare Select o Hamaspik Medicare Choice no cubre su medicamento, tiene dos alternativas:

- Puede solicitar a Servicios para Miembros una lista de medicamentos similares que tengan cobertura de Hamaspik Medicare Select o Hamaspik Medicare Choice. Cuando reciba la lista, muéstrela a su médico y pídale que recete un medicamento similar que tenga nuestra cobertura.

- Puede pedirle a Hamaspik Medicare Select o Hamaspik Medicare Choice que hagan una excepción y cubran su medicamento. Consulte la información acerca de cómo solicitar un excepción.

¿Cómo solicitar una excepción al Formulario de Hamaspik Medicare Select o Hamaspik Medicare Choice?

Puede pedirle a Hamaspik Medicare Select o Hamaspik Medicare Choice que hagan una excepción a nuestras normas de cobertura. Hay varios tipos de excepciones que usted puede solicitarnos realizar.

- Puede pedirnos que brindemos cobertura a un medicamento incluso si no está en nuestro formulario. En caso de aprobarse, este medicamento se cubrirá a un nivel de reparto de costos predeterminado y usted no podría optar a pedirnos que le proporcionemos el medicamento a un nivel de reparto de costos inferior.

- Puede solicitarnos que renunciemos a una restricción de cobertura que contemple autorización previa, terapia de pasos o un límite de cantidad en su medicamento. Por ejemplo, para ciertos medicamentos, Hamaspik Medicare Select o Hamaspik Medicare Choice limitan la cantidad del medicamento al que damos cobertura. Si su medicamento tiene un límite de cantidad, puede pedirnos que renunciemos al límite y cubramos una cantidad mayor.

Normalmente, Hamaspik Medicare Select o Hamaspik Medicare Choice sólo aprobarán su solicitud por una excepción si los medicamentos alternativos se incluían en el formulario del plan, o en caso de que la aplicación de dicha restricción no sea tan eficaz para usted y/o propiciara la aparición de efectos adversos.

Usted o su recetador deben comunicarse con nosotros para solicitar una excepción al formulario, incluida una excepción a una

restricción de cobertura. **Cuando solicite una excepción, su médico deberá explicar las razones médicas por las que necesita la excepción.** Generalmente, debemos tomar nuestra decisión dentro de 72 horas de obtener la declaración de respaldo de su recetador. Usted puede solicitar una decisión expedita (rápida) si usted cree, y nosotros estamos de acuerdo, que su salud podría verse seriamente perjudicada a raíz de una espera de hasta 72 horas para tomar una decisión. En caso de que aceptemos, o si su recetador solicita una decisión rápida, debemos darle una decisión a más tardar 24 horas después de que obtengamos la declaración de respaldo de su recetador.

¿Qué puede hacer si mi medicamento no figura en el formulario o tiene una restricción?

Como miembro nuevo o constante de nuestro plan usted podría estar consumiendo medicamentos que no figuren en nuestro formulario. O, podría estar consumiendo un medicamento que esté en nuestro formulario, pero que tiene una restricción de cobertura, como una autorización previa. Debería hablar con su recetador sobre solicitar una decisión de cobertura para indicar que usted cumple con los criterios para recibir aprobación, cambiar a un medicamento alternativo que cubramos o solicitar una excepción al formulario para que podamos cubrir el medicamento que usted consume. Si bien usted y su médico determinan el curso de acción indicado que mejor le parezca, nosotros podríamos cubrir un medicamento en determinados casos durante los primeros 90 días de su membresía en nuestro plan.

Para cada uno de los medicamentos que no figuren en nuestro formulario o que tengan restricción de cobertura, cubriremos un

suministro temporal de 30 días. Si su receta está escrita para menos días, permitiremos resurtidos para proporcionar hasta un suministro máximo 30 días de medicamento. En caso de no aprobarse la cobertura, después de su suministro de 30 días, no pagaremos por estos medicamentos, incluso si ha sido un miembro del plan durante menos de 90 días.

Si usted es residente de una instalación de atención a largo plazo y necesita un medicamento que no figure en nuestro formulario o si su capacidad para obtener su medicamento es limitada, pero sobrepasa los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia de 31 días de dicho medicamento mientras usted se encarga de obtener una excepción al formulario.

Para obtener más información

Para obtener más información sobre su cobertura de medicamentos recetados con Hamaspik Medicare Select o Hamaspik Medicare Choice, consulte su Evidencia de Cobertura y otros materiales del plan.

Si tiene alguna pregunta sobre Hamaspik Medicare Select o Hamaspik Medicare Choice, contáctenos. Nuestra información de contacto, junto con la última fecha de actualización del formulario, aparece en la parte frontal y última página.

Si tiene preguntas generales sobre la cobertura de medicamentos recetados de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227) 24 horas al día/7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. O, visite https://http://www.medicare.gov.

Formulario de Hamaspik Medicare Select o Hamaspik Medicare Choice

El formulario que comienza en la siguiente página proporciona información de cobertura sobre los medicamentos cubiertos por Hamaspik Medicare Select o Hamaspik Medicare Choice. Si tiene problemas para encontrar su medicamento en la lista, diríjase al Índice que comienza en la página 297.

La primera columna del recuadro muestra el nombre del medicamento. Los medicamentos de marca van en letra mayúscula (por ej., BRILINTA 60 MG EN TABLETA) y los medicamentos genéricos aparecen en minúscula y cursiva (por ej., *bumetanida 0.5 mg en tableta*).

La información en la columna de Requerimientos/Límites le indica si *bumetanida 0.5 mg en tableta* tiene algún requerimiento especial para la cobertura de su medicamento.

CLAVE DE ABREVIATURAS DEL FORMULARIO
LA – Disponibilidad limitada: Esta receta podría estar disponible sólo en determinadas farmacias. Para obtener más información, consulte el Directorio de Farmacias o llame a Servicios para Miembros al 1-888-426-2774. (Usuarios TTY deben llamar al 711). **PA – Autorización previa:** El Plan requiere que usted o su médico obtengan autorización previa para ciertos

medicamentos. Esto significa que usted deberá obtener aprobación antes de surtir sus recetas. Si no obtiene aprobación, es probable que no demos cobertura al medicamento.

PA – Determinación de Parte B vs. Parte D: Este medicamento recetado podría tener cobertura en virtud de la Parte B o Parte D de Medicare, dependiendo de las circunstancias. Puede que deba enviarse información describiendo el uso y contexto del medicamento para tomar la determinación.

QL – Límite de Cantidad: Para ciertos medicamentos, el Plan limita la cantidad del medicamento al que daremos cobertura.

ST – Terapia de Pasos: En algunos casos, el Plan requiere que usted primero intente con ciertos medicamentos para tratar su condición médica antes de cubrir otro medicamento para dicha condición. Por ejemplo, si un Medicamento A y un Medicamento B tratan su condición médica, podríamos no cubrir el Medicamento B a menos que usted pruebe el Medicamento A primero. Si el medicamento A no le funciona, entonces cubriremos el Medicamento B.

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Analgesics		
Analgesics, Other		
butalbital-acetaminophen butalbital-acetaminophn 50-325	1	QL (180 PER 30 DAYS)
butalbital-acetaminophen-caffe (50-300-40, 50-325-40)	1	QL (180 PER 30 DAYS)
butalbital-aspirin-caffeine cp	1	QL (180 PER 30 DAYS)
ESGIC 50-325-40 MG CAPSULE	1	QL (180 PER 30 DAYS)
tencon 50-325 mg tablet	1	QL (180 PER 30 DAYS)
ZEBUTAL 50-325-40 MG CAPSULE	1	QL (180 PER 30 DAYS)
Nonsteroidal Anti-inflammatory Drugs		
ARTHROTEC 50 MG-200 MCG TAB	1	QL (120 PER 30 DAYS)
ARTHROTEC 75 MG-200 MCG TAB	1	QL (90 PER 30 DAYS)
CELEBREX (50 MG CAPSULE, 100 MG CAPSULE, 200 MG CAPSULE)	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
CELEBREX 400 MG CAPSULE	1	QL (30 PER 30 DAYS)
celecoxib (50 mg capsule, 100 mg capsule, 200 mg capsule)	1	QL (60 PER 30 DAYS)
celecoxib 400 mg capsule	1	QL (30 PER 30 DAYS)
DAYPRO 600 MG CAPLET	1	QL (90 PER 30 DAYS)
diclofenac potassium 50 mg tablet	1	QL (120 PER 30 DAYS)
diclofenac sodium (dr 25 mg tab, ec 25 mg tab)	1	QL (240 PER 30 DAYS)
diclofenac sodium (dr 50 mg tab, ec 50 mg tab)	1	QL (120 PER 30 DAYS)
diclofenac sodium (dr 75 mg tab, ec 75 mg tab)	1	QL (60 PER 30 DAYS)
diclofenac sodium 1% gel	1	
diclofenac sodium 1.5% topical soln	1	PA
diclofenac sodium er 100 mg tab	1	QL (60 PER 30 DAYS)
diclofenac sodium-misoprostol (75-0.2 mg, 75-0.2 tb)	1	QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
diclofenac sodium-misoprostol diclofenac-misoprost 50-0.2 mg	1	QL (120 PER 30 DAYS)
ec-naproxen dr 375 mg tablet	1	QL (120 PER 30 DAYS)
ec-naproxen dr 500 mg tablet	1	QL (90 PER 30 DAYS)
etodolac (400 mg tablet, 500 mg tablet)	1	QL (60 PER 30 DAYS)
etodolac 200 mg capsule	1	QL (150 PER 30 DAYS)
etodolac 300 mg capsule	1	QL (90 PER 30 DAYS)
etodolac er (er 400 mg tablet, er 500 mg tablet)	1	QL (60 PER 30 DAYS)
etodolac er 600 mg tablet	1	QL (30 PER 30 DAYS)
flurbiprofen 100 mg tablet	1	QL (90 PER 30 DAYS)
ibu 400 mg tablet	1	QL (240 PER 30 DAYS)
ibu 600 mg tablet	1	QL (150 PER 30 DAYS)
ibu 800 mg tablet	1	QL (120 PER 30 DAYS)
ibuprofen 100 mg/5 ml susp	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ibuprofen 400 mg tablet	1	QL (240 PER 30 DAYS)
ibuprofen 600 mg tablet	1	QL (150 PER 30 DAYS)
ibuprofen 800 mg tablet	1	QL (120 PER 30 DAYS)
indomethacin 25 mg capsule	1	QL (240 PER 30 DAYS)
indomethacin 50 mg capsule	1	QL (120 PER 30 DAYS)
indomethacin er 75 mg capsule	1	QL (60 PER 30 DAYS)
ketorolac tromethamine 10 mg tablet	1	
meloxicam 15 mg tablet	1	QL (30 PER 30 DAYS)
meloxicam 7.5 mg tablet	1	QL (60 PER 30 DAYS)
nabumetone 500 mg tablet	1	QL (120 PER 30 DAYS)
nabumetone 750 mg tablet	1	QL (60 PER 30 DAYS)
naproxen (375 mg tablet, dr 375 mg tablet)	1	QL (120 PER 30 DAYS)
naproxen (500 mg kit, 500 mg tablet, dr 500 mg tablet)	1	QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
naproxen 125 mg/5 ml suspen	1	QL (1800 PER 30 DAYS)
naproxen 250 mg tablet	1	QL (180 PER 30 DAYS)
naproxen sodium 275 mg tab	1	QL (150 PER 30 DAYS)
naproxen sodium 550 mg tab	1	QL (90 PER 30 DAYS)
oxaprozin (600 mg caplet, 600 mg tablet)	1	QL (90 PER 30 DAYS)
piroxicam 10 mg capsule	1	QL (60 PER 30 DAYS)
piroxicam 20 mg capsule	1	QL (30 PER 30 DAYS)
sulindac (150 mg tablet, 200 mg tablet)	1	QL (60 PER 30 DAYS)
Opioid Analgesics, Long-acting		
BELBUCA (75 MCG FILM, 150 MCG FILM, 300 MCG FILM, 450 MCG FILM, 600 MCG FILM, 750 MCG FILM, 900 MCG FILM)	1	PA, QL (60 PER 30 DAYS)
buprenorphine (5 mcg/hr patch, 7.5 mcg/hr patch, 10 mcg/hr patch, 15 mcg/hr patch, 20 mcg/hr patch)	1	PA, QL (4 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
BUTRANS (5 MCG/HR PATCH, 7.5 MCG/HR PATCH, 10 MCG/HR PATCH, 15 MCG/HR PATCH, 20 MCG/HR PATCH)	1	PA, QL (4 PER 28 DAYS)
fentanyl (12 mcg/hr patch, 25 mcg/hr patch, 37.5 mcg/hr patch, 50 mcg/hr patch, 62.5 mcg/hr patch, 75 mcg/hr patch, 87.5 mcg/hr patch, 100 mcg/hr patch)	1	PA, QL (15 PER 30 DAYS)
hydrocodone bitartrate er (er 10 mg capsule, er 15 mg capsule, er 20 mg capsule, er 30 mg capsule, er 40 mg capsule, er 50 mg capsule)	1	PA, QL (60 PER 30 DAYS)
levorphanol tartrate (2 mg tablet, 3 mg tablet)	1	QL (120 PER 30 DAYS)
methadone hcl 10 mg tablet	1	QL (360 PER 30 DAYS)
methadone hcl 5 mg tablet	1	QL (180 PER 30 DAYS)
morphine sulfate er (er 15 mg tablet, er 30 mg tablet, er 60 mg tablet, er 100 mg tablet, er 200 mg tablet)	1	PA, QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
tramadol hcl er (er 100 mg tablet, er 200 mg tablet, er 300 mg tablet)	1	PA, QL (30 PER 30 DAYS)
Opioid Analgesics, Short-acting		
acetaminophen-codeine #4 tablet	1	QL (180 PER 30 DAYS)
acetaminophen-codeine (#2 tablet, #3 tablet)	1	QL (360 PER 30 DAYS)
acetaminophen-codeine (acetamin-codein 300-30 mg/12.5, acetaminop-codeine 120-12 mg/5)	1	QL (2700 PER 30 DAYS)
butorphanol tartrate 10 mg/ml spray	1	QL (48 PER 30 DAYS)
codeine sulfate (15 mg tablet, 30 mg tablet, 60 mg tablet)	1	QL (180 PER 30 DAYS)
endocet (2.5-325 mg tablet, 5-325 mg tablet)	1	QL (360 PER 30 DAYS)
endocet 10-325 mg tablet	1	QL (180 PER 30 DAYS)
endocet 7.5-325 mg tablet	1	QL (240 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
fentanyl citrate (cit 1,200 mcg, cit 1,600 mcg, citrate 200 mcg, citrate 400 mcg, citrate 600 mcg, citrate 800 mcg)	1	PA, QL (120 PER 30 DAYS)
hydrocodone-acetaminophen (5-300 mg, 5-325 mg)	1	QL (240 PER 30 DAYS)
hydrocodone-acetaminophen (7.5, 7.5, 10-300 mg, 10-325 mg)	1	QL (180 PER 30 DAYS)
hydrocodone-acetaminophen (hydrocodone-acetamin 2.5-108/5, hydrocodone-acetamin 5-217/10, hydrocodone-acetamn 7.5-325/15)	1	QL (2700 PER 30 DAYS)
hydrocodone-ibuprofen (5-200 mg, 7.5, 10)	1	QL (150 PER 30 DAYS)
hydromorphone hcl (1 mg/ml solution, 5 mg/5 ml soln)	1	QL (1440 PER 30 DAYS)
hydromorphone hcl (10 mg/ml ampule, 10 mg/ml vial, 50 mg/5 ml amp, 50 mg/5 ml vial, 500 mg/50 ml vl)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
hydromorphone hcl (2 mg tablet, 4 mg tablet, 8 mg tablet)	1	QL (180 PER 30 DAYS)
morphine sulfate (10 mg/5 ml cup, 10 mg/5 ml soln)	1	QL (2700 PER 30 DAYS)
morphine sulfate 100 mg/5 ml conc	1	QL (270 PER 30 DAYS)
morphine sulfate 20 mg/5 ml soln	1	QL (1350 PER 30 DAYS)
morphine sulfate ir 15 mg tab	1	QL (360 PER 30 DAYS)
morphine sulfate ir 30 mg tab	1	QL (180 PER 30 DAYS)
oxycodone hcl ((ir) 10 mg tab, (ir) 15 mg tab, (ir) 20 mg tab, (ir) 30 mg tab)	1	QL (180 PER 30 DAYS)
oxycodone hcl (ir) 5 mg tablet	1	QL (360 PER 30 DAYS)
oxycodone-acetaminophen (oxycodone-acetaminophen 5-325, oxycodone-acetaminophn 2.5-325)	1	QL (360 PER 30 DAYS)
oxycodone-acetaminophen 10	1	QL (180 PER 30 DAYS)
oxycodone-acetaminophen oxycodone-acetaminophn 7.5-325	1	QL (240 PER 30 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ROXICODONE (15 MG TABLET, 30 MG TABLET)	1	QL (180 PER 30 DAYS)
tramadol hcl 50 mg tablet	1	QL (240 PER 30 DAYS)
tramadol hcl-acetaminophen tramadol-acetaminophn 37.5-325	1	QL (240 PER 30 DAYS)
Anesthetics		
Local Anesthetics		
dermacinrx lidocan 5% patch	1	PA, QL (90 PER 30 DAYS)
lidocaine 5% ointment	1	PA, QL (100 PER 30 DAYS)
lidocaine 5% patch	1	PA, QL (90 PER 30 DAYS)
lidocaine hcl 4% solution	1	PA, QL (150 PER 30 DAYS)
lidocaine hcl laryngotracheal 4% solution	1	
lidocaine hcl viscous (2% 15 ml cup, 2% soln)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
lidocaine-prilocaine cream	1	PA, QL (60 PER 30 DAYS)
lidocan iii 5% patch	1	PA, QL (90 PER 30 DAYS)
lidocan iv 5% patch	1	PA, QL (90 PER 30 DAYS)
lidocan v 5% patch	1	PA, QL (90 PER 30 DAYS)
LIDODERM 5% PATCH	1	PA, QL (90 PER 30 DAYS)
ZTLIDO 1.8% TOPICAL SYSTEM	1	PA, QL (90 PER 30 DAYS)
Anti-Addiction/ Substance Abuse Treatment Agents		
Alcohol Deterrents/ Anti-craving		
acamprosate calcium dr 333 mg tab	1	
disulfiram (250 mg tablet, 500 mg tablet)	1	
Opioid Dependence		
buprenorphine hcl (2 mg tablet, 8 mg tablet)	1	QL (90 PER 30 DAYS)
buprenorphine-naloxone (2-0.5mg fm, 2-0.5mg tb)	1	QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
buprenorphine-naloxone (4-1mg film, 8-2mg film, 12-3mg flm)	1	QL (60 PER 30 DAYS)
buprenorphine-naloxone 8-2 mg tab	1	QL (90 PER 30 DAYS)
naltrexone hcl 50 mg tablet	1	
SUBLOCADE (100 MG/0.5 ML SYRING, 300 MG/1.5 ML SYRING)	1	
SUBOXONE (4 MG-1 MG FILM, 8 MG-2 MG FILM, 12 MG-3 MG FILM)	1	QL (60 PER 30 DAYS)
SUBOXONE 2 MG-0.5 MG SL FILM	1	QL (120 PER 30 DAYS)
VIVITROL (380 MG VIAL, 380 MG VIAL-DILUENT)	1	
Opioid Reversal Agents		
KLOXXADO 8 MG NASAL SPRAY	1	
naloxone hcl (0.4 mg/ml carpuject, 0.4 mg/ml syringe, 0.4 mg/ml vial, 2 mg/2 ml syringe, 4 mg/10 ml vial, hcl 4 mg nasal spray)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
NARCAN 4 MG NASAL SPRAY	1	
OPVEE 2.7 MG NASAL SPRAY	1	
REXTOVY 4 MG NASAL SPRAY	1	
Smoking Cessation Agents		
bupropion hcl sr 150 mg tablet	1	
NICOTROL CARTRIDGE INHALER	1	
NICOTROL NS 10 MG/ML SPRAY	1	
varenicline tartrate (apo-varenicline 0.5 mg tablet, apo-varenicline 1 mg tablet, varenicline 0.5 mg tablet, varenicline 1 mg cont month bx, varenicline 1 mg tablet, varenicline starting month box)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Antibacterials		
Aminoglycosides		
amikacin sulfate (1 gram/4 ml vial, 500 mg/2 ml vial, 1,000 mg/4 ml vl)	1	
ARIKAYCE 590 MG/8.4 ML VIAL	1	PA, QL (235.2 PER 28 DAYS)
gentamicin sulfate (80 mg/2 ml vial, 800 mg/20 ml vial)	1	
gentamicin sulfate in ns (iso 100 mg/100 ml, iso 120 mg/100 ml, isoton 60 mg/50 ml, isoton 80 mg/100 ml, isoton 80 mg/50 ml)	1	
HUMATIN 250 MG CAPSULE	1	
neomycin sulfate 500 mg tablet	1	
streptomycin sulfate 1 gm vial	1	
tobramycin sulfate (1.2 gm vial, 1.2 gram/30 ml vial, 20 mg/2 ml vial, 40 mg/ml vial, 80 mg/2 ml vial, 1,200 mg/30 ml vial)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Antibacterials, Other		
AZACTAM (1 GM VIAL, 2 GM VIAL)	1	
aztreonam (1 gm vial, 2 gm vial)	1	
CLEOCIN 2% VAGINAL CREAM	1	
CLEOCIN HCL (75 MG CAPSULE, 150 MG CAPSULE, 300 MG CAPSULE)	1	
CLEOCIN PHOSPHATE (9 G/60 ML VIAL, 150 MG/ML VIAL, 300 MG/2 ML VIAL, 600 MG/4 ML VIAL, 900 MG/6 ML VIAL)	1	
CLEOCIN T 1% LOION	1	
clindacin etz 1% pledget	1	
clindacin p 1% ledgets	1	
clindamycin (pediatric) (pedi) 75 mg/5 ml	1	
clindamycin hcl (75 mg capsule, 150 mg capsule, 300 mg capsule)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
clindamycin phosphate (ph 1% gel, ph 1% solution, 2% vaginal cream, ph 9 g/60 ml vial, ph 300 mg/2 ml vl, ph 600 mg/4 ml vl, ph 900 mg/6 ml vl, phos 1% pledget, phosp 1% lotion, phosphate 1% gel)	1	
clindamycin phosphate-d5w (300 mg/50, 600 mg/50, 900 mg/50)	1	
clindamycin-0.9% nacl (300 mg/50, 600 mg/50, 900 mg/50)	1	
colistimethate 150 mg vial	1	
CUBICIN 500 MG VIAL	1	
CUBICIN RF 500 MG VIAL	1	
DALVANCE 500 MG VIAL	1	
daptomycin 500 mg vial	1	
FLAGYL 375 CAPSULE	1	
IMPAVIDO 50 MG CAPSULE	1	
linezolid (100 mg/5 ml susp, 600 mg tablet)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
linezolid-0.9% nacl 600mg/300ml-0.9%nacl	1	
linezolid-d5w 600 mg/300 ml-d5w	1	
methenamine hippurate 1 gm tablet	1	
METRO IV 500 MG/100 ML	1	
metronidazole (vaginal 0.75% gl, 250 mg tablet, 375 mg capsule, 500 mg tablet, 500 mg/100 ml)	1	
nitrofurantoin (50 mg cap, 100 mg cap)	1	
nitrofurantoin mono-macro mono-mcr 100 mg	1	
SIVEXTRO 200 MG TABLET	1	PA
SIVEXTRO 200 MG VIAL	1	
tigecycline 50 mg vial	1	
tinidazole (250 mg tablet, 500 mg tablet)	1	
trimethoprim 100 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TYGACIL 50 MG VIAL	1	
vancomycin hcl (1 gm add-van vial, 1 gm vial, hcl 1.75 gram vial, hcl 2 gram vial, hcl 5 gm vial, hcl 10 gm vial, hcl 100 gm smartpak, 500 mg add-van vial, 500 mg vial, 750 mg add-van vial, hcl 750 mg vial)	1	
vancomycin hcl 125 mg capsule	1	QL (120 PER 30 DAYS)
vancomycin hcl 250 mg capsule	1	QL (240 PER 30 DAYS)
ZYVOX (100 MG/5 ML SUSPENSION, 600 MG TABLET)	1	PA
ZYVOX 600 MG/300 ML-D5W	1	
Beta-lactam, Cephalosporins		
cefaclor (250 mg capsule, 500 mg capsule)	1	
cefadroxil (1 gm tablet, 250 mg/5 ml susp, 500 mg capsule, 500 mg/5 ml susp)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
cefazolin sodium (1 gm add-van vial, 1 gm vial, 10 gm vial, 20 gm bulk vial, sod 100 gm bulk bag, sod 300 gm bulk bag, 500 mg vial)	1	
cefazolin sodium-dextrose 1 g/50 ml-dextrose	1	
cefdinir (125 mg/5 ml susp, 250 mg/5 ml susp, 300 mg capsule)	1	
cefepime (1 gm, 2 gm)	1	
cefepime hcl (1 gm vial, 2 gram vial)	1	
cefepime-dextrose (1 gm/50 ml, 2 gm/50 ml)	1	
cefixime 400 mg capsule	1	
cefoxitin (1 gm vial, 2 gm vial, 10 gm vial)	1	
cefoxitin sodium (1 gm, 2 gm)	1	
cefpodoxime proxetil (50 mg/5 ml susp, 100 mg tablet, 100 mg/5 ml susp, 200 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
cefprozil (125 mg/5 ml susp, 250 mg tablet, 250 mg/5 ml susp, 500 mg tablet)	1	
ceftazidime (1 gm vial, 2 gm vial, 6 gm vial)	1	
ceftriaxone (1 gm add-vant vial, 1 gm piggyback, 1 gm vial, 1 gm-d5w bag, 2 gm add vial, 2 gm piggyback, 2 gm vial, 2 gm-d5w bag, 10 gm vial, 100 gram bulk bag, 250 mg vial, 500 mg vial)	1	
cefuroxime (250 mg tab, 500 mg tab)	1	
cefuroxime sodium (1.5 gm vial, 750 mg vial)	1	
cephalexin (125 mg/5 ml susp, 250 mg capsule, 250 mg/5 ml susp, 500 mg capsule, 750 mg capsule)	1	
tazicef (1 gm add-vantage vial, 1 gram vial, 2 gm add-vantage vial, 2 gram vial, 6 gram vial)	1	
TEFLARO (400 MG VIAL, 600 MG VIAL)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Beta-lactam, Penicillins		
amoxicillin (125 mg tab chew, 125 mg/5 ml susp, 200 mg/5 ml susp, 250 mg capsule, 250 mg tab chew, 250 mg/5 ml susp, 400 mg/5 ml susp, 500 mg capsule, 500 mg tablet, 875 mg tablet)	1	
amoxicillin-clavulanate pot er amox-clav 1,000-62.5 mg tab	1	
amoxicillin-clavulanate potass (200-28.5 mg/5 ml sus, 250-125 mg tablet, 250-62.5 mg/5 ml sus, 400-57 mg tab chew, 400-57 mg/5 ml susp, 500-125 mg tablet, 600-42.9 mg/5 ml sus, 875-125 mg tablet)	1	
ampicillin sodium (1 gm add-vantage vl, 1 gm vial, 10 gm bottle, 10 gm vial)	1	
ampicillin trihydrate 500 mg capsule	1	
ampicillin-sulbactam (ampicillin-sulb 3 gm add vial, ampicillin-sulbactam 3 gm vial)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
BICILLIN L-A (600,000 UNIT/ML, 1,200,000 UNITS, 2,400,000 UNITS)	1	
dicloxacillin sodium (250 mg capsule, 500 mg capsule)	1	
EXTENCILLINE (1,200,000 UNIT VL, 2,400,000 UNIT VL)	1	
lentocilin s 1,200,000unit	1	
nafcillin (1 gm/ 50 ml, 2 gm/ 100 ml)	1	
nafcillin sodium (1 gm add-van vial, 1 gm vial, 2 gm add-vant vial, 2 gm vial, 10 gm bottle, 10 gm bulk vial)	1	
penicillin g potassium (5 million, 20 million)	1	
penicillin g sodium na 5 million unit	1	
penicillin gk-iso-osm dextrose (2 million unit/50 ml, 3 million unit/50 ml)	1	
penicillin v potassium (125 mg/5 ml soln, 250 mg tablet, 250 mg/5 ml soln, 500 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
pfizerpen (5 million vial, 20 million vial)	1	
piperacillin-tazobactam (piperacil-tazo 2.25 gm add vl, piperacil-tazo 3.375 gm add vl, piperacil-tazo 4.5 gm add vial, piperacil-tazobact 2.25 gm vl, piperacil-tazobact 3.375 gm vl, piperacil-tazobact 4.5 gm vial)	1	
ZOSYN 2.25 GM/50 ML GALAXY BAG	1	
Carbapenems		
ertapenem 1 gram vial	1	
imipenem-cilastatin sodium (250 mg, 500 mg)	1	
INVANZ 1 GM VIAL	1	
meropenem (1 gm vial, 500 mg vial)	1	
meropenem-0.9% nacl (1 gram/50, 500 mg/50)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Macrolides		
azithromycin (1 gm pwd packet, 100 mg/5 ml susp, 200 mg/5 ml susp, 250 mg tablet, 500 mg add-van vl, 500 mg tablet, 600 mg tablet, i.v. 500 mg vial)	1	
clarithromycin (125 mg/5 ml sus, 250 mg tablet, 250 mg/5 ml sus, 500 mg tablet)	1	
clarithromycin er 500 mg tab	1	
DIFICID 200 MG TABLET	1	QL (20 PER 10 OVER TIME)
DIFICID 40 MG/ML SUSPENSION	1	QL (136 PER 10 OVER TIME)
E.E.S. 200 MG/5 ML SUSPENSION	1	
ery 2% pads	1	
ERY-TAB (DR 250 MG TABLET, DR 333 MG TABLET, DR 500 MG TABLET)	1	
ERYPED 200 MG/5 ML SUSPENSION	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ERYPED 400 MG/5 ML SUSPENSION	1	
ERYTHROCIN LACTOBIONATE (500 MG ADDVAN VIAL, LACT 500 MG VIAL)	1	
erythromycin (2% solution, 250 mg tablet, dr 250 mg cap, dr 250 mg tablet, dr 333 mg tablet, 500 mg tablet, dr 500 mg tablet)	1	
erythromycin ethylsuccinate (200 mg/5 ml, 400 mg/5 ml)	1	
erythromycin lactobionate 500 mg vial	1	
fidaxomicin 200 mg tablet	1	QL (20 PER 10 OVER TIME)
ZITHROMAX (100 MG/5 ML SUSP, 200 MG/5 ML SUSP, 250 MG TABLET, 250 MG Z-PAK TABLET, 500 MG TABLET, I.V. 500 MG VIAL)	1	
ZITHROMAX TRI-PAK 500 MG TAB	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Quinolones		
CIPRO (5% SUSPENSION, 10% SUSPENSION, 250 MG TABLET, 500 MG TABLET)	1	
ciprofloxacin hcl (250 mg tab, 500 mg tab, 750 mg tab)	1	
ciprofloxacin-d5w (200 mg/100ml-d5w, 400 mg/200ml-d5w)	1	
levofloxacin (25 mg/ml solution, 250 mg tablet, 500 mg tablet, 750 mg tablet)	1	
levofloxacin-d5w (250 mg/50, 500 mg/100, 750 mg/150)	1	
moxifloxacin 400 mg/250 ml bag	1	
moxifloxacin hcl 400 mg tablet	1	
ofloxacin 400 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Sulfonamides		
BACTRIM 400-80 MG TABLET	1	
BACTRIM DS 800-160 MG TABLET	1	
sulfadiazine 500 mg tablet	1	
sulfamethoxazole-trimethoprim (20 ml cup, ds tablet, ss tablet, susp)	1	
Tetracyclines		
avidoxy 100 mg tablet	1	
demeclocycline hcl (150 mg tablet, 300 mg tablet)	1	
doxy 100 mg vial	1	
doxycycline hyclate (20 mg tab, 50 mg cap, 100 mg cap, 100 mg tab, 100 mg vl)	1	
doxycycline monohydrate (50 mg cap, 50 mg tablet, 75 mg capsule, 75 mg tablet, 100 mg cap, 100 mg tablet, 150 mg cap, 150 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
minocycline hcl (50 mg capsule, hcl 50 mg tablet, 75 mg capsule, hcl 75 mg tablet, 100 mg capsule, hcl 100 mg tablet)	1	
mondoxyne nl 100 mg capsule	1	
NUZYRA (100 MG VIAL, 150 MG TABLET)	1	
tetracycline hcl (250 mg capsule, 500 mg capsule)	1	
Anticonvulsants		
Anticonvulsants, Other		
BRIVIACT (10 MG TABLET, 25 MG TABLET, 50 MG TABLET, 75 MG TABLET, 100 MG TABLET)	1	QL (60 PER 30 DAYS)
BRIVIACT 10 MG/ML ORAL SOLN	1	QL (600 PER 30 DAYS)
BRIVIACT 50 MG/5 ML VIAL	1	
DEPAKOTE (DR 125 MG TABLET, DR 250 MG TABLET, DR 500 MG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DEPAKOTE ER (ER 250 MG TABLET, ER 500 MG TABLET)	1	
DEPAKOTE SPRINKLE DR 125 MG CP	1	
DIACOMIT (250 MG CAPSULE, 250 MG POWDER PACKET, 500 MG CAPSULE, 500 MG POWDER PACKET)	1	
divalproex sodium (dr 125 mg cap sprnk, sod dr 125 mg tab, sod dr 250 mg tab, sod dr 500 mg tab)	1	
divalproex sodium er (er 250 mg tab, er 500 mg tab)	1	
EPIDIOLEX (100 MG/ML SOLN PACK, 100 MG/ML SOLUTION)	1	PA
EPRONTIA 25 MG/ML SOLUTION	1	
felbamate (400 mg tablet, 600 mg tablet, 600 mg/5 ml susp, 600 mg/5 ml susp cup)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FINTEPLA 2.2 MG/ML SOLUTION	1	PA, QL (360 PER 30 DAYS)
FYCOMPA (2 MG TABLET, 4 MG TABLET, 6 MG TABLET, 8 MG TABLET, 10 MG TABLET, 12 MG TABLET)	1	QL (30 PER 30 DAYS)
FYCOMPA 0.5 MG/ML ORAL SUSP	1	QL (680 PER 28 DAYS)
KEPPRA (100 MG/ML ORAL SOLN, 250 MG TABLET, 500 MG TABLET, 750 MG TABLET, 1,000 MG TABLET)	1	
LAMICTAL (5 MG DISPER TABLET, 25 MG DISPER TABLET, 25 MG TABLET, 100 MG TABLET, 150 MG TABLET, 200 MG TABLET)	1	
LAMICTAL (BLUE) TAB START KIT	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
lamotrigine (5 mg disper tablet, 25 mg disper tab, 25 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet)	1	
lamotrigine (blue) tab start kit-blue	1	
lamotrigine er (er 25 mg tablet, er 50 mg tablet, er 100 mg tablet, er 200 mg tablet, er 300 mg tablet)	1	
levetiracetam (100 mg/ml soln, 250 mg tablet, 500 mg tablet, 500 mg/5 ml cup, 500 mg/5 ml soln, 750 mg tablet, 1,000 mg tablet, 1,000mg/10ml cup)	1	
levetiracetam er (er 500 mg tablet, er 750 mg tablet)	1	
perampanel (2 mg tablet, 4 mg tablet, 6 mg tablet, 8 mg tablet, 10 mg tablet, 12 mg tablet)	1	QL (30 PER 30 DAYS)
roweepra 500 mg tablet	1	
SPRITAM (250 MG TABLET, 500 MG TABLET, 750 MG TABLET, 1,000 MG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
subvenite (25 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet)	1	
subvenite (blue) tab start kit	1	
topiramate (15 mg sprinkle cap, 25 mg sprinkle cap, 25 mg tablet, 25 mg/ml solution, 50 mg tablet, 100 mg tablet, 200 mg tablet)	1	
valproic acid (250 mg capsule, 250 mg/5 ml cup, 250 mg/5 ml soln, 500 mg/10 ml cup, 500 mg/10 ml sol)	1	
Calcium Channel Modifying Agents		
CELONTIN 300 MG CAPSULE	1	
ethosuximide (250 mg capsule, 250 mg/5 ml soln)	1	
methsuximide 300 mg capsule	1	
ZARONTIN 250 MG CAPSULE	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Gamma-aminobutyric Acid (GABA) Modulating Agents		
clobazam (10 mg tablet, 20 mg tablet)	1	PA, QL (60 PER 30 DAYS)
clobazam 2.5 mg/ml suspension	1	PA, QL (480 PER 30 DAYS)
diazepam (2.5mg gel(2pk), 10 mg gel syrg, 10mg gel (2pk), 20 mg gel syrg, 20mg gel (2pk))	1	QL (5 PER 30 DAYS)
gabapentin (250 mg/5 ml soln, 250 mg/5ml soln cup, 300 mg/6 ml soln, 300 mg/6ml soln cup)	1	QL (2160 PER 30 DAYS)
gabapentin 100 mg capsule	1	QL (1080 PER 30 DAYS)
gabapentin 300 mg capsule	1	QL (360 PER 30 DAYS)
gabapentin 400 mg capsule	1	QL (270 PER 30 DAYS)
gabapentin 600 mg tablet	1	QL (180 PER 30 DAYS)
gabapentin 800 mg tablet	1	QL (135 PER 30 DAYS)
LIBERVANT (5 MG FILM, 7.5 MG FILM, 10 MG FILM, 12.5 MG FILM, 15 MG FILM)	1	QL (10 PER 30 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LYRICA (225 MG CAPSULE, 300 MG CAPSULE)	1	QL (60 PER 30 DAYS)
LYRICA (25 MG CAPSULE, 50 MG CAPSULE, 75 MG CAPSULE, 100 MG CAPSULE, 150 MG CAPSULE, 200 MG CAPSULE)	1	QL (90 PER 30 DAYS)
LYRICA 20 MG/ML ORAL SOLUTION	1	QL (900 PER 30 DAYS)
MYSOLINE (50 MG TABLET, 250 MG TABLET)	1	
NAYZILAM 5 MG NASAL SPRAY	1	QL (10 PER 30 DAYS)
NEURONTIN (250 MG/5 ML SOLN, 250 MG/5 ML SOLUTION)	1	QL (2160 PER 30 DAYS)
NEURONTIN 100 MG CAPSULE	1	QL (1080 PER 30 DAYS)
NEURONTIN 300 MG CAPSULE	1	QL (360 PER 30 DAYS)
NEURONTIN 400 MG CAPSULE	1	QL (270 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
NEURONTIN 600 MG TABLET	1	QL (180 PER 30 DAYS)
NEURONTIN 800 MG TABLET	1	QL (135 PER 30 DAYS)
ONFI (10 MG TABLET, 20 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
ONFI 2.5 MG/ML SUSPENSION	1	PA, QL (480 PER 30 DAYS)
phenobarbital (15 mg tablet, 16.2 mg tablet, 20 mg/5 ml cup, 20 mg/5 ml elix, 20 mg/5 ml soln, 30 mg tablet, 30 mg/7.5 ml cup, 32.4 mg tablet, 60 mg tablet, 60 mg/15 ml cup, 64.8 mg tablet, 97.2 mg tablet, 100 mg tablet)	1	
pregabalin (225 mg capsule, 300 mg capsule)	1	QL (60 PER 30 DAYS)
pregabalin (25 mg capsule, 50 mg capsule, 75 mg capsule, 100 mg capsule, 150 mg capsule, 200 mg capsule)	1	QL (90 PER 30 DAYS)
pregabalin 20 mg/ml solution	1	QL (900 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
primidone (50 mg tablet, 125 mg tablet, 250 mg tablet)	1	
SABRIL (500 MG POWDER PACKET, 500 MG TABLET)	1	QL (180 PER 30 DAYS)
SYMPAZAN (10 MG FILM, 20 MG FILM)	1	PA, QL (60 PER 30 DAYS)
SYMPAZAN 5 MG FILM	1	PA, QL (240 PER 30 DAYS)
tiagabine hcl (2 mg tablet, 4 mg tablet, 12 mg tablet, 16 mg tablet)	1	
VALTOCO (5 MG SPRAY, 10 MG SPRAY, 15 MG SPRAY, 20 MG SPRAY)	1	QL (10 PER 30 DAYS)
vigabatrin (500 mg powder packt, 500 mg tablet)	1	QL (180 PER 30 DAYS)
vigadrone (500 mg powder packet, 500 mg tablet)	1	QL (180 PER 30 DAYS)
VIGAFYDE 100 MG/ML ORAL SOLN	1	QL (750 PER 30 DAYS)
vigpoder 500 mg powder packet	1	QL (180 PER 30 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ZTALMY 50 MG/ML SUSPENSION	1	PA, QL (1100 PER 30 DAYS)
Sodium Channel Agents		
APTIOM (200 MG TABLET, 400 MG TABLET)	1	QL (30 PER 30 DAYS)
APTIOM (600 MG TABLET, 800 MG TABLET)	1	QL (60 PER 30 DAYS)
BANZEL (40 MG/ML SUSPENSION, 200 MG TABLET, 400 MG TABLET)	1	
carbamazepine (100 mg tab chew, 100 mg/5 ml cup, 100 mg/5 ml susp, 200 mg tablet, 200 mg/10 ml cup)	1	
carbamazepine er (er 100 mg cap, er 100 mg tablet, er 200 mg cap, er 200 mg tablet, er 300 mg cap, er 400 mg tablet)	1	
CARBATROL (ER 100 MG CAPSULE, ER 200 MG CAPSULE, ER 300 MG CAPSULE)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DILANTIN (DILANTIN 30 MG CAPSULE, DILANTIN 30 MG CAPSULE, DILANTIN 100 MG CAPSULE, DILANTIN 100 MG CAPSULE, DILANTIN 50 MG INFATAB)	1	
DILANTIN-125 MG/5 ML SUSP	1	
epitol 200 mg tablet	1	
eslicarbazepine acetate (200 mg tablet, 400 mg tablet)	1	QL (30 PER 30 DAYS)
eslicarbazepine acetate (600 mg tablet, 800 mg tablet)	1	QL (60 PER 30 DAYS)
lacosamide (10 mg/ml solution, 50 mg tablet, 50 mg/5 ml cup, 100 mg tablet, 100 mg/10 ml cup, 150 mg tablet, 150 mg/15 ml cup, 200 mg tablet, 200 mg/20 ml cup)	1	
oxcarbazepine (150 mg tablet, 300 mg tablet, 300 mg/5 ml cup, 300 mg/5 ml susp, 600 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
PHENYTEK (200 MG CAPSULE, 300 MG CAPSULE)	1	
phenytoin (50 mg infatab chew, 50 mg tablet chew, 100 mg/4 ml susp cup, 125 mg/5 ml susp)	1	
phenytoin sodium extended (100 mg cap, 200 mg cap, 300 mg cap)	1	
rufinamide (40 mg/ml suspension, 200 mg tablet, 400 mg tablet)	1	
TEGRETOL (100 MG/5 ML SUSP, 200 MG TABLET)	1	
TEGRETOL XR (100 MG TABLET, 200 MG TABLET, 400 MG TABLET)	1	
TRILEPTAL (150 MG TABLET, 300 MG TABLET, 300 MG/5 ML SUSP, 600 MG TABLET)	1	
VIMPAT (10 MG/ML SOLUTION, 50 MG TABLET, 100 MG TABLET, 150 MG TABLET, 200 MG	1	

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

TABLET)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
XCOPRI (12.5-25 MG TITRATION PK, 25 MG TABLET, 50 MG TABLET, 50-100 MG TITRATION PAK, 100 MG TABLET, 150 MG TABLET, 150-200 MG TITRATION PK, 200 MG TABLET, 250 MG DAILY DOSE PACK, 350 MG DAILY DOSE PACK)	1	
ZONEGRAN (25 MG CAPSULE, 100 MG CAPSULE)	1	
ZONISADE 100 MG/5 ML ORAL SUSP	1	
zonisamide (25 mg capsule, 50 mg capsule, 100 mg capsule)	1	
Antidementia Agents		
Cholinesterase Inhibitors		
ADLARITY (5 MG/DAY PATCH, 10MG/DAY PATCH)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ARICEPT (5 MG TABLET, 10 MG TABLET)	1	
donepezil hcl (5 mg tablet, 10 mg tablet, 23 mg tablet)	1	
donepezil hcl odt (odt 5 mg tablet, odt 10 mg tablet)	1	
EXELON (4.6 MG/24HR PATCH, 9.5 MG/24HR PATCH, 13.3 MG/24HR PATCH)	1	
galantamine er (er 8 mg capsule, er 16 mg capsule, er 24 mg capsule)	1	
galantamine hbr (4 mg tablet, 8 mg tablet, 12 mg tablet)	1	
galantamine hydrobromide 4 mg/ml oral soln	1	
rivastigmine (1.5 mg capsule, 3 mg capsule, 4.5 mg capsule, 4.6 mg/24hr patch, 6 mg capsule, 9.5 mg/24hr patch, 13.3 mg/24hr ptch)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
memantine hcl (hcl 2 mg/ml solution, 5-10 mg titration pk, hcl 5 mg tablet, hcl 10 mg tablet, hcl 10 mg/5 ml cup)	1	PA
memantine hcl er (er 7 mg capsule, er 14 mg capsule, er 21 mg capsule, er 28 mg capsule)	1	PA
NAMENDA (5 MG TABLET, 5-10 MG TITRATION PK, 10 MG TABLET)	1	PA
Antidepressants		
Antidepressants, Other		
AUVELITY ER 45-105 MG TABLET	1	QL (60 PER 30 DAYS)
bupropion hcl 100 mg tablet	1	QL (120 PER 30 DAYS)
bupropion hcl 75 mg tablet	1	QL (60 PER 30 DAYS)
bupropion hcl sr (150 mg tablet, 200 mg tablet)	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
bupropion hcl sr 100 mg tablet	1	QL (90 PER 30 DAYS)
bupropion hcl sr 150mg tablet	1	QL (60 PER 30 DAYS)
bupropion xl hcl 150 mg tablet	1	QL (90 PER 30 DAYS)
bupropion xl hcl 300 mg tablet	1	QL (30 PER 30 DAYS)
EXXUA (ER 18.2 MG TAB (TITRATN), ER 18.2 MG TABLET, ER 36.3 MG TABLET, ER 54.5 MG TABLET, ER 72.6 MG TABLET)	1	QL (30 PER 30 DAYS)
mirtazapine (7.5 mg tablet, 15 mg odt, 30 mg odt, 30 mg tablet, 45 mg odt, 45 mg tablet)	1	QL (30 PER 30 DAYS)
mirtazapine 15 mg tablet	1	QL (45 PER 30 DAYS)
REMERON (15 MG SOLTAB, 30 MG SOLTAB, 30 MG TABLET, 45 MG SOLTAB)	1	QL (30 PER 30 DAYS)
REMERON 15 MG TABLET	1	QL (45 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
WELLBUTRIN SR (SR 150 MG TABLET, SR 200 MG TABLET)	1	QL (60 PER 30 DAYS)
WELLBUTRIN SR 100 MG TABLET	1	QL (90 PER 30 DAYS)
WELLBUTRIN XL 150 MG TABLET	1	QL (90 PER 30 DAYS)
WELLBUTRIN XL 300 MG TABLET	1	QL (30 PER 30 DAYS)
ZURZUVAE (20 MG CAPSULE, 25 MG CAPSULE)	1	QL (28 PER 365 OVER TIME)
ZURZUVAE 30 MG CAPSULE	1	QL (14 PER 365 OVER TIME)
Monoamine Oxidase Inhibitors		
EMSAM (6 MG/24 PATCH, 9 MG/24 PATCH, 12 MG/24 PATCH)	1	PA, QL (30 PER 30 DAYS)
MARPLAN 10 MG TABLET	1	
NARDIL 15 MG TABLET	1	
PARNATE 10 MG TABLET	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
phenelzine sulfate 15 mg tab	1	
tranylcypromine sulfate 10 mg tab	1	
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibito		
CELEXA (10 MG TABLET, 20 MG TABLET)	1	QL (45 PER 30 DAYS)
CELEXA 40 MG TABLET	1	QL (30 PER 30 DAYS)
citalopram hbr (10 mg tablet, 20 mg tablet)	1	QL (45 PER 30 DAYS)
citalopram hbr (10 mg/5 ml soln, 20 mg/10 ml cup)	1	QL (600 PER 30 DAYS)
citalopram hbr 40 mg tablet	1	QL (30 PER 30 DAYS)
CYMBALTA (20 MG CAPSULE, 60 MG CAPSULE)	1	QL (60 PER 30 DAYS)
CYMBALTA 30 MG CAPSULE	1	QL (90 PER 30 DAYS)
desvenlafaxine succinate er (er 25 mg, er 50 mg, er 100mg)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DRIZALMA SPRINKLE (DR 20 MG CAP, DR 40 MG CAP, DR 60 MG CAP)	1	QL (60 PER 30 DAYS)
DRIZALMA SPRINKLE 30 MG CAP	1	QL (90 PER 30 DAYS)
duloxetine hcl (dr 20 mg cap, dr 60 mg cap)	1	QL (60 PER 30 DAYS)
duloxetine hcl dr 30 mg cap	1	QL (90 PER 30 DAYS)
EFFEXOR XR 150 MG CAPSULE	1	QL (30 PER 30 DAYS)
EFFEXOR XR 37.5 MG CAPSULE	1	QL (60 PER 30 DAYS)
EFFEXOR XR 75 MG CAPSULE	1	QL (90 PER 30 DAYS)
escitalopram oxalate (5 mg tablet, 10 mg tablet)	1	QL (45 PER 30 DAYS)
escitalopram oxalate (oxalate 5 mg/5 ml, 10 mg/10 ml cup)	1	QL (600 PER 30 DAYS)
escitalopram oxalate 20 mg tablet	1	QL (30 PER 30 DAYS)
FETZIMA (ER 20 MG CAPSULE, ER 40 MG CAPSULE, ER 80 MG CAPSULE, ER 120 MG CAPSULE)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FETZIMA 20-40 MG TITRATION PAK	1	QL (28 PER 28 DAYS)
fluoxetine dr 90 mg capsule	1	QL (4 PER 28 DAYS)
fluoxetine hcl (10 mg capsule, 10 mg tablet)	1	QL (90 PER 30 DAYS)
fluoxetine hcl (20 mg/5 ml soln cup, 20 mg/5 ml solution)	1	QL (600 PER 30 DAYS)
fluoxetine hcl 20 mg capsule	1	QL (120 PER 30 DAYS)
fluoxetine hcl 40 mg capsule	1	QL (60 PER 30 DAYS)
fluvoxamine maleate (25 mg tab, 50 mg tab)	1	QL (30 PER 30 DAYS)
fluvoxamine maleate 100 mg tab	1	QL (90 PER 30 DAYS)
LEXAPRO (5 MG TABLET, 10 MG TABLET)	1	QL (45 PER 30 DAYS)
LEXAPRO 20 MG TABLET	1	QL (30 PER 30 DAYS)
nefazodone hcl (50 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet, 250 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
paroxetine cr (25 mg tablet, 37.5 mg tablet)	1	QL (60 PER 30 DAYS)
paroxetine cr 12.5 mg tablet	1	QL (30 PER 30 DAYS)
paroxetine er (er 25 mg tablet, er 37.5 mg tablet)	1	QL (60 PER 30 DAYS)
paroxetine er 12.5 mg tablet	1	QL (30 PER 30 DAYS)
paroxetine hcl (10 mg tablet, 40 mg tablet)	1	QL (45 PER 30 DAYS)
paroxetine hcl 10 mg/5 ml susp	1	QL (900 PER 30 DAYS)
paroxetine hcl 20 mg tablet	1	QL (30 PER 30 DAYS)
paroxetine hcl 30 mg tablet	1	QL (60 PER 30 DAYS)
PAXIL (10 MG TABLET, 40 MG TABLET)	1	QL (45 PER 30 DAYS)
PAXIL 10 MG/5 ML SUSPENSION	1	QL (900 PER 30 DAYS)
PAXIL 20 MG TABLET	1	QL (30 PER 30 DAYS)
PAXIL 30 MG TABLET	1	QL (60 PER 30 DAYS)
PRISTIQ (ER 25 MG TABLET, ER 50 MG TABLET, ER 100 MG TABLET)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
PROZAC 10 MG PULVULE	1	QL (90 PER 30 DAYS)
PROZAC 20 MG PULVULE	1	QL (120 PER 30 DAYS)
PROZAC 40 MG PULVULE	1	QL (60 PER 30 DAYS)
RALDESY 10 MG/ML SOLUTION	1	QL (1200 PER 30 DAYS)
sertraline hcl (25 mg tablet, 50 mg tablet)	1	QL (45 PER 30 DAYS)
sertraline hcl 100 mg tablet	1	QL (60 PER 30 DAYS)
sertraline hcl 20 mg/ml oral conc	1	QL (300 PER 30 DAYS)
trazodone hcl (50 mg tablet, 100 mg tablet, 150 mg tablet, 300 mg tablet)	1	
TRINTELLIX (5 MG TABLET, 10 MG TABLET, 20 MG TABLET)	1	QL (30 PER 30 DAYS)
venlafaxine besylate er 112.5 mg tb	1	QL (60 PER 30 DAYS)
venlafaxine hcl (25 mg tablet, 37.5 mg tablet, 50 mg tablet, 75 mg tablet, 100 mg tablet)	1	QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
venlafaxine hcl er 150 mg cap	1	QL (30 PER 30 DAYS)
venlafaxine hcl er 37.5 mg cap	1	QL (60 PER 30 DAYS)
venlafaxine hcl er 75 mg cap	1	QL (90 PER 30 DAYS)
VIIBRYD (10 MG TABLET, 20 MG TABLET, 40 MG TABLET)	1	QL (30 PER 30 DAYS)
vilazodone hcl (10 mg tablet, 20 mg tablet, 40 mg tablet)	1	QL (30 PER 30 DAYS)
ZOLOFT (25 MG TABLET, 50 MG TABLET)	1	QL (45 PER 30 DAYS)
ZOLOFT 100 MG TABLET	1	QL (60 PER 30 DAYS)
ZOLOFT 20 MG/ML ORAL CONC	1	QL (300 PER 30 DAYS)
Tricyclics		
amitriptyline hcl (10 mg tab, 25 mg tab, 50 mg tab, 75 mg tab, 100 mg tab, 150 mg tab)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
amoxapine (25 mg tablet, 50 mg tablet, 100 mg tablet, 150 mg tablet)	1	
clomipramine hcl (25 mg capsule, 50 mg capsule, 75 mg capsule)	1	
desipramine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 75 mg tablet, 100 mg tablet, 150 mg tablet)	1	
doxepin hcl (10 mg capsule, 10 mg/ml oral conc, 25 mg capsule, 50 mg capsule, 75 mg capsule, 100 mg capsule, 150 mg capsule)	1	
imipramine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet)	1	
NORPRAMIN (10 MG TABLET, 25 MG TABLET)	1	
nortriptyline hcl (10 mg/5 ml soln, hcl 10 mg cap, hcl 25 mg cap, hcl 50 mg cap, hcl 75 mg cap)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
protriptyline hcl (5 mg tablet, 10 mg tablet)	1	
trimipramine maleate (25 mg cap, 50 mg cap, 100 mg cp)	1	
Antiemetics		
Antiemetics, Other		
chlorpromazine hcl (10 mg tablet, 25 mg tablet, 30 mg/ml conc, 50 mg tablet, 100 mg tablet, 100 mg/ml conc, 200 mg tablet)	1	PA
compro 25 mg suppository	1	
meclizine hcl (12.5 mg tablet, 25 mg tablet)	1	
perphenazine (2 mg tablet, 4 mg tablet, 8 mg tablet, 16 mg tablet)	1	PA
prochlorperazine 25 mg supp	1	
prochlorperazine maleate (5 mg tablet, 10 mg tab)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
promethazine hcl (6.25 mg/5 ml cup, 6.25 mg/5 ml soln, 6.25 mg/5 ml syrp, 12.5 mg suppos, 12.5 mg tablet, 12.5 mg/10 ml cup, 25 mg suppository, 25 mg tablet, 50 mg tablet)	1	PA
promethegan (12.5 mg suppos, 25 mg suppository)	1	PA
scopolamine 1 mg/3 day patch	1	PA
Emetogenic Therapy Adjuncts		
aprepitant (40 mg capsule, 80 mg capsule, 125 mg capsule, 125-80-80 mg pack)	1	PA
dronabinol (2.5 mg capsule, 5 mg capsule, 10 mg capsule)	1	PA
EMEND (80 MG CAPSULE, TRIPACK)	1	PA
granisetron hcl 1 mg tablet	1	PA
ondansetron hcl (4 mg/5 ml soln cup, 4 mg/5 ml solution, hcl 4 mg tablet, hcl 8 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ondansetron odt (odt 4 mg tablet, odt 8 mg tablet)	1	
Antifungals		
AMBISOME 50 MG VIAL	1	PA
amphotericin b 50 mg vial	1	PA
amphotericin b liposome 50 mg	1	PA
CANCIDAS (IV 50 MG VIAL, IV 70 MG VIAL)	1	
caspofungin acetate (50 mg vial, 70 mg vial)	1	
ciclodan 8% solution	1	QL (6.6 PER 30 DAYS)
ciclopirox (0.77% cream, 0.77% gel, 0.77% topical susp, 1% shampoo)	1	
ciclopirox 8% solution	1	QL (6.6 PER 30 DAYS)
clotrimazole (1% solution, 1% topical cream, 10 mg lozenge, 10 mg troche)	1	
CRESEMBA (74.5 MG CAPSULE, 186 MG CAPSULE, 372 MG VIAL)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DIFLUCAN (40 MG/ML SUSPENSION, 100 MG TABLET, 200 MG TABLET)	1	
econazole nitrate 1% cream	1	
fluconazole (10 mg/ml susp, 40 mg/ml susp, 50 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet)	1	
fluconazole-nacl (200 mg/100 ml, 400 mg/200 ml)	1	
flucytosine (250 mg capsule, 500 mg capsule)	1	PA
griseofulvin (125 mg/5 ml susp, micro 500 mg tab)	1	
griseofulvin ultramicrosize (125 mg tab, 250 mg tab)	1	
itraconazole 100 mg capsule	1	QL (120 PER 30 DAYS)
ketoconazole (2% cream, 2% shampoo, 200 mg tablet)	1	
klayesta 100,000 unit/gm powd	1	
LOPROX 1% SHAMPOO	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
micafungin (50 mg vial, 100 mg vial)	1	
micafungin-0.9% nacl (50 mg/50ml-0.9%nacl, 100 mg/100-0.9%nacl, 150 mg/150-0.9%nacl)	1	
NOXAFIL (40 MG/ML SUSPENSION, DR 100 MG TABLET, 300 MG POWDERMIX SUSP, 300 MG/16.7 ML VIAL)	1	PA
nyamyc 100,000 unit/gm powder	1	
nystatin (100,000 unit/gm cream, 100,000 unit/gm oint, 100,000 unit/gm powd, 100,000 unit/ml susp, 500,000 unit oral tab, 500,000 unit/5 ml cup, 500,000 unit/5 ml sus)	1	
nystop 100,000 unit/gm powder	1	
posaconazole (dr 100 mg tablet, 200 mg/5 ml susp, 300 mg/16.7 ml vl)	1	PA
SPORANOX 100 MG CAPSULE	1	QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
terbinafine hcl 250 mg tablet	1	QL (30 PER 30 DAYS)
terconazole (0.4% cream, 0.8% cream, 80 mg suppository)	1	
VFEND IV 200 MG VIAL	1	PA
voriconazole (40 mg/ml susp, 50 mg tablet, 200 mg tablet, 200 mg vial)	1	PA
voriconazole (hpbcd) 200 mg vl	1	PA

Antigout Agents

allopurinol (100 mg tablet, 300 mg tablet)	1	
colchicine 0.6 mg tablet	1	
COLCRYS 0.6 MG TABLET	1	
probenecid 500 mg tablet	1	
probenecid-colchicine tablet	1	

Antimigraine Agents

dihydroergotamine mesylate 4 mg/ml spry	1	PA, QL (8 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ergotamine-caffeine 1-100mg tb	1	
MIGRANAL NASAL SPRAY	1	PA, QL (8 PER 28 DAYS)
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists		
AIMOVIG AUTOINJECTOR 140 MG/ML	1	PA, QL (1 PER 30 DAYS)
AIMOVIG AUTOINJECTOR 70 MG/ML	1	PA, QL (2 PER 30 DAYS)
EMGALITY PEN 120 MG/ML	1	PA, QL (2 PER 30 DAYS)
EMGALITY SYRINGE (100 MG/ML SYR(1 OF 3), 300 MG (100 MG X3SYR))	1	PA, QL (3 PER 30 DAYS)
EMGALITY SYRINGE 120 MG/ML	1	PA, QL (2 PER 30 DAYS)
NURTEC ODT 75 MG TABLET	1	PA, QL (16 PER 30 DAYS)
UBRELVY (50 MG TABLET, 100 MG TABLET)	1	PA, QL (16 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Serotonin (5-HT) Receptor Agonist		
IMITREX (25 MG TABLET, 50 MG TABLET, 100 MG TABLET)	1	ST, QL (18 PER 30 DAYS)
IMITREX (4 MG/0.5 ML CARTRIDGES, 4 MG/0.5 ML PEN INJECT)	1	ST, QL (6 PER 30 DAYS)
IMITREX (6 MG/0.5 ML CARTRIDGES, 6 MG/0.5 ML PEN INJECT)	1	QL (6 PER 30 DAYS)
MAXALT 10 MG TABLET	1	ST, QL (18 PER 30 DAYS)
MAXALT MLT 10 MG TABLET	1	ST, QL (18 PER 30 DAYS)
naratriptan hcl (1 mg tablet, 2.5 mg tablet)	1	QL (18 PER 30 DAYS)
rizatriptan (5 mg odt, 5 mg tablet, 10 mg odt, 10 mg tablet)	1	QL (18 PER 30 DAYS)
sumatriptan (5 mg, 20 mg)	1	QL (12 PER 30 DAYS)
sumatriptan succinate (25 mg tablet, 50 mg tablet, 100 mg tablet)	1	QL (18 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
sumatriptan succinate (4 mg/0.5 ml cart, 4 mg/0.5 ml inject, 6 mg/0.5 ml cart, 6 mg/0.5ml autoinj)	1	QL (6 PER 30 DAYS)
sumatriptan succinate 6 mg/0.5 ml vial	1	QL (5 PER 30 DAYS)
zolmitriptan odt (2.5 mg odt, 5 mg odt)	1	QL (12 PER 30 DAYS)
Antimyasthenic Agents		
Parasympathomimetics		
MESTINON (60 MG TABLET, 60 MG/5 ML SOLUTION, 180 MG TIMESPAN)	1	
pyridostigmine bromide (60 mg/5 ml cup, 60 mg/5 ml soln, br 60 mg tablet)	1	
pyridostigmine bromide er 180 mg tab	1	
Antimycobacterials		
Antimycobacterials, Other		
dapsone (25 mg tablet, 100 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
MYCOBUTIN 150 MG CAPSULE	1	
rifabutin 150 mg capsule	1	
Antituberculars		
cycloserine 250 mg capsule	1	
ethambutol hcl (100 mg tablet, 400 mg tablet)	1	
isoniazid (50 mg/5 ml solution, 100 mg tablet, 300 mg tablet)	1	
PRETOMANID 200 MG TABLET	1	
PRIFTIN 150 MG TABLET	1	
pyrazinamide 500 mg tablet	1	
rifampin (150 mg capsule, 300 mg capsule, iv 600 mg vial)	1	
SIRTURO (20 MG TABLET, 100 MG TABLET)	1	
TRECATOR 250 MG TABLET	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Antineoplastics		
Alkylating Agents		
cyclophosphamide (25 mg capsule, 25 mg tablet, 50 mg capsule, 50 mg tablet)	1	PA
GLEOSTINE (10 MG CAPSULE, 40 MG CAPSULE, 100 MG CAPSULE)	1	
LEUKERAN 2 MG TABLET	1	
MATULANE 50 MG CAPSULE	1	PA
VALCHLOR 0.016% GEL	1	PA, QL (60 PER 30 DAYS)
Antiandrogens		
abiraterone acetate 250 mg tab	1	PA, QL (120 PER 30 DAYS)
abirtega 250 mg tablet	1	PA, QL (120 PER 30 DAYS)
bicalutamide 50 mg tablet	1	
CASODEX 50 MG TABLET	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ERLEADA 240 MG TABLET	1	PA, QL (30 PER 30 DAYS)
ERLEADA 60 MG TABLET	1	PA, QL (120 PER 30 DAYS)
EULEXIN 125 MG CAPSULE	1	
NILANDRON 150 MG TABLET	1	
nilutamide 150 mg tablet	1	
NUBEQA 300 MG TABLET	1	PA, QL (120 PER 30 DAYS)
XTANDI (40 MG CAPSULE, 40 MG TABLET)	1	PA, QL (120 PER 30 DAYS)
XTANDI 80 MG TABLET	1	PA, QL (60 PER 30 DAYS)
YONSA 125 MG TABLET	1	PA, QL (120 PER 30 DAYS)
Antiangiogenic Agents		
lenalidomide (15 mg capsule, 20 mg capsule, 25 mg capsule)	1	PA, QL (21 PER 28 DAYS)
lenalidomide (2.5 mg capsule, 5 mg capsule, 10 mg capsule)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
POMALYST (1 MG CAPSULE, 2 MG CAPSULE, 3 MG CAPSULE, 4 MG CAPSULE)	1	PA, QL (21 PER 28 DAYS)
THALOMID (150 MG CAPSULE, 200 MG CAPSULE)	1	PA, QL (60 PER 30 DAYS)
THALOMID 100 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
THALOMID 50 MG CAPSULE	1	PA, QL (90 PER 30 DAYS)
Antiestrogens/Modifiers		
FARESTON 60 MG TABLET	1	
INLURIYO 200 MG TABLET	1	PA, QL (60 PER 30 DAYS)
ORSERDU 345 MG TABLET	1	PA, QL (30 PER 30 DAYS)
ORSERDU 86 MG TABLET	1	PA, QL (90 PER 30 DAYS)
SOLTAMOX 20 MG/10 ML SOLN	1	
tamoxifen citrate (10 mg tablet, 20 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
toremifene citrate 60 mg tab	1	
Antimetabolites		
mercaptopurine (20 mg/ml suspen, 50 mg tablet)	1	
PURIXAN 20 MG/ML ORAL SUSP	1	
TABLOID 40 MG TABLET	1	
Antineoplastics, Other		
AVMAPKI-FAKZYNJA CO-PACK	1	PA, QL (66 PER 28 DAYS)
HYDREA 500 MG CAPSULE	1	
hydroxyurea 500 mg capsule	1	
INQOVI 35 MG-100 MG TABLET	1	PA, QL (5 PER 28 DAYS)
IWILFIN 192 MG TABLET	1	PA, QL (240 PER 30 DAYS)
KISQALI FEMARA CO-PACK 200 MG	1	PA, QL (49 PER 28 DAYS)
KISQALI FEMARA CO-PACK 400 MG	1	PA, QL (70 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
KISQALI FEMARA CO-PACK 600 MG	1	PA, QL (91 PER 28 DAYS)
leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab)	1	
LONSURF 15 MG-6.14 MG TABLET	1	PA, QL (100 PER 28 DAYS)
LONSURF 20 MG-8.19 MG TABLET	1	PA, QL (80 PER 28 DAYS)
LYSODREN 500 MG TABLET	1	
MODEYSO 125 MG CAPSULE	1	PA, QL (20 PER 28 DAYS)
NIPENT 10 MG VIAL	1	
ONUREG (200 MG TABLET, 300 MG TABLET)	1	PA, QL (14 PER 28 DAYS)
ORGOVYX 120 MG TABLET	1	PA, QL (90 PER 30 DAYS)
XPOVIO (40 MG TWICE, 80 MG ONCE, 100 MG ONCE)	1	PA, QL (8 PER 28 DAYS)
XPOVIO (40 MG, 60 MG)	1	PA, QL (4 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
XPOVIO 60 MG TWICE WEEKLY DOSE	1	PA, QL (24 PER 28 DAYS)
XPOVIO 80 MG TWICE WEEKLY DOSE	1	PA, QL (32 PER 28 DAYS)
ZOLINZA 100 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
Aromatase Inhibitors, 3rd Generation		
anastrozole 1 mg tablet	1	
ARIMIDEX 1 MG TABLET	1	
AROMASIN 25 MG TABLET	1	
exemestane 25 mg tablet	1	
FEMARA 2.5 MG TABLET	1	
letrozole 2.5 mg tablet	1	
Molecular Target Inhibitors		
AFINITOR (2.5 MG TABLET, 7.5 MG TABLET, 10 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
AFINITOR 5 MG TABLET	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
AFINITOR DISPERZ (2 MG TABLET, 5 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
AFINITOR DISPERZ 3 MG TABLET	1	PA, QL (90 PER 30 DAYS)
AKEEGA (50-500 MG TABLET, 100-500 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
ALECENSA 150 MG CAPSULE	1	PA, QL (240 PER 30 DAYS)
ALUNBRIG (90 MG TABLET, 90 MG-180 MG TAB PACK, 180 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
ALUNBRIG 30 MG TABLET	1	PA, QL (120 PER 30 DAYS)
AUGTYRO 160 MG CAPSULE	1	PA, QL (60 PER 30 DAYS)
AUGTYRO 40 MG CAPSULE	1	PA, QL (240 PER 30 DAYS)
AYVAKIT (25 MG TABLET, 50 MG TABLET, 100 MG TABLET, 200 MG TABLET, 300 MG TABLET)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
BALVERSA 3 MG TABLET	1	PA, QL (90 PER 30 DAYS)
BALVERSA 4 MG TABLET	1	PA, QL (60 PER 30 DAYS)
BALVERSA 5 MG TABLET	1	PA, QL (30 PER 30 DAYS)
BOSULIF (100 MG CAPSULE, 100 MG TABLET)	1	PA, QL (180 PER 30 DAYS)
BOSULIF (400 MG TABLET, 500 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
BOSULIF 50 MG CAPSULE	1	PA, QL (330 PER 30 DAYS)
BRAFTOVI 75 MG CAPSULE	1	PA, QL (180 PER 30 DAYS)
BRUKINSA 160 MG TABLET	1	PA, QL (60 PER 30 DAYS)
BRUKINSA 80 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
CABOMETYX (20 MG TABLET, 40 MG TABLET, 60 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
CALQUENCE (100 MG CAPSULE, 100 MG TABLET)	1	PA, QL (60 PER 30 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
CAPRELSA 100 MG TABLET	1	PA, QL (60 PER 30 DAYS)
CAPRELSA 300 MG TABLET	1	PA, QL (30 PER 30 DAYS)
COMETRIQ 100 MG DAILY-DOSE PK	1	PA, QL (56 PER 28 DAYS)
COMETRIQ 140 MG DAILY-DOSE PK	1	PA, QL (112 PER 28 DAYS)
COMETRIQ 60 MG DAILY-DOSE PACK	1	PA, QL (84 PER 28 DAYS)
COPIKTRA (15 MG CAPSULE, 25 MG CAPSULE)	1	PA, QL (56 PER 28 DAYS)
COTELLIC 20 MG TABLET	1	PA, QL (63 PER 28 DAYS)
DANZITEN (71 MG TABLET, 95 MG TABLET)	1	PA, QL (112 PER 28 DAYS)
dasatinib (50 mg tablet, 70 mg tablet, 80 mg tablet, 100 mg tablet, 140 mg tablet)	1	PA, QL (30 PER 30 DAYS)
dasatinib 20 mg tablet	1	PA, QL (90 PER 30 DAYS)
DAURISMO 100 MG TABLET	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DAURISMO 25 MG TABLET	1	PA, QL (60 PER 30 DAYS)
ERIVEDGE 150 MG CAPSULE	1	PA, QL (30 PER 30 DAYS)
erlotinib hcl (100 mg tablet, 150 mg tablet)	1	PA, QL (30 PER 30 DAYS)
erlotinib hcl 25 mg tablet	1	PA, QL (60 PER 30 DAYS)
everolimus (2 mg tab for susp, 5 mg tab for susp, 5 mg tablet)	1	PA, QL (60 PER 30 DAYS)
everolimus (2.5 mg tablet, 7.5 mg tablet, 10 mg tablet)	1	PA, QL (30 PER 30 DAYS)
everolimus 3 mg tab for susp	1	PA, QL (90 PER 30 DAYS)
EXKIVITY 40 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
FOTIVDA (0.89 MG CAPSULE, 1.34 MG CAPSULE)	1	PA, QL (21 PER 28 DAYS)
FRUZAQLA 1 MG CAPSULE	1	PA, QL (84 PER 28 DAYS)
FRUZAQLA 5 MG CAPSULE	1	PA, QL (21 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
GAVRETO 100 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
gefitinib 250 mg tablet	1	PA, QL (30 PER 30 DAYS)
GILOTRIF (20 MG TABLET, 30 MG TABLET, 40 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
GLEEVEC 100 MG TABLET	1	PA, QL (90 PER 30 DAYS)
GLEEVEC 400 MG TABLET	1	PA, QL (60 PER 30 DAYS)
GOMEKLI (1 MG CAPSULE, 1 MG TABLET FOR SUSP)	1	PA, QL (168 PER 28 DAYS)
GOMEKLI 2 MG CAPSULE	1	PA, QL (84 PER 28 DAYS)
HERNEXEOS 60 MG TABLET	1	PA, QL (180 PER 60 DAYS)
IBRANCE (75 MG CAPSULE, 75 MG TABLET, 100 MG CAPSULE, 100 MG TABLET, 125 MG CAPSULE, 125 MG TABLET)	1	PA, QL (21 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
IBTROZI 200 MG CAPSULE	1	PA, QL (90 PER 30 DAYS)
ICLUSIG (10 MG TABLET, 15 MG TABLET, 30 MG TABLET, 45 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
IDHIFA (50 MG TABLET, 100 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
imatinib mesylate 100 mg tab	1	PA, QL (90 PER 30 DAYS)
imatinib mesylate 400 mg tab	1	PA, QL (60 PER 30 DAYS)
IMBRUVICA (70 MG CAPSULE, 420 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
IMBRUVICA 140 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
IMBRUVICA 70 MG/ML SUSPENSION	1	PA, QL (324 PER 30 DAYS)
IMKELDI 80 MG/ML SOLUTION	1	PA, QL (280 PER 28 DAYS)
INLYTA 1 MG TABLET	1	PA, QL (180 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
INLYTA 5 MG TABLET	1	PA, QL (120 PER 30 DAYS)
INREBIC 100 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
IRESSA 250 MG TABLET	1	PA, QL (30 PER 30 DAYS)
ITOVEBI 3 MG TABLET	1	PA, QL (60 PER 30 DAYS)
ITOVEBI 9 MG TABLET	1	PA, QL (30 PER 30 DAYS)
JAKAFI (5 MG TABLET, 10 MG TABLET, 15 MG TABLET, 20 MG TABLET, 25 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
JAYPIRCA 100 MG TABLET	1	PA, QL (60 PER 30 DAYS)
JAYPIRCA 50 MG TABLET	1	PA, QL (30 PER 30 DAYS)
KISQALI 200 MG DAILY DOSE	1	PA, QL (21 PER 28 DAYS)
KISQALI 400 MG DAILY DOSE	1	PA, QL (42 PER 28 DAYS)
KISQALI 600 MG DAILY DOSE	1	PA, QL (63 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
KOSELUGO 10 MG CAPSULE	1	PA, QL (240 PER 30 DAYS)
KOSELUGO 25 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
KOSELUGO 5 MG SPRINKLE CAPSULE	1	PA, QL (600 PER 30 DAYS)
KOSELUGO 7.5 MG SPRINKLE CAP	1	PA, QL (360 PER 30 DAYS)
KRAZATI 200 MG TABLET	1	PA, QL (180 PER 30 DAYS)
lapatinib 250 mg tablet	1	PA, QL (180 PER 30 DAYS)
LAZCLUZE 240 MG TABLET	1	PA, QL (30 PER 30 DAYS)
LAZCLUZE 80 MG TABLET	1	PA, QL (60 PER 30 DAYS)
LENVIMA (12 MG DAILY, 18 MG DAILY, 24 MG DAILY)	1	PA, QL (90 PER 30 DAYS)
LENVIMA (4 MG CAPSULE, 10 MG DAILY DOSE)	1	PA, QL (30 PER 30 DAYS)
LENVIMA (8 MG DAILY, 14 MG DAILY, 20 MG DAILY)	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LORBRENA 100 MG TABLET	1	PA, QL (30 PER 30 DAYS)
LORBRENA 25 MG TABLET	1	PA, QL (90 PER 30 DAYS)
LUMAKRAS 120 MG TABLET	1	PA, QL (240 PER 30 DAYS)
LUMAKRAS 240 MG TABLET	1	PA, QL (120 PER 30 DAYS)
LUMAKRAS 320 MG TABLET	1	PA, QL (90 PER 30 DAYS)
LYNPARZA (100 MG TABLET, 150 MG TABLET)	1	PA, QL (120 PER 30 DAYS)
LYTGOBI 12 MG DOSE (3X 4MG TB)	1	PA, QL (84 PER 28 DAYS)
LYTGOBI 16 MG DOSE (4X 4MG TB)	1	PA, QL (112 PER 28 DAYS)
LYTGOBI 20 MG DOSE (5X 4MG TB)	1	PA, QL (140 PER 28 DAYS)
MEKINIST 0.05 MG/ML SOLUTION	1	PA, QL (1170 PER 28 DAYS)
MEKINIST 0.5 MG TABLET	1	PA, QL (90 PER 30 DAYS)
MEKINIST 2 MG TABLET	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
MEKTOVI 15 MG TABLET	1	PA, QL (180 PER 30 DAYS)
NERLYNX 40 MG TABLET	1	PA, QL (180 PER 30 DAYS)
NEXAVAR 200 MG TABLET	1	PA, QL (120 PER 30 DAYS)
NINLARO (2.3 MG CAPSULE, 3 MG CAPSULE, 4 MG CAPSULE)	1	PA, QL (3 PER 28 DAYS)
ODOMZO 200 MG CAPSULE	1	PA, QL (30 PER 30 DAYS)
OGSIVEO (100 MG TABLET, 150 MG TABLET)	1	PA, QL (56 PER 28 DAYS)
OGSIVEO 50 MG TABLET	1	PA, QL (180 PER 30 DAYS)
OJEMDA (100 MG TAB (400MG DOSE), 100 MG TAB (500MG DOSE), 100 MG TAB (600MG DOSE))	1	PA, QL (24 PER 28 DAYS)
OJEMDA 25 MG/ML ORAL SUSP	1	PA, QL (96 PER 28 DAYS)
OJJAARA (100 MG TABLET, 150 MG TABLET, 200 MG TABLET)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
pazopanib hcl 200 mg tablet	1	PA, QL (120 PER 30 DAYS)
PEMAZYRE (4.5 MG TABLET, 9 MG TABLET, 13.5 MG TABLET)	1	PA, QL (14 PER 21 DAYS)
PIQRAY (250 MG DAILY PACK, 300 MG DAILY PACK)	1	PA, QL (60 PER 30 DAYS)
PIQRAY 200 MG DAILY DOSE PACK	1	PA, QL (30 PER 30 DAYS)
QINLOCK 50 MG TABLET	1	PA, QL (90 PER 30 DAYS)
RETEVMO (80 MG TABLET, 120 MG TABLET, 160 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
RETEVMO 40 MG CAPSULE	1	PA, QL (180 PER 30 DAYS)
RETEVMO 40 MG TABLET	1	PA, QL (90 PER 30 DAYS)
RETEVMO 80 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
REVUFORJ 110 MG TABLET	1	PA, QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
REVUFORJ 160 MG TABLET	1	PA, QL (60 PER 30 DAYS)
REVUFORJ 25 MG TABLET	1	PA, QL (240 PER 30 DAYS)
REZLIDHIA 150 MG CAPSULE	1	PA, QL (60 PER 30 DAYS)
ROMVIMZA (14 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE)	1	PA, QL (8 PER 28 DAYS)
ROZLYTREK 100 MG CAPSULE	1	PA, QL (150 PER 30 DAYS)
ROZLYTREK 200 MG CAPSULE	1	PA, QL (90 PER 30 DAYS)
ROZLYTREK 50 MG PELLET PACKET	1	PA, QL (336 PER 28 DAYS)
RUBRACA (200 MG TABLET, 250 MG TABLET, 300 MG TABLET)	1	PA, QL (120 PER 30 DAYS)
RYDAPT 25 MG CAPSULE	1	PA, QL (240 PER 30 DAYS)
SCEMBLIX 100 MG TABLET	1	PA, QL (120 PER 30 DAYS)
SCEMBLIX 20 MG TABLET	1	PA, QL (60 PER 30 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SCEMBLIX 40 MG TABLET	1	PA, QL (300 PER 30 DAYS)
sorafenib 200 mg tablet	1	PA, QL (120 PER 30 DAYS)
SPRYCEL (50 MG TABLET, 70 MG TABLET, 80 MG TABLET, 100 MG TABLET, 140 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
SPRYCEL 20 MG TABLET	1	PA, QL (90 PER 30 DAYS)
STIVARGA 40 MG TABLET	1	PA, QL (84 PER 28 DAYS)
sunitinib malate (25 mg capsule, 37.5 mg cap, 50 mg capsule)	1	PA, QL (30 PER 30 DAYS)
sunitinib malate 12.5 mg cap	1	PA, QL (90 PER 30 DAYS)
SUTENT (25 MG CAPSULE, 37.5 MG CAPSULE, 50 MG CAPSULE)	1	PA, QL (30 PER 30 DAYS)
SUTENT 12.5 MG CAPSULE	1	PA, QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TABRECTA (150 MG TABLET, 200 MG TABLET)	1	PA, QL (120 PER 30 DAYS)
TAFINLAR (50 MG CAPSULE, 75 MG CAPSULE)	1	PA, QL (120 PER 30 DAYS)
TAFINLAR 10 MG TABLET FOR SUSP	1	PA, QL (840 PER 28 DAYS)
TAGRISSO (40 MG TABLET, 80 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
TALZENNA (0.1 MG CAPSULE, 0.1 MG SOFTGEL, 0.25 MG CAPSULE, 0.25 MG SOFTGEL, 0.35 MG CAPSULE, 0.35 MG SOFTGEL, 0.5 MG CAPSULE, 0.5 MG SOFTGEL, 0.75 MG CAPSULE, 0.75 MG SOFTGEL, 1 MG CAPSULE, 1 MG SOFTGEL)	1	PA, QL (30 PER 30 DAYS)
TASIGNA (50 MG CAPSULE, 150 MG CAPSULE, 200 MG CAPSULE)	1	PA, QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TAZVERIK 200 MG TABLET	1	PA, QL (240 PER 30 DAYS)
TEPMETKO 225 MG TABLET	1	PA, QL (60 PER 30 DAYS)
TIBSOVO 250 MG TABLET	1	PA, QL (60 PER 30 DAYS)
torpenz (2.5 mg tablet, 7.5 mg tablet, 10 mg tablet)	1	PA, QL (30 PER 30 DAYS)
torpenz 5 mg tablet	1	PA, QL (60 PER 30 DAYS)
TRUQAP (160 MG TABLET, 200 MG TABLET)	1	PA, QL (64 PER 28 DAYS)
TUKYSA 150 MG TABLET	1	PA, QL (120 PER 30 DAYS)
TUKYSA 50 MG TABLET	1	PA, QL (300 PER 30 DAYS)
TURALIO 125 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
TYKERB 250 MG TABLET	1	PA, QL (180 PER 30 DAYS)
VANFLYTA (17.7 MG TABLET, 26.5 MG TABLET)	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
VENCLEXTA (10 MG TAB (10MG X 2), 10 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
VENCLEXTA 100 MG TABLET	1	PA, QL (180 PER 30 DAYS)
VENCLEXTA 50 MG TABLET	1	PA, QL (30 PER 30 DAYS)
VENCLEXTA STARTING PACK	1	PA, QL (42 PER 28 DAYS)
VERZENIO (50 MG TABLET, 100 MG TABLET, 150 MG TABLET, 200 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
VITRAKVI 100 MG CAPSULE	1	PA, QL (60 PER 30 DAYS)
VITRAKVI 20 MG/ML SOLUTION	1	PA, QL (300 PER 30 DAYS)
VITRAKVI 25 MG CAPSULE	1	PA, QL (180 PER 30 DAYS)
VIZIMPRO (15 MG TABLET, 30 MG TABLET, 45 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
VONJO 100 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
VORANIGO 10 MG TABLET	1	PA, QL (60 PER 30 DAYS)
VORANIGO 40 MG TABLET	1	PA, QL (30 PER 30 DAYS)
VOTRIENT 200 MG TABLET	1	PA, QL (120 PER 30 DAYS)
XALKORI (20 MG PELLET, 50 MG PELLET, 200 MG CAPSULE, 250 MG CAPSULE)	1	PA, QL (120 PER 30 DAYS)
XALKORI 150 MG PELLET	1	PA, QL (180 PER 30 DAYS)
XOSPATA 40 MG TABLET	1	PA, QL (90 PER 30 DAYS)
ZEJULA (100 MG TABLET, 200 MG TABLET, 300 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
ZELBORAF 240 MG TABLET	1	PA, QL (240 PER 30 DAYS)
ZYDELIG (100 MG TABLET, 150 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
ZYKADIA 150 MG TABLET	1	PA, QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Monoclonal Antibody/Antibody-Drug Conjugate		
KANJINTI (150 MG VIAL, 420 MG VIAL, 420 MG VIAL W-DILUENT)	1	PA
MVASI (100 MG/4 ML VIAL, 400 MG/16 ML VIAL)	1	PA
ONTRUZANT (150 MG VIAL, 420 MG VIAL)	1	PA
RIABNI (100 MG/10 ML VIAL, 500 MG/50 ML VIAL)	1	PA
RUXIENCE (100 MG/10 ML VIAL, 500 MG/50 ML VIAL)	1	PA
TRAZIMERA (150 MG VIAL, 420 MG VIAL)	1	PA
ZIRABEV (100 MG/4 ML VIAL, 400 MG/16 ML VIAL)	1	PA
Retinoids		
bexarotene (1% gel, 75 mg capsule)	1	PA
PANRETIN 0.1% GEL	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TARGRETIN (1% GEL, 75 MG CAPSULE)	1	PA
tretinoin 10 mg capsule	1	PA
Treatment Adjuncts		
mesna 400 mg tablet	1	
MESNEX 400 MG TABLET	1	
Antiparasitics		
Anthelmintics		
albendazole 200 mg tablet	1	
benznidazole (12.5 mg tablet, 100 mg tablet)	1	
BILTRICIDE 600 MG TABLET	1	
ivermectin 3 mg tablet	1	PA
praziquantel 600 mg tablet	1	
STROMECTOL 3 MG TABLET	1	PA
Antiprotozoals		
atovaquone (750 mg/5 ml susp, 750 mg/5ml susp cup, 1,500 mg/10 ml cup)	1	PA, QL (600 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
atovaquone-proguanil hcl (62.5, 250)	1	
chloroquine phosphate (250 mg tablet, 500 mg tablet)	1	
COARTEM TABLETS	1	
DARAPRIM 25 MG TABLET	1	PA
hydroxychloroquine sulfate (100 mg tab, 200 mg tab, 300 mg tab, 400 mg tab)	1	
LAMPIT (30 MG TABLET, 120 MG TABLET)	1	
MALARONE (62.5-25 MG PED TAB, 250-100 MG TABLET)	1	
mefloquine hcl 250 mg tablet	1	
NEBUPENT 300 MG INHAL POWDER	1	PA
nitazoxanide 500 mg tablet	1	QL (20 PER 30 OVER TIME)
PENTAM 300 MG VIAL	1	
pentamidine isethionate 300 mg inhal powdr	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
pentamidine isethionate 300 mg inject vial	1	
PLAQUENIL 200 MG TABLET	1	
primaquine 26.3 mg tablet	1	
pyrimethamine 25 mg tablet	1	PA
quinine sulfate 324 mg capsule	1	PA

Antiparkinson Agents

Antiparkinson Agents, Other

amantadine (50 mg/5 ml solution, 100 mg capsule, 100 mg tablet, 100 mg/10 ml cup, 100 mg/10 ml soln)	1	
benztropine mesylate (0.5 mg tab, 1 mg tablet, 2 mg tablet)	1	PA
carbidopa-levodopa-entacapone (50, 75, 100, 125, 150, 200)	1	
COMTAN 200 MG TABLET	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
entacapone 200 mg tablet	1	
TASMAR 100 MG TABLET	1	
tolcapone 100 mg tablet	1	
trihexyphenidyl hcl (2 mg tablet, 5 mg tablet)	1	PA
Dopamine Agonists		
APOKYN 30 MG/3 ML CARTRIDGE	1	PA, QL (60 PER 30 DAYS)
apomorphine hcl 30 mg/3 ml cartrdg	1	PA, QL (60 PER 30 DAYS)
bromocriptine mesylate (2.5 mg tablet, 5 mg capsule)	1	
NEUPRO (1 MG/24 HR PATCH, 2 MG/24 HR PATCH, 3 MG/24 HR PATCH, 4 MG/24 HR PATCH, 6 MG/24 HR PATCH, 8 MG/24 HR PATCH)	1	
pramipexole dihydrochloride (0.125 mg tablet, 0.25 mg tablet, 0.5 mg tablet, 0.75 mg tablet, 1 mg tablet, 1.5 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ropinirole er (er 2 mg tablet, er 4 mg tablet, er 6 mg tablet, er 8 mg tablet, er 12 mg tablet)	1	
ropinirole hcl (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 3 mg tablet, 4 mg tablet, 5 mg tablet)	1	
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa 25 mg tablet	1	
carbidopa-levodopa (carbidopa-levo 10-100 mg odt, carbidopa-levo 25-100 mg odt, carbidopa-levo 25-250 mg odt, carbidopa-levodopa 10-100 tab, carbidopa-levodopa 25-100 tab, carbidopa-levodopa 25-250 tab)	1	
carbidopa-levodopa er (er 25-100 tab, er 50-200 tab)	1	
INBRIJA 42 MG INHALATION CAP	1	PA, QL (300 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
RYTARY (ER 23.75 MG-95 MG CAP, ER 36.25 MG-145 MG CAP, ER 48.75 MG-195 MG CAP, ER 61.25 MG-245 MG CAP)	1	
SINEMET (10-100 MG TABLET, 25-100 MG TABLET)	1	
SINEMET 10-100 MG TABLET	1	
SINEMET 25-100 MG TABLET	1	
Monoamine Oxidase B (MAO-B) Inhibitors		
AZILECT (0.5 MG TABLET, 1 MG TABLET)	1	
rasagiline mesylate (0.5 mg tab, 1 mg tab)	1	
selegiline hcl (5 mg capsule, 5 mg tablet)	1	
Antipsychotics		
1st Generation/Typical		
fluphenazine decanoate 125 mg/5 ml	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
fluphenazine hcl (1 mg tablet, 2.5 mg tablet, 2.5 mg/5 ml elix, 2.5 mg/ml vial, 5 mg tablet, 5 mg/ml conc, 10 mg tablet)	1	PA
HALDOL DECANOATE 100 AMPUL	1	PA
HALDOL DECANOATE 50 AMPUL	1	PA
haloperidol (0.5 mg tablet, 1 mg tablet, 2 mg tablet, 5 mg tablet, 10 mg tablet, 20 mg tablet)	1	PA
haloperidol decanoate (50 mg/ml ampul, 50 mg/ml vial, 100 mg/ml amp, 100 mg/ml vial, 250 mg/5 ml vl, 500 mg/5 ml vl)	1	PA
haloperidol decanoate 100 mg/ml amp	1	PA
haloperidol lactate (2 mg/ml conc, 5 mg/ml ampul, 5 mg/ml syring, 5 mg/ml vial, 10 mg/5 ml cup, 50 mg/10 ml vl)	1	PA
loxapine (5 mg capsule, 10 mg capsule, 25 mg capsule, 50 mg capsule)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
molindone hcl (5 mg tablet, 10 mg tablet, 25 mg tablet)	1	PA
pimozide (1 mg tablet, 2 mg tablet)	1	PA
thioridazine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 100 mg tablet)	1	PA
thiothixene (1 mg capsule, 2 mg capsule, 5 mg capsule, 10 mg capsule)	1	PA
trifluoperazine hcl (1 mg tablet, 2 mg tablet, 5 mg tablet, 10 mg tablet)	1	PA
2nd Generation/Atypical		
ABILIFY (10 MG TABLET, 15 MG TABLET, 20 MG TABLET, 30 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
ABILIFY (2 MG TABLET, 5 MG TABLET)	1	PA, QL (45 PER 30 DAYS)
ABILIFY ASIMTUFII 720 MG/2.4ML	1	QL (2.4 PER 56 OVER TIME)
ABILIFY ASIMTUFII 960 MG/3.2ML	1	QL (3.2 PER 56 OVER TIME)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ABILIFY MAINTENA (ER 300 MG SYR, ER 300 MG VL, ER 400 MG SYR, ER 400 MG VL)	1	QL (1 PER 28 DAYS)
aripiprazole (10 mg tablet, 15 mg tablet, 20 mg tablet, 30 mg tablet)	1	PA, QL (30 PER 30 DAYS)
aripiprazole (2 mg tablet, 5 mg tablet)	1	PA, QL (45 PER 30 DAYS)
aripiprazole 1 mg/ml solution	1	PA, QL (750 PER 30 DAYS)
aripiprazole odt (odt 10 mg tablet, odt 15 mg tablet)	1	PA, QL (60 PER 30 DAYS)
ARISTADA ER 1064 MG/3.9 ML SYR	1	QL (3.9 PER 56 OVER TIME)
ARISTADA ER 441 MG/1.6 ML SYRN	1	QL (1.6 PER 28 DAYS)
ARISTADA ER 662 MG/2.4 ML SYRN	1	QL (2.4 PER 28 DAYS)
ARISTADA ER 882 MG/3.2 ML SYRN	1	QL (3.2 PER 28 DAYS)
ARISTADA INITIO ER 675 MG/2.4	1	QL (2.4 PER 42 OVER TIME)
asenapine maleate (2.5 mg tablet, 5 mg tablet, 10 mg tablet)	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
CAPLYTA (10.5 MG CAPSULE, 21 MG CAPSULE, 42 MG CAPSULE)	1	QL (30 PER 30 DAYS)
FANAPT (1 MG TABLET, 2 MG TABLET, 4 MG TABLET, 6 MG TABLET, 8 MG TABLET, 10 MG TABLET, 12 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
FANAPT FNPT TITRTION PCK	1	PA, QL (56 PER 28 DAYS)
FANAPT TITRATION PACK C	1	PA, QL (8 PER 28 OVER TIME)
GEODON (20 MG CAPSULE, 40 MG CAPSULE)	1	PA, QL (90 PER 30 DAYS)
GEODON (20 MG/ML VIAL, 60 MG CAPSULE, 80 MG CAPSULE)	1	PA, QL (60 PER 30 DAYS)
INVEGA (ER 3 MG TABLET, ER 9 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
INVEGA ER 6 MG TABLET	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
INVEGA HAFYERA 1,092 MG/3.5 ML	1	QL (3.5 PER 180 OVER TIME)
INVEGA HAFYERA 1,560 MG/5 ML	1	QL (5 PER 180 OVER TIME)
INVEGA SUSTENNA 117 MG/0.75 ML	1	QL (0.75 PER 28 DAYS)
INVEGA SUSTENNA 156 MG/ML SYRG	1	QL (1 PER 28 DAYS)
INVEGA SUSTENNA 234 MG/1.5 ML	1	QL (1.5 PER 28 DAYS)
INVEGA SUSTENNA 39 MG/0.25 ML	1	QL (0.25 PER 28 DAYS)
INVEGA SUSTENNA 78 MG/0.5 ML	1	QL (0.5 PER 28 DAYS)
INVEGA TRINZA 273 MG/0.88 ML	1	QL (0.88 PER 84 OVER TIME)
INVEGA TRINZA 410 MG/1.32 ML	1	QL (1.32 PER 84 OVER TIME)
INVEGA TRINZA 546 MG/1.75 ML	1	QL (1.75 PER 84 OVER TIME)
INVEGA TRINZA 819 MG/2.63 ML	1	QL (2.63 PER 84 OVER TIME)
LATUDA (20 MG TABLET, 40 MG TABLET, 60 MG TABLET, 120 MG TABLET)	1	PA, QL (30 PER 30 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LATUDA 80 MG TABLET	1	PA, QL (60 PER 30 DAYS)
lurasidone hcl (20 mg tablet, 40 mg tablet, 60 mg tablet, 120 mg tablet)	1	PA, QL (30 PER 30 DAYS)
lurasidone hcl 80 mg tablet	1	PA, QL (60 PER 30 DAYS)
LYBALVI (5-10 MG TABLET, 10-10 MG TABLET, 15-10 MG TABLET, 20-10 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
NUPLAZID (10 MG TABLET, 34 MG CAPSULE)	1	PA, QL (30 PER 30 DAYS)
olanzapine (15 mg tablet, 20 mg tablet)	1	PA, QL (30 PER 30 DAYS)
olanzapine (2.5 mg tablet, 5 mg tablet, 7.5 mg tablet, 10 mg tablet)	1	PA, QL (45 PER 30 DAYS)
olanzapine 10 mg vial	1	PA, QL (90 PER 30 DAYS)
olanzapine odt (odt 5 mg tablet, odt 10 mg tablet, odt 15 mg tablet, odt 20 mg tablet)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
OPIPZA (5 MG FILM, 10 MG FILM)	1	PA, QL (90 PER 30 DAYS)
OPIPZA 2 MG FILM	1	PA, QL (30 PER 30 DAYS)
paliperidone er (er 1.5 mg tablet, er 3 mg tablet, er 9 mg tablet)	1	PA, QL (30 PER 30 DAYS)
paliperidone er 6 mg tablet	1	PA, QL (60 PER 30 DAYS)
PERSERIS (ER 90 MG POWDER SYRNG, ER 90 MG SYRINGE KIT, ER 120 MG SYRINGE KIT)	1	QL (1 PER 28 DAYS)
quetiapine fumarate (25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)	1	PA, QL (120 PER 30 DAYS)
quetiapine fumarate (300 mg tab, 400 mg tab)	1	PA, QL (60 PER 30 DAYS)
quetiapine fumarate 150 mg tablet	1	PA, QL (150 PER 30 DAYS)
quetiapine fumarate er (er 150 mg tablet, er 200 mg tablet)	1	PA, QL (30 PER 30 DAYS)
quetiapine fumarate er (er 50 mg tablet, er 300 mg tablet, er 400 mg tablet)	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
REXULTI (0.25 MG TABLET, 0.5 MG TABLET, 1 MG TABLET, 2 MG TABLET, 3 MG TABLET, 4 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
RISPERDAL (0.5 MG TABLET, 1 MG TABLET, 2 MG TABLET, 3 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
RISPERDAL 1 MG/ML SOLUTION	1	PA, QL (480 PER 30 DAYS)
RISPERDAL 4 MG TABLET	1	PA, QL (120 PER 30 DAYS)
RISPERDAL CONSTA (12.5 MG VIAL, 25 MG VIAL, 37.5 MG VIAL, 50 MG VIAL)	1	QL (2 PER 28 DAYS)
risperidone (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 3 mg tablet)	1	QL (60 PER 30 DAYS)
risperidone 1 mg/ml solution	1	PA, QL (480 PER 30 DAYS)
risperidone 4 mg tablet	1	QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
risperidone er (er 12.5 mg vial, er 25 mg vial, er 37.5 mg vial, er 50 mg vial)	1	QL (2 PER 28 DAYS)
risperidone odt (0.25 mg odt, 0.5 mg odt, 1 mg odt, 2 mg odt, 3 mg odt)	1	PA, QL (60 PER 30 DAYS)
risperidone odt 4 mg	1	PA, QL (120 PER 30 DAYS)
SAPHRIS (2.5 MG TAB, 5 MG TAB, 10 MG TAB)	1	PA, QL (60 PER 30 DAYS)
SECUADO (3.8 MG/24 HR PATCH, 5.7 MG/24 HR PATCH, 7.6 MG/24 HR PATCH)	1	PA, QL (30 PER 30 DAYS)
SEROQUEL (25 MG TABLET, 50 MG TABLET, 100 MG TABLET, 200 MG TABLET)	1	PA, QL (120 PER 30 DAYS)
SEROQUEL (300 MG TABLET, 400 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
SEROQUEL XR (150 MG TABLET, 200 MG TABLET)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SEROQUEL XR (50 MG TABLET, 300 MG TABLET, 400 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
UZEDY ER 100 MG/0.28 ML SYRING	1	QL (0.28 PER 28 DAYS)
UZEDY ER 125 MG/0.35 ML SYRING	1	QL (0.35 PER 28 DAYS)
UZEDY ER 150 MG/0.42 ML SYRING	1	QL (0.42 PER 56 OVER TIME)
UZEDY ER 200 MG/0.56 ML SYRING	1	QL (0.56 PER 56 OVER TIME)
UZEDY ER 250 MG/0.7 ML SYRINGE	1	QL (0.7 PER 56 OVER TIME)
UZEDY ER 50 MG/0.14 ML SYRINGE	1	QL (0.14 PER 28 DAYS)
UZEDY ER 75 MG/0.21 ML SYRINGE	1	QL (0.21 PER 28 DAYS)
VRAYLAR (1.5 MG CAPSULE, 3 MG CAPSULE, 4.5 MG CAPSULE, 6 MG CAPSULE)	1	QL (30 PER 30 DAYS)
ziprasidone hcl (20 mg capsule, 40 mg capsule)	1	QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ziprasidone hcl (60 mg capsule, 80 mg capsule)	1	QL (60 PER 30 DAYS)
ziprasidone mesylate 20 mg/ml vial	1	PA, QL (60 PER 30 DAYS)
ZYPREXA (15 MG TABLET, 20 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
ZYPREXA (2.5 MG TABLET, 5 MG TABLET, 7.5 MG TABLET, 10 MG TABLET)	1	PA, QL (45 PER 30 DAYS)
ZYPREXA 10 MG VIAL	1	PA, QL (90 PER 30 DAYS)
ZYPREXA RELPREVV (210 MG VIAL, 210 MG VL KIT, 300 MG VIAL, 300 MG VL KIT)	1	PA, QL (2 PER 28 DAYS)
ZYPREXA RELPREVV (405 MG VIAL, 405 MG VL KIT)	1	PA, QL (1 PER 28 DAYS)
ZYPREXA ZYDIS (5 MG TABLET, 10 MG TABLET, 15 MG TABLET, 20 MG TABLET)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Antipsychotics, Other		
COBENFY (50 MG-20 MG CAPSULE, 100 MG-20 MG CAPSULE, 125 MG-30 MG CAPSULE)	1	Cobenfy PA, QL (60 PER 30 DAYS)
COBENFY STARTER PACK	1	Cobenfy PA, QL (56 PER 28 DAYS)
Treatment-Resistant		
clozapine (25 mg tablet, 50 mg tablet)	1	PA, QL (90 PER 30 DAYS)
clozapine 100 mg tablet	1	PA, QL (270 PER 30 DAYS)
clozapine 200 mg tablet	1	PA, QL (120 PER 30 DAYS)
clozapine odt (odt 25 mg tablet, odt 100 mg tablet)	1	PA, QL (270 PER 30 DAYS)
clozapine odt 12.5 mg tablet	1	PA, QL (90 PER 30 DAYS)
clozapine odt 150 mg tablet	1	PA, QL (180 PER 30 DAYS)
clozapine odt 200 mg tablet	1	PA, QL (120 PER 30 DAYS)
CLOZARIL (25 MG TABLET, 50 MG TABLET)	1	PA, QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
CLOZARIL 100 MG TABLET	1	PA, QL (270 PER 30 DAYS)
CLOZARIL 200 MG TABLET	1	PA, QL (120 PER 30 DAYS)
VERSACLOZ 50 MG/ML SUSPENSION	1	PA, QL (540 PER 30 DAYS)
Antispasticity Agents		
baclofen (5 mg tablet, 10 mg tablet, 20 mg tablet)	1	
DANTRIUM 25 MG CAPSULE	1	
dantrolene sodium (25 mg cap, 50 mg cap, 100 mg cap)	1	
tizanidine hcl (2 mg capsule, 2 mg tablet, 4 mg capsule, 4 mg tablet, 6 mg capsule)	1	
Antivirals		
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
BIKTARVY (30-120-15 MG TABLET, 50-200-25 MG TABLET)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DOVATO 50-300 MG TABLET	1	QL (30 PER 30 DAYS)
GENVOYA TABLET	1	QL (30 PER 30 DAYS)
ISENTRESS (100 MG POWDER PACKET, 400 MG TABLET)	1	QL (60 PER 30 DAYS)
ISENTRESS (25 MG TABLET CHEW, 100 MG TABLET CHEW)	1	QL (180 PER 30 DAYS)
ISENTRESS HD 600 MG TABLET	1	QL (60 PER 30 DAYS)
JULUCA 50-25 MG TABLET	1	QL (30 PER 30 DAYS)
STRIBILD TABLET	1	QL (30 PER 30 DAYS)
TIVICAY (25 MG TABLET, 50 MG TABLET)	1	QL (60 PER 30 DAYS)
TIVICAY 10 MG TABLET	1	QL (240 PER 30 DAYS)
TIVICAY PD 5 MG TAB FOR SUSP	1	QL (360 PER 30 DAYS)
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
DELSTRIGO 100-300-300 MG TAB	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
EDURANT 25 MG TABLET	1	QL (30 PER 30 DAYS)
EDURANT PED 2.5MG TAB FOR SUSP	1	QL (180 PER 30 DAYS)
efavirenz 600 mg tablet	1	QL (30 PER 30 DAYS)
efavirenz-emtric-tenofov disop efavir-emtri-tenof 600-200-300	1	QL (30 PER 30 DAYS)
efavirenz-lamivu-tenofov disop (400-300-300, 600-300-300)	1	QL (30 PER 30 DAYS)
etravirine (100 mg tablet, 200 mg tablet)	1	QL (60 PER 30 DAYS)
INTELENCE (100 MG TABLET, 200 MG TABLET)	1	QL (60 PER 30 DAYS)
INTELENCE 25 MG TABLET	1	QL (120 PER 30 DAYS)
nevirapine 200 mg tablet	1	QL (60 PER 30 DAYS)
nevirapine 50 mg/5 ml susp	1	QL (1200 PER 30 DAYS)
nevirapine er 400 mg tablet	1	QL (30 PER 30 DAYS)
PIFELTRO 100 MG TABLET	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SYMFI 600-300-300 MG TABLET	1	QL (30 PER 30 DAYS)
SYMFI LO 400-300-300 MG TABLET	1	QL (30 PER 30 DAYS)
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
abacavir 20 mg/ml solution	1	QL (960 PER 30 DAYS)
abacavir 300 mg tablet	1	QL (60 PER 30 DAYS)
abacavir-lamivudine 600-300 mg	1	QL (30 PER 30 DAYS)
CIMDUO 300-300 MG TABLET	1	QL (30 PER 30 DAYS)
COMPLERA TABLET	1	QL (30 PER 30 DAYS)
DESCOVY (120-15 MG TABLET, 200-25 MG TABLET)	1	QL (30 PER 30 DAYS)
emtricitabine 200 mg capsule	1	QL (30 PER 30 DAYS)
emtricitabine-rilpivirne-tenof emtricit-rilp-tenof 200-25-300	1	QL (30 PER 30 DAYS)
emtricitabine-tenofovir disop (100-150mg, 133-200mg, 167-250mg, 200-300mg)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
EMTRIVA 10 MG/ML SOLUTION	1	QL (850 PER 30 DAYS)
EMTRIVA 200 MG CAPSULE	1	QL (30 PER 30 DAYS)
EPIVIR 10 MG/ML ORAL SOLN	1	QL (960 PER 30 DAYS)
EPIVIR 150 MG TABLET	1	QL (60 PER 30 DAYS)
EPIVIR 300 MG TABLET	1	QL (30 PER 30 DAYS)
EPZICOM TABLET	1	QL (30 PER 30 DAYS)
lamivudine (10 mg/ml oral soln, 300 mg/30ml sol cup)	1	QL (960 PER 30 DAYS)
lamivudine 150 mg tablet	1	QL (60 PER 30 DAYS)
lamivudine 300 mg tablet	1	QL (30 PER 30 DAYS)
lamivudine-zidovudine tablet	1	QL (60 PER 30 DAYS)
ODEFSEY TABLET	1	QL (30 PER 30 DAYS)
RETROVIR 10 MG/ML SYRUP	1	QL (1920 PER 30 DAYS)
RETROVIR 100 MG CAPSULE	1	QL (180 PER 30 DAYS)
tenofovir disoproxil fumarate 300 mg tb	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TRIUMEQ 600-50-300 MG TABLET	1	QL (30 PER 30 DAYS)
TRIUMEQ PD 60-5-30 MG TAB SUSP	1	QL (180 PER 30 DAYS)
TRUVADA (100 MG-150 MG TABLET, 133 MG-200 MG TABLET, 167 MG-250 MG TABLET, 200 MG-300 MG TABLET)	1	QL (30 PER 30 DAYS)
VIREAD (150 MG TABLET, 200 MG TABLET, 250 MG TABLET, 300 MG TABLET)	1	QL (30 PER 30 DAYS)
VIREAD POWDER	1	QL (240 PER 30 DAYS)
ZIAGEN 20 MG/ML SOLUTION	1	QL (960 PER 30 DAYS)
zidovudine 100 mg capsule	1	QL (180 PER 30 DAYS)
zidovudine 300 mg tablet	1	QL (60 PER 30 DAYS)
zidovudine 50 mg/5 ml syrup	1	QL (1920 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Anti-HIV Agents, Other		
FUZEON 90 MG VIAL	1	QL (60 PER 30 DAYS)
maraviroc 150 mg tablet	1	QL (60 PER 30 DAYS)
maraviroc 300 mg tablet	1	QL (120 PER 30 DAYS)
RUKOBIA ER 600 MG TABLET	1	QL (60 PER 30 DAYS)
SELZENTRY (75 MG TABLET, 150 MG TABLET)	1	QL (60 PER 30 DAYS)
SELZENTRY 20 MG/ML ORAL SOLN	1	QL (1840 PER 30 DAYS)
SELZENTRY 25 MG TABLET	1	QL (240 PER 30 DAYS)
SELZENTRY 300 MG TABLET	1	QL (120 PER 30 DAYS)
SUNLENCA (4- 300 MG TABLET, 300 MG TABLET)	1	QL (4 PER 28 OVER TIME)
SUNLENCA 5- 300 MG TABLET	1	QL (5 PER 28 OVER TIME)
TYBOST 150 MG TABLET	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Anti-HIV Agents, Protease Inhibitors		
APTIVUS 250 MG CAPSULE	1	QL (120 PER 30 DAYS)
atazanavir sulfate (150 mg cap, 300 mg cap)	1	QL (30 PER 30 DAYS)
atazanavir sulfate 200 mg cap	1	QL (60 PER 30 DAYS)
darunavir 600 mg tablet	1	QL (60 PER 30 DAYS)
darunavir 800 mg tablet	1	QL (30 PER 30 DAYS)
EVOTAZ 300 MG-150 MG TABLET	1	QL (30 PER 30 DAYS)
fosamprenavir calcium 700 mg tablet	1	QL (120 PER 30 DAYS)
KALETRA 100-25 MG TABLET	1	QL (300 PER 30 DAYS)
KALETRA 200-50 MG TABLET	1	QL (120 PER 30 DAYS)
KALETRA 80 MG-20 MG/ML SOLN	1	QL (480 PER 30 DAYS)
LEXIVA 700 MG TABLET	1	QL (120 PER 30 DAYS)
lopinavir-ritonavir 80-20mg/ml	1	QL (480 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
lopinavir-ritonavir lopinavir-ritonavr 100-25mg tb	1	QL (300 PER 30 DAYS)
lopinavir-ritonavir lopinavir-ritonavr 200-50mg tb	1	QL (120 PER 30 DAYS)
NORVIR (100 MG POWDER PACKET, 100 MG TABLET)	1	QL (360 PER 30 DAYS)
PREZCOBIX (675 MG TABLET, 800 MG TABLET)	1	QL (30 PER 30 DAYS)
PREZISTA 100 MG/ML SUSPENSION	1	QL (400 PER 30 DAYS)
PREZISTA 150 MG TABLET	1	QL (180 PER 30 DAYS)
PREZISTA 600 MG TABLET	1	QL (60 PER 30 DAYS)
PREZISTA 75 MG TABLET	1	QL (300 PER 30 DAYS)
PREZISTA 800 MG TABLET	1	QL (30 PER 30 DAYS)
REYATAZ 200 MG CAPSULE	1	QL (60 PER 30 DAYS)
REYATAZ 300 MG CAPSULE	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
REYATAZ 50 MG POWDER PACKET	1	QL (240 PER 30 DAYS)
ritonavir 100 mg tablet	1	QL (360 PER 30 DAYS)
SYMTUZA 800-150-200-10 MG TAB	1	QL (30 PER 30 DAYS)
VIRACEPT 250 MG TABLET	1	QL (270 PER 30 DAYS)
VIRACEPT 625 MG TABLET	1	QL (120 PER 30 DAYS)
Anti-cytomegalovirus (CMV) Agents		
LIVTENCITY 200 MG TABLET	1	QL (120 PER 30 DAYS)
PREVYMIS (240 MG TABLET, 480 MG TABLET)	1	QL (30 PER 30 DAYS)
VALCYTE (50 MG/ML SOLUTION, 450 MG TABLET)	1	
valganciclovir hcl (hcl 50 mg/ml, 450 mg tablet)	1	
Anti-hepatitis B (HBV) Agents		
adefovir dipivoxil 10 mg tab	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
BARACLUDE (0.05 MG/ML SOLUTION, 0.5 MG TABLET, 1 MG TABLET)	1	
entecavir (0.5 mg tablet, 1 mg tablet)	1	
lamivudine 100 mg tablet	1	
lamivudine hbv 100 mg tablet	1	
Anti-hepatitis C (HCV) Agents		
MAVYRET (50-20 MG PELLET PACKET, 100-40 MG TABLET)	1	PA
ribavirin (200 mg capsule, 200 mg tablet)	1	
ZEPATIER 50-100 MG TABLET	1	PA
Anti-influenza Agents		
oseltamivir phosphate (45 mg capsule, 75 mg capsule)	1	QL (84 PER 365 OVER TIME)
oseltamivir phosphate 30 mg capsule	1	QL (168 PER 365 OVER TIME)
oseltamivir phosphate 6 mg/ml suspension	1	QL (1080 PER 365 OVER TIME)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
RELENZA 5 MG DISKHALER	1	QL (120 PER 365 OVER TIME)
TAMIFLU (45 MG CAPSULE, 75 MG CAPSULE)	1	QL (84 PER 365 OVER TIME)
TAMIFLU 30 MG CAPSULE	1	QL (168 PER 365 OVER TIME)
TAMIFLU 6 MG/ML SUSPENSION	1	QL (1080 PER 365 OVER TIME)
XOFLUZA (40 MG TAB (80 MG DOSE), 40 MG TABLET)	1	QL (4 PER 365 OVER TIME)
XOFLUZA 80 MG TABLET	1	QL (2 PER 365 OVER TIME)
Antiherpetic Agents		
acyclovir (200 mg capsule, 200 mg/5 ml susp, 200 mg/5 ml susp cup, 400 mg tablet, 800 mg tablet, 800 mg/20ml susp cup)	1	
acyclovir 5% ointment	1	PA
acyclovir sodium (500 mg/10 ml vial, 1,000 mg/20 ml vial)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
famciclovir (125 mg tablet, 250 mg tablet, 500 mg tablet)	1	
valacyclovir (1 gram tablet, 500 mg tablet)	1	
VALTREX (1 GRAM, 500 MG)	1	
ZOVIRAX 5% OINTMENT	1	PA
Antiviral, Coronavirus agents		
PAXLOVID (EUA) (150-100 MG PACK, 300-100 MG PACK)	1	
PAXLOVID 150-100 MG (MODERATE)	1	QL (20 PER 30 OVER TIME)
PAXLOVID 300-100 MG DOSE PACK	1	QL (30 PER 30 OVER TIME)
PAXLOVID 300/150-100MG(SEVERE)	1	QL (11 PER 30 OVER TIME)
Anxiolytics		
alprazolam (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet)	1	QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
alprazolam 2 mg tablet	1	QL (150 PER 30 DAYS)
alprazolam er (er 0.5 mg tablet, er 1 mg tablet)	1	QL (30 PER 30 DAYS)
alprazolam er 2 mg tablet	1	QL (150 PER 30 DAYS)
alprazolam er 3 mg tablet	1	QL (90 PER 30 DAYS)
alprazolam xr (0.5 mg tablet, 1 mg tablet)	1	QL (30 PER 30 DAYS)
alprazolam xr 2 mg tablet	1	QL (150 PER 30 DAYS)
alprazolam xr 3 mg tablet	1	QL (90 PER 30 DAYS)
buspirone hcl (5 mg tablet, 7.5 mg tablet, 10 mg tablet, 15 mg tablet, 30 mg tablet)	1	
chlordiazepoxide hcl (5 mg capsule, 10 mg capsule)	1	PA, QL (120 PER 30 DAYS)
chlordiazepoxide hcl 25 mg capsule	1	PA, QL (360 PER 30 DAYS)
clonazepam (0.125 mg dis tab, 0.125 mg odt, 0.25 mg odt, 0.5 mg dis tablet, 0.5 mg odt, 1 mg dis tablet, 1 mg odt)	1	QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
clonazepam (0.5 mg tablet, 1 mg tablet)	1	QL (120 PER 30 DAYS)
clonazepam (2 mg odt, 2 mg tablet)	1	QL (300 PER 30 DAYS)
clorazepate dipotassium 15 mg tablet	1	PA, QL (180 PER 30 DAYS)
clorazepate dipotassium 3.75 mg tablet	1	PA, QL (120 PER 30 DAYS)
clorazepate dipotassium 7.5 mg tablet	1	PA, QL (360 PER 30 DAYS)
diazepam (2 mg tablet, 5 mg tablet, 10 mg tablet)	1	PA, QL (120 PER 30 DAYS)
diazepam (5 mg/5 ml oral cup, 5 mg/5 ml solution)	1	PA, QL (1200 PER 30 DAYS)
diazepam (5 mg/ml, 25 mg/5 ml)	1	PA, QL (240 PER 30 DAYS)
hydroxyzine hcl (10 mg/5 ml soln, 10 mg/5 ml syrup, hcl 10 mg tablet, hcl 25 mg tablet, 50 mg/25 ml cup, hcl 50 mg tablet)	1	PA
hydroxyzine pamoate (25 mg cap, 50 mg cap, 100 mg cap)	1	PA
lorazepam (0.5 mg tablet, 1 mg tablet)	1	PA, QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
lorazepam (2 mg tablet, 2 mg/ml oral concent)	1	PA, QL (150 PER 30 DAYS)
lorazepam intensol 2 mg/ml	1	PA, QL (150 PER 30 DAYS)
oxazepam (10 mg capsule, 15 mg capsule, 30 mg capsule)	1	PA, QL (120 PER 30 DAYS)
Bipolar Agents		
Mood Stabilizers		
lithium carbonate (150 mg cap, 300 mg cap, 300 mg tab, 600 mg cap)	1	
lithium carbonate er (er 300 mg, er 450 mg)	1	
lithium citrate (8 meq/5 ml soln cup, 8 meq/5 ml solution)	1	
LITHOBID ER 300 MG TABLET	1	
Blood Glucose Regulators		
Antidiabetic Agents		
acarbose 100 mg tablet	1	QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
acarbose 25 mg tablet	1	QL (360 PER 30 DAYS)
acarbose 50 mg tablet	1	QL (180 PER 30 DAYS)
ACTOS (30 MG TABLET, 45 MG TABLET)	1	QL (30 PER 30 DAYS)
ACTOS 15 MG TABLET	1	QL (90 PER 30 DAYS)
BYDUREON BCISE 2 MG AUTOINJECT	1	PA, QL (3.4 PER 28 DAYS)
CYCLOSET 0.8 MG TABLET	1	QL (180 PER 30 DAYS)
FARXIGA 10 MG TABLET	1	QL (30 PER 30 DAYS)
FARXIGA 5 MG TABLET	1	QL (60 PER 30 DAYS)
gauze pad gnp sterile pads 2" x 2"	1	PA
gauze pads & dressings - pads 2 x 2	1	PA
glimepiride 1 mg tablet	1	QL (240 PER 30 DAYS)
glimepiride 2 mg tablet	1	QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
glimepiride 4 mg tablet	1	QL (60 PER 30 DAYS)
glipizide 10 mg tablet	1	QL (120 PER 30 DAYS)
glipizide 2.5 mg tablet	1	QL (480 PER 30 DAYS)
glipizide 5 mg tablet	1	QL (240 PER 30 DAYS)
glipizide er 10 mg tablet	1	QL (60 PER 30 DAYS)
glipizide er 2.5 mg tablet	1	QL (240 PER 30 DAYS)
glipizide er 5 mg tablet	1	QL (120 PER 30 DAYS)
glipizide xl 10 mg tablet	1	QL (60 PER 30 DAYS)
glipizide xl 2.5 mg tablet	1	QL (240 PER 30 DAYS)
glipizide xl 5 mg tablet	1	QL (120 PER 30 DAYS)
glipizide-metformin (2.5-500 mg, 5-500 mg)	1	QL (120 PER 30 DAYS)
glipizide-metformin 2.5-250 mg	1	QL (240 PER 30 DAYS)
GLUCOTROL XL 10 MG TABLET	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
GLUCOTROL XL 5 MG TABLET	1	QL (120 PER 30 DAYS)
glyburide 1.25 mg tablet	1	QL (480 PER 30 DAYS)
glyburide 2.5 mg tablet	1	QL (240 PER 30 DAYS)
glyburide 5 mg tablet	1	QL (120 PER 30 DAYS)
glyburide micronized 1.5 mg tab	1	QL (240 PER 30 DAYS)
glyburide micronized 3 mg tablet	1	QL (120 PER 30 DAYS)
glyburide micronized 6 mg tablet	1	QL (60 PER 30 DAYS)
glyburide-metformin hcl (2.5-500 mg, 5-500 mg)	1	QL (120 PER 30 DAYS)
glyburide-metformin hcl glyburid-metformin 1.25-250 mg	1	QL (240 PER 30 DAYS)
GLYXAMBI (10 MG TABLET, 25 MG TABLET)	1	QL (30 PER 30 DAYS)
isopropyl alcohol 0.7 ml/ml medicated pad	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
JANUMET (50-1,000 MG TABLET, 50-500 MG TABLET)	1	QL (60 PER 30 DAYS)
JANUMET XR (50-500 MG TABLET, 100-1,000 MG TABLET)	1	QL (30 PER 30 DAYS)
JANUMET XR 50-1,000 MG TABLET	1	QL (60 PER 30 DAYS)
JANUVIA (25 MG TABLET, 50 MG TABLET, 100 MG TABLET)	1	QL (30 PER 30 DAYS)
JARDIANCE (10 MG TABLET, 25 MG TABLET)	1	QL (30 PER 30 DAYS)
JENTADUETO (2.5 MG-1000 MG TAB, 2.5 MG-500 MG TAB, 2.5 MG-850 MG TAB)	1	QL (60 PER 30 DAYS)
JENTADUETO XR 2.5 MG-1,000 MG	1	QL (60 PER 30 DAYS)
JENTADUETO XR 5 MG-1,000 MG TB	1	QL (30 PER 30 DAYS)
metformin hcl 1,000 mg tablet	1	QL (75 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
metformin hcl 500 mg tablet	1	QL (150 PER 30 DAYS)
metformin hcl 850 mg tablet	1	QL (90 PER 30 DAYS)
metformin hcl er 500 mg tablet	1	QL (120 PER 30 DAYS)
metformin hcl er 750 mg tablet	1	QL (60 PER 30 DAYS)
MOUNJARO (2.5 MG/0.5 ML PEN, 5 MG/0.5 ML PEN, 7.5 MG/0.5 ML PEN, 10 MG/0.5 ML PEN, 12.5 MG/0.5 ML PEN, 15 MG/0.5 ML PEN)	1	PA, QL (2 PER 28 DAYS)
nateglinide 120 mg tablet	1	QL (90 PER 30 DAYS)
nateglinide 60 mg tablet	1	QL (180 PER 30 DAYS)
OZEMPIC (0.25-0.5 MG/DOSE PEN, 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML))	1	PA, QL (3 PER 28 DAYS)
pioglitazone hcl (30 mg tablet, 45 mg tablet)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
pioglitazone hcl 15 mg tablet	1	QL (90 PER 30 DAYS)
pioglitazone-glimepiride (30, 30)	1	QL (30 PER 30 DAYS)
pioglitazone-metformin (15, 15)	1	QL (90 PER 30 DAYS)
repaglinide 0.5 mg tablet	1	QL (960 PER 30 DAYS)
repaglinide 1 mg tablet	1	QL (480 PER 30 DAYS)
repaglinide 2 mg tablet	1	QL (240 PER 30 DAYS)
RYBELSUS (3 MG TABLET, 7 MG TABLET, 14 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
saxagliptin hcl (2.5 mg tablet, 5 mg tablet)	1	QL (30 PER 30 DAYS)
saxagliptin-metformin er (saxagliptin-metformin er 5-500, saxagliptin-metformn er 5-1000)	1	QL (30 PER 30 DAYS)
saxagliptin-metformin er saxagliptn-metform 2.5-1000	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SOLIQUA 100-33 UNIT-33 MCG/ML PEN	1	QL (18 PER 30 DAYS)
sterile pads ft 2" x 2"	1	PA
SYMLINPEN 120 SYMLININJECTOR	1	
SYMLINPEN 60 SYMLININJECTOR	1	
SYNJARDY (5-1,000 MG TABLET, 12.5-1,000 MG TABLET, 12.5-500 MG TABLET)	1	QL (60 PER 30 DAYS)
SYNJARDY 5-500 MG TABLET	1	QL (120 PER 30 DAYS)
SYNJARDY XR (5-1,000 MG TABLET, 10-1,000 MG TABLET, 12.5-1,000 MG TAB)	1	QL (60 PER 30 DAYS)
SYNJARDY XR 25-1,000 MG TABLET	1	QL (30 PER 30 DAYS)
TRADJENTA 5 MG TABLET	1	QL (30 PER 30 DAYS)
TRULICITY (0.75 MG/0.5 ML PEN, 1.5 MG/0.5 ML PEN, 3 MG/0.5 ML PEN, 4.5 MG/0.5 ML PEN)	1	PA, QL (2 PER 28 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
XIGDUO XR (10 MG-1,000 MG TAB, 10 MG-500 MG TABLET)	1	QL (30 PER 30 DAYS)
XIGDUO XR (2.5 MG-1,000 MG TAB, 5 MG-1,000 MG TABLET, 5 MG-500 MG TABLET)	1	QL (60 PER 30 DAYS)
Glycemic Agents		
BAQSIMI (3 MG SPRAY, 3 MG SPRAY ONE PACK, 3 MG SPRAY TWO PACK)	1	QL (4 PER 30 DAYS)
diazoxide 50 mg/ml oral susp	1	
GLUCAGEN 1 MG HYPOKIT	1	QL (4 PER 30 DAYS)
glucagon emergency kit (glucagon 1 mg emergency kit, glucagon 1 mg vial, glucagon 1 mg emergency kit, glucagon 1 mg vial)	1	QL (4 PER 30 DAYS)
GVOKE (1 MG/0.2 ML KIT, 1 MG/0.2 ML VIAL)	1	QL (0.8 PER 30 DAYS)
GVOKE HYPOPEN 1-PACK -PK MG/0.2 ML	1	QL (0.8 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
GVOKE HYPOPEN 1-PACK 1PK 0.5MG/0.1 ML	1	QL (0.4 PER 30 DAYS)
GVOKE HYPOPEN 2-PACK 2-PK 1 MG/0.2 ML	1	QL (0.8 PER 30 DAYS)
GVOKE HYPOPEN 2-PACK 2PK 0.5MG/0.1 ML	1	QL (0.4 PER 30 DAYS)
GVOKE PFS 1-PACK SYRINGE -PK MG/0.2 ML	1	QL (0.8 PER 30 DAYS)
GVOKE PFS 2-PACK SYRINGE 2-PK 1 MG/0.2 ML	1	QL (0.8 PER 30 DAYS)
PROGLYCEM 50 MG/ML ORAL SUSP	1	
Insulins		
autoshield duo pen needle ndl 30g 5mm	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
droplet insulin syringe (0.3 ml 29g 12.7mm(1/2), 0.3 ml 30g 12.7mm(1/2), ins 0.3ml 30g 8mm(1/2), ins 0.3ml 31g 6mm(1/2), ins 0.3ml 31g 8mm(1/2), ins 0.5 ml 29g 12.7mm, ins 0.5 ml 30g 12.7mm, ins syr 0.5 ml 31g 6mm, ins syr 0.5 ml 31g 8mm, ins syr 0.5ml 30g 8mm, ins syr 1 ml 30g 8mm, ins syr 1 ml 31g 6mm, ins syr 1 ml 31g 8mm, ins syr 1ml 29g 12.7mm, ins syr 1ml 30g 12.7mm)	1	PA
droplet micron pen needle 34g 3.5mm	1	PA
droplet pen needle (29g 10mm, 29g 12mm, 31g 5mm, 31g 6mm, 31g 8mm, 32g 4mm, 32g 5mm, 32g 6mm, 32g 8mm)	1	PA
easy comfort insulin syringe (0.5ml, 1 ml)	1	PA
easy comfort pen needle (4mm, 5mm)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
HUMALOG (100 UNIT/ML CARTRIDGE, 100 UNIT/ML VIAL)	1	QL (60 PER 30 DAYS)
HUMALOG JUNIOR KWIKPEN JR 100 UNIT/ML	1	QL (60 PER 30 DAYS)
HUMALOG KWIKPEN U-100 UNIT/ML	1	QL (60 PER 30 DAYS)
HUMALOG KWIKPEN U-200 UNIT/ML	1	QL (60 PER 30 DAYS)
HUMALOG MIX 50-50 KWIKPEN	1	QL (60 PER 30 DAYS)
HUMALOG MIX 75-25 KWIKPEN	1	QL (60 PER 30 DAYS)
HUMALOG MIX 75-25 VIAL	1	QL (60 PER 30 DAYS)
HUMALOG TEMPO PEN U-100 UNIT/ML	1	QL (60 PER 30 DAYS)
HUMULIN 70-30 VIAL	1	QL (60 PER 30 DAYS)
HUMULIN 70/30 KWIKPEN	1	QL (60 PER 30 DAYS)
HUMULIN N 100 UIT/ML VIAL	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
HUMULIN N KWIKPEN 100 UIT/ML	1	QL (60 PER 30 DAYS)
HUMULIN R 100 UNIT/ML VIAL	1	QL (60 PER 30 DAYS)
HUMULIN R U-500 KWIKPEN UNIT/ML	1	QL (60 PER 30 DAYS)
HUMULIN R U-500 UNIT/ML VIAL	1	PA
insulin pen needle	1	PA
insulin syringe (disp) u-100 0.3 ml	1	PA
insulin syringe (disp) u-100 1 ml	1	PA
insulin syringe (disp) u-100 1/2 ml	1	PA
insulin syringe (syr 0.5 ml 28g 12.7mm, syringe 1 ml 27g 16mm, syringe 1ml 28g 12.7mm)	1	PA
LANTUS 100 UNIT/ML VIAL	1	QL (60 PER 30 DAYS)
LANTUS SOLOSTAR 100 UNIT/ML	1	QL (60 PER 30 DAYS)
LYUMJEV 100 UNIT/ML VIAL	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LYUMJEV KWIKPEN U-100 UNIT/ML	1	QL (60 PER 30 DAYS)
LYUMJEV KWIKPEN U-200 UNIT/ML	1	QL (60 PER 30 DAYS)
LYUMJEV TEMPO PEN U-100 UNIT/ML	1	QL (60 PER 30 DAYS)
nano 2nd gen pen needle 3g 4mm	1	PA
nano pen needle 32g 4mm	1	PA
needles, insulin disp., safety	1	PA
NOVOLIN 70-30 (70-30 100 UNIT/ML VIAL, RELION 70-30 VIAL)	1	QL (60 PER 30 DAYS)
NOVOLIN 70-30 FLEXPEN (70, RELION 70)	1	QL (60 PER 30 DAYS)
NOVOLIN N (N 100 UNIT/ML VIAL, RELION N 100 UNIT/ML)	1	QL (60 PER 30 DAYS)
NOVOLIN N FLEXPEN (N 100 UNIT/ML, RELION N U)	1	QL (60 PER 30 DAYS)
NOVOLIN R (R 100 UNIT/ML VIAL, RELION R 100 UNIT/ML)	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
NOVOLIN R FLEXPEN (R 100 UNIT/ML, RELION R U)	1	QL (60 PER 30 DAYS)
NOVOLOG (100 UNIT/ML VIAL, RELION 100 UNIT/ML VL)	1	QL (60 PER 30 DAYS)
NOVOLOG FLEXPEN (100 UNIT/ML, RELION U)	1	QL (60 PER 30 DAYS)
NOVOLOG MIX 70-30 (70-30 VIAL, RELION 70-30 VIAL)	1	QL (60 PER 30 DAYS)
NOVOLOG MIX 70-30 FLEXPEN (70-30 FLEXPEN, RELION 70-30 FLXPN)	1	QL (60 PER 30 DAYS)
NOVOLOG PENFILL 100 UNIT/ML	1	QL (60 PER 30 DAYS)
omnipod 5 (g6/libre 2 plus)	1	PA, QL (15 PER 30 DAYS)
omnipod 5 dexg7g6 intro(gen 5)	1	PA, QL (1 PER 720 OVER TIME)
omnipod 5 dexg7g6 pods (gen 5)	1	PA, QL (15 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
omnipod 5 g6-g7 intro kt(gen5)	1	PA, QL (1 PER 720 OVER TIME)
omnipod 5 g6-g7 pods (gen 5)	1	PA, QL (15 PER 30 DAYS)
omnipod 5 intro(g6/libre2plus)	1	PA, QL (1 PER 720 OVER TIME)
omnipod classic pods (gen 3) pods(gen3) 5pk	1	PA, QL (15 PER 30 DAYS)
omnipod dash intro kit (gen 4)	1	PA, QL (1 PER 720 OVER TIME)
omnipod dash pdm kit (gen 4)	1	PA, QL (1 PER 720 OVER TIME)
omnipod dash pods (gen 4) 5pk	1	PA, QL (15 PER 30 DAYS)
omnipod go pods (10 unit/day, 15 unit/day, 20 unit/day, 25 unit/day, 30 unit/day, 35 unit/day, 40 unit/day)	1	PA, QL (10 PER 30 DAYS)
pen needle (31g 5mm, 31g 8mm, 32g 4mm, 32g 6mm)	1	PA
TOUJEO MAX SOLOSTAR SOLOSTR 300 UNIT/ML	1	QL (60 PER 30 DAYS)
TOUJEO SOLOSTAR 300 UNIT/ML	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
true comfort safety pen needle (31g 5mm, 31g 6mm, 32g 4mm)	1	PA
ultiguard safepack-pen needle gnp	1	PA
ultra-fine insulin syringe (0.3 ml 30g 12.7mm, 0.3ml 31g 6mm (1/2), 0.3ml 31g 8mm (1/2), ins syr 1ml 31g 6mm, ins syr 1ml 31g 8mm, syr 0.3 ml 31g 6mm, syr 0.3 ml 31g 8mm, 0.5 ml 30g 12.7mm, syr 0.5 ml 31g 6mm, syr 0.5 ml 31g 8mm, syr 1 ml 30g 12.7mm)	1	PA
ultra-fine pen needle (ndl 29g 12.7mm, needle 31g 5mm, needle 31g 8mm, needle 32g 6mm)	1	PA
unifine otc pen needle (31g 5mm, 32g 4mm)	1	PA
unifine pentips 32g 4mm	1	PA
unifine pentips plus 33g 4mm	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Blood Products and Modifiers		
Anticoagulants		
dabigatran etexilate (75 mg cap, 150 mg cp)	1	QL (60 PER 30 DAYS)
dabigatran etexilate 110 mg cp	1	QL (120 PER 30 DAYS)
ELIQUIS (0.5 MG PKT(1X0.5MG TB), 1.5 MG PKT(3X0.5MG TB), 2 MG PKT(4X 0.5 MG TB))	1	QL (560 PER 28 DAYS)
ELIQUIS (5 MG TABLET, DVT-PE TREAT START 5MG)	1	QL (74 PER 30 DAYS)
ELIQUIS 2.5 MG TABLET	1	QL (60 PER 30 DAYS)
ELIQUIS SPRINKLE 0.15 MG CAP	1	QL (74 PER 30 DAYS)
enoxaparin sodium (100 mg/ml, 150 mg/ml)	1	QL (30 PER 90 OVER TIME)
enoxaparin sodium (80 mg/0.8 ml, 120 mg/0.8 ml)	1	QL (24 PER 90 OVER TIME)
enoxaparin sodium 30 mg/0.3 ml syr	1	QL (9 PER 90 OVER TIME)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
enoxaparin sodium 40 mg/0.4 ml syr	1	QL (12 PER 90 OVER TIME)
enoxaparin sodium 60 mg/0.6 ml syr	1	QL (18 PER 90 OVER TIME)
fondaparinux sodium 10 mg/0.8 ml syr	1	QL (24 PER 90 OVER TIME)
fondaparinux sodium 2.5 mg/0.5 ml syr	1	QL (15 PER 90 OVER TIME)
fondaparinux sodium 5 mg/0.4 ml syr	1	QL (12 PER 90 OVER TIME)
fondaparinux sodium 7.5 mg/0.6 ml syr	1	QL (18 PER 90 OVER TIME)
heparin sodium (sod 1,000 unit/ml vial, 2,000 unit/2 ml vial, 5,000 unit/ml carpujct, sod 5,000 unit/ml syrg, sod 5,000 unit/ml vial, 10,000 unit/10 ml vial, sod 10,000 unit/ml vl, sod 20,000 unit/ml vl, 30,000 unit/30 ml vial, 40,000 unit/4 ml vial, 50,000 unit/10 ml vial, 50,000 unit/5 ml vial)	1	
jantoven (1 mg tablet, 2 mg tablet, 2.5 mg tablet, 3 mg tablet, 4 mg tablet, 5 mg tablet, 6 mg tablet, 7.5 mg tablet, 10 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LOVENOX (100 MG/ML SYRINGE, 150 MG/ML SYRINGE)	1	QL (30 PER 90 OVER TIME)
LOVENOX (80 MG/0.8 ML SYRINGE, 120 MG/0.8 ML SYRINGE)	1	QL (24 PER 90 OVER TIME)
LOVENOX 30 MG/0.3 ML SYRINGE	1	QL (9 PER 90 OVER TIME)
LOVENOX 40 MG/0.4 ML SYRINGE	1	QL (12 PER 90 OVER TIME)
LOVENOX 60 MG/0.6 ML SYRINGE	1	QL (18 PER 90 OVER TIME)
rivaroxaban 1 mg/ml suspension	1	QL (620 PER 30 DAYS)
rivaroxaban 2.5 mg tablet	1	QL (60 PER 30 DAYS)
warfarin sodium (1 mg tablet, 2 mg tablet, 2.5 mg tablet, 3 mg tablet, 4 mg tablet, 5 mg tablet, 6 mg tablet, 7.5 mg tablet, 10 mg tablet)	1	
XARELTO (10 MG TABLET, 20 MG TABLET)	1	QL (30 PER 30 DAYS)
XARELTO (2.5 MG TABLET, 15 MG TABLET)	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
XARELTO 1 MG/ML SUSPENSION	1	QL (620 PER 30 DAYS)
XARELTO DVT-PE TREAT START 30D	1	QL (51 PER 30 DAYS)
ZONTIVITY 2.08 MG TABLET	1	

Blood Products and Modifiers, Other

AGRYLIN 0.5 MG CAPSULE	1	
anagrelide hcl (0.5 mg capsule, 1 mg capsule)	1	
ARANESP (10 MCG/0.4 ML SYRINGE, 25 MCG/0.42 ML SYRING, 25 MCG/ML VIAL, 40 MCG/0.4 ML SYRINGE, 40 MCG/ML VIAL, 60 MCG/0.3 ML SYRINGE, 60 MCG/ML VIAL, 100 MCG/0.5 ML SYRINGE, 100 MCG/ML VIAL, 150 MCG/0.3 ML SYRINGE, 200 MCG/0.4 ML SYRINGE, 200 MCG/ML VIAL, 300 MCG/0.6 ML SYRINGE, 500 MCG/1 ML SYRINGE)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FULPHILA 6 MG/0.6 ML SYRINGE	1	PA
GRANIX (300 MCG/0.5 ML SAFE SYR, 300 MCG/0.5 ML SYRINGE, 300 MCG/ML VIAL, 480 MCG/0.8 ML SAFE SYR, 480 MCG/0.8 ML SYRINGE, 480 MCG/1.6 ML VIAL)	1	PA
LEUKINE 250 MCG VIAL	1	PA
NIVESTYM (300 MCG/0.5 ML SYRING, 300 MCG/ML VIAL, 480 MCG/0.8 ML SYRING, 480 MCG/1.6 ML VIAL)	1	PA
PROCRIT (2,000 UNITS/ML VIAL, 3,000 UNITS/ML VIAL, 4,000 UNITS/ML VIAL, 10,000 UNITS/ML VIAL, 20,000 UNIT/2 ML VIAL, 20,000 UNITS/ML VIAL, 40,000 UNITS/ML VIAL)	1	PA
PROMACTA (12.5 MG SUSPEN PACKET, 12.5 MG TABLET, 25 MG SUSPENSION PCKT, 25 MG TABLET, 50 MG	1	PA

TABLET, 75 MG TABLET)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
RETACRIT (2,000 UNIT/ML VIAL, 3,000 UNIT/ML VIAL, 4,000 UNIT/ML VIAL, 10,000 UNIT/ML VIAL, 20,000 UNIT/2 ML VIAL, 20,000 UNIT/ML VIAL, 40,000 UNIT/ML VIAL)	1	PA
UDENYCA 6 MG/0.6 ML SYRINGE	1	PA
UDENYCA AUTOINJECTOR 6 MG/0.6 ML	1	PA
UDENYCA ONBODY 6 MG/0.6 ML	1	PA
ZIEXTENZO 6 MG/0.6 ML SYRINGE	1	PA
Hemostasis Agents		
tranexamic acid 650 mg tablet	1	
Platelet Modifying Agents		
aspirin-dipyridamole er 25-200 mg	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
BRILINTA (60 MG TABLET, 90 MG TABLET)	1	
CABLIVI (11 MG KIT, 11 MG VIAL)	1	
cilostazol (50 mg tablet, 100 mg tablet)	1	
clopidogrel 75 mg tablet	1	
dipyridamole (25 mg tablet, 50 mg tablet, 75 mg tablet)	1	
PLAVIX 75 MG TABLET	1	
prasugrel hcl (5 mg tablet, 10 mg tablet)	1	
ticagrelor (60 mg tablet, 90 mg tablet)	1	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine (0.1 mg/day patch, 0.2 mg/day patch, 0.3 mg/day patch)	1	
clonidine hcl (0.1 mg tablet, 0.2 mg tablet, 0.3 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
droxidopa (100 mg capsule, 200 mg capsule, 300 mg capsule)	1	PA
guanfacine hcl (1 mg tablet, 2 mg tablet)	1	
midodrine hcl (2.5 mg tablet, 5 mg tablet, 10 mg tablet)	1	
NORTHERA (100 MG CAPSULE, 200 MG CAPSULE, 300 MG CAPSULE)	1	PA
Alpha-adrenergic Blocking Agents		
CARDURA (1 MG TABLET, 2 MG TABLET, 4 MG TABLET, 8 MG TABLET)	1	QL (60 PER 30 DAYS)
doxazosin mesylate (1 mg tab, 2 mg tab, 4 mg tab, 8 mg tab)	1	QL (60 PER 30 DAYS)
phenoxybenzamine hcl 10 mg cap	1	
prazosin hcl (1 mg capsule, 2 mg capsule, 5 mg capsule)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
terazosin hcl (2 mg capsule, 5 mg capsule, 10 mg capsule)	1	QL (60 PER 30 DAYS)
terazosin hcl 1 mg capsule	1	QL (90 PER 30 DAYS)
Angiotensin II Receptor Antagonists		
ATACAND (4 MG TABLET, 8 MG TABLET, 16 MG TABLET)	1	QL (60 PER 30 DAYS)
ATACAND 32 MG TABLET	1	QL (30 PER 30 DAYS)
AVAPRO (75 MG TABLET, 150 MG TABLET, 300 MG TABLET)	1	QL (30 PER 30 DAYS)
BENICAR (20 MG TABLET, 40 MG TABLET)	1	QL (30 PER 30 DAYS)
BENICAR 5 MG TABLET	1	QL (60 PER 30 DAYS)
candesartan cilexetil (4 mg tab, 8 mg tab, 16 mg tb)	1	QL (60 PER 30 DAYS)
candesartan cilexetil 32 mg tb	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
COZAAR (25 MG TABLET, 50 MG TABLET)	1	QL (60 PER 30 DAYS)
COZAAR 100 MG TABLET	1	QL (30 PER 30 DAYS)
DIOVAN (40 MG TABLET, 80 MG TABLET, 160 MG TABLET)	1	QL (60 PER 30 DAYS)
DIOVAN 320 MG TABLET	1	QL (30 PER 30 DAYS)
EDARBI (40 MG TABLET, 80 MG TABLET)	1	QL (30 PER 30 DAYS)
irbesartan (75 mg tablet, 150 mg tablet, 300 mg tablet)	1	QL (30 PER 30 DAYS)
losartan potassium (25 mg tab, 50 mg tab)	1	QL (60 PER 30 DAYS)
losartan potassium 100 mg tab	1	QL (30 PER 30 DAYS)
MICARDIS (20 MG TABLET, 40 MG TABLET, 80 MG TABLET)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
olmesartan medoxomil (20 mg tab, 40 mg tab)	1	QL (30 PER 30 DAYS)
olmesartan medoxomil 5 mg tab	1	QL (60 PER 30 DAYS)
telmisartan (20 mg tablet, 40 mg tablet, 80 mg tablet)	1	QL (30 PER 30 DAYS)
valsartan (40 mg tablet, 80 mg tablet, 160 mg tablet)	1	QL (60 PER 30 DAYS)
valsartan 320 mg tablet	1	QL (30 PER 30 DAYS)
Angiotensin-converting Enzyme (ACE) Inhibitors		
ALTACE (1.25 MG CAPSULE, 2.5 MG CAPSULE, 5 MG CAPSULE, 10 MG CAPSULE)	1	
benazepril hcl (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet)	1	
captopril (12.5 mg tablet, 25 mg tablet, 50 mg tablet, 100 mg tablet)	1	
enalapril maleate (2.5 mg tab, 5 mg tablet, 10 mg tab, 20 mg tab)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
fosinopril sodium (10 mg tab, 20 mg tab, 40 mg tab)	1	
lisinopril (2.5 mg tablet, 5 mg tablet, 10 mg tablet, 20 mg tablet, 30 mg tablet, 40 mg tablet)	1	
LOTENSIN (10 MG TABLET, 20 MG TABLET, 40 MG TABLET)	1	
moexipril hcl (7.5 mg tablet, 15 mg tablet)	1	
perindopril erbumine (2 mg tab, 4 mg tab, 8 mg tab)	1	
quinapril hcl (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet)	1	
ramipril (1.25 mg capsule, 2.5 mg capsule, 5 mg capsule, 10 mg capsule)	1	
trandolapril (1 mg tablet, 2 mg tablet, 4 mg tablet)	1	
VASOTEC (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET, 20 MG TABLET)	1	

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ZESTRIL (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET, 20 MG TABLET, 30 MG TABLET, 40 MG TABLET)	1	
Antiarrhythmics		
amiodarone hcl (100 mg tablet, 200 mg tablet, 400 mg tablet)	1	
dofetilide (125 mcg capsule, 250 mcg capsule, 500 mcg capsule)	1	
flecainide acetate (50 mg tab, 100 mg tab, 150 mg tab)	1	
mexiletine hcl (150 mg capsule, 200 mg capsule, 250 mg capsule)	1	
MULTAQ 400 MG TABLET	1	
PACERONE (PACERONE 100 MG TABLET, PACERONE 400 MG TABLET, PACERONE 200 MG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
propafenone hcl (150 mg tablet, 225 mg tab, 300 mg tab)	1	
propafenone hcl er (er 225 mg cap, er 325 mg cap, er 425 mg cap)	1	
quinidine gluconate er 324 mg tab	1	
quinidine sulfate (200 mg tab, 300 mg tab)	1	
sorine (80 mg tablet, 120 mg tablet, 160 mg tablet, 240 mg tablet)	1	
sotalol (80 mg tablet, 120 mg tablet, 160 mg tablet, 240 mg tablet)	1	
sotalol af (80 mg tablet, 120 mg tablet, 160 mg tablet)	1	
TIKOSYN (125 MCG CAPSULE, 250 MCG CAPSULE, 500 MCG CAPSULE)	1	
Beta-adrenergic Blocking Agents		
acebutolol hcl (200 mg capsule, 400 mg capsule)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
atenolol (25 mg tablet, 50 mg tablet, 100 mg tablet)	1	
betaxolol hcl (10 mg tablet, 20 mg tablet)	1	
bisoprolol fumarate (5 mg tab, 10 mg tab)	1	
BYSTOLIC (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET, 20 MG TABLET)	1	
carvedilol (3.125 mg tablet, 6.25 mg tablet, 12.5 mg tablet, 25 mg tablet)	1	
carvedilol er (er 10 mg capsule, er 20 mg capsule, er 40 mg capsule, er 80 mg capsule)	1	
COREG CR (CR 10 MG CAPSULE, CR 20 MG CAPSULE, CR 40 MG CAPSULE, CR 80 MG CAPSULE)	1	
INDERAL LA (60 MG CAPSULE, 80 MG CAPSULE, 120 MG CAPSULE, 160 MG CAPSULE)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
INDERAL XL (80 MG CAPSULE, 120 MG CAPSULE)	1	
INNOPRAN XL (80 MG CAPSULE, 120 MG CAPSULE)	1	
labetalol hcl (100 mg tablet, 200 mg tablet, 300 mg tablet)	1	
LOPRESSOR (50 MG TABLET, 100 MG TABLET)	1	
metoprolol succinate (er 25 mg tab, er 50 mg tab, er 100 mg tab, er 200 mg tab)	1	
metoprolol tartrate (25 mg tab, 37.5 mg tb, 50 mg tab, 75 mg tab, 100 mg tab)	1	
nadolol (20 mg tablet, 40 mg tablet, 80 mg tablet)	1	
nebivolol hcl (2.5 mg tablet, 5 mg tablet, 10 mg tablet, 20 mg tablet)	1	
pindolol (5 mg tablet, 10 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
propranolol hcl (10 mg tablet, 20 mg tablet, 20 mg/5 ml soln, 40 mg tablet, 40 mg/5 ml soln, 60 mg tablet, 80 mg tablet)	1	
propranolol hcl er (er 60 mg capsule, er 80 mg capsule, er 120 mg capsule, er 160 mg capsule)	1	
TENORMIN (25 MG TABLET, 50 MG TABLET, 100 MG TABLET)	1	
timolol maleate (5 mg tablet, 10 mg tablet, 20 mg tablet)	1	
TOPROL XL (25 MG TABLET, 50 MG TABLET, 100 MG TABLET, 200 MG TABLET)	1	
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate (2.5 mg tab, 5 mg tab, 10 mg tab)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
felodipine er (er 2.5 mg tablet, er 5 mg tablet, er 10 mg tablet)	1	
isradipine (2.5 mg capsule, 5 mg capsule)	1	
nicardipine hcl (20 mg capsule, 30 mg capsule)	1	
nifedipine (10 mg capsule, 20 mg capsule)	1	
nifedipine er (er 30 mg tablet, er 60 mg tablet, er 90 mg tablet)	1	
nimodipine 30 mg capsule	1	
nisoldipine (er 8.5 mg tablet, er 17 mg tablet, er 25.5 mg tablet, er 34 mg tablet)	1	
NORVASC (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET)	1	
PROCARDIA XL (30 MG TABLET, 60 MG TABLET, 90 MG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SULAR (ER 8.5 MG TABLET, ER 17 MG TABLET, ER 34 MG TABLET)	1	
Calcium Channel Blocking Agents, Nondihydropyridines		
CARDIZEM (30 MG TABLET, 60 MG TABLET, 120 MG TABLET)	1	
CARDIZEM CD (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE, 300 MG CAPSULE, 360 MG CAPSULE)	1	
CARDIZEM LA (120 MG TABLET, 180 MG TABLET, 240 MG TABLET, 300 MG TABLET, 360 MG TABLET, 420 MG TABLET)	1	
cartia xt (120 mg capsule, 180 mg capsule, 240 mg capsule, 300 mg capsule)	1	
dilt-xr (120 mg capsule, 180 mg capsule, 240 mg capsule)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
diltiazem 12hr er (er 60 mg cap, er 90 mg cap, er 120 mg cap)	1	
diltiazem 24hr er (cd) (er(cd) 120 mg, er(cd) 180 mg, er(cd) 240 mg, er(cd) 300 mg, er(cd) 360 mg)	1	
diltiazem 24hr er (er 120 mg cap, er 180 mg cap, er 240 mg cap, er 300 mg cap, er 360 mg cap, er 420 mg cap)	1	
diltiazem 24hr er (la) (er(la) 120 mg, er(la) 180 mg, er(la) 240 mg, er(la) 300 mg, er(la) 360 mg, er(la) 420 mg)	1	
diltiazem 24hr er (xr) (er(xr) 120 mg, er(xr) 180 mg, er(xr) 240 mg)	1	
diltiazem hcl (30 mg tablet, 60 mg tablet, 90 mg tablet, 120 mg tablet)	1	
matzim la (180 mg tablet, 240 mg tablet, 300 mg tablet, 360 mg tablet, 420 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
taztia xt (120 mg capsule, 180 mg capsule, 240 mg capsule, 300 mg capsule, 360 mg capsule)	1	
tiadylt er (er 120 mg capsule, er 180 mg capsule, er 240 mg capsule, er 300 mg capsule, er 360 mg capsule, er 420 mg capsule)	1	
TIAZAC (ER 120 MG CAPSULE, ER 180 MG CAPSULE, ER 240 MG CAPSULE, ER 300 MG CAPSULE, ER 360 MG CAPSULE, ER 420 MG CAPSULE)	1	
verapamil er (er 120 mg capsule, er 120 mg tablet, er 180 mg capsule, er 180 mg tablet, er 240 mg capsule, er 240 mg tablet)	1	
verapamil er pm (er 100 mg capsule, er 200 mg capsule, er 300 mg capsule)	1	
verapamil hcl (40 mg tablet, 80 mg tablet, 120 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
verapamil sr (120 mg capsule, 180 mg capsule, 240 mg capsule, 360 mg capsule)	1	
VERELAN (120 MG CAP PELLET, 180 MG CAP PELLET, 240 MG CAP PELLET, 360 MG CAP PELLET)	1	
VERELAN PM (100 MG CAP PELLET, 200 MG CAP PELLET, 300 MG CAP PELLET)	1	
Cardiovascular Agents, Other		
acetazolamide (125 mg tablet, 250 mg tablet)	1	
acetazolamide er 500 mg cap	1	
aliskiren (150 mg tablet, 300 mg tablet)	1	QL (30 PER 30 DAYS)
amiloride-hydrochlorothiazide hcl-hctz 5-50 mg tab	1	
amlodipine besylate-benazepril (2.5, 5-10 mg, 5-20 mg, 5-40 mg, 10-20 mg, 10-40 mg)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
amlodipine-atorvastatin (2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg, 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg)	1	
amlodipine-olmesartan (5-20 mg, 5-40 mg, 10-20 mg, 10-40 mg)	1	QL (30 PER 30 DAYS)
amlodipine-valsartan (5-160 mg, 5-320 mg, 10-160 mg, 10-320 mg)	1	QL (30 PER 30 DAYS)
amlodipine-valsartan-hctz (5-160-12.5 mg, 5-160-25 mg, 10-160-12.5mg, 10-160-25 mg, 10-320-25 mg)	1	QL (30 PER 30 DAYS)
ATACAND HCT (16-12.5 MG TAB, 32-12.5 MG TAB, 32-25 MG TABLET)	1	QL (30 PER 30 DAYS)
atenolol-chlorthalidone (50, 100)	1	
AVALIDE (150-12.5 MG TABLET, 300-12.5 MG TABLET)	1	QL (30 PER 30 DAYS)
AZOR (5-20 MG TABLET, 5-40 MG TABLET, 10-20 MG TABLET, 10-40 MG	1	QL (30 PER 30 DAYS)

TABLET)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
benazepril-hydrochlorothiazide (5-6.25 mg tab, 10-12.5 mg tab, 20-12.5 mg tab, 20-25 mg tab)	1	
BENICAR HCT (20-12.5 MG TABLET, 40-12.5 MG TABLET, 40-25 MG TABLET)	1	QL (30 PER 30 DAYS)
bisoprolol-hydrochlorothiazide (2.5-6.25 mg tb, 5-6.25 mg tab, 10-6.25 mg tab)	1	
candesartan-hydrochlorothiazid (16-12.5 mg tb, 32-12.5 mg tb, 32-25 mg tab)	1	QL (30 PER 30 DAYS)
CORLANOR (5 MG TABLET, 7.5 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
CORLANOR 5 MG/5 ML ORAL SOLN	1	PA, QL (600 PER 30 DAYS)
DEMSER 250 MG CAPSULE	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
digitek (125 mcg tablet, 250 mcg tablet)	1	QL (30 PER 30 DAYS)
digoxin (0.125 mg tablet, 0.25 mg tablet, 62.5 mcg tablet, 125 mcg tablet, 250 mcg tablet)	1	QL (30 PER 30 DAYS)
digoxin 0.05 mg/ml solution	1	QL (150 PER 30 DAYS)
DIOVAN HCT (80-12.5 MG TABLET, 160-12.5 MG TAB, 160-25 MG TABLET, 320-12.5 MG TAB, 320-25 MG TABLET)	1	QL (30 PER 30 DAYS)
EDARBYCLOR (40-12.5 MG TABLET, 40-25 MG TABLET)	1	QL (30 PER 30 DAYS)
enalapril-hydrochlorothiazide (5-12.5 mg tab, 10-25 mg tablet)	1	
ENTRESTO (49 MG-51 MG TABLET, 97 MG-103 MG TABLET)	1	QL (60 PER 30 DAYS)
ENTRESTO 24 MG-26 MG TABLET	1	QL (180 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ENTRESTO SPRINKLE (6-6MG PELLET, 15-16 MG PLT)	1	QL (240 PER 30 DAYS)
EXFORGE (5-160 MG TABLET, 5-320 MG TABLET, 10-160 MG TABLET, 10-320 MG TABLET)	1	QL (30 PER 30 DAYS)
EXFORGE HCT (5-160-12.5 MG TAB, 5-160-25 MG TAB, 10-160-12.5 MG TAB, 10-160-25 MG TAB, 10-320-25 MG TAB)	1	QL (30 PER 30 DAYS)
fosinopril-hydrochlorothiazide (10-12.5 mg tab, 20-12.5 mg tab)	1	
HYZAAR (50-12.5 TABLET, 100-12.5 TABLET, 100-25 TABLET)	1	QL (30 PER 30 DAYS)
irbesartan-hydrochlorothiazide (150-12.5 mg, 300-12.5 mg)	1	QL (30 PER 30 DAYS)
ivabradine hcl (5 mg tablet, 7.5 mg tablet)	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LANOXIN (62.5 MCG TABLET, 125 MCG TABLET, 250 MCG TABLET)	1	QL (30 PER 30 DAYS)
lisinopril-hydrochlorothiazide (10-12.5 mg tab, 20-12.5 mg tab, 20-25 mg tab)	1	
losartan-hydrochlorothiazide (50-12.5 mg tab, 100-12.5 mg tab, 100-25 mg tab)	1	QL (30 PER 30 DAYS)
methazolamide (25 mg tablet, 50 mg tablet)	1	
metoprolol-hydrochlorothiazide (50-25 mg tab, 100-25 mg tab, 100-50 mg tab)	1	
metyrosine 250 mg capsule	1	
MICARDIS HCT (40-12.5 MG TABLET, 80-25 MG TABLET)	1	QL (30 PER 30 DAYS)
MICARDIS HCT 80-12.5 MG TABLET	1	QL (60 PER 30 DAYS)
olmesartan-amlodipine-hctz (20-5-12.5, 40-10-12.5, 40-10-25mg, 40-5-12.5, 40-5-25 mg)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
olmesartan-hydrochlorothiazide (20-12.5 mg tab, 40-12.5 mg tab, 40-25 mg tab)	1	QL (30 PER 30 DAYS)
pentoxifylline er 400 mg tab	1	
quinapril-hydrochlorothiazide (10-12.5 mg tab, 20-12.5 mg tab, 20-25 mg tab)	1	
ranolazine er (er 500 mg tablet, er 1,000 mg tablet)	1	QL (60 PER 30 DAYS)
sacubitril-valsartan (49-51 mg, 97-103 mg)	1	QL (60 PER 30 DAYS)
sacubitril-valsartan 24-26 mg	1	QL (180 PER 30 DAYS)
spironolactone-hctz 25-25 tab	1	
TEKTURNA (150 MG TABLET, 300 MG TABLET)	1	QL (30 PER 30 DAYS)
telmisartan-amlodipine (40, 40-5 mg, 80, 80-5 mg)	1	QL (30 PER 30 DAYS)
telmisartan-hydrochlorothiazid (40-12.5 mg tb, 80-25 mg tab)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
telmisartan-hydrochlorothiazid telmisartan-hctz 80-12.5 mg tb	1	QL (60 PER 30 DAYS)
TENORETIC 100 TABLET	1	
TENORETIC 50 TABLET	1	
trandolapril-verapamil er (er 1-240 mg, er 2-180 mg, er 2-240 mg, er 4-240 mg)	1	
TRIBENZOR (20-5-12.5 MG TABLET, 40-10-12.5 MG TABLET, 40-10-25 MG TABLET, 40-5-12.5 MG TABLET, 40-5-25 MG TABLET)	1	QL (30 PER 30 DAYS)
valsartan-hydrochlorothiazide (80-12.5 mg tab, 160-12.5 mg tab, 160-25 mg tab, 320-12.5 mg tab, 320-25 mg tab)	1	QL (30 PER 30 DAYS)
VASERETIC 10-25 MG TABLET	1	
ZESTORETIC (10-12.5 MG TABLET, 20-12.5 MG TABLET, 20-25 MG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ZIAC (2.5-6.25 MG TABLET, 5-6.25 MG TABLET, 10-6.25 MG TABLET)	1	
Diuretics, Loop		
bumetanide (0.25 mg/ml vial, 0.5 mg tablet, 1 mg tablet, 1 mg/4 ml vial, 2 mg tablet, 2.5 mg/10 ml vial)	1	
furosemide (10 mg/ml solution, 20 mg tablet, 20 mg/2 ml vial, 40 mg tablet, 40 mg/4 ml vial, 40 mg/5 ml soln, 80 mg tablet, 100 mg/10 ml vial, 500 mg/50 ml vial, 1,000 mg/100 ml vl)	1	
LASIX (20 MG TABLET, 40 MG TABLET, 80 MG TABLET)	1	
torsemide (5 mg tablet, 10 mg tablet, 20 mg tablet, 100 mg tablet)	1	
Diuretics, Potassium-sparing		
amiloride hcl 5 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
triamterene-hydrochlorothiazid (37.5-25 mg cp, 37.5-25 mg tb, 75-50 mg tab)	1	
Diuretics, Thiazide		
chlorthalidone (25 mg tablet, 50 mg tablet)	1	
hydrochlorothiazide (12.5 mg cp, 12.5 mg tb, 25 mg tab, 50 mg tab)	1	
indapamide (1.25 mg tablet, 2.5 mg tablet)	1	
metolazone (2.5 mg tablet, 5 mg tablet, 10 mg tablet)	1	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate (43 mg capsule, 48 mg tablet, 54 mg tablet)	1	QL (60 PER 30 DAYS)
fenofibrate (67 mg capsule, 130 mg capsule, 134 mg capsule, 145 mg tablet, 160 mg tablet, 200 mg capsule)	1	QL (30 PER 30 DAYS)
fenofibric acid dr 135 mg cap	1	QL (30 PER 30 DAYS)
fenofibric acid dr 45 mg cap	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
gemfibrozil 600 mg tablet	1	QL (60 PER 30 DAYS)
LOPID 600 MG TABLET	1	QL (60 PER 30 DAYS)
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin calcium (10 mg tablet, 20 mg tablet, 40 mg tablet)	1	QL (45 PER 30 DAYS)
atorvastatin calcium 80 mg tablet	1	QL (30 PER 30 DAYS)
CRESTOR (5 MG TABLET, 10 MG TABLET, 20 MG TABLET)	1	ST, QL (45 PER 30 DAYS)
CRESTOR 40 MG TABLET	1	ST, QL (30 PER 30 DAYS)
fluvastatin er 80 mg tablet	1	QL (30 PER 30 DAYS)
fluvastatin sodium (20 mg cap, 40 mg cap)	1	QL (60 PER 30 DAYS)
LIPITOR (10 MG TABLET, 20 MG TABLET, 40 MG TABLET)	1	ST, QL (45 PER 30 DAYS)
LIPITOR 80 MG TABLET	1	ST, QL (30 PER 30 DAYS)
lovastatin (10 mg tablet, 20 mg tablet, 40 mg tablet)	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
pravastatin sodium (10 mg tab, 20 mg tab, 40 mg tab)	1	QL (45 PER 30 DAYS)
pravastatin sodium 80 mg tab	1	QL (30 PER 30 DAYS)
rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab)	1	QL (45 PER 30 DAYS)
rosuvastatin calcium 40 mg tab	1	QL (30 PER 30 DAYS)
simvastatin (5 mg tablet, 10 mg tablet, 40 mg tablet)	1	QL (45 PER 30 DAYS)
simvastatin 20 mg tablet	1	QL (60 PER 30 DAYS)
simvastatin 80 mg tablet	1	QL (30 PER 30 DAYS)
ZOCOR (10 MG TABLET, 40 MG TABLET)	1	ST, QL (45 PER 30 DAYS)
ZOCOR 20 MG TABLET	1	ST, QL (60 PER 30 DAYS)
Dyslipidemics, Other		
cholestyramine (packet, powder)	1	
cholestyramine light (packet, powder)	1	
COLESTID 1 GM TABLET	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
colestipol hcl (1 gm tablet, granules, granules packet)	1	
ezetimibe 10 mg tablet	1	QL (30 PER 30 DAYS)
ezetimibe-simvastatin (10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg)	1	QL (30 PER 30 DAYS)
icosapent ethyl (0.5 gm capsule, 500 mg capsule)	1	QL (240 PER 30 DAYS)
icosapent ethyl 1 gram capsule	1	QL (120 PER 30 DAYS)
JUXTAPID (5 MG CAPSULE, 10 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE)	1	PA
niacin er (er 750 mg tablet, er 1,000 mg tablet)	1	QL (60 PER 30 DAYS)
niacin er 500 mg tablet	1	QL (30 PER 30 DAYS)
omega-3 acid ethyl esters 1 gm cap	1	
prevalite (packet, powder)	1	
REPATHA PUSHTRONEX 420 MG/3.5ML PUSHTRONX	1	PA, QL (7 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
REPATHA SURECLICK 140 MG/ML	1	PA, QL (6 PER 28 DAYS)
REPATHA SYRINGE 140 MG/ML	1	PA, QL (6 PER 28 DAYS)
triklo 1 gm capsule	1	
VASCEPA 0.5 GM CAPSULE	1	QL (240 PER 30 DAYS)
VASCEPA 1 GM CAPSULE	1	QL (120 PER 30 DAYS)
VYTORIN (10-10 MG TABLET, 10-20 MG TABLET, 10-40 MG TABLET, 10-80 MG TABLET)	1	ST, QL (30 PER 30 DAYS)
ZETIA 10 MG TABLET	1	QL (30 PER 30 DAYS)
Mineralocorticoid Receptor Antagonists		
ALDACTONE (25 MG TABLET, 50 MG TABLET, 100 MG TABLET)	1	
eplerenone (25 mg tablet, 50 mg tablet)	1	
INSPRA (25 MG TABLET, 50 MG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
KERENDIA (10 MG TABLET, 20 MG TABLET, 40 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
spironolactone (25 mg tablet, 50 mg tablet, 100 mg tablet)	1	
Vasodilators, Direct-acting Arterial		
hydralazine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 100 mg tablet)	1	
minoxidil (2.5 mg tablet, 10 mg tablet)	1	
Vasodilators, Direct-acting Arterial/Venous		
ISORDIL TITRADOSE 5 MG TAB	1	
isosorbide dinitrate (5 mg tab, 10 mg tab, 20 mg tab, 30 mg tab)	1	
isosorbide mononitrate (10 mg tab, 20 mg tab)	1	
isosorbide mononitrate er (er 30 mg tb, er 60 mg tb, er 120 mg)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
NITRO-BID 2% OINTMENT	1	
nitroglycerin (0.3 mg tablet sl, 0.4 mg tablet sl, 0.4% ointment, 0.6 mg tablet sl, 400 mcg spray)	1	
nitroglycerin patch (0.1 mg/hr patch, 0.2 mg/hr patch, 0.4 mg/hr patch, 0.6 mg/hr patch)	1	
NITROLINGUAL 400 MCG SPRAY	1	
NITROSTAT (0.3 MG TABLET, 0.4 MG TABLET, 0.6 MG TABLET)	1	
RECTIV 0.4% OINTMENT	1	
VERQUVO (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Central Nervous System Agents		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
ADDERALL XR (5 MG CAPSULE, 10 MG CAPSULE, 15 MG CAPSULE, 20 MG CAPSULE, 25 MG CAPSULE, 30 MG CAPSULE)	1	QL (30 PER 30 DAYS)
DEXEDRINE (10 MG, 15 MG, 15 MG CAP)	1	QL (120 PER 30 DAYS)
dextroamphetamine sulfate 10 mg tab	1	QL (180 PER 30 DAYS)
dextroamphetamine sulfate 5 mg tab	1	QL (90 PER 30 DAYS)
dextroamphetamine sulfate er (er 10 mg cap, er 15 mg cap)	1	QL (120 PER 30 DAYS)
dextroamphetamine sulfate er 5 mg cap	1	QL (90 PER 30 DAYS)
dextroamphetamine-amphet er (er 5 mg cap, er 10 mg cap, er 15 mg cap, er 20 mg cap, er 25 mg cap, er 30 mg cap)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
dextroamphetamine-amphetamine (dextroamp-amphetam 7.5 mg tab, dextroamp-amphetam 12.5 mg tab, dextroamp-amphetamin 10 mg tab, dextroamp-amphetamin 15 mg tab, dextroamp-amphetamin 30 mg tab, dextroamp-amphetamine 5 mg tab)	1	QL (60 PER 30 DAYS)
dextroamphetamine-amphetamine dextroamp-amphetamin 20 mg tab	1	QL (90 PER 30 DAYS)
lisdexamfetamine dimesylate (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule, 50 mg capsule, 60 mg capsule, 70 mg capsule)	1	QL (30 PER 30 DAYS)
VYVANSE (10 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE, 40 MG CAPSULE, 50 MG CAPSULE, 60 MG CAPSULE, 70 MG CAPSULE)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
zenzedi 10 mg tablet	1	QL (180 PER 30 DAYS)
zenzedi 5 mg tablet	1	QL (90 PER 30 DAYS)
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
atomoxetine hcl (10 mg capsule, 18 mg capsule, 25 mg capsule, 40 mg capsule)	1	QL (60 PER 30 DAYS)
atomoxetine hcl (60 mg capsule, 80 mg capsule, 100 mg capsule)	1	QL (30 PER 30 DAYS)
clonidine hcl er 0.1 mg tablet	1	QL (120 PER 30 DAYS)
dexmethylphenidate hcl (2.5 mg tab, 5 mg tab, 10 mg tab)	1	PA, QL (60 PER 30 DAYS)
FOCALIN (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
guanfacine hcl er (er 1 mg tablet, er 2 mg tablet, er 3 mg tablet, er 4 mg tablet)	1	QL (30 PER 30 DAYS)
methylphenidate er 20 mg tab	1	PA, QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
methylphenidate hcl (5 mg tablet, 10 mg tablet, 20 mg tablet)	1	PA, QL (90 PER 30 DAYS)
methylphenidate hcl 10 mg/5 ml sol	1	PA, QL (900 PER 30 DAYS)
methylphenidate hcl 5 mg/5 ml soln	1	PA, QL (450 PER 30 DAYS)
RITALIN (5 MG TABLET, 10 MG TABLET, 20 MG TABLET)	1	PA, QL (90 PER 30 DAYS)
STRATTERA (10 MG CAPSULE, 18 MG CAPSULE, 25 MG CAPSULE, 40 MG CAPSULE)	1	QL (60 PER 30 DAYS)
STRATTERA (60 MG CAPSULE, 80 MG CAPSULE, 100 MG CAPSULE)	1	QL (30 PER 30 DAYS)
Central Nervous System, Other		
AUSTEDO (9 MG TABLET, 12 MG TABLET)	1	PA, QL (120 PER 30 DAYS)
AUSTEDO 6 MG TABLET	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
AUSTEDO XR (12 MG TABLET, 18 MG TABLET, 30 MG TABLET, 36 MG TABLET, 42 MG TABLET, 48 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
AUSTEDO XR 24 MG TABLET	1	PA, QL (60 PER 30 DAYS)
AUSTEDO XR 6 MG TABLET	1	PA, QL (90 PER 30 DAYS)
AUSTEDO XR TITRATION KT(WK1-4) KT(6-12-24 MG)	1	PA, QL (42 PER 28 DAYS)
AUSTEDO XR TITRATION KT(WK1-4) TITR(12-18-24-30MG)	1	PA, QL (28 PER 28 DAYS)
INGREZZA (60 MG CAPSULE, 80 MG CAPSULE)	1	PA, QL (30 PER 30 DAYS)
INGREZZA 40 MG CAPSULE	1	PA, QL (60 PER 30 DAYS)
INGREZZA INITIATION PK(TARDIV)	1	PA, QL (28 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
INGREZZA SPRINKLE (60 MG CAP, 80 MG CAP)	1	PA, QL (30 PER 30 DAYS)
INGREZZA SPRINKLE 40 MG CAP	1	PA, QL (60 PER 30 DAYS)
NUEDEXTA 20-10 MG CAPSULE	1	PA, QL (60 PER 30 DAYS)
riluzole 50 mg tablet	1	
tetrabenazine 12.5 mg tablet	1	PA, QL (240 PER 30 DAYS)
tetrabenazine 25 mg tablet	1	PA, QL (120 PER 30 DAYS)
VEOZAH 45 MG TABLET	1	PA, QL (30 PER 30 DAYS)
XENAZINE 12.5 MG TABLET	1	PA, QL (240 PER 30 DAYS)
XENAZINE 25 MG TABLET	1	PA, QL (120 PER 30 DAYS)
Multiple Sclerosis Agents		
AMPYRA ER 10 MG TABLET	1	PA
AVONEX (4 PACK) 30 MCG/0.5 ML SYR (4PK)	1	PA, QL (1 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
AVONEX 30 MCG/0.5 ML SYRINGE	1	PA, QL (1 PER 28 DAYS)
AVONEX PEN (4 PACK) 30 MCG/0.5 ML (4PK)	1	PA, QL (1 PER 28 DAYS)
BETASERON (0.3 MG KIT, 0.3 MG VIAL)	1	PA, QL (15 PER 30 DAYS)
COPAXONE 20 MG/ML SYRINGE	1	PA, QL (30 PER 30 DAYS)
COPAXONE 40 MG/ML SYRINGE	1	PA, QL (12 PER 28 DAYS)
dalfampridine er 10 mg tablet	1	PA
dimethyl fumarate (30d start pk, dr 120 mg cp, dr 240 mg cp)	1	PA, QL (60 PER 30 DAYS)
fingolimod 0.5 mg capsule	1	PA, QL (30 PER 30 DAYS)
GILENYA 0.5 MG CAPSULE	1	PA, QL (30 PER 30 DAYS)
glatiramer acetate 20 mg/ml syringe	1	PA, QL (30 PER 30 DAYS)
glatiramer acetate 40 mg/ml syringe	1	PA, QL (12 PER 28 DAYS)
glatopa 20 mg/ml syringe	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
glatopa 40 mg/ml syringe	1	PA, QL (12 PER 28 DAYS)
KESIMPTA PEN 20 MG/0.4 ML	1	PA, QL (1.6 PER 28 DAYS)
PLEGRIDY (125 MCG/0.5 ML SYRING, SYRINGE STARTER PACK)	1	PA, QL (1 PER 28 DAYS)
PLEGRIDY PEN (125 MCG/0.5 ML PEN, PEN INJ STARTER PACK)	1	PA, QL (1 PER 28 DAYS)
TECFIDERA (DR 120 MG CAPSULE, DR 240 MG CAPSULE, STARTER PACK)	1	PA, QL (60 PER 30 DAYS)
VUMERITY DR 231 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)

Dental and Oral Agents

cevimeline hcl 30 mg capsule	1	
chlorhexidine gluconate (0.12% 15 ml cup, 0.12% rinse)	1	
kourzeq 0.1% dental paste	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
oralone 0.1% paste	1	
periogard 0.12% oral rinse	1	
pilocarpine hcl (5 mg tablet, 7.5 mg tablet)	1	
SALAGEN (5 MG TABLET, 7.5 MG TABLET)	1	
triamcinolone acetonide 0.1% paste	1	

Dermatological Agents

Acne and Rosacea Agents

accutane (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule)	1	
acitretin (10 mg capsule, 17.5 mg capsule, 25 mg capsule)	1	
amnesteem (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule)	1	
AVITA (0.025% CREAM, 0.025% GEL)	1	PA
azelaic acid 15% gel	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
AZELEX 20% CREAM	1	
BENZAMYCIN GEL	1	
claravis (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule)	1	
clindamycin phos-benzoyl perox ph-benzoyl 1.2-5%	1	
clindamycin-benzoyl peroxide (clindamycin-benzoyl 1-5%, clindamycin-bnz 1-5% pmp)	1	
doxycycline ir-dr 40 mg cap	1	
erythromycin-benzoyl peroxide gel	1	
FINACEA (15% FOAM, 15% GEL)	1	
isotretinoin (10 mg capsule, 20 mg capsule, 25 mg capsule, 30 mg capsule, 35 mg capsule, 40 mg capsule)	1	
KLARON 10% LOTION	1	
myorisan (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
neuac gel	1	
ORACEA 40 MG CAPSULE	1	
RETIN-A (0.01% GEL, 0.025% CREAM, 0.025% GEL, 0.05% CREAM, 0.1% CREAM)	1	PA
sulfacetamide sodium (sod 10% top susp, sodium 10% lotn)	1	
tazarotene (0.05% cream, 0.05% gel, 0.1% cream, 0.1% gel)	1	PA
TAZORAC (0.05% CREAM, 0.05% GEL, 0.1% GEL)	1	PA
tretinoin (0.01% gel, 0.025% cream, 0.025% gel, 0.05% cream, 0.1% cream)	1	PA
zenatane (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule)	1	
Dermatitis and Pruitus Agents		
ALA-CORT 1% CREAM	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
alclometasone dipropionate (dipr 0.05% oint, dipro 0.05% crm)	1	QL (120 PER 30 DAYS)
ammonium lactate (12% cream, 12% lotion)	1	
betamethasone diprop augmented (0.05% crm, 0.05% gel, 0.05% oin)	1	QL (200 PER 28 DAYS)
betamethasone diprop augmented dp 0.05% lot	1	QL (210 PER 30 DAYS)
betamethasone dipropionate (0.05% crm, 0.05% oint)	1	QL (135 PER 30 DAYS)
betamethasone dipropionate dp 0.05% lot	1	QL (120 PER 30 DAYS)
betamethasone valerate (va 0.1% cream, valer 0.1% ointm)	1	QL (135 PER 30 DAYS)
betamethasone valerate 0.1% lotion	1	QL (120 PER 30 DAYS)
clobetasol emollient 0.05% crm	1	QL (210 PER 28 DAYS)
clobetasol propionate (0.05% cream, 0.05% gel, 0.05% ointment)	1	QL (210 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
clobetasol propionate (0.05% solution, prop 0.05% foam)	1	QL (200 PER 28 DAYS)
clobetasol propionate 0.05% shampoo	1	QL (236 PER 30 DAYS)
clodan 0.05% shampoo	1	QL (236 PER 30 DAYS)
desonide (0.05% cream, 0.05% ointment)	1	QL (120 PER 30 DAYS)
desonide 0.05% lotion	1	QL (118 PER 30 DAYS)
desoximetasone (0.05% cream, 0.05% gel, 0.25% cream, 0.25% ointment)	1	QL (120 PER 30 DAYS)
DIPROLENE 0.05% OINTMENT	1	QL (200 PER 28 DAYS)
doxepin hcl 5% cream	1	PA
ELIDEL 1% CREAM	1	PA
fluocinolone acetonide (0.01% body, 0.01% scalp)	1	QL (118.28 PER 30 DAYS)
fluocinolone acetonide (0.01% cream, 0.01% solution, 0.025% cream, 0.025% ointment)	1	QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
fluocinonide (0.05% cream, 0.05% gel, 0.05% ointment, 0.05% solution)	1	QL (120 PER 30 DAYS)
fluocinonide 0.1% cream	1	QL (240 PER 28 DAYS)
fluocinonide-e 0.05% cream	1	QL (120 PER 30 DAYS)
fluticasone propionate (0.005% oint, 0.05% cream)	1	QL (120 PER 30 DAYS)
halobetasol propionate (0.05% cream, 0.05% ointmnt)	1	QL (200 PER 28 DAYS)
hydrocortisone (1% cream, 1% ointment)	1	
hydrocortisone 2.5% lotion	1	QL (118 PER 30 DAYS)
hydrocortisone 2.5% ointment	1	QL (454 PER 30 DAYS)
hydrocortisone butyrate (hydrocort buty 0.1% lipid crm, hydrocort buty 0.1% lipo cream, hydrocortisone buty 0.1% cream, hydrocortisone butyr 0.1% oint)	1	QL (135 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
hydrocortisone butyrate 0.1% soln	1	QL (120 PER 30 DAYS)
hydrocortisone valerate (0.2% cream, 0.2% ointmt)	1	QL (120 PER 30 DAYS)
LOCOID LIPOCREAM 0.1%	1	QL (135 PER 30 DAYS)
mometasone furoate (0.1% cream, 0.1% oint)	1	QL (135 PER 30 DAYS)
mometasone furoate 0.1% soln	1	QL (120 PER 30 DAYS)
pimecrolimus 1% cream	1	PA
PRUDOXIN 5% CREAM	1	PA
selenium sulfide 2.5% lotion	1	
tacrolimus (0.03%, 0.1%)	1	PA
triamcinolone acetonide (0.025% cream, 0.025% oint, 0.1% cream, 0.1% ointment, 0.5% cream)	1	QL (454 PER 30 DAYS)
triamcinolone acetonide (0.025% lotion, 0.1% lotion, 0.5% ointment)	1	QL (120 PER 30 DAYS)
triderm 0.5% cream	1	QL (454 PER 30 DAYS)
ZONALON 5% CREAM	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Dermatological Agents, Other		
calcipotriene (0.005% cream, 0.005% ointment, 0.005% solution)	1	QL (120 PER 30 DAYS)
calcitrene 0.005% ointment	1	QL (120 PER 30 DAYS)
clotrimazole-betamethasone (crm, lot)	1	
diclofenac sodium 3% gel	1	PA
EFUDEX 5% CREAM	1	
fluorouracil (2% topical soln, 5% cream, 5% topical soln)	1	
imiquimod 5% cream packet	1	PA
methoxsalen (10 mg capsule, 10 mg softgel)	1	
nystatin-triamcinolone (cream, ointm)	1	
OTEZLA (10-20 MG STARTER 28 DAY, 10-20-30MG START 28 DAY, 20 MG TABLET, 30 MG TABLET)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
podofilox 0.5% topical soln	1	
REGRANEX 0.01% GEL	1	PA, QL (15 PER 30 DAYS)
SANTYL OINTMENT	1	QL (180 PER 30 DAYS)
SILVADENE 1% CREAM	1	
silver sulfadiazine 1% cream	1	
SSD 1% CREAM	1	
Pediculicides/Scabicides		
ivermectin 1% cream	1	PA
malathion 0.5% lotion	1	
OVIDE 0.5% LOTION	1	
permethrin 5% cream	1	
SOOLANTRA 1% CREAM	1	PA
Topical Anti-infectives		
gentamicin sulfate (0.1% cream, 0.1% ointment)	1	
METROCREAM METRO0.75%	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
METROGEL (1% GEL, 1% PUMP)	1	
METROLOTION TOPICAL 0.75%	1	
metronidazole (0.75% cream, 0.75% lotion, top 1% gel pump, topical 0.75% gl, topical 1% gel)	1	
mupirocin (2% cream, 2% ointment)	1	QL (30 PER 30 OVER TIME)
rosadan (0.75% cream, 0.75% gel)	1	

Electrolytes/Minerals/ Metals/ Vitamins

Electrolyte/Mineral Replacement

aqua care sodium chloride 0.9% nacl irrigation	1	
CARBAGLU 200 MG TAB FOR SUSP	1	PA
carglumic acid 200 mg tab susp	1	PA
dextrose 2.5%-0.45% nacl iv	1	
dextrose 5%-0.2% nacl iv soln	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
dextrose 5%-0.225% nacl iv sol	1	
dextrose 5%-0.45% nacl iv soln	1	
dextrose 5%-0.9% nacl iv soln	1	
glucose 5%-0.9% nacl 1000 ml	1	
kcl-d5w-0.2% nacl (10 meq/500 ml-d5w-0.2%nacl, 20 meq/l-d5w-0.2% nacl)	1	
kcl-d5w-0.225% nacl (10meq/500ml-d5w-0.225%nacl, 20 meq/l-d5w-0.225% nacl)	1	
kcl-d5w-0.45% nacl (10 meq/500ml-d5w-0.45%nacl, 10 meq/l-d5w-0.45% nacl, 20 meq/l-d5w-0.45% nacl, 30 meq/l-d5w-0.45% nacl, 40 meq/l-d5w-0.45% nacl)	1	
KLOR-CON 10 MEQ TABLET	1	
KLOR-CON 8 MEQ TABLET	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
klor-con m10 tablet	1	
KLOR-CON M15 TABLET	1	
klor-con m20 tablet	1	
magnesium sulfate (50% 1 g/2 ml, 50% 10g/20ml, 50% 25g/50ml, 50% 5 g/10ml, 50% syringe)	1	
potassium chloride (cl10%(20meq/15ml)cup, cl10%(40meq/30ml)cup, cl20%(40meq/15ml)cup, cl 2 meq/ml conc, cl 10 meq/5 ml conc, cl 10% (20 meq/15ml), cl 10% (40 meq/30ml), cl 20 meq/10 ml conc, cl 20% (40 meq/15ml), cl 40 meq/20 ml conc, cl 60 meq/30 ml conc, cl er 8 meq capsule, cl er 8 meq tablet, cl er 10 meq capsule, cl er 10 meq tablet, cl er 15 meq tablet, cl er 20 meq tablet)	1	
potassium chloride in d5lr kcl 20 meqd5w-lact ringer	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
potassium chloride proamp cl 20 meq/10 ml conc	1	
potassium chloride-0.45% nacl 20 meq-0.45% na	1	
potassium chloride-dextrose 5% kcl 20 meq/l in d5w solution	1	
potassium citrate er (er 5 tab, er 10 tb, er 15 tb)	1	
sodium chloride (saline 0.45% soln-excel con, sodium chloride 0.45% soln, sodium chloride 0.9% 100 ml, sodium chloride 0.9% 1,000 ml, sodium chloride 0.9% 250 ml, sodium chloride 0.9% 50 ml, sodium chloride 0.9% 500 ml, sodium chloride 0.9% ampule, sodium chloride 0.9% irrig, sodium chloride 0.9% irrig., sodium chloride 0.9% prcss sol, sodium chloride 0.9% sol-excel, sodium chloride 0.9% soln, sodium chloride 0.9% solution, sodium chloride 0.9% vial)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
sodium chloride-water 0.9%-water	1	
Electrolyte/Mineral/Metal Modifiers		
CHEMET 100 MG CAPSULE	1	
deferasirox (90 mg granule pkt, 90 mg tablet, 125 mg tb for susp, 180 mg granule pkt, 180 mg tablet, 250 mg tb for susp, 360 mg granule pkt, 360 mg tablet, 500 mg tb for susp)	1	PA
EXJADE (125 MG TABLET, 250 MG TABLET, 500 MG TABLET)	1	PA
JADENU (90 MG TABLET, 180 MG TABLET, 360 MG TABLET)	1	PA
JADENU SPRINKLE (90 MG GRANULE, 180 MG GRANULE, 360 MG GRANULE)	1	PA
SAMSCA (15 MG TABLET, 30 MG TABLET)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SYPRINE 250 MG CAPSULE	1	PA, QL (240 PER 30 DAYS)
tolvaptan (15 mg tablet, 30 mg tablet)	1	PA
trientine hcl 250 mg capsule	1	PA, QL (240 PER 30 DAYS)
dextrose in water (5%-water 100 ml, 5%-water 1,000 ml, 5%-water 250 ml, 5%-water 50 ml, 5%-water iv soln, 10%-water iv solution)	1	
glucose in water (50 ml, 100 ml)	1	
INTRALIPID 20% IV FAT EMUL	1	PA
NUTRILIPID 20% IV FAT EMULSION	1	PA
TRAVASOL 10% SOLN VIAFLEX	1	PA
TROPHAMINE 10% IV SOLUTION	1	PA
Potassium Binders		
kionex 15 gm/60 ml suspension	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
sodium polystyrene sulfonate powder	1	
SPS (15 GM/60 ML SUSPENSION, 30 GM/120 ML ENEMA SUSP)	1	
VELTASSA (1 GM POWDER PACKET, 8.4 GM POWDER PACKET, 16.8 GM POWDER PACKET, 25.2 GM POWDER PACKET)	1	
Gastrointestinal Agents		
Anti-Constipation Agents		
constulose 10 gm/15 ml soln	1	
enulose 10 gm/15 ml solution	1	
generlac 10 gm/15 ml solution	1	
lactulose (10 gm/15 ml soln cup, 10 gm/15 ml solution, 20 gm/30 ml soln cup, 20 gm/30 ml solution)	1	
LINZESS (72 MCG CAPSULE, 145 MCG CAPSULE, 290 MCG CAPSULE)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
lubiprostone 24 mcg capsule	1	QL (60 PER 30 DAYS)
lubiprostone 8 mcg capsule	1	QL (120 PER 30 DAYS)
MOVANTIK (12.5 MG TABLET, 25 MG TABLET)	1	QL (30 PER 30 DAYS)
RELISTOR (12 MG/0.6 ML SYRINGE, 12 MG/0.6 ML VIAL)	1	PA, QL (18 PER 30 DAYS)
RELISTOR 150 MG TABLET	1	PA, QL (90 PER 30 DAYS)
RELISTOR 8 MG/0.4 ML SYRINGE	1	PA, QL (12 PER 30 DAYS)
Anti-Diarrheal Agents		
alosetron hcl (0.5 mg tablet, 1 mg tablet)	1	PA, QL (60 PER 30 DAYS)
diphenoxylate-atropine 2.5	1	PA
loperamide 2 mg capsule	1	
LOTRONEX (0.5 MG TABLET, 1 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
VIBERZI (75 MG TABLET, 100 MG TABLET)	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
XERMELO 250 MG TABLET	1	PA, QL (90 PER 30 DAYS)
Antispasmodics, Gastrointestinal		
dicyclomine hcl (10 mg capsule, 10 mg/5 ml soln, 20 mg tablet)	1	PA
glycopyrrolate (1 mg tablet, 2 mg tablet)	1	
methscopolamine bromide (2.5 mg tb, 5 mg tab)	1	
Gastrointestinal Agents, Other		
bismuth-metronidazole-tetracyc bismuth-metro-tetr 140-125-125	1	
chenodal 250 mg tablet	1	PA
GATTEX (5 MG 30-VIAL KIT, 5 MG ONE-VIAL KIT, 5 MG VIAL)	1	PA
gavilyte-c solution	1	
gavilyte-g solution	1	
gavilyte-n solution	1	
GOLYTELY SOLUTION	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
metoclopramide hcl (5 mg tablet, 5 mg/5 ml soln, 10 mg tablet, 10 mg/10 ml cup, 10 mg/10 ml sol)	1	
MOVIPREP POWDER PACKET	1	
MYALEPT 11.3 MG (5 MG/ML) VIAL	1	PA
OCALIVA (5 MG TABLET, 10 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
peg 3350-electrolyte solution	1	
peg-3350 and electrolytes soln	1	
peg3350-sod sul-nacl-kcl-asb-c 100-7.5-2.691-1.01-5.9	1	
PYLERA CAPSULE	1	
REGLAN (5 MG TABLET, 10 MG TABLET)	1	
sod sulf-potass sulf-mag sulf -potass -mag sol	1	
SUPREP SUBOWEL KIT	1	

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SUTAB SU1.479-0.225-0.188 GM	1	
ursodiol (250 mg tablet, 300 mg capsule, 500 mg tablet)	1	
VOWST CAPSULE	1	PA, QL (12 PER 56 OVER TIME)
XIFAXAN 550 MG TABLET	1	PA, QL (90 PER 30 DAYS)
Histamine2 (H2) Receptor Antagonists		
cimetidine (200 mg tablet, 300 mg tablet, 400 mg tablet, 800 mg tablet)	1	
famotidine (20 mg tablet, 40 mg tablet, 40 mg/5 ml susp)	1	
nizatidine (150 mg capsule, 300 mg capsule)	1	
Protectants		
CARAFATE (1 GM TABLET, 1 GM/10 ML SUSP)	1	
CYTOTEC (100 MCG TABLET, 200 MCG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
misoprostol (100 mcg tablet, 200 mcg tablet)	1	
sucralfate (1 gm tablet, 1 gm/10 ml susp, 1 gm/10 ml susp cup)	1	
Proton Pump Inhibitors		
esomeprazole magnesium (dr 2.5 mg packet, dr 5 mg packet, dr 10 mg packet, dr 20 mg packet, dr 40 mg packet, mag dr 20 mg cap, mag dr 40 mg cap)	1	QL (30 PER 30 DAYS)
lansoprazole (dr 15 mg capsule, dr 30 mg capsule)	1	QL (30 PER 30 DAYS)
NEXIUM (DR 10 MG PACKET, DR 20 MG CAPSULE, DR 20 MG PACKET, DR 40 MG CAPSULE, DR 40 MG PACKET)	1	ST, QL (30 PER 30 DAYS)
NEXIUM (DR 2.5 MG PACKET, DR 5 MG PACKET)	1	QL (30 PER 30 DAYS)
omeprazole (dr 20 mg capsule, dr 40 mg capsule)	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
omeprazole dr 10 mg capsule	1	QL (30 PER 30 DAYS)
pantoprazole sodium dr 20 mg tab	1	QL (30 PER 30 DAYS)
pantoprazole sodium dr 40 mg tab	1	QL (60 PER 30 DAYS)
PREVACID DR 30 MG CAPSULE	1	ST, QL (30 PER 30 DAYS)
PROTONIX DR 20 MG TABLET	1	ST, QL (30 PER 30 DAYS)
PROTONIX DR 40 MG TABLET	1	ST, QL (60 PER 30 DAYS)
rabeprazole sodium dr 20 mg tab	1	QL (30 PER 30 DAYS)

Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment

betaine anhydrous 1 gram/scoop powder	1	
BUPHENYL 500 MG TABLET	1	PA
CARNITOR (1 GM/10 ML ORAL SOLN, 100 MG/ML ORAL SOLN, 330 MG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
CARNITOR SF 1 GM/10 ML SOLN	1	
CEREZYME 400 UNIT VIAL	1	PA
CREON (DR 3,000 UNIT CAPSULE, DR 6,000 UNIT CAPSULE, DR 12,000 UNIT CAPSULE, DR 24,000 UNIT CAPSULE, DR 36,000 UNIT CAPSULE)	1	
cromolyn sodium 100 mg/5 ml oral conc	1	
CRYSVITA (10 MG/ML VIAL, 20 MG/ML VIAL, 30 MG/ML VIAL)	1	PA
CYSTADANE 1 GRAM/SCOOP POWDER	1	
CYSTAGON (50 MG CAPSULE, 150 MG CAPSULE)	1	PA
ELELYSO 200 UNITS VIAL	1	PA
ENDARI 5 GRAM POWDER PACKET	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
KUVAN (100 MG POWDER PACKET, 100 MG TABLET, 500 MG POWDER PACKET)	1	PA
l-glutamine 5 gram powder pkt	1	PA
levocarnitine (1 g/10 ml cup, 1 g/10 ml soln, 330 mg tablet, 500 mg/5 ml cup)	1	
levocarnitine sf 1 g/10 ml sol	1	
miglustat 100 mg capsule	1	PA, QL (180 PER 30 DAYS)
nitisinone (2 mg capsule, 5 mg capsule, 10 mg capsule, 20 mg capsule)	1	
ORFADIN (2 MG CAPSULE, 4 MG/ML SUSPENSION, 5 MG CAPSULE, 10 MG CAPSULE, 20 MG CAPSULE)	1	
PALYNZIQ (2.5 MG/0.5 ML SYRINGE, 10 MG/0.5 ML SYRINGE, 20 MG/ML SYRINGE)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
PROLASTIN C (MG VIAL, MG/20 ML VL)	1	PA
PYRUKYND (20-5 MG PACK, 50-20 MG PACK)	1	PA, QL (14 PER 28 DAYS)
PYRUKYND (5 MG TABLET, 20 MG TABLET, 20 MG TAPER PACK, 50 MG TABLET, 50 MG TAPER PACK)	1	PA, QL (56 PER 28 DAYS)
PYRUKYND 5 MG TAPER PACK	1	PA, QL (7 PER 28 DAYS)
REVCOVI 2.4 MG/1.5 ML VIAL	1	
sapropterin dihydrochloride (100 mg powder pkt, 100 mg tablet, 500 mg powder pkt)	1	PA
sodium phenylbutyrate (500mg tb, powder)	1	PA
STRENSIQ (18 MG/0.45 ML VIAL, 28 MG/0.7 ML VIAL, 40 MG/ML VIAL, 80 MG/0.8 ML VIAL)	1	PA
VPRIV 400 UNITS VIAL	1	PA
VYNDAMAX 61 MG CAPSULE	1	PA, QL (30 PER 30 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
VYNDAQEL 20 MG CAPSULE	1	PA, QL (120 PER 30 DAYS)
WELIREG 40 MG TABLET	1	PA, QL (90 PER 30 DAYS)
yargesa 100 mg capsule	1	PA, QL (180 PER 30 DAYS)
zelvysia (100 mg packet, 500 mg packet)	1	PA
ZENPEP (DR 3,000 UNIT CAPSULE, DR 5,000 UNIT CAPSULE, DR 10,000 UNIT CAPSULE, DR 15,000 UNIT CAPSULE, DR 20,000 UNIT CAPSULE, DR 25,000 UNIT CAPSULE, DR 40,000 UNIT CAPSULE, DR 60,000 UNIT CAPSULE)	1	
ZOKINVY (50 MG CAPSULE, 75 MG CAPSULE)	1	PA, QL (120 PER 30 DAYS)
Genitourinary Agents		
Antispasmodics, Urinary		
darifenacin er (er 7.5 mg tablet, er 15 mg tablet)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DETROL (1 MG TABLET, 2 MG TABLET)	1	ST, QL (60 PER 30 DAYS)
DETROL LA (2 MG CAPSULE, 4 MG CAPSULE)	1	ST, QL (30 PER 30 DAYS)
fesoterodine fumarate er (er 4 mg tablet, er 8 mg tablet)	1	QL (30 PER 30 DAYS)
GEMTESA 75 MG TABLET	1	QL (30 PER 30 DAYS)
MYRBETRIQ (ER 25 MG TABLET, ER 50 MG TABLET)	1	QL (30 PER 30 DAYS)
MYRBETRIQ ER 8 MG/ML SUSP	1	QL (300 PER 28 DAYS)
oxybutynin chloride (5 mg/5 ml soln cup, 5 mg/5 ml solution, 5 mg/5 ml syrup)	1	QL (600 PER 30 DAYS)
oxybutynin chloride 5 mg tablet	1	QL (120 PER 30 DAYS)
oxybutynin chloride er cl 10 mg tablet	1	QL (90 PER 30 DAYS)
oxybutynin chloride er cl 15 mg tablet	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
oxybutynin chloride er cl 5 mg tablet	1	QL (30 PER 30 DAYS)
solifenacin succinate (5 mg tablet, 10 mg tablet)	1	QL (30 PER 30 DAYS)
tolterodine tartrate (1 mg tab, 2 mg tab)	1	QL (60 PER 30 DAYS)
tolterodine tartrate er (er 2 mg cap, er 4 mg cap)	1	QL (30 PER 30 DAYS)
TOVIAZ (ER 4 MG TABLET, ER 8 MG TABLET)	1	ST, QL (30 PER 30 DAYS)
trospium chloride 20 mg tablet	1	QL (60 PER 30 DAYS)
trospium chloride er 60 mg cap	1	QL (30 PER 30 DAYS)
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er 10 mg tablet	1	QL (30 PER 30 DAYS)
AVODART 0.5 MG SOFTGEL	1	QL (30 PER 30 DAYS)
dutasteride 0.5 mg capsule	1	QL (30 PER 30 DAYS)
dutasteride-tamsulosin 0.5	1	QL (30 PER 30 DAYS)
finasteride 5 mg tablet	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FLOMAX 0.4 MG CAPSULE	1	QL (60 PER 30 DAYS)
PROSCAR 5 MG TABLET	1	QL (30 PER 30 DAYS)
RAPAFLO (4 MG CAPSULE, 8 MG CAPSULE)	1	QL (30 PER 30 DAYS)
silodosin (4 mg capsule, 8 mg capsule)	1	QL (30 PER 30 DAYS)
tadalafil (2.5 mg tablet, 5 mg tablet)	1	PA, QL (30 PER 30 DAYS)
tamsulosin hcl 0.4 mg capsule	1	QL (60 PER 30 DAYS)
Contraceptives, Other		
LILETTA 52 MG SYSTEM	1	
NEXPLANON 68 MG IMPLANT	1	
SKYLA 13.5 MG SYSTEM	1	
Genitourinary Agents, Other		
bethanechol chloride (5 mg tablet, 10 mg tablet, 25 mg tablet, 50 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DEPEN 250 MG TITRATAB	1	
penicillamine 250 mg tablet	1	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)		
ACTHAR GEL 400 UNIT/5 ML VIAL	1	PA
ACTHAR SELFJECT (40 UNIT/0.5 ML, 80 UNIT/ML)	1	PA
CORTEF (5 MG TABLET, 10 MG TABLET, 20 MG TABLET)	1	
dexamethasone (0.5 mg tablet, 0.5 mg/5 ml elx, 0.5 mg/5 ml liq, 0.75 mg tablet, 1 mg tablet, 1.5 mg tablet, 2 mg tablet, 4 mg tablet, 6 day 1.5 mg tab, 6 mg tablet, 10 day 1.5 mg tb, 13 day 1.5 mg tb)	1	
fludrocortisone acetate 0.1 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
HEMADY 20 MG TABLET	1	
hidex 6 day 1.5 mg tablet	1	
hydrocortisone (5 mg tablet, 10 mg tablet, 20 mg tablet)	1	
MEDROL (4 MG DOSEPAK, 4 MG TABLET, 8 MG TABLET, 16 MG TABLET)	1	
methylprednisolone (4 mg dosepk, 4 mg tablet, 8 mg tablet, 16 mg tab, 32 mg tab)	1	
prednisolone (15 mg/5 ml soln, 15 mg/5 ml syrup, 15mg/5ml soln cup)	1	
prednisolone sodium phosphate (5 mg/5 ml soln, 15 mg/5 ml soln, 15mg/5ml soln cup, sod ph 25 mg/5 ml)	1	
prednisone (1 mg tablet, 2.5 mg tablet, 5 mg tab dose pack, 5 mg tablet, 5 mg/5 ml solution, 10 mg tab dose pack, 10 mg tablet, 20 mg tablet, 50 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
taperdex 6 day 1.5 mg tablet	1	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
CHORIONIC GONADOTROPIN 10,000 UNIT VL	1	PA
DDAVP (0.1 MG TABLET, 0.2 MG TABLET)	1	
desmopressin acetate (0.01% solution, 0.01% spray, ac 4 mcg/ml ampul, ac 4 mcg/ml vial, acetate 0.1 mg tb, acetate 0.2 mg tb, 10 mcg/0.1 ml spr, 40 mcg/10 ml vial)	1	
INCRELEX 40 MG/4 ML VIAL	1	
OMNITROPE (5 MG/1.5 ML CRTG, 5.8 MG VIAL, 10 MG/1.5 ML CRTG)	1	PA
PREGNYL 10,000 UNIT VIAL	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)		
Androgens		
ANDROGEL 1.62% PUMP	1	PA, QL (150 PER 30 DAYS)
danazol (50 mg capsule, 100 mg capsule, 200 mg capsule)	1	PA
DEPO-TESTOSTERONE (200 MG/ML, 200 MG/ML VL, 1,000MG/10ML)	1	PA
methyltestosterone 10 mg cap	1	PA
testosterone (1% (50 mg/5 g) pk, 12.5 mg/1.25 gram, 50 mg/5 gram gel, 50 mg/5 gram pkt)	1	PA, QL (300 PER 30 DAYS)
testosterone (1.62% (2.5 g) pkt, 1.62% gel pump)	1	PA, QL (150 PER 30 DAYS)
testosterone 1% (25mg/2.5g) pk	1	PA, QL (225 PER 30 DAYS)
testosterone 1.62%(1.25 g) pkt	1	PA, QL (37.5 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
testosterone 30 mg/1.5 ml pump	1	PA, QL (180 PER 30 DAYS)
testosterone cypionate (100 mg/ml, 200 mg/ml, 500 mg/2.5 ml, 500 mg/5 ml, 1,000 mg/10ml, 1,000 mg/5 ml, 2,000 mg/10ml, 6,000 mg/30ml)	1	PA
testosterone enanthate (testosteron 1,000 mg/5 ml, testosterone 200 mg/ml)	1	PA
Estrogens		
conjugated estrogens (estrogen 0.625mg, estrogens 0.3 mg, estrogens 0.45mg, estrogens 0.9 mg, estrogens 1.25mg)	1	
DEPO-ESTRADIOL 5 MG/ML VIAL	1	
DIVIGEL (0.25 MG GEL PACKET, 0.5 MG GEL PACKET, 0.75 MG GEL PACKET, 1 MG GEL PACKET, 1.25 MG GEL PACKET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
dotti (0.025 mg patch, 0.0375 mg patch, 0.05 mg patch, 0.075 mg patch, 0.1 mg patch)	1	
ESTRACE 0.01% CREAM	1	
estradiol (0.01% cream, 0.1% (0.25mg) gel pk, 0.1% (0.5mg) gel pkt, 0.1% (0.75mg) gel pk, 0.1% (1 mg) gel pkt, 0.1% (1.25mg) gel pk, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 10 mcg vaginal insrt)	1	
estradiol (once weekly) (0.025 mg patch(1/wk), 0.0375mg patch(1/wk), 0.05 mg patch (1/wk), 0.06 mg patch (1/wk), 0.075 mg patch(1/wk), 0.1 mg patch (1/wk))	1	
estradiol (twice weekly) (0.025 mg patch(2/wk), 0.0375mg patch(2/wk), 0.05 mg patch (2/wk), 0.075 mg patch(2/wk), 0.1 mg patch (2/wk))	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
estradiol valerate (50 mg/5 ml, 100 mg/5 ml, 200 mg/5 ml)	1	
ESTRING (2 MG VAGINAL RING, 7.5 MCG/DAY (2MG) RING)	1	
lyllana (0.025 mg patch, 0.0375 mg patch, 0.05 mg patch, 0.075 mg patch, 0.1 mg patch)	1	
MENEST (0.3 MG TABLET, 0.625 MG TABLET, 1.25 MG TABLET, 2.5 MG TABLET)	1	
PREMARIN (0.3 MG TABLET, 0.45 MG TABLET, 0.625 MG TABLET, 0.9 MG TABLET, 1.25 MG TABLET, VAGINAL CREAM-APPL)	1	
VAGIFEM 10 MCG VAGINAL TAB	1	
yuvafem (10 mcg insert, 10 mcg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
abigale 1 mg-0.5 mg tablet	1	
abigale lo 0.5-0.1 mg tablet	1	
afirmelle afirmelle-28 tablet	1	
altavera altavera-28 tablet	1	
alyacen (1-35 28 tablet, 7-7-7-28 tablet)	1	
amabelz (0.5 mg-0.1 mg tablet, 1 mg-0.5 mg tablet)	1	
amethia 0.15-0.03-0.01 mg tab	1	
amethyst 90-20 mcg tablet	1	
apri 28 day tablet	1	
aranelle 28 tablet	1	
ashlyna 0.15-0.03-0.01 mg tab	1	
aubra aubra-28 tablet	1	
aubra eq eq-28 tablet	1	
aurovela (1 mg-20 mcg tablet, 21 1.5-30 tablet)	1	
aurovela 24 fe 1 mg-20 mcg tab	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
aurovela fe (1-20 tablet, 1.5 mg-30 mcg tab)	1	
aviane aviane-28 tablet	1	
ayuna ayuna-28 tablet	1	
azurette 28 day tablet	1	
balziva 28 tablet	1	
blisovi 24 fe tablet	1	
blisovi fe (1-20 tablet, 1.5-30 tablet)	1	
briellyn tablet	1	
camrese 0.15-0.03-0.01 mg tab	1	
camrese lo tablet	1	
chateal chateal-28 tablet	1	
chateal eq eq-28 tablet	1	
COMBIPATCH (0.05-0.14 MG, 0.05-0.25 MG)	1	
cryselle cryselle-28 tablet	1	
cyred 28 day tablet	1	
cyred eq 28 day tablet	1	
dasetta (1-35-28 tablet, 7/7/7-28 tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
daysee 0.15-0.03-0.01 mg tab	1	
desogestr-eth estrad eth estra	1	
desogestrel-ethinyl estradiol desogestrel-ee 0.15-0.03 mg tb	1	
dolishale 90-20 mcg tablet	1	
drospirenone-eth estra-levomef (3-0.02-0.451, 3-0.03-0.451)	1	
drospirenone-ethinyl estradiol (3-0.02 mg tab, 3-0.03 mg tab)	1	
elinest elinest-28 tablet	1	
eluryng vaginal ring	1	
enilloring vaginal	1	
enpresse enpresse-28 tablet	1	
enskyce 28 tablet	1	
estarylla 0.25-0.035 mg tablet	1	
estradiol-norethindrone acetat (0.5-0.1 mg tb, 1-0.5 mg tab)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ethynodiol-ethinyl estradiol (1mg-35mcg, 1mg-50mcg)	1	
etonogestrel-ethinyl estradiol etonogestrel-ee vaginal ring	1	
falmina falmina-28 tablet	1	
feirza (1 mg-20 mcg tablet, 1.5 mg-30 mcg tablet)	1	
femynor 28 tablet	1	
fyavolv 1 mg-5 mcg tablet	1	
galbriela 0.8-0.025 mg chew tb	1	
gemmily 1 mg-20 mcg capsule	1	
hailey 21 1.5 mg-30 mcg tab	1	
hailey 24 fe 1 mg-20 mcg tab	1	
hailey fe (1-20 tablet, 1.5-30 tablet)	1	
haloette vaginal ring	1	
iclevia 0.15 mg-0.03 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
introvale 0.15-0.03 mg tablet	1	
isibloom 28 day tablet	1	
jaimiess 0.15-0.03-0.01 mg tab	1	
jasmiel 3 mg-0.02 mg tablet	1	
jinteli 1 mg-5 mcg tablet	1	
jolessa 0.15 mg-0.03 mg tablet	1	
juleber 28 day tablet	1	
junel (1 mg-20 mcg tablet, 1.5 mg-30 mcg tablet)	1	
junel fe (1 mg-20 mcg tablet, 1.5 mg-30 mcg tablet)	1	
junel fe 24 tablet	1	
kaitlib fe 0.8-0.025mg chew tb	1	
kalliga 28 day tablet	1	
kariva 28 day tablet	1	
kelnor 1-35 28 tablet	1	
kelnor 1-50 tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
kurvelo kurvelo-28 tablet	1	
larin (1.5 mg-30 mcg tablet, 21 1-20 tablet)	1	
larin 24 fe 1 mg-20 mcg tablet	1	
larin fe (1-20 tablet, 1.5-30 tablet)	1	
LAYOLIS FE CHEWABLE TABLET	1	
leena 28 tablet	1	
lessina lessina-28 tablet	1	
levonest levonest-28 tablet	1	
levonorg-eth estrad eth estrad (levono-e 0.15-0.03-0.01, levonor-e 0.1-0.02-0.01)	1	
levonorgestrel-eth estradiol (estra 0.09-0.02 mg, estrad 0.1-0.02 mg, estrad 0.15, estrad triphasic)	1	
levora-28 tablet	1	
lo-zumandimine 3 mg-0.02 mg tb	1	
LOESTRIN (21 1-20 TABLET, 21 1.5-30 TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LOESTRIN FE (1-20 TABLET, 1.5-30 TABLET)	1	
lojaimiess 0.1-0.02-0.01 tab	1	
loryna 3 mg-0.02 mg tablet	1	
low-ogestrel low-ogestrel-28 tablet	1	
luizza (1 mg-20 mcg tablet, 1.5 mg-30 mcg tablet)	1	
lutera lutera-28 tablet	1	
marlissa marlissa-28 tablet	1	
merzee 1 mg-20 mcg capsule	1	
microgestin (21 1-20 tablet, 21 1.5-30 tab)	1	
microgestin 24 fe 1 mg-20 mcg	1	
microgestin fe (1-20 tablet, 1.5-30 tab)	1	
mili 0.25-0.035 mg tablet	1	
mimvey 1-0.5 mg tablet	1	
mono-linyah 28 tablet	1	
necon 0.5-35-28 tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
nikki 3 mg-0.02 mg tablet	1	
norelgestromin-eth estradiol norelgestrom-ee 150-35 mcg/day	1	
norethin-eth estra-ferrous fum (noret-estr-fe 0.4-0.035(21)-75, norethin-estra-fe 0.8-0.025 mg)	1	
norethindron-ethinyl estradiol (norethin-ee 1.5-0.03 mg(21) tb, norethin-eth estrad 1 mg-5 mcg, norethind-eth estrad 1-0.02 mg)	1	
norethindrone-e.estradiol-iron (1 mg/20-30-35 mcg, 1-0.02(21)-75 tab, 1-0.02(24)-75 cap, 1.5-0.03mg(21)-75)	1	
norgestimate-ethinyl estradiol (norg-ee 0.18-0.215-0.25/0.025, norg-ee 0.18-0.215-0.25/0.035, norg-ethin estra 0.25-0.035 mg, norgestimate-ee 0.25-0.035 mg)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
nortrel (0.5-35-28 tablet, 1-35 21 tablet, 1-35 28 tablet, 7-7-7-28 tablet)	1	
NUVARING NUVAVAGINAL	1	
nylia (1-35 28 tablet, 7-7-7-28 tablet)	1	
nymyo 0.25-0.035 mg (28) tab	1	
ocella 3 mg-0.03 mg tablet	1	
philith 0.4-0.035 mg tablet	1	
pimtrea 28 day tablet	1	
portia portia-28 tablet	1	
PREMPHASE 0.625-5 MG TABLET	1	
PREMPRO (0.3 MG-1.5 MG TABLET, 0.45-1.5 MG TABLET, 0.625-2.5 MG TABLET, 0.625-5 MG TABLET)	1	
reclipsen 28 day tablet	1	
setlakin 0.15 mg-0.03 mg tab	1	
simliya 28 day tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
simpesse 0.15-0.03-0.01 mg tab	1	
sprintec 28 day tablet	1	
sronyx 0.10-0.02 mg tablet	1	
syeda 28 tablet	1	
tarina 24 fe 1 mg-20 mcg tab	1	
tarina fe 1-20 eq tablet	1	
tarina fe 1-20 tablet	1	
taysofy 1 mg-20 mcg capsule	1	
tilia fe 28 tablet	1	
tri-estarylla tablet	1	
tri-legest fe fe-28 day tablet	1	
tri-linyah tablet	1	
tri-lo-estarylla tablet	1	
tri-lo-marzia tablet	1	
tri-lo-mili tablet	1	
tri-lo-sprintec tablet	1	
tri-mili 28 tablet	1	
tri-nymyo 28 tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
tri-sprintec tablet	1	
tri-vylibra 28 tablet	1	
tri-vylibra lo tablet	1	
trivora-28 tablet	1	
turqoz turqoz-28 tablet	1	
TYBLUME 0.1-0.02 MG CHEW TAB	1	
tydemy 3-0.03-0.451 mg tablet	1	
valtya (1 mg-35 mcg tablet, 1 mg-50 mcg tablet)	1	
velivet 28 day tablet	1	
vestura 3 mg-0.02 mg tablet	1	
vienva vienva-28 tablet	1	
viorele 28 day tablet	1	
volnea 0.15-0.02-0.01 mg tab	1	
vyfemla 0.4 mg-0.035 mg tablet	1	
vylibra 28 tablet	1	
wera 0.5/0.035 mg 28 tablet	1	
wymzya fe 0.4-0.035 mg chew tb	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
xarah fe 1 mg/20-30-35 mcg tab	1	
xelria fe 0.4-0.035 mg chew tb	1	
xulane 150-35 mcg/day patch	1	
YASMIN 28 TABLET	1	
YAZ 28 TABLET	1	
zafemy 150-35 mcg/day patch	1	
zovia 1-35 tablet	1	
zumandimine 3 mg-0.03 mg tab	1	

Progestins

camila 0.35 mg tablet	1	
deblitane 0.35 mg tablet	1	
DEPO-PROVERA (150 MG/ML SYRINGE, 150 MG/ML VIAL)	1	
DEPO-SUBQ PROVERA 104 SYRINGE	1	
emzahh 0.35 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
errin 0.35 mg tablet	1	
gallifrey 5 mg tablet	1	
heather 0.35 mg tablet	1	
incassia 0.35 mg tablet	1	
jencycla 0.35 mg tablet	1	
lyleq 0.35 mg tablet	1	
lyza 0.35 mg tablet	1	
medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab, 150 mg/ml)	1	
megestrol acetate (20 mg tablet, 40 mg tablet, acet 40 mg/ml susp, 400 mg/10 ml cup, 400 mg/10ml susp cup, acet 400 mg/10 ml)	1	
meleya 0.35 mg tablet	1	
nora-be (nora-be tablet, nora-be tablet)	1	
norethindrone 0.35 mg tablet	1	
norethindrone ac (lupaneta) norethindrn 5 mg tb	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
norethindrone acetate 5 mg tablet	1	
orquidea 0.35 mg tablet	1	
progesterone (100 mg capsule, 200 mg capsule)	1	
PROVERA (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET)	1	
sharobel 0.35 mg tablet	1	
Selective Estrogen Receptor Modifying Agents		
DUAVEE 0.45-20 MG TABLET	1	
EVISTA 60 MG TABLET	1	
raloxifene hcl 60 mg tablet	1	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
CYTOMEL (5 MCG TABLET, 25 MCG TABLET, 50 MCG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
EUTHYROX (25 MCG TABLET, 50 MCG TABLET, 75 MCG TABLET, 88 MCG TABLET, 100 MCG TABLET, 112 MCG TABLET, 125 MCG TABLET, 137 MCG TABLET, 150 MCG TABLET, 175 MCG TABLET, 200 MCG TABLET)	1	
LEVO-T (25 MCG TABLET, 50 MCG TABLET, 75 MCG TABLET, 88 MCG TABLET, 100 MCG TABLET, 112 MCG TABLET, 125 MCG TABLET, 137 MCG TABLET, 150 MCG TABLET, 175 MCG TABLET, 200 MCG TABLET, 300 MCG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
levothyroxine sodium (25 mcg tablet, 50 mcg tablet, 75 mcg tablet, 88 mcg tablet, 100 mcg tablet, 112 mcg tablet, 125 mcg tablet, 137 mcg tablet, 150 mcg tablet, 175 mcg tablet, 200 mcg tablet, 300 mcg tablet)	1	
LEVOXYL (25 MCG TABLET, 50 MCG TABLET, 75 MCG TABLET, 88 MCG TABLET, 100 MCG TABLET, 112 MCG TABLET, 125 MCG TABLET, 137 MCG TABLET, 150 MCG TABLET, 175 MCG TABLET, 200 MCG TABLET)	1	
liomny (5 mcg tablet, 25 mcg tablet, 50 mcg tablet)	1	
liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SYNTHROID (25 MCG TABLET, 50 MCG TABLET, 75 MCG TABLET, 88 MCG TABLET, 100 MCG TABLET, 112 MCG TABLET, 125 MCG TABLET, 137 MCG TABLET, 150 MCG TABLET, 175 MCG TABLET, 200 MCG TABLET, 300 MCG TABLET)	1	
TIROSINT (13 MCG CAPSULE, 25 MCG CAPSULE, 37.5 MCG CAPSULE, 44 MCG CAPSULE, 50 MCG CAPSULE, 62.5 MCG CAPSULE, 75 MCG CAPSULE, 88 MCG CAPSULE, 100 MCG CAPSULE, 112 MCG CAPSULE, 125 MCG CAPSULE, 137 MCG CAPSULE, 150 MCG CAPSULE, 175 MCG CAPSULE, 200 MCG CAPSULE)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TIROSINT-SOL (13 MCG/ML SOLN, 25 MCG/ML SOLN, 37.5 MCG/ML SOLN, 44 MCG/ML SOLN, 50 MCG/ML SOLN, 62.5 MCG/ML SOLN, 75 MCG/ML SOLN, 88 MCG/ML SOLN, 100 MCG/ML SOLN, 112 MCG/ML SOLN, 125 MCG/ML SOLN, 137 MCG/ML SOLN, 150 MCG/ML SOLN, 175 MCG/ML SOLN, 200 MCG/ML SOLN)	1	
UNITHROID (25 MCG TABLET, 50 MCG TABLET, 75 MCG TABLET, 88 MCG TABLET, 100 MCG TABLET, 112 MCG TABLET, 125 MCG TABLET, 137 MCG TABLET, 150 MCG TABLET, 175 MCG TABLET, 200 MCG TABLET, 300 MCG TABLET)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Hormonal Agents, Suppressant (Adrenal or Pituitary)		
cabergoline 0.5 mg tablet	1	
ELIGARD (7.5 MG SYRINGE B, 7.5 MG SYRINGE KIT, 22.5 MG SYRINGE B, 22.5 MG SYRINGE KIT, 30 MG SYRINGE B, 30 MG SYRINGE KIT, 45 MG SYRINGE B, 45 MG SYRINGE KIT)	1	PA
FIRMAGON (2 X 120 MG KIT, 80 MG KIT, 120 MG VIAL)	1	
KORLYM 300 MG TABLET	1	PA, QL (120 PER 30 DAYS)
leuprolide acetate (14 mg/2.8 ml kt, 14 mg/2.8 ml vl)	1	PA
leuprolide depot 22.5 mg vial	1	PA
LUPRON DEPOT (DEPOT 3.75 MG KIT, DEPOT-4 MONTH KIT, DEPOT 7.5 MG KIT)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LUPRON DEPOT (LUPANETA) 3.75MG	1	PA
LUPRON DEPOT-PED (7.5 MG KIT, 11.25 MG 3MO, 45 MG 6MO KIT)	1	PA
mifepristone 300 mg tablet	1	PA, QL (120 PER 30 DAYS)
octreotide acetate (acet 0.05 mg/ml vl, acet 50 mcg/ml amp, acet 50 mcg/ml syr, acet 50 mcg/ml vial, acet 100 mcg/ml amp, acet 100 mcg/ml syr, acet 100 mcg/ml vl, acet 200 mcg/ml vl, acet 500 mcg/ml amp, acet 500 mcg/ml syr, acet 500 mcg/ml vl, 1,000 mcg/5 ml vial, 1,000 mcg/ml vial, 5,000 mcg/5 ml vial)	1	PA
octreotide acetate er (er 10 mg, er 20 mg, er 30 mg)	1	PA
SANDOSTATIN LAR DEPOT (10 MG KT, 10 MG VL, 20 MG KT, 20 MG VL, 30 MG KT, 30 MG VL)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SIGNIFOR (0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML)	1	PA
SIGNIFOR LAR (10 MG KIT, 10 MG VIAL, 20 MG KIT, 20 MG VIAL, 30 MG KIT, 30 MG VIAL, 40 MG KIT, 40 MG VIAL, 60 MG KIT, 60 MG VIAL)	1	PA
SOMATULINE DEPOT (60 MG/0.2 ML, 90 MG/0.3 ML, 120 MG/0.5 ML)	1	PA
SOMAVERT (10 MG VIAL, 15 MG VIAL, 20 MG VIAL, 25 MG VIAL, 30 MG VIAL)	1	PA
SYNAREL 2 MG/ML NASAL SPRAY	1	
TRELSTAR (3.75 MG VIAL, 11.25 MG VIAL, 22.5 MG VIAL)	1	PA
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
methimazole (5 mg tablet, 10 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
propylthiouracil 50 mg tablet	1	
Immunological Agents		
Angioedema Agents		
CINRYZE (500 UNIT VIAL, 500 UNIT VIAL-DILUENT)	1	PA, QL (20 PER 30 DAYS)
FIRAZYR 30 MG/3 ML SYRINGE	1	PA, QL (18 PER 30 DAYS)
HAEGARDA 2,000 UNIT VIAL	1	PA, QL (27 PER 28 DAYS)
HAEGARDA 3,000 UNIT VIAL	1	PA, QL (18 PER 28 DAYS)
icatibant 30 mg/3 ml syringe	1	PA, QL (18 PER 30 DAYS)
sajazir 30 mg/3 ml syringe	1	PA, QL (18 PER 30 DAYS)
Immunoglobulins		
ATGAM 50 MG/ML AMPUL	1	PA
GAMMAGARD LIQUID 10% VIAL	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
GAMMAGARD S-D (5 G (IGA<1) SOLN, 10 G (IGA<1) SOL)	1	PA
GAMMAPLEX (5 GRAM/100 ML VIAL, 5 GRAM/50 ML VIAL, 10 GRAM/100 ML VIAL, 10 GRAM/200 ML VIAL, 20 GRAM/200 ML VIAL, 20 GRAM/400 ML VIAL)	1	PA
GAMUNEX-C (1 GRAM/10 ML VIAL, 2.5 GRAM/25 ML VIAL, 5 GRAM/50 ML VIAL, 10 GRAM/100 ML VIAL, 20 GRAM/200 ML VIAL, 40 GRAM/400 ML VIAL)	1	PA
THYMOGLOBULIN 25 MG VIAL	1	PA
Immunological Agents, Other		
ACTEMRA 162 MG/0.9 ML SYRINGE	1	PA
ACTEMRA ACTPEN 162 MG/0.9 ML	1	PA
ARCALYST 220 MG VIAL	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
BENLYSTA (200 MG/ML AUTOINJECT, 200 MG/ML SYRINGE)	1	PA
COSENTYX (2 SYRINGES) 300 MG DOSE	1	PA
COSENTYX SENSOREADY (2 PENS) SNRDY 300MG DOSE-2PEN	1	PA
COSENTYX SENSOREADY PEN 150 MG	1	PA
COSENTYX SYRINGE (75 MG/0.5 ML SYRINGE, 150 MG/ML SYRINGE)	1	PA
COSENTYX UNOREADY PEN 300 MG	1	PA
DUPIXENT PEN (200 MG/1.14 ML PEN, 300 MG/2 ML PEN)	1	PA
DUPIXENT SYRINGE (100 MG/0.67 ML SYRING, 200 MG/1.14 ML SYRING, 300 MG/2 ML SYRINGE)	1	PA

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 15

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ENTYVIO PEN 108 MG/0.68 ML	1	PA
ORENCIA (50 MG/0.4 ML SYRINGE, 87.5 MG/0.7 ML SYRINGE, 125 MG/ML SYRINGE, 250 MG VIAL)	1	PA
ORENCIA CLICKJECT 125 MG/ML	1	PA
RIDAURA 3 MG CAPSULE	1	
RINVOQ (ER 15 MG TABLET, ER 30 MG TABLET, ER 45 MG TABLET)	1	PA
RINVOQ LQ 1 MG/ML SOLUTION	1	PA
SKYRIZI (150 MG/ML SYRINGE, 600 MG/10 ML VIAL)	1	PA
SKYRIZI ON-BODY (180 MG/1.2 ML, 360 MG/2.4 ML)	1	PA
SKYRIZI PEN 150 MG/ML	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
STELARA (45 MG/0.5 ML SYRINGE, 45 MG/0.5 ML VIAL, 90 MG/ML SYRINGE, 130 MG/26 ML VIAL)	1	PA
STEQEYMA (45 MG/0.5 ML SYRINGE, 90 MG/ML SYRINGE)	1	PA
TREMFYA (100 MG/ML SYRINGE, 200 MG/2 ML SYRINGE)	1	PA
TREMFYA ONE-PRESS 100 MG/ML	1	PA
TREMFYA PEN 200 MG/2 ML	1	PA
TREMFYA PEN INDUCTION (2 PEN) INDCT 200MG/2ML X2	1	PA
TYENNE 162 MG/0.9 ML SYRINGE	1	PA
TYENNE AUTOINJECTOR 162 MG/0.9 ML AUTOINJCT	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
XOLAIR (75 MG/0.5 ML AUTOINJECT, 75 MG/0.5 ML SYRINGE, 150 MG/1.2 ML POWDER VL, 150 MG/ML AUTOINJECTOR, 150 MG/ML SYRINGE, 300 MG/2 ML AUTOINJECT, 300 MG/2 ML SYRINGE)	1	PA
Immunostimulants		
ACTIMMUNE 100 MCG/0.5 ML VIAL	1	PA
BESREMI 500 MCG/ML SYRINGE	1	PA, QL (2 PER 28 DAYS)
PEGASYS (180 MCG/0.5 ML SYRINGE, 180 MCG/ML VIAL)	1	PA
Immunosuppressants		
ASTAGRAF XL (0.5 MG CAPSULE, 1 MG CAPSULE, 5 MG CAPSULE)	1	PA
AZASAN (75 MG TABLET, 100 MG TABLET)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
azathioprine (50 mg tablet, 75 mg tablet, 100 mg tablet)	1	PA
CELLCEPT (200 MG/ML ORAL SUSP, 250 MG CAPSULE, 500 MG TABLET)	1	PA
cyclosporine (25 mg capsule, 100 mg capsule)	1	PA
cyclosporine modified (25 mg, 50 mg, 100 mg, 100mg/ml)	1	PA
ENBREL (25 MG/0.5 ML SYRINGE, 25 MG/0.5 ML VIAL, 50 MG/ML SYRINGE)	1	PA
ENBREL MINI 50 MG/ML CARTRIDGE	1	PA
ENBREL SURECLICK 50 MG/ML	1	PA
ENVARSUS XR (0.75 MG TABLET, 1 MG TABLET, 4 MG TABLET)	1	PA
everolimus (0.25 mg tablet, 0.5 mg tablet, 0.75 mg tablet, 1 mg tablet)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
gengraf (25 mg capsule, 100 mg capsule, 100 mg/ml solution)	1	PA
HADLIMA 40 MG/0.8 ML SYRINGE	1	PA
HADLIMA PUSHTOUCH 40 MG/0.8 ML	1	PA
HADLIMA(CF) 40 MG/0.4 ML SYRNG	1	PA
HADLIMA(CF) PUSHTOUCH 40MG/0.4	1	PA
HUMIRA 40 MG/0.8 ML SYRINGE	1	PA
HUMIRA PEN 40 MG/0.8 ML	1	PA
HUMIRA(CF) (10 MG/0.1 ML SYRING, CDV 10 MG/0.1ML SYR, 20 MG/0.2 ML SYRING, CDV 20 MG/0.2ML SYR, 40 MG/0.4 ML SYRING, CDV 40 MG/0.4ML SYR)	1	PA
HUMIRA(CF) PEN (CDV PEN 40 MG/0.4ML, CDV PEN 80 MG/0.8ML, PEN 40 MG/0.4 ML, PEN 80 MG/0.8 ML)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
HUMIRA(CF) PEN CROHN'S-UC-HS CRHN-UC-HS 80MG	1	PA
HUMIRA(CF) PEN PEDIATRIC UC 80 MG	1	PA
HUMIRA(CF) PEN PSOR-UV-ADOL HS PS-UV-AHS 80-40	1	PA
IMURAN 50 MG TABLET	1	PA
leflunomide (10 mg tablet, 20 mg tablet)	1	
methotrexate (1 gm vial, 2.5 mg tablet, 50 mg/2 ml vial, 250 mg/10 ml vial)	1	
methotrexate sodium (1 gram/40 ml vial, 25 mg/ml vial, 50 mg/2 ml vial, 250 mg/10 ml vial)	1	
mycophenolate mofetil (200 mg/ml susp, 250 mg capsule, 500 mg tablet)	1	PA
mycophenolic acid (dr 180 mg, dr 360 mg)	1	PA
MYFORTIC 180 MG TABLET	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
MYHIBBIN 200 MG/ML SUSPENSION	1	PA
NEORAL (25 MG GELATIN CAPSULE, 100 MG GELATIN CAPSULE, 100 MG/ML SOLUTION)	1	PA
PROGRAF (0.2 MG GRANULE PACKET, 0.5 MG CAPSULE, 1 MG CAPSULE, 1 MG GRANULE PACKET, 5 MG CAPSULE)	1	PA
RAPAMUNE 1 MG/ML ORAL SOLN	1	PA
RENFLEXIS 100 MG VIAL	1	PA
REZUROCK 200 MG TABLET	1	PA, QL (30 PER 30 DAYS)
SANDIMMUNE (25 MG CAPSULE, 100 MG CAPSULE, 100 MG/ML SOLN)	1	PA
SIMLANDI(CF) (20 MG/0.2 ML, 40 MG/0.4 ML, 80 MG/0.8 ML)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SIMLANDI(CF) AUTOINJECTOR (40 MG/0.4 ML, 80 MG/0.8 ML)	1	PA
sirolimus (0.5 mg tablet, 1 mg tablet, 1 mg/ml solution, 2 mg tablet)	1	PA
tacrolimus (0.5 mg capsule (ir), 1 mg capsule (ir), 5 mg capsule (ir))	1	PA
XATMEP 2.5 MG/ML ORAL SOLUTION	1	PA
ZORTRESS (0.25 MG TABLET, 0.5 MG TABLET, 0.75 MG TABLET, 1 MG TABLET)	1	PA
Vaccines		
ABRYSVO (ACT-O-VIAL, VIAL, VIAL WITH DILUENT SYRG)	1	QL (1 PER 365 OVER TIME)
ACTHIB (VIAL, WITH DILUENT)	1	
ADACEL TDAP (SYRINGE, VIAL)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
AREXVY VIAL KIT	1	QL (1 PER 999 OVER TIME)
BCG VACCINE (TICE STRAIN) VIAL	1	
BEXSERO PREFILLED SYRINGE	1	
BOOSTRIX TDAP (SYRINGE, VIAL)	1	
DAPTACEL DTAP VACCINE	1	
DENGVAXIA (VIAL, VIAL WITH DILUENT)	1	
DIPHTHERIA-TETANUS TOXOIDS-PED	1	
ENGERIX-B ADULT (20 MCG/ML SYRN, 20 MCG/ML VIAL)	1	PA
ENGERIX-B PEDIATRIC-ADOLESCENT 10 MCG/0.5 SYRN	1	PA
ERVEBO (NATIONAL STOCKPILE) 1 ML VIAL (STOCKPILE)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
GARDASIL 9 (9 SYRINGE, 9 VIAL)	1	
HAVRIX (720 UNIT/0.5 ML SYRINGE, 720 UNITS/0.5 ML VIAL, 1,440 UNIT/ML SYRINGE)	1	
HEPLISAV-B 20 MCG/0.5 ML SYRNG	1	PA
HIBERIX (VACCINE VIAL, VIAL AND DILUENT SYRG, VIAL WITH DILUENT VIAL)	1	
IMOVAX RABIES VACCINE VIAL	1	PA
INFANRIX DTAP SYRINGE	1	
IPOL VIAL	1	
IXIARO 6 UNIT(6 MCG)/0.5ML SYR	1	
JYNNEOS (NATIONAL STOCKPILE) 0.5 ML VIAL(STOCKPILE)	1	PA
JYNNEOS 0.5 ML VIAL	1	PA
KINRIX TIP-LOK SYRINGE	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
M-M-R II VACCINE VIAL	1	
MENACTRA VIAL	1	
MENQUADFI VIAL	1	
MENVEO A-C-Y-W-135-DIP (1 VIAL-A-C-Y-W-135-DIP, A-C-Y-W KIT (2 VIALS))	1	
MRESVIA 50 MCG/0.5 ML SYRINGE	1	QL (0.5 PER 999 OVER TIME)
PEDIARIX 0.5 ML SYRINGE	1	
PEDVAXHIB VACCINE VIAL	1	
PENBRAYA KIT	1	
PENMENVY MEN A-B-C-W-Y KIT	1	
PENTACEL VIAL KIT	1	
PREHEVBRIO 10 MCG/ML VIAL	1	PA
PRIORIX VIAL	1	
PROQUAD VIAL	1	
QUADRACEL DTAP-IPV (SYRINGE, VIAL)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
RABAVERT (VACC W-DILUENT, VACCINE VIAL)	1	PA
RECOMBIVAX HB (5 MCG/0.5 ML SYR, 5 MCG/0.5 ML VL, 10 MCG/ML SYR, 10 MCG/ML VIAL, 40 MCG/ML VIAL)	1	PA
ROTARIX (ORAL SYRINGE, SUSPENSION)	1	
ROTATEQ VACCINE	1	
SHINGRIX VIAL KIT	1	QL (2 PER 999 OVER TIME)
STAMARIL VIAL	1	
TDVAX VIAL	1	PA
TENIVAC (SYRINGE, VIAL)	1	PA
TICOVAC (1.2 MCG/0.25 ML SYRING, 2.4 MCG/0.5 ML SYRINGE)	1	
TRUMENBA 120 MCG/0.5 ML VACCIN	1	
TWINRIX VACCINE SYRINGE	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TYPHIM VI (25 MCG/0.5 ML AL, 25 MCG/0.5 ML SYRNG)	1	
VAQTA (25 UNITS/0.5 ML SYRINGE, 25 UNITS/0.5 ML VIAL, 50 UNITS/ML SYRINGE, 50 UNITS/ML VIAL)	1	
VARIVAX VACCINE (VIAL, WITH DILUENT)	1	
VAXCHORA VACCINE	1	
VIMKUNYA 40 MCG/0.8 ML SYRINGE	1	
VIVOTIF EC CAPSULE	1	
YF-VAX (1 VIAL, 5 VIAL)	1	
Inflammatory Bowel Disease Agents		
Aminosalicylates		
APRISO ER 0.375 GRAM CAPSULE	1	QL (120 PER 30 DAYS)
AZULFIDINE (500 MG TABLET, ENTAB 500 MG)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
balsalazide disodium 750 mg cp	1	
CANASA 1,000 MG SUPPOSITORY	1	
COLAZAL 750 MG CAPSULE	1	
DELZICOL DR 400 MG CAPSULE	1	QL (180 PER 30 DAYS)
DIPENTUM 250 MG CAPSULE	1	
LIALDA DR 1.2 GM TABLET	1	QL (120 PER 30 DAYS)
mesalamine (4 gm/60 ml enema, 4 gm/60 ml kit, 1,000 mg supp)	1	
mesalamine 800 mg dr tablet	1	QL (180 PER 30 DAYS)
mesalamine dr 1.2 gm tablet	1	QL (120 PER 30 DAYS)
mesalamine dr 400 mg capsule	1	QL (180 PER 30 DAYS)
mesalamine er 0.375 gram cap	1	QL (120 PER 30 DAYS)
mesalamine er 500 mg capsule	1	QL (240 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
PENTASA 250 MG CAPSULE	1	QL (480 PER 30 DAYS)
PENTASA 500 MG CAPSULE	1	QL (240 PER 30 DAYS)
ROWASA 4 GM/60 ML ENEMA KIT	1	
SFROWASA 4 GM/60 ML ENEMA	1	
sulfasalazine 500 mg tablet	1	
sulfasalazine dr 500 mg tab	1	
Glucocorticoids		
budesonide dr 3 mg capsule	1	PA, QL (90 PER 30 DAYS)
budesonide ec 3 mg capsule	1	PA, QL (90 PER 30 DAYS)
budesonide er 9 mg tablet	1	PA, QL (30 PER 30 DAYS)
hydrocortisone 100 mg/60 ml	1	
hydrocortisone 2.5% cream	1	QL (454 PER 30 DAYS)
procto-med hc 2.5% cream	1	QL (454 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
proctosol-hc 2.5% cream	1	QL (454 PER 30 DAYS)
proctozone-hc 2.5% cream	1	QL (454 PER 30 DAYS)
Metabolic Bone Disease Agents		
alendronate sodium (35 mg tab, 70 mg tab)	1	QL (4 PER 28 DAYS)
alendronate sodium 10 mg tab	1	QL (120 PER 30 DAYS)
ATELVIA DR 35 MG TABLET	1	QL (4 PER 28 DAYS)
BONSITY 560 MCG/2.24 ML PEN	1	PA
calcitonin-salmon 200 unit spr	1	
calcitriol (0.25 mcg capsule, 0.5 mcg capsule, 1 mcg/ml solution)	1	
cinacalcet hcl (30 mg tablet, 60 mg tablet, 90 mg tablet)	1	PA
FORTEO 560 MCG/2.24 ML PEN INJ	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FOSAMAX 70 MG TABLET	1	QL (4 PER 28 DAYS)
ibandronate sodium 150 mg tab	1	QL (1 PER 28 DAYS)
JUBBONTI 60 MG/ML SYRINGE	1	PA
paricalcitol (1 mcg capsule, 2 mcg capsule, 4 mcg capsule)	1	
PROLIA 60 MG/ML SYRINGE	1	PA
risedronate sodium (5 mg tablet, 30 mg tab)	1	QL (30 PER 30 DAYS)
risedronate sodium 150 mg tab	1	QL (1 PER 28 DAYS)
risedronate sodium 35 mg tab	1	QL (4 PER 28 DAYS)
risedronate sodium dr 35 mg tab	1	QL (4 PER 28 DAYS)
ROCALTROL (0.25 MCG CAPSULE, 0.5 MCG CAPSULE, 1 MCG/ML ORAL SOLN)	1	
SENSIPAR (30 MG TABLET, 60 MG TABLET, 90 MG TABLET)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
teriparatide (teriparatide 560mcg/2.24ml pen, teriparatide 560mcg/2.24ml pen)	1	PA
TYMLOS 80 MCG DOSE PEN INJECTR	1	PA
WYOST 120 MG/1.7 ML VIAL	1	PA
XGEVA 120 MG/1.7 ML VIAL	1	PA
Ophthalmic Agents		
Ophthalmic Agents, Other		
atropine sulfate (1% drop, 1% drops)	1	
brimonidine tartrate-timolol brimonidine-timolol 0.2%-0.5%	1	
COMBIGAN 0.2%-0.5% EYE DROPS	1	
COSOPT EYE DROPS	1	
CYSTADROPS CYSTA0.37% EYE	1	PA
CYSTARAN 0.44% EYE DROPS	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
dorzolamide-timolol eye drops	1	
MAXITROL EYE OINTMENT	1	
MIEBO 100% EYE DROP	1	PA, QL (12 PER 30 DAYS)
neo-polycin hc eye ointment	1	
neomycin-bacitracin-poly-hc neo-bacit-poly-hc eye ointment	1	
neomycin-polymyxin-dexameth (neomyc-polym-dexamet ointm, neomyc-polym-dexameth drop)	1	
RESTASIS 0.05% EYE EMULSION	1	QL (60 PER 30 DAYS)
RESTASIS MULTIDOSE 0.05% EYE	1	QL (11 PER 30 DAYS)
sulfacetamide-prednisolone sulf-pred 10-0.23% eye drops	1	
TOBRADEX (DROPS, OINTMENT)	1	
tobramycin-dexamethasone ophth susp	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
XDEMVY 0.25% DROP	1	PA
XIIDRA 5% EYE DROPS	1	PA, QL (60 PER 30 DAYS)
Ophthalmic Anti-Infectives		
bacitracin 500 unit/gm ophth	1	
bacitracin-polymyxin eye oint	1	
BESIVANCE 0.6% SUSP	1	
ciprofloxacin hcl 0.3% eye drop	1	
erythromycin 0.5% eye ointment	1	
gatifloxacin 0.5% eye drops	1	
gentamicin sulfate 0.3% eye drop	1	
moxifloxacin (0.5% drops, 0.5% drp-visc)	1	
NATACYN 5% EYE DROPS	1	
neo-polycin eye ointment	1	
neomycin-bacitracin-polymyxin neomyc-bacit-polymix eye oint	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
neomycin-polymyxin-gramicidin neomyc-polym-gramicid eye drop	1	
OCUFLOX 0.3% EYE DROPS	1	
ofloxacin 0.3% eye drops	1	
polycin eye ointment	1	
polymyxin b sul-trimethoprim b-tmp eye drops	1	
sulfacetamide sodium (10% drops, 10% ointment)	1	
tobramycin 0.3% eye drop	1	
trifluridine 1% eye drops	1	
VIGAMOX 0.5% EYE DROPS	1	
Ophthalmic Anti-allergy Agents		
azelastine hcl 0.05% drops	1	
cromolyn sodium 4% eye drops	1	
epinastine hcl 0.05% eye drops	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Ophthalmic Anti-inflammatories		
ACULAR 0.5% EYE DROPS	1	
ACULAR LS 0.4% OPHTH SOL	1	
bromfenac sodium (0.07%, 0.09%)	1	
dexamethasone sodium phosphate 0.1% eye drop	1	
diclofenac sodium 0.1% eye drops	1	
difluprednate 0.05% eye drop	1	
DUREZOL 0.05% EYE DROPS	1	
EYSUVIS 0.25% EYE DROPS	1	PA
fluorometholone 0.1% eye drop	1	
flurbiprofen sodium 0.03% eye drop	1	
FML LIQUIFILM 0.1% EYE DROP	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ILEVRO 0.3% OPHTH DROPS	1	
INVELTYS 1% EYE DROP	1	
ketorolac tromethamine (0.4%, 0.5%)	1	
PRED FORTE 1% EYE DROPS	1	
PRED MILD 0.12% EYE DROPS	1	
prednisolone acetate 1% eye drop	1	
prednisolone sodium phosphate 1% eye drop	1	
PROLENSA 0.07% EYE DROPS	1	
Ophthalmic Beta-Adrenergic Blocking Agents		
betaxolol hcl 0.5% eye drop	1	
BETOPTIC S (0.25% DROP, 0.25% DROP)	1	
carteolol hcl 1% eye drops	1	
ISTALOL 0.5% EYE DROPS	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
levobunolol hcl 0.5% eye drops	1	
timolol maleate (0.25% gel-solution, maleate 0.25% eye drop, 0.5% eye drop, 0.5% gel-solution, 0.5% gfs gel-solution, maleate 0.5% eye drop, maleate 0.5% eye drops)	1	
TIMOPTIC (0.25% DROP, 0.5% DROP)	1	
TIMOPTIC OCUDOSE (0.25% DROP, 0.5% DROP)	1	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
ALPHAGAN P (ALHAGAN 0.1% DROS, ALHAGAN 0.15% EYE DROS)	1	
AZOPT 1% EYE DROPS	1	
brimonidine tartrate (tartrate 0.1% drop, tartrate 0.15% drp, 0.2% eye drop)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
brinzolamide 1% eye drops	1	
dorzolamide hcl 2% eye drops	1	
pilocarpine hcl (1% drops, 2% drops, 4% drops)	1	
RHOPRESSA 0.02% OPHTH SOLUTION	1	QL (15 PER 75 OVER TIME)
ROCKLATAN 0.02%-0.005% EYE DRP	1	QL (15 PER 75 OVER TIME)
SIMBRINZA (DROP, DROPS)	1	
Ophthalmic Prostaglandin and Prostamide Analogs		
bimatoprost 0.03% eye drops	1	QL (15 PER 75 OVER TIME)
latanoprost 0.005% eye drops	1	QL (15 PER 75 OVER TIME)
LUMIGAN 0.01% EYE DROPS	1	QL (15 PER 75 OVER TIME)
TRAVATAN Z 0.004% EYE DROP	1	QL (15 PER 75 OVER TIME)
travoprost 0.004% eye drop	1	QL (15 PER 75 OVER TIME)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Otic Agents		
acetic acid 2% ear solution	1	
CIPRODEX OTIC SUSPENSION	1	
ciprofloxacin-dexamethasone ciproflox-dexameth otic susp	1	
flac otic oil 0.01% ear drop	1	
fluocinolone acetonide oil 0.01% ear drp	1	
hydrocortisone-acetic acid (hydrocortison-acetic acid soln, hydrocortisone-acetic ear drop)	1	
neomycin-polymyxin-hc ear susp	1	
neomycin-polymyxin-hydrocort neomycin-polymyxin-hc ear soln	1	
ofloxacin 0.3% ear drops	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Respiratory Tract/ Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA (50 MCG, 100 MCG, 200 MCG)	1	QL (30 PER 30 DAYS)
ASMANEX (TWISTHALER 110 MCG #30, TWISTHALER 220 MCG #14, TWISTHALER 220 MCG #30, TWISTHALER 220 MCG #60, TWISTHALR 220 MCG #120)	1	QL (1 PER 30 DAYS)
ASMANEX HFA (HFA 50 MCG INHALER, HFA 100 MCG INHALER, HFA 200 MCG INHALER)	1	QL (13 PER 30 DAYS)
budesonide (0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml inh)	1	PA
flunisolide 0.025% spray	1	QL (75 PER 30 DAYS)
fluticasone propionate 50 mcg spray	1	QL (16 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
fluticasone propionate hfa 110 mcg	1	QL (12 PER 30 DAYS)
fluticasone propionate hfa 220 mcg	1	QL (24 PER 30 DAYS)
fluticasone propionate hfa 44 mcg	1	QL (10.6 PER 30 DAYS)
mometasone furoate 50 mcg spry	1	QL (34 PER 30 DAYS)
QVAR REDIHALER 40 MCG	1	QL (10.6 PER 30 DAYS)
QVAR REDIHALER 80 MCG	1	QL (21.2 PER 30 DAYS)
XHANCE 93 MCG NASAL SPRAY	1	QL (32 PER 30 DAYS)
Antihistamines		
azelastine hcl 0.1% (137 mcg) spry	1	QL (60 PER 30 DAYS)
cetirizine hcl (1 mg/ml soln, 1 mg/ml syrup)	1	
clemastine fumarate 2.68 mg tablet	1	PA
cyproheptadine hcl (2 mg/5 ml soln, 2 mg/5 ml syrup, 4 mg tablet, 4 mg/10 ml syrp)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
desloratadine 5 mg tablet	1	
levocetirizine dihydrochloride 5 mg tablet	1	
olopatadine hcl 665 mcg nasal spry	1	QL (30.5 PER 30 DAYS)
Antileukotrienes		
ACCOLATE (10 MG TABLET, 20 MG TABLET)	1	
montelukast sodium (4 mg granules, 4 mg tab chew, 5 mg tab chew, 10 mg tablet)	1	
SINGULAIR (4 MG GRANULES, 4 MG TABLET CHEW, 5 MG TABLET CHEW, 10 MG TABLET)	1	
zafirlukast (10 mg tablet, 20 mg tablet)	1	
Bronchodilators, Anticholinergic		
ATROVENT HFA 17 MCG INHALER	1	QL (25.8 PER 30 DAYS)
INCRUSE ELLIPTA 62.5 MCG INH	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ipratropium bromide 0.02% soln	1	PA
ipratropium bromide 0.03% spray	1	QL (60 PER 30 DAYS)
ipratropium bromide 0.06% spray	1	QL (45 PER 30 DAYS)
SPIRIVA HANDIHALER 18 MCG CAP	1	ST, QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT (1.25 MCG, 2.5 MCG)	1	QL (4 PER 30 DAYS)
tiotropium bromide 18 mcg cap-inhaler	1	QL (30 PER 30 DAYS)
Bronchodilators, Sympathomimetic		
albuterol hfa 90 mcg inhaler (generic proair hfa)	1	QL (17 PER 30 DAYS)
albuterol hfa 90 mcg inhaler (generic proventil hfa)	1	QL (13.4 PER 30 DAYS)
albuterol sulfate (2 mg/5 ml syrup cup, sulf 2 mg/5 ml syrup, sulfate 2 mg tab, sulfate 4 mg tab, 8 mg/20 ml syrup cup)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
albuterol sulfate (sul 0.63 mg/3 ml sol, sul 1.25 mg/3 ml sol, 2.5 mg/0.5 ml sol, sul 2.5 mg/3 ml soln, 5 mg/ml solution, 15 mg/3 ml solution, 20 mg/4 ml solution, 25 mg/5 ml solution, 75 mg/15 ml soln, 100 mg/20 ml soln)	1	PA
epinephrine (0.15 mg auto-injct, 0.3 mg auto-inject)	1	
levalbuterol tartrate hfa 45mcg inh	1	QL (30 PER 30 DAYS)
PROAIR RESPICLICK 90 MCG INHLR	1	QL (2 PER 30 DAYS)
SEREVENT DISKUS 50 MCG	1	QL (60 PER 30 DAYS)
terbutaline sulfate (2.5 mg tab, 5 mg tab)	1	
VENTOLIN HFA 90 MCG INHALER	1	QL (36 PER 30 DAYS)
XOPENEX HFA 45 MCG INHALER	1	QL (30 PER 30 DAYS)
Cystic Fibrosis Agents		
CAYSTON 75 MG INHAL SOLUTION	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
KALYDECO (5.8 MG GRANULES PKT, 13.4 MG GRANULES PKT, 25 MG GRANULES PACKET, 50 MG GRANULES PACKET, 75 MG GRANULES PACKET, 150 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
ORKAMBI (100 MG TABLET, 200 MG TABLET)	1	PA, QL (120 PER 30 DAYS)
ORKAMBI (75-94 MG GRANULE PKT, 100-125 MG GRANULE PKT, 150-188 MG GRANULE PKT)	1	PA, QL (60 PER 30 DAYS)
PULMOZYME 1 MG/ML AMPUL	1	PA
tobramycin 300 mg/5 ml ampule	1	PA
TRIKAFTA (50-25-37.5 MG/75 MG, 100-50-75 MG/150 MG)	1	PA, QL (90 PER 30 DAYS)
TRIKAFTA (80-40-60MG/59.5MG PKT, 100-50-75 MG/75MG PKT)	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Mast Cell Stabilizers		
cromolyn sodium 20 mg/2 ml neb soln	1	PA
Phosphodiesterase Inhibitors, Airways Disease		
DALIRESP (250 MCG TABLET, 500 MCG TABLET)	1	PA, QL (30 PER 30 DAYS)
roflumilast (250 mcg tablet, 500 mcg tablet)	1	PA, QL (30 PER 30 DAYS)
THEO-24 (ER 100 MG CAPSULE, ER 200 MG CAPSULE, ER 300 MG CAPSULE, ER 400 MG CAPSULE)	1	
theophylline anhydrous (er 300 mg tab, er 450 mg tab)	1	
theophylline er (er 300 mg tablet, er 400 mg tablet, er 450 mg tablet, er 600 mg tablet)	1	
Pulmonary Antihypertensives		
ADCIRCA 20 MG TABLET	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ADEMPAS (0.5 MG TABLET, 1 MG TABLET, 1.5 MG TABLET, 2 MG TABLET, 2.5 MG TABLET)	1	PA, QL (90 PER 30 DAYS)
ambrisentan (5 mg tablet, 10 mg tablet)	1	PA, QL (30 PER 30 DAYS)
bosentan (62.5 mg tablet, 125 mg tablet)	1	PA, QL (60 PER 30 DAYS)
bosentan 32 mg tablet for susp	1	PA, QL (120 PER 30 DAYS)
LETAIRIS (5 MG TABLET, 10 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
OPSUMIT 10 MG TABLET	1	PA, QL (30 PER 30 DAYS)
sildenafil citrate 20 mg tablet	1	PA, QL (90 PER 30 DAYS)
tadalafil 20 mg tablet	1	PA, QL (60 PER 30 DAYS)
TRACLEER (62.5 MG TABLET, 125 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
TRACLEER 32 MG TABLET FOR SUSP	1	PA, QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
VENTAVIS (10 MCG/1 ML SOLUTION, 20 MCG/1 ML SOLUTION)	1	PA, QL (270 PER 30 DAYS)
Pulmonary Fibrosis Agents		
ESBRIET (267 MG CAPSULE, 267 MG TABLET)	1	PA, QL (270 PER 30 DAYS)
ESBRIET 801 MG TABLET	1	PA, QL (90 PER 30 DAYS)
OFEV (100 MG CAPSULE, 150 MG CAPSULE)	1	PA, QL (60 PER 30 DAYS)
pirfenidone (267 mg capsule, 267 mg tablet)	1	PA, QL (270 PER 30 DAYS)
pirfenidone 801 mg tablet	1	PA, QL (90 PER 30 DAYS)
Respiratory Tract Agents, Other		
acetylcysteine (10% vial, 20% vial)	1	PA
ADVAIR HFA (HFA 45-21 MCG INHALER, HFA 115-21 MCG INHALER, HFA 230-21 MCG INHALER)	1	QL (12 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ANORO ELLIPTA 62.5-25 MCG INH	1	QL (60 PER 30 DAYS)
BREO ELLIPTA (50-25 MCG INHALER, 100-25 MCG INHALR, 200-25 MCG INHALR)	1	QL (60 PER 30 DAYS)
breyna (80-4.5 mcg, 160-4.5 mcg)	1	QL (30.9 PER 30 DAYS)
BREZTRI AEROSPHERE INHALER	1	QL (10.7 PER 30 DAYS)
budesonide-formoterol fumarate (80, 160)	1	QL (30.9 PER 30 DAYS)
COMBIVENT RESPIMAT 20-100 MCG	1	QL (8 PER 30 DAYS)
DULERA (50 MCG INHALER, 100 MCG INHALER, 200 MCG INHALER)	1	QL (39 PER 30 DAYS)
FASENRA (10 MG/0.5 ML SYRINGE, 30 MG/ML SYRINGE)	1	PA
FASENRA PEN 30 MG/ML	1	PA
fluticasone-salmeterol (100, 250, 500)	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
fluticasone-salmeterol (55, 113, 232)	1	QL (1 PER 30 DAYS)
ipratropium-albuterol iprat-albut 0.5-3(2.5) mg/3 ml	1	PA
ORALAIR (300 IR ADULT SAMPLE KT, 300 IR STARTER PACK, 300 IR SUBLINGUAL TAB)	1	PA, QL (30 PER 30 DAYS)
STIOLTO RESPIMAT (INHAL SPRAY, INHALER (10), INHALER (60))	1	QL (4 PER 30 DAYS)
TRELEGY ELLIPTA (100-62.5-25, 200-62.5-25)	1	QL (60 PER 30 DAYS)
wixela inhub (100, 250, 500)	1	QL (60 PER 30 DAYS)
Skeletal Muscle Relaxants		
carisoprodol 350 mg tablet	1	
chlorzoxazone 500 mg tablet	1	
cyclobenzaprine hcl (5 mg tablet, 10 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
methocarbamol (500 mg tablet, 750 mg tablet)	1	
vanadom 350 mg tablet	1	
Sleep Disorder Agents		
Sleep Promoting Agents		
BELSOMRA (5 MG TABLET, 10 MG TABLET, 15 MG TABLET, 20 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
DAYVIGO (5 MG TABLET, 10 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
doxepin hcl (3 mg tablet, 6 mg tablet)	1	QL (30 PER 30 DAYS)
eszopiclone (1 mg tablet, 2 mg tablet, 3 mg tablet)	1	QL (30 PER 30 DAYS)
HETLIOZ 20 MG CAPSULE	1	PA, QL (30 PER 30 DAYS)
ramelteon 8 mg tablet	1	QL (30 PER 30 DAYS)
ROZEREM 8 MG TABLET	1	QL (30 PER 30 DAYS)
SILENOR (3 MG TABLET, 6 MG TABLET)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
tasimelteon 20 mg capsule	1	PA, QL (30 PER 30 DAYS)
temazepam (15 mg capsule, 30 mg capsule)	1	QL (30 PER 30 DAYS)
zaleplon 10 mg capsule	1	QL (60 PER 30 DAYS)
zaleplon 5 mg capsule	1	QL (30 PER 30 DAYS)
zolpidem tartrate (5 mg tablet, 10 mg tablet)	1	QL (30 PER 30 DAYS)
zolpidem tartrate er (er 6.25 mg tab, er 12.5 mg tab)	1	QL (30 PER 30 DAYS)
Wakefulness Promoting Agents		
armodafinil (50 mg tablet, 150 mg tablet, 200 mg tablet, 250 mg tablet)	1	PA, QL (30 PER 30 DAYS)
LUMRYZ (ER 4.5 GM PACKET, ER 6 GM PACKET, ER 7.5 GM PACKET, ER 9 GM PACKET)	1	PA, QL (30 PER 30 DAYS)
LUMRYZ STARTER PACK 4.5-6-7.5 GM PK	1	PA, QL (28 PER 28 DAYS)
modafinil (100 mg tablet, 200 mg tablet)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
NUVIGIL (50 MG TABLET, 150 MG TABLET, 200 MG TABLET, 250 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
sodium oxybate 0.5 g/ml soln	1	PA, QL (540 PER 30 DAYS)

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Aviso de no discriminación

Los planes Hamaspik Medicare Advantage cumplen con las leyes de derechos civiles federales aplicables y no discriminan sobre la base de raza, color, nacionalidad, edad, discapacidad o sexo. Hamaspik no excluye a las personas ni las trata de modo diferente a causa de su raza, color, nacionalidad, edad, discapacidad o sexo.

Los planes Hamaspik Medicare Advantage:

- Proporcionan asistencias y servicios gratuitos a las personas con discapacidades para permitirles comunicarse de manera eficaz con nosotros, como intérpretes del lenguaje de señas calificados e información escrita en otros formatos (letra grande, formatos electrónicos accesibles y otros tipos de formato).
- Proporcionan servicios de idioma gratuitos a las personas cuya lengua materna no es el inglés, como intérpretes calificados e información escrita en otros idiomas.

Si necesita estos servicios, comuníquese al número de teléfono del Departamento de Servicios para Miembros del plan de Hamaspik Medicare que figura en su tarjeta de identificación. Desde el 1 de octubre hasta el 31 de marzo, puede llamarnos todos los días de la semana de 8:00 a. m. a 8:00 p. m. Desde el 1 de abril hasta el 30 de septiembre, puede llamarnos de lunes a viernes, de 8:00 a. m. a 8:00 p. m. Fuera del horario de atención, los fines de semana y en feriados federales, se usa un sistema de mensajes. Los usuarios de TTY deben llamar al 711.

Si considera que el plan Hamaspik Medicare Advantage no ha proporcionado estos servicios o que lo ha discriminado de alguna otra forma sobre la base de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja llamando al número que figura en su tarjeta de identificación y explicando que necesita ayuda para presentar una queja. El Departamento de Servicios para Miembros de Hamaspik está disponible para ayudarlo.

También puede enviar su queja a la siguiente dirección:

Hamaspik Medicare Advantage
Attn: Grievance and Appeals
775 N. Main St.
Spring Valley, NY 10977

Además, puede presentar un reclamo de derechos civiles ante el Departamento de Salud y Servicios Humanos de los EE. UU, Oficina de Derechos Civiles, por medios electrónicos a través del Portal de Reclamos de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

También puede presentar una queja por correo o por teléfono usando la siguiente información:

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

Los formularios de reclamos están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

Hamaspik Medicare

LANGUAGE ASSISTANCE NOTICE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-888-426-2774 TTY 711.	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-888-426-2774 TTY 711	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 。1-888-426-2774 TTY 711	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 1-888-426-2774 TTY 711.	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-888-426-2774 TTY 711 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-888-426-2774 TTY 711.	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-888-426-2774 TTY 711.	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-888-426-2774 TTY 711.	French

ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-888-426-2774 TTY 711.	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט 1-888-426-2774 TTY 711.	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-888-426-2774 TTY 711.	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-888-426-2774 TTY 711	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 1-888-426-2774 TTY 711এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-888-426-2774 TTY 711.	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-888-426-2774 TTY 711	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 1-888-426-2744 TTY 711-	Urdu

Hamaspik Medicare Select (HMO-DSNP)
y
Hamaspik Medicare Choice (HMO-DSNP)

Formulario 2025

(Lista de Medicamentos Cubiertos o "Lista de Medicamentos")

LEA CON ATENCIÓN: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

Identificación de Envío de Archivo de Formulario Aprobado por HPMS: 25014

Este formulario fue actualizado el 01/12/2025.

Para obtener información más reciente o resolver otras preguntas, comuníquese con nosotros llamando al 888-426-2774. (Usuarios TTY deben llamar al 711). Estamos disponible los 7 días a la semana, de 8:00 am a 8:00 pm, desde el 1 de octubre de 2024 al 31 de marzo de 2025; y de lunes a viernes a las 8:00 am a 8:00 pm, desde el 1 abril de 2025 al 30 de septiembre de 2025.