Hamaspik Medicare Select (HMO-DSNP)

y

Hamaspik Medicare Choice (HMO-DSNP)

Formulario 2026

(Lista de medicamentos cubiertos o "Lista de medicamentos")

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

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Este formulario se actualizó el 01/11/2026.

Para obtener información más reciente o si tiene otras preguntas, comuníquese con el Servicio para afiliados de Hamaspik Medicare Select y Hamaspik Medicare Choice al 888-426-2774. (Los usuarios de TTY deben llamar al 711). Estamos abiertos los 7 días de la semana, de 8:00 a. m. to 8:00 p. m., del 1 de octubre de 2025 al 31 de marzo de 2026; y de lunes a viernes, de 8:00 a. m. a 8:00 p. m., desde el 1 de abril de 2026 hasta el 30 de septiembre de 2026, o visite www.hamaspik.com.

Nota para los afiliados actuales:

Este formulario ha cambiado desde el año pasado. Revise este documento para asegurarse de que todavía contiene los medicamentos que toma.

Cuando esta Lista de Medicamentos (formulario) se refiere a "nosotros", "nos" o "nuestro", se refiere a Hamaspik, Inc. Cuando se refiere a "plan" o "nuestro plan", se refiere a Hamaspik Medicare Select y Hamaspik Medicare Choice.

Este documento incluye la Lista de Medicamentos (formulario) de nuestro plan, la cual está vigente al 01/11/2026. Para obtener una lista actualizada de medicamentos (formulario), comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la Lista de Medicamentos (formulario), aparece en la portada y la contraportada.

Por lo general, debe utilizar las farmacias de la red para usar su beneficio de medicamentos con receta. Los beneficios, el formulario, la red de farmacias o los copagos o el coseguro pueden cambiar el 1 de enero de 2027 y, ocasionalmente, durante el transcurso del año.

¿Qué son los formularios Hamaspik Medicare Select y Hamaspik Medicare Choice?

En este documento usamos los términos Lista de medicamentos y formulario para referirnos a lo mismo. Un formulario es una lista de medicamentos cubiertos seleccionados por Hamaspik Medicare Select y Hamaspik Medicare Choice, en consulta con un equipo de proveedores de atención médica, que representa las terapias con receta que se consideran una parte necesaria de un programa de tratamiento de calidad. Hamaspik Medicare Select y Hamaspik Medicare Choice generalmente cubrirán los medicamentos incluidos en nuestro formulario siempre que el medicamento sea médicamente necesario, la receta se surta en una farmacia participante de la red y se cumplan las demás reglas del plan. Para obtener más información sobre cómo surtir sus recetas, revise su Evidencia de cobertura.

¿Puede cambiar el formulario?

La mayoría de los cambios en la cobertura de medicamentos ocurren el 1 de enero, pero podemos agregar o eliminar medicamentos del formulario durante el año, trasladarlos a diferentes niveles de costos compartidos o agregar nuevas restricciones. Debemos seguir las normas de Medicare al realizar estos cambios. Las actualizaciones del formulario se publican mensualmente en nuestro sitio web aquí: www.hamaspik.com.

Cambios que pueden afectarle este año*:* En los siguientes casos, usted 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 estamos reemplazando con una nueva versión específica del mismo medicamento que aparecerá en la misma cantidad o en menos farmacias. Cuando agregamos una nueva versión de un medicamento a nuestro formulario, podemos decidir mantener el medicamento de marca o el producto biológico original en nuestro formulario, pero agregar inmediatamente nuevas restricciones.

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

  Si actualmente está tomando el medicamento de marca o el producto biológico original, es posible que no le informemos con anticipación antes de realizar un cambio inmediato, pero posteriormente le proporcionaremos información sobre los cambios específicos que hemos realizado.

Si realizamos dicho cambio, usted o la persona que emite la receta puede solicitarnos que hagamos una excepción y continuemos cubriendo el medicamento que se está modificando. Para obtener más información, consulte la sección a continuación titulada "¿Cómo solicito una excepción al formulario de Hamaspik Medicare Select y Hamaspik Medicare Choice?"

Puede que algunos de estos tipos de medicamentos sean nuevos para usted. Para obtener más información, consulte la sección a continuación titulada "¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?"

- **Medicamentos retirados del mercado.** Si el fabricante retira un medicamento del mercado o si la Administración de Alimentos y Medicamentos (FDA) determina que debe retirarse por razones de seguridad o eficacia, podemos eliminar inmediatamente el medicamento de nuestro formulario y posteriormente notificar a los afiliados que toman el medicamento.

- **Otros cambios.** Es posible que realicemos otros cambios que afecten a los afiliados que actualmente toman algún medicamento. Por ejemplo, podemos eliminar un medicamento de marca del formulario al agregar un equivalente genérico o eliminar un producto biológico original al agregar un biosimilar. También podemos aplicar nuevas restricciones al medicamento de marca o al producto biológico original. Es posible que

realicemos cambios en función de las nuevas pautas clínicas. Si eliminamos medicamentos de nuestro formulario o agregamos autorización previa, límites de cantidad o restricciones de terapia escalonada a un medicamento, debemos notificar a los afiliados afectados sobre el cambio al menos 30 días antes de que el cambio entre en vigor. Alternativamente, cuando un afiliado solicita un surtido del medicamento, puede recibir un suministro del medicamento para 30 días y un aviso del cambio.

Si realizamos estos otros cambios, usted o la persona que emite la receta puede solicitarnos que hagamos una excepción y continuemos cubriendo el medicamento que ha estado tomando. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción y también puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al formulario de Hamaspik Medicare Select y Hamaspik Medicare Choice?"

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si usted está tomando un medicamento incluido en nuestro formulario de 2026 que estaba cubierto al comienzo del año, no suspenderemos ni reduciremos la cobertura del medicamento durante el año de cobertura, excepto como se describe anteriormente. Esto significa que estos medicamentos seguirán estando disponibles con el mismo coste compartido y sin nuevas restricciones para los afiliados que los tomen durante el resto del año de cobertura.

Este año no recibirá un aviso directo sobre cambios que no le afecten. Sin embargo, el 1 de enero del año siguiente, dichos cambios le afectarían, y es importante consultar el formulario del nuevo año de beneficios para comprobar si se han producido cambios en los medicamentos.

El formulario adjunto está vigente al 01/11/2026. Para obtener información actualizada sobre los medicamentos cubiertos por Hamaspik Medicare Select y Hamaspik Medicare Choice, comuníquese con nosotros. Nuestra información de contacto aparece en la portada y la contraportada.

¿Cómo utilizo el formulario?

Hay dos maneras de encontrar su medicamento en el formulario:

Condición médica

El formulario comienza en la página 18. Los medicamentos incluidos en este formulario están agrupados en categorías según el tipo de condiciones médicas que se utilizan para tratar. Por ejemplo, los medicamentos utilizados para tratar una condición cardíaca se incluyen en la categoría “Agentes cardiovasculares”. Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en 9. Luego, busque su medicamento bajo el nombre de la categoría.

Listado alfabético

Si no está seguro de en qué categoría buscar, debe buscar su medicamento en el índice que comienza en la página 301. El índice proporciona una lista alfabética de todos los medicamentos incluidos en este documento. En el índice figuran tanto los medicamentos de marca como los genéricos. Busque en el índice y encuentre su medicamento. Junto al nombre de su medicamento, verá el número de página donde podrá encontrar información sobre la cobertura. Diríjase a la página que aparece en el índice y busque 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 tanto medicamentos de marca como medicamentos genéricos. Un medicamento genérico es aquel que la FDA aprueba por tener el mismo ingrediente activo que el medicamento de marca. En general, los medicamentos genéricos funcionan igual de bien y suelen costar menos que los medicamentos de marca. Existen sustitutos genéricos para muchos medicamentos de marca. Dependiendo de las leyes estatales, los medicamentos genéricos generalmente pueden sustituir a los de marca en la farmacia sin necesidad de una nueva receta.

¿Qué son los productos biológicos originales y qué relación tienen con los biosimilares?

En el formulario, cuando nos referimos a medicamentos, esto podría significar un medicamento o un producto biológico. Los productos biológicos son medicamentos más complejos que los medicamentos típicos. Dado que los productos biológicos son más complejos que los medicamentos típicos, en lugar de tener una forma genérica, tienen alternativas llamadas biosimilares. En general, los biosimilares funcionan igual de bien que el producto biológico original y pueden costar menos. Existen alternativas biosimilares para algunos productos biológicos originales. Algunos biosimilares son intercambiables y, dependiendo de las leyes estatales, pueden sustituir al producto biológico original en la farmacia sin necesidad de una nueva receta, al igual que los medicamentos genéricos pueden sustituir a los de marca.

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

¿Existen restricciones en mi cobertura?

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

- **Autorización previa:** Hamaspik Medicare Select y Hamaspik Medicare Choice requieren que usted [o la persona que emite la receta] obtenga una autorización previa para ciertos medicamentos. Esto significa que necesitará obtener la aprobación de Hamaspik Medicare Select y Hamaspik Medicare Choice antes de surtir sus recetas. Si no obtiene la aprobación, es posible que no cubramos el medicamento.

- **Límites de cantidad:** Para ciertos medicamentos, Hamaspik Medicare Select y Hamaspik Medicare Choice limitan la cantidad del medicamento que cubriremos. Por ejemplo, Hamaspik Medicare Select y Hamaspik Medicare Choice proporcionan 3 unidades cada 28 días por receta de Ozempic. Esto puede ser adicional al suministro estándar de uno o tres meses.

- **Terapia escalonada:** En algunos casos, Hamaspik Medicare Select y Hamaspik Medicare Choice requieren que primero pruebe ciertos medicamentos para tratar su condición médica antes de que cubramos otro medicamento para esa condición. Por ejemplo, si tanto el medicamento A como el medicamento B tratan su condición médica, es posible que Hamaspik Medicare Select y Hamaspik Medicare Choice no cubran el medicamento B a menos que pruebe primero el medicamento A. Si el medicamento A no le funciona, entonces cubriremos el tratamiento con el medicamento B.

Puede averiguar si su medicamento tiene algún requisito o límite adicional consultando el formulario que comienza en la página 18. También puede obtener más información sobre las restricciones aplicadas a medicamentos cubiertos específicos visitando nuestro sitio web. Hemos publicado documentos que explican nuestras restricciones sobre autorización previa y terapia escalonada. También puede solicitarnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y la contraportada.

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

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

Los medicamentos OTC son medicamentos que no requieren receta médica y que normalmente no están cubiertos por un plan de medicamentos recetados de Medicare. Nuestro plan también cubre ciertos medicamentos de venta libre como beneficio adicional. (Este beneficio es independiente de su cobertura de medicamentos recetados de Medicare y se describe en el Capítulo 4 de su Evidencia de cobertura). Algunos medicamentos de venta libre son más baratos que los medicamentos con receta y funcionan igual de bien. Para obtener más

información, llame a Servicio para afiliados. El costo de estos medicamentos OTC no se contabilizará dentro del total de sus costos de medicamentos de la Parte D.

¿Qué ocurre si mi medicamento no está en el formulario?

Si su medicamento no está incluido en este formulario (lista de medicamentos cubiertos), primero debe comunicarse con el Servicio para afiliados y preguntar si su medicamento está cubierto. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y la contraportada.

Si descubre que Hamaspik Medicare Select y Hamaspik Medicare Choice no cubren su medicamento, tiene dos opciones:

- Puede solicitar a Servicios para afiliados una lista de medicamentos similares que estén cubiertos por Hamaspik Medicare Select y Hamaspik Medicare Choice. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por nosotros.

- Puedes solicitar a Hamaspik Medicare Select y Hamaspik Medicare Choice que hagan una excepción y cubran su medicamento. Consulte a continuación la información sobre cómo solicitar una excepción.

¿Cómo puedo solicitar una excepción al formulario de Hamaspik Medicare Select y Hamaspik Medicare Choice?

Puede solicitar a Hamaspik Medicare Select y Hamaspik Medicare Choice que hagan una excepción a nuestras reglas de cobertura. Existen varios tipos de excepciones que puede solicitarnos.

- Puedes solicitarnos que cubramos un medicamento, aunque no esté incluido en nuestro formulario. Si se aprueba, este medicamento estará cubierto a un nivel de costos compartidos predeterminado, y usted no podrá solicitarnos que lo proporcionemos a un nivel de costos compartidos menor.

- Puede solicitarnos que le eximamos de alguna restricción de cobertura, incluyendo la autorización previa, la terapia escalonada o un límite de cantidad de su medicamento. Por ejemplo, para ciertos medicamentos, Hamaspik Medicare Select y Hamaspik Medicare Choice limitan la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede solicitarnos que eliminemos dicho límite y cubramos una cantidad mayor.

Por lo general, Hamaspik Medicare Select y Hamaspik Medicare Choice solo aprobarán su solicitud de excepción si los medicamentos alternativos incluidos en el formulario del plan, o la aplicación de la restricción, no serían tan efectivos para usted o le causarían efectos adversos.

Usted o la persona que emite la receta debe comunicarse con nosotros para solicitar una excepción a la lista de medicamentos, incluida una excepción a una restricción de cobertura. ***Cuando solicite una excepción, la persona que emite la receta deberá explicarle las razones médicas por las que necesita dicha excepción*.** Por lo general, debemos tomar nuestra decisión dentro de las 72 horas posteriores a la recepción de la declaración de respaldo de la persona que emite la receta. Puede solicitar una decisión acelerada (rápida) si cree, y nosotros estamos de acuerdo, que su salud podría verse seriamente perjudicada si espera hasta 72 horas para obtener una decisión. Si estamos de acuerdo, o si la persona que emite la receta solicita una decisión rápida, debemos darle una respuesta en un plazo máximo de 24 horas después de recibir la declaración de respaldo de la persona que emite la receta.

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

Como afiliado nuevo o recurrente de nuestro plan, es posible que esté tomando medicamentos que no están incluidos en nuestro formulario. O puede que esté tomando un medicamento que figura en nuestro formulario pero que tiene una restricción de cobertura, como la autorización previa. Debe hablar con la persona que emite la receta sobre la posibilidad de solicitar una decisión de cobertura para demostrar que cumple con los criterios de aprobación, cambiar a un medicamento alternativo que cubrimos o solicitar una excepción a la lista de medicamentos para que cubramos el medicamento que toma. Mientras usted y su médico determinan el curso de acción adecuado para usted,

podemos cubrir su medicamento en ciertos casos durante los primeros 90 días que sea afiliado a nuestro plan.

Por cada uno de sus medicamentos que no esté en nuestro formulario o tenga una restricción de cobertura, cubriremos un suministro temporal de 30 días. Si su receta es para menos días, le permitiremos solicitar resurtidos para proporcionarle un suministro máximo de medicamento para 30 días. Si no se aprueba la cobertura, después de su primer suministro de 30 días, no pagaremos estos medicamentos, incluso si ha sido afiliado al plan por menos de 90 días.

Si usted reside en un centro de atención a largo plazo y necesita un medicamento que no está en nuestro formulario o si su capacidad para obtener sus medicamentos es limitada, pero ya han transcurrido los primeros 90 días de afiliación a nuestro plan, cubriremos un suministro de emergencia de 31 días de ese medicamento mientras usted solicita una excepción a la lista de medicamentos.

Para obtener más información

Para obtener información más detallada sobre su cobertura de medicamentos recetados de Hamaspik Medicare Select y Hamaspik Medicare Choice, revise su Evidencia de cobertura y otros materiales del plan.

Si tiene preguntas sobre Hamaspik Medicare Select y Hamaspik Medicare Choice, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en la portada y la contraportada.

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

Formulario de Hamaspik Medicare Select y Hamaspik Medicare Choice

El formulario que aparece a continuación proporciona información sobre la cobertura de los medicamentos cubiertos por Hamaspik Medicare Select y Hamaspik Medicare Choice. Si tiene problemas para encontrar su medicamento en la lista, consulte el índice que comienza en la página 301.

La primera columna de la tabla enumera el nombre del medicamento. Los medicamentos de marca se escriben con mayúscula inicial (por ejemplo, BRILINTA COMPRIMIDOS 60 MG) y los medicamentos genéricos se enumeran en minúsculas cursiva (por ejemplo, *bumetanida comprimidos 0,5 mg).*

La información de la columna Requisitos/Límites le indica si Hamaspik Medicare Select y Hamaspik Medicare Choice tienen algún requisito especial para la cobertura de su medicamento.

LEGEND

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

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)
JOURNAVX 50 MG TABLET	1	QL (29 PER 90 OVER TIME)
tencon 50-325 mg tablet	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	
lurbipr 100 mg tablet	1	QL (90 PER 30 DAYS)
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)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

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)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

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)
xyvona (2 mg tablet, 3 mg tablet)	1	QL (120 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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ENDOCET 7.5-325 MG TABLET	1	QL (240 PER 30 DAYS)
fentanyl citrate (cit 1,600 mcg, citrate 200 mcg, citrate 400 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)

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)
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 sl	1	QL (480 PER 30 DAYS)
buprenorphine hcl 8 mg tablet sl	1	QL (120 PER 30 DAYS)
buprenorphine-naloxone (2-0.5mg fm, 2-0.5mg tb)	1	QL (480 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
buprenorphine-naloxone (8-2 mg tab, 8-2mg film)	1	QL (120 PER 30 DAYS)
buprenorphine-naloxone 12-3mg flm	1	QL (90 PER 30 DAYS)
buprenorphine-naloxone 4-1mg film	1	QL (240 PER 30 DAYS)
naltrexone hcl 50 mg tablet	1	
SUBOXONE 12 MG-3 MG SL FILM	1	QL (90 PER 30 DAYS)
SUBOXONE 2 MG-0.5 MG SL FILM	1	QL (480 PER 30 DAYS)
SUBOXONE 4 MG-1 MG SL FILM	1	QL (240 PER 30 DAYS)
SUBOXONE 8 MG-2 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 syringe, 0.4 mg/ml vial, 2 mg/2 ml syringe, 4 mg/10 ml vial)	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	
dalbavancin hcl 500 mg vial	1	
DALVANCE 500 MG VIAL	1	
daptomycin 500 mg vial	1	
fosfomycin tromethamine 3 gm sachet	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 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	
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	1	

vial)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
cefprozil (125 mg/5 ml susp, 250 mg tablet, 250 mg/5 ml susp, 500 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ceftaroline fosamil (400 mg, 600 mg)	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/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	
nafcillin 2 gm/ 100 ml inj	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	
pfizerpen (5 million vial, 20 million vial)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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, piperacillin-tazo 2.25 g dplx, piperacillin-tazo 3.375 g dplx, piperacillin-tazo 4.5 g duplex)	1	
ZOSYN 2.25 GM/50 ML GALAXY BAG	1	
Carbapenems		
ertapenem 1 gram vial	1	
imipenem-cilastatin sodium (250 mg, 500 mg)	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	
tetracycline hcl (250 mg capsule, 500 mg capsule)	1	
Anticonvulsants		
Anticonvulsants, Other		
brivaracetam (10 mg tablet, 25 mg tablet, 50 mg tablet, 75 mg tablet, 100 mg tablet)	1	QL (60 PER 30 DAYS)
brivaracetam 10 mg/ml oral sol	1	QL (600 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DEPAKOTE (DR 125 MG TABLET, DR 250 MG TABLET, DR 500 MG TABLET)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
felbamate (400 mg tablet, 600 mg tablet, 600 mg/5 ml susp, 600 mg/5 ml susp cup)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LAMICTAL (BLUE) TAB START KIT	1	
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)
perampanel 0.5 mg/ml oral susp	1	QL (680 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
roweepra 500 mg tablet	1	
SPRITAM (250 MG TABLET, 500 MG TABLET, 750 MG TABLET, 1,000 MG TABLET)	1	
subvenite (blue) tab start kit	1	
subvenite (subvenite 100 mg tablet, subvenite 150 mg tablet, subvenite 10 mg/ml suspension, subvenite 25 mg tablet, subvenite 200 mg tablet)	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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ethosuximide (250 mg capsule, 250 mg/5 ml cup, 250 mg/5 ml soln)	1	
methsuximide 300 mg capsule	1	
ZARONTIN 250 MG CAPSULE	1	
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 (2.5 mg gel, 2.5mg gel(2pk), 10 mg gel, 10 mg gel syrg, 10mg gel (2pk), 20 mg gel, 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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
CARBATROL (ER 100 MG CAPSULE, ER 200 MG CAPSULE, ER 300 MG CAPSULE)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
oxcarbazepine (150 mg tablet, 300 mg tablet, 300 mg/5 ml cup, 300 mg/5 ml susp, 600 mg tablet)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
VIMPAT (10 MG/ML SOLUTION, 50 MG TABLET, 100 MG TABLET, 150 MG TABLET, 200 MG TABLET)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Antidementia Agents		
Cholinesterase Inhibitors		
ADLARITY (5 MG/DAY PATCH, 10MG/DAY PATCH)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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
Antidepressants		
Antidepressants, Other		
AUVELITY ER 45-105 MG TABLET	1	QL (60 PER 30 DAYS)
AUVELITY TITRATION PACK	1	QL (51 PER 28 OVER TIME)
bupropion hcl 100 mg tablet	1	QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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 TABLET, ER 36.3 MG TABLET, ER 54.5 MG TABLET, ER 72.6 MG TABLET)	1	QL (30 PER 30 DAYS)
EXXUA ER 18.2 MG TAB (TITRATN)	1	QL (32 PER 30 OVER TIME)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
REMERON 15 MG TABLET	1	QL (45 PER 30 DAYS)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
PARNATE 10 MG TABLET	1	
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
desvenlafaxine succinate er (er 25 mg, er 50 mg, er 100mg)	1	QL (30 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FETZIMA (ER 20 MG CAPSULE, ER 40 MG CAPSULE, ER 80 MG CAPSULE, ER 120 MG CAPSULE)	1	QL (30 PER 30 DAYS)
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 capsule, 20 mg tablet)	1	QL (120 PER 30 DAYS)
fluoxetine hcl (20 mg/5 ml soln cup, 20 mg/5 ml solution)	1	QL (600 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)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
nefazodone hcl (50 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet, 250 mg tablet)	1	
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 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	
promethegan (12.5 mg suppos, 25 mg suppository)	1	
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% solution spray, 1% topical cream, 10 mg lozenge, 10 mg troche)	1	
CRESEMBA (74.5 MG CAPSULE, 186 MG CAPSULE)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DIFLUCAN 40 MG/ML SUSPENSION	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	
micafungin (50 mg vial, 100 mg vial)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
NOXAFIL (40 MG/ML SUSPENSION, DR 100 MG TABLET, 300 MG POWDERMIX SUSP)	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)
terbinafine hcl 250 mg tablet	1	QL (30 PER 30 DAYS)
terconazole (0.4% cream, 0.8% cream, 80 mg suppository)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
febuxostat (40 mg tablet, 80 mg tablet)	1	QL (30 PER 30 DAYS)
probenecid 500 mg tablet	1	
probenecid-colchicine tablet	1	
Antimigraine Agents		
dihydroergotamine mesylate 4 mg/ml spry	1	PA, QL (8 PER 28 DAYS)
ergotamine-caffeine 1-100mg tb	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
Serotonin (5-HT) Receptor Agonist		
IMITREX (25 MG TABLET, 50 MG TABLET, 100 MG TABLET)	1	QL (18 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
IMITREX (4 MG/0.5 ML CARTRIDGES, 4 MG/0.5 ML PEN INJECT, 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)
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)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
rifabutin 150 mg capsule	1	
Antituberculars		
cycloserine 250 mg capsule	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
rifapentine 150 mg tablet	1	
SIRTURO (20 MG TABLET, 100 MG TABLET)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LEUKERAN 2 MG TABLET	1	
lomustine (10 mg capsule, 40 mg capsule, 100 mg capsule)	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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)
pomalidomide (1 mg capsule, 2 mg capsule, 3 mg capsule, 4 mg capsule)	1	PA, QL (21 PER 28 DAYS)
POMALYST (1 MG CAPSULE, 2 MG CAPSULE, 3 MG CAPSULE, 4 MG CAPSULE)	1	PA, QL (21 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
ZENBEXUS (0.75 MG CAPSULE, 1 MG CAPSULE)	1	PA, QL (21 PER 28 DAYS)
Antiestrogens/Modifiers		
ETCAMAH 75 MG TABLET	1	PA, QL (28 PER 28 DAYS)
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	
VEPPANU (100 MG TABLET, 200 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
KISQALI FEMARA CO-PACK 600 MG	1	PA, QL (91 PER 28 DAYS)
leucovorin calcium (calcium 5 mg tab, calcium 10 mg tab, calcium 15 mg tab, calcium 25 mg tab, lederle 5 mg tablet)	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	
MIMRYLO (41 MG VIAL, 54 MG VIAL)	1	PA, QL (8 PER 28 DAYS)
MIMRYLO (9.5 MG VIAL, 19 MG VIAL, 28 MG VIAL)	1	PA, QL (4 PER 28 DAYS)
ONUREG (200 MG TABLET, 300 MG TABLET)	1	PA, QL (14 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
XPOVIO 40 MG ONCE WEEKLY	1	PA, QL (16 PER 28 DAYS)
XPOVIO 60 MG TWICE WEEKLY DOSE	1	PA, QL (24 PER 28 DAYS)
XPOVIO 80 MG ONCE WEEKLY 16 PACK	1	PA, QL (4 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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 (180 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)
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)
BEQALZI (1 MG TABLET, 5 MG TABLET)	1	PA, QL (11 PER 28 DAYS)
BEQALZI 20 MG TABLET	1	PA, QL (14 PER 28 DAYS)
BEQALZI 80 MG TABLET	1	PA, QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
BEQALZI STARTER PACK	1	PA, QL (44 PER 28 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)
bosutinib (400 mg tablet, 500 mg tablet)	1	PA, QL (30 PER 30 DAYS)
bosutinib 100 mg tablet	1	PA, QL (180 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 TABLET	1	PA, QL (60 PER 30 DAYS)

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)
CAVHANZA (60 MG ODT, 80 MG ODT)	1	PA, QL (112 PER 28 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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DAURISMO 100 MG TABLET	1	PA, QL (30 PER 30 DAYS)
DAURISMO 25 MG TABLET	1	PA, QL (60 PER 30 DAYS)
ENSACOVE (25 MG CAPSULE, 100 MG CAPSULE)	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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FRUZAQLA 5 MG CAPSULE	1	PA, QL (21 PER 28 DAYS)
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)
HYRNUO 10 MG TABLET	1	PA, QL (120 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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, 140 MG TABLET, 280 MG TABLET, 420 MG TABLET)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
JAYPIRCA 50 MG TABLET	1	PA, QL (30 PER 30 DAYS)
JIDEYTRO 100 MG TABLET	1	PA, QL (30 PER 30 DAYS)
JIDEYTRO 25 MG TABLET	1	PA, QL (90 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)
KOMZIFTI 200 MG CAPSULE	1	PA, QL (90 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
MEKTOVI 15 MG TABLET	1	PA, QL (180 PER 30 DAYS)
MODEYSO 125 MG CAPSULE	1	PA, QL (20 PER 28 DAYS)
NERLYNX 40 MG TABLET	1	PA, QL (180 PER 30 DAYS)
NEXAVAR 200 MG TABLET	1	PA, QL (120 PER 30 DAYS)
nilotinib hcl (50 mg capsule, 150 mg capsule, 200 mg capsule)	1	PA, QL (120 PER 30 DAYS)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
pazopanib hcl 200 mg tablet	1	PA, QL (120 PER 30 DAYS)
pazopanib hcl 400 mg tablet	1	PA, QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
RASONQUE (100 MG TABLET, 150 MG TABLET)	1	PA, QL (60 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 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SCEMBLIX 40 MG TABLET	1	PA, QL (240 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)
yulithira (2.5 mg tablet, 7.5 mg tablet, 10 mg tablet)	1	PA, QL (30 PER 30 DAYS)
yulithira 5 mg tablet	1	PA, QL (60 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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
Retinoids		
bexarotene (1% gel, 75 mg capsule)	1	PA
PANRETIN 0.1% GEL	1	PA
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	
BILTRICIDE 600 MG TABLET	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
benztropine mesylate (0.5 mg tab, 1 mg tablet, 2 mg tablet)	1	
carbidopa-levodopa-entacapone (50, 75, 100, 125, 150, 200)	1	
COMTAN 200 MG TABLET	1	
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		
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
carbidopa-levodopa er (er 25-100 tab, er 50-200 tab)	1	
INBRIJA 42 MG INHALATION CAP	1	PA, QL (300 PER 30 DAYS)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Antipsychotics		
1st Generation/Typical		
fluphenazine decanoate 125 mg/5 ml	1	PA
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
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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
loxapine (5 mg capsule, 10 mg capsule, 25 mg capsule, 50 mg capsule)	1	PA
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
BYSANTI (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)
BYSANTI (PACK A, PACK C)	1	PA, QL (8 PER 28 OVER TIME)
BYSANTI YSANTI TITRATION PACK	1	PA, QL (12 PER 28 OVER TIME)
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)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FANAPT FNPT TITRTION PCK	1	PA, QL (56 PER 28 DAYS)
FANAPT TITRATION PACK B	1	PA, QL (12 PER 28 OVER TIME)
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 (0.5 MG CAPSULE, 0.75 MG CAPSULE, 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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 ZYDIS (5 MG TABLET, 10 MG TABLET, 15 MG TABLET, 20 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
Antipsychotics, Other		
COBENFY (50 MG-20 MG CAPSULE, 100 MG-20 MG CAPSULE, 125 MG-30 MG CAPSULE)	1	PA, QL (60 PER 30 DAYS)
COBENFY STARTER PACK	1	PA, QL (56 PER 28 DAYS)
Treatment-Resistant		
clozapine (25 mg tablet, 50 mg tablet)	1	PA, QL (90 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 100 MG TABLET	1	PA, QL (270 PER 30 DAYS)
CLOZARIL 25 MG TABLET	1	PA, QL (90 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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
BIXLENVO 75-50 MG TABLET	1	QL (30 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
rilpivirine 25 mg tablet	1	QL (30 PER 30 DAYS)
rilpivirine hcl 25 mg tablet	1	QL (30 PER 30 DAYS)
SYMFI 600-300-300 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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
EPIVIR 150 MG TABLET	1	QL (60 PER 30 DAYS)
EPIVIR 300 MG 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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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 150 MG TABLET	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SELZENTRY 20 MG/ML ORAL SOLN	1	QL (1840 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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
IDVYNSO 100 MG-0.25 MG TABLET	1	QL (30 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)
lopinavir-ritonavir 80-20mg/ml	1	QL (480 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ribavirin (200 mg capsule, 200 mg tablet)	1	
VOSEVI 400-100-100 MG TABLET	1	PA
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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, QL (30 PER 30 OVER TIME)
acyclovir sodium (500 mg/10 ml vial, 1,000 mg/20 ml vial)	1	PA
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, QL (30 PER 30 OVER TIME)
Antiviral, Coronavirus agents		
PAXLOVID (EUA) 150-100 MG PACK	1	QL (20 PER 30 OVER TIME)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
PAXLOVID (EUA) 300-100 MG PACK	1	QL (30 PER 30 OVER TIME)
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)
alcohol pads 70%	1	PA
CYCLOSET 0.8 MG TABLET	1	QL (180 PER 30 DAYS)
dapagliflozin (5 mg tablet, 10 mg tablet)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
dapagliflozin-metfor er 5-1000 mg	1	QL (60 PER 30 DAYS)
dapagliflozin-metformin er (dapagliflozin-metfo er 10-1000, dapagliflozin-metfor er 5-500, dapagliflozin-metfor er 10-500)	1	QL (30 PER 30 DAYS)
FARXIGA (5 MG TABLET, 10 MG TABLET)	1	QL (30 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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
OZEMPIC (1.5 MG TABLET, 4 MG TABLET, 9 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
pioglitazone hcl (30 mg tablet, 45 mg tablet)	1	QL (30 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
sitagliptin phos-metformin (phos-metf 50-1,000, phos-metfor 50-500)	1	QL (60 PER 30 DAYS)
sitagliptin phos-metformin er (er 50, er 100)	1	QL (30 PER 30 DAYS)
sitagliptin phos-metformin er 50-1,000	1	QL (60 PER 30 DAYS)
sitagliptin phosphate (phos 100 mg tablet, phosphate 25 mg tb, phosphate 50 mg tb)	1	QL (30 PER 30 DAYS)
SOLIQUA 100-33 UNIT-33 MCG/ML PEN	1	QL (18 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
sterile pads ft 2" x 2"	1	PA
SYMLINPEN 120 SYMLININJECTOR	1	
SYMLINPEN 60 SYMLININJECTOR	1	
SYNJARDY (5-1,000 MG TABLET, 5-500 MG TABLET, 12.5-1,000 MG TABLET, 12.5-500 MG TABLET)	1	QL (60 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)
XIGDUO XR (2.5 MG TAB, 5 MG TABLET)	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
XIGDUO XR (5 MG-500 MG TABLET, 10 MG-1,000 MG TAB, 10 MG-500 MG TABLET)	1	QL (30 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	
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
dropsafe pen needle (5mm, 8mm)	1	PA
easy comfort insulin syringe (0.5ml 29g, 1 ml 29g, 1 ml 32g)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
easy comfort pen needle (29g 4mm, 29g 5mm, 32g 4mm)	1	PA
easy touch insulin syringe (0.3 ml 30g 8mm, 0.3 ml 31g 8mm, 0.5 ml 30g 8mm, 0.5 ml 31g 8mm, 1 ml 27g 12.7mm, 1 ml 28g 12.7mm, 1 ml 29g 12.7mm, 1 ml 30g 12.7mm, syr 1ml 30g 8mm, syr 1ml 31g 8mm)	1	PA
FIASP 100 UNIT/ML VIAL	1	QL (60 PER 30 DAYS)
FIASP FLEXTOUCH 100 UNIT/ML	1	QL (60 PER 30 DAYS)
FIASP PENFILL 100 UNIT/ML CART	1	QL (60 PER 30 DAYS)
FIASP PUMPCART 100 UNIT/ML	1	QL (60 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
INSULIN ASPART 100 UNIT/ML VL	1	QL (60 PER 30 DAYS)
INSULIN ASPART FLEXPEN 100 UNIT/ML	1	QL (60 PER 30 DAYS)
INSULIN ASPART PENFILL 100 UNIT/ML CRT	1	QL (60 PER 30 DAYS)
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
insupen pen needle insu32g 6mm	1	PA
LANTUS 100 UNIT/ML VIAL	1	QL (60 PER 30 DAYS)
LANTUS SOLOSTAR 100 UNIT/ML	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LYUMJEV 100 UNIT/ML VIAL	1	QL (60 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
NOVOLIN R (R 100 UNIT/ML VIAL, RELION R 100 UNIT/ML)	1	QL (60 PER 30 DAYS)
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 (libre 2/3 plus)	1	PA, QL (15 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
omnipod 5 intro (libre2/3plus)	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, gnp 31g 5mm, gnp 31g 8mm, 32g 4mm, gnp 32g 4mm, gnp 32g 6mm)	1	PA
TOUJEO MAX SOLOSTAR SOLOSTR 300 UNIT/ML	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TOUJEO SOLOSTAR 300 UNIT/ML	1	QL (60 PER 30 DAYS)
true comfort safety pen needle (31g 5mm, 31g 6mm, 32g 4mm)	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
unifine ultra pen needle (31g 5mm, 31g 6mm, 31g 8mm, 32g 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)
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
eltrombopag olamine (12.5 mg susp pkt, 12.5 mg tablet, 25 mg susp packet, 25 mg tablet, 50 mg tablet, 75 mg tablet)	1	PA
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 UNIT/ML VIAL, 10,000 UNIT/ML VIAL, 20,000 UNIT/2 ML VIAL, 20,000 UNITS/ML VIAL, 40,000 UNITS/ML VIAL)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
PROMACTA (12.5 MG SUSPEN PACKET, 12.5 MG TABLET, 25 MG SUSPENSION PCKT, 25 MG TABLET, 50 MG TABLET, 75 MG TABLET)	1	PA
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Platelet Modifying Agents		
aspirin-dipyridamole er 25-200 mg	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
clonidine hcl (0.1 mg tablet, 0.2 mg tablet, 0.3 mg tablet)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
prazosin hcl (1 mg capsule, 2 mg capsule, 5 mg capsule)	1	
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 (150 MG TABLET, 300 MG TABLET)	1	QL (30 PER 30 DAYS)
azilsartan medoxomil (40 mg tab, 80 mg tab)	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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

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		
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
ZESTRIL (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET, 20 MG TABLET, 30 MG TABLET, 40 MG TABLET)	1	

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
quinidine gluconate er 324 mg tab	1	
quinidine sulfate (200 mg tab, 300 mg tab)	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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
INDERAL LA (60 MG CAPSULE, 80 MG CAPSULE, 120 MG CAPSULE, 160 MG CAPSULE)	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
NORVASC (2.5 MG TABLET, 5 MG TABLET, 10 MG TABLET)	1	
PROCARDIA XL (30 MG TABLET, 60 MG TABLET, 90 MG TABLET)	1	
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	1	

TABLET)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
verapamil sr (120 mg capsule, 180 mg capsule, 240 mg capsule, 360 mg capsule)	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
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)
ENTRESTO SPRINKLE (6-6MG PELLET, 15-16 MG PLT)	1	QL (240 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
LANOXIN (62.5 MCG TABLET, 125 MCG TABLET, 250 MCG TABLET)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
olmesartan-hydrochlorothiazide (20-12.5 mg tab, 40-12.5 mg tab, 40-25 mg tab)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
telmisartan-hydrochlorothiazid telmisartan-hctz 80-12.5 mg tb	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
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	
triamterene-hydrochlorothiazid (37.5-25 mg cp, 37.5-25 mg tb, 75-50 mg tab)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
gemfibrozil 600 mg tablet	1	QL (60 PER 30 DAYS)
LOPID 600 MG TABLET	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
pravastatin sodium (10 mg tab, 20 mg tab, 40 mg tab)	1	QL (45 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
colestipol hcl (1 gm tablet, granules, granules packet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 (2 MG CAPSULE, 5 MG CAPSULE, 10 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE)	1	PA
NEXLETOL 180 MG TABLET	1	PA, QL (30 PER 30 DAYS)
NEXLIZET 180-10 MG TABLET	1	PA, QL (30 PER 30 DAYS)
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	

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 GRAM 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, 2% ointment, 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 (er 10 mg tab, 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 (6 MG TABLET, 12 MG TABLET, 18 MG TABLET, 24 MG TABLET, 30 MG TABLET, 36 MG TABLET, 42 MG TABLET, 48 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
AUSTEDO XR TITRATION KT(WK1-4) TITR(12-18-24-30MG)	1	PA, QL (28 PER 28 DAYS)
dextromethorphan hbr-quinidine dextromethorphan-quinidn 20-10	1	PA, QL (60 PER 30 DAYS)
INGREZZA (40 MG CAPSULE, 60 MG CAPSULE, 80 MG CAPSULE)	1	PA, QL (30 PER 30 DAYS)
INGREZZA INITIATION PK(TARDIV)	1	PA, QL (28 PER 28 DAYS)
INGREZZA SPRINKLE (40 MG CAP, 60 MG CAP, 80 MG CAP)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Dermatological Agents		
Acne and Rosacea Agents		
accutane (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule)	1	PA
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	PA
azelaic acid 15% gel	1	
AZELEX 20% CREAM	1	
BENZAMYCIN GEL	1	
claravis (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule)	1	PA
clindamycin phos-benzoyl perox ph-benzoyl 1.2-5%	1	
clindamycin-benzoyl peroxide (clindamycin-benzoyl 1-5%, clindamycin-bnz 1-5% pmp)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
doxycycline ir-dr 40 mg cap	1	
erythromycin-benzoyl peroxide gel	1	
FINACEA 15% FOAM	1	
isotretinoin (10 mg capsule, 20 mg capsule, 25 mg capsule, 30 mg capsule, 35 mg capsule, 40 mg capsule)	1	PA
KLARON 10% LOTION	1	
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, QL (45 PER 30 DAYS)
sulfacetamide sodium (sod 10% top susp, sodium 10% lotn)	1	
tazarotene (0.05% gel, 0.1% gel)	1	PA, QL (100 PER 30 DAYS)
tazarotene (0.05%, 0.1%)	1	PA, QL (60 PER 30 DAYS)
TAZORAC (0.05% GEL, 0.1% GEL)	1	PA, QL (100 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TAZORAC 0.05% CREAM	1	PA, QL (60 PER 30 DAYS)
tretinoin (0.01% gel, 0.025% cream, 0.025% gel, 0.05% cream, 0.1% cream)	1	PA, QL (45 PER 30 DAYS)
trilitas 0.1% gel	1	PA, QL (100 PER 30 DAYS)
zenatane (10 mg capsule, 20 mg capsule, 30 mg capsule, 40 mg capsule)	1	PA
Dermatitis and Pruitus Agents		
ALA-CORT 1% CREAM	1	
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
DIPROLENE 0.05% OINTMENT	1	QL (200 PER 28 DAYS)
doxepin hcl 5% cream	1	PA
ELIDEL 1% CREAM	1	PA
EUCRISA 2% OINTMENT	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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
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
fluorouracil (2% soln, 5% soln)	1	QL (10 PER 30 OVER TIME)
fluorouracil 5% cream	1	QL (40 PER 30 OVER TIME)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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, 10-20-30MG START 28)	1	PA, QL (55 PER 180 OVER TIME)
OTEZLA (20 MG TABLET, 30 MG TABLET)	1	PA, QL (60 PER 30 DAYS)
OTEZLA XR 75 MG TABLET	1	PA, QL (30 PER 30 DAYS)
OTEZLA XR INITIATION PK 28 DAY	1	PA, QL (41 PER 180 OVER TIME)
podofilox 0.5% topical soln	1	
SANTYL OINTMENT	1	QL (180 PER 30 DAYS)
SILVADENE 1% CREAM	1	
silver sulfadiazine 1% cream	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
METROGEL (1% GEL, 1% PUMP)	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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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 20 meq/l-d5w-0.2%	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 (KLOR-CON 10 MEQ TABLET, KLOR-CON 10 MEQ TABLET)	1	
KLOR-CON 8 MEQ TABLET	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
sodium chloride-water 0.9%-water	1	
Electrolyte/Mineral/Metal Modifiers		
CHEMET 100 MG CAPSULE	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
JYNARQUE (15 MG TABLET, 15 MG-15 MG TABLET, 30 MG TABLET, 30 MG-15 MG TABLET, 45 MG-15 MG TABLET, 60 MG-30 MG TABLET, 90 MG-30 MG TABLET)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SAMSCA (15 MG TABLET, 30 MG TABLET)	1	PA
SYPRINE 250 MG CAPSULE	1	PA, QL (240 PER 30 DAYS)
tolvaptan (15 mg tablet, 15 mg-15 mg tablet, 30 mg tablet, 30 mg-15 mg tablet, 45 mg-15 mg tablet, 60 mg-30 mg tablet, 90 mg-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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TRAVASOL 10% SOLN VIAFLEX	1	PA
TROPHAMINE 10% IV SOLUTION	1	PA
Potassium Binders		
kionex 15 gm/60 ml suspension	1	
LOKELMA (5 POWDER PACKET, 10 POWDER PACKET)	1	
sodium polystyrene sulfonate (sodium polystyrene sulf powder, sps 15 gm/60 ml suspension)	1	
SPS (15 GM/60 ML SUSPENSION, 30 GM/120 ML ENEMA SUSP)	1	
Gastrointestinal Agents		
Anti-Constipation Agents		
constulose 10 gm/15 ml soln	1	
enulose 10 gm/15 ml solution	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
chenodal 250 mg tablet	1	PA
gavilyte-c solution	1	
gavilyte-g solution	1	
gavilyte-n solution	1	
GOLYTELY SOLUTION	1	
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	
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 140-125-125 MG CAPSULE	1	
REGLAN (5 MG TABLET, 10 MG TABLET)	1	
sod sulf-potass sulf-mag sulf -potass -mag sol	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SUPREP SUBOWEL KIT	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
CYTOTEC (100 MCG TABLET, 200 MCG TABLET)	1	
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 2.5 MG PACKET, DR 5 MG PACKET, 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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
omeprazole (dr 20 mg capsule, dr 40 mg capsule)	1	QL (60 PER 30 DAYS)
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

ATTRUBY 356 MG TABLET	1	PA, QL (112 PER 28 DAYS)
betaine anhydrous 1 gram/scoop powder	1	
BUPHENYL 500 MG TABLET	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
CARNITOR (1 GM/10 ML ORAL SOLN, 330 MG TABLET)	1	
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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ELELYSO 200 UNITS VIAL	1	PA
ENDARI 5 GRAM POWDER PACKET	1	PA, QL (180 PER 30 DAYS)
KUVAN (100 MG POWDER PACKET, 100 MG TABLET, 500 MG POWDER PACKET)	1	PA
l-glutamine 5 gram powder pkt	1	PA, QL (180 PER 30 DAYS)
levocarnitine (1 g/10 ml cup, 1 g/10 ml soln, 330 mg tablet, 500 mg/5 ml cup)	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	PA
REZDIFFRA (60 MG TABLET, 80 MG TABLET, 100 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
VPRIV 400 UNITS VIAL	1	Gaucher Enzyme Replacement PA - Vpriv
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Genitourinary Agents		
Antispasmodics, Urinary		
darifenacin er (er 7.5 mg tablet, er 15 mg tablet)	1	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)
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)
PROSCAR 5 MG TABLET	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
DEPEN 250 MG TITRATAB	1	
penicillamine 250 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 cup, 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	
HEMADY 20 MG TABLET	1	
hidex 6 day 1.5 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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		
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)
testosterone 30 mg/1.5 ml pump	1	PA, QL (180 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
dotti (0.025 mg patch, 0.0375 mg patch, 0.05 mg patch, 0.075 mg patch, 0.1 mg patch)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
estradiol valerate (50 mg/5 ml, 100 mg/5 ml, 200 mg/5 ml)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
abigale 1 mg-0.5 mg tablet	1	
abigale lo 0.5-0.1 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
aurovela fe (1-20 tablet, 1.5 mg-30 mcg tab)	1	
aviane aviane-28 tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 0.4 mg-0.035 mg tab	1	
camrese 0.15-0.03-0.01 mg tab	1	
camrese lo 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	
daysee 0.15-0.03-0.01 mg tab	1	
desogestr-eth estrad eth estra	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
ethynodiol-ethinyl estradiol (1mg-35mcg, 1mg-50mcg)	1	
etonogestrel-ethinyl estradiol etonogestrel-ee vaginal ring	1	
falmina falmina-28 tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
feirza (1 mg-20 mcg tablet, 1.5 mg-30 mcg 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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	
ocella 3 mg-0.03 mg tablet	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
tri-sprintec tablet	1	
tri-vylibra 28 tablet	1	
tri-vylibra lo tablet	1	
trivora-28 tablet	1	
turqoz turqoz-28 tablet	1	
tydemy 3-0.03-0.451 mg tablet	1	
valtya (1 mg-35 mcg tablet, 1 mg-50 mcg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
megestrol acetate (20 mg tablet, 40 mg tablet, acet 40 mg/ml susp, 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	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
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 (22.5 MG SYRINGE B, 22.5 MG SYRINGE KIT)	1	PA, QL (1 PER 84 OVER TIME)
ELIGARD (30 MG SYRINGE B, 30 MG SYRINGE KIT)	1	PA, QL (1 PER 112 OVER TIME)
ELIGARD (45 MG SYRINGE B, 45 MG SYRINGE KIT)	1	PA, QL (1 PER 168 OVER TIME)
ELIGARD (7.5 MG SYRINGE B, 7.5 MG SYRINGE KIT)	1	PA, QL (1 PER 28 DAYS)
FIRMAGON (2 X 120 MG KIT, 80 MG KIT, 120 MG VIAL)	1	PA
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, QL (2 PER 28 DAYS)
leuprolide depot 22.5 mg vial	1	PA, QL (1 PER 84 OVER TIME)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
LIFYORLI 125 MG DOSE PACK	1	PA, QL (18 PER 28 DAYS)
LIFYORLI 150 MG DOSE PACK	1	PA, QL (27 PER 28 DAYS)
LUPRON DEPOT (3.75 MG KIT, 7.5 MG 1 MONTH KT)	1	PA, QL (1 PER 28 DAYS)
LUPRON DEPOT (LUPANETA) 3.75MG	1	PA, QL (1 PER 28 DAYS)
LUPRON DEPOT-PED 11.25 MG 3MO	1	PA, QL (1 PER 84 OVER TIME)
LUPRON DEPOT-PED 45 MG 6MO KIT	1	PA, QL (1 PER 168 OVER TIME)
LUPRON DEPOT-PED 7.5 MG KIT	1	PA, QL (1 PER 28 DAYS)
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	1	PA

ml vial)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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	
propylthiouracil 50 mg tablet	1	
Immunological Agents		
Angioedema Agents		
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Immunoglobulins		
ATGAM 50 MG/ML AMPUL	1	PA
GAMMAGARD LIQUID 10% VIAL	1	PA
GAMMAGARD LIQUID ERC (LIQUID 5 G/50 ML, LIQUID 10G/100ML)	1	PA
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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
THYMOGLOBULIN 25 MG VIAL	1	PA
Immunological Agents, Other		
ACTEMRA 162 MG/0.9 ML SYRINGE	1	PA, QL (3.6 PER 28 DAYS)
ACTEMRA ACTPEN 162 MG/0.9 ML	1	PA, QL (3.6 PER 28 DAYS)
ARCALYST 220 MG VIAL	1	PA, QL (8 PER 28 DAYS)
BENLYSTA (200 MG/ML AUTOINJECT, 200 MG/ML SYRINGE)	1	PA, QL (8 PER 28 DAYS)
COSENTYX (2 SYRINGES) 300 MG DOSE	1	PA, QL (8 PER 28 DAYS)
COSENTYX SENSOREADY (2 PENS) SNRDY 300MG DOSE-2PEN	1	PA, QL (8 PER 28 DAYS)
COSENTYX SENSOREADY PEN 150 MG	1	PA, QL (8 PER 28 DAYS)
COSENTYX SYRINGE 150 MG/ML	1	PA, QL (8 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
COSENTYX SYRINGE 75 MG/0.5 ML	1	PA, QL (2 PER 28 DAYS)
COSENTYX UNOREADY PEN 300 MG	1	PA, QL (8 PER 28 DAYS)
DUPIXENT PEN 200 MG/1.14 ML	1	PA, QL (3.42 PER 28 DAYS)
DUPIXENT PEN 300 MG/2 ML	1	PA, QL (8 PER 28 DAYS)
DUPIXENT SYRINGE 200 MG/1.14 ML	1	PA, QL (3.42 PER 28 DAYS)
DUPIXENT SYRINGE 300 MG/2 ML	1	PA, QL (8 PER 28 DAYS)
ENTYVIO PEN 108 MG/0.68 ML	1	PA, QL (1.36 PER 28 DAYS)
ORENCIA 125 MG/ML SYRINGE	1	PA, QL (4 PER 28 DAYS)
ORENCIA 50 MG/0.4 ML SYRINGE	1	PA, QL (1.6 PER 28 DAYS)
ORENCIA 87.5 MG/0.7 ML SYRINGE	1	PA, QL (2.8 PER 28 DAYS)
ORENCIA CLICKJECT 125 MG/ML	1	PA, QL (4 PER 28 DAYS)
PYZCHIVA (45 MG/0.5 ML SYRINGE, CDV 45 MG/0.5 ML SYR)	1	PA, QL (1.5 PER 84 OVER TIME)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
PYZCHIVA (90 MG/ML SYRINGE, CDV 90 MG/ML SYRINGE)	1	PA, QL (3 PER 84 OVER TIME)
PYZCHIVA 45 MG/0.5 ML VIAL	1	PA, QL (1.5 PER 84 DAYS)
RIDAURA 3 MG CAPSULE	1	
RINVOQ (ER 15 MG TABLET, ER 30 MG TABLET)	1	PA, QL (30 PER 30 DAYS)
RINVOQ ER 45 MG TABLET	1	PA, QL (84 PER 180 OVER TIME)
RINVOQ LQ 1 MG/ML SOLUTION	1	PA, QL (360 PER 30 DAYS)
SKYRIZI 150 MG/ML SYRINGE	1	PA, QL (6 PER 365 OVER TIME)
SKYRIZI 55 MG/0.37 ML SYRINGE	1	PA, QL (2.22 PER 365 OVER TIME)
SKYRIZI 600 MG/10 ML VIAL	1	PA, QL (60 PER 180 OVER TIME)
SKYRIZI ON-BODY 180 MG/1.2 ML	1	PA, QL (8.4 PER 365 OVER TIME)
SKYRIZI ON-BODY 360 MG/2.4 ML	1	PA, QL (16.8 PER 365 OVER TIME)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SKYRIZI PEN 150 MG/ML	1	PA, QL (6 PER 365 OVER TIME)
STELARA (45 MG/0.5 ML SYRINGE, 45 MG/0.5 ML VIAL)	1	PA, QL (1.5 PER 84 OVER TIME)
STELARA 130 MG/26 ML VIAL	1	PA, QL (104 PER 180 OVER TIME)
STELARA 90 MG/ML SYRINGE	1	PA, QL (3 PER 84 OVER TIME)
STEQEYMA (45 MG/0.5 ML SYRINGE, 45 MG/0.5 ML VIAL)	1	PA, QL (1.5 PER 84 OVER TIME)
STEQEYMA 130 MG/26 ML VIAL	1	PA, QL (104 PER 180 OVER TIME)
STEQEYMA 90 MG/ML SYRINGE	1	PA, QL (3 PER 84 OVER TIME)
TREMFYA 100 MG/ML SYRINGE	1	PA, QL (3 PER 56 OVER TIME)
TREMFYA 200 MG/2 ML SYRINGE	1	PA, QL (2 PER 28 DAYS)
TREMFYA ONE-PRESS 100 MG/ML	1	PA, QL (3 PER 56 OVER TIME)
TREMFYA PEN 100 MG/ML	1	PA, QL (3 PER 56 OVER TIME)

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TREMFYA PEN 200 MG/2 ML	1	PA, QL (2 PER 28 DAYS)
TREMFYA PEN INDUCTION (2 PEN) INDCT 200MG/2ML X2	1	PA, QL (12 PER 180 OVER TIME)
TYENNE 162 MG/0.9 ML SYRINGE	1	PA, QL (3.6 PER 28 DAYS)
TYENNE AUTOINJECTOR 162 MG/0.9 ML AUTOINJCT	1	PA, QL (3.6 PER 28 DAYS)
USTEKINUMAB (45 MG/0.5 ML VIAL, 45MG/0.5ML SYRINGE)	1	PA, QL (1.5 PER 84 OVER TIME)
USTEKINUMAB 130 MG/26 ML VIAL	1	PA, QL (104 PER 180 OVER TIME)
USTEKINUMAB 90 MG/ML SYRINGE	1	PA, QL (3 PER 84 OVER TIME)
USTEKINUMAB-AEKN 45 MG SYRINGE	1	PA, QL (1.5 PER 84 OVER TIME)
USTEKINUMAB-AEKN 90 MG/ML SYR	1	PA, QL (3 PER 84 OVER TIME)

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)
BESREMI PEN 500 MCG/0.5 ML	1	PA, QL (1 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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
AZASAN (75 MG TABLET, 100 MG TABLET)	1	PA
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	1	PA, QL (2 PER 28 DAYS)
ENBREL 25 MG/0.5 ML VIAL	1	PA, QL (4 PER 28 DAYS)
ENBREL 50 MG/ML SYRINGE	1	PA, QL (8 PER 28 DAYS)
ENBREL MINI 50 MG/ML CARTRIDGE	1	PA, QL (8 PER 28 DAYS)
ENBREL SURECLICK 50 MG/ML	1	PA, QL (8 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
gengraf (25 mg capsule, 100 mg capsule, 100 mg/ml solution)	1	PA
HADLIMA 40 MG/0.8 ML SYRINGE	1	PA, QL (4.8 PER 28 DAYS)
HADLIMA PUSHTOUCH 40 MG/0.8 ML	1	PA, QL (4.8 PER 28 DAYS)
HADLIMA(CF) 40 MG/0.4 ML SYRNG	1	PA, QL (2.4 PER 28 DAYS)
HADLIMA(CF) PUSHTOUCH 40MG/0.4	1	PA, QL (2.4 PER 28 DAYS)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
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
SANDIMMUNE (25 MG CAPSULE, 100 MG CAPSULE)	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
SIMLANDI(CF) 20 MG/0.2 SYRG	1	PA, QL (2 PER 28 DAYS)
SIMLANDI(CF) 40 MG/0.4 SYRG	1	PA, QL (4 PER 28 DAYS)
SIMLANDI(CF) 80 MG/0.8 SYRG	1	PA, QL (3 PER 28 DAYS)
SIMLANDI(CF) AUTOINJECTOR AI 40 MG/0.4	1	PA, QL (4 PER 28 DAYS)
SIMLANDI(CF) AUTOINJECTOR AI 80 MG/0.8	1	PA, QL (3 PER 28 DAYS)
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
tacrolimus xl (0.5 mg capsule, 1 mg capsule, 5 mg capsule)	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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Vaccines		
ABRYSVO (ACT-O-VIAL, VIAL, VIAL WITH DILUENT SYRG)	1	QL (1 PER 999 OVER TIME)
ACTHIB (VIAL, WITH DILUENT)	1	
ADACEL TDAP (SYRINGE, VIAL)	1	
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	
ENGERIX-B ADULT (20 MCG/ML SYRN, 20 MCG/ML VIAL)	1	PA
ENGERIX-B PEDIATRIC-ADOLESCENT 10 MCG/0.5 SYRN	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ERVEBO (NATIONAL STOCKPILE) 1 ML VIAL (STOCKPILE)	1	
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)	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

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
JYNNEOS 0.5 ML VIAL	1	PA
KINRIX TIP-LOK SYRINGE	1	
M-M-R II VACCINE 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	
PRIORIX VIAL	1	
PROQUAD VIAL	1	
QUADRACEL DTAP-IPV (SYRINGE, VIAL)	1	

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17

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 VACCINE ORAL SYRINGE	1	
ROTATEQ VACCINE	1	
SHINGRIX 50 MCG/0.5 ML SYRINGE	1	QL (1 PER 999 OVER TIME)
SHINGRIX VIAL KIT	1	QL (2 PER 999 OVER TIME)
STAMARIL VIAL	1	
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	
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 250 mg capsule	1	QL (480 PER 30 DAYS)
mesalamine er 500 mg capsule	1	QL (240 PER 30 DAYS)
PENTASA 250 MG CAPSULE	1	QL (480 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
proctosol-hc 2.5% cream	1	QL (454 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
FOSAMAX 70 MG TABLET	1	QL (4 PER 28 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ibandronate sodium 150 mg tab	1	QL (1 PER 28 DAYS)
JUBBONTI 60 MG/ML SYRINGE	1	PA
OSENVELT 120 MG/1.7 ML VIAL	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
STOBOCLO 60 MG/ML SYRINGE	1	PA
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
cyclosporine 0.05% eye emuls	1	QL (60 PER 30 DAYS)
CYSTADROPS CYSTA0.37% EYE	1	PA, QL (20 PER 28 DAYS)
CYSTARAN 0.44% EYE DROPS	1	PA, QL (60 PER 28 DAYS)
dorzolamide-timolol eye drops	1	
MAXITROL EYE OINTMENT	1	
MIEBO 100% EYE DROP	1	PA, QL (3 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)
sulfacetamide-prednisolone sulf-pred 10-0.23% eye drops	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TOBRADEX EYE OINTMENT	1	
tobramycin-dexamethasone ophth susp	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
neo-polycin eye ointment	1	
neomycin-bacitracin-polymyxin neomyc-bacit-polymix eye oint	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
epinastine hcl 0.05% eye drops	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
FML LIQUIFILM 0.1% EYE DROP	1	
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ISTALOL 0.5% EYE DROPS	1	
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 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	
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	
Respiratory Tract/ Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA (50 MCG, 100 MCG, 200 MCG)	1	QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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
desloratadine 5 mg tablet	1	
levocetirizine dihydrochloride 5 mg tablet	1	
olopatadine hcl 665 mcg nasal spry	1	QL (30.5 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ipratropium bromide 17 mcg hfa inh	1	QL (25.8 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 hfa 90 mcg inhaler (generic ventolin hfa)	1	QL (36 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
albuterol sulfate hfa 90 mcg inhaler	1	QL (17 PER 30 DAYS)
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Cystic Fibrosis Agents		
CAYSTON 75 MG INHAL SOLUTION	1	PA
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)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
TRIKAFTA (80-40-60MG/59.5MG PKT, 100-50-75 MG/75MG PKT)	1	PA, QL (60 PER 30 DAYS)
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	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
Pulmonary Antihypertensives		
ADCIRCA 20 MG TABLET	1	PA, QL (60 PER 30 DAYS)
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)
ORENITRAM ER (ER 0.125 MG TABLET, ER 0.25 MG TABLET, ER 1 MG TABLET, ER 2.5 MG TABLET, ER 5 MG TABLET)	1	PA
ORENITRAM MONTH 1 TITRATION KT	1	PA

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
ORENITRAM MONTH 2 TITRATION KT	1	PA
ORENITRAM MONTH 3 TITRATION KT	1	PA
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)
VENTAVIS (10 MCG/1 ML SOLUTION, 20 MCG/1 ML SOLUTION)	1	Pulmonary Hypertension PA - Ventavis, QL (270 PER 30 DAYS)
WINREVAIR (2 PACK) (45 MG KIT, 60 MG KIT)	1	PA, QL (1 PER 21 DAYS)
WINREVAIR (45 MG ONE-VIAL KIT, 45 MG VIAL, 60 MG ONE-VIAL KIT, 60 MG VIAL)	1	PA, QL (1 PER 21 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
nintedanib esylate (100 mg cap, 150 mg cap)	1	PA, QL (60 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)
ANORO ELLIPTA 62.5-25 MCG INH	1	QL (60 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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 (160-18-4.8MCG, 160-9-4.8 MCG)	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	1	PA, QL (0.5 PER 28 DAYS)
FASENRA 30 MG/ML SYRINGE	1	PA, QL (1 PER 28 DAYS)
FASENRA PEN 30 MG/ML	1	PA, QL (1 PER 28 DAYS)
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
STIOLTO RESPIMAT (INHAL SPRAY, INHALER (10), INHALER (28), 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

chlorzoxazone 500 mg tablet	1	
cyclobenzaprine hcl (5 mg tablet, 10 mg tablet)	1	
methocarbamol (500 mg tablet, 750 mg tablet)	1	

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
tasimelteon 20 mg capsule	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
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)
NUVIGIL (50 MG TABLET, 150 MG TABLET, 200 MG TABLET, 250 MG TABLET)	1	PA, QL (30 PER 30 DAYS)

NOMBRE DEL MEDICAMENTO	NIVEL DE MEDICAMENTO	REQUISITOS/ LÍMITES
sodium oxybate 0.5 g/ml soln	1	PA, QL (540 PER 30 DAYS)

Índice de medicamentos

A

abacavir 125,126
abacavir-lamivudine 126
abigale 235
abigale lo 235
ABILIFY 111
ABILIFY ASIMTUFII 112
ABILIFY MAINTENA 112
abiraterone acetate 79
abirtega 79
ABRYSVO 268
acamprosate calcium 28
acarbose 138
ACCOLATE 288
accutane 200
acebutolol hcl 169
acetaminophen-codeine 24
acetazolamide 176
acetazolamide er 176
acetic acid 285
acetylcysteine 295
acitretin 200
ACTEMRA 258
ACTEMRA ACTPEN 258
ACTHAR 229
ACTHAR SELFJECT 229
ACTHIB 268
ACTIMMUNE 263
ACTOS 138
ACULAR 281
ACULAR LS 281
acyclovir 134
acyclovir sodium 134
ADACEL TDAP 268
ADCIRCA 293
ADDERALL XR 192
adefovir dipivoxil 132
ADEMPAS 293
ADLARITY 58
ADVAIR HFA 295
AFINITOR 85
AFINITOR DISPERZ 85
afirmelle 236
AGRYLIN 159
AIMOVIG AUTOINJECTOR 75
AKEEGA 85
ALA-CORT 202
albendazole 104
ALBUTEROL HFA 90 MCG INHALER (generic ProAir HFA) 289
ALBUTEROL HFA 90 MCG INHALER (generic Proventil HFA) 289
albuterol hfa 90 mcg inhaler (generic Ventolin hfa) 289
albuterol sulfate 289,290
albuterol sulfate hfa 290
alclometasone dipropionate 202
alcohol pads 138
ALDACTONE 189
ALECENSA 85
alendronate sodium 275
alfuzosin hcl er 227
aliskiren 176
allopurinol 74
alosetron hcl 217
ALPHAGAN P 283
alprazolam 135
alprazolam er 135
alprazolam xr 135,136
altavera 236
ALUNBRIG 85,86
alyacen 236
amabelz 236
amantadine 106
AMBISOME 71
ambrisentan 293
amethia 236
amethyst 236

amikacin sulfate 31
amiloride hcl 184
amiloride-hydrochlorothiazide 176
amiodarone hcl 168
amitriptyline hcl 67
amlodipine besylate 172
amlodipine besylate-benazepril 176
amlodipine-atorvastatin 177
amlodipine-olmesartan 177
amlodipine-valsartan 177
amlodipine-valsartan-hctz 177
ammonium lactate 202
amnesteem 200
amoxapine 68
amoxicillin 38
amoxicillin-clavulanate pot er 38
amoxicillin-clavulanate potass 38
amphotericin b 71
amphotericin b liposome 71
ampicillin sodium 38
ampicillin trihydrate 38
ampicillin-sulbactam 38
AMPYRA 197
anagrelide hcl 159
anastrozole 84
ANORO ELLIPTA 295
apomorphine hcl 107
aprepitant 70
apri 236
APRISO 272
APTIOM 54
APTIVUS 129
aqua care sodium chloride 209
aranelle 236
ARANESP 159
ARCALYST 258
AREXVY 268
ARICEPT 58
ARIKAYCE 31
ARIMIDEX 84
aripiprazole 112
aripiprazole odt 112
ARISTADA 112
ARISTADA INITIO 113
armodafinil 299
ARNUITY ELLIPTA 285
AROMASIN 84
ARTHROTEC 50 18
ARTHROTEC 75 18
asenapine maleate 113
ashlyna 236
ASMANEX 286
ASMANEX HFA 286
aspirin-dipyridamole er 162
ASTAGRAF XL 263
ATACAND 164
ATACAND HCT 177
atazanavir sulfate 129
ATELVIA 275
atenolol 169
atenolol-chlorthalidone 177
ATGAM 257
atomoxetine hcl 194
atorvastatin calcium 186
atovaquone 105
atovaquone-proguanil hcl 105
atropine sulfate 277
ATROVENT HFA 288
ATTRUBY 221
aubra 236
aubra eq 236
AUGTYRO 86
aurovela 236
aurovela 24 fe 236
aurovela fe 236
AUSTEDO 195
AUSTEDO XR 196

AUSTEDO XR TITRATION KT(WK1-4) 196
autoshield duo pen needle 147
AUVELITY 59
AVALIDE 177
AVAPRO 164
aviane 236
avidoxy 44
AVMAPKI-FAKZYNJA 82
AVONEX 197
AVONEX (4 PACK) 197
AVONEX PEN (4 PACK) 197
ayuna 237
AYVAKIT 86
AZACTAM 32
AZASAN 264
azathioprine 264
azelaic acid 200
azelastine hcl 280,287
AZELEX 200
AZILECT 109
azilsartan medoxomil 164
azithromycin 41
AZOPT 283
AZOR 178
aztreonam 32
AZULFIDINE 272
azurette 237

B

bacitracin 279
bacitracin-polymyxin 279
baclofen 122
BACTRIM 44
BACTRIM DS 44
balsalazide disodium 273
BALVERSA 86
balziva 237
BANZEL 54
BAQSIMI 146
BARACLUDE 132
BCG VACCINE (TICE STRAIN) 268
BELBUCA 22
BELSOMRA 298
benazepril hcl 166
benazepril-hydrochlorothiazide 178
BENICAR 164
BENICAR HCT 178
BENLYSTA 258
BENZAMYCIN 200
benztropine mesylate 107
BEQALZI 86,87
BESIVANCE 279
BESREMI 263
BESREMI PEN 263
betaine anhydrous 221
betamethasone diprop augmented 202
betamethasone dipropionate 202,203
betamethasone valerate 203
BETASERON 197
betaxolol hcl 169,282
bethanechol chloride 228
BETOPTIC S 282
bexarotene 104
BEXSERO 268
bicalutamide 79
BICILLIN L-A 39
BIKTARVY 123
BILTRICIDE 104
bimatoprost 284
bismuth-metronidazole-tetracyc 217
bisoprolol fumarate 169
bisoprolol-hydrochlorothiazide 178
BIXLENVO 123
blisovi 24 fe 237
blisovi fe 237

BONSITY 275
BOOSTRIX TDAP 268
bosentan 293
BOSULIF 87
bosutinib 87
BRAFTOVI 87
BREO ELLIPTA 296
breyna 296
BREZTRI AEROSPHERE 296
briellyn 237
BRILINTA 162
brimonidine tartrate 283
brimonidine tartrate-timolol 277
brinzolamide 284
brivaracetam 45
BRIVIACT 45
bromfenac sodium 281
bromocriptine mesylate 107
BRUKINSA 87
budesonide 286
budesonide dr 274
budesonide ec 274
budesonide er 274
budesonide-formoterol fumarate 296
bumetanide 184
BUPHENYL 221
buprenorphine 22
buprenorphine hcl 28
buprenorphine-naloxone 28,29
bupropion hcl 59,60
bupropion hcl sr 30,60
bupropion hcl sr 150mg tablet 60
bupropion xl 60
buspirone hcl 136
butalbital-acetaminophen 18
butalbital-acetaminophen-caffe 18
butalbital-aspirin-caffeine 18
butorphanol tartrate 24
BUTRANS 23
BYSANTI 113
BYSTOLIC 169

C

cabergoline 253
CABLIVI 162
CABOMETYX 87
calcipotriene 206
calcitonin-salmon 275
calcitrene 206
calcitriol 275
CALQUENCE 87
camila 247
camrese 237
camrese lo 237
CANASA 273
CANCIDAS 71
candesartan cilexetil 165
candesartan-hydrochlorothiazid 178
CAPLYTA 113
CAPRELSA 88
captopril 166
CARAFATE 219
CARBAGLU 209
carbamazepine 54
carbamazepine er 54
CARBATROL 55
carbidopa 108
carbidopa-levodopa 108
carbidopa-levodopa er 109
carbidopa-levodopa-entacapone 107
CARDIZEM 173
CARDIZEM CD 173
CARDIZEM LA 174
CARDURA 163
carglumic acid 209
CARNITOR 222
CARNITOR SF 222

carteolol hcl 282
cartia xt 174
carvedilol 170
carvedilol er 170
CASODEX 79
caspofungin acetate 71
CAVHANZA 88
CAYSTON 291
cefaclor 35
cefadroxil 35
cefazolin sodium 36
cefazolin sodium-dextrose 36
cefdinir 36
cefepime 36
cefepime hcl 36
cefepime-dextrose 36
cefixime 36
cefoxitin 36
cefoxitin sodium 36
cefpodoxime proxetil 36
cefprozil 36
ceftaroline fosamil 37
ceftazidime 37
ceftriaxone 37
cefuroxime 37
cefuroxime sodium 37
CELEBREX 18,19
celecoxib 19
CELEXA 62
CELLCEPT 264
CELONTIN 49
cephalexin 37
CEREZYME 222
cetirizine hcl 287
cevimeline hcl 199
chateal eq 237
CHEMET 212
chenodal 218
chlordiazepoxide hcl 136
chlorhexidine gluconate 199
chloroquine phosphate 105
chlorpromazine hcl 69
chlorthalidone 185
chlorzoxazone 297
cholestyramine 187
cholestyramine light 187
CHORIONIC GONADOTROPIN 231
ciclodan 71
ciclopirox 71
cilostazol 162
CIMDUO 126
cimetidine 219
cinacalcet hcl 275
CIPRO 43
ciprofloxacin hcl 43,279
ciprofloxacin-d5w 43
ciprofloxacin-dexamethasone 285
citalopram hbr 62
claravis 200
clarithromycin 41
clarithromycin er 41
clemastine fumarate 287
CLEOCIN 32
CLEOCIN HCL 32
CLEOCIN PHOSPHATE 32
CLEOCIN T 32
clindacin etz 32
clindacin p 32
clindamycin (pediatric) 32
clindamycin hcl 32
clindamycin phos-benzoyl perox 200
clindamycin phosphate 33
clindamycin phosphate-d5w 33
clindamycin-0.9% nacl 33
clindamycin-benzoyl peroxide 200
clobazam 50
clobetasol emollient 203
clobetasol propionate 203

clodan 203
clomipramine hcl 68
clonazepam 136
clonidine 162
clonidine hcl 163
clonidine hcl er 194
clopidogrel 162
clorazepate dipotassium 136
clotrimazole 71
clotrimazole-betamethasone 206
clozapine 121,122
clozapine odt 122
CLOZARIL 122
COARTEM 105
COBENFY 121
COBENFY STARTER PACK 121
codeine sulfate 24
colchicine 74
COLESTID 187
colestipol hcl 187
colistimethate 33
COMBIGAN 277
COMBIPATCH 237
COMBIVENT RESPIMAT 296
COMETRIQ 88
COMPLERA 126
compro 69
COMTAN 107
conjugated estrogens 233
constulose 215
COPIKTRA 88
CORLANOR 178
CORTEF 229
COSENTYX (2 SYRINGES) 258
COSENTYX SENSOREADY (2 PENS) 258
COSENTYX SENSOREADY PEN 258
COSENTYX SYRINGE 258,259
COSENTYX UNOREADY PEN 259
COSOPT 277
COTELLIC 88
COZAAR 165
CREON 222
CRESEMBA 71
CRESTOR 186
cromolyn sodium 222,280,292
cryselle 237
CRYSVITA 222
cyclobenzaprine hcl 297
cyclophosphamide 78
cycloserine 77
CYCLOSET 138
cyclosporine 264,278
cyclosporine modified 264
CYMBALTA 62
cyproheptadine hcl 287
cyred 237
cyred eq 237
CYSTADANE 222
CYSTADROPS 278
CYSTAGON 222
CYSTARAN 278
CYTOMEL 249
CYTOTEC 220

D

dabigatran etexilate 156
dalbavancin hcl 33
dalfampridine er 198
DALIRESP 292
DALVANCE 33
danazol 232
DANTRIUM 122
dantrolene sodium 123
DANZITEN 88
dapagliflozin 138

dapagliflozin-metfor er 5-1000 mg 139
dapagliflozin-metformin er 139
dapsone 77
DAPTACEL DTAP 268
daptomycin 33
DARAPRIM 105
darifenacin er 226
darunavir 129
dasatinib 88
dasetta 237
DAURISMO 89
DAYPRO 19
daysee 237
DAYVIGO 298
DDAVP 231
deblitane 247
deferasirox 213
DELSTRIGO 124
demeclocycline hcl 44
DEMSER 178
DENGVAXIA 268
DEPAKOTE 46
DEPAKOTE ER 46
DEPAKOTE SPRINKLE 46
DEPEN 228
DEPO-ESTRADIOL 233
DEPO-PROVERA 247
DEPO-SUBQ PROVERA 104 247
DEPO-TESTOSTERONE 232
dermacinrx lidocan 27
DESCOVY 126
desipramine hcl 68
desloratadine 287
desmopressin acetate 231
desogestr-eth estrad eth estra 237
desonide 203
desoximetasone 203
desvenlafaxine succinate er 63
dexamethasone 229
dexamethasone sodium phosphate 281
DEXEDRINE 192
dexmethylphenidate hcl 194
dextroamphetamine sulfate 192
dextroamphetamine sulfate er 192
dextroamphetamine-amphet er 192
dextroamphetamine-amphetamine 193
dextromethorphan hbr-quinidine 196
dextrose 2.5%-0.45% nacl 209
dextrose 5%-0.2% nacl 209
dextrose 5%-0.225% nacl 209
dextrose 5%-0.45% nacl 209
dextrose 5%-0.9% nacl 209
dextrose in water 214
DIACOMIT 46
diazepam 50,136,137
diazoxide 146
diclofenac potassium 19
diclofenac sodium 19,206,281
diclofenac sodium er 19
diclofenac sodium-misoprostol 19,20
dicloxacillin sodium 39
dicyclomine hcl 217
DIFICID 41
DIFLUCAN 72
difluprednate 281
digoxin 179
dihydroergotamine mesylate 74
DILANTIN 55
DILANTIN-125 55
dilt-xr 174
diltiazem 12hr er 174
diltiazem 24hr er 174
diltiazem 24hr er (cd) 174

diltiazem 24hr er (la) 174
diltiazem 24hr er (xr) 174
diltiazem hcl 175
dimethyl fumarate 198
DIOVAN 165
DIOVAN HCT 179
DIPENTUM 273
diphenoxylate-atropine 217
DIPROLENE 204
dipyridamole 162
disulfiram 28
divalproex sodium 46
divalproex sodium er 46
DIVIGEL 233
dofetilide 168
dolishale 238
donepezil hcl 58
donepezil hcl odt 58
dorzolamide hcl 284
dorzolamide-timolol 278
dotti 233
DOVATO 123
doxazosin mesylate 163
doxepin hcl 68,204,298
doxy 100 44
doxycycline hyclate 44
doxycycline ir-dr 201
doxycycline monohydrate 44
DRIZALMA SPRINKLE 63
dronabinol 70
droplet insulin syringe 148
droplet micron pen needle 148
droplet pen needle 148
dropsafe pen needle 148
drospirenone-eth estra-levomef 238
drospirenone-ethinyl estradiol 238
droxidopa 163
DUAVEE 249
DULERA 296
duloxetine hcl 63
DUPIXENT PEN 259
DUPIXENT SYRINGE 259
DUREZOL 281
dutasteride 227
dutasteride-tamsulosin 227

E

E.E.S. 200 41
easy comfort insulin syringe 148
easy comfort pen needle 149
easy touch insulin syringe 149
ec-naproxen 20
econazole nitrate 72
EDARBI 165
EDARBYCLOR 179
EDURANT 124
EDURANT PED 124
efavirenz 124
efavirenz-emtric-tenofov disop 124
efavirenz-lamivu-tenofov disop 125
EFFEXOR XR 63
ELELYSO 223
ELIDEL 204
ELIGARD 253
elinest 238
ELIQUIS 156
ELIQUIS SPRINKLE 156
eltrombopag olamine 160
eluryng 238
EMEND 70
EMGALITY PEN 75
EMGALITY SYRINGE 75
EMSAM 61
emtricitabine 126
emtricitabine-rilpivirne-tenof 126
emtricitabine-tenofovir disop 126

EMTRIVA 126
emzahh 247
enalapril maleate 166
enalapril-hydrochlorothiazide 179
ENBREL 264
ENBREL MINI 264
ENBREL SURECLICK 264
ENDARI 223
ENDOCET 24,25
ENGERIX-B ADULT 268
ENGERIX-B PEDIATRIC-ADOLESCENT 268
enilloring 238
enoxaparin sodium 156,157
enpresse 238
ENSACOVE 89
enskyce 238
entacapone 107
entecavir 132
ENTRESTO 179
ENTRESTO SPRINKLE 179
ENTYVIO PEN 259
enulose 215
ENVARSUS XR 265
EPIDIOLEX 46
epinastine hcl 281
epinephrine 290
epitol 55
EPIVIR 126,127
eplerenone 189
EPRONTIA 46
ergotamine-caffeine 74
ERIVEDGE 89
ERLEADA 79
erlotinib hcl 89
errin 247
ertapenem 40
ERVEBO (NATIONAL STOCKPILE) 269
ery 41
ERY-TAB 41
ERYPED 200 41
ERYPED 400 42
ERYTHROCIN LACTOBIONATE 42
erythromycin 42,279
erythromycin ethylsuccinate 42
erythromycin lactobionate 42
erythromycin-benzoyl peroxide 201
ESBRIET 295
escitalopram oxalate 63
ESGIC 18
eslicarbazepine acetate 55
esomeprazole magnesium 220
estarylla 238
ESTRACE 234
estradiol 234
estradiol (once weekly) 234
estradiol (twice weekly) 234
estradiol valerate 234
estradiol-norethindrone acetat 238
ESTRING 235
eszopiclone 298
ETCAMAH 81
ethambutol hcl 78
ethosuximide 50
ethynodiol-ethinyl estradiol 238
etodolac 20
etodolac er 20
etonogestrel-ethinyl estradiol 238
etravirine 125
EUCRISA 204
EULEXIN 79
everolimus 89,265
EVISTA 249
EVOTAZ 129
EXELON 58
exemestane 85

EXFORGE 180
EXFORGE HCT 180
EXJADE 213
EXXUA 60
EYSUVIS 281
ezetimibe 188
ezetimibe-simvastatin 188

F

falmina 238
famciclovir 134
famotidine 219
FANAPT 113,114
FARESTON 81
FARXIGA 139
FASENRA 296
FASENRA PEN 296
febuxostat 74
feirza 239
felbamate 47
felodipine er 172
FEMARA 85
fenofibrate 185
fenofibric acid 185
fentanyl 23
fentanyl citrate 25
fesoterodine fumarate er 226
FETZIMA 64
FIASP 149
FIASP FLEXTOUCH 149
FIASP PENFILL 149
FIASP PUMPCART 149
fidaxomicin 42
FINACEA 201
finasteride 227
fingolimod 198
FINTEPLA 47
FIRAZYR 256
FIRMAGON 253
flac otic oil 285
flecainide acetate 168
fluconazole 72
fluconazole-nacl 72
flucytosine 72
fludrocortisone acetate 229
flunisolide 286
fluocinolone acetonide 204
fluocinolone acetonide oil 285
fluocinonide 204
fluocinonide-e 204
fluorometholone 281
fluorouracil 206
fluoxetine dr 64
fluoxetine hcl 64
fluphenazine decanoate 110
fluphenazine hcl 110
flurbiprofen 20
flurbiprofen sodium 281
fluticasone propionate 204,286
fluticasone propionate hfa 286
fluticasone-salmeterol 296,297
fluvastatin er 186
fluvastatin sodium 186
fluvoxamine maleate 64
FML 282
FOCALIN 194
fondaparinux sodium 157
FORTEO 275
FOSAMAX 275
fosamprenavir calcium 129
fosfomycin tromethamine 33
fosinopril sodium 166
fosinopril-hydrochlorothiazide 180
FOTIVDA 89
FRUZAQLA 89,90
FULPHILA 160
furosemide 184
FUZEON 128
fyavolv 239
FYCOMPA 47

G

gabapentin 50,51
galantamine er 58
galantamine hbr 58
galantamine hydrobromide 58
galbriela 239
gallifrey 247
GAMMAGARD LIQUID 257
GAMMAGARD LIQUID ERC 257
GAMMAGARD S-D 257
GAMMAPLEX 257
GAMUNEX-C 257
GARDASIL 9 269
gatifloxacin 279
gauze pad 139
GAUZE PADS & DRESSINGS - PADS 2 X 2 139
gavilyte-c 218
gavilyte-g 218
gavilyte-n 218
GAVRETO 90
gefitinib 90
gemfibrozil 185
gemmily 239
GEMTESA 226
generlac 216
gengraf 265
gentamicin sulfate 31,208,279
gentamicin sulfate in ns 31
GENVOYA 123
GEODON 114
GILENYA 198
GILOTRIF 90
glatiramer acetate 198
glatopa 198
GLEEVEC 90
GLEOSTINE 78
glimepiride 139
glipizide 139
glipizide er 140
glipizide xl 140
glipizide-metformin 140
GLUCAGON EMERGENCY KIT 146
glucose 5%-0.9% nacl 209
glucose in water 214
GLUCOTROL XL 140
glyburide 140
glyburide micronized 141
glyburide-metformin hcl 141
glycopyrrolate 217
GLYXAMBI 141
GOLYTELY 218
GOMEKLI 90
granisetron hcl 70
GRANIX 160
griseofulvin 72
griseofulvin ultramicrosize 72
guanfacine hcl 163
guanfacine hcl er 194
GVOKE 146
GVOKE HYPOPEN 1-PACK 146,147
GVOKE HYPOPEN 2-PACK 147
GVOKE PFS 1-PACK SYRINGE 147
GVOKE PFS 2-PACK SYRINGE 147

H

HADLIMA 265
HADLIMA PUSHTOUCH 265
HADLIMA(CF) 265
HADLIMA(CF) PUSHTOUCH 265
HAEGARDA 256
hailey 239
hailey 24 fe 239
hailey fe 239

HALDOL DECANOATE 100 110
halobetasol propionate 204
haloette 239
haloperidol 110
haloperidol decanoate 110
haloperidol decanoate 100 110
haloperidol lactate 110
HAVRIX 269
heather 247
HEMADY 229
heparin sodium 157
HEPLISAV-B 269
HERNEXEOS 90
HETLIOZ 298
HIBERIX 269
hidex 229
HUMALOG 149
HUMALOG JUNIOR KWIKPEN 149
HUMALOG KWIKPEN U-100 150
HUMALOG KWIKPEN U-200 150
HUMALOG MIX 50-50 KWIKPEN 150
HUMALOG MIX 75-25 150
HUMALOG MIX 75-25 KWIKPEN 150
HUMALOG TEMPO PEN U-100 150
HUMATIN 31
HUMULIN 70-30 150
HUMULIN 70/30 KWIKPEN 150
HUMULIN N 150
HUMULIN N KWIKPEN 150
HUMULIN R 150
HUMULIN R U-500 150
HUMULIN R U-500 KWIKPEN 150
hydralazine hcl 190
HYDREA 82
hydrochlorothiazide 185
hydrocodone bitartrate er 23
hydrocodone-acetaminophen 25
hydrocodone-ibuprofen 25
hydrocortisone 205,230,274
hydrocortisone butyrate 205
hydrocortisone valerate 205
hydrocortisone-acetic acid 285
hydromorphone hcl 25,26
hydroxychloroquine sulfate 105
hydroxyurea 82
hydroxyzine hcl 137
hydroxyzine pamoate 137
HYRNUO 90
HYZAAR 180

I

ibandronate sodium 276
IBRANCE 91
IBTROZI 91
ibu 20
ibuprofen 20,21
icatibant 256
iclevia 239
ICLUSIG 91
icosapent ethyl 188
IDHIFA 91
IDVYNSO 130
ILEVRO 282
imatinib mesylate 91
IMBRUVICA 91,92
imipenem-cilastatin sodium 40
imipramine hcl 68
imiquimod 207
IMITREX 75,76
IMKELDI 92
IMOVAX RABIES VACCINE 269
IMPAVIDO 33

IMURAN 265
INBRIJA 109
incassia 247
INCRELEX 231
INCRUSE ELLIPTA 288
indapamide 185
INDERAL LA 170
INDERAL XL 170
indomethacin 21
indomethacin er 21
INFANRIX DTAP 269
INGREZZA 196
INGREZZA INITIATION PK(TARDIV) 196
INGREZZA SPRINKLE 196
INLURIYO 81
INLYTA 92
INNOPRAN XL 170
INQOVI 82
INREBIC 92
INSPRA 189
INSULIN ASPART 151
INSULIN ASPART FLEXPEN 151
INSULIN ASPART PENFILL 151
INSULIN PEN NEEDLE 151
insulin syringe 151
INSULIN SYRINGE (DISP) U-100 0.3 ML 151
INSULIN SYRINGE (DISP) U-100 1 ML 151
INSULIN SYRINGE (DISP) U-100 1/2 ML 151
insupen pen needle 151
INTELENCE 125
INTRALIPID 214
introvale 239
INVEGA 114
INVEGA HAFYERA 114
INVEGA SUSTENNA 114,115
INVEGA TRINZA 115
INVELTYS 282
IPOL 269
ipratropium bromide 288,289
ipratropium-albuterol 297
irbesartan 165
irbesartan-hydrochlorothiazide 180
IRESSA 92
ISENTRESS 123
ISENTRESS HD 124
isibloom 239
isoniazid 78
ISOPROPYL ALCOHOL 0.7 ML/ML MEDICATED PAD 141
ISORDIL TITRADOSE 190
isosorbide dinitrate 190
isosorbide mononitrate 190
isosorbide mononitrate er 190
isotretinoin 201
isradipine 172
ISTALOL 283
ITOVEBI 92
itraconazole 72
ivabradine hcl 180
ivermectin 105,208
IWILFIN 82
IXIARO 269

J

JADENU 213
JADENU SPRINKLE 213
jaimiess 239
JAKAFI 92
jantoven 157
JANUMET 141
JANUMET XR 141
JANUVIA 141
JARDIANCE 142
jasmiel 239

JAYPIRCA 92,93
jencycla 247
JENTADUETO 142
JENTADUETO XR 142
JIDEYTRO 93
jinteli 239
jolessa 240
JOURNAVX 18
JUBBONTI 276
juleber 240
JULUCA 124
junel 240
junel fe 240
junel fe 24 240
JUXTAPID 188
JYNARQUE 213
JYNNEOS 270
JYNNEOS (NATIONAL STOCKPILE) 269

K

kaitlib fe 240
KALETRA 130
kalliga 240
KALYDECO 291
kariva 240
kcl-d5w-0.2% nacl 209
kcl-d5w-0.225% nacl 210
kcl-d5w-0.45% nacl 210
kelnor 1-35 240
kelnor 1-50 240
KEPPRA 47
KERENDIA 190
KESIMPTA PEN 198
ketoconazole 72
ketorolac tromethamine 21,282
KINRIX 270
kionex 215
KISQALI 93
KISQALI FEMARA CO-PACK 83
KLARON 201
klayesta 72
KLOR-CON 10 210
KLOR-CON 8 210
klor-con m10 210
KLOR-CON M15 210
klor-con m20 210
KLOXXADO 29
KOMZIFTI 93
KORLYM 253
KOSELUGO 93
kourzeq 199
KRAZATI 93
kurvelo 240
KUVAN 223

L

l-glutamine 223
labetalol hcl 170
lacosamide 55
lactulose 216
LAMICTAL 47
LAMICTAL (BLUE) 48
lamivudine 127,132
lamivudine hbv 132
lamivudine-zidovudine 127
lamotrigine 48
lamotrigine (blue) 48
lamotrigine er 48
LAMPIT 105
LANOXIN 180
lansoprazole 220
LANTUS 151
LANTUS SOLOSTAR 151
lapatinib 94
larin 240
larin 24 fe 240
larin fe 240
LASIX 184
latanoprost 284
LATUDA 115

LAYOLIS FE 240
LAZCLUZE 94
leena 241
leflunomide 265
lenalidomide 80
LENVIMA 94
lessina 241
LETAIRIS 293
letrozole 85
leucovorin calcium 83
LEUKERAN 79
LEUKINE 160
leuprolide acetate 253
leuprolide depot 253
levalbuterol tartrate hfa 290
levetiracetam 48
levetiracetam er 48
LEVO-T 249
levobunolol hcl 283
levocarnitine 223
levocetirizine dihydrochloride 287
levofloxacin 43
levofloxacin-d5w 43
levonest 241
levonorg-eth estrad eth estrad 241
levonorgestrel-eth estradiol 241
levora-28 241
levorphanol tartrate 23
levothyroxine sodium 250
LEVOXYL 250
LEXAPRO 64
LIALDA 273
lidocaine 27
lidocaine hcl 27
lidocaine hcl laryngotracheal 4% solution 27
lidocaine hcl viscous 27
lidocaine-prilocaine 28
lidocan iii 28
lidocan iv 28
lidocan v 28
LIFYORLI 254
LILETTA 228
linezolid 33
linezolid-0.9% nacl 34
linezolid-d5w 34
LINZESS 216
liomny 250
liothyronine sodium 250
LIPITOR 186
lisdexamfetamine dimesylate 193
lisinopril 166
lisinopril-hydrochlorothiazide 181
lithium carbonate 137
lithium carbonate er 138
lithium citrate 138
LITHOBID 138
LIVTENCITY 131
lo-zumandimine 241
LOESTRIN 241
LOESTRIN FE 241
lojaimiess 241
LOKELMA 215
lomustine 79
LONSURF 83
loperamide 217
LOPID 185
lopinavir-ritonavir 130
LOPRESSOR 170
lorazepam 137
lorazepam intensol 137
LORBRENA 94
loryna 241
losartan potassium 165
losartan-hydrochlorothiazide 181
LOTENSIN 167
LOTRONEX 217

lovastatin 186
LOVENOX 158
low-ogestrel 241
loxapine 111
lubiprostone 216
luizza 242
LUMAKRAS 94
LUMIGAN 284
LUMRYZ 299
LUMRYZ STARTER PACK 299
LUPRON DEPOT 254
LUPRON DEPOT (LUPANETA) 254
LUPRON DEPOT-PED 254
lurasidone hcl 115
lurbipr 21
lutera 242
LYBALVI 116
lyleq 247
lyllana 235
LYNPARZA 95
LYRICA 51
LYSODREN 83
LYTGOBI 95
LYUMJEV 152
LYUMJEV KWIKPEN U-100 152
LYUMJEV KWIKPEN U-200 152
LYUMJEV TEMPO PEN U-100 152
lyza 247

M

M-M-R II VACCINE 270
magnesium sulfate 210
MALARONE 105
malathion 208
maraviroc 128
marlissa 242
MARPLAN 61
MATULANE 79
matzim la 175
MAVYRET 132
MAXALT 76
MAXALT MLT 76
MAXITROL 278
meclizine hcl 69
MEDROL 230
medroxyprogesterone acetate 247
mefloquine hcl 106
megestrol acetate 248
MEKINIST 95
MEKTOVI 95
meleya 248
meloxicam 21
memantine hcl 59
memantine hcl er 59
MENEST 235
MENQUADFI 270
MENVEO A-C-Y-W-135-DIP 270
mercaptopurine 82
meropenem 40
meropenem-0.9% nacl 40
merzee 242
mesalamine 273
mesalamine dr 273
mesalamine er 273
mesna 104
MESNEX 104
MESTINON 77
metformin hcl 142
metformin hcl er 142
methadone hcl 23
methazolamide 181
methenamine hippurate 34
methimazole 256
methocarbamol 297
methotrexate 265

methotrexate sodium 266
methoxsalen 207
methscopolamine bromide 217
methsuximide 50
methylphenidate er 194
methylphenidate hcl 195
methylprednisolone 230
methyltestosterone 232
metoclopramide hcl 218
metolazone 185
metoprolol succinate 170
metoprolol tartrate 171
metoprolol-hydrochlorothiazide 181
METRO IV 34
METROCREAM 208
METROGEL 208
metronidazole 34,208
metyrosine 181
mexiletine hcl 168
micafungin 72
MICARDIS HCT 181
microgestin 242
microgestin fe 242
midodrine hcl 163
MIEBO 278
mifepristone 254
miglustat 223
mili 242
MIMRYLO 83
mimvey 242
minocycline hcl 45
minoxidil 190
mirtazapine 60
misoprostol 220
modafinil 299
MODEYSO 95
moexipril hcl 167
molindone hcl 111
mometasone furoate 205,287
mondoxyne nl 45
mono-linyah 242
montelukast sodium 288
morphine sulfate 26
morphine sulfate er 23
MOUNJARO 142
MOVANTIK 216
MOVIPREP 218
moxifloxacin 43,279
moxifloxacin hcl 43
MRESVIA 270
MULTAQ 168
mupirocin 208
mycophenolate mofetil 266
mycophenolic acid 266
MYFORTIC 266
MYHIBBIN 266
MYRBETRIQ 226
MYSOLINE 51

N

nabumetone 21
nadolol 171
nafcillin 39
nafcillin sodium 39
naloxone hcl 29
naltrexone hcl 29
nano 2nd gen pen needle 152
nano pen needle 152
naproxen 21,22
naproxen sodium 22
naratriptan hcl 76
NARCAN 30
NARDIL 61
NATACYN 279
nateglinide 143
NAYZILAM 51
nebivolol hcl 171
NEBUPENT 106
necon 242
NEEDLES, INSULIN DISP., SAFETY 152

nefazodone hcl 65
neo-polycin 280
neo-polycin hc 278
neomycin sulfate 31
neomycin-bacitracin-poly-hc 278
neomycin-bacitracin-polymyxin 280
neomycin-polymyxin-dexameth 278
neomycin-polymyxin-gramicidin 280
neomycin-polymyxin-hc 285
neomycin-polymyxin-hydrocort 285
NEORAL 266
NERLYNX 95
neuac 201
NEUPRO 107
NEURONTIN 51,52
nevirapine 125
nevirapine er 125
NEXAVAR 95
NEXIUM 220
NEXLETOL 188
NEXLIZET 188
NEXPLANON 228
niacin er 188
nicardipine hcl 172
NICOTROL 30
NICOTROL NS 30
nifedipine 172
nifedipine er 172
nikki 242
NILANDRON 80
nilotinib hcl 95
nilutamide 80
nimodipine 172
NINLARO 96
nintedanib esylate 295
nisoldipine 172
nitazoxanide 106
nitisinone 223
NITRO-BID 191
nitrofurantoin 34
nitrofurantoin mono-macro 34
nitroglycerin 191
nitroglycerin patch 191
NITROLINGUAL 191
NITROSTAT 191
NIVESTYM 160
nizatidine 219
NORA-BE 248
norelgestromin-eth estradiol 242
norethin-eth estra-ferrous fum 242
norethindron-ethinyl estradiol 243
norethindrone 248
norethindrone ac (lupaneta) 248
norethindrone acetate 248
norethindrone-e.estradiol-iron 243
norgestimate-ethinyl estradiol 243
NORPRAMIN 68
NORTHERA 163
nortrel 243
nortriptyline hcl 68
NORVASC 173
NORVIR 130
NOVOLIN 70-30 152
NOVOLIN 70-30 FLEXPEN 152
NOVOLIN N 152
NOVOLIN N FLEXPEN 152
NOVOLIN R 153
NOVOLIN R FLEXPEN 153
NOVOLOG 153
NOVOLOG FLEXPEN 153
NOVOLOG MIX 70-30 153

NOVOLOG MIX 70-30 FLEXPEN 153
NOVOLOG PENFILL 153
NOXAFIL 73
NUBEQA 80
NUEDEXTA 197
NUPLAZID 116
NURTEC ODT 75
NUTRILIPID 214
NUVARING 243
NUVIGIL 299
nyamyc 73
nylia 243
nystatin 73
nystatin-triamcinolone 207
nystop 73

O

ocella 243
octreotide acetate 255
octreotide acetate er 255
OCUFLOX 280
ODEFSEY 127
ODOMZO 96
OFEV 295
ofloxacin 43,280,285
OGSIVEO 96
OJEMDA 96
OJJAARA 96
olanzapine 116
olanzapine odt 116
olmesartan medoxomil 166
olmesartan-amlodipine-hctz 181
olmesartan-hydrochlorothiazide 181
olopatadine hcl 287
omega-3 acid ethyl esters 188
omeprazole 221
omnipod 5 (libre 2/3 plus) 153
omnipod 5 dexg7g6 intro(gen 5) 154
omnipod 5 dexg7g6 pods (gen 5) 154
omnipod 5 intro (libre2/3plus) 154
omnipod classic pods (gen 3) 154
omnipod dash intro kit (gen 4) 154
omnipod dash pdm kit (gen 4) 154
omnipod dash pods (gen 4) 154
omnipod go pods 154
OMNITROPE 231
ondansetron hcl 70
ondansetron odt 71
ONFI 52
ONUREG 83
OPIPZA 116
OPVEE 30
ORACEA 201
oralone 199
ORENCIA 259
ORENCIA CLICKJECT 259
ORENITRAM ER 293
ORENITRAM MONTH 1 TITRATION KT 293
ORENITRAM MONTH 2 TITRATION KT 294
ORENITRAM MONTH 3 TITRATION KT 294
ORFADIN 223
ORGOVYX 84
ORKAMBI 291
orquidea 248
ORSERDU 81
oseltamivir phosphate 133
OSENVELT 276
OTEZLA 207
OTEZLA XR 207
OVIDE 208
oxaprozin 22

oxazepam 137
oxcarbazepine 56
oxybutynin chloride 226
oxybutynin chloride er 226,227
oxycodone hcl 26
oxycodone-acetaminophen 26
OZEMPIC 143

P

PACERONE 168
paliperidone er 116,117
PALYNZIQ 223
PANRETIN 104
pantoprazole sodium 221
paricalcitol 276
PARNATE 62
paroxetine cr 65
paroxetine er 65
paroxetine hcl 65
PAXIL 65
PAXLOVID 135
PAXLOVID (EUA) 134,135
pazopanib hcl 96
PEDIARIX 270
PEDVAXHIB 270
peg 3350-electrolyte 218
peg-3350 and electrolytes 218
peg3350-sod sul-nacl-kcl-asb-c 218
PEGASYS 263
PEMAZYRE 97
pen needle 154
PENBRAYA 270
penicillamine 228
penicillin g potassium 39
penicillin g sodium 39
penicillin gk-iso-osm dextrose 39
penicillin v potassium 39
PENMENVY MEN A-B-C-W-Y 270
PENTACEL 270
PENTAM 300 106
pentamidine isethionate 106
PENTASA 273,274
pentoxifylline 182
perampanel 48
perindopril erbumine 167
periogard 199
permethrin 208
perphenazine 69
PERSERIS 117
pfizerpen 39
phenelzine sulfate 62
phenobarbital 52
phenoxybenzamine hcl 163
PHENYTEK 56
phenytoin 56
phenytoin sodium extended 56
philith 244
PIFELTRO 125
pilocarpine hcl 199,284
pimecrolimus 205
pimozide 111
pimtrea 244
pindolol 171
pioglitazone hcl 143
pioglitazone-glimepiride 143
pioglitazone-metformin 143
piperacillin-tazobactam 40
PIQRAY 97
pirfenidone 295
piroxicam 22
PLAQUENIL 106
PLAVIX 162
PLEGRIDY 198
PLEGRIDY PEN 198
podofilox 207
polycin 280
polymyxin b sul-trimethoprim 280
pomalidomide 80

POMALYST 80
portia 244
posaconazole 73
potassium chloride 211
potassium chloride in d5lr 211
potassium chloride proamp 211
potassium chloride-0.45% nacl 211
potassium chloride-dextrose 5% 211
potassium citrate er 211
pramipexole dihydrochloride 108
prasugrel hcl 162
pravastatin sodium 186,187
praziquantel 105
prazosin hcl 164
PRED FORTE 282
PRED MILD 282
prednisolone 230
prednisolone acetate 282
prednisolone sodium phosphate 230,282
prednisone 230
pregabalin 52,53
PREGNYL 231
PREMARIN 235
PREMPHASE 244
PREMPRO 244
PRETOMANID 78
PREVACID 221
prevalite 188
PREVYMIS 132
PREZCOBIX 130
PREZISTA 130,131
PRIFTIN 78
primaquine 106
primidone 53
PRIORIX 270
PRISTIQ 65
PROAIR RESPICLICK 290
probenecid 74
probenecid-colchicine 74
PROCARDIA XL 173
prochlorperazine 69
prochlorperazine maleate 69
PROCRIT 160
procto-med hc 274
proctosol-hc 274
proctozone-hc 275
progesterone 248
PROGLYCEM 147
PROGRAF 266
PROLASTIN C 224
PROLENSA 282
PROLIA 276
PROMACTA 161
promethazine hcl 70
promethegan 70
propafenone hcl 168
propafenone hcl er 168
propranolol hcl 171
propranolol hcl er 171
propylthiouracil 256
PROQUAD 270
PROSCAR 227
PROTONIX 221
protriptyline hcl 69
PROVERA 248
PROZAC 66
PRUDOXIN 205
PULMOZYME 291
PURIXAN 82
PYLERA 218
pyrazinamide 78
pyridostigmine bromide 77
pyridostigmine bromide er 77
pyrimethamine 106
PYRUKYND 224
PYZCHIVA 259,260

Q

QINLOCK 97
QUADRACEL DTAP-IPV 270
quetiapine fumarate 117
quetiapine fumarate er 117
quinapril hcl 167
quinapril-hydrochlorothiazide 182
quinidine gluconate 169
quinidine sulfate 169
quinine sulfate 106
QVAR REDIHALER 287

R

RABAVERT 271
rabeprazole sodium 221
RALDESY 66
raloxifene hcl 249
ramelteon 298
ramipril 167
ranolazine er 182
RAPAFLO 228
rasagiline mesylate 109
RASONQUE 97
reclipsen 244
RECOMBIVAX HB 271
RECTIV 191
REGLAN 218
RELENZA 133
RELISTOR 216
REMERON 60,61
repaglinide 143
REPATHA SURECLICK 189
REPATHA SYRINGE 189
RESTASIS 278
RETACRIT 161
RETEVMO 97
RETIN-A 201
RETROVIR 127
REVCOVI 224
REVUFORJ 97,98
REXTOVY 30
REXULTI 117
REYATAZ 131
REZDIFFRA 224
REZLIDHIA 98
RHOPRESSA 284
ribavirin 133
RIDAURA 260
rifabutin 77
rifampin 78
rifapentine 78
rilpivirine 125
rilpivirine hcl 125
riluzole 197
RINVOQ 260
RINVOQ LQ 260
risedronate sodium 276
risedronate sodium dr 276
RISPERDAL 118
RISPERDAL CONSTA 118
risperidone 118
risperidone er 118
risperidone odt 118,119
RITALIN 195
ritonavir 131
rivaroxaban 158
rivastigmine 59
rizatriptan 76
ROCALTROL 276
ROCKLATAN 284
roflumilast 292
ROMVIMZA 98
ropinirole er 108
ropinirole hcl 108
rosuvastatin calcium 187
ROTARIX 271
ROTATEQ 271
ROWASA 274
roweepra 49
ROXICODONE 27

ROZEREM 298
ROZLYTREK 98
RUBRACA 98
rufinamide 56
RUKOBIA 128
RYBELSUS 144
RYDAPT 98
RYTARY 109

S

SABRIL 53
sacubitril-valsartan 182
sajazir 256
SALAGEN 199
SAMSCA 214
SANDIMMUNE 266
SANDOSTATIN LAR DEPOT 255
SANTYL 207
SAPHRIS 119
sapropterin dihydrochloride 224
saxagliptin hcl 144
saxagliptin-metformin er 144
SCEMBLIX 98,99
scopolamine 70
SECUADO 119
selegiline hcl 109
selenium sulfide 205
SELZENTRY 128,129
SENSIPAR 276
SEREVENT DISKUS 290
SEROQUEL 119
SEROQUEL XR 119
sertraline hcl 66
setlakin 244
SFROWASA 274
sharobel 248
SHINGRIX 271
SIGNIFOR 255
SIGNIFOR LAR 255
sildenafil citrate 294
SILENOR 298
silodosin 228
SILVADENE 207
silver sulfadiazine 207
SIMBRINZA 284
SIMLANDI(CF) 267
SIMLANDI(CF) AUTOINJECTOR 267
simliya 244
simpesse 244
simvastatin 187
SINEMET 109
SINEMET 10-100 109
SINEMET 25-100 109
SINGULAIR 288
sirolimus 267
SIRTURO 78
sitagliptin phos-metformin 144
sitagliptin phos-metformin er 144
sitagliptin phosphate 144
SIVEXTRO 34
SKYLA 228
SKYRIZI 260
SKYRIZI ON-BODY 260
SKYRIZI PEN 261
sod sulf-potass sulf-mag sulf 218
sodium chloride 212
sodium chloride-water 212
sodium oxybate 300
sodium phenylbutyrate 224
sodium polystyrene sulfonate 215
solifenacin succinate 227
SOLIQUA 100-33 144
SOLTAMOX 81
SOMATULINE DEPOT 255
SOMAVERT 255
SOOLANTRA 208
sorafenib 99
sotalol 169

sotalol af 169
SPIRIVA HANDIHALER 289
SPIRIVA RESPIMAT 289
spironolactone 190
spironolactone-hctz 182
SPORANOX 73
sprintec 244
SPRITAM 49
SPRYCEL 99
SPS 215
sronyx 244
SSD 208
STAMARIL 271
STELARA 261
STEQEYMA 261
sterile pads 145
STIOLTO RESPIMAT 297
STIVARGA 99
STOBOCLO 277
STRATTERA 195
STRENSIQ 224
streptomycin sulfate 31
STRIBILD 124
STROMECTOL 105
SUBOXONE 29
subvenite 49
subvenite (blue) 49
sucralfate 220
SULAR 173
sulfacetamide sodium 201,280
sulfacetamide-prednisolone 278
sulfadiazine 44
sulfamethoxazole-trimethoprim 44
sulfasalazine 274
sulfasalazine dr 274
sulindac 22
sumatriptan 76
sumatriptan succinate 76
sunitinib malate 99
SUNLENCA 129
SUPREP 219
SUTAB 219
SUTENT 99
syeda 244
SYMFI 125
SYMLINPEN 120 145
SYMLINPEN 60 145
SYMPAZAN 53
SYMTUZA 131
SYNAREL 255
SYNJARDY 145
SYNJARDY XR 145
SYNTHROID 251
SYPRINE 214

T

TABLOID 82
TABRECTA 100
tacrolimus 206,267
tacrolimus xl 267
tadalafil 228,294
TAFINLAR 100
TAGRISSO 100
TALZENNA 100
TAMIFLU 133
tamoxifen citrate 81
tamsulosin hcl 228
taperdex 231
TARGRETIN 104
tarina 24 fe 244
tarina fe 244
tarina fe 1-20 eq 244
TASIGNA 100
tasimelteon 298
TASMAR 107
taysofy 245
tazarotene 201
tazicef 37
TAZORAC 201,202
taztia xt 175
TAZVERIK 101

TECFIDERA 199
TEFLARO 37
TEGRETOL 56
TEGRETOL XR 56
TEKTURNA 182
telmisartan 166
telmisartan-amlodipine 182
telmisartan-hydrochlorothiazid 182
temazepam 299
tencon 18
TENIVAC 271
tenofovir disoproxil fumarate 127
TENORETIC 100 183
TENORETIC 50 183
TENORMIN 171
TEPMETKO 101
terazosin hcl 164
terbinafine hcl 73
terbutaline sulfate 290
terconazole 73
TERIPARATIDE 277
testosterone 232
testosterone cypionate 233
testosterone enanthate 233
tetrabenazine 197
tetracycline hcl 45
THALOMID 81
THEO-24 292
theophylline anhydrous 292
theophylline er 292
thioridazine hcl 111
thiothixene 111
THYMOGLOBULIN 258
tiadylt er 175
tiagabine hcl 53
TIAZAC 175
TIBSOVO 101
ticagrelor 162
TICOVAC 271
tigecycline 34
TIKOSYN 169
tilia fe 245
timolol maleate 171,283
TIMOPTIC OCUDOSE 283
tinidazole 34
tiotropium bromide 289
TIROSINT 251
TIROSINT-SOL 252
TIVICAY 124
TIVICAY PD 124
tizanidine hcl 123
TOBRADEX 279
tobramycin 280,291
tobramycin sulfate 31
tobramycin-dexamethasone 279
tolcapone 107
tolterodine tartrate 227
tolterodine tartrate er 227
tolvaptan 214
topiramate 49
TOPROL XL 172
toremifene citrate 82
torpenz 101
torsemide 184
TOUJEO MAX SOLOSTAR 154
TOUJEO SOLOSTAR 155
TOVIAZ 227
TRACLEER 294
TRADJENTA 145
tramadol hcl 27
tramadol hcl er 24
tramadol hcl-acetaminophen 27
trandolapril 167
trandolapril-verapamil er 183
tranexamic acid 161
tranylcypromine sulfate 62
TRAVASOL 215
TRAVATAN Z 284
travoprost 284

trazodone hcl 66
TRELEGY ELLIPTA 297
TRELSTAR 256
TREMFYA 261
TREMFYA ONE-PRESS 261
TREMFYA PEN 261,262
TREMFYA PEN INDUCTION (2 PEN) 262
tretinoin 104,202
tri-estarylla 245
tri-legest fe 245
tri-linyah 245
tri-lo-estarylla 245
tri-lo-marzia 245
tri-lo-mili 245
tri-lo-sprintec 245
tri-mili 245
tri-nymyo 245
tri-sprintec 245
tri-vylibra 245
tri-vylibra lo 245
triamcinolone acetonide 199,206
triamterene-hydrochlorothiazid 184
TRIBENZOR 183
triderm 206
trientine hcl 214
trifluoperazine hcl 111
trifluridine 280
trihexyphenidyl hcl 107
TRIKAFTA 291,292
triklo 189
TRILEPTAL 56
trilitas 202
trimethoprim 34
trimipramine maleate 69
TRINTELLIX 66
TRIUMEQ 127
TRIUMEQ PD 127
trivora-28 245
TROPHAMINE 215
trospium chloride 227
trospium chloride er 227
true comfort safety pen needle 155
TRULICITY 145
TRUMENBA 271
TRUQAP 101
TRUVADA 127
TUKYSA 101
TURALIO 101
turqoz 245
TWINRIX 271
TYBOST 129
tydemy 245
TYENNE 262
TYENNE AUTOINJECTOR 262
TYGACIL 35
TYKERB 101
TYMLOS 277
TYPHIM VI 272

U

UDENYCA 161
UDENYCA AUTOINJECTOR 161
UDENYCA ONBODY 161
ultra-fine insulin syringe 155
ultra-fine pen needle 155
unifine otc pen needle 155
unifine pentips 155
unifine pentips plus 155
unifine ultra pen needle 155
UNITHROID 252
ursodiol 219
USTEKINUMAB 262
USTEKINUMAB-AEKN 262
UZEDY 119,120

V

VAGIFEM 235

valacyclovir 134
VALCHLOR 79
VALCYTE 132
valganciclovir hcl 132
valproic acid 49
valsartan 166
valsartan-hydrochlorothiazide 183
VALTOCO 53
VALTREX 134
valtya 245
vancomycin hcl 35
VANFLYTA 101
VAQTA 272
varenicline tartrate 30
VARIVAX VACCINE 272
VASCEPA 189
VASERETIC 183
VASOTEC 167
VAXCHORA VACCINE 272
velivet 246
VENCLEXTA 102
VENCLEXTA STARTING PACK 102
venlafaxine besylate er 66
venlafaxine hcl 66
venlafaxine hcl er 67
VENTAVIS 294
VENTOLIN HFA 290
VEOZAH 197
VEPPANU 82
verapamil er 175
verapamil er pm 176
verapamil hcl 176
verapamil sr 176
VERELAN PM 176
VERQUVO 191
VERSACLOZ 122
VERZENIO 102
vestura 246
VFEND IV 74
VIBERZI 217
vienva 246
vigabatrin 53
vigadrone 54
VIGAFYDE 54
VIGAMOX 280
vigpoder 54
VIIBRYD 67
vilazodone hcl 67
VIMKUNYA 272
VIMPAT 57
viorele 246
VIRACEPT 131
VIREAD 128
VITRAKVI 102
VIVITROL 29
VIVOTIF 272
VIZIMPRO 102
volnea 246
VONJO 102
VORANIGO 103
voriconazole 74
voriconazole (hpbcd) 74
VOSEVI 133
VOTRIENT 103
VOWST 219
VPRIV 225
VRAYLAR 120
VUMERITY 199
vyfemla 246
vylibra 246
VYTORIN 189
VYVANSE 193

W

warfarin sodium 158
WELIREG 225
WELLBUTRIN SR 61
WELLBUTRIN XL 61
wera 246
WINREVAIR 294

WINREVAIR (2 PACK) 294
wixela inhub 297
wymzya fe 246
WYOST 277

X

XALKORI 103
xarah fe 246
XARELTO 158,159
XATMEP 267
XCOPRI 57
XDEMVY 279
xelria fe 246
XENAZINE 197
XERMELO 217
XGEVA 277
XHANCE 287
XIFAXAN 219
XIGDUO XR 145,146
XIIDRA 279
XOFLUZA 133,134
XOLAIR 263
XOPENEX HFA 290
XOSPATA 103
XPOVIO 84
XPOVIO 40 MG ONCE WEEKLY 84
Xpovio 80 mg once weekly 16 pack 84
XTANDI 80
xulane 246
xyvona 24

Y

yargesa 225
YASMIN 28 246
YAZ 246
YF-VAX 272
yulithira 103
yuvafem 235

Z

zafemy 246
zafirlukast 288
zaleplon 299
ZARONTIN 50
ZEJULA 103
ZELBORAF 103
zelvysia 225
zenatane 202
ZENBEXUS 81
ZENPEP 225
zenzedi 194
ZEPATIER 133
ZESTORETIC 183
ZESTRIL 167
ZETIA 189
ZIAGEN 128
zidovudine 128
ZIEXTENZO 161
ziprasidone hcl 120
ziprasidone mesylate 120
ZITHROMAX 42
ZITHROMAX TRI-PAK 42
ZOCOR 187
ZOKINVY 225
ZOLINZA 84
zolmitriptan odt 77
ZOLOFT 67
zolpidem tartrate 299
zolpidem tartrate er 299
ZONALON 206
ZONEGRAN 57
ZONISADE 57
zonisamide 57
ZORTRESS 267
ZOSYN 40
zovia 1-35 247
ZOVIRAX 134
ZTALMY 54
ZTLIDO 28

zumandimine.....247
ZURZUVAE.....61
ZYDELIG.....104
ZYKADIA.....104
ZYPREXA.....121
ZYPREXA ZYDIS.....121
ZYVOX.....35

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 2026

(Lista de medicamentos cubiertos o "Lista de medicamentos")

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

ID de presentación del archivo del formulario aprobado por HPMS: 26303

Este formulario se actualizó el 01/11/2026.

Para obtener información más reciente o si tiene otras preguntas, comuníquese con el Servicio para afiliados de Hamaspik Medicare Select y Hamaspik Medicare Choice al 888-426-2774. (Los usuarios de TTY deben llamar al 711). Estamos abiertos los 7 días de la semana, de 8:00 a. m. to 8:00 p. m., del 1 de octubre de 2025 al 31 de marzo de 2026; y de lunes a viernes, de 8:00 a. m. a 8:00 p. m., del 1 de abril de 2026 al 30 de septiembre de 2026, o visite www.hamaspik.com.