

# Prescription Guidelines for Formularies 1, 2, and 3

(effective July 1, 2020)

Some medications are only intended to be used in limited quantities, others require advanced approval or prior authorization by your doctor before they can be filled and some are prescribed in steps.

**Quantity limits** have been placed on the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Prior Authorization** is required before you fill prescriptions for certain drugs. Without prior approval, your drugs may not be covered.

**Step Therapy** ensures lower costs. When similar medications are available, step therapy guides your doctor to prescribe the lower-cost option first. You may then move up the cost levels until you find the drug that works best for you. Higher step drugs will require advanced approval or prior authorization by your doctor before they can be filled.

Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. In addition, some medications not listed are covered under the medical benefit. To learn more about your specific drug benefit, log into *My Account* at [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links or call CareFirst Pharmacy Services at 800-241-3371.

Note: Due to the lack of Food and Drug Administration (FDA) approval for many ingredients included in compounds, as well as the lack of validated clinical support for use of these high-cost compounds, they may not be covered by your prescription plan or may require prior authorization. If the compound ingredients are not covered, you will be responsible for the full cost of those ingredients. In situations where the compound ingredients are covered through prior authorization, you will pay the cost share specified in your prescription plan.

## QUANTITY LIMITS

### ANTI-PARASITE

ALBENZA ( <i>albendazole</i> )	336 tablets per 365 days
BILTRICIDE ( <i>praziquantel</i> )	24 tablets per 365 days
EGATEN	16 tablets per 365 days
EMVERM	12 tablets per 365 days

### ASTHMA

<i>albuterol inhalation solution</i> 0.63 mg/3 mL, 1.25 mg/3 mL	5 packages (125 vials) per month 4 packages (120 vials) per month
<i>albuterol inhalation solution</i> 0.083%, 2.5 mg/3 mL	5 packages (125 vials) per month 4 packages (120 vials) per month 2 packages (120 vials) per month
<i>albuterol inhalation solution</i> 0.5%, 2.5 mg/0.5 mL	3 packages (20 mL each) per month 4 packages (120 vials) per month
PROAIR DIGIHALER	2 packages per month
PROAIR HFA	2 packages per month
PROAIR RESPICLICK	2 packages per month
PROVENTIL HFA	2 packages per month
VENTOLIN HFA	6 packages (8 grams each) per month 2 packages (18 grams each) per month
XOPENEX ( <i>levalbuterol inhalation solution</i> ) 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/3 mL	4 packages (96 vials) per month 4 packages (100 vials) per month 3 packages (90 vials) per month
XOPENEX concentrate 1.25 mg/0.5 mL	3 packages per month
XOPENEX HFA	2 packages per month

### ATTENTION DEFICIT HYPERACTIVITY DISORDERS (ADHD)

ADDERALL ( <i>amphetamine/dextroamphetamine mixed salts</i> ) 5 mg, 7.5 mg, 10 mg, 12.5 mg	90 tablets per month
ADDERALL ( <i>amphetamine/dextroamphetamine mixed salts</i> ) 15 mg, 20 mg	60 tablets per month
ADDERALL ( <i>amphetamine/dextroamphetamine mixed salts</i> ) 30 mg	30 tablets per month
ADDERALL XR ( <i>amphetamine/dextroamphetamine mixed salts ext-rel</i> ) 5 mg, 10 mg	90 capsules per month

ADDERALL XR ( <i>amphetamine/dextroamphetamine mixed salts ext-rel</i> ) 15 mg, 20 mg, 25 mg, 30 mg	30 capsules per month
ADHANSIA XR 25 mg, 35 mg, 45 mg	60 capsules per month
ADHANSIA XR 55 mg, 70 mg, 85 mg	30 capsules per month
ADZENYS ER ( <i>amphetamine</i> ) 1.25 mg/mL	450 mL per month
ADZENYS XR-ODT 3.1 mg, 6.3 mg, 9.4 mg	60 tablets per month
ADZENYS XR-ODT 12.5 mg, 15.7 mg, 18.8 mg	30 tablets per month
APTENSIO XR 10 mg, 15 mg, 20 mg, 30 mg	60 capsules per month
APTENSIO XR 40 mg, 50 mg, 60 mg	30 capsules per month
CONCERTA ( <i>methylphenidate ext-rel</i> ) 18 mg, 27 mg, 36 mg	60 tablets per month
CONCERTA ( <i>methylphenidate ext-rel</i> ) 54 mg	30 tablets per month
COTEMPLA XR 8.6 mg, 17.3 mg, 25.9 mg	60 tablets per month
DAYTRANA 10 mg, 15 mg, 20 mg, 30 mg	30 patches per month
DESOXYN ( <i>methamphetamine</i> ) 5 mg	150 tablets per month
DEXEDRINE SPANSULE ( <i>dextroamphetamine ext-rel</i> ) 5 mg, 10 mg	120 capsules per month
DEXEDRINE SPANSULE ( <i>dextroamphetamine ext-rel</i> ) 15 mg	60 capsules per month
<i>dextroamphetamine</i> 5 mg, 10 mg	120 tablets per month
DYANAVEL XR 2.5 mg/mL	240 mL per month
EVEKEO ( <i>amphetamine sulfate</i> ) 5 mg, 10 mg	120 tablets per month
EVEKEO ODT 5 mg, 10 mg	120 tablets per month
EVEKEO ODT 15 mg, 20 mg	60 tablets per month
FOCALIN ( <i>dexmethylphenidate</i> ) 2.5 mg, 5 mg	120 tablets per month
FOCALIN ( <i>dexmethylphenidate</i> ) 10 mg	60 tablets per month
FOCALIN XR ( <i>dexmethylphenidate ext-rel</i> ) 5 mg, 10 mg, 15 mg, 20 mg	60 capsules per month
FOCALIN XR ( <i>dexmethylphenidate ext-rel</i> ) 25 mg, 30 mg, 35 mg, 40 mg	30 capsules per month
JORNAY PM 20 mg, 40 mg	60 capsules per month
JORNAY PM 60 mg, 80 mg, 100 mg	30 capsules per month
<i>methylphenidate</i> 5 mg, 10 mg	180 tablets per month
<i>methylphenidate</i> 20 mg	90 tablets per month
<i>methylphenidate chew tablets</i> 2.5 mg, 5 mg, 10 mg	180 tablets per month
<i>methylphenidate oral solution</i> 5 mg/5 mL	1800 mL per month
<i>methylphenidate oral solution</i> 10 mg/5 mL	900 mL per month
<i>methylphenidate ext-rel</i> 10 mg, 20 mg	90 tablets per month
<i>methylphenidate ext-rel</i> 10 mg, 20 mg, 30 mg	60 capsules per month
<i>methylphenidate ext-rel</i> 40 mg, 50 mg, 60 mg	30 capsules per month
METHYLPHENIDATE OSMOTIC EXT-REL 72 mg	30 tablets per month
MYDAYIS 12.5 mg, 25 mg	60 capsules per month
MYDAYIS 37.5 mg, 50 mg	30 capsules per month
PROCENTRA ( <i>dextroamphetamine solution</i> ) 5 mg/5 mL	1200 mL per month
QUILLICHEW ER 20 mg, 30 mg	60 tablets per month
QUILLICHEW ER 40 mg	30 tablets per month
QUILLIVANT XR 25 mg/5 mL	360 mL per month
RITALIN LA ( <i>methylphenidate ext-rel</i> ) 10 mg, 20 mg, 30 mg	60 capsules per month
RITALIN LA ( <i>methylphenidate ext-rel</i> ) 40 mg	30 capsules per month
STRATTERA ( <i>atomoxetine</i> ) 10 mg, 18 mg, 25 mg	120 capsules per month
STRATTERA ( <i>atomoxetine</i> ) 40 mg	60 capsules per month
STRATTERA ( <i>atomoxetine</i> ) 60 mg, 80 mg, 100 mg	30 capsules per month
VYVANSE 10 mg, 20 mg, 30 mg	60 capsules per month
VYVANSE 40 mg, 50 mg, 60 mg, 70 mg	30 capsules per month
ZENZEDI ( <i>dextroamphetamine</i> ) 2.5 mg, 5 mg, 7.5 mg, 10 mg	120 tablets per month
ZENZEDI ( <i>dextroamphetamine</i> ) 15 mg, 20 mg	60 tablets per month
ZENZEDI ( <i>dextroamphetamine</i> ) 30 mg	30 tablets per month
<b>DIABETES</b>	
ADLYXIN	2 pens or syringes per month
BYDUREON	4 units per 30 days
BYETTA	1 pen (60 doses) per month
OZEMPIC	2 pens (3 mL) per month
RYBELSUS	30 tablets per month
SOLIQUA	10 pens per month
TRULICITY	4 pens or syringes per month
VICTOZA	3 pens per month
XULTOPHY	5 pens per month
diabetic test strips - all brands	204 test strips per month
<b>DIABETES - INSULIN MANAGEMENT SYSTEMS</b>	
DEXCOM G4 PLATINUM PEDIATRIC RECEIVER KIT	1 kit per 365 days
DEXCOM G4 PLATINUM RECEIVER KIT	1 kit per 365 days

DEXCOM G4 PLATINUM RECEIVER KIT/SHARE KIT	1 kit per 365 days
DEXCOM G4 PLATINUM TRANSMITTER KIT	1 kit per 75 days
DEXCOM G4 SENSOR KIT	1 kit per 25 days
DEXCOM G5 MOBILE RECEIVER KIT	1 kit per 365 days
DEXCOM G5 MOBILE TRANSMITTER KIT	1 kit per 75 days
DEXCOM G5 MOBILE/G4 PLATINUM SENSOR KIT	4 kits per 25 days
DEXCOM G5 RECEIVER KIT	1 kit per 365 days
DEXCOM G6 RECEIVER	1 kit per 365 days
DEXCOM G6 SENSOR	3 sensor per 25 days
DEXCOM G6 TRANSMITTER	1 transmitter per 75 days
FREESTYLE LIBRE 14 DAY/READER/FLASH MONITORING SYSTEM	1 system per 365 days
FREESTYLE LIBRE 14 DAY/SENSOR/FLASH MONITORING SYSTEM KIT	2 kits per 25 days
FREESTYLE LIBRE/FLASH MONITORING SYSTEM READER	1 reader per 365 days
FREESTYLE LIBRE/FLASH MONITORING SYSTEM SENSOR	3 sensors per 25 days
OMNIPOD MIS 5 PACK	6 packs per month
OMNIPOD MIS 10 PACK	3 packs per month
OMNIPOD DASH MIS 5 PACK	6 packs per month
OMNIPOD DASH KIT SYSTEM	1 system per year
OMNIPOD STARTER KIT	1 kit per year
V-GO 20 KIT	1 kit per month
V-GO 30 KIT	1 kit per month
V-GO 40 KIT	1 kit per month
<b>EMERGENCY TREATMENT OF ALLERGIC REACTIONS</b>	
AUVI-Q	6 injectors per 300 days
EPIPEN, EPIPEN JR ( <i>epinephrine solution auto-injector</i> )	6 injectors per 300 days
SYMJEPI	6 injectors per 300 days
<b>ERECTILE DYSFUNCTION</b>	
CAVERJECT	6 units per month
CIALIS ( <i>tadalafil</i> ) 2.5 mg	30 tablets per month
CIALIS ( <i>tadalafil</i> ) 5 mg	30 tablets per month
CIALIS ( <i>tadalafil</i> ) 10 mg, 20 mg	6 tablets per month
EDEX	6 units per month
LEVITRA ( <i>vardenafil</i> )	6 tablets per month
MUSE	6 units per month
STAXYN ( <i>vardenafil orally disintegrating tablets</i> )	6 tablets per month
STENDRA	6 tablets per month
VIAGRA ( <i>sildenafil</i> )	6 tablets per month
<b>GASTROESOPHAGEAL REFLUX DISEASE (GERD)</b>	
ACIPHEX ( <i>rabeprazole</i> )	90 units of therapy per 365 days
ACIPHEX SPRINKLES	90 units of therapy per 365 days
DEXILANT	90 units of therapy per 365 days
NEXIUM ( <i>esomeprazole</i> )	90 units of therapy per 365 days
<i>omeprazole</i>	90 units of therapy per 365 days
PREVACID ( <i>lansoprazole</i> )	90 units of therapy per 365 days
PROTONIX ( <i>pantoprazole</i> )	90 units of therapy per 365 days
ZEGERID ( <i>omeprazole/sodium bicarbonate</i> )	90 units of therapy per 365 days
<b>INFLUENZA TREATMENT &amp; PREVENTION</b>	
RELENZA	40 blisters per 90 days
TAMIFLU ( <i>oseltamivir</i> ) 30 mg	28 capsules per 90 days
TAMIFLU ( <i>oseltamivir</i> ) 45 mg, 75 mg	14 capsules per 90 days
TAMIFLU SUSPENSION ( <i>oseltamivir suspension</i> )	3 bottles per 90 days
XOFLUZA	4 tablets per 90 days
<b>MIGRAINE</b>	
<i>almotriptan</i>	12 tablets per month
AMERGE ( <i>naratriptan</i> )	12 tablets per month
FROVA ( <i>frovatriptan</i> )	18 tablets per month
IMITREX ( <i>sumatriptan</i> )	12 tablets per month
IMITREX INJ ( <i>sumatriptan inj</i> ) 4 mg	18 syringes per month
IMITREX INJ ( <i>sumatriptan inj</i> ) 6 mg	12 syringes per month
IMITREX NASAL SPRAY ( <i>sumatriptan nasal spray</i> ) 5 mg	24 units per month
IMITREX NASAL SPRAY ( <i>sumatriptan nasal spray</i> ) 20 mg	12 units per month
MAXALT ( <i>rizatriptan</i> )	18 tablets per month
MAXALT MLT ( <i>rizatriptan orally disintegrating tablets</i> )	18 tablets per month
MIGRANAL NS ( <i>dihydroergotamine spray</i> )	1 x 8 mL per month
ONZETRA XSAIL	16 nosepieces per month
RELPAX ( <i>eletriptan</i> )	12 tablets per month

TOSYMRA	18 units per month
TREXIMET ( <i>sumatriptan/naproxen</i> )	9 tablets per month
ZEMBRACE SYMTOUCH	24 injectors per month
ZOMIG ( <i>zolmitriptan</i> )	12 tablets per month
ZOMIG NASAL SPRAY	12 units per month
ZOMIG ZMT ( <i>zolmitriptan orally disintegrating tablets</i> )	12 tablets per month
<b>NAUSEA &amp; VOMITING</b>	
ANZEMET	6 tablets per month
EMEND ( <i>aprepitant capsules</i> ) 40 mg	3 capsules per 180 days
EMEND ( <i>aprepitant capsules</i> ) 80 mg	4 capsules per month
EMEND ( <i>aprepitant capsules</i> ) 125 mg	2 capsules per month
EMEND ( <i>fosaprepitant injection</i> ) 150 mg	2 vials per month
EMEND SUSPENSION 125 mg	6 kits per month
EMEND TRIPACK ( <i>aprepitant pack</i> ) 80 mg & 125mg	2 packs per month
<i>granisetron tablets 1 mg</i>	12 tablets per 21 days
<i>ondansetron orally disintegrating tablets 4 mg, 8 mg</i>	18 tablets per month
<i>ondansetron solution 4 mg/5mL</i>	200 mL per month
<i>ondansetron tablets 24 mg</i>	2 tablets per month
SANCUSO	2 patches per month
VARUBI	4 tablets per month
ZOFRAN ( <i>ondansetron tablets</i> ) 4 mg, 8 mg	18 tablets per month
ZUPLENZ	18 films per month
<b>NEUROPATHIC PAIN</b>	
LYRICA ( <i>pregabalin capsules</i> ) 25 mg, 50 mg, 75 mg, 100 mg, 150 mg	120 capsules per month
LYRICA ( <i>pregabalin capsules</i> ) 200 mg	90 capsules per month
LYRICA ( <i>pregabalin capsules</i> ) 225 mg, 300 mg	60 capsules per month
LYRICA ( <i>pregabalin oral solution</i> ) 20 mg/mL	900 mL per month
LYRICA CR 82.5 mg, 165 mg, 330 mg	60 tablets per month
<b>PROSTATE &amp; BENIGN PROSTATIC HYPERPLASIA (BPH)</b>	
CIALIS ( <i>tadalafil</i> ) 5 mg	30 tablets per month
<b>TOPICAL CORTICOSTEROIDS</b>	
<i>alclometasone</i>	120 grams per month
<i>amcinonide cream, ointment</i>	120 grams per month
<i>amcinonide lotion</i>	120 mL per month
<i>betamethasone cream, ointment</i>	120 grams per month
<i>betamethasone lotion</i>	120 mL per month
<i>clocortolone</i>	120 grams per month
<i>clobetasol cream, emollient cream, foam, gel, spray, ointment</i>	120 grams per month
<i>clobetasol lotion, shampoo, solution</i>	120 mL per month
CORDRAN tape	1 package (1 roll) per month
<i>desonide cream, ointment</i>	120 grams per month
<i>desonide lotion</i>	120 mL per month
<i>desoximetasone cream, gel, ointment</i>	120 grams per month
<i>desoximetasone spray</i>	120 mL per month
<i>diflorasone</i>	120 grams per month
<i>fluocinolone cream, ointment</i>	120 grams per month
<i>fluocinolone oil, solution</i>	120 mL per month
<i>fluocinonide cream, gel, ointment</i>	120 grams per month
<i>fluocinonide solution</i>	120 mL per month
<i>flurandrenolide cream, ointment</i>	120 grams per month
<i>flurandrenolide lotion</i>	120 mL per month
<i>fluticasone cream, ointment</i>	120 grams per month
<i>fluticasone lotion</i>	120 mL per month
<i>halcinonide</i>	120 grams per month
<i>halobetasol</i>	120 grams per month
<i>hydrocortisone cream, ointment</i>	120 grams per month
<i>hydrocortisone lotion</i>	120 mL per month
<i>mometasone cream, ointment</i>	120 grams per month
<i>mometasone lotion, solution</i>	120 mL per month
<i>prednicarbate</i>	120 grams per month
<i>triamcinolone cream, ointment, spray</i>	120 grams per month
<i>triamcinolone lotion</i>	120 mL per month
<b>TOPICAL LIDOCAINE PRODUCTS</b>	
ASTERO gel 4%	30 grams per month
LDO PLUS gel 4%	30 grams per month
<i>lidocaine gel 2%</i>	30 grams per month

<i>lidocaine ointment 5%</i>	50 grams per month
<i>lidocaine solution 4%</i>	50 mL per month
<i>lidocaine/prilocaine cream 2.5%/2.5%</i>	30 grams per month
LIDOCAINE/TETRACAINE cream	30 grams per month
LIDODERM ( <i>lidocaine patch</i> ) 5%*	90 patches per month
PLIAGLIS	30 grams per month
SYNERA	2 patches per month
ZTLIDO*	90 patches per month
<b>TOPICAL PRODUCTS, OTHER</b>	
<i>diclofenac sodium solution 1.5%*</i>	150 mL per month
OXISTAT ( <i>oxiconazole cream</i> )	90 grams per month
OXISTAT lotion	90 mL per month
<i>mupirocin</i>	30 units per month
PENNSAID SOLUTION 2%*	112 grams per month
PRUDOXIN CREAM ( <i>doxepin cream</i> ) 5%*	90 grams per month
ZONALON CREAM ( <i>doxepin cream</i> ) 5%*	90 grams per month

\*Prior Authorization required

## OPIOID QUANTITY LIMITS

Immediate-release opioid prescriptions (including combination products) are limited to a 7-day supply for the first fill or if previous fills were less than 7 days.

<i>acetaminophen/caffeine/dihydrocodeine 320.5/30/16 mg</i>	300 capsules per month
<i>acetaminophen/codeine 300/15 mg</i>	400 tablets per month
<i>acetaminophen/codeine 300/30 mg</i>	360 tablets per month
<i>acetaminophen/codeine 300/60 mg</i>	180 tablets per month
<i>acetaminophen/codeine solution, 120-12 mg/5 mL</i>	2700 mL per month
APADAZ 4.08/325 mg, 6.12/325 mg, 8.16/325 mg	168 tablets per month
ARYMO ER <sup>Δ</sup> 15 mg, 30 mg	90 tablets per month
BELBUCA <sup>Δ</sup> 75 mcg, 150 mcg, 300 mcg, 450 mcg	60 films per month
<i>benzhydrocodone/acetaminophen 4.08 mg/325 mg</i>	360 tablets per month
<i>benzhydrocodone/acetaminophen 6.12 mg/325 mg</i>	360 tablets per month
<i>benzhydrocodone/acetaminophen 8.16 mg/325 mg</i>	360 tablets per month
<i>butorphanol nasal spray</i>	2 inhalers per month
BUTRANS <sup>Δ</sup> ( <i>buprenorphine transdermal</i> ) 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr	4 patches per month
<i>codeine sulfate 15 mg</i>	180 tablets per month
<i>codeine sulfate 30 mg</i>	180 tablets per month
CODEINE SULFATE 60 MG	180 tablets per month
CONZIP <sup>Δ</sup> ( <i>tramadol ext-rel capsules</i> ) 100 mg	30 capsules per month
DOLOPHINE ( <i>methadone</i> ) 5 mg	90 tablets per month
DOLOPHINE ( <i>methadone</i> ) 10 mg	60 tablets per month
DURAGESIC <sup>Δ</sup> ( <i>fentanyl transdermal</i> ) 12 mcg, 25 mcg	10 patches per month
<i>hydrocodone/acetaminophen 5/300 mg, 5/325 mg</i>	240 tablets per month
<i>hydrocodone/acetaminophen 7.5/300 mg, 7.5/325 mg, 10/300 mg, 10/325 mg</i>	180 tablets per month
<i>hydrocodone/acetaminophen solution 7.5 mg-325 mg/15 mL, 10-325 mg/15 mL</i>	2700 mL per month
<i>hydrocodone/acetaminophen solution 10-325 mg/15 mL</i>	2700 mL per month
<i>hydrocodone/acetaminophen solution 7.5-325 mg/15 mL (5-217 mg/10 mL)</i>	2700 mL per month
<i>hydrocodone/ibuprofen 5/200 mg, 7.5 mg/200 mg, 10/200 mg</i>	150 tablets per month
<i>hydromorphone 2 mg</i>	180 tablets per month
<i>hydromorphone 4 mg</i>	150 tablets per month
<i>hydromorphone 8 mg</i>	60 tablets per month
<i>hydromorphone ext-rel</i> <sup>Δ</sup> 8 mg, 12 mg, 16 mg	30 tablets per month
<i>hydromorphone liquid 1 mg/mL</i>	600 mL per month
<i>hydromorphone suppositories 3 mg</i>	120 suppositories per month
HYSINGLA ER <sup>Δ</sup> 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	30 tablets per month
KADIAN <sup>Δ</sup> ( <i>morphine ext-rel</i> ) 10 mg, 20 mg, 30 mg, 40 mg	60 capsules per month
KADIAN <sup>Δ</sup> ( <i>morphine ext-rel</i> ) 50 mg, 60 mg, 80 mg	30 capsules per month
<i>levorphanol 2 mg</i>	120 tablets per month
<i>levorphanol 3 mg</i>	60 tablets per month
LORTAB ELIXIR 10-300 mg/15 mL	2025 mL per month
<i>meperidine 50 mg, 100 mg</i>	180 tablets per month
<i>meperidine oral solution 50 mg/5 mL</i>	900 mL per month
<i>methadone 5 mg</i>	90 tablets per month
<i>methadone 10 mg</i>	60 tablets per month
METHADONE INTENSOL ( <i>methadone</i> ) 10 mg/mL	60 mL per month



<i>methadone oral solution</i> 5 mg/5mL	450 mL per month
<i>methadone oral solution</i> 10 mg/5 mL	300 mL per month
MORPHABOND <sup>Δ</sup> 15 mg, 30 mg	90 tablets per month
<i>morphine ext-rel beads</i> <sup>Δ</sup> 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	30 capsules per month
<i>morphine sulfate</i> 15 mg	180 tablets per month
<i>morphine sulfate</i> 30 mg	90 tablets per month
<i>morphine sulfate oral concentrate</i> 20 mg/mL	135 mL per month
<i>morphine sulfate oral solution</i> 10 mg/5 mL	900 mL per month
<i>morphine sulfate oral solution</i> 20 mg/5 mL	675 mL per month
<i>morphine sulfate suppositories</i> 5 mg, 10 mg	180 suppositories per month
<i>morphine sulfate suppositories</i> 20 mg	120 suppositories per month
<i>morphine sulfate suppositories</i> 30 mg	90 suppositories per month
MS CONTIN <sup>Δ</sup> ( <i>morphine ext-rel</i> ) 15 mg, 30 mg	90 tablets per month
NUCYNTA 50 mg	120 tablets per month
NUCYNTA 75 mg	90 tablets per month
NUCYNTA 100 mg	60 tablets per month
NUCYNTA ER <sup>Δ</sup> 50 mg, 100 mg	60 tablets per month
OXAYDO 5 mg, 7.5 mg	180 tablets per month
<i>oxycodone capsules</i> 5 mg	180 capsules per month
<i>oxycodone oral concentrate</i> 100 mg/5 mL	90 mL per month
<i>oxycodone oral solution</i> 5 mg/5 mL	900 mL per month
<i>oxycodone tablets</i> 5 mg, 10 mg	180 tablets per month
<i>oxycodone tablets</i> 15 mg	120 tablets per month
<i>oxycodone tablets</i> 20 mg	90 tablets per month
<i>oxycodone tablets</i> 30 mg	60 tablets per month
<i>oxycodone/acetaminophen</i> 2.5/325 mg, 5/325 mg	360 tablets per month
<i>oxycodone/acetaminophen</i> 10/325 mg	180 tablets per month
<i>oxycodone/aspirin</i> 4.8355/325 mg	360 tablets per month
<i>oxycodone/ibuprofen</i> 5/400 mg	120 tablets per month
OXYCONTIN <sup>Δ</sup> 10 mg, 15 mg, 20 mg, 30 mg	60 tablets per month
<i>oxymorphone</i> 5 mg	180 tablets per month
<i>oxymorphone</i> 10 mg	90 tablets per month
pentazocine/naloxone 50/0.5 mg	120 tablets per month
PRIMLEV 5/300 mg	360 tablets per month
PRIMLEV 10/300 mg	180 tablets per month
<i>tramadol</i> 50 mg	180 tablets per month
<i>tramadol</i> 100 mg	90 tablets per month
<i>tramadol ext-rel</i> <sup>Δ</sup> 100 mg	30 tablets per month
<i>tramadol ext-rel</i> <sup>Δ</sup> 150 mg	30 capsules per month
<i>tramadol/acetaminophen</i> 37.5/325 mg	240 tablets per month
XTAMPZA ER <sup>Δ</sup> 9 mg, 13.5 mg, 18 mg, 27 mg	60 capsules per month
ZOHYDRO ER <sup>Δ</sup> ( <i>hydrocodone ext-rel</i> ) 10 mg, 15 mg, 20 mg, 30 mg, 40 mg	60 capsules per month

<sup>Δ</sup> The initial limit for additional strengths not listed here is zero. All requests for strengths not listed will be considered through post limit prior authorization.

**Prior authorization is required for a member to receive more than one product within each group at a time**

<b>Influenza Products</b>	RELENZA TAMIFLU ( <i>oseltamivir</i> )
<b>Lidocaine Topical Products</b>	ASTERO gel 4% LDO PLUS gel 4% <i>lidocaine gel 2%</i> <i>lidocaine ointment 5%</i> <i>lidocaine solution 4%</i> <i>lidocaine/prilocaine cream 2.5/2.5%</i> LIDOCAINE/TETRACAINE <i>cream 7/7%</i> PLIAGLIS <i>cream 7/7%</i> SYNERA patch 70/70 mg
<b>Migraine Products</b>	<i>almotriptan</i> AMERGE ( <i>naratriptan</i> ) FROVA ( <i>almotriptan</i> ) IMITREX INJECTION/STATDOSE ( <i>sumatriptan</i> ) IMITREX NASAL SPRAY ( <i>sumatriptan</i> ) IMITREX TABLETS ( <i>sumatriptan</i> ) MAXALT/MAXALT-MLT ( <i>rizatriptan</i> ) ONZETRA XSAIL RELPAK ( <i>eletriptan</i> ) TOSYMRA TREMIMET ( <i>sumatriptan/naproxen</i> ) ZEMBRACE SYMTOUCH ZOMIG NASAL SPRAY ZOMIG TABLETS/ZOMIG-ZMT ( <i>zolmitriptan</i> )
<b>Proton Pump Inhibitors</b>	ACIPHEX ( <i>rabeprazole</i> ) ACIPHEX SPRINKLES DEXILANT NEXIUM ( <i>esomeprazole</i> ) <i>omeprazole</i> PREVACID ( <i>lansoprazole</i> ) PROTONIX ( <i>pantoprazole</i> ) ZEGERID ( <i>omeprazole/sodium bicarbonate</i> )

## NON-SPECIALTY PRODUCTS REQUIRING PRIOR AUTHORIZATION

ABSTRAL  
 ACTIQ  
 AIMOVIG  
 AJOVY  
*armodafinil*  
 ATRALIN  
 BREEZE 2 TEST STRIPS  
*buprenorphine patch*  
 CIALIS 2.5 MG  
 CIALIS 5 MG  
*clindamycin/tretinoin*  
 CONTOUR NEXT TEST STRIPS  
 CONTOUR TEST STRIPS  
 DARAPRIM  
 DESCOVY  
*diclofenac sodium gel 3%*  
*diclofenac sodium solution 1.5%*  
*doxepin cream 5%*  
 EMGALITY  
*fentanyl citrate*  
*fentanyl transmucosal lozenge*  
 FENTORA  
 FORTAMET  
 FREESTYLE TEST STRIPS  
 GLUMETZA  
 JUBLIA  
 KERYDIN

LAZANDA  
 LOVAZA  
*metformin ext-rel (generic FORTAMET)*  
*metformin ext-rel (generic GLUMETZA)*  
*modafinil*  
 NOXAFIL  
 NUVIGIL  
*omeprazole/sodium bicarbonate*  
 ONETOUCH TEST STRIPS \*  
 PENNSAID  
*posaconazole*  
 PROVIGIL  
 RETIN-A  
 RETIN-A MICRO  
 SUBSYS  
 SUCRAID  
*tadalafil 2.5 mg*  
*tadalafil 5 mg*  
*tretinoin cream, gel*  
 TRETIN-X  
 VASCEPA  
 VELTIN  
 VYLEESI  
 ZEGERID  
 ZIANA  
 ZONALON

All other glucose test strips that are not ACCU-CHEK brand\*

Compound drugs with a cost of \$300 or more

\*Not applicable to Formulary 1

## SPECIALTY DRUGS REQUIRING PRIOR AUTHORIZATION

ABRAXANE  
 ACTEMRA \*  
 ACTIMMUNE \*  
 ADCETRIS  
 ADCIRCA  
 ADEMPAS  
 ADVATE  
 ADYNOVATE  
 AFINITOR  
 AFSTYLA  
 ALDURAZYME  
 ALECENSA  
 ALIMTA  
 ALPHANATE  
 ALPHANINE SD  
 ALPROLIX  
 ALUNBRIG  
*ambrisentan*  
 AMPYRA  
 APOKYN  
 ARALAST NP \*  
 ARANESP  
 ARCALYST  
 AUBAGIO  
 AUSTEDO  
 AVASTIN  
 AVEED  
 AVONEX  
*azacitidine*  
 BALVERSA

BAVENCIO  
 BENDEKA  
 BENEFIX  
 BENLYSTA \*  
 BENLYSTA SC  
 BERINERT  
 BETASERON  
 BETHKIS  
*bexarotene capsules*  
 BIVIGAM \*  
 BORTEZOMIB  
*bosentan*  
 BOSULIF  
 BRAFTOVI  
 BRINEURA  
 BUPHENYL  
 CABOMETYX  
 CALQUENCE  
*capecitabine*  
 CAPRELSA  
 CARBAGLU  
 CARIMUNE NF \*  
 CAYSTON  
 CERDELGA  
 CEREZYME \*  
 CETROTIDE  
 CHOLBAM  
 CHORIONIC GONADOTROPIN  
 CIMZIA  
*cinacalcet*

CINQAIR  
 CINRYZE  
 COAGADEX  
 COMETRIQ  
 COPAXONE  
 COPEGUS  
 COPIKTRA  
 CORIFACT  
 COSENTYX  
 COTELLIC  
 CUVITRU  
 CYRAMZA  
 CYSTAGON  
 CYSTARAN  
 CYTOGAM  
*dalfampridine*  
 DARZALEX  
 DAURISMO  
*deferasirox*  
 DIACOMIT  
*dofetilide*  
 DUPIXENT  
 DUROLANE  
 EGRIFTA  
 ELAPRASE \*  
 ELELYSO \*  
 ELIGARD  
 ELOCTATE  
 EMFLAZA  
 EMLICITI



ENBREL  
ENDARI  
ENTYVIO \*  
EPCLUSA  
EPIDIOLEX  
EPOGEN \*  
*epoprostenol sodium*  
ERBITUX  
ERIVEDGE  
ERLEADA  
*erlotinib*  
ERWINAZE  
ESBRIET  
*everolimus*  
EXJADE  
EXONDYS 51  
EXTAVIA  
EYLEA  
FABRAZYME \*  
FARYDAK  
FASENRA  
FASENRA PEN  
FEIBA NF  
FERRIPROX  
FIRAZYR  
FIRDAPSE  
FIRMAGON  
FLEBOGAMMA \*  
FLOLAN  
FOLLISTIM AQ  
FOLOTYN  
FORTEO  
FULPHILA  
FUZEON  
GALAFOLD  
GAMASTAN S/D \*  
GAMMAGARD LIQUID \*  
GAMMAGARD S/D \*  
GAMMAKED \*  
GAMMAPLEX \*  
GAMUNEX-C  
*ganirelix acetate*  
GANIRELIX ACETATE  
GATTEX  
GAZYVA  
*gemcitabine*  
GENOTROPIN  
GILENYA  
GILOTRIF  
GLASSIA \*  
*glatiramer acetate*  
*glatopa*  
GLEEVEC  
GONAL-F  
GRANIX  
HAEGARDA  
HALAVEN  
HARVONI  
HEMLIBRA  
HEMOFIL M  
HERCEPTIN  
HETLIOZ  
HIZENTRA  
HUMATE-P  
HUMATROPE  
HUMIRA  
HYCAMTIN  
*hydroxyprogesterone caproate*

HYQVIA \*  
IBRANCE  
*icatibant*  
ICLUSIG  
IDELVION  
IDHIFA  
ILARIS  
*imatinib*  
IMBRUVICA  
IMFINZI  
INBRIJA  
INCRELEX  
INFLECTRA \*  
INGREZZA  
INLYTA  
INTRON A  
IRESSA  
IXEMPRA  
IXINITY  
JADENU  
JADENU SPRINKLE  
JAKAFI  
JEVTANA  
JUXTAPID  
JYNARQUE  
KADCYLA  
KALBITOR  
KALYDECO  
KANUMA \*  
KEVEYIS  
KEVZARA  
KEYTRUDA  
KINERET  
KISQALI  
KISQALI FEMARA CO-PACK  
KITABIS PAK  
KOATE-DVI  
KOGENATE FS  
KORLYM  
KOSELUGO  
KOVALTRY  
KRYSTEXXA  
KUVAN  
KYMRIAH  
KYPROLIS  
LEMTRADA  
LENVIMA  
LETAIRIS  
LEUKINE  
*leuprolide acetate*  
LONSURF  
LORBRENA  
LUCENTIS  
LUMIZYME \*  
LUPRON  
LUPRON DEPOT  
LUXTURNA  
LYNPARZA  
MAKENA  
MAVENCLAD  
MAVYRET  
MAYZENT  
MEKINIST  
MEKTOVI  
MENOPUR  
*miglustat*  
MIRCERA  
MONONINE

MULPLETA  
MYALEPT  
NAGLAZYME \*  
NATPARA  
NERLYNX  
NEULASTA  
NEUPOGEN  
NEXAVAR  
NINLARO  
*nitisinone*  
NITYR  
NIVESTYM  
NORDITROPIN  
NORTHERA  
NOVAREL  
NOVOEIGHT  
NOVOSEVEN RT  
NPLATE  
NUBEQA  
NUCALA  
NUPLAZID  
NUTROPIN AQ  
NUWIQ  
OBIZUR  
OCALIVA  
OCREVUS  
OCTAGAM \*  
*octreotide acetate*  
ODOMZO  
OFEV  
OLUMIANT  
OMNITROPE  
ONCASPAR  
ONPATTRO  
OPDIVO  
OPSUMIT  
ORENCIA \*  
ORENITRAM  
ORFADIN  
ORKAMBI  
OTEZLA  
OTREXUP  
OVIDREL  
*oxaliplatin*  
OXERVATE  
PALYNZIQ  
PANZYGA  
PEGASYS  
PEG-INTRON  
PERJETA  
PLEGRIDY  
POMALYST  
PRALUENT  
PREGNYL  
PRIVIGEN \*  
PROCRIT  
PROCYSBI  
PROFILNINE SD  
PROLASTIN-C \*  
PROLIA  
PROMACTA  
PROVENGE  
PULMOZYME  
RASUVO  
RAVICTI  
REBIF  
REBINYN  
RECLAST

RECOMBINATE  
REMICADE \*  
REMODULIN  
RENFLEXIS \*  
REPATHA  
RETACRIT  
REVATIO  
REVLIMID  
RIASTAP  
*ribavirin capsules*  
*ribavirin tablets*  
RINVOQ  
RITUXAN  
RIXUBIS  
RUBRACA  
RUCONEST  
RYDAPT  
SABRIL  
SAIZEN  
SAMSCA  
SANDOSTATIN  
SANDOSTATIN LAR  
SENSIPAR  
SEROSTIM  
SIGNIFOR  
SIGNIFOR LAR  
*sildenafil 20 mg*  
*sildenafil suspension*  
SILIQ  
SIMPONI  
SIMPONI ARIA \*  
SKYRIZI  
*sodium phenylbutyrate*  
SOLIRIS \*  
SOMATULINE DEPOT  
SOMAVERT  
SOVALDI  
SPINRAZA  
SPRYCEL  
STELARA  
STIMATE  
STIVARGA  
STRENSIQ  
SUPPRELIN LA  
SUTENT  
SYLATRON  
SYMDEKO

SYMTUZA  
SYNAGIS  
*tadalafil*  
TAFINLAR  
TAGRISSO  
TAKHZYRO  
TALTZ  
TALZENNA  
TARCEVA  
TARGRETIN  
TARGRETIN GEL  
TASIGNA  
TAVALISSE  
TAXOTERE  
TECENTRIQ  
TECFIDERA  
TEGSEDI  
TEMODAR  
*temozolomide*  
*tetrabenazine*  
THALOMID  
TIBSOVO  
TIKOSYN  
TOBI  
TOBI PODHALER  
*tobramycin inhalation solution*  
TRACLEER  
TREANDA  
TRELSTAR  
TREMIFYA  
TRETEN  
TRIKAFTA  
TRIPTODUR  
TUKYSA  
TURALIO  
TYKERB  
TYMLOS  
TYSABRI  
TYVASO  
UPTRAVI  
VALCHLOR  
VANTAS  
VECTIBIX  
VELCADE  
VELETRI  
VENCLEXTA  
VENTAVIS

VERZENIO  
VIDAZA  
VIEKIRA PAK  
*vigabatrin*  
VIMIZIM \*  
VISUDYNE  
VITRAKVI  
VIZIMPRO  
VONVENDI  
VOSEVI  
VOTRIENT  
VPRIV \*  
VUMERITY  
VYNDAQEL  
WAKIX  
WILATE  
XALKORI  
XELJANZ  
XELJANZ XR  
XELODA  
XENAZINE  
XERMELLO  
XGEVA  
XOLAIR  
XOSPATA  
XPOVIO  
XTANDI  
XYNTHA  
XYREM  
YERVOY  
YESCARTA  
YONSA  
ZALTRAP  
ZARXIO  
ZAVESCA  
ZEJULA  
ZELBORAF  
ZEMAIRA \*  
ZEPATIER  
ZOLADEX  
*zoledronic acid*  
ZOLINZA  
ZOMACTON  
ZORBITIVE  
ZYDELIG  
ZYKADIA  
ZYTIGA

\* Prior authorization required for medical benefits coverage and subjected to site of care (outpatient hospital, physician's office, home infusion).

## DRUGS REQUIRING STEP THERAPY

You must try one of these drugs first or your doctor must request an exception for you ...	Used to treat	... before you can get coverage for these drugs
First Choice Drugs		Second Choice Drugs
At least a 7-day supply of a generic topical corticosteroid <b>AND</b> at least a 7-day supply of topical PROTOPIC ( <i>tacrolimus</i> ) or ELIDEL ( <i>pimecrolimus</i> ) within the past 120 days	Short-term (up to 8 days) management of moderate pruritus in adult patients with atopic dermatitis or lichen simplex chronicus	PRUDOXIN cream 5%, ZONALON cream 5%, or doxepin cream 5%
If the patient has filled a prescription for at least a 56 day supply of <i>divalproex sodium</i> , <i>topiramate</i> , <i>valproate sodium</i> , <i>metoprolol</i> , <i>propranolol</i> , <i>timolol</i> , <i>atenolol</i> , <i>nadolol</i> , <i>amitriptyline</i> , or <i>venlafaxine</i> within the past 730 days	Indicated for the preventive treatment of migraine in adults.	AIMOVIG, AJOVY, EMGALITY
At least a 30 day supply of at least one alpha-blocker (i.e., <i>alfuzosin</i> , <i>doxazosin</i> , <i>silodosin</i> , <i>tamsulosin</i> , or <i>terazosin</i> ), 5 alpha-reductase inhibitor (5-ARI) (e.g., <i>dutasteride</i> , <i>finasteride 5 mg</i> ), or combination alpha-blocker and 5-ARI [e.g., JALYN ( <i>dutasteride/tamsulosin</i> )] within the past 180 days	Symptomatic benign prostatic hyperplasia (BPH) with or without erectile dysfunction (ED)	CIALIS ( <i>tadalafil</i> ) 5 mg for 30 tablets

Your specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance in this document. To learn more about your specific drug benefit, log into *My Account* at [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links or call CareFirst Pharmacy Services at 800-241-3371.

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