

Table of Contents

Section	Page
INTRODUCTION	I-1
ANTI-INFECTIVE AGENTS	1
HIV AGENTS.....	2
BIOLOGICALS	3
ANTINEOPLASTICS	3
ENDOCRINE & METABOLIC DRUGS.....	4
CARDIOVASCULAR AGENTS	7
RESPIRATORY AGENTS.....	9
GASTROINTESTINAL AGENTS.....	11
GENITOURINARY	13
CENTRAL NERVOUS SYSTEM DRUGS	13
ANALGESICS & ANESTHETICS.....	14
NEUROMUSCULAR AGENTS	15
NUTRITIONAL PRODUCTS.....	16
HEMATOLOGICAL AGENTS	17
BEHAVIORAL HEALTH AGENTS	18
TOPICAL AGENTS	18
MISCELLANEOUS PRODUCTS	21
PRIOR AUTHORIZATION GUIDELINES	PA-1

Table of Contents

INDEX	IDX-1
-------------	-------

ProCare Rx/Jai Medical Systems Managed Care Organization 2021 Therapeutic Formulary

This formulary describes the circumstances under which pharmacies participating in a particular medical benefit program will be reimbursed for medications dispensed to patients covered by the program. This formulary does not:

- a) Require or prohibit the prescribing or dispensing of any medication.
- b) Substitute for the independent professional judgment of the physician or pharmacist.
- c) Relieve the physician or pharmacist of any obligation to the patient or others.

I. Non-Prescription Medication Policy

The only over-the-counter (OTC) medications that are covered by Jai Medical Systems are listed within the program formulary. All OTC medications, with the exception of OTC emergency contraception, can be reimbursed only if it is written on a valid prescription form by a licensed prescriber. OTC emergency contraception may be obtained without a written prescription; see page 6 of the formulary for limitations.

II. Unapproved Use of Formulary Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications, which are accepted as safe and effective by the balance of current medical opinion and available scientific evidence, may also be covered. The Pharmacy Benefits Manager (PBM), ProCare Rx, utilizing the procedures outlined in Section IV, will make decisions about reimbursement for these other indications. Experimental, investigational drugs and drugs used for cosmetic purposes are not eligible for coverage.

III. Prior Authorization Procedure

To promote the most appropriate utilization of selected high risk and/or high cost medication, a prior authorization procedure has been created. The criteria for this system have been established by the ProCare Rx/Jai Medical Systems Managed Care Organization program, with input from pharmacists and physician practitioners and in consideration of the available medical literature. The Pharmacy and Therapeutics Committee will have final approval responsibility for this list. In order for a dispensed prior authorization medication to be reimbursed to the pharmacy, the patient's prescribing physician must apply for pre-authorization for a specific patient and drug. The physician may phone or fax the PBM to initiate a request for prior authorization:

**ProCare Rx
Prior Authorization Desk
1267 Professional Parkway
Gainesville, Georgia 30507
(800) 555-8513
(800) 583-6010 (fax)**

Please have patient information, including member ID number, complete diagnosis, medication history, and current medications readily available. Special request forms are required for Hepatitis C treatments and for opioids. All forms can be found online at www.jaimedicalsystems.com/providers/pharmacy/.

A completed, signed prior authorization form is needed in order for a request to be approved, but providers may call the ProCare Rx Prior Authorization department for prior authorization request forms and for help with the prior authorization request process. These phone lines are dedicated to physicians making requests for prior authorization medication and non-formulary items. Members cannot be assisted if they call the prior authorization toll-free number, but they may call the ProCare Rx Customer Service Department at 800-213-5640 for help getting a prior authorization form faxed to their provider. For all requests for drugs requiring prior authorization, a decision will be provided within 24 hours of receiving the request. That decision will be to either approve, deny, or request more information. The requesting provider will receive a telecommunication response informing them of this decision. If the requested information is not received, this process could take up to 14

calendar days. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific patient to receive the requested drug. A prior authorization number will be issued to the prescribing physician and may be clearly written on the top of the prescription to inform the dispensing pharmacist of the approval. This number is for identification purposes only and does not need to be submitted for adjudication to occur. If the request is denied, information about the denial will be provided to the prescribing physician along with the patient and the patient's PCP.

Additionally, most injectables (except Depo-Provera, enoxaparin sodium, Makena, insulin, Glucagon Kit, and formulary epinephrine products) require prior approval. Questions about injectable drugs administered by home health or healthcare providers should be directed to ProCare Rx at 800-555-8513. If the medication will be billed for a medical claim rather than through the pharmacy, the provider may contact the Provider Relations Department at 888-524-1999 with any questions.

Our prior authorization criteria can be found on our website, www.jaimedicalsystems.com, as well as in this formulary. Any updates made to our criteria will be posted on the website above within 30 days.

IV. Non-Formulary Medication

This formulary attempts to provide appropriate and cost effective drug therapy to all participants in the Jai Medical Systems Managed Care Organization program. If a patient requires medication that is not covered by the formulary, a request can be made for payment of the non-covered item. It is anticipated that such exceptions will be rare, and that formulary medications will be appropriate to treat the vast majority of medical conditions. **Requests for non-formulary medications should be made in writing** (on the prior authorization form, if possible) and mailed or faxed to:

**ProCare Rx
Prior Authorization Desk
1267 Professional Parkway
Gainesville, Georgia 30507
(800) 555-8513
(800) 583-6010 (fax)**

Appropriate documentation must be provided to support the request. For all requests for drugs requiring prior authorization, a decision will be provided within 24 hours of receiving the request. That decision will be either to approve, deny, or request more information. The requesting provider will receive a telecommunication response informing them of this decision. If the requested information is not received, this process could take up to 14 calendar days. Approval of non-formulary items will be considered based upon Medicaid HealthChoice Benefit Coverage and any applicable criteria sourced or developed by the Pharmacy and Therapeutics Committee of Jai Medical Systems Managed Care Organization and the PBM.

Physicians are expected to comply with this formulary when prescribing medication for those patients covered by the Jai Medical Systems Managed Care Organization plan. If a pharmacist receives a prescription for a non-formulary medication, the pharmacist should attempt to contact the prescribing physician to request a change to a product included in this formulary guide.

The pharmacy will not be reimbursed for non-formulary medications.

In an emergency situation outside of the PBM’s regular business hours where the physician cannot be contacted, the pharmacist is authorized to dispense a 72-hour emergency supply of a medication, unless the medication is classified as a DESI, LTE, or specifically excluded drug category (see Section VI) product or is one of the treatments for Hepatitis C, which should not be dispensed until the member has prior authorization to begin treatment.

The pharmacist should contact the PBM’s Help Desk at (800) 213-5640 to arrange for reimbursement for the emergency supply.

V. Newly Marketed Products

Standard medications will be reviewed for coverage decisions within 180 calendar days of FDA approval. Priority medications will be reviewed for coverage decisions within 90 calendar days of FDA approval. Newly marketed drug products will not normally be placed on the formulary during their first year on the market. Exceptions to this rule will be made on a case-by-case basis using the medical necessity procedure.

VI. Specific Exclusions

The following drug categories are not part of the Jai Medical Systems Managed Care Organization formulary and are not covered by the 72-hour emergency supply reimbursement policy:

- Antiobesity products
- Blood and blood plasma
- Cosmetic drugs
- Cough and cold products (except those listed in the formulary)
- DESI drugs
- Diagnostic products (except those listed in the formulary)
- Erectile/sexual dysfunction agents
- Medical supplies and durable medical equipment (except certain diabetic supplies)
- Most vitamins (except those listed in the formulary)
- Nutritional and dietary supplements
- Research drugs
- Topical minoxidil

VII. Fee-for-Service Carve-outs

In addition to the above exclusions, the following are also excluded from the formulary and are covered by the Maryland Department of Health:

- Mental health drugs (refer to Section VIII). A list of Mental Health medications can be found online at:
[https://mmcp.health.maryland.gov/pap/docs/Mental Health Formulary.pdf](https://mmcp.health.maryland.gov/pap/docs/Mental%20Health%20Formulary.pdf)
- Substance use disorder medications, including, but not limited to, buprenorphine, buprenorphine/naloxone, Campral®, Chantix®, Revia®, naloxone, Nicotrol®, nicotine patches, gum, and lozenges. (Refer to Section VIII). A list of substance use disorder medications is available online at:
[https://mmcp.health.maryland.gov/pap/docs/Substance Use Disorder Medication Clinical Criteria Final updated Aug2018.pdf](https://mmcp.health.maryland.gov/pap/docs/Substance%20Use%20Disorder%20Medication%20Clinical%20Criteria%20Final%20updated%20Aug2018.pdf)

VIII. Behavioral Health Medication Policy

Please refer to the Maryland Department of Health's Mental Health Formulary for a complete listing of behavioral health medications. Any behavioral health medications that are covered by Jai Medical Systems Managed Care Organization are listed in the prescription formulary.

- Kapvay – For recipients 6 -17 years old, Kapvay is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, Kapvay continues to be a part of the MCO pharmacy benefit, and would require prior authorization.
- Intuniv – For recipients 6 -17 years old, Intuniv is part of the mental health formulary and billed fee-for-service. For individuals not in this age range, Intuniv continues to be a part of the MCO pharmacy benefit, and would require prior authorization.

IX. Mandatory Generic Substitution & Therapeutic Interchange

Generic substitution is mandatory when a generic equivalent is available, unless the brand is specified as the preferred medication on the formulary. All branded products that have 3 or more generic equivalents available will be reimbursed at the maximum allowable cost. No other therapeutic interchange is permitted.

X. Specialty Medications

Specialty medications will be covered under the pharmacy benefit for Jai Medical Systems. All requests will undergo prior authorization review when available drug-specific prior authorization criteria will apply. When prior authorization criteria do not exist, the request will be reviewed for FDA approved indications according to Jai Medical Systems' approved medical necessity review process. All specialty drug requests should contain the following:

- Drug name, strength, dose, and quantity requested
- Diagnosis for use
- Any previous drug therapies tried and failed, or why medications on the drug list are not appropriate
- Any additional clinical information pertinent to the drug review

XI. High Cost Low Utilization Medications

In accordance with the Maryland Department of Health’s High Cost, Low Volume Drug Risk Mitigation Policy and the Social Security Act 1927 (d)(5), Jai Medical Systems **will not pay** for any of the aforementioned high cost drugs that are not appropriately pre-certified by Jai Medical Systems. The current list of NDCs and J-Codes Covered by High Cost Low Volume Risk Mitigation Policy:

Drug Name	NDC Code	J Code (if applicable)
Actimmune	75987011111	
Actimmune	42238011112	
Cinryze	42227008105	J0598
Novoseven	00169720101	
Orfadin	66658020490	J8499
Ravicti	75987005006	
Revcovi	57665000201	J3590, J3490
Soliris	25682000101	J1300
Vimizim	68135010001	J1322
Spinraza	64406005801	J2326
Zolgensma	see list below *	J3590

*Zolgensma NDC List: 71894011001, 71894011501, 71894012002, 71894012103, 71894012203, 71894012303, 71894012404, 71894012504, 71894012604, 71894012705, 71894012805, 71894012905, 71894013006, 71894013106, 71894013307, 71894013407, 71894013507, 71894013608, 71894013708, 71894013808, 71894013909, 71894014009, 71894014109

Our health plan will not conduct any retrospective review for these drugs; they must be pre-certified and approved by our plan beforehand. Please be advised that this policy includes both Physician Administered Drugs and retail pharmacy drugs.

Please be advised that this list is subject to change. If you are unsure of whether or not a medication requires prior authorization and/or pre-certification, please contact our Utilization Management Department at 1-888-JAI-1999.

XII. General Parameters

- Valid DEA and NPI numbers are required.
- Refill too soon - 75% of the days supplied must elapse before the prescription can be refilled. For opioid medications, 85% of the days supplied must have elapsed before the prescription can be refilled.
- The standard maximum allowable quantity is a 30-day supply. The allowed quantity limit for formulary asthma controller medications is a 90-day supply. The quantity limit on most medications is a 400-unit maximum limit per month. Most narcotics have individualized quantity and dosage form limitations, which are listed on page 16 of the formulary. If necessary, a healthcare provider may request a quantity override by contacting ProCare Rx's Prior Authorization Department. Even with an override, the quantity may not exceed a 100-day supply, except for contraceptives as described below. Opioid prescriptions cannot exceed a 30-day supply.
- Contraceptives will be available in up to 12-month supplies when ordered by a qualified practitioner.
- All generic oral contraceptives (including emergency contraceptives) and brand oral contraceptives that do not have a generic version available are formulary. Examples are listed on pages 6 and 7.
- A current listing of HIV medications covered by Jai Medical Systems are listed on page 3.
- Requests for Hepatitis C treatment or for opioid medications require special forms. All pharmacy prior authorization request forms can be found online at:
<http://www.jaimedicalsystems.com/providers/pharmacy/>.
- Prior authorization is required for all extended release opioid products as well as methadone prescribed for pain and any other opioids prescribed for quantities greater than 90 MMEs. A specialized form is required for these requests and can be found online at
<http://www.jaimedicalsystems.com/providers/pharmacy/>.
- Prior authorization requests for medications for the treatment of Hepatitis C require a special prior authorization request form. While they still require prior authorization, Jai Medical Systems prefers Mavyret, Zepatier, generic Harvoni, and generic Epclusa unless they are not medically appropriate. These forms and prior authorization criteria can be found at

<http://www.jaimedicalsystems.com/providers/pharmacy/>.

- Vacation fill overrides may be requested by contacting Jai Medical Systems at 1-800-524-1999. Information from the prescribing doctor or primary care provider may be required before the request can be approved.
- Overrides for lost or stolen prescriptions may be requested by contacting Jai Medical Systems at 1-800-524-1999. Information from the prescribing doctor or primary care provider may be required before the request can be approved. Requests for lost/stolen/vacation overrides for opioids are not generally available.

XIII. Where to Call?

PHYSICIANS

Formulary Questions:

ProCare Rx (800) 555-8513

Medical Necessity:

ProCare Rx (800) 555-8513

Prior Authorization:

ProCare Rx (800) 555-8513

Provider Relations:

Jai Medical Systems

Managed Care Organization, Inc. (888) JAI-1999

PHARMACISTS

Provider Network Questions:

ProCare Rx (800) 213-5640

Provider Relations:

ProCare Rx (800) 213-5640

XIV. Abbreviations

Providers are encouraged to prescribe generically available drugs whenever possible and to prescribe first-line lower cost options when appropriate. Drugs are ranked by cost with the following abbreviations:

*	=	This product has a MAC price attached to some or all strengths.
\$	=	Cost per Rx is <\$20
\$\$	=	Cost per Rx is <\$40
\$\$\$	=	Cost per Rx is \$40 - \$80
\$\$\$\$	=	Cost per Rx is \$80 - \$160
\$\$\$\$\$	=	Cost per Rx is >\$160

XV. Reference

The formulary is available online at Formulary Navigator. This is updated monthly and will have the most up-to-date information. Formulary access is free and available at: http://www.marylandmedicaidpharmacyinformation.com/formulary_navigator.htm

Links to pdf copies of the most recent printed versions of all Maryland Medicaid Managed Care Organization’s formularies can be found on the website listed below:

<http://www.marylandmedicaidpharmacyinformation.com/MCOInfo.htm>

A link to a pdf copy of the Jai Medical Systems formulary and copies of our recent formulary change notices is also available in the Providers section of our homepage:

<http://www.jaimedicalsystems.com/providers/pharmacy/>

XVI. Copays

Currently, there is no copay for active members of Jai Medical Systems Managed Care Organization, Inc.’s HealthChoice Program. Copays may be charged for medications covered directly by Maryland Medicaid (refer to Section VII. Fee-for-Service Carve-Outs.)

XVII. Prior Authorization Auto-Renewal

Jai Medical Systems offers automatic prior authorization renewals for Advair and Symbicort. For members with a current approved prior

authorization, claims will continue to process as long as the member has filled for that medication within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to therapy, or with no claim history of that medication within the last 4 months.

XVIII. Notice of Non-Discrimination

Jai Medical Systems Managed Care Organization, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of language, age, race, color, sex, sexual orientation, national origin, disability, medical condition, or religion against members, contracted providers, staff, and/or non-affiliated individuals. This includes women, individuals of minority and non-minority groups, individuals of the LGBT community, individuals with disabilities, and/or members with limited English proficiency. Jai Medical Systems Managed Care Organization, Inc. does not exclude people or treat them differently because of language, age, race, color, sex or sexual orientation, national origin, disability, medical condition, or religion.

To ensure effective communication for individuals with disabilities, Jai Medical Systems Managed Care Organization, Inc. shall:

- Provide equal access to auxiliary aids and services as necessary for individuals with disabilities, in accordance with applicable law.
- Include taglines for language accessibility in top 15 languages on the website, and in larger significant publications and significant communications.
- Include taglines for language accessibility in two popular languages in significant publications including Member Handbook, and significant communications.
- Provide free language assistance and interpretation services for members with limited English proficiency to communicate effectively.
- Provide free sign language interpretation for members with hearing disabilities.
- Provide free oral language assistance and written translation through Jai Medical Systems Managed Care Organization, Inc.'s multilingual staff, oral interpreters, and translators.

If you need these services, contact our Non-Discrimination Compliance Coordinator at monisha.kota@jaimedical.com. Additionally, information is made available in languages other than English upon request.

XIX. Equal Employment Opportunity Statement

Jai Medical Systems Managed Care Organization, Inc. provides equal employment opportunity for everyone regardless of language, age, sex, color, creed, national origin, pregnancy, ancestry, marital status, political belief, genetic information, and physical or mental disability that does not prohibit performance of essential job functions. In addition, Jai Medical Systems Managed Care Organization, Inc. complies with Section 1557 of the Affordable Care Act, all applicable federal, state, and local anti-discrimination laws. This policy is reflected in all of Jai Medical Systems Managed Care Organization, Inc.'s practices and policies regarding hiring, training, promotions, transfers, rates of pay, layoffs, and other forms of compensation. All matters relating to employment are based upon ability to perform the job, as well as dependability and reliability once hired.

If you believe that Jai Medical Systems Managed Care Organization, Inc. has failed to provide these services or discriminated on the basis of language, age, race, color, sex or sexual orientation, national origin, disability, medical condition, or religion, you can file a grievance with:

Monisha Priya Kota, Non-Discrimination Compliance Coordinator
Jai Medical Systems Managed Care Organization, Inc.
301 International Circle, Hunt Valley, MD 21030
Phone: 410-433-2200 | Fax: 410-433-4615 |
Email: monisha.kota@jaimedical.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Non-Discrimination Compliance Coordinator is available to help you. Grievances must be submitted to the Coordinator within sixty days of the date you become aware of the alleged discrimination.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through

the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, and by mail or phone at:

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

Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>

XX. Language Accessibility Statement

Interpreter Services are Available for Free
Help is available in your language:
1-888-524-1999 (TTY: 1-800-735-2258).
These services are available for free.

中文/Chinese

用您的语言为您提供帮助：1-888-524-1999 (TTY: 1-800-735-2258)
的这些服务都是免费的

فارسی/Farsi

ماسټ خط) 1-800-735-2258 دی کون یم تبصیح ماش که یباز هب مک ن تلف خط
(ناشنوا افراد) 1999-524-888-1

رسم س ددر ن گه یرا فر ص ه ب فسخ خ ن یا

ن م س

Español/Spanish

Hay ayuda disponible en su idioma: 1-888-524-1999 (TTY: 1-800-735-2258). Estos servicios están disponibles gratis.

አማርኛ/Amharic

እገዛ በ ቋንቋዎ ማግኘት ይችላሉ:-: 1-888-524-1999 (TTY:

1-800-735-2258): እነዚህ አገልግሎቶች ያለክፍያ የሚገኙ ነጻናቸው

العربى/Arabic

1-888-524-1999 (1-800-735-2258) للمعاقين سمعياً

المساعدة متوفرة في لغتك: اتصل على الرقم

ذو خله جرت خم فسخه الم ا

Français/French

Vous pouvez disposer d'une assistance dans votre langue : 1-888-524-1999 (TTY: 1-800-735-2258). Ces services sont disponibles pour gratuitement.

ગજઃ રાતી/Gujarati

તમારી ભાષામાં મદદ ઉપલબ્ધ છે: 1-888-524-1999 (ટીટીવાય: 1-800-735-2258). સેવાઓ મફત ઉપલબ્ધ છે

kreyòl ayisyen/Haitian Creole

Gen ed ki disponib nan lang ou: 1-888-524-1999 (TTY: 1-800-735-2258). Sèvis sa yo disponib gratis.

Igbo

Enyemaka di na asusu gi: 1-888-524-1999 (TTY: 1-800-735-2258). Oru ndi a di na enweghi ugwo i ga akwu maka ya.

한국어/Korean

사용하시는 언어로 지원해드립니다: 1-888-524-1999 (TTY: 1-800-735-2258). 무료로 제공됩니다

Português/Portuguese

A ajuda está disponível em seu idioma: 1-888-524-1999 (TTY: 1-800-735-2258). Estes serviços são oferecidos de graça.

Русский/Russian

Помощь доступна на вашем языке: 1-888-524-1999 (TTY: 1-800-735-2258). Эти услуги предоставляются бесплатно.

Tagalog

Makakakuha kayo ng tulong sa iyong wika: 1-888-524-1999 (TTY: 1-800-735-2258). Ang mga serbisyong ito ay libre.

Urdu/اردو

آپ کی زبان میں مدد دستیاب ہے: 1-888-524-1999 (ٹی ٹی وائی: 1-800-735-2258)

رہدہ ہاؤس سے ذرا سے کتھم تاملدخ

Tiếng Việt/Vietnamese

Hỗ trợ là có sẵn trong ngôn ngữ của quý vị 1-888-524-1999 (TTY: 1-800-735-2258). Những dịch vụ này có sẵn miễn phí.

Yorùbá/Yoruba

Iranlò wò wà ní àrò wò tó ní èdè rẹ: 1-888-524-1999 (TTY: 1-800-735-2258). Awon ise yi wa fun o free.

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

ANTHELMINTIC

\$\$ Albendazole	ALBENZA	
\$\$ Ivermectin*	STROMECTOL	tablets only
\$\$ Pyrantel Pamoate*	PIN - X	OTC product

AMINOGLYCOSIDES

\$ Gentamicin Sulfate*	GARAMYCIN	
\$ Neomycin Sulfate*	NEOMYCIN	tablets only

SULFONAMIDES

\$ Erythromycin/Sulfisoxazole*	ERYTHROMYCIN/SULFISOXAZOLE	
\$ Sulfadiazine*	SULFADIAZINE	
\$ Sulfasalazine*	AZULFIDINE	no EN tabs
\$ Sulfisoxazole*	SULFISOXAZOLE	
\$ Trimethoprim/Sulfamethoxazole*	BACTRIM / DS	

ANTIMYCOBACTERIAL AGENTS

\$\$\$\$ Cycloserine	SEROMYCIN	
\$\$\$ Ethambutol*	MYAMBUTOL	
\$\$\$ Ethionamide	TRECATOR	
\$ Isoniazid*	ISONIAZID	
\$\$\$ Pyrazinamide*	PYRAZINAMIDE	
\$\$\$\$ Rifabutin*	MYCOBUTIN	
\$\$\$\$ Rifampin*	RIFADIN	

MISC. ANTIINFECTIVES

\$ Metronidazole*	FLAGYL	
\$ Trimethoprim*	TRIMETHOPRIM	
\$\$ Chlorhexidine*	PERIOGARD	0.12% oral rinse

Leprostatics

\$ Dapsone*	DAPSONE	
-------------	---------	--

ANTIFUNGALS

\$ Griseofulvin Microsize*	GRIFULVIN V	
\$ Griseofulvin Ultramicrosize*	GRIS-PEG	
\$ Nystatin*	NYSTATIN TAB	

Imidazole-Related Antifungals

\$ Ketoconazole*	NIZORAL	
\$ Miconazole*	MONISTAT	OTC product
\$\$ Terbinafine*	LAMISIL	

\$\$ Itraconazole*	SPORANOX	
--------------------	----------	--

Prior Authorization Required

Triazoles

\$ Fluconazole*	DIFLUCAN	150mg x2 tablets/month is formulary. Authorization required for higher quantity or other strengths
-----------------	----------	--

Prior Authorization Required

ANTIVIRAL

Neuraminidase Inhibitors

\$\$ Oseltamivir Phosphate	TAMIFLU	QL=1 course of treatment per calendar year
\$\$ Zanamivir	RELENZA	QL=1 course of treatment per calendar year

CMV Agents

\$\$\$\$ Ganciclovir*	CYTOVENE	
-----------------------	----------	--

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

Hepatic Agents

\$\$\$\$\$ Lamivudine HBV	EPIVIR	
\$\$\$\$\$ Elbasvir-Grazoprevir	ZEPATIER	<i>Preferred for types 1,4</i>
\$\$\$\$\$ Glecaprevir-Pibrentasvir	MAVYRET	<i>Preferred all types</i>
\$\$\$\$\$ Sofosbuvir-Velpatasvir*	GENERIC EPCLUSA	<i>Preferred all types</i>
\$\$\$\$\$ Sofosbuvir-Velpatasvir-Voxilaprevir	VOSEVI	<i>Retreatment only</i>
\$\$\$\$\$ Peginterferon	PEG-INTRON, PEGASYS	
\$\$\$\$\$ Ribavirin*	REBETOL	
\$\$\$\$\$ Ledipasvir-Sofosbuvir*	GENERIC HARVONI	<i>Preferred for 1,4,5,6</i>
Special PA forms required. Please see www.jaimedicalsystems.com/providers/pharmacy for forms and full Maryland Medicaid prior authorization criteria.		

Herpes Agents

\$\$ Amantadine*	AMANTADINE	
\$\$\$ Acyclovir*	ZOVIRAX	<i>PA for ointment & susp.</i>

HIV Agents

\$\$\$\$\$ Abacavir	ZIAGEN	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Epzicom	ABACAVIR-LAMIVUDINE	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Trizivir	ABACAVIR-LAMIVUDINE-ZIDOV T	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Atazanavir Sulfate	REYATAZ	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Efavirenz / Emtricitabine / Tenofovir	GENERIC ATRIPLA	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Biktarvy	BIKTARVY	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Complera	COMPLERA	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Sustiva	EFAVIRENZ	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Atazanavir and Cobicistat	EVOTAZ	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Genvoya	GENVOYA	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Etravirine	INTELENCE	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Raltegravir	ISENTRESS	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Juluca	JULUCA	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Lopinavir / Ritonavir	KALETRA	<i>QL = 120 tabs / month</i>
\$\$\$\$\$ Lamivudine	EPIVIR	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Lamivudine-Zidovudine	COMBIVIR	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Odefsey	ODEFSEY	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Darunavir and Cobicistat	PREZCOBIX	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Darunavir Ethanolate	PREZISTA	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Atazanavir	REYATAZ	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Stribild	STRIBILD	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Symtuza	SYMTUZA	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Emtricitabine / Tenofovir	GENERIC TRUVADA	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Emtricitabine / Tenofovir Alafenamide	GENERIC DESCOVY	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Tenofovir	VIREAD	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Dolutegravir	TIVICAY	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Dolutegravir, Abacavir, and Lamivudine	TRIUMEQ	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Zidovudine	RETROVIR	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Fosamprenavir	LEXIVA	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Ritonavir	NORVIR	<i>QL = 30 tabs / month</i>
\$\$\$\$\$ Nevirapine	VIRAMUNE	<i>QL = 60 tabs / month</i>
\$\$\$\$\$ Stavudine	ZERIT	<i>QL = 60 tabs / month</i>

II. BIOLOGICALS

ANTISERA

Antiviral Monoclonal Antibodies

\$\$\$\$\$ Palivizumab	SYNAGIS	
Prior Authorization Required		

III. ANTINEOPLASTICS

ANTINEOPLASTICS

Alkylating Agents

\$\$\$\$\$ Busulfan	MYLERAN	
---------------------	---------	--

Nitrogen Mustards

\$\$\$\$\$ Chlorambucil	LEUKERAN	
\$\$\$\$\$ Cyclophosphamide*	CYTOXAN	
\$\$\$\$\$ Melphalan	ALKERAN	

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

Nitrosoureas

\$\$\$\$ Lomustine	LOMUSTINE	
--------------------	-----------	--

Antimetabolites

\$\$\$\$ Capecitabine*	XELODA	
\$\$\$ Fluorouracil*	EFUDEX	2% and 5% cream only
\$\$\$\$ Mercaptopurine*	PURINETHOL	
\$\$\$ Methotrexate*	RHEUMATREX	
\$\$\$\$ Thioguanine	TABLOID	

Progestins-Antineoplastic

\$\$\$ Megestrol*	MEGACE	Tabs & Oral Susp
-------------------	--------	------------------

Antiandrogens

\$\$\$\$ Flutamide*	FLUTAMIDE	
---------------------	-----------	--

Aromatase Inhibitors

\$\$\$\$ Letrozole*	FEMARA	
\$\$\$\$ Anastrozole*	ARIMIDEX	
\$\$\$ Exemestane*	AROMASIN	

Antineoplastic Hormones Misc.

\$\$\$\$ Bicalutamide*	CASODEX	
\$\$\$ Tamoxifen*	TAMOXIFEN	

\$\$\$\$ Leuprolide	LUPRON	
---------------------	--------	--

Prior Authorization Required

Mitotic Inhibitors

\$\$\$ Etoposide*	ETOPOSIDE	
-------------------	-----------	--

Antineoplastics Misc.

\$\$\$\$ Afatinib Dimaleate	GILOTRIF	
\$\$\$\$ Erlotinib	TARCEVA	
\$\$\$ Hydroxyurea*	HYDREA	
\$\$\$\$ Mitotane	LYSODREN	
\$\$\$\$ Procarbazine	MATULANE	
\$\$\$\$ Sorafenib	NEXAVAR	

\$\$\$\$ Interferon Alfa-2A	ROFERON-A	
\$\$\$\$ Interferon Alfa-2B	INTRON-A	
\$\$\$\$ Interferon Alfa-n3	ALFERON N	
\$\$\$\$ Interferon Beta-1a	AVONEX	
\$\$\$\$ Interferon Beta-1a	REBIF	
\$\$\$\$ Interferon Beta-1b	BETASERON	
\$\$\$\$ Glatiramer acetate	COPAXONE	

Prior Authorization Required

IV. ENDOCRINE & METABOLIC DRUGS

CORTICOSTEROIDS

Glucocorticosteroids

\$ Cortisone*	CORTISONE	
\$ Dexamethasone*	DEXAMETHASONE	no dose paks
\$ Hydrocortisone*	CORTEF	
\$ Methylprednisolone*	MEDROL	tabs & dose paks
\$ Prednisone*	PREDNISONE	
\$ Prednisolone*	PRELONE	
\$\$ Prednisolone Na Phosphate*	PEDIAPRED	
\$\$ Prednisolone Na Phosphate*	ORAPRED	
\$ Prednisolone Acetate	FLO-PRED	

Mineralocorticoids

\$ Fludrocortisone*	FLUDROCORTISONE	
---------------------	-----------------	--

ANDROGEN-ANABOLIC

Androgens

\$\$\$ Methyltestosterone	ANDROID	
\$\$\$ Danazol*	DANAZOL	
\$\$\$ Testosterone Gel	ANDROGEL, TESTIM	

Prior Authorization Required

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

ESTROGENS

\$ Estradiol*	ESTRACE	
\$\$ Esterified Estrogens	MENEST	
\$\$ Estrogens, Conjugated	PREMARIN	
\$\$\$ Estradiol TD Patch*	CLIMARA	
<i>Estrogen Combinations</i>		
\$\$ Conjugated Estrogens & Medroxyprogesterone	PREMPRO	

CONTRACEPTIVES

All generic oral contraceptives are formulary

Progestin

\$\$\$ Norethindrone*	NOR-QD, ORTHO MICRON	<i>Females only</i>
\$\$ Norethindrone*	Lyleq	<i>Females only</i>

Combinations

\$\$ Desogestrel & Ethinyl Estradiol*	DESOGEN, ORTHO-CEPT	<i>Females only</i>
\$\$ Drospirenone-Ethinyl Estradiol*	YASMIN, YAZ	<i>Females only</i>
\$\$ Drospirenone-Eth Estrad Levomefolate	SAFYRAL, BEYAZ	<i>Females only</i>
\$\$ Ethynodiol Diacet-Eth Estrad*	ZOVIA	<i>Females only</i>
\$\$\$ Etonogestrel-Ethinyl Estradiol	NUVARING	<i>QL= 1 ring / month</i>
\$\$\$ Etonogestrel-Ethinyl Estradiol	ELURYNG	<i>QL= 1 ring / month</i>
		<i>Females only</i>
\$\$ Levonorgestrel & Ethinyl Estradiol*	NORDETTE, AVIANE, ICLEVIA	<i>Females only</i>
\$\$ Norethindrone-Ethinyl Estradiol*	MODICON, BREVICON	<i>Females only</i>
\$\$ Norethindrone Ace-Ethinyl Estrad*	LOESTRIN	<i>Females only</i>
\$\$ Norgestrel-Ethinyl Estradiol*	CRYSSELLE, OGESTREL	<i>Females only</i>
\$\$ Norgestimate-Ethinyl Estradiol*	ORTHO-CYCLEN	<i>Females only</i>
\$\$ Norethindrone & Ethinyl Estrad FE*	FEMCON FE	<i>Females only</i>
\$\$ Norethindrone Ace-Ethinyl Estrad FE*	LOESTRIN FE	<i>Females only</i>
\$\$\$ Norelgestromin-Ethinyl Estradiol*	ORTHO EVRA PATCH	<i>Females only</i>

Biphasic

\$\$ Desogest-Eth Estrad & Eth Estrad	MIRCETTE	<i>Females only</i>
\$\$ Norethindrone-Mestranol	NORINYL, NECON	<i>Females only</i>
\$\$ Norethindrone-Ethinyl Estradiol FE	LO LOESTRIN FE	<i>Females only</i>

Triphasic

\$\$ Desogest-Ethin Est*	CYCLESSA	<i>Females only</i>
\$\$ Levonorgestrel-Eth Estradiol*	TRIVORA	<i>Females only</i>
\$\$ Norethindrone-Ethinyl Estradiol*	ORTHO NOVUM 7/ 7/ 7	<i>Females only</i>
\$\$ Norgestimate-Ethinyl Estradiol*	ORTHO TRI-CYCLEN / LO	<i>Females only</i>
\$\$\$ Norethindrone Ac-Ethinyl Estrad FE*	ESTROSTEP FE	<i>Females only</i>
\$ Norethindrone-Ethinyl Estradiol*	Nylia 7/7/7	<i>Females only</i>
\$\$ Norethindrone-Ethinyl Estradiol*	Tri-Nymyo	<i>Females only</i>

Four Phase

\$\$ Estradiol Valerate-Dienogest	NATAZIA	<i>Females only</i>
-----------------------------------	---------	---------------------

Extended

\$\$ Levonorgestrel-Ethinyl Estradiol*	SEASONIQUE,QUARTETTE LOSEASONIQUE	<i>Females only</i>
--	--------------------------------------	---------------------

Continuous

\$\$ Levonorgestrel-Ethinyl Estradiol	AMETHYST	<i>Females only</i> <i>Females only</i>
---------------------------------------	----------	--

PROGESTINS

\$\$\$\$ Hydroxyprogesterone	MAKENA	<i>Special prescription form from manufacturer</i>
\$ Medroxyprogesterone*	PROVERA	<i>tabs only / females only</i>
\$\$\$ Medroxyprogesterone Acetate	DEPO-PROVERA DEPO-SQ PROVERA 104	<i>Females only</i>
\$ Norethindrone Acetate*	AYGESTIN	<i>Females only</i>

EMERGENCY CONTRACEPTIVE

\$\$ Levonorgestrel*	PLAN B ONE STEP PLAN B	<i>1 kit / month / 3 kits / yr</i> <i>Females only</i> <i>No prescription required for OTC formulation</i>
----------------------	---------------------------	--

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

Hormone Receptor Modulators

\$\$\$\$ Raloxifene*	EVISTA	
Prior Authorization Required		

Gonadotropin Releasing Hormones

\$\$\$\$ Nafarelin	SYNAREL	
Prior Authorization Required		

Growth Hormone

\$\$\$\$ Somatropin	HUMATROPE ONLY	
Prior Authorization Required		

Posterior Pituitary

\$\$\$ Alendronate*	FOSAMAX	
\$\$\$\$ Alendronate + Cholecalciferol	FOSAMAX PLUS D	
\$\$\$\$ Ibandronate*	BONIVA	
\$\$\$\$ Risedronate	ACTONEL	
\$\$\$ Desmopressin*	DDAVP	<i>(all dosage forms)</i>
Prior Authorization Required		

Parathyroid Hormone

\$\$\$\$ Teriparatide	FORTEO	
-----------------------	--------	--

V. CARDIOVASCULAR AGENTS

CARDIOTONICS

Digitalis

\$ Digoxin*	LANOXIN	<i>no caps</i>
-------------	---------	----------------

PED Inhibitors

\$\$\$\$ Sildenafil Citrate	REVATIO	<i>20mg tablets and 10mg/mL liquid</i>
Prior Authorization Required		

ANTIANGINAL AGENTS

Nitrates

\$ Isosorbide Dinitrate*	ISORDIL, ISORDIL TEMBIDS	
\$ Nitroglycerin (oral)*	NITROSTAT	
\$\$\$ Nitroglycerin (topical)*	NITRODUR, NITROBID	
\$\$ Isosorbide Mononitrate*	IMDUR	
Prior Authorization Required		

Antianginals-Other

\$ Dipyridamole*	PERSANTINE	
------------------	------------	--

BETA BLOCKERS

Beta Blockers Non-Selective

\$ Propranolol*	INDERAL/LA	
\$ Timolol*	TIMOLOL	
\$\$\$ Sotalol*	BETAPACE	
\$\$\$ Carvedilol*	COREG	

Beta Blockers Cardio-Selective

\$ Atenolol*	TENORMIN	
\$ Metoprolol Tartrate*	LOPRESSOR	
\$\$\$ Metoprolol Succinate*	TOPROL XL	

Alpha-Beta Blockers

\$\$\$ Labetalol*	TRANDATE	
-------------------	----------	--

CALCIUM BLOCKERS

\$\$\$ Amlodipine*	NORVASC	
\$\$\$ Amlodipine & Benazepril*	LOTREL	
\$\$\$ Diltiazem*	CARDIZEM/CD, DILACOR/XR	
\$\$ Felodipine*	FELODIPINE	
\$\$\$ Nifedipine*	ADALAT CC, PROCARDIA XL	
\$\$ Verapamil*	CALAN, SR	

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

<i>Loop Diuretics</i>		
\$ Furosemide*	LASIX	
<i>Potassium Sparing Diuretics</i>		
\$ Spironolactone*	ALDACTONE	
<i>Thiazides</i>		
\$ Chlorothiazide*	DIURIL	
\$ Chlorthalidone*	CHLORTHALIDONE	
\$ Hydrochlorothiazide*	HYDROCHLOROTHIAZIDE	
\$ Methyclothiazide*	METHYCLOTHIAZIDE	
\$ Metolazone*	ZAROXOLYN	
\$ Indapamide*	INDAPAMIDE	
<i>Combination Diuretics</i>		
\$ Spironolactone & HCTZ*	ALDACTAZIDE	
\$ Triamterene & HCTZ*	MAXZIDE	
<i>Osmotic Diuretics</i>		
\$ Glycerin Supp*	GLYCERIN	adult, infant, child

PRESSORS

<i>Emergency Kits</i>		
\$\$\$\$ Epinephrine	EPI-PEN, EPI-PEN JR, ADRENALICK	

ANTHYPERLIPIDEMIC

<i>Bile Sequestrants</i>		
\$\$\$ Cholestyramine*	QUESTRAN, LIGHT	cans only
\$\$\$ Colestipol*	COLESTID	cans only
<i>Misc.</i>		
\$ Niacin*	NIACIN	OTC (slow release)
\$ Niacin CR*	NIASPAN	
\$\$\$ Fenofibrate tablets*	LOFIBRA	54mg and 160mg
\$\$\$ Fenofibrate*	TRICOR	48mg and 145mg
\$\$ Gemfibrozil*	LOPID	
\$\$\$\$ Omega-3-acid ethyl esters*	LOVAZA	

\$\$\$\$ Fenofibrate	LIPOFEN, TRIGLIDE	
\$\$\$\$ Fenofibrate acid*	TRILIPIX	
\$\$\$\$ Fenofibrate micronized	ANTARA	
\$\$\$\$ Ezetimibe	ZETIA	
\$\$\$\$ Fenofibric Acid	FIBRICOR	
Prior Authorization Required		

<i>HMG CoA Reductase Inhibitors</i>		
\$\$\$\$ Amlodipine & Atorvastatin*	CADUET	
\$\$\$\$ Atorvastatin*	LIPITOR	
\$\$\$\$ Fluvastatin*	LESCOL	
\$\$ Lovastatin*	MEVACOR	
\$\$\$\$ Niacin & Lovastatin	ADVICOR	
\$ Pravastatin*	PRAVACHOL	
\$\$\$\$ Niacin-Simvastatin	SIMCOR	
\$\$\$\$ Rosuvastatin Calcium	CRESTOR	
\$\$\$ Simvastatin*	ZOCOR	
\$\$\$\$ Sacubitril & Valsartan	ENTRESTO	

\$\$\$\$ Simvastatin*	ZOCOR	80mg only
\$\$\$\$ Ezetimibe + Simvastatin	VYTORIN	
<i>PCSK9 Inhibitors</i>		
\$\$\$\$ Evolocumab	REPATHA	140MG/ML
Prior Authorization Required		

VI. RESPIRATORY AGENTS

ANTIHISTAMINES

<i>Antihistamines - Ethanolamines</i>		
\$ Diphenhydramine*	BENADRYL	OTC product

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

Antihistamines - Non Sedating

\$\$ Loratadine*	ALAVERT, CLARITIN	OTC product
\$\$ Loratadine / Pseudoephedrine*	CLARITIN-D 12hr, 24hr	OTC product
\$\$ Cetirizine*	ZYRTEC	chew tabs/liquid AL ≤ 18
\$\$ Cetirizine tabs*	ZYRTEC	
\$\$ Fexofenadine*	ALLEGRA OTC, ALLEGRA SUSP, ALLEGRA ODT	30 or 60 per 30 days
\$\$ Fexofenadine / Pseudoephedrine*	ALLEGRA-D OTC 12hr, 24hr	30 or 60 per 30 days

Antihistamines - Phenothiazines

\$ Promethazine*	PROMETHAZINE	tabs only AL ≥ 2 years
------------------	--------------	---------------------------

SYSTEMIC AND TOPICAL NASAL PRODUCTS

Nasal Antihistamines

\$\$\$\$ Azelastine*	ASTELIN	
Prior Authorization Required		

Nasal Steroids

\$\$ Flunisolide*	NASALIDE
\$\$ Triamcinolone*	NASACORT AQ
\$\$\$ Fluticasone*	FLONASE
\$\$\$\$ Mometasone furoate	NASONEX

Mucolytics

\$\$ Acetylcysteine*	MUCOMYST
----------------------	----------

ANTIASTHMATIC

Anticholinergics

\$\$ Ipratropium*	ATROVENT NASAL	
\$\$\$ Ipratropium	ATROVENT HFA	
\$\$\$ Tiotropium	SPIRIVA	
\$\$\$\$ Acclidinium Bromide	TUDORZA PRESSAIR	QL = 1 inh / 30 days
Prior Authorization Required		

Anti-Inflammatory Agents

\$\$\$ Cromolyn (inhalation)*	INTAL
\$ Cromolyn (nasal)*	NASALCROM

Beta Adrenergics

\$\$ Albuterol	PROVENTIL HFA, VENTOLIN HFA, PROAIR HFA	
\$\$ Albuterol*	ALBUTEROL NEBULIZER SOLUTION	0.5% (5mg/mL) and 0.083% (2.5mg/3ml)
\$\$\$ Pirbuterol	MAXAIR AUTOHALER	
\$\$\$\$ Olodaterol	STRIVERDI	
\$\$\$ Salmeterol	SEREVENT DISKUS	
Prior Authorization Required		

Adrenergic Combinations

\$\$\$\$ Ipratropium-Albuterol	COMBIVENT RESPIMAT	
\$\$\$ Albuterol-Ipratropium*	DUONEB	
\$\$\$\$ Tiotropium-Olodaterol	STIOLTO	
\$\$ Umeclidinium-Vilanterol	ANORO ELLIPTA	
\$\$\$ Salmeterol-Fluticasone	ADVAIR, ADVAIR HFA	
\$\$\$ Budesonide-Formoterol	SYMBICORT	
Prior Authorization Required		

Steroid Inhalants

\$\$\$\$ Fluticasone	FLOVENT HFA	
\$\$\$ Triamcinolone	AZMACORT	
\$\$\$ Budesonide	PULMICORT FLEXHALER	
\$\$\$ Budesonide*	PULMICORT RESPULES	AL = 4 years and under QL = 1 box / 30 days
\$\$\$ Beclomethasone Dipropionate	QVAR	

Sympathomimetic Agents

\$ Pseudoephedrine HCL*	PSEUDOEPHEDRINE	OTC product
-------------------------	-----------------	-------------

Mixed Adrenergics

\$\$\$\$ Epinephrine	EPI-PEN, EPI-PEN JR, ADRENAClick	
----------------------	----------------------------------	--

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

<i>Xanthines</i>		
\$ Aminophylline*	AMINOPHYLLINE	
\$\$ Theophylline*	THEO-24, THEOCHRON	
 <i>Leukotriene Receptor Antagonists</i>		
\$\$\$ Montelukast Sodium*	SINGULAIR	

COUGH/COLD/ALLERGY

<i>Expectorants</i>		
\$ Guaifenesin*	GUAIFENESIN	<i>OTC product</i>
\$ Guaifenesin/DM*	GUAIFENESIN DM	<i>OTC product</i>
 <i>Cough/Cold/Allergy Combinations</i>		
\$ Brompheniramine*	BROMPHENIRAMINE	<i>Pediatric formulation</i>
\$ Brompheniramine / Pseudoephedrine*	BROMPHENIRAMINE / PSEUDOEPHEDRINE	
\$ Chlorpheniramine*	CHLORPHENIRAMINE	<i>Pediatric formulation</i>
\$ Clemastine*	TAVIST	<i>Pediatric formulation</i>
\$ Phenylephrine*	SUDAFED	<i>Pediatric formulation</i>
\$ Pseudoephedrine-Bromphen-DM*	PSEUDOEPHED-BROMPHEN DM	
\$ Pseudoephedrine-Chlorphen-DM*	PEDIA RELIEF LIQ COUGH/COLD	
\$ Pseudoephedrine-DM liquid*	TRIAMINIC AM LIQ CGH/DECON	
\$ Pseudoephedrine-DM soln*	PSEUDOEPHEDRINE-DM SOLN	
\$ GG/Codeine sol*	GUIATUSS AC	
\$ Benzonatate*	TESSALON, TESSALON PERLES	
\$\$ Pseudoephedrine-GG*	PSEUDO-G / PSI	
\$ Pseudoephedrine HCL*	PSEUDOEPHEDRINE	<i>OTC product</i>

VII. GASTROINTESTINAL AGENTS

LAXATIVES

<i>Osmotic Laxatives</i>		
\$ Polyethylene Glycol powder*	MIRALAX	
 <i>Surfactant Laxatives</i>		
\$ Docusate Sodium*	COLACE	<i>OTC product</i>
 <i>Stimulant Laxatives</i>		
\$ Bisacodyl*	DULCOLAX	<i>OTC product / caps only</i>
\$ Sennosides*	SENOKOT	<i>OTC product</i>
\$ Sennosides/Docustate*	SENNA-S	<i>OTC product</i>
 <i>Bulk Laxatives</i>		
\$ Polycarbophil Calcium*	FIBERCON	<i>OTC product</i>
\$ Psyllium*	METAMUCIL	<i>OTC product</i>
 <i>Miscellaneous Laxatives</i>		
\$ Glycerin*	GLYCERIN	<i>OTC product</i>
\$ LACTULOSE	LACTULOSE	
\$ Magnesium Citrate*	CITROMA	<i>OTC product</i>
\$ PEG-Electrolyte*	GOLYTELY	

Lubiprostone	AMITIZA	
Prior Authorization Required		

ANTIDIARRHEALS

<i>Antiperistaltic Agents</i>		
\$ Diphenoxylate w/ Atropine*	LOMOTIL	
\$ Loperamide*	IMODIUM	<i>OTC product</i>
 <i>Misc Antidiarrheal Agents</i>		
\$ Bismuth Subsalicylate*	PEPTO-BISMOL	<i>no tabs, OTC</i>

\$\$\$ Octreotide Acetate*	SANDOSTATIN	
Prior Authorization Required		

ANTACIDS

<i>Antacids - Aluminum Salts</i>		
\$ Aluminum Hydroxide Gel*	ALUMINUM HYDROXIDE	<i>OTC product</i>

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
<i>Antacids - Calcium Salts</i> \$ Calcium Carbonate*	OS-CAL	OTC product
<i>Antacid Combinations</i> \$ Al Hydrox-Mag Carb* \$ Aluminum & Magnesium Hydroxide*	MAALOX MYLANTA	no tabs, OTC no tabs, OTC
ULCER DRUGS		
<i>Belladonna Alkaloids</i> \$ Hyoscyamine Sulfate*	LEVSIN	tablets or SL only
<i>Quaternary Anticholinergics</i> \$ Propantheline Bromide*	PROPANTHELINE BROMIDE	
<i>Antispasmodics</i> \$ Dicyclomine*	BENTYL	
<i>H-2 Antagonists</i> \$ Famotidine* \$ Ranitidine*	PEPCID ZANTAC	tabs only no caps
<i>Proton Pump Inhibitors</i> \$ Esomeprazole Magnesium \$\$ Omeprazole* \$\$ Lansoprazole* \$\$\$\$ Lansoprazole* \$\$\$ Pantoprazole* \$\$\$ Rabeprazole* \$\$\$\$ Lansoprazole*	NEXIUM 24 HR OTC PRILOSEC OTC PREVACID PREVACID (Generic) PROTONIX ACIPHEX PREVACID SOLU-TAB	OTC OTC OTC RX
Prior Authorization Required		
<i>Misc. Anti-Ulcer</i> \$\$ Sucralfate*	CARAFATE TABLETS	
\$\$\$\$ Sucralfate*	CARAFATE SUSPENSION	
Prior Authorization Required		
ANTIEMETICS		
<i>Antiemetics - Anticholinergic</i> \$ Meclizine* \$\$ Prochlorperazine*	MECLIZINE PROCHLORPERAZINE	no SR
<i>5-HT3 Receptor Antagonists</i> \$\$\$\$ Ondansetron* \$\$\$\$ Ondansetron* \$\$\$\$ Ondansetron*	ZOFRAN ZOFRAN ODT ZOFRAN	QL = 10 tabs per fill QL = 10 tabs per fill Suspension: QL = 50mls per fill
Prior Authorization Required		
<i>Neurokinin 1 Receptor</i> \$\$\$\$ Aprepitant	EMEND	
Prior Authorization Required		
DIGESTIVE AIDS		
<i>Digestive Aids - Mixtures</i> \$\$\$\$ Pancrelipase (Lip-Prot-Amyl) \$\$\$\$ Pancrelipase (Lip-Prot-Amyl) DR	VIOKACE CREON, ZENPEP, ULTRESA PANCREAZE, PANCRELIPASE PERTZYE	
MISC. GI		
<i>GI Stimulants</i> \$ Metoclopramide*	REGLAN	no 5mg tabs
<i>Inflammatory Bowel Agents</i> \$\$\$\$ Mesalamine \$\$\$\$ Mesalamine* \$ Sulfasalazine*	PENTASA ROWASA AZULFIDINE	no EN tabs

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

COX-2 Inhibitor

\$\$\$\$ Celecoxib	CELEBREX	
Prior Authorization Required		

Anti-Rheumatic Antimetabolite

\$\$\$\$ Methotrexate*	RHEUMATREX	
------------------------	------------	--

GOUT

\$ Allopurinol*	ZYLOPRIM	
\$\$\$\$ Colchicine	COLCRYS	

Uricosurics

\$ Probenecid*	PROBENECID	
----------------	------------	--

LOCAL ANESTHETICS

\$ Lidocaine*	LIDOCAINE	2% soln, 3%, 5% cream
Lidocaine/Prilocaine	EMLA	2.5/2.5%

\$\$\$\$ Lidocaine*	LIDODERM PATCHES	QL = 90 patches /30 days
Prior Authorization Required		

MIGRAINE PRODUCTS

\$\$\$ Ergoloid mesylates*	HYDERGINE	
\$\$\$\$ Sumatriptan tablets*	IMITREX	QL = 9 tabs/30 days
\$\$\$\$ Sumatriptan injection*	IMITREX	QL = 2 injections/30 days
\$\$\$\$ Sumatriptan nasal*	IMITREX	QL = 6 sprays/30 days
\$\$\$\$ Sumatriptan-naproxen	TREXIMET	QL = 9 tabs/30 days
\$\$\$\$ Rizatriptan tablets*	MAXALT	QL = 6 tabs/30 days
\$\$\$\$ Zolmitriptan tablets*	ZOMIG	QL = 6 tabs/30 days tabs only
Prior Authorization Required		

XI. NEUROMUSCULAR AGENTS

ANTICONVULSANT

Hydantoins

\$\$ Phenytoin*	DILANTIN	
-----------------	----------	--

Succinimides

\$\$ Ethosuximide*	ZARONTIN	
--------------------	----------	--

Miscellaneous Anticonvulsants

\$\$\$ Primidone*	MYSOLINE	
-------------------	----------	--

ANTIPARKINSONIAN

COMT Inhibitors

\$\$\$ Entacapone*	COMTAN	
Prior Authorization Required		

Dopaminergic

\$ Amantadine*	AMANTADINE	
\$\$\$ Bromocriptine*	PARLODEL	no postpartum use
\$\$ Ropinirole*	REQUIP	
Prior Authorization Required		

Levodopa Combinations

\$\$\$ Carbidopa-Levodopa*	SINEMET, CR	no 100-25 CR
----------------------------	-------------	--------------

Monoamine Oxidase Inhibitor

\$\$\$\$ Selegiline*	ELDEPRYL	
----------------------	----------	--

MUSCULOSKELETAL THERAPY AGENTS

Central Muscle Relaxants

\$\$ Baclofen*	BACLOFEN	
\$ Cyclobenzaprine*	CYCLOBENZAPRINE	
\$ Methocarbamol*	ROBAXIN	

Direct Muscle Relaxants

\$\$\$\$ Dantrolene*	DANTRIUM	
Prior Authorization Required		

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

DIETARY PRODUCTS

\$\$ Infant Foods	ENFAMIL / SIMILAC	OTC product
\$\$ Phenyl-Free*	PHENYL-FREE	OTC product

MISCELLANEOUS NUTRITIONAL PRODUCTS

\$\$ Nutritional Supplements	ENSURE, PEDIASURE, BOOST, VIVONEX	
Prior Authorization Required		
For enteral access only. For members without enteral access, follow the DME process. (Nutritional Supplements are not limited to this list)		

XIII. HEMATOLOGICAL AGENTS

HEMATOPOIETIC AGENTS

Cobalamines

\$ Cyanocobalamin*	VITAMIN B-12	1,000mg tabs only
\$ Folic Acid*	FOLIC ACID	
\$\$\$ Leucovorin Calcium*	LEUCOVORIN	
\$ Thiamine	THIAMINE	
\$ Cyanocobalamin*	VITAMIN B-12	injection
\$ Hydroxocobalamin*	HYDROXOCOBALAMIN	
Prior Authorization Required		

Iron

\$ Ferrous Gluconate*	FERGON	OTC product
\$ Ferrous Sulfate*	FEOSOL	OTC product

Hematopoietic Growth Factors

\$\$\$\$\$ Darbepoetin	ARANESP	4 injections / month
Prior Authorization Required		

Erythropoietins

\$\$\$\$\$ Epoetin Alfa	EPOGEN	2,000U, 3,000U, 4,000U, 10,000 - QL = 12 injections / month
Prior Authorization Required		
20,000U, 40,000U - QL = 4 injections / month		

Leukocytes

\$\$\$\$\$ Filgrastim	NEUPOGEN	QL = 30 injections / month
Prior Authorization Required		

ANTICOAGULANTS

Coumarin Anticoagulants

\$\$ Warfarin Sodium*	COUMADIN	
-----------------------	----------	--

Heparin Agents

\$\$\$\$\$ Enoxaparin*	LOVENOX	
\$\$\$\$\$ Apixaban	ELIQUIS	

Thrombin Inhibitors

\$\$\$\$\$ Dabigatran	PRADAXA	
Prior Authorization Required		

HEMOSTATICS

Hemostatics - Topical

\$\$\$\$ Thrombin	THROMBIN	
Prior Authorization Required		

MISC. HEMATOLOGICAL

Antihemophilic Products

\$\$\$\$\$ Antihemophilic Factor (Human)	KOATE-DVI, HP, HEMOFIL M	
\$\$\$\$\$ Antihemophilic Factor (Recombinate)	RECOMBINATE	
\$\$\$\$\$ Antiinhibitor Coagulant Complex	FEIBA VH	
\$\$\$\$\$ Antithrombin III (Human)	THROMBATE III	
Prior Authorization Required		

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

Steroid Combinations

\$ Bacitracin-Polymyxin-Neomycin-HC*	BACITRACIN-POLYMYXIN-NEOMYCIN-HC	
\$ Neomycin-Polymyxin-Dexamethasone*	MAXITROL	
\$\$ Tobramycin-Dexamethasone*	TOBRADEX	
\$\$\$ Neomycin-Polymyxin-HC*	CORTISPORIN	
\$\$\$ Sulfacetamide Sod-Prednisolone*	BLEPHAMIDE	

Cycloplegics

\$ Atropine Sulfate*	ISOPTO ATROPINE	
----------------------	-----------------	--

Decongestants

\$ Naphazoline*	NAPHAZOLINE	
\$\$ Phenylephrine*	MYDRIN	

Ophthalmic NSAID's

\$ Diclofenac Sodium*	VOLTAREN	
\$\$ Flurbiprofen*	OCUFEN	

Miotics - Direct Acting

\$ Pilocarpine*	ISOPTO-CARPINE	<i>no Ocusert</i>
-----------------	----------------	-------------------

\$\$\$ Brimonidine Tartrate	ALPHAGAN 0.2%, ALPHAGAN P 0.15%	
-----------------------------	---------------------------------	--

Prior Authorization Required

Prostaglandins

\$\$\$ Latanoprost*	XALATAN	
---------------------	---------	--

Carbonic Anhydrase Inhibitors

\$\$ Dorzolamide*	TRUSOPT	
-------------------	---------	--

OTIC

Steroids

\$ Hydrocortisone w/Acetic Acid*	ACETASOL HC	QL = 20 mls / 30 days
----------------------------------	-------------	-----------------------

Antibiotics & Steroid-Antibiotic Combinations

\$ Neomycin-Polymyxin-HC*	CORTISPORIN	QL = 20 mls / 30 days
---------------------------	-------------	-----------------------

Antibiotics

\$\$\$ Ofloxacin*	OFLOXACIN	QL = 20 mls / 30 days
-------------------	-----------	-----------------------

Anti Infective

\$ Carbamide Peroxide*	DEBROX	
------------------------	--------	--

Analgesic Combinations

\$ Benzocaine & Antipyrine*	A/B OTIC	
-----------------------------	----------	--

MOUTH & THROAT (Local)

Antiinfectives - Throat

\$\$\$ Clotrimazole*	CLOTRIMAZOLE TROCHE	
\$ Nystatin*	NYSTATIN	

ANORECTAL

Rectal Steroids

\$ Hydrocortisone*	ANUSOL-HC	2.5% cream
\$\$ Hydrocortisone*	PROCTOCREAM	2.5% cream

DERMATOLOGICAL

Antibiotics - Topical

\$\$ Bacitracin*	BACITRACIN	OTC product
\$ Gentamicin Sulfate*	GENTAMICIN	
\$\$\$ Metronidazole*	METROGEL	
\$\$\$ Mupirocin*	BACTROBAN	
\$ Neomycin Sulfate*	NEOMYCIN	

Antibiotic Mixtures Topical

\$ Neomycin-Bacitracin-Polymyxin*	NEOSPORIN	OTC product
-----------------------------------	-----------	-------------

Antibiotic Steroid Combinations

\$\$ Neomycin-Polymyxin-HC*	CORTISPORIN	
-----------------------------	-------------	--

ProCare/Jai Medical Systems Therapeutic Formulary

<u>Generic Name</u>	<u>Brand Name</u>	<u>Annotation</u>
---------------------	-------------------	-------------------

Imidazole-Related Antifungals (Topical)

\$\$ Clotrimazole Topical*	LOTRIMIN	OTC product
\$ Miconazole*	MONISTAT	OTC product

Antifungals

\$ Nystatin*	NYSTATIN	no powder
--------------	----------	-----------

Antifungals - Topical Combinations

\$\$ Nystatin-Triamcinolone*	NYSTATIN-TRIAMCINOLONE	
------------------------------	------------------------	--

Antipsoriatics

\$\$\$\$ Calcipotriene*	DOVONEX	
-------------------------	---------	--

Antiseborrheic Products

\$ Sulfacetamide Sodium*	SULFACETAMIDE SODIUM	
--------------------------	----------------------	--

Burn Products

\$ Silver Sulfadiazine*	SILVADENE	
-------------------------	-----------	--

Tar Products

\$ Coal Tar*	COAL TAR SHAMPOO	1% only
--------------	------------------	---------

Enzymes - Topical

\$\$\$ Collagenase	SANTYL	
--------------------	--------	--

Keratolytics/Antimitotics

\$\$\$\$ Podofilox*	CONDYLOX	
\$\$\$\$ Urea*	KERALAC, UMECTA	
\$\$\$\$ Urea 45%*	URAMAXIN GEL 45%	

Local Anesthetics - Topical

\$ Lidocaine viscous*	LIDOCAINE VISCOUS	
\$\$ Diclofenac*	VOLTAREN	1% gel

Scabicides & Pediculocides

\$ Lindane*	LINDANE	
\$\$ Permethrin*	ELIMITE	
\$\$ Permethrin*	NIX	OTC product

Misc. Topical

\$\$ Ammonium Lactate*	LAC-HYDRIN	cream & lotion
\$\$\$ Fluorouracil*	EFUDEX	2% and 5% cream only

\$\$\$ Tacrolimus oint*	PROTOPIC	
\$\$\$ Pimecrolimus	ELIDEL	

Prior Authorization Required

Antiviral Topical

\$\$\$\$ Acyclovir	ZOVIRAX	ointment & suspension
--------------------	---------	-----------------------

Prior Authorization Required

Corticosteroids - Topical

\$ Betamethasone Dipropionate*	BETAMETHASONE DIPROPIONATE	
\$ Betamethasone Valerate*	BETAMETHASONE VALERATE	
\$ Clobetasol Propionate*	TEMOVATE	
\$ Desonide*	DESOWEN	
\$ Fluocinonide*	FLUOCINONIDE	
\$ Fluocinonide Acetonide*	SYNALAR	
\$ Hydrocortisone*	HYDROCORTISONE	OTC product
\$ Triamcinolone Acetonide*	KENALOG	Topical and injectable
\$ Triamcinolone Acetonide in Orabase*	TRIAM. ACET. IN ORABASE	

Acne Products

\$ Benzoyl Peroxide*	BENZAC W	
\$\$ Tretinoin*	RETIN-A	Ages 0-21 only / no Micro
\$\$\$ Adapalene*	DIFFERIN	Ages 0-21 only Gel / Cream

Acne Antibiotics

\$\$ Clindamycin Phosphate*	CLEOCIN	
\$\$ Erythromycin Gel*	ERYGEL	

Prior Authorization Guidelines

GENERIC: ACARBOSE

BRAND: PRECOSE®

INDICATION:

(1) Type 2 diabetes mellitus

Criteria:

(a) Failure of maximal doses of *one* oral sulfonylurea (e.g., glyburide 20mg daily or equivalent). Failure is defined as Hemoglobin A1c > 7.0.

GENERIC: ACLIDINIUM BROMIDE AEROSOL POWDER

BRAND: TUDORZA PRESSAIR®

INDICATION:

(1) Long-term maintenance treatment of bronchospasm associated with COPD (including bronchitis and emphysema)

Criteria:

- (a) Diagnosis of COPD **and**
- (b) Must be greater than 18 years of age **and**
- (c) Documented inadequate response or intolerance to Spiriva

GENERIC: ACYCLOVIR TOPICAL OINTMENT/SUSPENSION

BRAND: ZOVIRAX® 5%

INDICATIONS:

- (1) Herpes genitalis
- (2) Oral herpes infection

Criteria:

- (a) Herpes genitalis – for initial episode only; **or**
- (b) Oral herpes infection – for immunocompromised patients *only*.

Additional Criteria for Suspension:

- (c) Patient is <17 years of age; **or**
- (d) Unable to ingest solid dosage form (e.g. capsules) due to dysphagia

GENERIC: ADALIMUMAB

BRAND: HUMIRA®

INDICATIONS:

- (1) Moderate to severely active rheumatoid arthritis
- (2) Psoriatic arthritis
- (3) Ankylosing spondylitis

Prior Authorization Guidelines

(4) Moderate to severely active Crohn's disease

Criteria:

- (a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Humira therapy; **and**
- (b) The patient does not have a clinically important active infection

Additional Criteria for RA:

- (a) The patient has failed or is intolerant to one formulary NSAID **and**
- (b) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for Crohn's:

- (a) The patient has failed or is intolerant to infliximab; **or**
- (b) The patient has failed or is intolerant to mesalamine or sulfasalazine; **and**
- (c) The patient has failed or is intolerant to corticosteroids; **and**
- (d) The patient has failed or is intolerant to an immunomodulator (e.g., methotrexate, 6-mercaptopurine or azathioprine)

GENERIC: ANTIHEMOPHILIC FACTORS

BRAND: KOATE-DVI[®], FEIBA VH[®], RECOMBINATE[®], THROMBATE III[®]

INDICATION:

- (1) Hemophilia A

Criteria:

- (a) Diagnosis of Hemophilia A

GENERIC: APREPITANT

BRAND: EMEND[®]

INDICATION:

- (1) Nausea and vomiting

Criteria:

- (a) For the prevention of post-operative nausea and vomiting; **or**
- (b) For the prevention of chemotherapy-induced nausea and vomiting

Prior Authorization Guidelines

GENERIC: AZELASTINE NASAL SPRAY

BRAND: ASTELIN[®]

INDICATIONS:

- (1) Perennial allergic rhinitis
- (2) Seasonal allergic rhinitis

Criteria:

- (a) Patient is ≥ 5 years of age with one of the above diagnoses; **and**
- (b) Failure of at least one formulary nasal steroid after a period of at least two months on the maximum dose appropriate and tolerated by the patient

GENERIC: AZELASTINE 0.05% Eye Drops

INDICATION:

- (1) Allergic conjunctivitis

Criteria:

- (a) Patient is ≥ 3 years of age with the above diagnoses
- (b) Failure of Ketotifen and any various store brands OTC shelf

GENERIC: BRIMONIDINE

BRAND: ALPHAGAN 0.2%[®], ALPHAGAN P 0.15%[®]

INDICATION:

- (1) Glaucoma

Criteria:

- (a) Failure of formulary ophthalmic beta blocker (betaxolol, Timolol, dorzolamide/timolol)

GENERIC: BUDESONIDE/FORMOTEROL

BRAND: SYMBICORT[®]

INDICATION:

- (1) Maintenance treatment of asthma in patients 12 years of age and older

Criteria:

- (a) Currently on, but not adequately controlled by an inhaled corticosteroid; **or**
- (b) Maintenance treatment of airflow obstruction in patients with chronic bronchitis and emphysema
- (c) Patients must be reevaluated after 6 months

Prior Authorization Guidelines

For members currently with an approved prior authorization for Symbicort, claims will process as long as the member has filled Symbicort within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Symbicort therapy or with no claims history of Symbicort within the last 4 months. Once approved, 90-day supplies are allowed.

GENERIC: CALCITONIN-SALMON

BRAND: MIACALCIN[®]

INDICATIONS:

- (1) Mild to moderate Paget's disease of bone
- (2) Osteoporosis

Criteria:

- (a) Failure, contraindication or intolerance to adequate trial of oral bisphosphonate; **and**
- (b) One of the following:
 - (1) Bone density measurement ≥ 2.5 standard deviations below the mean for normal, young adults of same gender (T-score ≤ -2.5); **or**
 - (2) History of an osteoporotic vertebral fracture; **or**
 - (3) Postmenopausal woman with low bone mineral density defined by T-score between -2.0 and -2.5 AND one of the following risk factors for fracture:
 - (a) Thinness or low body mass index defined by weight < 127 lb (57.7 kg) or BMI < 21 kg/m²
 - (b) History of fragility fracture since menopause
 - (c) History of hip fracture in a parent
 - (4) Diagnosis of Paget's disease of bone
- (c) Patients receiving glucocorticoids in daily dosages of > 7.5 mg prednisone daily (see table) AND who have bone density measurement > 1 standard deviations below the mean for normal, young adults of same gender (T-score < -1.0)

Prior Authorization Guidelines

Glucocorticoid Potency Equivalencies			
Glucocorticoid	Approximate equivalent dose (mg)	Relative anti-inflammatory (glucocorticoid) potency	Relative mineralocorticoid potency
<i>Short-acting</i>			
Cortisone	25	0.8	2
Hydrocortisone	20	1	2
<i>Intermediate-acting</i>			
	5	4	1
Prednisone	5	4	1
Prednisolone	4	5	0
Triamcinolone	4	5	0
Methylprednisolone			
<i>Long-acting</i>			
Dexamethasone	0.75	20-30	0
Betamethasone	0.6-0.75	20-30	0

Table adapted from Facts and Comparisons® 1999:122

* *For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.*

* *If documentation of osteoporosis is available, please submit with PA request.*

GENERIC: CANAGLIFLOZIN

BRAND: INVOKANA®

INDICATION:

(1) Type 2 diabetes mellitus

Criteria:

(a) Diagnosis of Type 2 diabetes mellitus

(b) Has not achieved adequate glycemic control on at least ONE of the following:

(1) Metformin (alone or in a combination)

(2) Sulfonylurea (alone or in a combination)

(3) A preferred DPP-4 (Januvia)

(c) Contraindication to BOTH metformin and a sulfonylurea

(d) Contraindication to a preferred DPP-4 inhibitor

Prior Authorization Guidelines

GENERIC: CELECOXIB

BRAND: CELEBREX®

INDICATIONS:

- (1) Relief of signs and symptoms of rheumatoid arthritis (RA) in adults
- (2) Relief of signs and symptoms of osteoarthritis (OA)
- (3) Relief of signs and symptoms of ankylosing spondylitis
- (4) Management of acute pain in adults
- (5) Treatment of primary dysmenorrhea
- (6) To reduce the number of adenomatous polyps in familial adenomatous polyposis, as an adjunct to usual care

Criteria:

- (a) Failure, intolerance, or contraindication to at least 2 formulary NSAIDs; **and**
- (b) One of the following:
 - (1) Age greater than 65; **or**
 - (2) Concomitant use of warfarin or other antiplatelet therapy; **or**
 - (3) Concomitant use of chronic systemic corticosteroid therapy; **or**
 - (4) Documented history of ulcer disease or GI bleed; **or**
 - (5) Documented history of significant GI disease requiring therapy with an H2 antagonist or PPI; **or**
 - (6) Documented history of nonselective NSAID-induced GI adverse effects; **and**
- (c) For OA, therapeutic failure (≥ 21 day trial), intolerance of, or contraindication to at least 1 of the following: acetaminophen or opioid analgesics or topical analgesics (capsaicin, etc.)

GENERIC: CLOXACILLIN SODIUM

INDICATION:

- (1) Treatment of infections due to penicillinase-producing staphylococci

Criteria:

- (a) Diagnosis of staphylococcal infection; **and**
- (b) Failure of dicloxacillin sodium.

Prior Authorization Guidelines

GENERIC: CYANOCOBALAMIN (HYDROXOCOBALAMIN)

BRAND: VITAMIN B-12[®]

INDICATION:

(1) Vitamin B-12 deficiency

Criteria:

- (a) Patients who lack intrinsic factor; **or**
- (b) Patients who are on long-term PPI therapy; **or**
- (c) Patients with a partial or complete gastrectomy.

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: DABIGATRAN ETEXILATE MESYLATE

BRAND: PRADAXA[®]

INDICATION:

(1) Reduce the risk of stroke and systemic embolism in patients with non-vascular atrial fibrillation.

Criteria:

- (a) Diagnosis of non-vascular atrial fibrillation; **and**
- (b) Must have recent CrCl levels or Scr and current patient weight; **and**
- (c) No active pathological bleeding; **and**
- (d) Must have tried and failed or intolerant to Warfarin

NOTE: Conversion to Pradaxa:

- (a) From Warfarin: discontinue warfarin and start pradaxa when INR<2.0
- (b) From Parenteral Anticoagulants: start pradaxa 0-2 hrs prior to next scheduled dose of parenteral anticoagulant, or at the time of discontinuation of continuous parenteral drug (e.g. heparin)

GENERIC: DALFAMPRIDINE

BRAND: AMPYRA[®]

INDICATION:

(1) Improved walking speed in patients with multiple sclerosis

Criteria:

- (a) Diagnosis of multiple sclerosis; **and**
- (b) Prescribed by a neurologist; **and**
- (c) Currently taking a disease modifying drug for multiple sclerosis (Avonex, Aubagio, Betaseron, Copaxone, Extavia, Gilenya, Rebif, Tecfidera or Tysabri)

Prior Authorization Guidelines

* Renewals will require documented improvement in walking speed
(demonstrated improvement in timed 25 foot walk)

GENERIC: DANTROLENE

BRAND: DANTRIUM[®]

INDICATION:

(1) Spasticity resulting from upper motor neuron disorders

Criteria:

(a) Demonstrated failure of, or intolerance to, Baclofen (Lioresal[®]).

GENERIC: DARBEPOETIN ALFA

BRAND: ARANESP[®]

INDICATIONS:

(1) Anemia with cancer chemotherapy (nonmyeloid)

(2) Anemia due to chronic renal failure

Criteria:

(a) Ensure patient's iron stores are adequate (Ferritin \geq 100 ng/mL and/or Transferrin saturation \geq 20%) or patient is being treated with iron; **and**

(b) Adequate blood pressure control; **and**

Chronic kidney disease patients:

(a) Initiate treatment when hemoglobin is $<10\text{g/dL}$; **or**

Anemia due to chemotherapy in cancer:

(a) Initiate treatment only if hemoglobin is $<10\text{g/dL}$; **and**

(b) Anticipated duration of myelosuppressive chemotherapy is \geq 2 months

For renewals:

(a) **Chronic kidney disease patients:**

(1) With dialysis Hgb <11 ; **or**

(2) Without dialysis Hgb <10

(b) **Anemia due to chemotherapy in cancer patients:**

(1) Hgb <11

Prior Authorization Guidelines

GENERIC: DARIFENACIN

BRAND: ENABLEX®

INDICATION:

(1) Overactive bladder

Criteria:

(a) Failure of Oxybutynin

GENERIC: DESMOPRESSIN

BRAND: DDAVP®

INDICATIONS:

(1) Central cranial diabetes insipidus (CCDI)

(2) Primary nocturnal enuresis

Criteria:

(a) Diagnosis of CCDI; **or**

(b) For the treatment of enuresis, age 6 to 18 years; **and**

(c) Failure of behavior modification for 6 months (e.g., alarms, no beverages after 5pm, special diapers, etc.)

** Renewals for the indication of nocturnal enuresis will require the documentation of a retrial of behavior modification.*

GENERIC: DIMETHYL FUMERATE

BRAND: TECFIDERA®

INDICATION:

(1) Diagnosis of a relapsing form of Multiple Sclerosis;

Criteria:

(a) Prescribed by neurologist, and

(b) Not requesting combination of any 2 agents together:

Copaxone, Betaseron, Avonex, Tysabri, Gilenya, Aubagio or Tecfidera.

GENERIC: DONEPEZIL

BRAND: ARICEPT®

INDICATION:

(1) Alzheimer's disease: for the treatment of dementia.

Criteria:

(a) Dementia must be confirmed by clinical evaluation

Prior Authorization Guidelines

GENERIC: DULAGLUTIDE

BRAND: TRULICITY®

INDICATION:

- (1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes mellitus

Criteria:

- (a) Diagnosis of type II diabetes mellitus; **and**
- (b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by diabetes educator
- (c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications

GENERIC: ELBASVIR-GRAZOPREVIR

BRAND: ZEPATIER®

INDICATION:

- (1) Chronic Hepatitis C

Criteria:

- (a) Preferred for genotypes 1 and 4
- (b) Must follow the clinical criteria as set by the Maryland Department of Health
- (c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513

GENERIC: EMPAGLIFLOZIN

BRAND: JARDIANCE®

INDICATION:

- (1) Type II Diabetes Mellitus

Criteria:

- (a) Failure of metformin, a sulfonylurea, or pioglitazone

Prior Authorization Guidelines

GENERIC: EMPAGLIFLOZIN-LINAGLIPTIN

BRAND: GLYXAMBI®

INDICATION:

(1) Type II Diabetes Mellitus

Criteria:

(a) For use when an SGLT2 and a DPP-4 Inhibitor is appropriate.

GENERIC: ENTACAPONE

BRAND: COMTAN®

INDICATION:

(1) As an adjunct to levodopa/carbidopa to treat patients with idiopathic Parkinson's disease

Criteria:

(a) Diagnosis of idiopathic Parkinson's disease; **and**

(b) Patient is receiving concomitant levodopa/carbidopa therapy.

GENERIC: EPOETIN ALFA

BRAND: EPOGEN®

INDICATIONS:

(1) Anemia with cancer chemotherapy (nonmyeloid)

(2) Anemia due to chronic renal failure

(3) Anemia of HIV infection associated with zidovudine

(4) Reduction of allogenic blood transfusion for elective, noncardiac, nonvascular surgery

Criteria:

(a) Patient's iron stores are adequate (Ferritin ≥ 100 mcg/mL and/or Transferrin saturation $\geq 20\%$) or patient is being treated with iron; **and**

(b) Adequate blood pressure control

Chronic kidney disease patients:

(a) Initiate treatment when hemoglobin is < 10 g/dL (3 month approval)

Anemia due to chemotherapy in cancer patients:

(a) Initiate treatment only if hemoglobin < 10 g/dL and anticipated duration of myelosuppressive chemotherapy is ≥ 2 months

Anemia due to zidovudine in HIV-infected patients:

(a) Initiate treatment when hemoglobin is < 10 g/dL

Surgical procedure - Transfusion of blood product, Allogeneic; Prophylaxis:

Prior Authorization Guidelines

(a) Patient's pre-operative Hgb >10 to ≤13 g/dL (14 day approval)

For renewals:

Chronic kidney disease patients:

- (a) With dialysis Hgb <11
- (b) Without dialysis Hgb <10

Anemia due to chemotherapy in cancer patients:

- (a) Hgb <11

Anemia due to zidovudine in HIV-infected patients:

- (a) Hgb <11

GENERIC: ETANERCEPT

BRAND: ENBREL[®]

INDICATIONS:

- (1) Moderate to severely active rheumatoid arthritis
- (2) Moderate to severely active polyarticular juvenile rheumatoid arthritis
- (3) Psoriatic spondylitis
- (4) Ankylosing spondylitis
- (5) Plaque psoriasis

Criteria:

- (a) The patient had a NEGATIVE tuberculin skin test, or if positive, has received treatment for latent TB prior to Enbrel therapy; **and**
- (b) The patient does not have a clinically important active infection

Additional Criteria for RA:

- (a) The patient has failed or is intolerant to one formulary NSAID **and**
- (b) The patient has failed or is intolerant to one formulary DMARD

Additional Criteria for Plaque Psoriasis:

- (a) Involvement of ≥ 10% body surface area (BSA)

GENERIC: EVOLOCUMAB

BRAND: REPATHA[®]

INDICATION:

- (1) Primary hyperlipidemia
- (2) High cholesterol in the blood
- (3) Heterozygous familial hypercholesterolemia (HeFH)
- (4) Reduce the risk of heart attack, stroke, and certain types of heart surgery in patients.

Prior Authorization Guidelines

- (5) Atherosclerotic cardiovascular disease (ASCVD)
- (6) Homozygous familial hypercholesterolemia

Criteria:

- (a) Documentation of positive clinical response
- (b) Comprehensive counseling regarding diet
- (c) Not used in combination with another type 9 (PCSK9) INHIBITOR

GENERIC: EXENATIDE

BRAND: BYETTA®

INDICATION:

- (1) Adjunctive therapy of type 2 diabetes mellitus

Criteria:

- (a) Diagnosis of type 2 diabetes; **and**
- (b) Failure or intolerance to sulfonylureas and/or metformin at optimal dosing. Failure defined as Hemoglobin A1c ≥ 7.0 ; **and**
- (c) Patient ≥ 18 years of age

GENERIC: EZETIMIBE

BRAND: ZETIA®

INDICATIONS:

- (1) Hypercholesterolemia
- (2) Sitosterolemia

Criteria:

- (a) Diagnosis of Sitosterolemia; **or**
- (b) For the diagnosis of hypercholesterolemia, failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

GENERIC: EZETIMIBE/SIMVASTATIN

BRAND: VYTORIN®

INDICATION:

- (1) Hypercholesterolemia

Criteria:

- (a) Failure of optimal dosing/duration or intolerance/contraindication to 2 formulary anti-lipid agents (with at least one agent being a statin)

Prior Authorization Guidelines

GENERIC: FENOFIBRATE

BRAND: LIPOFEN[®], TRIGLIDE[®]

INDICATION:

(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

(a) Failure of generic fenofibrate 48, 54, 154, or 160 mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRIC ACID

BRAND: TRILIPIX[®]

INDICATION:

(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

(a) Failure of generic fenofibrate 48, 54, 154 or 160 mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRATE MICRONIZED

BRAND: ANTARA[®]

INDICATION:

(1) Hypercholesterolemia, Hypertriglyceridemia

Criteria:

(a) Failure of generic fenofibrate 54 or 160 mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

GENERIC: FENOFIBRIC ACID TAB

BRAND: FIBRICOR[®]

INDICATIONS:

(1) Hypercholesterolemia

(2) Hypertriglyceridemia

Criteria:

(a) Failure of generic Fenofibrates

Prior Authorization Guidelines

GENERIC: FENTANYL TRANSDERMAL PATCH

BRAND: DURAGESIC®

INDICATION:

- (1) Persistent, moderate to severe chronic pain OR cancer-related pain that requires continuous, around-the-clock opioid (narcotic) administration for an extended period of time

Criteria:

- (a) Diagnosis of persistent, moderate to severe chronic or cancer-related pain requiring continuous, around-the-clock opioid administration for an extended period of time; **and**
- (b) Patient unable to take medications by mouth; **or**
- (c) Failure of or intolerance/contraindication to a long-acting oral opiate (narcotic) medication (controlled-release morphine, oxycodone, or oxymorphone)
- (d) Completion of Opioid Prior Authorization/Attestation Form required, available at <http://www.jaimedicalsystems.com/providers/pharmacy/>

GENERIC: FESOTERODINE

BRAND: TOVIAZ®

INDICATION:

- (1) Overactive bladder

Criteria:

- (a) Failure of Oxybutynin

GENERIC: FILGRASTIM

BRAND: NEUPOGEN®

INDICATIONS:

- (1) Prevention of neutropenia in patients receiving myelosuppressive chemotherapy for non-myeloid malignancies
- (2) Patients undergoing peripheral blood progenitor cell collection and therapy
- (3) Patients with severe chronic neutropenia

Criteria:

- (a) The patient is undergoing peripheral blood progenitor cell collection and therapy; **or**
- (b) Diagnosis of severe chronic neutropenia with an absolute neutrophil count (ANC) < 1,000; **or**

Prior Authorization Guidelines

- (c) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given to prophylax for all future chemo cycles.

** For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.*

** Please indicate estimated duration of therapy.*

GENERIC: FLUCONAZOLE

BRAND: DIFLUCAN®

(PA required after 150mg x2 tablet dispensed)

INDICATIONS:

- (1) Vaginal candidiasis
- (2) Cryptococcal meningitis
- (3) Serious systemic candidal infections
- (4) Oropharyngeal and esophageal candidiasis

Criteria:

- (a) Any of the above diagnoses; **except**
- (b) For the diagnosis of oropharyngeal candidiasis, failure of nystatin therapy; **and**
- (c) For the diagnosis of vaginal candidiasis, patients who are immunocompromised and/or have recurrent or refractory infections.

GENERIC: GALANTAMINE HYDROBROMIDE

BRAND: RAZADYNE®, RAZADYNE ER®

INDICATION:

- (1) Alzheimer’s disease: for the treatment of dementia

Criteria:

- (a) Confirmation by clinical evaluation

Prior Authorization Guidelines

GENERIC: GATIFLOXACIN

BRAND: ZYMAXID®

INDICATION:

- (1) Bacterial conjunctivitis

Criteria:

- (a) Failure of, contraindication to, or intolerance to ciprofloxacin ophthalmic formulation.

GENERIC: GLATIRAMER ACETATE

BRAND: COPAXONE®

INDICATIONS:

- (1) Relapsing-remitting Multiple Sclerosis
- (2) To prevent or slow the development of clinically definite Multiple Sclerosis in patients who have experienced a first clinical episode and have MRI features consistent with Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; and
- (b) Not requesting combination therapy of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

GENERIC: GLECAPREVIR-PIBRENTASVIR

BRAND: MAVYRET®

INDICATION:

- (1) Chronic Hepatitis C

Criteria:

- (a) Preferred for genotypes 1, 2, 3, 4, 5 and 6
- (b) Must follow the clinical criteria as set by the Maryland Department of Health
- (c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513

Prior Authorization Guidelines

GENERIC: HYDROXOCOBALAMIN

BRAND: HYDROXOCOBALAMIN

INDICATION:

- (1) Vitamin B-12 deficiency

Criteria:

- (a) Patients who lack intrinsic factor; **or**
- (b) Patients who are on long-term PPI therapy; **or**
- (c) Patients with a partial or complete gastrectomy.

GENERIC: INTERFERON ALFA

BRAND: ROFERON-A[®], INTRON-A[®], and ALFERON N[®]

INDICATIONS:

- (1) Hairy cell leukemia
- (2) AIDS-related Kaposi's sarcoma
- (3) Chronic Hepatitis B or C
- (4) Malignant melanoma

Criteria:

- (a) Any of the above diagnoses.

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: INTERFERON BETA

BRAND: AVONEX[®], BETASERON[®], REBIF[®]

INDICATIONS:

- (1) Diagnosis of a relapsing form of Multiple Sclerosis; **or**
- (2) First clinical demyelinating event with MRI evidence consistent with Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; **and**
- (b) If patient has a history of or is currently being treated for severe psychiatric disorders, suicidal ideation or severe depression, this condition is well controlled; **and**
- (c) Not requesting combination of any 2 agents together:
Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera

** For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

Prior Authorization Guidelines

GENERIC: ISOSORBIDE MONONITRATE

BRAND: IMDUR®

INDICATION:

- (1) Prevention of angina pectoris

Criteria:

- (a) Failure of formulary nitrates.

GENERIC: ITRACONAZOLE

BRAND: SPORANOX®

INDICATIONS:

- (1) Histoplasmosis infections
- (2) Aspergillosis infections
- (3) Blastomycosis

Criteria:

- (a) Any of the above diagnoses.

GENERIC: LANSOPRAZOLE

BRAND: PREVACID SOLU-TAB®

INDICATION:

- (1) Gastroesophageal reflux disease (GERD), heartburn, gastric ulcer, and duodenal ulcer.

Criteria:

- (a) Unable to ingest a solid dosage form (e.g. oral tablet or capsule) due to one of the following:
 - (1) Age
 - (2) Oral/motor difficulties
 - (3) Dysphagia
 - (4) Patient utilizes a feeding tube for medication administration

GENERIC: LEDIPASVIR-SOFOSBUVIR

BRAND: HARVONI®

INDICATION:

- (1) Chronic Hepatitis C

Criteria:

- (a) Generic tablet only
- (b) Must follow the clinical criteria as set by the Maryland Department of Health

Prior Authorization Guidelines

- (c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513

GENERIC: LEUPROLIDE

BRAND: LUPRON®

INDICATIONS:

- (1) Advanced prostate cancer
- (2) Central precocious puberty
- (3) Endometriosis
- (4) Uterine leiomyomata (fibroids)

Criteria:

- (a) Diagnosis of advanced prostate cancer, precocious puberty or fibroids; **or**
- (b) For the diagnosis of endometriosis, failure of NSAIDS **and** oral contraceptives **or** endometriosis diagnosed by laparoscopy.

** Note: This agent is ordinarily administered at the physician's office. For injectable medications administered by a healthcare professional, Please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.*

GENERIC: LIDOCAINE PATCH 5%

BRAND: LIDODERM PATCH 5%®

INDICATION:

- (1) Relief of pain associated with post-herpetic neuralgia.

Criteria:

- (a) Skin application site is intact, and
- (b) For the relief of pain associated with post-herpetic neuralgia; **and**
- (c) Failure, adverse reaction, or contraindication to two prescription analgesics, including formulary lidocaine topical cream or gel.

Prior Authorization Guidelines

GENERIC: LIRAGLUTIDE

BRAND: VICTOZA®

INDICATION:

- (1) Adjunct to diet and exercise to improve glycemic control in patients with type II diabetes mellitus

Criteria:

- (a) Diagnosis of type II diabetes mellitus; **and**
- (b) Must be under the care of a healthcare provider skilled with the use of insulin and supported by a diabetes educator
- (c) Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications; **and**
- (d) Must have tried and failed or intolerant to treatment with Byetta; **and**
- (e) NO personal or family history of medullary thyroid carcinoma

GENERIC: LODOXAMDE TROMETHAMINE OPHTH SOLN 0.1%

BRAND: ALOMIDE®

INDICATION:

- (1) Allergic conjunctivitis

Criteria:

- (a) Failure or contraindication of Ketotifen

GENERIC: LUBIPROSTONE

BRAND: AMITIZA®

INDICATION:

- (1) Chronic idiopathic constipation
- (2) Irritable bowel syndrome
- (3) Opioid-induced constipation

Criteria:

- (a) Must have a diagnosis of either chronic idiopathic constipation, irritable bowel syndrome, or opioid-induced constipation; and
- (b) Failure of Miralax, Senna-S, and/or lactulose

Prior Authorization Guidelines

GENERIC: MEMANTINE

BRAND: NAMENDA®

INDICATION:

- (1) Alzheimer's disease: for treatment of moderate-to-severe cases of dementia

Criteria:

- (a) Dementia must be confirmed by clinical evaluation; **and**
- (b) Documented dementia is either moderate or severe

GENERIC: MEPHYTON

BRAND: VITAMIN K

INDICATION:

- (1) Anticoagulant-induced prothrombin deficiency

Criteria:

- (a) Diagnosis of anticoagulant-induced prothrombin deficiency caused by coumadin or indandione derivatives

GENERIC: METHADONE

BRAND: METHADONE

Criteria:

- (a) Completion of Opioid Prior Authorization/Attestation Form required, available at <http://www.jaimedicalsystems.com/providers/pharmacy/>

GENERIC: METRONIDAZOLE VAGINAL GEL

BRAND: METROGEL®

INDICATION:

- (1) Bacterial vaginosis

Criteria:

- (a) Pregnancy; **or**
- (b) Intolerance to oral metronidazole

Prior Authorization Guidelines

GENERIC: MILNACIPRAN

BRAND: SAVELLA®

INDICATION:

(1) Moderate to severe fibromyalgia

Criteria:

- (a) Diagnosis of fibromyalgia; **and**
(b) Documented failure or contraindication to:
(1) Pain relievers (e.g. Tramadol); **or**
(2) Muscle Relaxants (e.g. cyclobenzaprine, Baclofen)

GENERIC: MIRABEGRON

BRAND: MYRBETRIQ®

INDICATION:

(1) Overactive bladder

Criteria:

(a) Failure of Oxybutynin oxycontinjanuvia

GENERIC: MORPHINE SULFATE SUSTAINED-RELEASE

BRAND: MS CONTIN®

Criteria:

- (a) Completion of Opioid Prior Authorization/Attestation Form required, available at
<http://www.jaimedicalsystems.com/providers/pharmacy/>

GENERIC: MOXIFLOXACIN

BRAND: AVELOX®

INDICATIONS:

- (1) Acute bacterial sinusitis
(2) Acute bacterial exacerbations of chronic bronchitis
(3) Mild to moderate pelvic inflammatory disease
(4) Complicated/Uncomplicated skin and skin structure infections
(5) Community-acquired pneumonia
(6) Complicated intra-abdominal infections

Criteria:

In patients ≥ 18 years of age with any of the above listed indications when:

- (a) Cultures show sensitivity to Avelox® only; **or**
(b) Patient discharged on Avelox® from the hospital and needs to complete regimen on an outpatient basis

Prior Authorization Guidelines

GENERIC: NAFARELIN

BRAND: SYNAREL®

INDICATIONS:

- (1) Central precocious puberty
- (2) Endometriosis

Criteria:

- (a) Diagnosis of central precocious puberty; **or**
- (b) For the diagnosis of endometriosis in patients ≥ 18 years of age, failure of NSAIDs **and** oral contraceptives, **or** endometriosis diagnosed by laparoscopy.

GENERIC: NUTRITIONAL SUPPLEMENTS

BRAND: ENSURE®, PEDIASURE®, BOOST®, VIVONEX®

INDICATION:

- (1) Nutritional supplementation

Criteria:

- (a) Patient must have enteral access via one of the following: nasogastric (NG) tube, nasoduodenal (ND) tube, nasojejunal (NJ) tube, percutaneous endoscopic gastrostomy (PEG) or percutaneous endoscopic jejunostomy (PEJ).

To obtain nutritional supplements (e.g. Ensure or Pediasure) for members without enteral access, please follow the DME process. For assistance accessing the DME process, please contact Customer Service at 1-888-524-1999.

GENERIC: OCTREOTIDE

BRAND: SANDOSTATIN®

INDICATIONS:

- (1) Symptomatic treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumors
- (2) Profuse, watery diarrhea associated with vasoactive intestinal peptide (VIP) secreting tumors
- (3) To reduce the blood levels of growth hormone and IGF-I associated with acromegaly

Criteria:

- (a) Any of the above diagnoses; **and**
- (b) For the diagnosis of acromegaly, the patient has had an inadequate response to, or cannot be treated with surgical

Prior Authorization Guidelines

- (c) resection, pituitary irradiation **and** bromocriptine at maximally tolerated doses.

For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.

GENERIC: OLODATEROL HCL

BRAND: STRIVERDI®

INDICATION:

- (1) COPD

Criteria:

- (a) Patient must be on, and not currently controlled on, an ICS (inhaled corticosteroid)

GENERIC: OLOPATADINE HCL OPHTH SOLN 0.2%

BRAND: PATADAY®

INDICATION:

- (1) Allergic conjunctivitis

Criteria:

- (a) Failure or contraindication to Ketotifen

GENERIC: OLOPATADINE HCL OPHTH SOLN 0.1%

BRAND: PATANOL®

INDICATION:

- (1) Allergic conjunctivitis

Criteria:

- (a) Failure or contraindication of Ketotifen

GENERIC: ONDANSETRON SOLUTION

BRAND: ZOFRAN®

INDICATIONS:

- (1) Chemotherapy induced nausea and vomiting
(2) Post-operative nausea and vomiting
(3) Radiation induced nausea and vomiting

Criteria:

- (a) For patients who have a contraindication or failure of ondansetron tablets

Prior Authorization Guidelines

GENERIC: OXYCODONE, CONTROLLED-RELEASE

BRAND: OXYCONTIN®

INDICATION:

- (1) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires continuous, around-the-clock opioid

(narcotic) administration for an extended period of time; not intended as an as-needed analgesic.

Criteria:

- (a) Persistent, moderate to severe chronic pain **or** cancer-related pain that requires around-the-clock analgesia for an extended period of time; **and**
- (b) For chronic pain, failure, intolerance, or contraindication to at least 2 short-acting formulary narcotic analgesics and controlled-release morphine (MS Contin, others) For cancer pain, failure intolerance, or contraindication to controlled-release morphine (MS Contin, others)
- (c) Completion of Opioid Prior Authorization/Attestation Form required, available at <http://www.jaimedicalsystems.com/providers/pharmacy/>

GENERIC: PALIVIZUMAB

BRAND: SYNAGIS®

INDICATION:

- (1) Prevention of serious lower respiratory disease caused by respiratory syncytial virus (RSV)

Criteria:

- (a) Administration within RSV season (Nov-Apr); **and**
- (b) Pt < 2 yrs of age at start of RSV season with chronic lung disease that has required treatment (supplemental oxygen, bronchodilator, diuretic or corticosteroid) within prior 6 months **or**
- (c) Pt born \leq 28 weeks gestation and is \leq 12 months at the start of the RSV season **or**
- (d) Pt born between 29-32 weeks gestation and is \leq 6 months at the start of the RSV season **or**
- (e) Pt \leq 24 months of age at the start of the RSV season with hemodynamically significant congenital heart disease, including one of the following:

Prior Authorization Guidelines

- (1) Receiving medication to control congestive heart failure; **or**
 - (2) With moderate to severe pulmonary artery hypertension; **or**
 - (3) With cyanotic congenital heart disease; **or**
- (f) Pt born between 32-35 weeks gestation, and is \leq 3 months at the start of the RSV season **and** has one of the following risk factors:
- (1) Child care attendance; **or**
 - (2) Siblings less than 5 years and children born between 32-35 weeks receive a maximum of 3 doses; **or**
- (g) Is the patient born before 35 weeks of gestation and has either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions during the first year of life?

Once the prior authorization is received, please contact your Synagis provider. One such provider is Walgreens Specialty pharmacy:

Phone = 866-230-8102

Fax = 888-325-6544

GENERIC: PEGINTERFERON ALFA-2A

BRAND: PEGASYS®

INDICATIONS:

- (1) Use in combination with ribavirin or ribavirin and other Direct-Acting Antivirals for the treatment of chronic Hepatitis C
- (2) Treatment of chronic Hepatitis C in patients coinfectd with HIV whose HIV is clinically stable.
- (3) Treatment of patients with HBeAg positive and HBeAg negative chronic Hepatitis B

Criteria:

(In combination with ribavirin or ribavirin and other Direct-Acting Antivirals)

- (a) Diagnosis as indicated above including any applicable labs and/or tests
- (b) Clinically documented chronic Hepatitis C with detectable HCV RNA levels > 50 IU/mL
- (c) Age ≥ 3 years

Prior Authorization Guidelines

- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) Intolerant to Peg-Intron
- (f) If HIV positive, patient is clinically stable.
- (For chronic Hepatitis B)**
- (a) Documented HBeAg positive or negative chronic Hepatitis B
- (b) Compensated liver disease

- (c) Evidence of viral replication
- (d) Evidence of liver inflammation
- (e) Not contraindicated

GENERIC: PEGINTERFERON ALFA-2B

BRAND: PEG-INTRON®

INDICATIONS:

- (1) Use in combination with ribavirin for the treatment of chronic Hepatitis C
- (2) Treatment of chronic Hepatitis C in patients coinfecting with HIV whose HIV is clinically stable.

Criteria:

(In combination with ribavirin or ribavirin and other Direct-Acting Antivirals)

- (a) Diagnosis as indicated above including any applicable labs and/or tests
- (b) Clinically documented chronic Hepatitis C with detectable HCV RNA levels > 50 IU/mL
- (c) Age ≥ 3 years
- (d) Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis
- (e) If HIV positive, patient is clinically stable.

Prior Authorization Guidelines

GENERIC: PENTOXIFYLLINE

BRAND: TRENTAL®

INDICATION:

- (1) Intermittent claudication

Criteria:

- (a) Pain on walking or ABI < 0.8; **or**
- (b) Diabetic foot ulcer; **or**
- (c) Gangrene; **or**
- (d) Risk of, or existing, amputation.

GENERIC: PIMECROLIMUS

BRAND: ELIDEL®

INDICATION:

- (1) Second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when treatments are not advisable.

Criteria:

- (a) Documented failure of optimal dosing/adequate duration; **or**
- (b) Intolerance or contraindication to at least one formulary topical corticosteroid; **and**
- (c) Diagnosis of mild to moderate atopic dermatitis; **and**
- (d) Using for short-term and non-continuous treatment.

GENERIC: RABEPRAZOLE

BRAND: ACIPHEX®

INDICATIONS:

- (1) Gastric hypersecretion, pathological conditions including Zollinger-Ellison Syndrome
- (2) Erosive esophagitis - gastroesophageal reflux disease
- (3) Erosive esophagitis, maintenance therapy - gastroesophageal reflux disease

Criteria:

- (a) Failure, intolerance, or contraindication to 2 formulary PPI after a period of at least two months on the maximum dose appropriate and tolerated by the patient.

Prior Authorization Guidelines

GENERIC: RALOXIFENE

BRAND: EVISTA[®]

INDICATION:

- (1) Treatment and prevention of osteoporosis in postmenopausal women

Criteria:

- (a) Personal or family history of breast cancer; **or**
- (b) Intolerable side effects to at least one formulary estrogen.

GENERIC: RIBAVIRIN

BRAND: REBETOL[®]

INDICATION:

- (1) Indicated **only** in combination with a recombinant interferon alfa-2a or alfa-2b product or in combination with other Direct-Acting Antivirals for the treatment of chronic Hepatitis C.

Criteria:

- (a) Diagnosis of chronic Hepatitis C; **and**
- (b) Patient is receiving concomitant recombinant interferon alfa-2a or alfa-2b therapy or other Direct-Acting Antivirals.

GENERIC: REPAGLINIDE

BRAND: PRANDIN

INDICATION:

- (1) Type 2 diabetes mellitus

Criteria:

- (a) Diagnosis of Type 2 diabetes mellitus
- (b) Has not achieved adequate glycemic control on at least ONE of the following:
 - (1) Metformin (alone or in combination)
 - (2) A Sulfonylurea (alone or in combination)
 - (3) A preferred DPP-4 inhibitor
- (c) Contraindication of BOTH metformin and a sulfonylurea
- (d) Contraindication to a preferred DPP-4 inhibitor

Prior Authorization Guidelines

GENERIC: RILUZOLE

BRAND: RILUTEK®

INDICATION:

(1) Amyotrophic lateral sclerosis (ALS)

Criteria:

(a) Diagnosis of ALS.

GENERIC: RIVASTIGMINE TARTRATE

BRAND: EXELON®

INDICATION:

(1) Alzheimer's disease: for the treatment of dementia

Criteria:

(a) Confirmation by clinical evaluation

GENERIC: RIZATRIPTAN

BRAND: MAXALT®

INDICATION:

(1) Acute treatment of migraine headache

Criteria:

- (a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID's, ergotamine, or combination analgesic); **or**
- (b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
- (c) Patient is not currently using ergotamine or another 5-HT₁ Receptor Agonist.

GENERIC: ROPINIROLE

BRAND: REQUIP®

INDICATIONS:

- (1) For the treatment of signs and symptoms of idiopathic Parkinson's disease.
- (2) Moderate to severe primary Restless Leg Syndrome.

Criteria:

- (a) Diagnosis of idiopathic Parkinson's disease; **or**
- (b) Diagnosis of Restless Leg Syndrome and normal iron stores (serum ferritin and/or iron-binding saturation)

Prior Authorization Guidelines

GENERIC: SALMETEROL / FLUTICASONE

BRAND: ADVAIR® / ADVAIR HFA®

INDICATION:

- (1) Long-term, twice-daily maintenance treatment of asthma in patients 4 years of age and older.

Criteria:

- (a) Currently on, but not controlled by an inhaled corticosteroid
- (b) Twice daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease.

Criteria for the 250/50mg Strength:

- (a) The 250/50mg strength is the only approved strength for COPD **and**
- (b) The patient must be reevaluated after 6 months

** For members currently with an approved prior authorization for Advair, claims will process as long as the member has filled Advair within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to Advair therapy, or with no claim history of Advair within the last 4 months. Once approved, 90-day supplies are allowed.*

GENERIC: SALMETEROL XINAFOATE

BRAND: SEREVENT DISKUS®

INDICATIONS:

- (1) Maintenance treatment of asthma and prevention of bronchospasm in adults and children 4 years of age and older
- (2) Prevention of exercise-induced bronchospasm in patients 4 years of age and older
- (3) Serevent Diskus® is indicated for the maintenance treatment of bronchospasm associated with chronic obstructive pulmonary disease

Criteria:

- (a) Currently on but not controlled by an inhaled corticosteroid

Prior Authorization Guidelines

GENERIC: SILDENAFIL

BRAND: REVATIO®

INDICATION:

(1) Pulmonary Arterial Hypertension (PAH)

Criteria:

- (a) For the treatment of PAH; **and**
- (b) Current utilization of nitrates is contraindicated; **and**
- (c) Age limit of 2 years and younger for the solution

GENERIC: SIMVASTATIN 80mg

BRAND: ZOCOR®

INDICATIONS:

- (1) Heterozygous or homozygous familial hypercholesterolemia
- (2) Familial type 3 hyperlipoproteinemia
- (3) Hypertriglyceridemia
- (4) Primary hypercholesterolemia, or mixed hyperlipidemia
- (5) Decrease cardiovascular event risk in patients with high coronary event risk

(6) Cerebrovascular accident prophylaxis

Criteria:

- (a) Age \leq 65 years
- (b) Male gender (female gender predisposed to myopathy including rhabdomyolysis)
- (c) Controlled hypothyroidism
- (d) Normal renal function

- (e) Documentation of all cholesterol lowering agents tried and failed must be provided.

GENERIC: SITAGLIPTIN PHOSPHATE

BRAND: JANUVIA®

INDICATION:

(1) Type 2 Diabetes Mellitus

Criteria:

- (a) Diagnosis of type 2 diabetes mellitus and
- (b) Must be used adjunct to diet and exercise and
- (c) Failure or contraindication to metformin or
- (d) Failure or contraindication of sulfonylurea or thiazolidinedione

Prior Authorization Guidelines

GENERIC: SOFOSBUVIR-VELPATASVIR

BRAND: EPCLUSA®

INDICATION:

- (1) Chronic Hepatitis C

Criteria:

- (a) Generic tablets only
- (b) Preferred for genotypes 1, 2, 3, 4, 5 and 6
- (c) Must follow the clinical criteria as set by the Maryland Department of Health
- (d) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513

GENERIC: SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR

BRAND: VOSEVI®

INDICATION:

- (1) Chronic Hepatitis C

Criteria:

- (a) For retreatment only
- (b) Must follow the clinical criteria as set by the Maryland Department of Health
- (c) Special Hepatitis C PA request forms, treatment plan template, preferred status information, and full criteria can be obtained at <http://www.jaimedicalsystems.com/providers/pharmacy/> or by contacting ProCare at 1-800-555-8513

GENERIC: SOLIFENACIN

BRAND: VESICARE®

INDICATION:

- (1) Overactive bladder

Criteria:

- (a) Failure of Oxybutynin

GENERIC: SOMATROPIN

BRAND: HUMATROPE®

INDICATIONS:

- (1) Growth failure in children due to inadequate growth hormone (GH) secretion

Prior Authorization Guidelines

- (2) Idiopathic short stature in children defined by height standard deviation (SD) score less than or equal to -2.25 and growth rate not likely to attain normal adult height
- (3) Short stature in children associated with Turner syndrome

Criteria:

- (a) Patient with open epiphyses (as confirmed by radiograph of wrist and hand) who has not reached final height; **and**
- (b) Medication prescribed by an endocrinologist; **and**
- (c) Patient meets one of the following criteria:
 - (1) Growth Hormone Deficiency (GHD) with diagnosis confirmed by one of the following:
 - i. Severe short stature defined as patient's height at ≥ 2 SD below the population mean
 - ii. Patient's height ≥ 1.5 SD below the midparental height (average of mother's and father's heights)
 - iii. Patient's height ≥ 2 SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1-year decrease of more than 0.5 SD in height
 - iv. In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD)
 - v. Signs indicative of an intracranial lesion
 - vi. Signs of multiple pituitary hormone deficiencies
 - vii. Neonatal symptoms and signs of GHD
 - (2) Idiopathic short stature with patient's height at ≥ 2.25 SD below the mean height for normal children of the same age and gender
 - (3) Short stature associated with Turner syndrome and height below the 5th percentile of normal growth curve

** To continue therapy, requests will be reviewed every six months.*

For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

Prior Authorization Guidelines

GENERIC: SUCCIMER

BRAND: CHEMET[®]

INDICATIONS:

- (1) Treatment of lead poisoning in children with blood lead levels > 45 mcg/dl
- (2) Unlabeled uses: Succimer may be beneficial in the treatment of other heavy metal poisonings

Criteria:

- (a) Diagnosis of lead poisoning with blood levels > 45mcg/dl; **and**
- (b) Child is hospitalized; **or**
- (c) Child was started on the medication in the hospital and needs to continue upon discharge.

GENERIC: SUCRALFATE SUSPENSION

BRAND: CARAFATE[®]

INDICATIONS:

- (1) Gastric ulcers
- (2) Duodenal ulcers
- (3) Gastritis
- (4) GERD

Criteria:

- (a) For patients who have a contraindication or failure of sucralfate tablets

GENERIC: TACROLIMUS

BRAND: PROTOPIC[®]

INDICATION:

- (1) Moderate to severe atopic dermatitis

Criteria:

- (a) Patient must be non-immunocompromised **and**
- (b) Must be at least 2 years of age or older for the 0.03% strength;
or
- (c) 16 years of age or older for 0.1% strength **and**
- (d) Diagnosis of atopic dermatitis
- (e) Documented failure of 2 different topical corticosteroids of medium to high potency in the past 90 days
- (f) Must be prescribed by a dermatologist, allergist, or for children, a pediatrician

Prior Authorization Guidelines

GENERIC: TERIFLUNOMIDE

BRAND: AUBAGIO®

INDICATION:

(1) Diagnosis of a relapsing form of Multiple Sclerosis

Criteria:

- (a) Prescribed by neurologist; **and**
- (b) Not requesting combination of any 2 agents together:
Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya,
Aubagio, or Tecfidera.

GENERIC: TESTOSTERONE

BRAND: ANDROGEL®, TESTIM®

INDICATION:

(1) Hypogonadism

Criteria:

- (a) Must be prescribed by an Endocrinologist
- (b) Initial therapy: The patient has documented low testosterone concentration
- (c) Renewal: The patient has documented therapeutic concentration to confirm response

Criteria for transgender members:

- (a) Referral from mental health professional; **and**
- (b) Persistent, well-documented gender dysphoria; **and**
- (c) Capacity to make fully informed decision and to consent for treatment; **and**
- (d) 18 years of age or older

GENERIC: THROMBIN

BRAND: THROMBIN

INDICATION:

(1) Hemostasis

Criteria:

- (a) Diagnosis of a bleeding disorder

Prior Authorization Guidelines

GENERIC: TOLTERODINE

BRAND: DETROL®/DETROL LA®

INDICATION:

(1) Overactive bladder

Criteria:

(a) Failure of oxybutynin

GENERIC: TRAMADOL ER

BRAND: ULTRAM ER®

INDICATION:

(1) Pain, chronic (moderate to severe)

Criteria:

(a) For patients who have a contraindication or failure of tramadol regular release tablets

(b) Completion of Opioid Prior Authorization/Attestation Form required, available at

<http://www.jaimedicalsystems.com/providers/pharmacy/>

GENERIC: TROSPIUM

BRAND: SANCTURA®

INDICATION:

(1) Overactive bladder

Criteria:

(a) Failure of Oxybutynin

GENERIC: UMECLIDINIUM BROMIDE/VILANTEROL
RIFENATATE

BRAND: ANORO ELLIPTA®

INDICATION:

(1) Chronic obstructive pulmonary disease (COPD): maintenance of airflow obstruction in patients with COPD, including chronic bronchitis and emphysema.

Criteria:

(a) Trial of long acting or short acting inhaled anticholinergic (Spiriva, Tudorza, Atrovent) within the last 120 days without adequate control of symptoms

Prior Authorization Guidelines

GENERIC: VALSARTAN

BRAND: DIOVAN®

INDICATION:

(2) Hypertension

Criteria:

(d) Failure or contraindication of 2 formulary ARBs (irbesartan, Losartan)

GENERIC: ZOLMITRIPTAN TABLETS

BRAND: ZOMIG®

INDICATION:

(1) Acute treatment of migraine headache

Criteria:

- (a) Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID, ergotamine, or combination analgesic); **or**
- (b) Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., beta-blockers, calcium channel blockers, tri-cyclic antidepressants or anticonvulsants); **and**
- (c) Patient is not currently using ergotamine or another 5-HT₁ Receptor Agonist

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
A/B OTIC	19	Aluminum Hydroxide Gel*	11
ABACAVIR	3	AMANTADINE	15
ABACAVIR-LAMIVUDINE	3	Amantadine*	3
ABACAVIR-LAMIVUDINE-ZIDOV T	3	AMARYL	6
Acarbose*	6	AMETHYST	5
ACCUPRIL	7	AMINOPHYLLINE	11
ACETAMINOPHEN W / COD	14	Aminophylline*	11
Acetaminophen w/ Codeine Sol*	14	Amiodarone*	8
Acetaminophen w/ Codeine*	14	AMITIZA	11
Acetaminophen w/ Hydrocodone*	14	Amlodipine & Atorvastatin*	9
Acetaminophen*	16	Amlodipine & Benazepril*	7
ACETASOL HC	19	Amlodipine*	7
Acetazolamide*	8	Ammonium Lactate*	20
ACETEST	21	Amox & K Clavulanate*	1
Acetone Tablets	21	Amoxicillin*	1
Acetone Test*	21	AMOXIL	1
Acetylcysteine*	10	AMPICILLIN	1
ACIPHEX	12	Ampicillin*	1
Aclidinium Bromide	10	AMPYRA	21
ACTONEL	7	ANAPROX	14
ACTOPLUS MET	6	Anastrozole*	4
ACTOPLUS MET XR	6	and Iron*	16
ACTOS	6	ANDROGEL, TESTIM	4
Acyclovir	20	ANDROID	4
Acyclovir*	3	ANORO ELLIPTA	10
ADALAT CC, PROCARDIA XL	7	ANTARA	9
Adalimumab	21	Antihemophilic Factor (Human)	17
Adapalene*	20	Antihemophilic Factor (Recombinate)	17
ADVAIR, ADVAIR HFA	10	Antiinhibitor Coagulant Complex	17
ADVICOR	9	Antithrombin III (Human)	17
Afatinib Dimaleate	4	ANUSOL-HC	19
AK-TRACIN	18	APAP/Caffeine/Butalbital*	14
Al Hydrox-Mag Carb*	12	Apixaban	17
ALAVERT, CLARITIN	10	Aprepitant	12
Albendazole	2	APRESOLINE	8
ALBENZA	2	AP-ZEL, BACMIN, CENTRUM	16
Albuterol	10	ARALEN	1
ALBUTEROL NEBULIZER SOLUTION	10	ARANESP	17
Albuterol*	10	ARICEPT	18
Albuterol-Ipratropium*	10	ARIMIDEX	4
ALCOHOL PADS	21	AROMASIN	4
Alcohol Swabs*	21	ASPIRIN / CODEINE	14
ALDACTAZIDE	9	ASPIRIN BUFFERED	14
ALDACTONE	9	Aspirin Enteric Coated*	14
Alendronate + Cholecalciferol	7	Aspirin w/ Codeine*	14
Alendronate*	7	Aspirin with Buffers*	14
ALFERON N	4	Aspirin zero order*	14
ALKERAN	3	Aspirin/Caffeine/Butalbital*	14
ALLEGRA OTC, ALLEGRA	10	ASTELIN	10
ALLEGRA-D OTC 12hr, 24hr	10	Atazanavir	3
Allopurinol*	15	Atazanavir and Cobicistat	3
ALOMIDE	18	ATAZANAVIR SULFATE	3
ALPHAGAN 0.2%, ALPHAGAN P 0.15%	19	Atenolol & Chlorthalidone*	8
ALTACE	8	Atenolol*	7
Aluminum & Magnesium Hydroxide*	12	Atorvastatin*	9
ALUMINUM HYDROXIDE	11	ATRIPLA	3

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
Atropine Sulfate*	19	BLEPH-10	12
ATROVENT HFA	10	BLEPHAMIDE	19
ATROVENT NASAL	10	Blood Glucose Monitoring Tests*	21
AUBAGIO	21	BONIVA	7
AUGMENTIN	1	Brimonidine Tartrate	19
AVALIDE	8	Bromocriptine*	15
AVAPRO	8	BROMPHENIRAMINE	11
AVC	13	BROMPHENIRAMINE / PSEUDOEPHEDRINE	11
AVELOX	1	Brompheniramine / Pseudoephedrine*	11
AVONEX	4	Brompheniramine*	11
AYGESTIN	5	Budesonide	10
Azathioprine*	21	Budesonide*	10
Azelastine*	10	Budesonide-Formoterol	10
Azelastine 0.05% eye drops	10	Busulfan	3
Azithromycin suspension*	1	Butabarbital	13
Azithromycin*	1	BUTISOL	13
AZMACORT	10	Butoconazole Nitrate*	13
AZULFIDINE	2	BYETTA	6
AZULFIDINE	12	CADUET	9
BACITRACIN	18	CALAN, SR	7
Bacitracin*	19	Calcipotriene*	20
Bacitracin*	19	Calcitonin (Salmon)	6
BACITRACIN-POLYMYXIN-NEOMYCIN-HC	19	Calcitonin (Salmon)*	6
Bacitracin-Polymyxin B*	18	Calcitriol*	16
Bacitracin-Polymyxin-Neomycin-HC*	19	Calcium Acetate*	16
BACLOFEN	15	Calcium Carbonate*	16
Baclofen*	15	Calcium Carbonate*	14
BACTRIM / DS	2	CALIBRATION SOLUTION	21
BACTROBAN	19	Calibration Solution*	21
BASAGLAR	6	Canagliflozin	6
B-D INSULIN SYRINGE	21	Capecitabine*	4
Beclomethasone Dipropionate	10	CAPTOPRIL	9
BENADRYL	9	Captopril*	9
BENADRYL	10	CARAFATE SUSPENSION	12
Benazepril*	8	CARAFATE TABLETS	12
BENTYL	12	Carbamide Peroxide*	19
BENZAC W	20	Carbidopa-Levodopa*	15
Benzocaine & Antipyrine*	19	CARDIZEM/CD, DILACOR/XR	7
Benzonatate*	11	CARDURA	8
Benzoyl Peroxide*	20	Carvedilol*	7
BETAMETHASONE DIPROPIONATE	20	CASODEX	4
Betamethasone Dipropionate*	20	CATAPRES	8
BETAMETHASONE VALERATE	20	CEFACTOR	1
Betamethasone Valerate*	20	Cefaclor*	1
BETAPACE	7	CEFDINIR	1
BETASERON	4	Cefdinir*	1
Betaxolol*	18	Cefixime	1
Bethanechol*	13	CEFPROZIL	1
BETIMOL, TIMOPTIC	19	Cefprozil*	1
BETOPTIC, BETOPTIC S	18	CEFTIN	1
BIAXIN	1	Ceftriaxone*	1
Bicalutamide*	4	Cefuroxime*	1
BICILLIN	1	CELEBREX	15
Biktarvy	3	Celecoxib	15
Bisacodyl*	11	CELLCEPT	21
Bismuth Subsalicylate*	11	Cephalexin*	1

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
CEPHRADINE	1	COLESTID	9
Cephadrine*	1	Colestipol*	9
CERALYTE, CERASPORT	16	Collagenase	20
Cetirizine tabs*	10	COMBIVENT RESPIMAT	10
Cetirizine*	10	COMBIVIR	3
Charcoal Activated	21	Complera	3
CHARCOCAPS	21	COMTAN	15
CHEMET	21	Condoms	21
Chlorambucil	3	CONDYLOX	20
Chlorhexidine*	2	Conjugated Estrogens &	5
Chloroquine*	2	COPAXONE	4
Chlorothiazide*	9	CORDARONE	8
CHLORPHENIRAMINE	11	COREG	7
Chlorpheniramine*	11	CORTEF	4
CHLORTHALIDONE	8	CORTISONE	4
Chlorthalidone*	9	Cortisone*	4
Cholecalciferol*	16	CORTISPORIN	19
Cholestyramine*	9	CORTISPORIN	19
CHOLINE & MAG SALICYLATE	14	CORTISPORIN	19
Choline & Mag Salicylate*	14	COSOPT	18
Cilostazol	18	COUMADIN	17
CILOXAN	18	COZAAR	8
CIPRO	1	CREON, ZENPEP, ULTRESA	12
Ciprofloxacin*	1	CRESTOR	9
CITROMA	11	Cromolyn (inhalation)*	10
Clarithromycin*	1	Cromolyn (nasal)*	12
CLARITIN-D 12hr, 24hr	10	CRYSSELLE, OGESTREL	5
Clemastine*	11	CUPRIMINE	21
CLEOCIN	13	Cyanocobalamin*	17
CLEOCIN	13	CYCLESSA	5
CLEOCIN	20	CYCLOBENZAPRINE	15
CLIMARA	5	Cyclobenzaprine*	15
Clindamycin Phosphate*	20	Cyclophosphamide*	3
Clindamycin*	13	Cycloserine	2
Clindamycin*	1	Cyclosporine Microsize*	21
CLINITEST	21	CYTOMEL	6
Clobetasol Propionate*	20	CYTOVENE	2
Clonidine & Chlorthalidone*	8	CYTOXAN	3
Clonidine*	8	Dabigatran	17
Clonidine*	18	Dalfampridine	21
Clopidogrel*	18	DANAZOL	4
CLORPRES	8	Danazol*	4
Clotrimazole Topical*	20	DANTRIUM	15
CLOTRIMAZOLE TROCHE	19	Dantrolene*	15
Clotrimazole Vag*	13	DAPSONE	2
Clotrimazole*	19	Dapsone*	2
CLOXACILLIN SODIUM	1	DARAPRIM	1
Cloxacillin Sodium*	1	Darbepoetin	17
COAL TAR SHAMPOO	20	Darifenacin Hydrobromide	13
Coal Tar*	20	Darunavir and Cobicistat	3
CODEINE PHOSPHATE	14	Darunavir Ethanolate	3
Codeine Phosphate*	14	DDAVP	7
CODEINE SULFATE	14	DEBROX	19
Codeine Sulfate*	16	DEMEROL	14
COLACE	14	DEPO-PROVERA	5
Colchicine	14	DEPO-SQ PROVERA 104	5

ProCare / Jai Medical Systems Therapeutic Formulary

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
COLCRYS	15	EFUDEX	20
DESCOVY	3	EFUDEX	4
Desmopressin*	7	Elbasvir-Grazoprevir	3
DESOGEN, ORTHO-CEPT	5	ELDEPRYL	15
Desogest-Eth Estrad & Eth Estrad	5	ELIDEL	20
Desogest-Ethin Est*	5	ELIMITE	20
Desogestrel & Ethinyl Estradiol*	5	ELIQUIS	17
Desonide*	10	ELURYNG	5
DESOWEN	20	EMEND	12
DETROL	13	EMLA	15
DEXAMETHASONE	18	Empagliflozin	6
Dexamethasone*	18	Empagliflozin/linagliptin	6
Dexamethasone*	18	Emtricitabine / Tenofovir	3
DIABETA, GLYNASE	6	Emtricitabine / Tenofovir Alafenamide	3
DIAMOX	8	ENABLEX	13
Diclofenac Sodium*	19	Enalapril*	8
Diclofenac*	20	ENBREL	21
DICLOXACILLIN SODIUM	1	ENFAMIL / SIMILAC	17
Dicloxacillin Sodium*	1	Enoxaparin*	17
Dicyclomine*	12	ENSURE, PEDIASURE, BOOST,	17
DIFFERIN	20	Entacapone*	15
DIFLUCAN	2	ENTRESTO	9
Digoxin*	7	EPCLUSA	3
DILANTIN	15	Epinephrine	9
DILAUDID	14	Epinephrine	10
Diltiazem*	7	EPI-PEN, EPI-PEN JR, ADRENALICK	10
Dimethyl Fumarate	21	EPI-PEN, EPI-PEN JR, ADRENALICK	10
DIOVAN	8	EPIVIR	3
DIOVAN HCT	8	Epoetin Alfa	17
Diphenhydramine*	9	EPOGEN	17
Diphenoxylate w/ Atropine*	11	Epzicom	3
Dipyridamole*	7	Ergocalciferol*	16
DISALCID	14	Ergoloid mesylates*	15
Disopyramide*	8	Erlotinib	4
Disposable Needles & Syringes*	21	ERYGEL	20
DITROPAN	13	ERY-TAB	1
DIURIL	9	ERYTHROCIN	1
Docusate Sodium*	11	Erythromycin Base*	1
Dolutegravir	3	ERYTHROMYCIN ESTOLATE	1
Dolutegravir, Abacavir, and Lamivudine	3	Erythromycin Estolate*	1
Donepezil*	18	Erythromycin Ethylsuccinate*	1
Dorzolamide HCL-Timolol Maleate*	18	Erythromycin Gel*	20
Dorzolamide*	19	Erythromycin Stearate*	1
DOVONEX	20	Erythromycin*	18
Doxazosin*	8	ERYTHROMYCIN/SULFISOXAZOLE	2
Doxycycline*	1	Erythromycin/Sulfisoxazole*	2
DRISDOL	16	Esomeprazole Magnesium	12
Drospirenone-Eth Estrad Levomefolate	5	Esterified Estrogens	5
Drospirenone-Ethinyl Estradiol*	5	ESTRACE	5
DUETACT	6	Estradiol TD Patch*	5
DULAGLUTIDE	6	Estradiol Valerate-Dienogest	5
DULCOLAX	11	Estradiol*	5
DUONEB	10	Estrogens, Conjugated	5
DURAGESIC	14	ESTROSTEP FE	5
E.E.S.	1	Etanercept	21
ECOTRIN	14	Ethambutol*	2

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
EFAVIRENZ	3	Flunisolide*	10
Efavirenz / Emtricitabine / Tenofovir	3	FLUOCINONIDE	20
Ethionamide	2	Fluocinonide Acetonide*	20
Ethosuximide*	15	Fluocinonide*	20
Ethinodiol Diacet-Eth Estrad*	5	Fluorouracil*	4
ETODOLAC	14	Fluorouracil*	20
Etodolac*	14	FLURBIPROFEN	14
Etonogestrel-Ethinyl Estradiol	5	Flurbiprofen*	14
ETOPOSIDE	4	Flurbiprofen*	19
Etoposide*	4	FLUTAMIDE	4
Etravirine	3	Flutamide*	4
EVISTA	7	Fluticasone	10
Evolocumab	9	Fluticasone*	10
EVOTAZ	3	Fluvastatin*	9
EXELON	18	FOLIC ACID	17
Exemestane*	4	Folic Acid & Vitamin B Complex*	16
Exenatide	6	Folic Acid*	17
Ezetimibe	9	FORTEO	7
Ezetimibe + Simvastatin	9	FOSAMAX	7
Famotidine*	12	FOSAMAX PLUS D	7
FEIBA VH	17	FOSINOPRIL	8
FELDENE	14	Fosinopril*	8
FELODIPINE	7	FURADANTIN	13
Felodipine*	7	Furosemide*	9
FEMARA	4	Galantamine*	18
FEMCON FE	5	Ganciclovir*	2
Fenofibrate	9	GARAMYCIN	2
Fenofibrate acid*	9	Gatifloxacin*	18
Fenofibrate micronized	9	Gemfibrozil*	9
Fenofibrate tablets*	9	GENTAK	18
Fenofibrate*	9	GENTAMICIN	19
Fenofibric Acid	9	Gentamicin Sulfate*	2
Fenoprofen*	14	Gentamicin Sulfate*	18
Fentanyl*	14	Gentamicin Sulfate*	19
FEOSOL	17	Genvoya	3
FERGON	17	GG/Codeine sol*	11
Ferrous Gluconate*	17	GILOTRIF	4
Ferrous Sulfate*	17	Glatiramer acetate	4
Fesoterodine Fumarate	13	Glecaprevir-Pibrentasvir	3
Fexofenadine / Pseudoephedrine*	10	Glimepiride*	6
Fexofenadine*	10	Glipizide*	6
FIBERCON	11	Glucagon	6
FIBRICOR	9	GLUCOLET / AUTOLET	21
Filgrastim	17	GLUCOMETER	21
Finasteride*	13	GLUCOPHAGE	6
FIORICET	14	GLUCOSE BLOOD	21
FIORINAL	14	Glucose Blood*	21
FLAGYL	2	Glucose Urine Test*	21
FLAVOXATE	13	GLUCOTROL/XL	6
Flavoxate*	13	Glyburide*	6
Flecainide*	8	GLYCERIN	9
FLOMAX	8	GLYCERIN	11
FLONASE	10	Glycerin Supp*	9
FLO-PRED	4	Glycerin*	11
FLOVENT HFA	10	GLYXAMBI	6
Fluconazole*	2	GOLYTELY	11

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
FLUDROCORTISONE	4	GRIFULVIN V	2
Fludrocortisone*	4	Insulin Reg & Isophane	6
Griseofulvin Microsize*	2	Insulin Reg & NPH	6
Griseofulvin Ultramicronsize*	2	Insulin Regular	6
GRIS-PEG	2	INTAL	10
GUAIFENESIN	11	INTELENCE	3
GUAIFENESIN DM	11	Interferon Alfa-2A	4
Guaifenesin*	11	Interferon Alfa-2B	4
Guaifenesin/DM*	11	Interferon Alfa-n3	4
Guanfacine*	8	Interferon Beta-1a	4
Guanfacine*	18	Interferon Beta-1b	4
GUIATUSS AC	11	INTRON-A	4
GYNAZOLE-1	13	INTUNIV	18
HARVONI	3	INVOKANA	6
HUMALOG	6	IPECAC	21
HUMATROPE ONLY	7	Ipecac*	21
HUMIRA	21	Ipratropium	10
HUMULIN 50/50	6	Ipratropium*	10
HUMULIN 70/30	6	Ipratropium-Albuterol	10
HUMULIN N	6	Irbesartan & HCTZ*	8
HUMULIN R	6	Irbesartan*	8
HYDERGINE	15	ISENTRESS	3
HYDRALAZINE & HCTZ	8	ISONIAZID	2
Hydralazine & HCTZ*	8	Isoniazid*	2
Hydralazine*	8	ISOPTO ATROPINE	19
HYDREA	4	ISOPTO-CARPINE	19
HYDROCHLOROTHIAZIDE	9	ISORDIL, ISORDIL TEMBIDS	7
Hydrochlorothiazide*	9	Isosorbide Dinitrate*	7
HYDROCORTISONE	20	Isosorbide Mononitrate*	7
Hydrocortisone w/Acetic Acid*	19	Itraconazole*	2
Hydrocortisone*	19	Ivermectin*	2
Hydrocortisone*	19	JANUVIA	6
Hydrocortisone*	19	JARDIANCE	6
Hydromorphone*	14	Juluca	3
HYDROXOCOBALAMIN	17	KALETRA	3
Hydroxocobalamin*	17	KAPVAY	18
Hydroxychloroquine*	1	KAYEXALATE	21
Hydroxyprogesterone	5	KEFLEX	1
Hydroxyurea*	4	KENALOG	20
Hyoscyamine Sulfate*	12	KERALAC, UMECTA	20
Hyoscyamine*	13	Ketoconazole*	2
HYZAAR	8	KETOSTIX	21
Ibandronate*	7	Ketotifen Fumarate Opth Soln*	18
Ibuprofen*	14	KLOR-CON	16
IMDUR	7	KOATE-DVI, HP, HEMOFIL M	17
IMITREX	15	Labetalol*	7
IMODIUM	11	LAC-HYDRIN	20
IMURAN	21	LACTULOSE	11
ICLEVIA	5	LAMISIL	2
INDAPAMIDE	9	Lamivudine	3
Indapamide*	9	Lamivudine HBV	3
INDERAL/LA	7	Lamivudine-Zidovudine	3
INDOCIN	14	Lancet Device	21
Indomethacin*	14	LANCETS	21
Infant Foods	17	Lancets*	21
Insulin Aspart	6	LANOXIN	7

ProCare / Jai Medical Systems Therapeutic Formulary

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
Insulin Glargine	6	LOTREL	7
Insulin Isophane	6	LOTRIMIN	20
Insulin Lispro	6	Lovastatin*	9
Insulin Pen Needles	21	LOVAZA	9
Lansoprazole*	12	LOVENOX	17
LANTUS	6	Lubiprostone	11
LASIX	9	LUPRON	4
Latanoprost*	19	LURIDE	16
Ledipasvir-Sofosbuvir*	3	LYSODREN	4
LESCOL	9	MAALOX	12
Letrozole*	4	MACROBID	13
LEUCOVORIN	17	Magnesium Citrate*	11
Leucovorin Calcium*	17	MAKENA	5
LEUKERAN	3	MANDELAMINE	13
Leuprolide	4	MATULANE	4
LEVAQUIN	1	MAVYRET	3
Levofloxacin*	1	MAXAIR AUTOHALER	10
Levonorgestrel & Ethinyl Estradiol*	5	MAXALT	15
Levonorgestrel*	5	MAXITROL	19
Levonorgestrel-Eth Estradiol*	5	MAXZIDE	9
Levonorgestrel-Ethinyl Estradiol	5	MEBARAL	13
Levonorgestrel-Ethinyl Estradiol*	5	MECLIZINE	12
Levothyroxine*	6	Meclizine*	12
LEVOXYL, SYNTHROID	6	MEDROL	4
LEVSIN	12	Medroxyprogesterone	5
LEVSINEX	13	Medroxyprogesterone Acetate	5
LIDOCAINE	15	Medroxyprogesterone*	5
LIDOCAINE VISCOUS	20	MEGACE	4
Lidocaine viscous*	20	Megestrol*	4
Lidocaine*	15	Meloxicam*	14
Lidocaine/Prilocaine	15	Melphalan	3
LIDODERM PATCHES	15	Memantine	18
LINDANE	20	MENEST	5
Lindane*	20	Meperidine*	14
Liothyronine*	6	Mephobarbital	13
LIPITOR	9	Mephyton	16
LIPOFEN, TRIGLIDE	9	Mercaptopurine*	4
Liraglutide	6	Mesalamine	12
Lisinopril & HCTZ*	8	Mesalamine*	12
Lisinopril*	8	MESTINON	16
LO LOESTRIN FE	5	METAMUCIL	11
Lodoxamide Tromethamine	18	Metformin*	6
LOESTRIN	5	METHADONE	14
LOFIBRA	9	Methadone*	14
LOMOTIL	11	METHAZOLAMIDE	8
Lomustine	4	Methazolamide*	8
Loperamide*	11	Methenamine Mandelate*	13
LOPID	9	METHERGINE	6
Lopinavir / Ritonavir	3	Methimazole*	6
LOPRESSOR	7	Methocarbamol w/ Aspirin*	16
LOPRESSOR HCT	8	METHOCARBAMOL w/ASA	16
LORABID SUSPENSION	1	Methocarbamol*	15
Loracarbef	1	Methotrexate	4
Loratadine / Pseudoephedrine*	10	Methotrexate*	15
Loratadine*	10	METHYCLOTHIAZIDE	9
Losartan potassium*	8	Methyclothiazide*	9

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
Losartan potassium/HCTZ*	8	MYLANTA	12
LOSEASONIQUE	5	MYLERAN	3
LOTENSIN	8	MYSOLINE	15
Lyleq	5	MYSOLINE	18
METHYLDOPA	8	Nafarelin	7
METHYLDOPA & HCTZ	8	NALFON	14
Methyldopa & HCTZ*	8	NAMENDA	18
Methyldopa*	8	NAPHAZOLINE	19
Methylergonovine*	6	Naphazoline*	19
Methylprednisolone*	4	NAPROSYN	14
Methyltestosterone	4	Naproxen Sodium*	14
Metoclopramide*	12	Naproxen*	14
Metolazone*	9	NASACORT AQ	10
Metoprolol & HCTZ*	8	NASALCROM	10
Metoprolol Succinate*	7	NASALIDE	10
Metoprolol Tartrate*	7	NASONEX	10
METROGEL	19	NATAZIA	5
METROGEL-VAGINAL	13	NEOMYCIN	2
Metronidazole*	2	NEOMYCIN	19
Metronidazole*	13	Neomycin Sulfate*	2
Metronidazole*	19	NEOMYCIN-BAC ZN-POLYMYXIN	18
MEVACOR	9	Neomycin-Bac Zn-Polymyxin*	18
MEXILETINE	8	Neomycin-Bacitracin-Polymyxin*	19
Mexiletine*	8	Neomycin-Polymy-Gramicidin*	18
MIACALCIN INJ	6	Neomycin-Polymyxin-Dexamethasone*	19
MIACALCIN NASAL	6	Neomycin-Polymyxin-HC*	19
Miconazole*	2	NEORAL	21
Miconazole*	13	NEOSPORIN	18
MICRO-K	16	NEOSPORIN	19
Milnacipran	16	NEPHROCAPS	16
MINIPRESS	8	NEUPOGEN	17
MINOXIDIL	8	NEXAVAR	4
Minoxidil*	8	NEXIUM 24 HR OTC	12
Mirabergon	13	NIACIN	9
MIRALAX	11	NIACIN	16
MIRCETTE	5	Niacin & Lovastatin	9
Mitotane	4	Niacin CR*	9
MOBIC	14	Niacin*	9
MODICON, BREVICON	5	Niacin-Simvastatin	9
Mometasone furoate	10	NIASPAN	9
MONISTAT	2	Nifedipine*	7
MONISTAT	13	NITRODUR,NITROBID	7
MONISTAT	20	Nitrofurantoin Macrocrystals*	13
Montelukast Sodium*	11	Nitrofurantoin*	13
MORPHINE SULFATE	14	Nitroglycerin (oral)*	7
Morphine Sulfate SR*	14	Nitroglycerin (topical)*	7
Morphine Sulfate*	14	NITROSTAT	7
MOTRIN	14	NIX	20
Moxifloxacin Hydrochloride	18	NIZORAL	2
Moxifloxacin*	1	NORDETTE, AVIANE	5
MS CONTIN	14	Norelgestromin-Ethinyl Estradiol*	5
MUCOMYST	10	Norethindrone & Ethinyl Estrad FE*	5
Multiple Vitamin w/ Minerals*	16	Norethindrone Ace-Ethinyl Estrad FE*	5
Multiple Vitamin*	16	Norethindrone Ace-Ethinyl Estrad*	5
Mupirocin*	19	Norethindrone Acetate*	5
MYAMBUTOL	2	Norethindrone Ac-Ethinyl Estrad FE*	5

ProCare / Jai Medical Systems Therapeutic Formulary

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
MYBETRIQ	13	Norethindrone*	5
MYCELEX	13	Pancrelipase (Lip-Prot-Amyl)	12
MYCOBUTIN	2	Pancrelipase (Lip-Prot-Amyl) DR	12
Mycophenolate Mofetil*	21	Pantoprazole*	12
Mycophenolate Sodium*	21	PARLODEL	15
MYDFRIN	19	PATADAY	18
MYFORTIC	21	PATANOL	18
Norethindrone-Ethinyl Estradiol FE	5	PEDIA RELIEF LIQ COUGH/COLD	11
Norethindrone-Ethinyl Estradiol*	5	PEDIALYTE	16
Norethindrone-Mestranol	5	PEDIAPRED	4
Norgestimate-Ethinyl Estradiol*	5	Pediatric Multivitamins w/Fluoride	16
Norgestrel-Ethinyl Estradiol*	5	Pediatric Multivitamins w/Fluoride*	16
NORINYL, NECON	5	Pediatric Multivitamins w/Iron*	16
NORPACE, CR	8	Pediatric Multivitamins*	16
NOR-QD, ORTHO MICRON	5	Pediatric Vitamin ADC w/Iron*	16
NORVASC	7	Pediatric Vitamin ADC*	16
NOVOLIN 70/30	6	PEDIATRIC VITAMINS	16
HUMLIN N, NOVOLIN N	6	Pediatric Vitamins*	16
HUMLIN R, NOVOLIN R	6	PEG-Electrolyte*	11
NOVOLOG	6	Peginterferon	3
Nutritional Supplements	17	PEG-INTRON, PEGASYS	3
NUVARING	5	Penicillamine	21
Nylia 7/7/7	5	Penicillin G Benzathine	1
NYSTATIN	13	PENICILLIN V POTASSIUM	1
NYSTATIN TAB	2	Penicillin V Potassium*	1
Nystatin*	2	PENTASA	12
Nystatin*	13	Pentoxifylline*	18
Nystatin*	19	PEPCID	12
NYSTATIN-TRIAMCINOLONE	20	PEPTO-BISMOL	11
Nystatin-Triamcinolone*	20	PERCOCET	14
Octreotide Acetate*	11	PERIOGARD	2
OCUFEN	19	Permethrin*	20
OCUFLOX	18	PERSANTINE	7
Odefsey	3	PERTZYE	12
Ofloxacin	18	Phenazopyridine*	13
Ofloxacin*	19	PHENOBARBITAL	13
Olodaterol	10	Phenobarbital*	13
Olopatadine HCL Ophth soln 0.1%	18	Phenylephrine*	19
Olopatadine HCL Ophth soln 0.2%	18	Phenylephrine*	11
Omega-3-acid ethyl esters*	9	PHENYL-FREE	17
Omeprazole*	12	Phenyl-Free*	17
Ondansetron*	12	Phenytoin*	15
ONE-A-DAY	16	PHOSLO	16
ORACIT	13	Pilocarpine*	19
ORACIT	16	Pimecrolimus	20
Oral Electrolytes Packets*	16	PIN - X	2
Oral Electrolytes*	16	Pioglitazone*	6
ORAPRED	4	Pioglitazone-Glimepiride*	6
ORTHO EVRA PATCH	5	Pioglitazone-Metformin SR	6
ORTHO NOVUM 7/ 7/ 7	5	Pioglitazone-Metformin*	6
ORTHO TRI-CYCLEN / LO	5	Pirbuterol	10
ORTHO-CYCLEN	5	Piroxicam*	14
OS-CAL	12	PLAN B	5
OS-CAL	16	PLAN B ONE STEP	5
Oseltamivir Phosphate	2	PLAQUENIL	1
OXACILLIN	1	PLAVIX	18

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
Oxacillin*	1	PLETAL	18
Oxybutynin*	13	Propranolol & HCTZ*	8
OXYCODONE	14	Propranolol*	7
Oxycodone CR*	14	PROPYLTHIOURACIL	6
Oxycodone w/ Acetaminophen*	14	Propylthiouracil*	6
Oxycodone*	14	PROSCAR	13
OXYCONTIN	14	PROTONIX	12
Palivizumab	3	PROTOPIC	20
PANCREAZE, PANCRELIPASE	12	PROVENTIL HFA, VENTOLIN HFA,	10
Podofilox*	20	PROVERA	5
Polycarbophil Calcium*	11	PSEUDOEPHED-BROMPHEN DM	11
Polyethylene Glycol powder*	11	PSEUDOEPHEDRINE	10
Polymyxin B-Trimethoprim*	18	Pseudoephedrine HCL*	11
POLYSPORIN	18	Pseudoephedrine-Bromphen-DM*	11
POLYTRIM	18	Pseudoephedrine-Chlorphen-DM*	11
POLY-VI-SOL	16	Pseudoephedrine-DM liquid*	11
POLY-VI-SOL / IRON	16	PSEUDOEPHEDRINE-DM SOLN	11
Potassium Chloride Capsule*	16	Pseudoephedrine-DM soln*	11
POTASSIUM CHLORIDE LIQUID	16	Pseudoephedrine-GG*	11
Potassium Chloride Liquid*	16	PSEUDO-G / PSI	11
Potassium Chloride Tablet*	16	Psyllium*	11
PRADAXA	17	PULMICORT FLEXHALER	10
PRANDIN	6	PULMICORT RESPULES	10
PRAVACHOL	9	PURINETHOL	4
Pravastatin*	9	Pyrantel Pamoate*	2
Prazosin*	8	PYRAZINAMIDE	2
PRECOSE	6	Pyrazinamide*	2
PRED FORTE, MILD	18	PYRIDIDIUM	13
Prednisolone Acetate	4	Pyridostigmine*	16
Prednisolone Acetate*	18	Pyrimethamine	1
Prednisolone Na Phosphate*	4	QUESTRAN, LIGHT	9
Prednisolone*	4	Quinapril*	8
PREDNISONONE	4	QUINIDINE SULFATE	8
Prednisone*	4	Quinidine Sulfate*	8
PRELONE	4	QVAR	10
PREMARIN	5	Rabeprazole*	12
PREMPRO	5	Raloxifene*	7
PRENATABS RX	16	Raltegravir	3
Prenatal MV & Min w/FE-FA*	16	Ramipril*	8
Prenatal Vitamins*	16	Ranitidine*	12
PRENATAL-1	16	RAPAMUNE	21
PREVACID	12	RAZADYNE / RAZADYNE ER	18
PREVACID SOLU-TAB	12	REBETOL	3
PREZCOBIX	3	REBIF	4
PREZISTA	3	RECOMBINATE	17
PRILOSEC OTC	12	REGLAN	12
Primidone*	15	RELENZA	2
PROAIR HFA	10	Repaglinide	6
PROBENECID	15	REPATHA	9
Probenecid*	15	REQUIP	15
PROCAINAMIDE	8	RESERPINE	8
Procaïnamide*	8	Reserpine*	8
Procarbazine	4	RETIN-A	20
PROCHLORPERAZINE	12	RETROVIR	3
Prochlorperazine*	12	REVATIO	7
PROCTOCREAM	19	Reyataz	3

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
PROGRAF	21	RHEUMATREX	4
PROMETHAZINE	10	RHEUMATREX	15
Promethazine*	10	Sorafenib	4
Propafenone*	8	Sotalol*	7
PROPANTHELINE BROMIDE	12	SPIRIVA	10
Propantheline Bromide*	12	Spirolactone & HCTZ*	9
PROPOXYPHENE W/ APAP	14	Spirolactone*	9
Propoxyphene w/ APAP*	14	SPORANOX	2
PROPRANOLOL & HCTZ	8	STIOLTO	10
Ribavirin*	3	Stribild	3
Rifabutin*	2	STRIVERDI	10
RIFADIN	2	STROMECTOL	2
Rifampin*	2	Succimer	21
RILUTEK	16	Sucralfate*	12
Riluzole*	16	SUDAFED	11
Risedronate	7	SULFACETAMIDE SODIUM	20
Rivastigmine*	18	Sulfacetamide Sodium*	20
Rizatriptan tablets*	15	Sulfacetamide Sod-Prednisolone*	19
ROBAXIN	15	SULFADIAZINE	2
ROCALTROL	16	Sulfadiazine*	2
ROCEPHIN	1	Sulfanilamide	13
ROFERON-A	4	Sulfasalazine*	2
ROMYCIN	18	SULFISOXAZOLE	2
Ropinirole*	15	Sulfisoxazole*	2
Rosuvastatin Calcium	9	SULINDAC	14
ROWASA	12	Sulindac*	14
ROXICODONE	14	Sumatriptan injection*	15
RYTHMOL	8	Sumatriptan nasal*	15
Sacubitril & Valsartan	9	Sumatriptan tablets*	15
SAFYRAL, BEYAZ	5	Sumatriptan-naproxen	15
Salmeterol	10	SUMYCIN	1
Salmeterol-Fluticasone	10	SUPRAX	1
Salsalate*	14	SUSP, ALLEGRA ODT	10
SANDOSTATIN	11	Sustiva	3
SANTYL	20	SYMBICORT	10
SAVELLA	16	Symtuza	3
SEASONIQUE,QUARTETTE	5	SYNAGIS	3
Selegiline*	15	SYNALAR	20
Semglee	6	SYNAREL	7
SENNA-S	11	TABLOID	4
Sennosides*	11	Tacrolimus oint*	20
Sennosides/Docustate*	11	Tacrolimus*	21
SENOKOT	11	TAMBOCOR	8
SEREVENT DISKUS	10	TAMIFLU	2
SEROMYCIN	2	TAMOXIFEN	4
Sildenafil Citrate	7	Tamoxifen*	4
SILVADENE	20	Tamsulosin*	8
Silver Sulfadiazine*	20	TAPAZOLE	6
SIMCOR	9	TARCEVA	4
Simvastatin*	9	TAVIST	11
SINEMET, CR	15	TECFIDERA	21
SINGULAIR	11	TEMOVATE	20
Sirolimus*	21	TENEX	8
Sitagliptin Phosphate	6	Tenofovir	3
Sodium Citrate & Citric Acid*	13	TENORETIC	8
Sodium Fluoride*	16	TENORMIN	7

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
Sodium Polystyrene Sulfonate*	21	TERAZOSIN	8
Sodium Sulfacetamide*	18	Terazosin*	8
Sofosbuvir-Velpatasvir*	3	Thyquidity	6
Sofosbuvir-Velpatasvir-Voxilaprevir	3	Tri-Nymyo	5
Solifenacin	13	TRULICITY	6
SOLUTION	10	TROSPIUM	13
Somatropin	7	Trospium*	13
Terbinafine*	2	TRUSOPT	19
Teriflunomide	21	TRUVADA	3
Teriparatide	7	TUDORZA PRESSAIR	10
TESSALON, TESSALON PERLES	11	TYLENOL	14
Testosterone Gel	4	TYLENOL / CODEINE	14
Tetracycline*	1	ULTRACET	14
THEO-24, THEOCHRON	11	ULTRAM	14
Theophylline*	11	ULTRAM ER	14
Thiamine	17	Umeclidinium-Vilanterol	10
Thioguanine	4	URAMAXIN GEL 45%	20
THROMBATE III	17	Urea 45%*	20
Thrombin	17	Urea*	20
THYROID	6	URECHOLINE	13
Thyroid*	6	Valsartan	8
TIMOLOL	7	Valsartan & HCTZ*	8
Timolol*	7	VASOTEC	8
Timolol*	18	Verapamil*	7
Tiotropium	10	VESICARE	13
Tiotropium-Olodaterol	10	VIBRAMYCIN	1
TIVICAY	3	VICODIN, LORTAB, NORCO	14
TOBRADEX	19	VICTOZA	6
Tobramycin-Dexamethasone*	19	VIGAMOX	18
Tolterodine Tartrate	13	VIOKACE	12
TOPROL XL	7	VIREAD	3
TOUJEO	6	VIROPTIC	18
TOVIAZ	13	VITAMIN A	16
Tramadol ER*	14	Vitamin A*	16
Tramadol*	14	VITAMIN B-12	17
Tramadol/APAP*	14	VITAMIN D3	16
TRANDATE	7	VITAMIN K	16
TRECATOR	2	VIVONEX	17
TRENTAL	18	VOLTAREN	14
Tretinoin*	20	VOLTAREN	19
TREXIMET	15	VOLTAREN	20
TRIAM. ACET. IN ORABASE	20	VOSEVI	3
Triamcinolone	10	VYTORIN	9
Triamcinolone Acetonide in Orabase*	20	Warfarin Sodium*	17
Triamcinolone Acetonide*	20	XALATAN	19
Triamcinolone*	10	XELODA	4
TRIAMINIC AM LIQ CGH/DECON	11	XODOL	14
Triamterene & HCTZ*	9	YASMIN, YAZ	5
TRICOR	11	ZADITOR	18
Trifluridine*	18	Zanamivir	2
TRILIPIX	9	ZANTAC	12
TRIMETHOPRIM	2	ZARONTIN	15
Trimethoprim*	2	ZAROXOLYN	9
Trimethoprim/Sulfamethoxazole*	2	ZEPATIER	3
TRIPLE SULFAS VAGINAL	13	ZESTORETIC	8
Triple Sulfas Vaginal*	13	ZESTRIL	8

ProCare / Jai Medical Systems Therapeutic Formulary

<u>Product Name</u>	<u>Page</u>	<u>Product Name</u>	<u>Page</u>
TRIUMEQ	3	ZETIA	9
TRI-VI-FLOR	16	Ziagen	3
TRI-VI-FLOR / IRON	16	Zidovudine	3
TRI-VI-SOL	16	ZITHROMAX	1
TRI-VI-SOL / IRON	16	ZOCOR	9
TRIVORA	5		
Trizivir	3		
ZOCOR	9		
ZOFRAN	12		
ZOFRAN ODT	12		
Zolmitriptan tablets*	15		
ZOMIG	15		
ZORPRIN	14		
ZOVIA	5		
ZOVIRAX	3		
ZOVIRAX	20		
ZYLOPRIM	15		
ZYMAXID	18		
ZYRTEC	10		