

Michigan Department of Health and Human Services

Medicaid Health Plan Common Formulary

Contents

Drugs Reimbursed through Fee-For-Service Benefit (Carve-Out) 2

Products Covered As A Medical Benefit 2

Medicaid Health Plans May Be Less Restrictive 2

Standard Prior Authorization Form 3

Non-Formulary Prior Authorization Requests 3

Michigan Pharmaceutical Product List 3

Mandatory Generic Drug Policy for products whose drug class(es) are not present on the Single Preferred Drug List..... 3

Unit Dose Packaging..... 3

Non-Rebatable Drugs 3

Medically Accepted Indications 4

Vitamins and Supplements 4

Formulary Change Summary List 4

Medicaid Health Plan 4

Medicaid Health Plan Common Formulary Changes Effective April 1, 2026 4

State of Michigan Medicaid Health Plan Common Formulary: 11

4/1/2026

In order to streamline drug coverage policies for Medicaid and Healthy Michigan Plan members and providers, the Michigan Department of Health and Human Services (MDHHS) has created a formulary that is common across all contracted Medicaid Health Plans (MHPs) for the current Comprehensive Health Plan Contract. The development of the Common Formulary was required under Section 1806 of Public Act 84 of 2015.

Effective for dates of service on or after October 1, 2020, the Michigan Department of Health and Human Services (MDHHS) Policy Bulletin 20-51 https://www.michigan.gov/documents/mdhhs/MSA_20-51_695442_7.pdf will require Medicaid Health Plans (MHPs) to follow the Michigan PDL used by the Fee-for-Service (FFS) pharmacy program. This will be described as the Single PDL. The Michigan PDL is available on the web at <https://mi.primetherapeutics.com> >> Provider >> Michigan Preferred Drug List (PDL)/Single PDL. Drugs not part of the Single PDL will continue to be covered in accordance with the Common Formulary

Drugs Reimbursed through Fee-For-Service Benefit (Carve-Out)

MDHHS contracts with capitated managed care plans to provide services for its beneficiaries. These plans are responsible for most pharmacy services. Selected drugs and classes are carved out from the managed care plan coverage and are paid directly to a pharmacy by the MDHHS fee-for service program. This list is available at [Medicaid Health Plan Carveout](#). For these drugs, pharmacies must bill Prime Therapeutics for reimbursement. Refer to the D.O Pharmacy Claims Processing Manual at [Pharmacy Claims Processing Manual \(primetherapeutics.com\)](#) for instructions on submitting these claims.

Products Covered As A Medical Benefit

The Common Formulary includes drugs that are covered as a pharmacy benefit. The following are examples of products that may not be identified on the Common Formulary because a MHP may cover them as a medical benefit:

- Physician-administered injectable drugs
- Vaccines
- Intrauterine Devices

Members and providers should work with their MHPs to determine how these products are covered.

Medicaid Health Plans May Be Less Restrictive

As part of the Common Formulary, minimum requirements will be established for drug utilization management policies such as quantity limits, age and gender edits, prior authorization criteria and step therapies. MHPs may be less restrictive, for products whose drug class(es) are not present on the Single Preferred Drug List, but not more restrictive, than the coverage parameters of the Common Formulary.

4/1/2026

Standard Prior Authorization Form

A standard prior authorization form, FIS 2288, was created to simplify the process of requesting prior authorization for prescription drugs. The form is available at [Michigan.gov/difs](https://michigan.gov/difs) >> **Forms >> Insurance**.

Non-Formulary Prior Authorization Requests

For any drug that is not on the Common Formulary but is on the Michigan Pharmaceutical Product List (MPPL), providers can request a Non-Formulary Prior Authorization from the Health Plan. (see more below regarding MPPL). Prescribers can use the standard prior authorization form referenced above to request any non-formulary prior authorization.

Michigan Pharmaceutical Product List

As a reminder, with the exception of products that are carved out, MHPs must have a process to approve provider requests for any prescribed medically appropriate product identified on the Medicaid Pharmaceutical Product List (MPPL), found at <https://mi.primetherapeutics.com> >> **Provider Portal >> MPPL and Coverage Information**. Products that are listed on the MPPL but are not listed on the MHP Common Formulary are available for coverage consideration through a non-formulary prior authorization process.

Mandatory Generic Drug Policy for products whose drug class(es) are not present on the Single Preferred Drug List.

A mandatory generic drug policy encourages the generic version to be dispensed rather than a brand-name product. In most instances, a brand-name drug for which a generic product becomes available will become non-formulary, with the generic product covered in its place, upon release of the generic product onto the market. Mandatory generic coverage is permitted only for products whose drug class(es) are not present on the Single Preferred Drug List.

Prescription generic drugs are approved by the US Food and Drug Administration for safety and effectiveness and are manufactured under the same strict standards that apply to brand-name drugs. When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic equivalence).

Unit Dose Packaging

Products in Unit Dose packaging are not typically covered. Individual Medicaid Health Plans may be less restrictive and cover unit dose packaged products on a case by case basis.

Non-Rebatable Drugs

Products that do not have a Federal Medicaid rebate are not typically covered. Individual Medicaid Health Plans may be less restrictive and cover non-rebatable products on a case by case medical necessity basis.

4/1/2026

Medically Accepted Indications

Medically accepted indications will also be considered for approval. Medically accepted indications include any use of a drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in the compendia listed in Section 1927(g)(l)(B)(i) of the Social Security Act.

Vitamins and Supplements

Select vitamins are covered only for beneficiaries in the Children’s Special Health Care Services (CSHCS) program as indicated on the MPPL. These are shown on the formulary as “Covered for CSHCS Only”. Prenatal vitamins are available for coverage for women of child-bearing age. Vitamin D, Fluoride and Folic Acid are also available for coverage for select ages and conditions.

Formulary Change Summary List

The Medicaid Health Plan Common Formulary will be reviewed on a quarterly basis. During these reviews new medications that are FDA-approved will be evaluated after they have been available in the marketplace for at least six months. Specific drug classes will also be reviewed at this time. MDHHS regularly monitors drug product pricing and will convene special Workgroup meetings to address significant price fluctuations. Any changes made to the formulary as a result of these reviews will be reflected in the drug formulary documents. These changes made periodically throughout the year are reflected below.

Medicaid Health Plan

Medicaid Health Plan Common Formulary Changes Effective April 1, 2026

Changes Effective April 1, 2026		
Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic	ADALIMUMAB-AATY(CF) AUTO CD-UC-HS START 80	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic	ENBREL 25 MG KIT	Not Covered on Formulary
Anorectal Preparations	PROCTOCORT 30 MG SUPPOSITORY	Not Covered on Formulary
Anti-Infective Agents	XIFAXAN 200 MG TABLET XIFAXAN 550 MG TABLET	Not Covered on Formulary

4/1/2026

Changes Effective April 1, 2026		
Drug Class	Drug Name	New Status
Antineoplastics	BORTEZOMIB 1 MG VIAL # BORTEZOMIB 2.5 MG VIAL #	Not Covered on formulary; Carved Out
Antineoplastics	DASATINIB 20 MG TABLET # DASATINIB 50 MG TABLET # DASATINIB 70 MG TABLET # DASATINIB 80 MG TABLET # DASATINIB 100 MG TABLET # DASATINIB 140 MG TABLET #	Not Covered on formulary; Carved Out
Antineoplastics	HERNEXEOS 60 MG TABLET #	Not Covered on formulary; Carved Out
Antineoplastics	NILOTINIB HCL 150 MG 1tab # NILOTINIB HCL 200 MG 1tab #	Not Covered on formulary; Carved Out
Cardiovascular Therapy Agents	ORLADEYO 72 MG PELLETT PACKET # ORLADEYO 96 MG PELLETT PACKET # ORLADEYO 108 MG PELLETT PACKET # ORLADEYO 132 MG PELLETT PACKET #	Not Covered on formulary; Carved Out
Cardiovascular Therapy Agents	WINREVAIR 45 MG ONE-VIAL KIT WINREVAIR 45 MG TWO-VIAL KIT WINREVAIR 60 MG ONE-VIAL KIT WINREVAIR 60 MG TWO-VIAL KIT	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Central Nervous System Agents	AUSTEDO 6 MG TABLET AUSTEDO 9 MG TABLET AUSTEDO 12 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit

4/1/2026

Changes Effective April 1, 2026		
Drug Class	Drug Name	New Status
Central Nervous System Agents	AUSTEDO XR 6 MG TABLET AUSTEDO XR 12 MG TABLET AUSTEDO XR 18 MG TABLET AUSTEDO XR 24 MG TABLET AUSTEDO XR 30 MG TABLET AUSTEDO XR 36 MG TABLET AUSTEDO XR 42 MG TABLET AUSTEDO XR 48 MG TABLET AUSTEDO XR TITR(12-18-24-30MG)	Covered on formulary with Prior Authorization and Quantity Limit
Central Nervous System Agents	DAYBUE STIX 5,000 MG PACKET # DAYBUE STIX 6,000 MG PACKET # DAYBUE STIX 8,000 MG PACKET #	Not Covered on formulary; Carved Out
Central Nervous System Agents	EXXUA ER 18.2 MG TAB (TITRATN) # EXXUA ER 18.2 MG TABLET # EXXUA ER 36.3 MG TABLET # EXXUA ER 54.5 MG TABLET # EXXUA ER 72.6 MG TABLET #	Not Covered on formulary; Carved Out
Central Nervous System Agents	INGREZZA 40 MG CAPSULE INGREZZA 60 MG CAPSULE INGREZZA 80 MG CAPSULE INGREZZA INITIATION PACK	Covered on formulary with Prior Authorization and Quantity Limit
Central Nervous System Agents	INGREZZA 40 MG SPRINKLES CAP INGREZZA 60 MG SPRINKLES CAP INGREZZA 80 MG SPRINKLES CAP	Covered on formulary with Prior Authorization and Quantity Limit
Central Nervous System Agents	OSMOLEX ER 129 MG TABLET OSMOLEX ER 322 MG DAILY DOSE	Not Covered on Formulary

4/1/2026

Changes Effective April 1, 2026		
Drug Class	Drug Name	New Status
Cognitive Disorder Therapy	ADLARITY 5 MG/DAY WEEKLY PATCH ADLARITY 10MG/DAY WEEKLY PATCH	Covered on formulary with Prior Authorization – Non-Preferred
Dermatological	FLUOCINOLONE 0.01% SOLUTION	Covered on formulary – Preferred
Dermatological	PROCTOCORT 1% CREAM	Not Covered on Formulary
Dermatological	ZORYVE 0.05% CREAM	Covered on formulary with Prior Authorization and Age Edit
Dermatological	ZORYVE 0.15% CREAM ZORYVE 0.3% CREAM ZORYVE 0.3% FOAM	Covered on formulary with Prior Authorization and Age Edit
Eating Disorder Therapy	ZEPBOUND 2.5MG/DOS(10MG/2.4ML) ZEPBOUND 5MG/DOSE (20MG/2.4ML) ZEPBOUND 7.5MG/DOS(30MG/2.4ML) ZEPBOUND 10MG/DOSE(40MG/2.4ML) ZEPBOUND 12.5MG/DOS(50MG/2.4ML) ZEPBOUND 15MG/DOSE(60MG/2.4ML)	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred
Electrolyte Balance-Nutritional Products	COMPLETE NATAL DHA	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	MAGNESIUM GLYCINATE 100 MG CAP	Covered for CSHCS Only
Electrolyte Balance-Nutritional Products	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
Electrolyte Balance-Nutritional Products	MARNATAL-F CAPSULE	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	NEO-VITAL RX TABLET	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	NESTABS ABC PRENATAL COMBO PK	Covered on formulary with Quantity Limit and Age Edit

4/1/2026

Changes Effective April 1, 2026		
Drug Class	Drug Name	New Status
Electrolyte Balance-Nutritional Products	OB COMPLETE PREMIER TABLET	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	OB COMPLETE WITH DHA SOFTGEL	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	ONE NATAL RX PRENATAL TABLET	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	PNV-DHA SOFTGEL	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	PNV-SELECT TABLET	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	PRENATAL PLUS VITAMIN-MINERAL	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	PRENATE ENHANCE SOFTGEL	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	PRENATE STAR TABLET	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	PROVIDA OB CAPSULE	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	SELECT-OB + DHA PACK	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	SELECT-OB CHEWABLE CAPLET	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	SE-NATAL 19 CHEWABLE TABLET	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	VITAFOL FE PLUS SOFTGEL	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	VITAFOL GUMMIES	Covered on formulary with Quantity Limit and Age Edit

4/1/2026

Changes Effective April 1, 2026		
Drug Class	Drug Name	New Status
Electrolyte Balance-Nutritional Products	VITAFOL ULTRA SOFTGEL	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	VITAFOL-OB CAPLET	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	VITAFOL-OB+DHA COMBO PACK	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	VITAFOL-ONE CAPSULE	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
Electrolyte Balance-Nutritional Products	VITAMIN C 500 MG TABLET *	Covered for CSHCS Only
Electrolyte Balance-Nutritional Products	VITAMIN D3 50 MCG SOFTGEL *	Covered for CSHCS Only
Electrolyte Balance-Nutritional Products	VITAMIN E 180 MG SOFTGEL *	Covered for CSHCS Only
Electrolyte Balance-Nutritional Products	WESCAP-PN DHA CAPSULE	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	WESNATAL DHA COMPLETE	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	WESNATE DHA SOFTGEL	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	WESTGEL DHA SOFTGEL	Covered on formulary with Quantity Limit and Age Edit
Electrolyte Balance-Nutritional Products	ZATEAN-PN DHA CAPSULE	Covered on formulary with Quantity Limit and Age Edit
Endocrine	DESMOPRESSIN 0.01% SOLUTION DESMOPRESSIN 10 MCG/0.1 ML SPR	Covered on formulary with Prior Authorization and Age Edit

4/1/2026

Changes Effective April 1, 2026		
Drug Class	Drug Name	New Status
Endocrine	NOCDURNA 27.7 MCG TABLET SL NOCDURNA 55.3 MCG TABLET SL	Not Covered on Formulary
Gastrointestinal Therapy Agents	ENEMA *	Not Covered on Formulary
Gastrointestinal Therapy Agents	QC READY TO USE ENEMA *	Not Covered on Formulary
Gastrointestinal Therapy Agents	ZYMFENTRA 120 MG/ML PEN KIT (2 Pack)	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Genitourinary Therapy	TROSPIUM CHLORIDE ER 60 MG CAP	Covered on formulary with Prior Authorization – Non-Preferred
Hematological Agents	STIMUFEND 6 MG/0.6 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Miscellaneous	SODIUM CHLORIDE 1 GM TABLET *	Covered for CSHCS Only
Ophthalmic Agents	BESIFLOXACIN 0.6% EYE DROP	Covered on formulary with Prior Authorization – Non-Preferred
Respiratory Therapy Agents	ASMANEX HFA 100 MCG INHALER ASMANEX HFA 200 MCG INHALER	Covered on formulary with Quantity Limit – Preferred
Respiratory Therapy Agents	ASMANEX HFA 50 MCG INHALER	Covered on formulary with Quantity Limit and Age Edit – Preferred

State of Michigan Medicaid Health Plan Common Formulary

Drug Class	Drug Name	Utilization Management
ACE Inhibitor and Calcium Channel Blocker Combinations	AMLODIPINE-BENAZEPRIL 10-20 MG	*PDL-P
	AMLODIPINE-BENAZEPRIL 10-40 MG	*PDL-P
	AMLODIPINE-BENAZEPRIL 2.5-10	*PDL-P
	AMLODIPINE-BENAZEPRIL 5-10 MG	*PDL-P
	AMLODIPINE-BENAZEPRIL 5-20 MG	*PDL-P
	AMLODIPINE-BENAZEPRIL 5-40 MG	*PDL-P
	LOTREL 10-20 MG CAPSULE	PDL-NP PA
	LOTREL 10-40 MG CAPSULE	PDL-NP PA
	LOTREL 5-10 MG CAPSULE	PDL-NP PA
	LOTREL 5-20 MG CAPSULE	PDL-NP PA
	TRANDOLAPR-VERAPAM ER 1-240 MG	PDL-NP PA
	TRANDOLAPR-VERAPAM ER 2-180 MG	PDL-NP PA
	TRANDOLAPR-VERAPAM ER 2-240 MG	PDL-NP PA
	TRANDOLAPR-VERAPAM ER 4-240 MG	PDL-NP PA
ACE Inhibitors	ACCUPRIL 10 MG TABLET	PDL-NP PA
	ACCUPRIL 20 MG TABLET	PDL-NP PA
	ACCUPRIL 40 MG TABLET	PDL-NP PA
	ACCUPRIL 5 MG TABLET	PDL-NP PA
	ALTACE 1.25 MG CAPSULE	PDL-NP PA
	ALTACE 10 MG CAPSULE	PDL-NP PA
	ALTACE 2.5 MG CAPSULE	PDL-NP PA
	ALTACE 5 MG CAPSULE	PDL-NP PA
	BENAZEPRIL HCL 10 MG TABLET	*PDL-P
	BENAZEPRIL HCL 20 MG TABLET	*PDL-P
	BENAZEPRIL HCL 40 MG TABLET	*PDL-P
	BENAZEPRIL HCL 5 MG TABLET	*PDL-P
	CAPTOPRIL 100 MG TABLET	PDL-NP PA
	CAPTOPRIL 12.5 MG TABLET	PDL-NP PA
	CAPTOPRIL 25 MG TABLET	PDL-NP PA
	CAPTOPRIL 50 MG TABLET	PDL-NP PA
	ENALAPRIL 1 MG/ML ORAL SOLN	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
ACE Inhibitors	ENALAPRIL MALEATE 10 MG TAB	*PDL-P
	ENALAPRIL MALEATE 2.5 MG TAB	*PDL-P
	ENALAPRIL MALEATE 20 MG TAB	*PDL-P
	ENALAPRIL MALEATE 5 MG TABLET	*PDL-P
	EPANED 1 MG/ML ORAL SOLUTION	PDL-NP PA
	FOSINOPRIL SODIUM 10 MG TAB	PDL-NP PA
	FOSINOPRIL SODIUM 20 MG TAB	PDL-NP PA
	FOSINOPRIL SODIUM 40 MG TAB	PDL-NP PA
	LISINOPRIL 10 MG TABLET	*PDL-P
	LISINOPRIL 2.5 MG TABLET	*PDL-P
	LISINOPRIL 20 MG TABLET	*PDL-P
	LISINOPRIL 30 MG TABLET	*PDL-P
	LISINOPRIL 40 MG TABLET	*PDL-P
	LISINOPRIL 5 MG TABLET	*PDL-P
	LOTENSIN 10 MG TABLET	PDL-NP PA
	LOTENSIN 20 MG TABLET	PDL-NP PA
	LOTENSIN 40 MG TABLET	PDL-NP PA
	MOEXIPRIL HCL 15 MG TABLET	PDL-NP PA
	MOEXIPRIL HCL 7.5 MG TABLET	PDL-NP PA
	PERINDOPRIL ERBUMINE 2 MG TAB	PDL-NP PA
	PERINDOPRIL ERBUMINE 4 MG TAB	PDL-NP PA
	PERINDOPRIL ERBUMINE 8 MG TAB	PDL-NP PA
	QBRELIS 1MG/ML SOLUTION	PDL-NP PA
	QUINAPRIL 10 MG TABLET	PDL-NP PA
	QUINAPRIL 20 MG TABLET	PDL-NP PA
	QUINAPRIL 40 MG TABLET	PDL-NP PA
	QUINAPRIL 5 MG TABLET	PDL-NP PA
	RAMIPRIL 1.25 MG CAPSULE	*PDL-P
	RAMIPRIL 10 MG CAPSULE	*PDL-P
	RAMIPRIL 2.5 MG CAPSULE	*PDL-P
RAMIPRIL 5 MG CAPSULE	*PDL-P	
TRANDOLAPRIL 1 MG TABLET	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
ACE Inhibitors	TRANDOLAPRIL 2 MG TABLET	PDL-NP PA
	TRANDOLAPRIL 4 MG TABLET	PDL-NP PA
	VASOTEC 10 MG TABLET	PDL-NP PA
	VASOTEC 2.5 MG TABLET	PDL-NP PA
	VASOTEC 20 MG TABLET	PDL-NP PA
	VASOTEC 5 MG TABLET	PDL-NP PA
	ZESTRIL 10 MG TABLET	PDL-NP PA
	ZESTRIL 2.5 MG TABLET	PDL-NP PA
	ZESTRIL 20 MG TABLET	PDL-NP PA
	ZESTRIL 30 MG TABLET	PDL-NP PA
	ZESTRIL 40 MG TABLET	PDL-NP PA
	ZESTRIL 5 MG TABLET	PDL-NP PA
	ACE Inhibitors-Diuretic Combinations	ACCURETIC 10-12.5 MG TABLET
ACCURETIC 20-12.5 MG TABLET		PDL-NP PA
ACCURETIC 20-25 MG TABLET		PDL-NP PA
BENAZEPRIL-HCTZ 10-12.5 MG TAB		*PDL-P
BENAZEPRIL-HCTZ 20-12.5 MG TAB		*PDL-P
BENAZEPRIL-HCTZ 20-25 MG TAB		*PDL-P
BENAZEPRIL-HCTZ 5-6.25 MG TAB		*PDL-P
CAPTOPRIL-HCTZ 25-15 MG TABLET		PDL-NP PA
CAPTOPRIL-HCTZ 25-25 MG TABLET		PDL-NP PA
CAPTOPRIL-HCTZ 50-15 MG TABLET		PDL-NP PA
CAPTOPRIL-HCTZ 50-25 MG TABLET		PDL-NP PA
ENALAPRIL-HCTZ 10-25 MG TABLET		*PDL-P
ENALAPRIL-HCTZ 5-12.5 MG TAB		*PDL-P
FOSINOPRIL-HCTZ 10-12.5 MG TAB		PDL-NP PA
FOSINOPRIL-HCTZ 20-12.5 MG TAB		PDL-NP PA
LISINOPRIL-HCTZ 10-12.5 MG TAB		*PDL-P
LISINOPRIL-HCTZ 20-12.5 MG TAB		*PDL-P
LISINOPRIL-HCTZ 20-25 MG TAB		*PDL-P
LOTENSIN HCT 10-12.5 MG TABLET		PDL-NP PA
LOTENSIN HCT 20-12.5 MG TABLET	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
ACE Inhibitors-Diuretic Combinations	LOTENSIN HCT 20-25 MG TABLET	PDL-NP PA
	QUINAPRIL-HCTZ 10-12.5 MG TAB	PDL-NP PA
	QUINAPRIL-HCTZ 20-12.5 MG TAB	PDL-NP PA
	QUINAPRIL-HCTZ 20-25 MG TAB	PDL-NP PA
	VASERETIC 10-25 MG TABLET	PDL-NP PA
	ZESTORETIC 10-12.5 MG TABLET	PDL-NP PA
	ZESTORETIC 20-12.5 MG TABLET	PDL-NP PA
	ZESTORETIC 20-25 MG TABLET	PDL-NP PA
Acne Therapy Systemic - Retinoids & Derivatives	AMNESTEEM 10 MG CAPSULE	PA QL
	AMNESTEEM 20 MG CAPSULE	PA QL
	AMNESTEEM 40 MG CAPSULE	PA QL
	CLARAVIS 10 MG CAPSULE	PA QL
	CLARAVIS 20 MG CAPSULE	PA QL
	CLARAVIS 30 MG CAPSULE	PA QL
	CLARAVIS 40 MG CAPSULE	PA QL
	ISOTRETINOIN 10 MG CAPSULE	PA QL
	ISOTRETINOIN 20 MG CAPSULE	PA QL
	ISOTRETINOIN 30 MG CAPSULE	PA QL
	ISOTRETINOIN 40 MG CAPSULE	PA QL
	ZENATANE 10 MG CAPSULE	PA QL
	ZENATANE 20 MG CAPSULE	PA QL
	ZENATANE 30 MG CAPSULE	PA QL
ZENATANE 40 MG CAPSULE	PA QL	
Acne Therapy Topical - Anti-infective	CLINDAMYCIN PH 1% SOLUTION	QL
	CLINDAMYCIN PHOS 1% PLEDGET	
	ERYTHROMYCIN 2% SOLUTION	
	METRONIDAZOLE 0.75% CREAM	
	METRONIDAZOLE TOPICAL 0.75% GL	
Acne Therapy Topical - Anti-infective-Keratolytic Combinations	ACANYA GEL PUMP	PDL-NP PA
	CABTREO 1.2%-0.15%-3.15% GEL	PDL-NP PA
	CLIND PH-BENZOYL PERO 1.2-2.5%	*PDL-P
	CLIND PH-BENZOYL PEROX 1.2-5%	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Acne Therapy Topical - Anti-infective-Keratolytic Combinations	CLINDA-BENZOYL PEROX 1-5% PUMP	*PDL-P
	CLINDAMYC-BNZ PEROX 1.2-3.75%	PDL-NP PA
	CLINDAMYCIN-BENZOYL PEROX 1-5%	*PDL-P
	ERYTHROMYCIN-BENZOYL GEL	
	NEUAC 1.2-5% KIT	PDL-NP PA
	NEUAC GEL	PDL-NP PA
	ONEXTON 1.2%-3.75% GEL	PDL-NP PA
	ONEXTON GEL PUMP	PDL-NP PA
Acne Therapy Topical - Keratolytic	BENZOYL PEROXIDE 10% GEL *	QL
	BENZOYL PEROXIDE 10% WASH *	
	BENZOYL PEROXIDE 5% GEL *	
	BENZOYL PEROXIDE 5% WASH *	
Acne Therapy Topical - Retinoid Combinations Other	ADAPALENE-BNZYL PEROX 0.1-2.5%	AGE QL
Acne Therapy Topical - Retinoids & Derivatives	ADAPALENE 0.1% GEL	QL
	ADAPALENE 0.3% GEL	AGE QL
	TRETINOIN 0.025% CREAM	AGE QL
	TRETINOIN 0.05% CREAM	AGE QL
Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitor	NEXLETOL 180 MG TABLET	PDL-NP AGE PA
Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitor and a Cholesterol Absorption Inhi	NEXLIZET 180-10 MG TABLET	PDL-NP AGE PA
Adrenergics, Aromatic, Non-Catecholamine	ADZENYS XR-ODT 12.5 MG TABLET #	
	ADZENYS XR-ODT 15.7 MG TABLET #	
	ADZENYS XR-ODT 18.8 MG TABLET #	
	ADZENYS XR-ODT 3.1 MG TABLET #	
	ADZENYS XR-ODT 6.3 MG TABLET #	
	ADZENYS XR-ODT 9.4 MG TABLET #	
	AMPHETAMINE ER 12.5 MG ODT #	
	AMPHETAMINE ER 15.7 MG ODT #	
	AMPHETAMINE ER 18.8 MG ODT #	
	AMPHETAMINE ER 3.1 MG ODT #	
	AMPHETAMINE ER 6.3 MG ODT #	
	AMPHETAMINE ER 9.4 MG ODT #	
	DYANAVEL XR 2.5 MG/ML SUSP #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Adrenergics, Aromatic, Non-Catecholamine	MYDAYIS ER 12.5 MG CAPSULE #	
	MYDAYIS ER 25 MG CAPSULE #	
	MYDAYIS ER 37.5 MG CAPSULE #	
	MYDAYIS ER 50 MG CAPSULE #	
Adrenocorticotrophic Hormones	ACTHREL 100 MCG VIAL #	
	CORTROSYN 0.25 MG VIAL #	
	COSYNTROPIN 0.25 MG VIAL #	
	HP ACTHAR GEL 80 UNIT/ML VIAL #	
Agents for Narcotic Withdrawal	BRIXADI MONTH 128MG/0.36ML SYR #	
	BRIXADI MONTH 64 MG/0.18ML SYR #	
	BRIXADI MONTH 96 MG/0.27ML SYR #	
	BRIXADI WEEKLY 16MG/0.32ML SYR #	
	BRIXADI WEEKLY 24MG/0.48ML SYR #	
	BRIXADI WEEKLY 32MG/0.64ML SYR #	
	BRIXADI WEEKLY 8 MG/0.16ML SYR #	
	BUNAVAIL 2.1-0.3 MG FILM #	
	BUNAVAIL 4.2-0.7 MG FILM #	
	BUNAVAIL 6.3-1 MG FILM #	
	BUPRENO-NALOX 2-0.5 MG SL FILM #	
	BUPRENOR-NALOX 12-3 MG SL FILM #	
	BUPRENORPHINE 2 MG TABLET SL #	
	BUPRENORPHINE 8 MG TABLET SL #	
	BUPRENORPHIN-NALOXON 8-2 MG SL #	
	BUPRENORPHN-NALOXN 2-0.5 MG SL #	
	BUPRENORP-NALOX 4-1 MG SL FILM #	
	BUPRENORP-NALOX 8-2 MG SL FILM #	
	SUBLOCADE 100 MG/0.5 ML SYRING #	
	SUBLOCADE 300 MG/1.5 ML SYRING #	
	SUBOXONE 12 MG-3 MG SL FILM #	
	SUBOXONE 2 MG-0.5 MG SL FILM #	
	SUBOXONE 4 MG-1 MG SL FILM #	
SUBOXONE 8 MG-2 MG SL FILM #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Agents for Narcotic Withdrawal	ZUBSOLV 0.7-0.18 MG TABLET SL #	
	ZUBSOLV 1.4-0.36 MG TABLET SL #	
	ZUBSOLV 11.4-2.9 MG TABLET SL #	
	ZUBSOLV 2.9-0.71 MG TABLET SL #	
	ZUBSOLV 5.7-1.4 MG TABLET SL #	
	ZUBSOLV 8.6-2.1 MG TABLET SL #	
Agents for Opioid Withdrawal, Central Alpha-2 Adrenergic Agonist-Type	LOFEXIDINE 0.18 MG TABLET	*PDL-P
	LUCEMYRA 0.18 MG TABLET	*PDL-P
	LUCEMYRA 0.18 MG TABLET	*PDL-P
Agents to treat Hypoglycemia (Hyperglycemics)	BAQSIMI 3 MG SPRAY ONE PACK	*PDL-P QL
	BAQSIMI 3 MG SPRAY TWO PACK	*PDL-P QL
	DIAZOXIDE 50 MG/ML ORAL SUSP	PDL-NP PA
	GLUCAGON 1 MG EMERGENCY KIT	PDL-NP PA
	GLUCAGON 1 MG EMERGENCY KIT	PDL-NP PA
	GVOKE 1 MG/0.2 ML KIT	PDL-NP PA QL
	GVOKE 1 MG/0.2 ML SYRINGE	PDL-NP PA QL
	GVOKE 1 MG/0.2 ML SYRINGE	PDL-NP PA QL
	GVOKE 1 MG/0.2 ML VIAL	PDL-NP PA QL
	GVOKE HYPOPEN 1PK 0.5MG/0.1 ML	PDL-NP PA QL
	GVOKE HYPOPEN 1-PK 1 MG/0.2 ML	PDL-NP PA QL
	GVOKE HYPOPEN 2PK 0.5MG/0.1 ML	PDL-NP PA QL
	GVOKE HYPOPEN 2-PK 1 MG/0.2 ML	PDL-NP PA QL
	PROGLYCEM 50 MG/ML ORAL SUSP	*PDL-P
	Alcohol Abstinence Therapy - Glutamate and GABA System Type	ACAMPROSATE CALC DR 333 MG TAB #
Alcohol Abstinence Therapy - Opioid Receptor Antagonist-Type	VIVITROL 380 MG VIAL #	
	VIVITROL 380 MG VIAL + DILUENT #	
Alcohol Deterrents	ANTABUSE 250 MG TABLET #	
	ANTABUSE 500 MG TABLET #	
	DISULFIRAM 250 MG TABLET #	
	DISULFIRAM 500 MG TABLET #	
Allergenic Extracts - Peanuts	PALFORZIA 12 MG (LEVEL 3)	AGE PA
	PALFORZIA 120 MG (LEVEL 7)	AGE PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Allergenic Extracts - Peanuts	PALFORZIA 160 MG (LEVEL 8)	AGE PA
	PALFORZIA 20 MG (LEVEL 4)	AGE PA
	PALFORZIA 200 MG (LEVEL 9)	AGE PA
	PALFORZIA 240 MG (LEVEL 10)	AGE PA
	PALFORZIA 3 MG (LEVEL 1)	AGE PA
	PALFORZIA 300 MG (LEVEL 11)	AGE PA
	PALFORZIA 300 MG (MAINTENANCE)	AGE PA
	PALFORZIA 40 MG (LEVEL 5)	AGE PA
	PALFORZIA 6 MG (LEVEL 2)	AGE PA
	PALFORZIA 80 MG (LEVEL 6)	AGE PA
	PALFORZIA INITIAL (4-17 YRS)	AGE PA
Alopecia Agents, Janus Kinase (JAK) Inhibitors	LITFULO 50 MG CAPSULE	AGE PA QL
Alpha-Beta Blockers	CARVEDILOL 12.5 MG TABLET	*PDL-P
	CARVEDILOL 25 MG TABLET	*PDL-P
	CARVEDILOL 3.125 MG TABLET	*PDL-P
	CARVEDILOL 6.25 MG TABLET	*PDL-P
	CARVEDILOL ER 10 MG CAPSULE	PDL-NP PA
	CARVEDILOL ER 20 MG CAPSULE	PDL-NP PA
	CARVEDILOL ER 40 MG CAPSULE	PDL-NP PA
	CARVEDILOL ER 80 MG CAPSULE	PDL-NP PA
	LABETALOL HCL 100 MG TABLET	*PDL-P
	LABETALOL HCL 200 MG TABLET	*PDL-P
	LABETALOL HCL 300 MG TABLET	*PDL-P
LABETALOL HCL 400 MG TABLET	*PDL-P	
ALS Agent - Benzothiazoles	EXSERVAN 50 MG FILM	AGE PA
	RILUZOLE 50 MG TABLET	
	TIGLUTIK 50 MG/10 ML SUSP	AGE PA
Alternative Therapy - Unclassified	MG-PLUS-PROTEIN TABLET *	Covered for CSHCS Only
	MG-PLUS-PROTEIN TABLET *	Covered for CSHCS Only
Alzheimer's Disease Therapy - Cholinesterase Inhibitors	ADLARITY 10MG/DAY WEEKLY PATCH	PDL-NP PA
	ADLARITY 5 MG/DAY WEEKLY PATCH	PDL-NP PA
	ARICEPT 10 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Alzheimer's Disease Therapy - Cholinesterase Inhibitors	ARICEPT 23 MG TABLET	PDL-NP PA
	ARICEPT 5 MG TABLET	PDL-NP PA
	DONEPEZIL HCL 10 MG TABLET	*PDL-P
	DONEPEZIL HCL 23 MG TABLET	PDL-NP PA
	DONEPEZIL HCL 5 MG TABLET	*PDL-P
	DONEPEZIL HCL ODT 10 MG TABLET	*PDL-P
	DONEPEZIL HCL ODT 5 MG TABLET	*PDL-P
	EXELON 13.3 MG/24HR PATCH	*PDL-P
	EXELON 4.6 MG/24HR PATCH	*PDL-P
	EXELON 9.5 MG/24HR PATCH	*PDL-P
	GALANTAMINE 4 MG/ML ORAL SOLN	PDL-NP PA
	GALANTAMINE ER 16 MG CAPSULE	PDL-NP PA
	GALANTAMINE ER 24 MG CAPSULE	PDL-NP PA
	GALANTAMINE ER 8 MG CAPSULE	PDL-NP PA
	GALANTAMINE HBR 12 MG TABLET	*PDL-P
	GALANTAMINE HBR 4 MG TABLET	*PDL-P
	GALANTAMINE HBR 8 MG TABLET	*PDL-P
	RIVASTIGMINE 1.5 MG CAPSULE	*PDL-P
	RIVASTIGMINE 13.3 MG/24HR PTCH	PDL-NP PA
	RIVASTIGMINE 3 MG CAPSULE	*PDL-P
	RIVASTIGMINE 4.5 MG CAPSULE	*PDL-P
	RIVASTIGMINE 4.6 MG/24HR PATCH	PDL-NP PA
	RIVASTIGMINE 6 MG CAPSULE	*PDL-P
	RIVASTIGMINE 9.5 MG/24HR PATCH	PDL-NP PA
Zunveyl 10 mg Tablet Dr	PDL-NP PA	
Zunveyl 15 mg Tablet Dr	PDL-NP PA	
Zunveyl 5 mg Tablet Dr	PDL-NP PA	
Alzheimer's Disease Therapy - NMDA Receptor Antagonists	MEMANTINE 5-10 MG TITRATION PK	*PDL-P
	MEMANTINE HCL 10 MG TABLET	*PDL-P
	MEMANTINE HCL 2 MG/ML SOLUTION	*PDL-P
	MEMANTINE HCL 5 MG TABLET	*PDL-P
	MEMANTINE HCL ER 14 MG CAPSULE	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Alzheimer's Disease Therapy - NMDA Receptor Antagonists	MEMANTINE HCL ER 21 MG CAPSULE	PDL-NP PA
	MEMANTINE HCL ER 28 MG CAPSULE	PDL-NP PA
	MEMANTINE HCL ER 7 MG CAPSULE	PDL-NP PA
	NAMENDA 5-10 MG TITRATION PK	PDL-NP PA
	NAMENDA XR 7 MG CAPSULE	PDL-NP PA
	NAMENDA XR TITRATION PACK	PDL-NP PA
Alzheimer's Thx - NMDA Receptor Antag. & Cholinesterase Inhib. Comb	NAMZARIC 14 MG-10 MG CAPSULE	PDL-NP PA
	NAMZARIC 21 MG-10 MG CAPSULE	PDL-NP PA
	NAMZARIC 28 MG-10 MG CAPSULE	PDL-NP PA
	NAMZARIC 7 MG-10 MG CAPSULE	PDL-NP PA
	NAMZARIC TITRATION PACK	PDL-NP PA
Amebicides	PAROMOMYCIN 250 MG CAPSULE	
Aminoglycoside Antibiotic	BETHKIS 300 MG/4 ML AMPULE	*PDL-P
	KITABIS PAK 300 MG/5 ML	*PDL-P
	NEOMYCIN 500 MG TABLET	*PDL-P
	TOBI 300 MG/5 ML SOLUTION	PDL-NP PA
	TOBI PODHALER 28 MG INHALE CAP	*PDL-P
	TOBI PODHALER 28 MG INHALE CAP	*PDL-P
	TOBRAMYCIN 300 MG/4 ML AMPULE	PDL-NP PA
	TOBRAMYCIN 300 MG/5 ML AMPULE	*PDL-P
	TOBRAMYCIN PAK 300 MG/5 ML	PDL-NP PA
Aminopenicillin Antibiotic	AMOXICILLIN 125 MG TAB CHEW	
	AMOXICILLIN 125 MG/5 ML SUSP	
	AMOXICILLIN 200 MG/5 ML SUSP	
	AMOXICILLIN 250 MG CAPSULE	
	AMOXICILLIN 250 MG TAB CHEW	
	AMOXICILLIN 250 MG/5 ML SUSP	
	AMOXICILLIN 400 MG/5 ML SUSP	
	AMOXICILLIN 400 MG/5 ML SUSP	
	AMOXICILLIN 400 MG/5 ML SUSP	
	AMOXICILLIN 400 MG/5 ML SUSP	
	AMOXICILLIN 500 MG CAPSULE	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Aminopenicillin Antibiotic	AMOXICILLIN 500 MG TABLET	
	AMOXICILLIN 875 MG TABLET	
	AMPICILLIN 500 MG CAPSULE	
Aminopenicillin Antibiotic - Beta-lactamase Inhibitor Combinations	AMOX-CLAV 200-28.5 MG TAB CHEW	
	AMOX-CLAV 200-28.5 MG/5 ML SUS	
	AMOX-CLAV 250-125 MG TABLET	
	AMOX-CLAV 250-62.5 MG/5 ML SUS	
	AMOX-CLAV 400-57 MG TAB CHEW	
	AMOX-CLAV 400-57 MG/5 ML SUSP	
	AMOX-CLAV 500-125 MG TABLET	
	AMOX-CLAV 600-42.9 MG/5 ML SUS	
	AMOX-CLAV 875-125 MG TABLET	
Ammonia Inhibitors	OLPRUVA 2 GRAM DOSE KIT #	
	OLPRUVA 3 GRAM DOSE KIT #	
	OLPRUVA 4 GRAM DOSE KIT #	
	OLPRUVA 5 GRAM DOSE KIT #	
	OLPRUVA 6.67 GRAM DOSE KIT #	
Anaerobic Antiprotozoal-Antibacterial Agents	LIKMEZ 500 MG/5 ML SUSPENSION	PDL-NP PA QL
Analgesic Narcotic Agonists	CODEINE SULFATE 15 MG TABLET	*PDL-P AGE QL
	CODEINE SULFATE 30 MG TABLET	*PDL-P AGE QL
	CODEINE SULFATE 60 MG TABLET	*PDL-P AGE QL
	CONZIP 100 MG CAPSULE	PDL-NP AGE PA QL
	CONZIP 200 MG CAPSULE	PDL-NP AGE PA QL
	CONZIP 300 MG CAPSULE	PDL-NP AGE PA QL
	DILAUDID 2 MG TABLET	PDL-NP PA QL
	DILAUDID 4 MG TABLET	PDL-NP PA QL
	DILAUDID 5 MG/5 ML ORAL LIQUID	PDL-NP PA QL
	DILAUDID 8 MG TABLET	PDL-NP PA QL
	DISKETS 40 MG TABLET DISPR	PDL-NP PA QL
	FENTANYL 100 MCG/HR PATCH	*PDL-P QL
	FENTANYL 12 MCG/HR PATCH	*PDL-P QL
FENTANYL 25 MCG/HR PATCH	*PDL-P QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Analgesic Narcotic Agonists	FENTANYL 37.5 MCG/HR PATCH	PDL-NP PA QL
	FENTANYL 50 MCG/HR PATCH	*PDL-P QL
	FENTANYL 62.5 MCG/HR PATCH	PDL-NP PA QL
	FENTANYL 75 MCG/HR PATCH	*PDL-P QL
	FENTANYL 87.5 MCG/HR PATCH	PDL-NP PA QL
	FENTANYL CIT 100 MCG BUCCAL TB	PDL-NP PA QL
	FENTANYL CIT 200 MCG BUCCAL TB	PDL-NP PA QL
	FENTANYL CIT 400 MCG BUCCAL TB	PDL-NP PA QL
	FENTANYL CIT 600 MCG BUCCAL TB	PDL-NP PA QL
	FENTANYL CIT 800 MCG BUCCAL TB	PDL-NP PA QL
	FENTANYL CIT OTFC 1,200 MCG	PDL-NP PA QL
	FENTANYL CIT OTFC 1,600 MCG	PDL-NP PA QL
	FENTANYL CITRATE OTFC 200 MCG	PDL-NP PA QL
	FENTANYL CITRATE OTFC 400 MCG	PDL-NP PA QL
	FENTANYL CITRATE OTFC 600 MCG	PDL-NP PA QL
	FENTANYL CITRATE OTFC 800 MCG	PDL-NP PA QL
	HYDROCODONE ER 10 MG CAPSULE	PDL-NP PA QL
	HYDROCODONE ER 100 MG TABLET	PDL-NP PA QL
	HYDROCODONE ER 120 MG TABLET	PDL-NP PA QL
	HYDROCODONE ER 15 MG CAPSULE	PDL-NP PA QL
	HYDROCODONE ER 20 MG CAPSULE	PDL-NP PA QL
	HYDROCODONE ER 20 MG TABLET	PDL-NP PA QL
	HYDROCODONE ER 30 MG CAPSULE	PDL-NP PA QL
	HYDROCODONE ER 30 MG TABLET	PDL-NP PA QL
	HYDROCODONE ER 40 MG CAPSULE	PDL-NP PA QL
	HYDROCODONE ER 40 MG TABLET	PDL-NP PA QL
	HYDROCODONE ER 50 MG CAPSULE	PDL-NP PA QL
	HYDROCODONE ER 60 MG TABLET	PDL-NP PA QL
	HYDROCODONE ER 80 MG TABLET	PDL-NP PA QL
	HYDROMORPHONE 1 MG/ML SOLUTION	*PDL-P QL
	HYDROMORPHONE 2 MG TABLET	*PDL-P QL
	HYDROMORPHONE 3 MG SUPPOS	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Analgesic Narcotic Agonists	HYDROMORPHONE 4 MG TABLET	*PDL-P QL
	HYDROMORPHONE 5 MG/5 ML SOLN	*PDL-P QL
	HYDROMORPHONE 8 MG TABLET	*PDL-P QL
	HYDROMORPHONE HCL ER 12 MG TAB	PDL-NP PA QL
	HYDROMORPHONE HCL ER 16 MG TAB	PDL-NP PA QL
	HYDROMORPHONE HCL ER 32 MG TAB	PDL-NP PA QL
	HYDROMORPHONE HCL ER 8 MG TAB	PDL-NP PA QL
	HYSINGLA ER 100 MG TABLET	PDL-NP PA QL
	HYSINGLA ER 120 MG TABLET	PDL-NP PA QL
	HYSINGLA ER 20 MG TABLET	PDL-NP PA QL
	HYSINGLA ER 30 MG TABLET	PDL-NP PA QL
	HYSINGLA ER 40 MG TABLET	PDL-NP PA QL
	HYSINGLA ER 60 MG TABLET	PDL-NP PA QL
	HYSINGLA ER 80 MG TABLET	PDL-NP PA QL
	LEVORPHANOL 2 MG TABLET	PDL-NP PA QL
	LEVORPHANOL 3 MG TABLET	PDL-NP PA QL
	MEPERIDINE 50 MG TABLET	PDL-NP PA QL
	MEPERIDINE 50 MG/5 ML SOLUTION	PDL-NP PA QL
	METHADONE 10 MG/5 ML SOLUTION	PDL-NP PA QL
	METHADONE 10 MG/ML ORAL CONC	PDL-NP PA QL
	METHADONE 40 MG TABLET DISPR	PDL-NP PA QL
	METHADONE 5 MG/5 ML SOLUTION	PDL-NP PA QL
	METHADONE HCL 10 MG TABLET	PDL-NP PA QL
	METHADONE HCL 5 MG TABLET	PDL-NP PA QL
	METHADONE INTENSOL 10 MG/ML	PDL-NP PA QL
	METHADOSE 10 MG/ML ORAL CONC	PDL-NP PA QL
	METHADOSE 40 MG TABLET DISPR	PDL-NP PA QL
	MORPHINE 10 MG/0.5 ML ORAL SYR	*PDL-P QL
	MORPHINE 20 MG/ML ORAL SYRINGE	*PDL-P QL
	MORPHINE SULF 10 MG SUPPOS	*PDL-P QL
	MORPHINE SULF 10 MG/5 ML SOLN	*PDL-P QL
	MORPHINE SULF 100 MG/5 ML CONC	*PDL-P QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Analgesic Narcotic Agonists	MORPHINE SULF 20 MG SUPPOS	*PDL-P QL
	MORPHINE SULF 20 MG/5 ML SOLN	*PDL-P QL
	MORPHINE SULF 30 MG SUPPOS	*PDL-P QL
	MORPHINE SULF 5 MG SUPPOS	*PDL-P QL
	MORPHINE SULF ER 100 MG TABLET	*PDL-P QL
	MORPHINE SULF ER 15 MG TABLET	*PDL-P QL
	MORPHINE SULF ER 200 MG TABLET	*PDL-P QL
	MORPHINE SULF ER 30 MG TABLET	*PDL-P QL
	MORPHINE SULF ER 60 MG TABLET	*PDL-P QL
	MORPHINE SULFATE ER 10 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 100 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 120 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 20 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 30 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 30 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 45 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 50 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 60 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 60 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 75 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 80 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE ER 90 MG CAP	PDL-NP PA QL
	MORPHINE SULFATE IR 15 MG TAB	*PDL-P QL
	MORPHINE SULFATE IR 30 MG TAB	*PDL-P QL
	MS CONTIN ER 100 MG TABLET	PDL-NP PA QL
	MS CONTIN ER 15 MG TABLET	PDL-NP PA QL
	MS CONTIN ER 200 MG TABLET	PDL-NP PA QL
	MS CONTIN ER 30 MG TABLET	PDL-NP PA QL
	MS CONTIN ER 60 MG TABLET	PDL-NP PA QL
	OPANA 10 MG TABLET	PDL-NP PA QL
	OXYCODONE HCL (IR) 10 MG TAB	*PDL-P QL
	OXYCODONE HCL (IR) 15 MG TAB	*PDL-P QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Analgesic Narcotic Agonists	OXYCODONE HCL (IR) 20 MG TAB	PDL-NP PA QL
	OXYCODONE HCL (IR) 30 MG TAB	PDL-NP PA QL
	OXYCODONE HCL (IR) 5 MG CAP	PDL-NP PA QL
	OXYCODONE HCL (IR) 5 MG TABLET	*PDL-P QL
	OXYCODONE HCL 100 MG/5 ML CONC	PDL-NP PA QL
	OXYCODONE HCL 5 MG/5 ML SOLN	*PDL-P QL
	OXYCODONE HCL ER 10 MG TABLET	PDL-NP PA QL
	OXYCODONE HCL ER 20 MG TABLET	PDL-NP PA QL
	OXYCODONE HCL ER 40 MG TABLET	PDL-NP PA QL
	OXYCODONE HCL ER 80 MG TABLET	PDL-NP PA QL
	OXYCONTIN ER 10 MG TABLET	*PDL-P QL
	OXYCONTIN ER 15 MG TABLET	*PDL-P QL
	OXYCONTIN ER 20 MG TABLET	*PDL-P QL
	OXYCONTIN ER 30 MG TABLET	*PDL-P QL
	OXYCONTIN ER 40 MG TABLET	*PDL-P QL
	OXYCONTIN ER 60 MG TABLET	*PDL-P QL
	OXYCONTIN ER 80 MG TABLET	*PDL-P QL
	OXYMORPHONE HCL 10 MG TABLET	PDL-NP PA QL
	OXYMORPHONE HCL 5 MG TABLET	PDL-NP PA QL
	OXYMORPHONE HCL ER 10 MG TAB	PDL-NP PA QL
	OXYMORPHONE HCL ER 15 MG TAB	PDL-NP PA QL
	OXYMORPHONE HCL ER 20 MG TAB	PDL-NP PA QL
	OXYMORPHONE HCL ER 30 MG TAB	PDL-NP PA QL
	OXYMORPHONE HCL ER 40 MG TAB	PDL-NP PA QL
	OXYMORPHONE HCL ER 5 MG TABLET	PDL-NP PA QL
	OXYMORPHONE HCL ER 7.5 MG TAB	PDL-NP PA QL
	ROXICODONE 15 MG TABLET	PDL-NP PA QL
	ROXICODONE 30 MG TABLET	PDL-NP PA QL
	ROXICODONE 5 MG TABLET	PDL-NP PA QL
	ROXYBOND 10 MG TABLET	PDL-NP PA QL
ROXYBOND 15 MG TABLET	PDL-NP PA QL	
ROXYBOND 30 MG TABLET	PDL-NP PA QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Analgesic Narcotic Agonists	ROXYBOND 5 MG TABLET	PDL-NP PA QL
	TRAMADOL ER 100 MG TABLET	*PDL-P AGE QL
	TRAMADOL ER 200 MG TABLET	*PDL-P AGE QL
	TRAMADOL ER 300 MG TABLET	*PDL-P AGE QL
	TRAMADOL HCL 100 MG TABLET	*PDL-P AGE QL
	TRAMADOL HCL 25 MG/5 ML CUP	PDL-NP AGE PA QL
	TRAMADOL HCL 50 MG TABLET	*PDL-P AGE QL
	TRAMADOL HCL ER 100 MG CAPSULE	PDL-NP AGE PA QL
	TRAMADOL HCL ER 100 MG TABLET	*PDL-P AGE QL
	TRAMADOL HCL ER 200 MG CAPSULE	PDL-NP AGE PA QL
	TRAMADOL HCL ER 200 MG TABLET	*PDL-P AGE QL
	TRAMADOL HCL ER 300 MG CAPSULE	PDL-NP AGE PA QL
	TRAMADOL HCL ER 300 MG TABLET	*PDL-P AGE QL
	Analgesic Narcotic Codeine Combinations	ACETAMIN-CODEIN 300-30 MG/12.5
ACETAMINOP-CODEINE 120-12 MG/5		*PDL-P AGE QL
ACETAMINOP-CODEINE 120-12 MG/5		*PDL-P AGE QL
ACETAMINOPHEN-COD #2 TABLET		*PDL-P AGE QL
ACETAMINOPHEN-COD #3 TABLET		*PDL-P AGE QL
ACETAMINOPHEN-COD #4 TABLET		*PDL-P AGE QL
ASA-BUTALB-CAFF-COD #3 CAPSULE		PDL-NP AGE PA QL
ASCOMP WITH CODEINE CAPSULE		PDL-NP AGE PA QL
BUTALB-ACETAMIN-CAF-COD 50-300		PDL-NP AGE PA QL
BUTALB-ACETAMIN-CAF-COD 50-325		PDL-NP AGE PA QL
FIORICET-COD 50-300-40-30 CAP		PDL-NP AGE PA QL
Analgesic Narcotic Dihydrocodeine Combinations	ACETAMN-CAF-DIHYDRCODEIN 320.5	PDL-NP AGE PA QL
Analgesic Narcotic Hydrocodone Combinations	HYDROCODONE-ACETAMIN 10-300 MG	*PDL-P QL
	HYDROCODONE-ACETAMIN 10-325 MG	*PDL-P QL
	HYDROCODONE-ACETAMIN 2.5-108/5	*PDL-P QL
	HYDROCODONE-ACETAMIN 5-217/10	*PDL-P QL
	HYDROCODONE-ACETAMIN 5-300 MG	*PDL-P QL
	HYDROCODONE-ACETAMIN 5-325 MG	*PDL-P QL
	HYDROCODONE-ACETAMIN 7.5-300	*PDL-P QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Analgesic Narcotic Hydrocodone Combinations	HYDROCODONE-ACETAMIN 7.5-325	*PDL-P QL
	HYDROCODONE-ACETAMN 7.5-325/15	*PDL-P QL
	HYDROCODONE-ACETAMN 7.5-325/15	*PDL-P QL
	HYDROCODONE-IBUPROFEN 10-200	PDL-NP PA QL
	HYDROCODONE-IBUPROFEN 5-200 MG	PDL-NP PA QL
	HYDROCODONE-IBUPROFEN 7.5-200	PDL-NP PA QL
Analgesic Narcotic Oxycodone Combinations	ENDOCET 10-325 MG TABLET	*PDL-P QL
	ENDOCET 5-325 TABLET	*PDL-P QL
	ENDOCET 7.5-325 MG TABLET	*PDL-P QL
	NALOCET 2.5-300 MG TABLET	PDL-NP PA QL
	OXYCODONE-ACETAMINOPHEN 10-325	*PDL-P QL
	OXYCODONE-ACETAMINOPHEN 5-325	*PDL-P QL
	OXYCODONE-ACETAMINOPHN 2.5-325	*PDL-P QL
	OXYCODONE-ACETAMINOPHN 5-325/5	*PDL-P QL
	OXYCODONE-ACETAMINOPHN 7.5-325	*PDL-P QL
	PERCOCET 10-325 MG TABLET	PDL-NP PA QL
	PERCOCET 2.5-325 MG TABLET	PDL-NP PA QL
	PERCOCET 5-325 MG TABLET	PDL-NP PA QL
	PERCOCET 7.5-325 MG TABLET	PDL-NP PA QL
	PROLATE 10 MG-300 MG/5 ML SOLN	PDL-NP PA QL
	PROLATE 10-300 MG TABLET	PDL-NP PA QL
	PROLATE 5-300 MG TABLET	PDL-NP PA QL
PROLATE 7.5-300 MG TABLET	PDL-NP PA QL	
Analgesic Narcotic Partial-Mixed Agonists	BELBUCA 150 MCG FILM	PDL-NP PA QL
	BELBUCA 300 MCG FILM	PDL-NP PA QL
	BELBUCA 450 MCG FILM	PDL-NP PA QL
	BELBUCA 600 MCG FILM	PDL-NP PA QL
	BELBUCA 75 MCG FILM	PDL-NP PA QL
	BELBUCA 750 MCG FILM	PDL-NP PA QL
	BELBUCA 900 MCG FILM	PDL-NP PA QL
	BUPRENORPHINE 10 MCG/HR PATCH	PDL-NP PA QL
	BUPRENORPHINE 15 MCG/HR PATCH	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Analgesic Narcotic Partial-Mixed Agonists	BUPRENORPHINE 20 MCG/HR PATCH	PDL-NP PA QL
	BUPRENORPHINE 5 MCG/HR PATCH	PDL-NP PA QL
	BUPRENORPHINE 7.5 MCG/HR PATCH	PDL-NP PA QL
	BUTORPHANOL 10 MG/ML SPRAY	PDL-NP PA QL
	BUTRANS 10 MCG/HR PATCH	*PDL-P QL
	BUTRANS 15 MCG/HR PATCH	*PDL-P QL
	BUTRANS 20 MCG/HR PATCH	*PDL-P QL
	BUTRANS 5 MCG/HR PATCH	*PDL-P QL
	BUTRANS 7.5 MCG/HR PATCH	*PDL-P QL
	PENTAZOCINE-NALOXONE TABLET	PDL-NP PA QL
Analgesic Narcotic Tramadol Combinations	SEGLENTIS 56 MG-44 MG TABLET	PDL-NP AGE PA QL
	TRAMADOL-ACETAMINOPHN 37.5-325	*PDL-P AGE QL
Analgesic or Antipyretic Non-Narcotic	8 HOUR ACETAMINOPHEN ER 650 MG *	QL
	ACETAMINOPHEN 120 MG SUPPOS *	QL
	ACETAMINOPHEN 160 MG RAPID TAB *	QL
	ACETAMINOPHEN 160 MG/5 ML LIQ *	QL
	ACETAMINOPHEN 160 MG/5 ML SOL *	QL
	ACETAMINOPHEN 160 MG/5 ML SUSP *	QL
	ACETAMINOPHEN 325 MG TABLET *	QL
	ACETAMINOPHEN 500 MG CAPLET *	QL
	ACETAMINOPHEN 500 MG GELCAP *	QL
	ACETAMINOPHEN 650 MG SUPPOS *	QL
	ACETAMINOPHEN ER 650 MG CAPLET *	QL
	BETATEMP 160 MG/5 ML SUSP *	QL
	CHILD ACETAMINOPHEN 80 MG CHEW *	QL
	CHILD PAIN-FEVER 160 MG/5 ML *	QL
	CHILD PAIN-FEVER 80 MG TAB CHW *	QL
	CHILD TACTINAL 80 MG TAB CHW *	QL
	CHLD ACETAMINOPHEN 160 MG/5 ML *	QL
	CHLD ACETAMINOPHEN 160 MG/5 ML *	QL
	CHLD ACETAMINOPHEN 160 MG/5 ML *	QL
	EQ CHLD ACETAMINOPHEN 160 MG/5 *	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Analgesic or Antipyretic Non-Narcotic	EQ JR ACETAMINOPHEN 160 MG TAB *	QL
	EQL ACETAMINOPHEN 160 MG ODT *	QL
	FEVERALL 120 MG SUPPOSITORY *	QL
	FEVERALL 325 MG SUPPOSITORY *	QL
	FEVERALL 650 MG SUPPOSITORY *	QL
	FT CHILD PAIN REL 120 MG SUPP *	QL
	INFANT PAIN & FEVER SUSP *	QL
	INFANT PAIN & FEVER SUSPENSION *	QL
	INFANTS' PAIN & FEVER SUSP *	QL
	JR PAIN-FEVER 160 MG RAPID TAB *	QL
	LITTLE REMEDIES FEVER 160 MG/5 *	QL
	MAPAP 500 MG CAPSULE *	QL
	MAPAP 80 MG TABLET CHEW *	QL
	M-PAP 160 MG/5 ML LIQUID *	QL
	NON-ASPIRIN 80 MG TAB CHEW *	QL
	PAIN RELIEVER 325 MG TABLET *	QL
	PAIN RELIEVER 500 MG GELCAP *	QL
	PUB CHILD PAIN RLF 160 MG/5 ML *	QL
	RA FEVER REDUCER-PAIN REL SUSP *	QL
	RA INFANT FEVER-PAIN REL SUSP *	QL
	RA NON-ASPIRIN 160 MG/5 ML *	QL
	SM CHILD PAIN & FEVER 160 MG/5 *	QL
	TYLENOL 325 MG TABLET *	QL
Analgesic or Antipyretic Non-Narcotic/Sedative Combinations	BUTALB-ACETAMIN-CAFF 50-325-40	AGE QL
	BUTALBITAL-ACETAMINOPHN 50-325	AGE QL
	ESGIC 50-325-40 MG TABLET	AGE QL
	MARTEN-TAB 325-50 TABLET	AGE QL
	TENCON 50-325 MG TABLET	AGE QL
Analgesics - Sodium Channel Pain Signal Blocker	Journavx 50 mg tablet	AGE QL
Androgen - Single Agents	ANDROGEL 1% (25 MG/2.5 G) PKT	PDL-NP PA
	ANDROGEL 1% (50 MG/5 G) PKT	PDL-NP PA
	ANDROGEL 1.62% GEL PUMP	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Androgen - Single Agents	ANDROGEL 1.62%(1.25G) GEL PCKT	PDL-NP PA
	ANDROGEL 1.62%(2.5G) GEL PCKT	PDL-NP PA
	FORTESTA 10 MG GEL PUMP	PDL-NP PA
	NATESTO NASAL 5.5 MG/0.122 GM	PDL-NP PA
	TESTIM 1% (50MG) GEL	PDL-NP PA
	TESTOSTERON CYP 1,000 MG/10 ML	
	TESTOSTERON CYP 2,000 MG/10 ML	
	TESTOSTERONE 1% (25MG/2.5G) PK	PDL-NP PA
	TESTOSTERONE 1% (50 MG/5 G) PK	PDL-NP PA
	TESTOSTERONE 1.62% (2.5 G) PKT	PDL-NP PA
	TESTOSTERONE 1.62% GEL PUMP	*PDL-P PA
	TESTOSTERONE 1.62%(1.25 G) PKT	PDL-NP PA
	TESTOSTERONE 10 MG GEL PUMP	PDL-NP PA
	TESTOSTERONE 12.5 MG/1.25 GRAM	PDL-NP PA
	TESTOSTERONE 30 MG/1.5 ML PUMP	PDL-NP PA
	TESTOSTERONE 50 MG/5 GRAM GEL	PDL-NP PA
	TESTOSTERONE CYP 100 MG/ML	
	TESTOSTERONE CYP 200 MG/ML	
	VOGELXO 12.5 MG/1.25 GRAM PUMP	PDL-NP PA
	VOGELXO 50 MG/5 GRAM GEL	PDL-NP PA
VOGELXO 50 MG/5 GRAM GEL PACKT	PDL-NP PA	
Angiotensin II Receptor Blocker (ARB)-Calcium Channel Blocker Comb.	AMLODIPINE-OLMESARTAN 10-20 MG	*PDL-P
	AMLODIPINE-OLMESARTAN 10-40 MG	*PDL-P
	AMLODIPINE-OLMESARTAN 5-20 MG	*PDL-P
	AMLODIPINE-OLMESARTAN 5-40 MG	*PDL-P
	AMLODIPINE-VALSARTAN 10-160 MG	*PDL-P
	AMLODIPINE-VALSARTAN 10-320 MG	*PDL-P
	AMLODIPINE-VALSARTAN 5-160 MG	*PDL-P
	AMLODIPINE-VALSARTAN 5-320 MG	*PDL-P
	AZOR 10-20 MG TABLET	PDL-NP PA
	AZOR 10-40 MG TABLET	PDL-NP PA
AZOR 5-20 MG TABLET	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Angiotensin II Receptor Blocker (ARB)-Calcium Channel Blocker Comb.	AZOR 5-40 MG TABLET	PDL-NP PA
	EXFORGE 10-160 MG TABLET	PDL-NP PA
	EXFORGE 10-320 MG TABLET	PDL-NP PA
	EXFORGE 5-160 MG TABLET	PDL-NP PA
	EXFORGE 5-320 MG TABLET	PDL-NP PA
	TELMISARTAN-AMLODIPINE 40-10	PDL-NP PA
	TELMISARTAN-AMLODIPINE 40-5 MG	PDL-NP PA
	TELMISARTAN-AMLODIPINE 80-10	PDL-NP PA
	TELMISARTAN-AMLODIPINE 80-5 MG	PDL-NP PA
Angiotensin II Receptor Blocker (ARB)-Calcium Channel Blocker-Diuretic	AMLOD-VALSA-HCTZ 10-160-12.5MG	*PDL-P
	AMLOD-VALSA-HCTZ 10-160-25 MG	*PDL-P
	AMLOD-VALSA-HCTZ 10-320-25 MG	*PDL-P
	AMLOD-VALSA-HCTZ 5-160-12.5 MG	*PDL-P
	AMLOD-VALSA-HCTZ 5-160-25 MG	*PDL-P
	EXFORGE HCT 10-160-12.5 MG TAB	PDL-NP PA
	EXFORGE HCT 10-160-25 MG TAB	PDL-NP PA
	EXFORGE HCT 10-320-25 MG TAB	PDL-NP PA
	EXFORGE HCT 5-160-12.5 MG TAB	PDL-NP PA
	EXFORGE HCT 5-160-25 MG TAB	PDL-NP PA
	OLMSRTN-AMLDPN-HCTZ 20-5-12.5	PDL-NP PA
	OLMSRTN-AMLDPN-HCTZ 40-10-12.5	PDL-NP PA
	OLMSRTN-AMLDPN-HCTZ 40-10-25MG	PDL-NP PA
	OLMSRTN-AMLDPN-HCTZ 40-5-12.5	PDL-NP PA
	OLMSRTN-AMLDPN-HCTZ 40-5-25 MG	PDL-NP PA
	TRIBENZOR 20-5-12.5 MG TABLET	PDL-NP PA
	TRIBENZOR 40-10-12.5 MG TABLET	PDL-NP PA
	TRIBENZOR 40-10-25 MG TABLET	PDL-NP PA
	TRIBENZOR 40-5-12.5 MG TABLET	PDL-NP PA
TRIBENZOR 40-5-25 MG TABLET	PDL-NP PA	
Angiotensin II Receptor Blocker (ARB)-Diuretic Combinations	ATACAND HCT 16-12.5 MG TAB	PDL-NP PA
	ATACAND HCT 32-12.5 MG TAB	PDL-NP PA
	ATACAND HCT 32-25 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Angiotensin II Receptor Blocker (ARB)-Diuretic Combinations	AVALIDE 150-12.5 MG TABLET	PDL-NP PA
	AVALIDE 300-12.5 MG TABLET	PDL-NP PA
	BENICAR HCT 20-12.5 MG TABLET	PDL-NP PA
	BENICAR HCT 40-12.5 MG TABLET	PDL-NP PA
	BENICAR HCT 40-25 MG TABLET	PDL-NP PA
	CANDESARTAN-HCTZ 16-12.5 MG TB	PDL-NP PA
	CANDESARTAN-HCTZ 32-12.5 MG TB	PDL-NP PA
	CANDESARTAN-HCTZ 32-25 MG TAB	PDL-NP PA
	DIOVAN HCT 160-12.5 MG TAB	PDL-NP PA
	DIOVAN HCT 160-25 MG TABLET	PDL-NP PA
	DIOVAN HCT 320-12.5 MG TAB	PDL-NP PA
	DIOVAN HCT 320-25 MG TABLET	PDL-NP PA
	DIOVAN HCT 80-12.5 MG TABLET	PDL-NP PA
	EDARBYCLOR 40-12.5 MG TABLET	PDL-NP PA
	EDARBYCLOR 40-25 MG TABLET	PDL-NP PA
	HYZAAR 100-12.5 TABLET	PDL-NP PA
	HYZAAR 100-25 TABLET	PDL-NP PA
	HYZAAR 50-12.5 TABLET	PDL-NP PA
	IRBESARTAN-HCTZ 150-12.5 MG TB	PDL-NP PA
	IRBESARTAN-HCTZ 300-12.5 MG TB	PDL-NP PA
	LOSARTAN-HCTZ 100-12.5 MG TAB	*PDL-P
	LOSARTAN-HCTZ 100-25 MG TAB	*PDL-P
	LOSARTAN-HCTZ 50-12.5 MG TAB	*PDL-P
	MICARDIS HCT 40-12.5 MG TABLET	PDL-NP PA
	MICARDIS HCT 80-12.5 MG TABLET	PDL-NP PA
	MICARDIS HCT 80-25 MG TABLET	PDL-NP PA
	OLMESARTAN-HCTZ 20-12.5 MG TAB	*PDL-P
	OLMESARTAN-HCTZ 40-12.5 MG TAB	*PDL-P
	OLMESARTAN-HCTZ 40-25 MG TAB	*PDL-P
	TELMISARTAN-HCTZ 40-12.5 MG TB	PDL-NP PA
TELMISARTAN-HCTZ 80-12.5 MG TB	PDL-NP PA	
TELMISARTAN-HCTZ 80-25 MG TAB	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Angiotensin II Receptor Blocker (ARB)-Diuretic Combinations	VALSARTAN-HCTZ 160-12.5 MG TAB	*PDL-P
	VALSARTAN-HCTZ 160-25 MG TAB	*PDL-P
	VALSARTAN-HCTZ 320-12.5 MG TAB	*PDL-P
	VALSARTAN-HCTZ 320-25 MG TAB	*PDL-P
	VALSARTAN-HCTZ 80-12.5 MG TAB	*PDL-P
Angiotensin II Receptor Blocker-Nepriylsin Inhibitor Comb. (ARNi)	ENTRESTO 24 MG-26 MG TABLET	PDL-NP PA QL
	ENTRESTO 49 MG-51 MG TABLET	PDL-NP PA QL
	ENTRESTO 97 MG-103 MG TABLET	PDL-NP PA QL
	ENTRESTO SPRINKLE 15-16 MG PLT	PDL-NP PA QL
	ENTRESTO SPRINKLE 6-6MG PELLETT	PDL-NP PA QL
	SACUBITRIL-VALSARTAN 24-26 MG	*PDL-P QL
	SACUBITRIL-VALSARTAN 49-51 MG	*PDL-P QL
	SACUBITRIL-VALSARTAN 97-103 MG	*PDL-P QL
Angiotensin II Receptor Blockers (ARBs)	ATACAND 16 MG TABLET	PDL-NP PA
	ATACAND 32 MG TABLET	PDL-NP PA
	ATACAND 4 MG TABLET	PDL-NP PA
	ATACAND 8 MG TABLET	PDL-NP PA
	AVAPRO 150 MG TABLET	PDL-NP PA
	AVAPRO 300 MG TABLET	PDL-NP PA
	AVAPRO 75 MG TABLET	PDL-NP PA
	BENICAR 20 MG TABLET	PDL-NP PA
	BENICAR 40 MG TABLET	PDL-NP PA
	BENICAR 5 MG TABLET	PDL-NP PA
	CANDESARTAN CILEXETIL 16 MG TB	PDL-NP PA
	CANDESARTAN CILEXETIL 32 MG TB	PDL-NP PA
	CANDESARTAN CILEXETIL 4 MG TAB	PDL-NP PA
	CANDESARTAN CILEXETIL 8 MG TAB	PDL-NP PA
	COZAAR 100 MG TABLET	PDL-NP PA
	COZAAR 25 MG TABLET	PDL-NP PA
	COZAAR 50 MG TABLET	PDL-NP PA
	DIOVAN 160 MG TABLET	PDL-NP PA
	DIOVAN 320 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Angiotensin II Receptor Blockers (ARBs)	DIOVAN 40 MG TABLET	PDL-NP PA
	DIOVAN 80 MG TABLET	PDL-NP PA
	EDARBI 40 MG TABLET	PDL-NP PA
	EDARBI 80 MG TABLET	PDL-NP PA
	EPROSARTAN MESYLATE 600 MG TAB	PDL-NP PA
	IRBESARTAN 150 MG TABLET	PDL-NP PA
	IRBESARTAN 300 MG TABLET	PDL-NP PA
	IRBESARTAN 75 MG TABLET	PDL-NP PA
	LOSARTAN POTASSIUM 100 MG TAB	*PDL-P
	LOSARTAN POTASSIUM 25 MG TAB	*PDL-P
	LOSARTAN POTASSIUM 50 MG TAB	*PDL-P
	MICARDIS 20 MG TABLET	PDL-NP PA
	MICARDIS 40 MG TABLET	PDL-NP PA
	MICARDIS 80 MG TABLET	PDL-NP PA
	OLMESARTAN MEDOXOMIL 20 MG TAB	*PDL-P
	OLMESARTAN MEDOXOMIL 40 MG TAB	*PDL-P
	OLMESARTAN MEDOXOMIL 5 MG TAB	*PDL-P
	TELMISARTAN 20 MG TABLET	PDL-NP PA
	TELMISARTAN 40 MG TABLET	PDL-NP PA
	TELMISARTAN 80 MG TABLET	PDL-NP PA
	VALSARTAN 160 MG TABLET	*PDL-P
	VALSARTAN 320 MG TABLET	*PDL-P
VALSARTAN 4 MG/ML SOLUTION	PDL-NP PA	
VALSARTAN 40 MG TABLET	*PDL-P	
VALSARTAN 80 MG TABLET	*PDL-P	
Anorectal - Glucocorticoids	HYDROCORTISONE 2.5% CREAM	
Anorexiant Combinations	PHENTERMINE-TOPIR ER 11.25-69	*PDL-P AGE PA
	PHENTERMINE-TOPIR ER 15-92 MG	*PDL-P AGE PA
	PHENTERMINE-TOPIR ER 3.75-23MG	*PDL-P AGE PA
	PHENTERMINE-TOPIR ER 7.5-46 MG	*PDL-P AGE PA
Anorexiants	ADIPEX-P 37.5 MG CAPSULE	*PDL-P AGE PA
	ADIPEX-P 37.5 MG TABLET	*PDL-P AGE PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anorexiant	BENZPHETAMINE HCL 50 MG TABLET	*PDL-P AGE PA
	DIETHYLPROPION 25 MG TABLET	*PDL-P AGE PA
	DIETHYLPROPION ER 75 MG TABLET	*PDL-P AGE PA
	LOMAIRA 8 MG TABLET	*PDL-P AGE PA
	PHENDIMETRAZINE 35 MG TABLET	*PDL-P AGE PA
	PHENDIMETRAZINE ER 105 MG CAP	*PDL-P AGE PA
	PHENTERMINE 15 MG CAPSULE	*PDL-P AGE PA
	PHENTERMINE 30 MG CAPSULE	*PDL-P AGE PA
	PHENTERMINE 37.5 MG CAPSULE	*PDL-P AGE PA
	PHENTERMINE 37.5 MG TABLET	*PDL-P AGE PA
Antacid - Aluminum	ALUMINUM HYDROXIDE GEL *	
Antacid - Antacid Combinations	ACID GONE ANTACID LIQUID *	
	FOAMING ANTACID LIQUID *	
	GAVISCON LIQUID *	
Antacid - Bicarbonate	SODIUM BICARB 325 MG TABLET *	
	SODIUM BICARB 650 MG TABLET *	
Antacid - Calcium	ANTACID 500 MG CHEW TABLET *	
	ANTACID 500 MG CHEWABLE TABLET *	
	ANTACID CALCIUM 500 MG CHW TAB *	
	ANTACID EX-STR 750 MG TAB CHEW *	
	ANTACID ULTRA STR 1,000 MG CHW *	
	ANTACID XTRA STRENGTH CHEW TAB *	
	CALCIUM ANTACID 750 MG TB CHEW *	
	CALCIUM CARB 500 MG TAB CHEW *	
	CAL-GEST 500 MG TABLET CHEW *	
	EQL ANTACID 500 MG CHEW TABLET *	
	GS ANTACID 500 MG CHEW TABLET *	
	PUB ANTACID 500 MG CHEW TABLET *	
	PUB CALCIUM ANTACID 750 MG *	
	QC ANTACID ULTRA 1,000 MG CHEW *	
	TUMS FRESHERS ANTACID CHEW TAB *	
TUMS TABLET CHEWABLE *		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antacid - Simethicone Combinations	ALMACONE-2 LIQUID *	
	MAG-AL PLUS SUSPENS 30 ML CUP *	
	MAG-AL PLUS XS SUSP 30 ML CUP *	
	MINTOX MAXIMUM STRENGTH SUSP *	
	QC ANTACID-ANTIGAS MAX STR LIQ *	
Anthelmintic Agents Other	BENZNIDAZOLE 100 MG TABLET	PA
	BENZNIDAZOLE 12.5 MG TABLET	PA
	IVERMECTIN 3 MG TABLET	QL
Antianginal - Coronary Vasodilators (Nitrates)	ISOSORBIDE DINITRATE 10 MG TAB	
	ISOSORBIDE DINITRATE 20 MG TAB	
	ISOSORBIDE DINITRATE 30 MG TAB	
	ISOSORBIDE DINITRATE 5 MG TAB	
	ISOSORBIDE MONONIT 10 MG TAB	
	ISOSORBIDE MONONIT 20 MG TAB	
	ISOSORBIDE MONONIT ER 120 MG	QL
	ISOSORBIDE MONONIT ER 30 MG TB	QL
	ISOSORBIDE MONONIT ER 60 MG TB	QL
	NITRO-BID 2% OINTMENT	
	NITROGLYCERIN 0.1 MG/HR PATCH	QL
	NITROGLYCERIN 0.2 MG/HR PATCH	QL
	NITROGLYCERIN 0.3 MG TABLET SL	
	NITROGLYCERIN 0.4 MG TABLET SL	
	NITROGLYCERIN 0.4 MG/HR PATCH	QL
	NITROGLYCERIN 0.6 MG TABLET SL	
	NITROGLYCERIN 0.6 MG/HR PATCH	QL
	NITROGLYCERIN 400 MCG SPRAY	
Antianginal and Anti-ischemic Agents, Non-hemodynamic	ASPRUZYO SPRINKLE ER 1000MG PK	AGE PA QL
	ASPRUZYO SPRINKLE ER 500MG PKT	AGE PA QL
	RANOLAZINE ER 1,000 MG TABLET	PA QL
	RANOLAZINE ER 500 MG TABLET	PA QL
Antianxiety Agent - Antihistamine Type	HYDROXYZINE 10 MG/5 ML SOLN	AGE
	HYDROXYZINE 10 MG/5 ML SYRUP	AGE

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antianxiety Agent - Antihistamine Type	HYDROXYZINE HCL 10 MG TABLET	AGE
	HYDROXYZINE HCL 25 MG TABLET	AGE
	HYDROXYZINE HCL 50 MG TABLET	AGE
	HYDROXYZINE PAM 100 MG CAP	AGE
	HYDROXYZINE PAM 25 MG CAP	AGE
	HYDROXYZINE PAM 50 MG CAP	AGE
Antianxiety Agent - Benzodiazepines	ALPRAZOLAM 0.25 MG TABLET #	
	ALPRAZOLAM 0.5 MG TABLET #	
	ALPRAZOLAM 1 MG TABLET #	
	ALPRAZOLAM 2 MG TABLET #	
	ALPRAZOLAM ER 0.5 MG TABLET #	
	ALPRAZOLAM ER 1 MG TABLET #	
	ALPRAZOLAM ER 2 MG TABLET #	
	ALPRAZOLAM ER 3 MG TABLET #	
	ALPRAZOLAM INTENSOL 1 MG/ML #	
	ALPRAZOLAM ODT 0.25 MG TAB #	
	ALPRAZOLAM ODT 0.5 MG TAB #	
	ALPRAZOLAM ODT 1 MG TAB #	
	ALPRAZOLAM ODT 2 MG TAB #	
	ALPRAZOLAM XR 0.5 MG TABLET #	
	ALPRAZOLAM XR 1 MG TABLET #	
	ALPRAZOLAM XR 2 MG TABLET #	
	ALPRAZOLAM XR 3 MG TABLET #	
	ATIVAN 0.5 MG TABLET #	
	ATIVAN 1 MG TABLET #	
	ATIVAN 2 MG TABLET #	
	CHLORDIAZEPOXIDE 10 MG CAPSULE #	
	CHLORDIAZEPOXIDE 25 MG CAPSULE #	
	CHLORDIAZEPOXIDE 5 MG CAPSULE #	
CLORAZEPATE 15 MG TABLET #		
CLORAZEPATE 3.75 MG TABLET #		
CLORAZEPATE 7.5 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antianxiety Agent - Benzodiazepines	DIAZEPAM 10 MG TABLET #	
	DIAZEPAM 2 MG TABLET #	
	DIAZEPAM 5 MG TABLET #	
	DIAZEPAM 5 MG/5 ML ORAL SOLN #	
	DIAZEPAM 5 MG/5 ML SOLUTION #	
	DIAZEPAM 5 MG/ML ORAL CONC #	
	LORAZEPAM 0.5 MG TABLET #	
	LORAZEPAM 1 MG TABLET #	
	LORAZEPAM 2 MG TABLET #	
	LORAZEPAM 2 MG/ML ORAL CONCENT #	
	LORAZEPAM INTENSOL 2 MG/ML #	
	OXAZEPAM 10 MG CAPSULE #	
	OXAZEPAM 15 MG CAPSULE #	
	OXAZEPAM 30 MG CAPSULE #	
	XANAX 0.25 MG TABLET #	
	XANAX 0.5 MG TABLET #	
	XANAX 1 MG TABLET #	
	XANAX 2 MG TABLET #	
	XANAX XR 0.5 MG TABLET #	
	XANAX XR 1 MG TABLET #	
XANAX XR 2 MG TABLET #		
XANAX XR 3 MG TABLET #		
Antianxiety Agent - Dicarbamate Type	MEPROBAMATE 200 MG TABLET #	
	MEPROBAMATE 400 MG TABLET #	
Antianxiety Agent - Non-Benzodiazepine	BUSPIRONE HCL 10 MG TABLET #	
	BUSPIRONE HCL 15 MG TABLET #	
	BUSPIRONE HCL 30 MG TABLET #	
	BUSPIRONE HCL 5 MG TABLET #	
	BUSPIRONE HCL 7.5 MG TABLET #	
Antiarrhythmic - Class Ia	DISOPYRAMIDE 100 MG CAPSULE	AGE
	DISOPYRAMIDE 150 MG CAPSULE	AGE
	QUINIDINE SULFATE 200 MG TAB	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antiarrhythmic - Class Ia	QUINIDINE SULFATE 300 MG TAB	
Antiarrhythmic - Class Ib	MEXILETINE 150 MG CAPSULE	
	MEXILETINE 200 MG CAPSULE	
	MEXILETINE 250 MG CAPSULE	
Antiarrhythmic - Class Ic	FLECAINIDE ACETATE 100 MG TAB	
	FLECAINIDE ACETATE 150 MG TAB	
	FLECAINIDE ACETATE 50 MG TAB	
	PROPAFENONE HCL 150 MG TABLET	
	PROPAFENONE HCL 225 MG TAB	
	PROPAFENONE HCL 300 MG TAB	
Antiarrhythmic - Class II	BETAPACE 120 MG TABLET	PDL-NP PA
	BETAPACE 160 MG TABLET	PDL-NP PA
	BETAPACE 80 MG TABLET	PDL-NP PA
	BETAPACE AF 120 MG TABLET	PDL-NP PA
	BETAPACE AF 160 MG TABLET	PDL-NP PA
	BETAPACE AF 80 MG TABLET	PDL-NP PA
	SOTALOL 120 MG TABLET	*PDL-P
	SOTALOL 160 MG TABLET	*PDL-P
	SOTALOL 240 MG TABLET	*PDL-P
	SOTALOL 80 MG TABLET	*PDL-P
	SOTALOL AF 120 MG TABLET	*PDL-P
	SOTALOL AF 160 MG TABLET	*PDL-P
	SOTALOL AF 80 MG TABLET	*PDL-P
	SOTYLIZE 5 MG/ML ORAL SOLUTION	PDL-NP PA
Antiarrhythmic - Class III	AMIODARONE HCL 100 MG TABLET	QL
	AMIODARONE HCL 200 MG TABLET	
	AMIODARONE HCL 400 MG TABLET	
	DOFETILIDE 125 MCG CAPSULE	
	DOFETILIDE 250 MCG CAPSULE	
	DOFETILIDE 500 MCG CAPSULE	
Antibacterial Folate Antagonist - Other Combinations	SULFAMETHOXAZOLE-TMP DS TABLET	
	SULFAMETHOXAZOLE-TMP SS TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antibacterial Folate Antagonist - Other Combinations	SULFAMETHOXAZOLE-TMP SUSP	
	SULFATRIM PEDIATRIC SUSPENSION	
Antibacterial Folate Antagonist Others	TRIMETHOPRIM 100 MG TABLET	
Anticoagulants - Coumarin	JANTOVEN 1 MG TABLET	*PDL-P
	JANTOVEN 10 MG TABLET	*PDL-P
	JANTOVEN 2 MG TABLET	*PDL-P
	JANTOVEN 2.5 MG TABLET	*PDL-P
	JANTOVEN 3 MG TABLET	*PDL-P
	JANTOVEN 4 MG TABLET	*PDL-P
	JANTOVEN 5 MG TABLET	*PDL-P
	JANTOVEN 6 MG TABLET	*PDL-P
	JANTOVEN 7.5 MG TABLET	*PDL-P
	WARFARIN SODIUM 1 MG TABLET	*PDL-P
	WARFARIN SODIUM 10 MG TABLET	*PDL-P
	WARFARIN SODIUM 2 MG TABLET	*PDL-P
	WARFARIN SODIUM 2.5 MG TABLET	*PDL-P
	WARFARIN SODIUM 3 MG TABLET	*PDL-P
	WARFARIN SODIUM 4 MG TABLET	*PDL-P
	WARFARIN SODIUM 5 MG TABLET	*PDL-P
	WARFARIN SODIUM 6 MG TABLET	*PDL-P
WARFARIN SODIUM 7.5 MG TABLET	*PDL-P	
Anticonvulsant - AMPA-Type Glutamate Receptor Antagonists	FYCOMPA 0.5 MG/ML ORAL SUSP #	
	FYCOMPA 10 MG TABLET #	
	FYCOMPA 12 MG TABLET #	
	FYCOMPA 2 MG TABLET #	
	FYCOMPA 4 MG TABLET #	
	FYCOMPA 6 MG TABLET #	
	FYCOMPA 8 MG TABLET #	
	PERAMPANEL 10 MG TABLET #	
	PERAMPANEL 12 MG TABLET #	
	PERAMPANEL 2 MG TABLET #	
PERAMPANEL 4 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - AMPA-Type Glutamate Receptor Antagonists	PERAMPANEL 6 MG TABLET #	
	PERAMPANEL 8 MG TABLET #	
Anticonvulsant - Barbiturates and Derivatives	MYSOLINE 250 MG TABLET #	
	MYSOLINE 50 MG TABLET #	
	PHENOBARBITAL 100 MG TABLET #	
	PHENOBARBITAL 15 MG TABLET #	
	PHENOBARBITAL 16.2 MG TABLET #	
	PHENOBARBITAL 20 MG/5 ML ELIX #	
	PHENOBARBITAL 20 MG/5 ML SOLN #	
	PHENOBARBITAL 30 MG TABLET #	
	PHENOBARBITAL 32.4 MG TABLET #	
	PHENOBARBITAL 60 MG TABLET #	
	PHENOBARBITAL 64.8 MG TABLET #	
	PHENOBARBITAL 97.2 MG TABLET #	
	PRIMIDONE 250 MG TABLET #	
	PRIMIDONE 50 MG TABLET #	
Anticonvulsant - Benzodiazepines	CLOBAZAM 10 MG TABLET #	
	CLOBAZAM 2.5 MG/ML SUSPENSION #	
	CLOBAZAM 20 MG TABLET #	
	CLONAZEPAM 0.125 MG DIS TAB #	
	CLONAZEPAM 0.125 MG ODT #	
	CLONAZEPAM 0.25 MG ODT #	
	CLONAZEPAM 0.5 MG DIS TABLET #	
	CLONAZEPAM 0.5 MG ODT #	
	CLONAZEPAM 0.5 MG TABLET #	
	CLONAZEPAM 1 MG DIS TABLET #	
	CLONAZEPAM 1 MG ODT #	
	CLONAZEPAM 1 MG TABLET #	
	CLONAZEPAM 2 MG ODT #	
	CLONAZEPAM 2 MG TABLET #	
	DIAZEPAM 10 MG RECTAL GEL SYST #	
DIAZEPAM 20 MG RECTAL GEL SYST #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - Benzodiazepines	KLONOPIN 0.5 MG TABLET #	
	KLONOPIN 1 MG TABLET #	
	KLONOPIN 2 MG TABLET #	
	NAYZILAM 5 MG NASAL SPRAY #	
	ONFI 10 MG TABLET #	
	ONFI 2.5 MG/ML SUSPENSION #	
	ONFI 20 MG TABLET #	
	SYMPAZAN 10 MG FILM #	
	SYMPAZAN 20 MG FILM #	
	SYMPAZAN 5 MG FILM #	
	VALTOCO 10 MG NASAL SPRAY #	
	VALTOCO 15 MG NASAL SPRAY #	
	VALTOCO 20 MG NASAL SPRAY #	
	VALTOCO 5 MG NASAL SPRAY #	
Anticonvulsant - Cannabinoid Type	EPIDIOLEX 100 MG/ML SOLUTION #	
Anticonvulsant - Carbamates	FELBAMATE 400 MG TABLET #	
	FELBAMATE 600 MG TABLET #	
	FELBAMATE 600 MG/5 ML SUSP #	
	FELBATOL 400 MG TABLET #	
	FELBATOL 600 MG TABLET #	
	FELBATOL 600 MG/5 ML SUSP #	
Anticonvulsant - Carboxylic Acid Derivatives	DEPACON 500 MG VIAL #	
	DEPAKOTE DR 125 MG SPRINKLE CP #	
	DEPAKOTE DR 125 MG TABLET #	
	DEPAKOTE DR 250 MG TABLET #	
	DEPAKOTE DR 500 MG TABLET #	
	DEPAKOTE ER 250 MG TABLET #	
	DEPAKOTE ER 500 MG TABLET #	
	DIVALPROEX DR 125 MG CAP SPRNK #	
	DIVALPROEX SOD DR 125 MG TAB #	
	DIVALPROEX SOD DR 250 MG TAB #	
DIVALPROEX SOD DR 500 MG TAB #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - Carboxylic Acid Derivatives	DIVALPROEX SOD ER 250 MG TAB #	
	DIVALPROEX SOD ER 500 MG TAB #	
	VALPROATE SOD 500 MG/5 ML VL #	
	VALPROIC ACID 250 MG CAPSULE #	
	VALPROIC ACID 250 MG/5 ML SOLN #	
	VALPROIC ACID 250 MG/5 ML SOLN #	
	VALPROIC ACID 500 MG/10 ML SOL #	
Anticonvulsant - Functionalized Amino Acid	VIMPAT 10 MG/ML SOLUTION #	
	VIMPAT 100 MG TABLET #	
	VIMPAT 150 MG TABLET #	
	VIMPAT 200 MG TABLET #	
	VIMPAT 200 MG/20 ML VIAL #	
	VIMPAT 50 MG TABLET #	
	VIMPAT STARTER KIT #	
Anticonvulsant - GABA Analogs	GABAPENTIN 100 MG CAPSULE #	
	GABAPENTIN 250 MG/5 ML SOLN #	
	GABAPENTIN 250 MG/5 ML SOLN #	
	GABAPENTIN 300 MG CAPSULE #	
	GABAPENTIN 300 MG/6 ML SOLN #	
	GABAPENTIN 400 MG CAPSULE #	
	GABAPENTIN 600 MG TABLET #	
	GABAPENTIN 800 MG TABLET #	
	LYRICA 100 MG CAPSULE #	
	LYRICA 150 MG CAPSULE #	
	LYRICA 20 MG/ML ORAL SOLUTION #	
	LYRICA 200 MG CAPSULE #	
	LYRICA 225 MG CAPSULE #	
	LYRICA 25 MG CAPSULE #	
	LYRICA 300 MG CAPSULE #	
	LYRICA 50 MG CAPSULE #	
	LYRICA 75 MG CAPSULE #	
NEURONTIN 100 MG CAPSULE #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - GABA Analogs	NEURONTIN 250 MG/5 ML SOLN #	
	NEURONTIN 250 MG/5 ML SOLUTION #	
	NEURONTIN 300 MG CAPSULE #	
	NEURONTIN 400 MG CAPSULE #	
	NEURONTIN 600 MG TABLET #	
	NEURONTIN 800 MG TABLET #	
	PREGABALIN 100 MG CAPSULE #	
	PREGABALIN 150 MG CAPSULE #	
	PREGABALIN 20 MG/ML SOLUTION #	
	PREGABALIN 200 MG CAPSULE #	
	PREGABALIN 225 MG CAPSULE #	
	PREGABALIN 25 MG CAPSULE #	
	PREGABALIN 300 MG CAPSULE #	
	PREGABALIN 50 MG CAPSULE #	
	PREGABALIN 75 MG CAPSULE #	
Anticonvulsant - GABA Re-uptake Inhibitor, Nipecotic Acid Derivatives	GABITRIL 12 MG TABLET #	
	GABITRIL 16 MG TABLET #	
	GABITRIL 2 MG TABLET #	
	GABITRIL 4 MG TABLET #	
	TIAGABINE HCL 12 MG TABLET #	
	TIAGABINE HCL 16 MG TABLET #	
	TIAGABINE HCL 2 MG TABLET #	
	TIAGABINE HCL 4 MG TABLET #	
Anticonvulsant - GABA Transaminase (GABA-T) Inhibitor	SABRIL 500 MG POWDER PACKET #	
	SABRIL 500 MG TABLET #	
	VIGABATRIN 500 MG POWDER PACKET #	
	VIGABATRIN 500 MG TABLET #	
	VIGADRONE 500 MG POWDER PACKET #	
Anticonvulsant - Hydantoins	CEREBYX 100 MG PE/2 ML VIAL #	
	CEREBYX 500 MG PE/10 ML VIAL #	
	DILANTIN 100 MG CAPSULE #	
	DILANTIN 125 MG/5 ML SUSP #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - Hydantoins	DILANTIN 30 MG CAPSULE #	
	DILANTIN 50 MG INFATAB #	
	FOSPHENYTOIN 100 MG PE/2 ML VL #	
	FOSPHENYTOIN 500 MG PE/10 ML #	
	PEGANONE 250 MG TABLET #	
	PHENYTEK 200 MG CAPSULE #	
	PHENYTEK 300 MG CAPSULE #	
	PHENYTOIN 100 MG/2 ML VIAL #	
	PHENYTOIN 100 MG/4 ML SUSP #	
	PHENYTOIN 125 MG/5 ML SUSP #	
	PHENYTOIN 250 MG/5 ML VIAL #	
	PHENYTOIN 50 MG INFATAB #	
	PHENYTOIN 50 MG TABLET CHEW #	
	PHENYTOIN 50 MG/ML AMPUL #	
	PHENYTOIN 50 MG/ML SYRINGE #	
	PHENYTOIN 50 MG/ML VIAL #	
	PHENYTOIN SOD EXT 100 MG CAP #	
	PHENYTOIN SOD EXT 200 MG CAP #	
	PHENYTOIN SOD EXT 300 MG CAP #	
	Anticonvulsant - Iminostilbene Derivatives	APTiom 200 MG TABLET #
APTiom 400 MG TABLET #		
APTiom 600 MG TABLET #		
APTiom 800 MG TABLET #		
CARBAMAZEPINE 100 MG TAB CHEW #		
CARBAMAZEPINE 100 MG/5 ML SUSP #		
CARBAMAZEPINE 100 MG/5 ML SUSP #		
CARBAMAZEPINE 200 MG TABLET #		
CARBAMAZEPINE 200 MG/10 ML LIQ #		
CARBAMAZEPINE 200 MG/10ML SUSP #		
CARBAMAZEPINE ER 100 MG CAP #		
CARBAMAZEPINE ER 100 MG TABLET #		
CARBAMAZEPINE ER 200 MG CAP #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - Iminostilbene Derivatives	CARBAMAZEPINE ER 200 MG TABLET #	
	CARBAMAZEPINE ER 300 MG CAP #	
	CARBAMAZEPINE ER 400 MG TABLET #	
	CARBATROL ER 100 MG CAPSULE #	
	CARBATROL ER 200 MG CAPSULE #	
	CARBATROL ER 300 MG CAPSULE #	
	EPITOL 200 MG TABLET #	
	OXCARBAZEPINE 150 MG TABLET #	
	OXCARBAZEPINE 300 MG TABLET #	
	OXCARBAZEPINE 300 MG/5 ML SUSP #	
	OXCARBAZEPINE 600 MG TABLET #	
	OXTELLAR XR 150 MG TABLET #	
	OXTELLAR XR 300 MG TABLET #	
	OXTELLAR XR 600 MG TABLET #	
	TEGRETOL 100 MG/5 ML SUSP #	
	TEGRETOL 200 MG TABLET #	
	TEGRETOL XR 100 MG TABLET #	
	TEGRETOL XR 200 MG TABLET #	
	TEGRETOL XR 400 MG TABLET #	
	TRILEPTAL 150 MG TABLET #	
TRILEPTAL 300 MG TABLET #		
TRILEPTAL 300 MG/5 ML SUSP #		
TRILEPTAL 600 MG TABLET #		
Anticonvulsant - Monosaccharide Derivatives	QUDEXY XR 100 MG CAPSULE #	
	QUDEXY XR 150 MG CAPSULE #	
	QUDEXY XR 200 MG CAPSULE #	
	QUDEXY XR 25 MG CAPSULE #	
	QUDEXY XR 50 MG CAPSULE #	
	TOPAMAX 100 MG TABLET #	
	TOPAMAX 15 MG SPRINKLE CAP #	
	TOPAMAX 200 MG TABLET #	
TOPAMAX 25 MG SPRINKLE CAP #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - Monosaccharide Derivatives	TOPAMAX 25 MG TABLET #	
	TOPAMAX 50 MG TABLET #	
	TOPIRAMATE 100 MG TABLET #	
	TOPIRAMATE 15 MG SPRINKLE CAP #	
	TOPIRAMATE 200 MG TABLET #	
	TOPIRAMATE 25 MG SPRINKLE CAP #	
	TOPIRAMATE 25 MG TABLET #	
	TOPIRAMATE 50 MG TABLET #	
	TOPIRAMATE ER 100 MG CAPSULE #	
	TOPIRAMATE ER 150 MG CAPSULE #	
	TOPIRAMATE ER 200 MG CAPSULE #	
	TOPIRAMATE ER 25 MG CAPSULE #	
	TOPIRAMATE ER 50 MG CAPSULE #	
	TROKENDI XR 100 MG CAPSULE #	
	TROKENDI XR 200 MG CAPSULE #	
	TROKENDI XR 25 MG CAPSULE #	
	TROKENDI XR 50 MG CAPSULE #	
Anticonvulsant - Phenyltriazine Derivatives	LAMICTAL 100 MG TABLET #	
	LAMICTAL 150 MG TABLET #	
	LAMICTAL 200 MG TABLET #	
	LAMICTAL 25 MG DISPER TABLET #	
	LAMICTAL 25 MG TABLET #	
	LAMICTAL 5 MG DISPER TABLET #	
	LAMICTAL ODT 100 MG TABLET #	
	LAMICTAL ODT 200 MG TABLET #	
	LAMICTAL ODT 25 MG TABLET #	
	LAMICTAL ODT 50 MG TABLET #	
	LAMICTAL ODT START KIT (BLUE) #	
	LAMICTAL ODT START KIT (GREEN) #	
	LAMICTAL ODT START KT (ORANGE) #	
	LAMICTAL TAB START KIT (BLUE) #	
LAMICTAL TAB START KIT (GREEN) #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - Phenyltriazine Derivatives	LAMICTAL TB START KIT (ORANGE) #	
	LAMICTAL XR 100 MG TABLET #	
	LAMICTAL XR 200 MG TABLET #	
	LAMICTAL XR 25 MG TABLET #	
	LAMICTAL XR 250 MG TABLET #	
	LAMICTAL XR 300 MG TABLET #	
	LAMICTAL XR 50 MG TABLET #	
	LAMICTAL XR START KIT (BLUE) #	
	LAMICTAL XR START KIT (GREEN) #	
	LAMICTAL XR START KIT (ORANGE) #	
	LAMOTRIGINE 100 MG TABLET #	
	LAMOTRIGINE 150 MG TABLET #	
	LAMOTRIGINE 200 MG TABLET #	
	LAMOTRIGINE 25 MG DISPER TAB #	
	LAMOTRIGINE 25 MG TABLET #	
	LAMOTRIGINE 5 MG DISPER TABLET #	
	LAMOTRIGINE ER 100 MG TABLET #	
	LAMOTRIGINE ER 200 MG TABLET #	
	LAMOTRIGINE ER 25 MG TABLET #	
	LAMOTRIGINE ER 250 MG TABLET #	
	LAMOTRIGINE ER 300 MG TABLET #	
	LAMOTRIGINE ER 50 MG TABLET #	
	LAMOTRIGINE ODT 100 MG TABLET #	
	LAMOTRIGINE ODT 200 MG TABLET #	
	LAMOTRIGINE ODT 25 MG TABLET #	
	LAMOTRIGINE ODT 50 MG TABLET #	
	LAMOTRIGINE ODT KIT (BLUE) #	
	LAMOTRIGINE ODT KIT (GREEN) #	
	LAMOTRIGINE ODT KIT (ORANGE) #	
	LAMOTRIGINE TAB START KIT-BLUE #	
LAMOTRIGINE TAB START KT-GREEN #		
LAMOTRIGINE TAB START KT-ORANG #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - Phenyltriazine Derivatives	SUBVENITE 100 MG TABLET #	
	SUBVENITE 150 MG TABLET #	
	SUBVENITE 200 MG TABLET #	
	SUBVENITE 25 MG TABLET #	
	SUBVENITE TAB START KIT (BLUE) #	
	SUBVENITE TAB START KIT(GREEN) #	
	SUBVENITE TAB START KT(ORANGE) #	
Anticonvulsant - Potassium Channel Opener	POTIGA 200 MG TABLET #	
	POTIGA 300 MG TABLET #	
	POTIGA 400 MG TABLET #	
	POTIGA 50 MG TABLET #	
Anticonvulsant - Pyrrolidine Derivatives	BRIVIACT 10 MG TABLET #	
	BRIVIACT 10 MG/ML ORAL SOLN #	
	BRIVIACT 100 MG TABLET #	
	BRIVIACT 25 MG TABLET #	
	BRIVIACT 50 MG TABLET #	
	BRIVIACT 75 MG TABLET #	
	KEPPRA 1,000 MG TABLET #	
	KEPPRA 100 MG/ML ORAL SOLN #	
	KEPPRA 250 MG TABLET #	
	KEPPRA 500 MG TABLET #	
	KEPPRA 500 MG/5 ML VIAL #	
	KEPPRA 750 MG TABLET #	
	KEPPRA XR 500 MG TABLET #	
	KEPPRA XR 750 MG TABLET #	
	LEVETIRACETAM 1,000 MG TABLET #	
	LEVETIRACETAM 100 MG/ML SOLN #	
	LEVETIRACETAM 250 MG TABLET #	
	LEVETIRACETAM 500 MG TABLET #	
LEVETIRACETAM 500 MG/5 ML SOLN #		
LEVETIRACETAM 500 MG/5 ML VIAL #		
LEVETIRACETAM 750 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anticonvulsant - Pyrrolidine Derivatives	LEVETIRACETAM ER 500 MG TABLET #	
	LEVETIRACETAM ER 750 MG TABLET #	
	LEVETIRACETAM-NAACL 1,000MG/100 #	
	LEVETIRACETAM-NAACL 1,500MG/100 #	
	LEVETIRACETAM-NAACL 500 MG/100 #	
	ROWEEPRA 1,000 MG TABLET #	
	ROWEEPRA 500 MG TABLET #	
	ROWEEPRA 750 MG TABLET #	
	SPRITAM 1,000 MG TABLET #	
	SPRITAM 250 MG TABLET #	
	SPRITAM 500 MG TABLET #	
	SPRITAM 750 MG TABLET #	
Anticonvulsant - Succinimides	CELONTIN 300 MG KAPSEAL #	
	ETHOSUXIMIDE 250 MG CAPSULE #	
	ETHOSUXIMIDE 250 MG/5 ML SOLN #	
	ZARONTIN 250 MG CAPSULE #	
	ZARONTIN 250 MG/5 ML SOLUTION #	
Anticonvulsant - Sulfonamide Derivatives	ZONISAMIDE 100 MG CAPSULE #	
	ZONISAMIDE 25 MG CAPSULE #	
	ZONISAMIDE 50 MG CAPSULE #	
Anticonvulsant - Triazole Derivatives	BANZEL 200 MG TABLET #	
	BANZEL 40 MG/ML SUSPENSION #	
	BANZEL 400 MG TABLET #	
	RUFINAMIDE 40 MG/ML SUSPENSION #	
Anticonvulsant Others	DIACOMIT 250 MG CAPSULE #	
	DIACOMIT 250 MG POWDER PACKET #	
	DIACOMIT 500 MG CAPSULE #	
	DIACOMIT 500 MG POWDER PACKET #	
	FINTEPLA 2.2 MG/ML SOLUTION #	
Antidepressant - Alpha-2 Receptor Antagonists (NaSSA)	MIRTAZAPINE 15 MG ODT #	
	MIRTAZAPINE 15 MG TABLET #	
	MIRTAZAPINE 30 MG ODT #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidepressant - Alpha-2 Receptor Antagonists (NaSSA)	MIRTAZAPINE 30 MG TABLET #	
	MIRTAZAPINE 45 MG ODT #	
	MIRTAZAPINE 45 MG TABLET #	
	MIRTAZAPINE 7.5 MG TABLET #	
	REMERON 15 MG SOLTAB #	
	REMERON 15 MG TABLET #	
	REMERON 30 MG SOLTAB #	
	REMERON 30 MG TABLET #	
	REMERON 45 MG SOLTAB #	
	REMERON 45 MG TABLET #	
Antidepressant - GABA Receptor Modulator - Neuroactive Steroid	ZURZUVAE 20 MG CAPSULE #	
	ZURZUVAE 25 MG CAPSULE #	
	ZURZUVAE 30 MG CAPSULE #	
Antidepressant - MAO Inhibitor Nonselective & Irreversible -Types A,B	EMSAM 12 MG/24 HOURS PATCH #	
	EMSAM 6 MG/24 HOURS PATCH #	
	EMSAM 9 MG/24 HOURS PATCH #	
	MARPLAN 10 MG TABLET #	
	NARDIL 15 MG TABLET #	
	PARNATE 10 MG TABLET #	
	PHENELZINE SULFATE 15 MG TAB #	
	TRANLYCYPROMINE SULF 10 MG TAB #	
Antidepressant - N-methyl D-aspartate (NMDA) receptor antagonist	SPRAVATO 56 MG DOSE PACK #	
	SPRAVATO 56 MG DOSE PACK #	
	SPRAVATO 84 MG DOSE PACK #	
Antidepressant - Norepinephrine & Dopamine Reuptake Inhibitors (NDRIs)	APLENZIN ER 174 MG TABLET #	
	APLENZIN ER 348 MG TABLET #	
	APLENZIN ER 522 MG TABLET #	
	BUPROPION HCL 100 MG TABLET #	
	BUPROPION HCL 75 MG TABLET #	
	BUPROPION HCL SR 100 MG TABLET #	
	BUPROPION HCL SR 150 MG TABLET #	
BUPROPION HCL SR 200 MG TAB #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidepressant - Norepinephrine & Dopamine Reuptake Inhibitors (NDRIs)	BUPROPION HCL XL 150 MG TABLET #	
	BUPROPION HCL XL 300 MG TABLET #	
	FORFIVO XL 450 MG TABLET #	
	WELLBUTRIN 100 MG TABLET #	
	WELLBUTRIN 75 MG TABLET #	
	WELLBUTRIN SR 100 MG TABLET #	
	WELLBUTRIN SR 150 MG TABLET #	
	WELLBUTRIN SR 200 MG TABLET #	
	WELLBUTRIN XL 150 MG TABLET #	
	WELLBUTRIN XL 300 MG TABLET #	
Antidepressant - Selective Serotonin Reuptake Inhibitors (SSRIs)	CELEXA 10 MG TABLET #	
	CELEXA 20 MG TABLET #	
	CELEXA 40 MG TABLET #	
	CITALOPRAM HBR 10 MG TABLET #	
	CITALOPRAM HBR 10 MG/5 ML SOLN #	
	CITALOPRAM HBR 20 MG TABLET #	
	CITALOPRAM HBR 40 MG TABLET #	
	ESCITALOPRAM 10 MG TABLET #	
	ESCITALOPRAM 20 MG TABLET #	
	ESCITALOPRAM 5 MG TABLET #	
	ESCITALOPRAM OXALATE 5 MG/5 ML #	
	FLUOXETINE 20 MG/5 ML SOLUTION #	
	FLUOXETINE DR 90 MG CAPSULE #	
	FLUOXETINE HCL 10 MG CAPSULE #	
	FLUOXETINE HCL 10 MG CAPSULE #	
	FLUOXETINE HCL 10 MG TABLET #	
	FLUOXETINE HCL 20 MG CAPSULE #	
	FLUOXETINE HCL 20 MG CAPSULE #	
	FLUOXETINE HCL 20 MG TABLET #	
	FLUOXETINE HCL 40 MG CAPSULE #	
FLUOXETINE HCL 60 MG TABLET #		
FLUVOXAMINE ER 100 MG CAPSULE #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidepressant - Selective Serotonin Reuptake Inhibitors (SSRIs)	FLUVOXAMINE ER 150 MG CAPSULE #	
	FLUVOXAMINE MALEATE 100 MG TAB #	
	FLUVOXAMINE MALEATE 25 MG TAB #	
	FLUVOXAMINE MALEATE 50 MG TAB #	
	LEXAPRO 10 MG TABLET #	
	LEXAPRO 20 MG TABLET #	
	LEXAPRO 5 MG TABLET #	
	LEXAPRO 5 MG/5 ML SOLUTION #	
	PAROXETINE CR 12.5 MG TABLET #	
	PAROXETINE CR 25 MG TABLET #	
	PAROXETINE CR 37.5 MG TABLET #	
	PAROXETINE ER 37.5 MG TABLET #	
	PAROXETINE HCL 10 MG TABLET #	
	PAROXETINE HCL 20 MG TABLET #	
	PAROXETINE HCL 30 MG TABLET #	
	PAROXETINE HCL 40 MG TABLET #	
	PAXIL 10 MG TABLET #	
	PAXIL 10 MG/5 ML SUSPENSION #	
	PAXIL 20 MG TABLET #	
	PAXIL 30 MG TABLET #	
	PAXIL 40 MG TABLET #	
	PAXIL CR 12.5 MG TABLET #	
	PAXIL CR 25 MG TABLET #	
	PAXIL CR 37.5 MG TABLET #	
	PEXEVA 10 MG TABLET #	
	PEXEVA 20 MG TABLET #	
	PEXEVA 30 MG TABLET #	
	PEXEVA 40 MG TABLET #	
	PROZAC 10 MG PULVULE #	
	PROZAC 20 MG PULVULE #	
	PROZAC 40 MG PULVULE #	
	PROZAC WEEKLY 90 MG CAPSULE #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidepressant - Selective Serotonin Reuptake Inhibitors (SSRIs)	SARAFEM 10 MG TABLET #	
	SARAFEM 20 MG TABLET #	
	SERTRALINE 20 MG/ML ORAL CONC #	
	SERTRALINE HCL 100 MG TABLET #	
	SERTRALINE HCL 25 MG TABLET #	
	SERTRALINE HCL 50 MG TABLET #	
	ZOLOFT 100 MG TABLET #	
	ZOLOFT 20 MG/ML ORAL CONC #	
	ZOLOFT 25 MG TABLET #	
	ZOLOFT 50 MG TABLET #	
Antidepressant - Serotonin-2 Antagonist-Reuptake Inhibitors (SARIs)	NEFAZODONE HCL 100 MG TABLET #	
	NEFAZODONE HCL 150 MG TABLET #	
	NEFAZODONE HCL 200 MG TABLET #	
	NEFAZODONE HCL 250 MG TABLET #	
	NEFAZODONE HCL 50 MG TABLET #	
	OLEPTRO ER 150 MG TABLET #	
	OLEPTRO ER 300 MG TABLET #	
	TRAZODONE 100 MG TABLET #	
	TRAZODONE 150 MG TABLET #	
	TRAZODONE 300 MG TABLET #	
TRAZODONE 50 MG TABLET #		
Antidepressant - Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	CYMBALTA 20 MG CAPSULE #	
	CYMBALTA 30 MG CAPSULE #	
	CYMBALTA 60 MG CAPSULE #	
	DESVENLAFAXINE ER 100 MG TAB #	
	DESVENLAFAXINE ER 50 MG TAB #	
	DESVENLAFAXINE FUM ER 100 MG #	
	DESVENLAFAXINE FUM ER 50 MG #	
	DRIZALMA SPRINKLE DR 20 MG CAP #	
	DRIZALMA SPRINKLE DR 30 MG CAP #	
	DRIZALMA SPRINKLE DR 40 MG CAP #	
DRIZALMA SPRINKLE DR 60 MG CAP #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidepressant - Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	DULOXETINE HCL DR 20 MG CAP #	
	DULOXETINE HCL DR 30 MG CAP #	
	DULOXETINE HCL DR 40 MG CAP #	
	DULOXETINE HCL DR 60 MG CAP #	
	EFFEXOR XR 150 MG CAPSULE #	
	EFFEXOR XR 37.5 MG CAPSULE #	
	EFFEXOR XR 75 MG CAPSULE #	
	FETZIMA 20-40 MG TITRATION PAK #	
	FETZIMA ER 120 MG CAPSULE #	
	FETZIMA ER 20 MG CAPSULE #	
	FETZIMA ER 40 MG CAPSULE #	
	FETZIMA ER 80 MG CAPSULE #	
	PRISTIQ ER 100 MG TABLET #	
	PRISTIQ ER 25 MG TABLET #	
	PRISTIQ ER 50 MG TABLET #	
	VENLAFAXINE HCL 100 MG TABLET #	
	VENLAFAXINE HCL 25 MG TABLET #	
	VENLAFAXINE HCL 37.5 MG TABLET #	
	VENLAFAXINE HCL 50 MG TABLET #	
	VENLAFAXINE HCL 75 MG TABLET #	
	VENLAFAXINE HCL ER 150 MG CAP #	
	VENLAFAXINE HCL ER 150 MG TAB #	
	VENLAFAXINE HCL ER 225 MG TAB #	
	VENLAFAXINE HCL ER 37.5 MG CAP #	
VENLAFAXINE HCL ER 37.5 MG TAB #		
VENLAFAXINE HCL ER 75 MG CAP #		
VENLAFAXINE HCL ER 75 MG TAB #		
Antidepressant - SSRI & 5HT1A Partial Agonist	VIIBRYD 10 MG TABLET #	
	VIIBRYD 10-20 MG STARTER PACK #	
	VIIBRYD 20 MG TABLET #	
	VIIBRYD 40 MG TABLET #	
Antidepressant - SSRI & Serotonin (5-HT) Receptor Modulator	BRINTELLIX 10 MG TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidepressant - SSRI & Serotonin (5-HT) Receptor Modulator	BRINTELLIX 20 MG TABLET #	
	BRINTELLIX 5 MG TABLET #	
	TRINTELLIX 10 MG TABLET #	
	TRINTELLIX 20 MG TABLET #	
	TRINTELLIX 5 MG TABLET #	
Antidepressant - Tricyclic & Antipsychotic, Phenothiazine Comb	PERPHEN-AMITRIP 2 MG-10 MG TAB #	
	PERPHEN-AMITRIP 2 MG-25 MG TAB #	
	PERPHEN-AMITRIP 4 MG-10 MG TAB #	
	PERPHEN-AMITRIP 4 MG-25 MG TAB #	
	PERPHEN-AMITRIP 4 MG-50 MG TAB #	
Antidepressant - Tricyclic-Benzodiazepine Combinations	CHLORDIAZEPO-AMITRIPTYL 5-12.5 #	
	CHLORDIAZEPOX-AMITRIPTYL 10-25 #	
Antidepressant - Tricyclics & Related (Non-Select Reuptake Inhibitors)	AMITRIPTYLINE HCL 10 MG TAB #	
	AMITRIPTYLINE HCL 100 MG TAB #	
	AMITRIPTYLINE HCL 150 MG TAB #	
	AMITRIPTYLINE HCL 25 MG TAB #	
	AMITRIPTYLINE HCL 50 MG TAB #	
	AMITRIPTYLINE HCL 75 MG TAB #	
	AMOXAPINE 100 MG TABLET #	
	AMOXAPINE 150 MG TABLET #	
	AMOXAPINE 25 MG TABLET #	
	AMOXAPINE 50 MG TABLET #	
	ANAFRANIL 25 MG CAPSULE #	
	ANAFRANIL 50 MG CAPSULE #	
	ANAFRANIL 75 MG CAPSULE #	
	CLOMIPRAMINE 25 MG CAPSULE #	
	CLOMIPRAMINE 50 MG CAPSULE #	
	CLOMIPRAMINE 75 MG CAPSULE #	
	DESIPRAMINE 10 MG TABLET #	
	DESIPRAMINE 100 MG TABLET #	
	DESIPRAMINE 150 MG TABLET #	
DESIPRAMINE 25 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidepressant - Tricyclics & Related (Non-Select Reuptake Inhibitors)	DESIPRAMINE 50 MG TABLET #	
	DESIPRAMINE 75 MG TABLET #	
	DOXEPIN 10 MG CAPSULE #	
	DOXEPIN 10 MG/ML ORAL CONC #	
	DOXEPIN 100 MG CAPSULE #	
	DOXEPIN 150 MG CAPSULE #	
	DOXEPIN 25 MG CAPSULE #	
	DOXEPIN 50 MG CAPSULE #	
	DOXEPIN 75 MG CAPSULE #	
	IMIPRAMINE HCL 10 MG TABLET #	
	IMIPRAMINE HCL 25 MG TABLET #	
	IMIPRAMINE HCL 50 MG TABLET #	
	IMIPRAMINE PAMOATE 100 MG CAP #	
	IMIPRAMINE PAMOATE 125 MG CAP #	
	IMIPRAMINE PAMOATE 150 MG CAP #	
	IMIPRAMINE PAMOATE 75 MG CAP #	
	MAPROTILINE 25 MG TABLET #	
	MAPROTILINE 50 MG TABLET #	
	MAPROTILINE 75 MG TABLET #	
	NORPRAMIN 10 MG TABLET #	
	NORPRAMIN 100 MG TABLET #	
	NORPRAMIN 150 MG TABLET #	
	NORPRAMIN 25 MG TABLET #	
	NORPRAMIN 50 MG TABLET #	
	NORTRIPTYLINE 10 MG/5 ML SOL #	
	NORTRIPTYLINE HCL 10 MG CAP #	
	NORTRIPTYLINE HCL 25 MG CAP #	
	NORTRIPTYLINE HCL 50 MG CAP #	
	NORTRIPTYLINE HCL 75 MG CAP #	
	PAMELOR 10 MG CAPSULE #	
	PAMELOR 25 MG CAPSULE #	
	PAMELOR 50 MG CAPSULE #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidepressant - Tricyclics & Related (Non-Select Reuptake Inhibitors)	PAMELOR 75 MG CAPSULE #	
	PROTRIPTYLINE HCL 10 MG TABLET #	
	PROTRIPTYLINE HCL 5 MG TABLET #	
	SURMONTIL 100 MG CAPSULE #	
	SURMONTIL 25 MG CAPSULE #	
	SURMONTIL 50 MG CAPSULE #	
	TOFRANIL 10 MG TABLET #	
	TOFRANIL 25 MG TABLET #	
	TOFRANIL 50 MG TABLET #	
	TOFRANIL-PM 100 MG CAPSULE #	
	TOFRANIL-PM 125 MG CAPSULE #	
	TOFRANIL-PM 150 MG CAPSULE #	
	TOFRANIL-PM 75 MG CAPSULE #	
Antidepressant-SSRI & Atypical Antipsych,Dopamine&Serotonin Antag Comb	OLANZAPINE-FLUOXETINE 12-25 MG #	
	OLANZAPINE-FLUOXETINE 12-50 MG #	
	OLANZAPINE-FLUOXETINE 3-25 MG #	
	OLANZAPINE-FLUOXETINE 6-25 MG #	
	OLANZAPINE-FLUOXETINE 6-50 MG #	
	SYMBYAX 12-50 MG CAPSULE #	
	SYMBYAX 3-25 MG CAPSULE #	
	SYMBYAX 6-25 MG CAPSULE #	
SYMBYAX 6-50 MG CAPSULE #		
Antidiarrheal - Antiperistaltic Agents	ANTI-DIARRHEAL 1 MG/7.5 ML SOL	*PDL-P
	ANTI-DIARRHEAL 2 MG SOFTGEL	*PDL-P
	ANTI-DIARRHEAL 2 MG TABLET	*PDL-P
	GS ANTI-DIARRHEAL 2 MG CAPLET	*PDL-P
	HM ANTI-DIARRHEAL 2 MG CAPLET	*PDL-P
	LOPERAMIDE 1 MG/7.5 ML SOLN	*PDL-P
	LOPERAMIDE 1 MG/7.5 ML SUSP	*PDL-P
	LOPERAMIDE 2 MG CAPSULE	*PDL-P
	SM ANTI-DIARRHEAL 1 MG/7.5 ML	*PDL-P
	SM ANTI-DIARRHEAL 2 MG CAPLET	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antidiarrheal - Antiperistaltic Agents	SM ANTI-DIARRHEAL 2 MG SOFTGEL	*PDL-P
Antidiarrheal - Bismuth Agents	BISMUTH 262 MG TABLET CHEW *	
	DIOTAME 262 MG TABLET CHEW *	
	HM STOMACH RLF 262 MG CHEW TAB *	
	KAOPECTATE 262 MG/15 ML SUSP *	
	KRO STOMACH RLF 262 MG CHEW TB *	
	PEPTO-BISMOL 262 MG CAPLET *	
	PEPTO-BISMOL TABLET CHEW *	
	PEPTO-BISMOL TO-GO 262 MG CHEW *	
	PINK BISMUTH CAPLET *	
	PUB STOMACH RLF 262 MG CHEW TB *	
	QC STOMACH RELIEF 525 MG/30 ML *	
	RA PINK BISMUTH TABLET CHEW *	
	SM STOMACH RLF 262 MG CHEW TAB *	
	SOOTHE 262 MG CHEWABLE TABLET *	
	STOMACH RELIEF 525 MG/15 ML *	
	STOMACH RLF 525 MG/30 ML SUSP *	
Antidiarrheal Antiperistaltic-Anticholinergic Combinations	DIPHENOXYLAT-ATROP 2.5-0.025/5	*PDL-P
	DIPHENOXYLATE-ATROP 2.5-0.025	*PDL-P
Antidiuretic and Vasopressor Hormones	DESMOPRESSIN 0.01% SOLUTION	AGE PA
	DESMOPRESSIN 10 MCG/0.1 ML SPR	AGE PA
	DESMOPRESSIN ACETATE 0.1 MG TB	QL
	DESMOPRESSIN ACETATE 0.2 MG TB	QL
Antiemetic - Antihistamines	DIMENHYDRINATE 50 MG TABLET *	
	MECLIZINE 12.5 MG CAPLET *	
	MECLIZINE 12.5 MG TABLET	
	MECLIZINE 12.5 MG TABLET *	
	MECLIZINE 25 MG TABLET	
	MECLIZINE 25 MG TABLET *	
	MECLIZINE 25 MG TABLET CHEW *	
Antiemetic - Cannabinoids	DRONABINOL 10 MG CAPSULE	PA
	DRONABINOL 2.5 MG CAPSULE	PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antiemetic - Cannabinoids	DRONABINOL 5 MG CAPSULE	PA
Antiemetic - Phenothiazines	PROCHLORPERAZINE 10 MG TAB	QL
	PROCHLORPERAZINE 25 MG SUPP	QL
	PROCHLORPERAZINE 5 MG TABLET	QL
	PROMETHAZINE 12.5 MG SUPPOS	AGE QL
	PROMETHAZINE 12.5 MG SUPPOS	AGE QL
	PROMETHAZINE 25 MG SUPPOSITORY	AGE QL
	PROMETHEGAN 50 MG SUPPOSITORY	AGE QL
Antiemetic - Selective Serotonin 5-HT3 Antagonists	ANZEMET 50 MG TABLET	PDL-NP PA QL
	GRANISETRON HCL 1 MG TABLET	*PDL-P QL
	ONDANSETRON 4 MG/5 ML SOLUTION	*PDL-P QL
	ONDANSETRON HCL 4 MG TABLET	*PDL-P QL
	ONDANSETRON HCL 8 MG TABLET	*PDL-P QL
	ONDANSETRON ODT 16 MG TABLET	PDL-NP PA QL
	ONDANSETRON ODT 4 MG TABLET	*PDL-P QL
	ONDANSETRON ODT 8 MG TABLET	*PDL-P QL
	SANCUSO 3.1 MG/24 HR PATCH	PDL-NP PA QL
Antiemetic - Substance P-Neurokinin 1 (NK1) Receptor Antagonists	APREPITANT 125 MG CAPSULE	*PDL-P AGE QL
	APREPITANT 125-80-80 MG PACK	PDL-NP AGE PA QL
	APREPITANT 40 MG CAPSULE	*PDL-P AGE QL
	APREPITANT 80 MG CAPSULE	*PDL-P AGE QL
	EMEND 125 MG POWDER PACKET	PDL-NP AGE PA
	EMEND 80 MG CAPSULE	PDL-NP AGE PA QL
	EMEND TRIPACK	PDL-NP AGE PA QL
Antiemetic - Substance P-Neurokinin 1 and 5-HT3 Recept Antagonist Comb	AKYNZEO 300-0.5 MG CAPSULE	PDL-NP PA QL
Antifungal - Allylamines	TERBINAFINE HCL 250 MG TABLET	*PDL-P QL
Antifungal - Amphoteric Polyene Macrolides	NYSTATIN 500,000 UNIT ORAL TAB	*PDL-P
Antifungal - Azole Antifungal Agent	VIVJOA 150 MG CAPSULE	PDL-NP PA QL
Antifungal - Glucan Synthesis Inhibitors	BREXAFEMME 150 MG TABLET	PDL-NP PA QL
Antifungal - Imidazoles	KETOCONAZOLE 200 MG TABLET	*PDL-P
	ORAVIG 50 MG BUCCAL TABLET	PDL-NP PA
Antifungal - Triazoles	CRESEMBA 186 MG CAPSULE	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antifungal - Triazoles	CRESEMBA 74.5 MG CAPSULE	PDL-NP PA
	DIFLUCAN 100 MG TABLET	PDL-NP PA
	DIFLUCAN 200 MG TABLET	PDL-NP PA
	DIFLUCAN 40 MG/ML SUSPENSION	PDL-NP PA
	FLUCONAZOLE 10 MG/ML SUSP	*PDL-P
	FLUCONAZOLE 100 MG TABLET	*PDL-P
	FLUCONAZOLE 150 MG TABLET	*PDL-P QL
	FLUCONAZOLE 200 MG TABLET	*PDL-P
	FLUCONAZOLE 40 MG/ML SUSP	*PDL-P
	FLUCONAZOLE 50 MG TABLET	*PDL-P
	ITRACONAZOLE 10 MG/ML SOLUTION	PDL-NP PA QL
	ITRACONAZOLE 100 MG CAPSULE	PDL-NP PA QL
	NOXAFIL 300 MG POWDERMIX SUSP	PDL-NP AGE PA
	NOXAFIL 40 MG/ML SUSPENSION	PDL-NP PA
	NOXAFIL DR 100 MG TABLET	PDL-NP PA
	POSACONAZOLE DR 100 MG TABLET	PDL-NP PA
	SPORANOX 10 MG/ML SOLUTION	PDL-NP PA QL
	SPORANOX 100 MG CAPSULE	PDL-NP PA QL
	TOLSURA 65 MG CAPSULE	PDL-NP PA
	VFEND 200 MG TABLET	PDL-NP PA
	VFEND 40 MG/ML SUSPENSION	PDL-NP PA
	VFEND 50 MG TABLET	PDL-NP PA
	VORICONAZOLE 200 MG TABLET	PDL-NP PA
VORICONAZOLE 40 MG/ML SUSP	PDL-NP PA	
VORICONAZOLE 50 MG TABLET	PDL-NP PA	
Antifungal other	ANCOBON 250 MG CAPSULE	PDL-NP PA
	ANCOBON 500 MG CAPSULE	PDL-NP PA
	FLUCYTOSINE 250 MG CAPSULE	PDL-NP PA
	FLUCYTOSINE 500 MG CAPSULE	PDL-NP PA
	GRISEOFULVIN 125 MG/5 ML SUSP	*PDL-P
	GRISEOFULVIN MICRO 500 MG TAB	PDL-NP PA
	GRISEOFULVIN ULTRA 125 MG TAB	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antifungal other	GRISEOFULVIN ULTRA 250 MG TAB	PDL-NP PA
Antihemophilic Products - Antithrombin-Directed siRNA	Qfitlia 20mg/0.2ml Vial #	
	Qfitlia 50mg/0.5ml Pen Injctr #	
Antihistamines - 1st Generation	ALLER-G-TIME 25 MG CAPLET *	AGE
	ALLERGY 4 MG TABLET *	
	ALLERGY RELIEF 4 MG TABLET *	
	ALLERGY-TIME 4 MG TABLET *	
	BANOPHEN 25 MG CAPSULE *	AGE
	BANOPHEN 25 MG TABLET *	AGE
	CARBINOXAMINE 4 MG/5 ML LIQUID	
	CARBINOXAMINE MALEATE 4 MG TAB	
	CVS ALLERGY RELIEF 4 MG TABLET *	
	CYPROHEPTADINE 2 MG/5 ML SYRUP	AGE
	CYPROHEPTADINE 4 MG TABLET	AGE
	DAYHIST ALLERGY 1.34 MG TABLET *	
	DIPHENHYDRAMINE 12.5 MG/5 ML *	
	DIPHENHYDRAMINE 25 MG CAPSULE *	AGE
	DIPHENHYDRAMINE 50 MG CAPSULE *	AGE
	DIPHENHYDRAMINE 50 MG/ML VIAL	AGE
	DIPHENHYDRAMINE HCL 50 MG/ML	AGE
	EQ CHLORTABS 4 MG TABLET *	
	EQL ALLERGY 4 MG TABLET *	
	GNP ALLERGY 4 MG TABLET *	
	GNP DAYHIST ALLERGY 1.34 MG TB *	
	GS ALLERGY RELIEF 25 MG TABLET *	AGE
	KRO ALLERGY 4 MG TABLET *	
	PROMETHAZINE 12.5 MG TABLET	AGE
	PROMETHAZINE 25 MG TABLET	AGE
	PROMETHAZINE 50 MG TABLET	AGE
	PROMETHAZINE 6.25 MG/5 ML SOLN	AGE
PROMETHAZINE 6.25 MG/5 ML SYRP	AGE	
PUB DAYHIST ALLERGY 1.34 MG TB *		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihistamines - 1st Generation	QC CHLORPHENIRAMINE 4 MG TAB *	
	RA CHLORPHENIRAMINE 4 MG TAB *	
	SM ALLERGY 4-HR 4 MG TABLET *	
	SM ALLERGY RELIEF 1.34 MG TAB *	
	WAL-FINATE 4 MG TABLET *	
Antihistamines - 2nd Generation	24HR ALLERGY(LEVOCETIRZN) 5 MG	*PDL-P
	ALL DAY ALLERGY 10 MG TABLET	*PDL-P
	ALLER-EASE 60 MG TABLET	*PDL-P
	ALLERGY (LORATADINE) 10 MG TAB	*PDL-P
	ALLERGY RELIEF 180 MG TABLET	*PDL-P
	ALLERGY RELIEF 5 MG/5 ML SOLN	*PDL-P
	ALLERGY RLF (CETRZN) 10 MG TAB	*PDL-P
	ALLERGY RLF(CETRZN) 10 MG SFGL	PDL-NP PA
	CETIRIZINE HCL 1 MG/ML SOLN	*PDL-P
	CETIRIZINE HCL 1 MG/ML SOLN *	*PDL-P
	CETIRIZINE HCL 1 MG/ML SYRUP	*PDL-P
	CETIRIZINE HCL 10 MG CHEW TAB	PDL-NP PA
	CETIRIZINE HCL 10 MG TABLET	*PDL-P
	CETIRIZINE HCL 5 MG CHEW TAB	PDL-NP PA
	CETIRIZINE HCL 5 MG TABLET	*PDL-P
	CETIRIZINE HCL 5 MG/5 ML SOLN	PDL-NP PA
	CHILD ALLERGY 5 MG/5 ML SOLN	*PDL-P
	CHILD ALLERGY RELIEF 1 MG/ML	*PDL-P
	CHILD CETIRIZINE 10 MG CHEW TB	PDL-NP PA
	CHILD CETIRIZINE 5 MG CHEW TAB	PDL-NP PA
	CHILD CETIRIZINE HCL 1 MG/ML	*PDL-P
	CHILD LORATADINE 10 MG/10 ML	*PDL-P
	CHILD LORATADINE 5 MG TAB CHEW	*PDL-P
	CHILD LORATADINE 5 MG/5 ML SOL	*PDL-P
	CLARINEX 5 MG TABLET	PDL-NP PA
	DESLORATADINE 2.5 MG ODT	PDL-NP AGE PA
DESLORATADINE 5 MG ODT	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihistamines - 2nd Generation	DESLORATADINE 5 MG TABLET	PDL-NP PA
	FEXOFENADINE HCL 180 MG TABLET	*PDL-P
	FEXOFENADINE HCL 30 MG/5 ML	*PDL-P
	FEXOFENADINE HCL 60 MG TABLET	*PDL-P
	GS CHILD ALL DAY ALLER 1 MG/ML	*PDL-P
	HM ALLERGY RELIEF 10 MG TABLET	*PDL-P
	HM LORATADINE 10 MG TABLET	*PDL-P
	LEVOCETIRIZINE 2.5 MG/5 ML SOL	PDL-NP PA
	LEVOCETIRIZINE 5 MG TABLET	*PDL-P
	LORATADINE 10 MG TABLET	*PDL-P
	LORATADINE 5 MG/5 ML SYRUP	*PDL-P
	LORATADINE ALLERGY 5 MG/5 ML	*PDL-P
	SM CHILD ALLERGY 5 MG/5 ML SOL	*PDL-P
	SM LORATADINE 5 MG/5 ML SYRUP	*PDL-P
Antihyperglycemic - Alpha-Glucosidase Inhibitors	ACARBOSE 100 MG TABLET	*PDL-P
	ACARBOSE 25 MG TABLET	*PDL-P
	ACARBOSE 50 MG TABLET	*PDL-P
	MIGLITOL 100 MG TABLET	*PDL-P
	MIGLITOL 25 MG TABLET	*PDL-P
	MIGLITOL 50 MG TABLET	*PDL-P
	PRECOSE 100 MG TABLET	PDL-NP PA
	PRECOSE 25 MG TABLET	PDL-NP PA
	PRECOSE 50 MG TABLET	PDL-NP PA
Antihyperglycemic - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	ALOGLIPTIN 12.5 MG TABLET	PDL-NP PA
	ALOGLIPTIN 25 MG TABLET	PDL-NP PA
	ALOGLIPTIN 6.25 MG TABLET	PDL-NP PA
	BRYNOVIN 25 MG/ML SOLUTION	PDL-NP PA QL
	JANUVIA 100 MG TABLET	*PDL-P PA QL
	JANUVIA 25 MG TABLET	*PDL-P PA QL
	JANUVIA 50 MG TABLET	*PDL-P PA QL
	NESINA 12.5 MG TABLET	PDL-NP PA
	NESINA 25 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperglycemic - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	NESINA 6.25 MG TABLET	PDL-NP PA
	SAXAGLIPTIN HCL 2.5 MG TABLET	PDL-NP PA
	SAXAGLIPTIN HCL 5 MG TABLET	PDL-NP PA
	SITAGLIPTIN 100 MG TABLET	PDL-NP PA
	SITAGLIPTIN 25 MG TABLET	PDL-NP PA
	SITAGLIPTIN 50 MG TABLET	PDL-NP PA
	TRADJENTA 5 MG TABLET	*PDL-P PA QL
	ZITUVIO 100 MG TABLET	PDL-NP PA
	ZITUVIO 25 MG TABLET	PDL-NP PA
	ZITUVIO 50 MG TABLET	PDL-NP PA
Antihyperglycemic - Meglitinide Analogs	NATEGLINIDE 120 MG TABLET	*PDL-P
	NATEGLINIDE 60 MG TABLET	*PDL-P
	REPAGLINIDE 0.5 MG TABLET	*PDL-P
	REPAGLINIDE 1 MG TABLET	*PDL-P
	REPAGLINIDE 2 MG TABLET	*PDL-P
Antihyperglycemic - SGLT-2 Inhibitor & Biguanide Combinations	DAPAGLIFLOZIN-METFO ER 10-1000	PDL-NP PA
	DAPAGLIFLOZIN-METFOR ER 5-1000	PDL-NP PA
	INVOKAMET 150-1,000 MG TABLET	PDL-NP PA
	INVOKAMET 150-500 MG TABLET	PDL-NP PA
	INVOKAMET 50-1,000 MG TABLET	PDL-NP PA
	INVOKAMET 50-500 MG TABLET	PDL-NP PA
	INVOKAMET XR 150-1,000 MG TAB	PDL-NP PA
	INVOKAMET XR 150-500 MG TABLET	PDL-NP PA
	INVOKAMET XR 50-1,000 MG TAB	PDL-NP PA
	INVOKAMET XR 50-500 MG TABLET	PDL-NP PA
	SEGLUROMET 2.5-1,000 MG TABLET	PDL-NP PA
	SEGLUROMET 2.5-500 MG TABLET	PDL-NP PA
	SEGLUROMET 7.5-1,000 MG TABLET	PDL-NP PA
	SEGLUROMET 7.5-500 MG TABLET	PDL-NP PA
	XIGDUO XR 10 MG-1,000 MG TAB	*PDL-P
	XIGDUO XR 10 MG-500 MG TABLET	*PDL-P
XIGDUO XR 2.5 MG-1,000 MG TAB	*PDL-P	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperglycemic - SGLT-2 Inhibitor & Biguanide Combinations	XIGDUO XR 5 MG-1,000 MG TABLET	*PDL-P
	XIGDUO XR 5 MG-500 MG TABLET	*PDL-P
Antihyperglycemic - SGLT-2 Inhibitor & DPP-4 Inhibitor Combinations	GLYXAMBI 10 MG-5 MG TABLET	PDL-NP PA
	GLYXAMBI 25 MG-5 MG TABLET	PDL-NP PA
	QTERN 10 MG-5 MG TABLET	PDL-NP PA
	QTERN 5 MG-5 MG TABLET	PDL-NP PA
	STEGLUJAN 15-100 MG TABLET	PDL-NP PA
	STEGLUJAN 5-100 MG TABLET	PDL-NP PA
Antihyperglycemic - SGLT-2 Inhibitor and Biguanide Combinations	SYNJARDY 12.5-1,000 MG TABLET	*PDL-P
	SYNJARDY 12.5-500 MG TABLET	*PDL-P
	SYNJARDY 5-1,000 MG TABLET	*PDL-P
	SYNJARDY 5-500 MG TABLET	*PDL-P
	SYNJARDY XR 10-1,000 MG TABLET	*PDL-P
	SYNJARDY XR 12.5-1,000 MG TAB	*PDL-P
	SYNJARDY XR 25-1,000 MG TABLET	*PDL-P
Antihyperglycemic - SGLT-2 Inhibitor- DPP-4 Inhibitor & Biguanide Combinations	TRIJARDY XR 10-5-1,000 MG TAB	PDL-NP PA
	TRIJARDY XR 12.5-2.5-1,000 MG	PDL-NP PA
	TRIJARDY XR 25-5-1,000 MG TAB	PDL-NP PA
	TRIJARDY XR 5-2.5-1,000 MG TAB	PDL-NP PA
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	DAPAGLIFLOZIN 10 MG TABLET	PDL-NP PA
	DAPAGLIFLOZIN 5 MG TABLET	PDL-NP PA
	FARXIGA 10 MG TABLET	*PDL-P
	FARXIGA 5 MG TABLET	*PDL-P
	INPEFA 200 MG TABLET	PDL-NP PA
	INPEFA 400 MG TABLET	PDL-NP PA
	INVOKANA 100 MG TABLET	PDL-NP PA
	INVOKANA 300 MG TABLET	PDL-NP PA
	JARDIANCE 10 MG TABLET	*PDL-P
	JARDIANCE 25 MG TABLET	*PDL-P
	STEGLATRO 15 MG TABLET	PDL-NP PA
STEGLATRO 5 MG TABLET	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperglycemic - Sulfonylurea and Biguanide Combinations	GLIPIZIDE-METFORMIN 2.5-250 MG	PDL-NP PA
	GLIPIZIDE-METFORMIN 2.5-500 MG	PDL-NP PA
	GLIPIZIDE-METFORMIN 5-500 MG	PDL-NP PA
	GLYBURIDE-METFORMIN 2.5-500 MG	*PDL-P
	GLYBURIDE-METFORMIN 5-500 MG	*PDL-P
	GLYBURID-METFORMIN 1.25-250 MG	*PDL-P
Antihyperglycemic - Sulfonylurea Derivatives	GLIMEPIRIDE 1 MG TABLET	*PDL-P
	GLIMEPIRIDE 2 MG TABLET	*PDL-P
	GLIMEPIRIDE 4 MG TABLET	*PDL-P
	GLIPIZIDE 10 MG TABLET	*PDL-P
	GLIPIZIDE 5 MG TABLET	*PDL-P
	GLIPIZIDE ER 10 MG TABLET	*PDL-P
	GLIPIZIDE ER 2.5 MG TABLET	*PDL-P
	GLIPIZIDE ER 5 MG TABLET	*PDL-P
	GLIPIZIDE XL 10 MG TABLET	*PDL-P
	GLIPIZIDE XL 2.5 MG TABLET	*PDL-P
	GLIPIZIDE XL 5 MG TABLET	*PDL-P
	GLUCOTROL XL 10 MG TABLET	PDL-NP PA
	GLUCOTROL XL 2.5 MG TABLET	PDL-NP PA
	GLUCOTROL XL 5 MG TABLET	PDL-NP PA
	GLYBURIDE 1.25 MG TABLET	*PDL-P
	GLYBURIDE 2.5 MG TABLET	*PDL-P
	GLYBURIDE 5 MG TABLET	*PDL-P
	GLYBURIDE MICRO 1.5 MG TAB	*PDL-P
	GLYBURIDE MICRO 3 MG TABLET	*PDL-P
GLYBURIDE MICRO 6 MG TABLET	*PDL-P	
Antihyperglycemic - Thiazolidinedione and Biguanide Combinations	ACTOPLUS MET 15 MG-500 MG TAB	PDL-NP PA
	ACTOPLUS MET 15 MG-850 MG TAB	PDL-NP PA
	PIOGLITAZONE-METFORMIN 15-500	PDL-NP PA
	PIOGLITAZONE-METFORMIN 15-850	PDL-NP PA
Antihyperglycemic - Thiazolidinedione and Sulfonylurea Combinations	DUETACT 30-2 MG TABLET	PDL-NP PA
	DUETACT 30-4 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperglycemic - Thiazolidinedione and Sulfonylurea Combinations	PIOGLITAZONE-GLIMEPIRIDE 30-2	PDL-NP PA
	PIOGLITAZONE-GLIMEPIRIDE 30-4	PDL-NP PA
Antihyperglycemic, Amylin Analog-Type	SYMLINPEN 120 PEN INJECTOR	*PDL-P
	SYMLINPEN 60 PEN INJECTOR	*PDL-P
Antihyperglycemic, DPP-4 Inhibitor-Biguanide Combinations	SITAGLIPTIN-METFO ER 100-1,000	PDL-NP PA
	SITAGLIPTIN-METFOR ER 50-1,000	PDL-NP PA
	SITAGLIPTIN-METFORM ER 50-500	PDL-NP PA
	SITAGLIPTIN-METFORMIN 50-1000	PDL-NP PA
	SITAGLIPTIN-METFORMIN 50-500	PDL-NP PA
	ZITUVIMET 50-1,000 MG TABLET	PDL-NP PA
	ZITUVIMET 50-500 MG TABLET	PDL-NP PA
	ZITUVIMET XR 100-1,000 MG TAB	PDL-NP PA
	ZITUVIMET XR 50-1000 MG TABLET	PDL-NP PA
	ZITUVIMET XR 50-500 MG TABLET	PDL-NP PA
Antihyperglycemic, Incretin Mimetic Combinations, Long Acting-GLP-1 Recept. Agonist	SOLIQUA 100 UNIT-33 MCG/ML PEN	PDL-NP PA QL
	XULTOPHY 100 UNIT-3.6MG/ML PEN	PDL-NP PA QL
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	BYDUREON BCISE 2 MG AUTOINJECT	PDL-NP PA QL
	BYETTA 10 MCG DOSE PEN INJ	*PDL-P PA QL
	BYETTA 5 MCG DOSE PEN INJ	*PDL-P PA QL
	EXENATIDE 10 MCG DOSE PEN INJ	PDL-NP PA QL
	EXENATIDE 5 MCG DOSE PEN INJ	PDL-NP PA QL
	LIRAGLUTIDE 2-PAK 18 MG/3 ML	PDL-NP PA QL
	LIRAGLUTIDE 3-PAK 18 MG/3 ML	PDL-NP PA QL
	MOUNJARO 10 MG/0.5 ML PEN	PDL-NP PA QL
	MOUNJARO 12.5 MG/0.5 ML PEN	PDL-NP PA QL
	MOUNJARO 15 MG/0.5 ML PEN	PDL-NP PA QL
	MOUNJARO 2.5 MG/0.5 ML PEN	PDL-NP PA QL
	MOUNJARO 5 MG/0.5 ML PEN	PDL-NP PA QL
	MOUNJARO 7.5 MG/0.5 ML PEN	PDL-NP PA QL
	OZEMPIC 0.25-0.5 MG/DOSE PEN	*PDL-P PA QL
	OZEMPIC 0.25-0.5 MG/DOSE PEN	*PDL-P PA QL
	OZEMPIC 1 MG/DOSE (4 MG/3 ML)	*PDL-P PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	OZEMPIC 2 MG/DOSE (8 MG/3 ML)	*PDL-P PA QL
	RYBELSUS 1.5 MG TABLET	PDL-NP PA QL
	RYBELSUS 14 MG TABLET	PDL-NP PA QL
	RYBELSUS 3 MG TABLET	PDL-NP PA QL
	RYBELSUS 4 MG TABLET	PDL-NP PA QL
	RYBELSUS 7 MG TABLET	PDL-NP PA QL
	RYBELSUS 9 MG TABLET	PDL-NP PA QL
	TRULICITY 0.75 MG/0.5 ML PEN	*PDL-P PA QL
	TRULICITY 1.5 MG/0.5 ML PEN	*PDL-P PA QL
	TRULICITY 3 MG/0.5 ML PEN	*PDL-P PA QL
	TRULICITY 4.5 MG/0.5 ML PEN	*PDL-P PA QL
	VICTOZA 2-PAK 18 MG/3 ML PEN	*PDL-P PA QL
	VICTOZA 3-PAK 18 MG/3 ML PEN	*PDL-P PA QL
Antihyperglycemic-Dipeptidyl Peptidase-4 (DPP-4) Inhibitor & Biguanide	ALOGLIPTIN-METFORMIN 12.5-1000	PDL-NP PA
	ALOGLIPTIN-METFORMIN 12.5-500	PDL-NP PA
	JANUMET 50-1,000 MG TABLET	*PDL-P PA QL
	JANUMET 50-500 MG TABLET	*PDL-P PA QL
	JANUMET XR 100-1,000 MG TABLET	*PDL-P PA
	JANUMET XR 50-1,000 MG TABLET	*PDL-P PA
	JANUMET XR 50-500 MG TABLET	*PDL-P PA
	JENTADUETO 2.5 MG-1000 MG TAB	*PDL-P PA
	JENTADUETO 2.5 MG-500 MG TAB	*PDL-P PA
	JENTADUETO 2.5 MG-850 MG TAB	*PDL-P PA
	JENTADUETO XR 2.5 MG-1,000 MG	*PDL-P PA
	JENTADUETO XR 5 MG-1,000 MG TB	*PDL-P PA
	KAZANO 12.5-1,000 MG TABLET	PDL-NP PA
	KAZANO 12.5-500 MG TABLET	PDL-NP PA
	LINAGLIPTIN-METFOR 2.5-1,000MG	PDL-NP PA
	LINAGLIPTIN-METFOR 2.5-500 MG	PDL-NP PA
	LINAGLIPTIN-METFOR 2.5-850 MG	PDL-NP PA
	SAXAGLIPTIN-METFORMIN ER 5-500	PDL-NP PA
	SAXAGLIPTIN-METFORMN ER 5-1000	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperglycemic-Dipeptidyl Peptidase-4 (DPP-4) Inhibitor & Biguanide	SAXAGLIPTN-METFORM ER 2.5-1000	PDL-NP PA
Antihyperglycemic-Dipeptidyl Peptidase-4 Inhibitor & Thiazolidinedione	ALOGLIPTIN-PIOGLIT 12.5-30 MG	PDL-NP PA
	ALOGLIPTIN-PIOGLIT 25-15 MG TB	PDL-NP PA
	ALOGLIPTIN-PIOGLIT 25-30 MG TB	PDL-NP PA
	ALOGLIPTIN-PIOGLIT 25-45 MG TB	PDL-NP PA
	OSENI 12.5-30 MG TABLET	PDL-NP PA
	OSENI 25-15 MG TABLET	PDL-NP PA
	OSENI 25-30 MG TABLET	PDL-NP PA
	OSENI 25-45 MG TABLET	PDL-NP PA
Antihyperlipidemic - apolipoprotein B-100 Synthesis Inhibitor	TRYNGOLZA 80 MG/0.8 ML AUTOINJ #	
Antihyperlipidemic - Bile Acid Sequestrants	CHOLESTYRAMINE LIGHT PACKET	*PDL-P
	CHOLESTYRAMINE LIGHT POWDER	*PDL-P
	CHOLESTYRAMINE PACKET	*PDL-P
	CHOLESTYRAMINE POWDER	*PDL-P
	COLESEVELAM 625 MG TABLET	PDL-NP PA
	COLESEVELAM HCL 3.75 G PACKET	PDL-NP PA
	COLESTID 1 GM TABLET	PDL-NP PA
	COLESTID GRANULES	PDL-NP PA
	COLESTID GRANULES	PDL-NP PA
	COLESTIPOL HCL 1 GM TABLET	*PDL-P
	COLESTIPOL HCL GRANULES	PDL-NP PA
	COLESTIPOL HCL GRANULES PACKET	PDL-NP PA
	COLESTIPOL MICRONIZED 1 GM TAB	*PDL-P
	PREVALITE PACKET	*PDL-P
	PREVALITE POWDER	*PDL-P
	QUESTRAN LIGHT POWDER	PDL-NP PA
	QUESTRAN PACKET	PDL-NP PA
	QUESTRAN POWDER	PDL-NP PA
	WELCHOL 3.75G PACKET	PDL-NP PA
	WELCHOL 625 MG TABLET	PDL-NP PA
Antihyperlipidemic - Fibric Acid Derivatives	ANTARA 90 MG CAPSULE	PDL-NP PA
	FENOFIBRATE 120 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperlipidemic - Fibric Acid Derivatives	FENOFIBRATE 130 MG CAPSULE	PDL-NP PA
	FENOFIBRATE 134 MG CAPSULE	*PDL-P
	FENOFIBRATE 145 MG TABLET	*PDL-P
	FENOFIBRATE 150 MG CAPSULE	PDL-NP PA
	FENOFIBRATE 160 MG TABLET	*PDL-P
	FENOFIBRATE 200 MG CAPSULE	*PDL-P
	FENOFIBRATE 40 MG TABLET	PDL-NP PA
	FENOFIBRATE 43 MG CAPSULE	PDL-NP PA
	FENOFIBRATE 48 MG TABLET	*PDL-P
	FENOFIBRATE 50 MG CAPSULE	PDL-NP PA
	FENOFIBRATE 54 MG TABLET	*PDL-P
	FENOFIBRATE 67 MG CAPSULE	*PDL-P
	FENOFIBRATE 90 MG CAPSULE	PDL-NP PA
	FENOFIBRIC ACID 105 MG TABLET	PDL-NP PA
	FENOFIBRIC ACID 35 MG TABLET	PDL-NP PA
	FENOFIBRIC ACID DR 135 MG CAP	PDL-NP PA
	FENOFIBRIC ACID DR 45 MG CAP	PDL-NP PA
	FENOGLIDE 120 MG TABLET	PDL-NP PA
	FENOGLIDE 40 MG TABLET	PDL-NP PA
	FIBRICOR 105 MG TABLET	PDL-NP PA
	GEMFIBROZIL 600 MG TABLET	*PDL-P
	LIPOFEN 150 MG CAPSULE	PDL-NP PA
	LIPOFEN 50 MG CAPSULE	PDL-NP PA
	LOPID 600 MG TABLET	PDL-NP PA
	TRICOR 145 MG TABLET	PDL-NP PA
	TRICOR 48 MG TABLET	PDL-NP PA
TRILIPIX DR 135 MG CAPSULE	PDL-NP PA	
TRILIPIX DR 45 MG CAPSULE	PDL-NP PA	
Antihyperlipidemic - HMG CoA Reductase Inhibitors (statins)	ALTOPREV 20 MG TABLET	PDL-NP PA QL
	ALTOPREV 40 MG TABLET	PDL-NP PA QL
	ALTOPREV 60 MG TABLET	PDL-NP PA QL
	ATORVALIQ 20 MG/5 ML SUSP	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperlipidemic - HMG CoA Reductase Inhibitors (statins)	ATORVASTATIN 10 MG TABLET	*PDL-P QL
	ATORVASTATIN 20 MG TABLET	*PDL-P QL
	ATORVASTATIN 40 MG TABLET	*PDL-P QL
	ATORVASTATIN 80 MG TABLET	*PDL-P QL
	CRESTOR 10 MG TABLET	PDL-NP PA QL
	CRESTOR 20 MG TABLET	PDL-NP PA QL
	CRESTOR 40 MG TABLET	PDL-NP PA QL
	CRESTOR 5 MG TABLET	PDL-NP PA QL
	EZALLOR SPRINKLE 10 MG CAPSULE	PDL-NP PA QL
	EZALLOR SPRINKLE 20 MG CAPSULE	PDL-NP PA QL
	EZALLOR SPRINKLE 40 MG CAPSULE	PDL-NP PA QL
	EZALLOR SPRINKLE 5 MG CAPSULE	PDL-NP PA QL
	FLUVASTATIN ER 80 MG TABLET	PDL-NP PA QL
	FLUVASTATIN SODIUM 20 MG CAP	PDL-NP PA QL
	FLUVASTATIN SODIUM 40 MG CAP	PDL-NP PA QL
	LESCOL XL 80 MG TABLET	PDL-NP PA QL
	LIPITOR 10 MG TABLET	PDL-NP PA QL
	LIPITOR 20 MG TABLET	PDL-NP PA QL
	LIPITOR 40 MG TABLET	PDL-NP PA QL
	LIPITOR 80 MG TABLET	PDL-NP PA QL
	LIVALO 1 MG TABLET	PDL-NP PA QL
	LIVALO 2 MG TABLET	PDL-NP PA QL
	LIVALO 4 MG TABLET	PDL-NP PA QL
	LOVASTATIN 10 MG TABLET	*PDL-P QL
	LOVASTATIN 20 MG TABLET	*PDL-P QL
	LOVASTATIN 40 MG TABLET	*PDL-P QL
	PITAVASTATIN 1 MG TABLET	PDL-NP PA QL
	PITAVASTATIN 2 MG TABLET	PDL-NP PA QL
	PITAVASTATIN 4 MG TABLET	PDL-NP PA QL
	PRAVASTATIN SODIUM 10 MG TAB	*PDL-P QL
PRAVASTATIN SODIUM 20 MG TAB	*PDL-P QL	
PRAVASTATIN SODIUM 40 MG TAB	*PDL-P QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperlipidemic - HMG CoA Reductase Inhibitors (statins)	PRAVASTATIN SODIUM 80 MG TAB	*PDL-P QL
	ROSUVASTATIN CALCIUM 10 MG TAB	*PDL-P QL
	ROSUVASTATIN CALCIUM 20 MG TAB	*PDL-P QL
	ROSUVASTATIN CALCIUM 40 MG TAB	*PDL-P QL
	ROSUVASTATIN CALCIUM 5 MG TAB	*PDL-P QL
	SIMVASTATIN 10 MG TABLET	*PDL-P QL
	SIMVASTATIN 20 MG TABLET	*PDL-P QL
	SIMVASTATIN 40 MG TABLET	*PDL-P QL
	SIMVASTATIN 5 MG TABLET	*PDL-P QL
	SIMVASTATIN 80 MG TABLET	*PDL-P QL
	ZOCOR 10 MG TABLET	PDL-NP PA QL
	ZOCOR 20 MG TABLET	PDL-NP PA QL
	ZOCOR 40 MG TABLET	PDL-NP PA QL
	ZOCOR 80 MG TABLET	PDL-NP PA QL
	ZYPITAMAG 2 MG TABLET	PDL-NP PA QL
ZYPITAMAG 4 MG TABLET	PDL-NP PA QL	
Antihyperlipidemic - Nicotinic Acid Derivatives	NIACIN 100 MG TABLET *	*PDL-P
	NIACIN 500 MG CAPSULE SA *	*PDL-P
	NIACIN 500 MG TABLET *	*PDL-P
	NIACIN ER 1,000 MG TABLET	PDL-NP PA
	NIACIN ER 500 MG TABLET	PDL-NP PA
	NIACIN ER 500 MG TABLET *	*PDL-P
	NIACIN ER 750 MG TABLET	PDL-NP PA
SLO-NIACIN 750 MG TABLET *	*PDL-P	
Antihyperlipidemic - Selective Cholesterol Absorption Inhibitor	EZETIMIBE 10 MG TABLET	*PDL-P
	ZETIA 10 MG TABLET	PDL-NP PA
Antihyperlipidemic Agents - Dietary Source	ICOSAPENT ETHYL 1 GRAM CAPSULE	PDL-NP PA
	ICOSAPENT ETHYL 500 MG CAPSULE	PDL-NP PA
	OMEGA-3 ETHYL ESTERS 1 GM CAP	PDL-NP PA
Antihyperlipidemic Agents - Dietary Source Combinations	CVS FISH OIL 1,000 MG SOFTGEL *	
	CVS FISH OIL 1,000 MG SOFTGEL *	
	CVS FISH OIL 1,200 MG SOFTGEL *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperlipidemic Agents - Dietary Source Combinations	EQL FISH OIL 1,200 MG SOFTGEL *	
	FISH OIL 1,000 MG CAPSULE *	
	FISH OIL 1,000 MG SOFTGEL *	
	FISH OIL 1,000 MG SOFTGEL *	
	FISH OIL 1,200 MG SOFTGEL *	
	FISH OIL 500 MG SOFTGEL *	
	FISH OIL EC 1,000 MG SOFTGEL *	
	GNP FISH OIL 1,000 MG SOFTGEL *	
	GNP FISH OIL EC 1,000 MG SFTGL *	
	HM FISH OIL 1,200 MG SOFTGEL *	
	HM FISH OIL EC 1,000 MG SFTGL *	
	OMEGA-3 FISH OIL 1,000 MG SFGL *	
	OMEGA-3 FISH OIL 1,000 MG SFTG *	
	OMEGA-3 FISH OIL 1,000MG SFTGL *	
	OMEGA-3 FISH OIL SOFTGEL *	
	RA FISH OIL 1,000 MG SOFTGEL *	
	SEA-OMEGA 30 CAPSULE *	
	SM FISH OIL 1,000 MG SOFTGEL *	
	SM FISH OIL 1,200 MG SOFTGEL *	
	Antihyperlipidemic HMG CoA Reduct Inhib & Calcium Channel Blocker Comb	AMLODIPINE-ATORVAST 10-10 MG
AMLODIPINE-ATORVAST 10-20 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 10-40 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 10-80 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 2.5-10 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 2.5-20 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 2.5-40 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 5-10 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 5-20 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 5-40 MG		PDL-NP PA QL
AMLODIPINE-ATORVAST 5-80 MG		PDL-NP PA QL
CADUET 10 MG-10 MG TABLET		PDL-NP PA QL
CADUET 10 MG-20 MG TABLET		PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antihyperlipidemic HMG CoA Reduct Inhib & Calcium Channel Blocker Comb	CADUET 10 MG-40 MG TABLET	PDL-NP PA QL
	CADUET 10 MG-80 MG TABLET	PDL-NP PA QL
	CADUET 5 MG-10 MG TABLET	PDL-NP PA QL
	CADUET 5 MG-20 MG TABLET	PDL-NP PA QL
	CADUET 5 MG-40 MG TABLET	PDL-NP PA QL
	CADUET 5 MG-80 MG TABLET	PDL-NP PA QL
Antihyperlipidemic-HMG CoA Reduct Inhib & Cholesterol Absorption Inhib	EZETIMIBE-SIMVASTATIN 10-10 MG	*PDL-P QL
	EZETIMIBE-SIMVASTATIN 10-20 MG	*PDL-P QL
	EZETIMIBE-SIMVASTATIN 10-40 MG	*PDL-P QL
	EZETIMIBE-SIMVASTATIN 10-80 MG	*PDL-P QL
	VYTORIN 10-10 MG TABLET	PDL-NP PA QL
	VYTORIN 10-20 MG TABLET	PDL-NP PA QL
	VYTORIN 10-40 MG TABLET	PDL-NP PA QL
	VYTORIN 10-80 MG TABLET	PDL-NP PA QL
Anti-inflammatory - Interleukin-1 beta Blockers	ILARIS 150 MG/ML VIAL #	
Anti-inflammatory - Interleukin-1 Receptor Antagonist	ARCALYST 220 MG INJECTION #	
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,Non-Selective	ENBREL 25 MG/0.5 ML SYRINGE	*PDL-P QL
	ENBREL 25 MG/0.5 ML VIAL	*PDL-P
	ENBREL 50 MG/ML MINI CARTRIDGE	*PDL-P QL
	ENBREL 50 MG/ML SURECLICK	*PDL-P QL
	ENBREL 50 MG/ML SYRINGE	*PDL-P QL
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	ABRILADA(CF) 20 MG/0.4 ML SYRN	PDL-NP AGE PA QL
	ABRILADA(CF) 40 MG/0.8 ML SYRN	PDL-NP AGE PA QL
	ABRILADA(CF) PEN 40 MG/0.8 ML	PDL-NP AGE PA QL
	ABRILADA(CF) PEN 40 MG/0.8 ML	PDL-NP AGE PA QL
	ADALIMUMAB-AACF(CF) CROHN 40MG	PDL-NP AGE PA QL
	ADALIMUMAB-AACF(CF) PEN 40 MG	PDL-NP AGE PA QL
	ADALIMUMAB-AACF(CF) PS-UV 40MG	PDL-NP AGE PA QL
	ADALIMUMAB-AACF(CF) SYR 40 MG	PDL-NP AGE PA
	ADALIMUMAB-AACF(CF) SYR 40 MG	PDL-NP AGE PA QL
	ADALIMUMAB-AATY(CF) 20MG/0.2ML	PDL-NP AGE PA QL
	ADALIMUMAB-AATY(CF) 40MG/0.4ML (2 Pen)	PDL-NP AGE PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	ADALIMUMAB-AATY(CF) 40MG/0.4ML (2 Syrg)	PDL-NP AGE PA QL
	ADALIMUMAB-AATY(CF) 40MG/0.4ML (Pen)	PDL-NP AGE PA QL
	ADALIMUMAB-AATY(CF) 80MG/0.8ML	PDL-NP AGE PA QL
	ADALIMUMAB-AATY(CF) AUTO CD-UC-HS START 80	PDL-NP AGE PA QL
	ADALIMUMAB-ADAZ(CF) 10MG/0.1ML	PDL-NP AGE PA QL
	ADALIMUMAB-ADAZ(CF) 40 MG SYRG	PDL-NP AGE PA QL
	ADALIMUMAB-ADAZ(CF) PEN 40 MG	PDL-NP AGE PA QL
	ADALIMUMAB-ADAZ(CF) PEN 80 MG	PDL-NP AGE PA QL
	ADALIMUMAB-ADB(M) (CF) 10 MG SYRG	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) 20 MG SYRG	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) 40 MG SYRG	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) 40 MG SYRG	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) CRHN 40MG	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) CRHN 40MG	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) PEN 40 MG/0.4ML	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) PEN 40 MG/0.8ML	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) PS-UV 40MG	*PDL-P AGE QL
	ADALIMUMAB-ADB(M) (CF) PS-UV 40MG	*PDL-P AGE QL
	ADALIMUMAB-FKJP(CF) 20 MG SYRG	PDL-NP AGE PA QL
	ADALIMUMAB-FKJP(CF) 40 MG SYRG	PDL-NP AGE PA QL
	ADALIMUMAB-FKJP(CF) PEN 40MG/0.8ML	PDL-NP AGE PA QL
	ADALIMUMAB-RYVK(CF) 40 MG/0.4ML SYRG	PDL-NP AGE PA QL
	ADALIMUMAB-RYVK(CF) AI 40 MG/0.4ML	PDL-NP AGE PA QL
	AMJEVITA(CF) 10MG/0.2ML SYRING	PDL-NP AGE PA QL
	AMJEVITA(CF) 20MG/0.4ML SYRING	PDL-NP AGE PA QL
	AMJEVITA(CF) 40MG/0.8ML AUTOIN	PDL-NP AGE PA QL
	AMJEVITA(CF) 40MG/0.8ML SYRING	PDL-NP AGE PA QL
	CYLTEZO(CF) 10 MG/0.2 ML SYRNG	PDL-NP AGE PA QL
	CYLTEZO(CF) 20 MG/0.4 ML SYRNG	PDL-NP AGE PA QL
	CYLTEZO(CF) 40 MG/0.4 ML SYRNG	PDL-NP AGE PA QL
	CYLTEZO(CF) 40 MG/0.8 ML SYRNG	PDL-NP AGE PA QL
	CYLTEZO(CF) PEN 40 MG/0.4 ML	PDL-NP AGE PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	CYLTEZO(CF) PEN 40 MG/0.8 ML	PDL-NP AGE PA QL
	CYLTEZO(CF) PEN CRH-UC-HS 40MG	PDL-NP AGE PA QL
	CYLTEZO(CF) PEN CRH-UC-HS 40MG	PDL-NP AGE PA QL
	CYLTEZO(CF) PEN PSORIASIS 40MG	PDL-NP AGE PA QL
	CYLTEZO(CF) PEN PSORIA-UV 40MG	PDL-NP AGE PA QL
	HADLIMA 40 MG/0.8 ML SYRINGE	PDL-NP AGE PA QL
	HADLIMA PUSHTOUCH 40 MG/0.8 ML	PDL-NP AGE PA QL
	HADLIMA(CF) 40 MG/0.4 ML SYRNG	PDL-NP AGE PA QL
	HADLIMA(CF) PUSHTOUCH 40MG/0.4	PDL-NP AGE PA QL
	HULIO(CF) 20 MG/0.4 ML SYRINGE	PDL-NP AGE PA QL
	HULIO(CF) 40 MG/0.8 ML SYRINGE	PDL-NP AGE PA QL
	HULIO(CF) PEN 40 MG/0.8 ML	PDL-NP AGE PA QL
	HUMIRA 40 MG/0.8 ML SYRINGE	*PDL-P QL
	HUMIRA PEN 40 MG/0.8 ML	*PDL-P QL
	HUMIRA(CF) 10 MG/0.1 ML SYRING	*PDL-P QL
	HUMIRA(CF) 20 MG/0.2 ML SYRING	*PDL-P QL
	HUMIRA(CF) 40 MG/0.4 ML SYRING	*PDL-P QL
	HUMIRA(CF) PEN 40 MG/0.4 ML	*PDL-P QL
	HUMIRA(CF) PEN 80 MG/0.8 ML	*PDL-P QL
	HUMIRA(CF) PEN CRHN-UC-HS 80MG	*PDL-P QL
	HUMIRA(CF) PEN PS-UV-AHS 80-40	*PDL-P QL
	HYRIMOZ(CF) 10 MG/0.1 ML SYRNG	PDL-NP AGE PA QL
	HYRIMOZ(CF) 20 MG/0.2 ML SYRNG	PDL-NP AGE PA QL
	HYRIMOZ(CF) 40 MG/0.4 ML SYRNG	PDL-NP AGE PA QL
	HYRIMOZ(CF) PEDI CROHN 80 MG	PDL-NP AGE PA QL
	HYRIMOZ(CF) PEDI CROHN 80-40MG	PDL-NP AGE PA QL
	HYRIMOZ(CF) PEN 40 MG/0.4 ML	PDL-NP AGE PA QL
	HYRIMOZ(CF) PEN 80 MG/0.8 ML	PDL-NP AGE PA QL
	HYRIMOZ(CF) PEN CROHN-UC 80 MG	PDL-NP AGE PA QL
	HYRIMOZ(CF) PEN PSORIA 80-40MG	PDL-NP AGE PA QL
	IDACIO(CF) PEN CROHNS-UC 40 MG	PDL-NP AGE PA QL
	IDACIO(CF) PEN PSORIASIS 40 MG	PDL-NP AGE PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	SIMLANDI(CF) 20 MG/0.2 ML SYRG	PDL-NP AGE PA QL
	SIMLANDI(CF) 40 MG/0.4 ML SYRG	PDL-NP AGE PA QL
	SIMLANDI(CF) 80 MG/0.8 ML SYRG	PDL-NP AGE PA QL
	SIMLANDI(CF) AI 40 MG/0.4 ML	PDL-NP AGE PA QL
	SIMLANDI(CF) AI 80 MG/0.8 ML	PDL-NP AGE PA QL
	SIMPONI 100 MG/ML PEN INJECTOR	PDL-NP PA QL
	SIMPONI 100 MG/ML SYRINGE	PDL-NP PA QL
	SIMPONI 50 MG/0.5 ML PEN INJEC	PDL-NP PA QL
	SIMPONI 50 MG/0.5 ML SYRINGE	PDL-NP PA QL
	SIMPONI ARIA 50 MG/4 ML VIAL	PDL-NP PA
	YUFLYMA(CF) 20 MG/0.2 ML SYRNG	PDL-NP AGE PA QL
	YUFLYMA(CF) 40 MG/0.4 ML SYRNG	PDL-NP AGE PA QL
	YUFLYMA(CF) 40MG/0.4ML AUTOINJ	PDL-NP AGE PA QL
	YUFLYMA(CF) 40MG/0.4ML AUTOINJ (2 pk)	PDL-NP AGE PA QL
	YUFLYMA(CF) 80MG/0.8ML AUTOINJ	PDL-NP AGE PA QL
	YUFLYMA(CF) AI CROHNS-UC-HS 80	PDL-NP AGE PA QL
	YUSIMRY(CF) 40 MG/0.8 ML PEN	PDL-NP AGE PA QL
	Anti-Inhibitor Coagulation Complex	FEIBA NF 1,000 UNIT (NOMINAL) #
FEIBA NF 2,500 UNIT (NOMINAL) #		
FEIBA NF 500 UNIT (NOMINAL) #		
Antileprotic - Immunomodulators	THALOMID 100 MG CAPSULE	
	THALOMID 150 MG CAPSULE	
	THALOMID 200 MG CAPSULE	
	THALOMID 50 MG CAPSULE	
Antileprotic - Sulfone Agents	DAPSONE 100 MG TABLET	
	DAPSONE 25 MG TABLET	
Antimalarials	CHLOROQUINE PH 250 MG TABLET	QL
	CHLOROQUINE PH 500 MG TABLET	QL
	HYDROXYCHLOROQUINE 100 MG TAB	
	HYDROXYCHLOROQUINE 200 MG TAB	
	HYDROXYCHLOROQUINE 300 MG TAB	
	HYDROXYCHLOROQUINE 400 MG TAB	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antimalarials	KRINTAFEL 150 MG TABLET	AGE PA QL
	MEFLOQUINE HCL 250 MG TABLET	PA QL
	PRIMAQUINE 26.3 MG TABLET	
	PYRIMETHAMINE 25 MG TABLET	PA QL
Antimigraine Preparations	ZEMBRACE SYMTOUCH 3 MG/0.5 ML	PDL-NP PA
Antimyasthenic Agent - Reversible Cholinesterase Inhibitors	PYRIDOSTIGMINE BR 60 MG TABLET	
Antineoplastic - 1st generation EGFR tyrosine kinase inhibitor	IRESSA 250 MG TABLET #	
Antineoplastic - 2nd generation EGFR tyrosine kinase inhibitor	GILOTRIF 20 MG TABLET #	
	GILOTRIF 30 MG TABLET #	
	GILOTRIF 40 MG TABLET #	
	NERLYNX 40 MG TABLET #	
	VIZIMPRO 15 MG TABLET #	
	VIZIMPRO 30 MG TABLET #	
	VIZIMPRO 45 MG TABLET #	
Antineoplastic - 3rd generation EGFR tyrosine kinase inhibitor	TAGRISSO 40 MG TABLET #	
	TAGRISSO 80 MG TABLET #	
Antineoplastic - AKT Inhibitors	TRUQAP 160 MG TABLET #	
	TRUQAP 200 MG TABLET #	
Antineoplastic - Alkylating Agent - Methylhydrazines	MATULANE 50 MG CAPSULE	
Antineoplastic - Alkylating Agent - Nitrogen Mustards	CYCLOPHOSPHAMIDE 25 MG CAPSULE	
	CYCLOPHOSPHAMIDE 50 MG CAPSULE	
	CYCLOPHOSPHAMIDE 50 MG TABLET	
Antineoplastic - Alkylating Agent - Triazenes	TEMODAR 140 MG CAPSULE	
	TEMOZOLOMIDE 100 MG CAPSULE	
	TEMOZOLOMIDE 140 MG CAPSULE	
	TEMOZOLOMIDE 180 MG CAPSULE	
	TEMOZOLOMIDE 20 MG CAPSULE	
	TEMOZOLOMIDE 250 MG CAPSULE	
	TEMOZOLOMIDE 5 MG CAPSULE	
Antineoplastic - Anaplastic Lymphoma Kinase (ALK) Inhibitors	ALUNBRIG 180 MG TABLET #	
	ALUNBRIG 30 MG TABLET #	
	ALUNBRIG 90 MG TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Anaplastic Lymphoma Kinase (ALK) Inhibitors	ALUNBRIG 90 MG-180 MG TAB PACK #	
	LORBRENA 100 MG TABLET #	
	LORBRENA 25 MG TABLET #	
Antineoplastic - Antiadrenals	LYSODREN 500 MG TABLET	
Antineoplastic - Antiandrogens	ABIRATERONE ACETATE 250 MG TAB	
	ABIRATERONE ACETATE 500 MG TAB	
	BICALUTAMIDE 50 MG TABLET	
	CASODEX 50 MG TABLET	
	ERLEADA 240 MG TABLET	
	ERLEADA 60 MG TABLET	
	FLUTAMIDE 125 MG CAPSULE	
	NILANDRON 150 MG TABLET	
	NILUTAMIDE 150 MG TABLET	
	NUBEQA 300 MG TABLET	
	XTANDI 40 MG CAPSULE	
	XTANDI 40 MG TABLET	
	XTANDI 80 MG TABLET	
	YONSA 125 MG TABLET	
	ZYTIGA 250 MG TABLET	
ZYTIGA 500 MG TABLET		
Antineoplastic - Antimetabolite - Folic Acid Analogs	JYLAMVO 2 MG/ML ORAL SOLUTION	
	METHOTREXATE 2.5 MG TABLET	
	TREXALL 10 MG TABLET	
	TREXALL 15 MG TABLET	
	TREXALL 5 MG TABLET	
	TREXALL 7.5 MG TABLET	
	XATMEP 2.5 MG/ML ORAL SOLUTION	
Antineoplastic - Antimetabolite - Purine Analogs	MERCAPTOPYRINE 20 MG/ML SUSPEN	
	MERCAPTOPYRINE 50 MG TABLET	
	PURIXAN 20 MG/ML ORAL SUSP	
Antineoplastic - Antimetabolite - Pyrimidine Analogs	CAPECITABINE 150 MG TABLET	
	CAPECITABINE 500 MG TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Antimetabolite - Pyrimidine Analogs	XELODA 150 MG TABLET	
	XELODA 500 MG TABLET	
Antineoplastic - Antimetabolite - Urea Derivatives	HYDREA 500 MG CAPSULE	
	HYDROXYUREA 500 MG CAPSULE	
Antineoplastic - Antimetabolites	INQOVI 35 MG-100 MG TABLET	
	KISQALI FEMARA 200 MG CO-PACK	
	KISQALI FEMARA 400 MG CO-PACK	
	KISQALI FEMARA 600 MG CO-PACK	
	LONSURF 15 MG-6.14 MG TABLET	
	LONSURF 20 MG-8.19 MG TABLET	
	ONUREG 200 MG TABLET	
	ONUREG 300 MG TABLET	
Antineoplastic - Aromatase Inhibitors	ANASTROZOLE 1 MG TABLET	
	ARIMIDEX 1 MG TABLET	
	AROMASIN 25 MG TABLET	
	EXEMESTANE 25 MG TABLET	
	FEMARA 2.5 MG TABLET	
	LETROZOLE 2.5 MG TABLET	
Antineoplastic - B-cell lymphoma-2 (BCL-2) inhibitors	VENCLEXTA 10 MG TABLET	
	VENCLEXTA 100 MG TABLET	
	VENCLEXTA 50 MG TABLET	
	VENCLEXTA STARTING PACK	
Antineoplastic - BCR-ABL Kinase inhibitors	DANZITEN 71 MG TABLET #	
	DANZITEN 95 MG TABLET #	
	NILOTINIB HCL 150 MG 1tab #	
	NILOTINIB HCL 200 MG 1tab #	
	SCEMBLIX 100 MG TABLET #	
	SCEMBLIX 20 MG TABLET #	
SCEMBLIX 40 MG TABLET #		
Antineoplastic - BRAF Kinase Inhibitors	BRAFTOVI 75 MG CAPSULE	
Antineoplastic - Bruton's tyrosine kinase (BTK) inhibitor	CALQUENCE 100 MG CAPSULE #	
	IMBRUVICA 140 MG CAPSULE #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Bruton's tyrosine kinase (BTK) inhibitor	IMBRUVICA 140 MG TABLET #	
	IMBRUVICA 280 MG TABLET #	
	IMBRUVICA 420 MG TABLET #	
	IMBRUVICA 560 MG TABLET #	
	IMBRUVICA 70 MG CAPSULE #	
	IMBRUVICA 70 MG/ML SUSPENSION #	
	JAYPIRCA 100 MG TABLET #	
	JAYPIRCA 50 MG TABLET #	
Antineoplastic - Cyclin-Dependent Kinase (CDK) 4/6 Inhibitors	IBRANCE 100 MG CAPSULE #	
	IBRANCE 125 MG CAPSULE #	
	IBRANCE 75 MG CAPSULE #	
	KISQALI 200 MG DAILY DOSE #	
	KISQALI 400 MG DAILY DOSE #	
	KISQALI 600 MG DAILY DOSE #	
	VERZENIO 100 MG TABLET #	
	VERZENIO 150 MG TABLET #	
	VERZENIO 200 MG TABLET #	
VERZENIO 50 MG TABLET #		
Antineoplastic - EGFR tyrosine kinase inhibitor	LAZCLUZE 240 MG TABLET #	
	LAZCLUZE 80 MG TABLET #	
Antineoplastic - Epiderm.Growth Factor-EGFR (ErbB1)&HER-2 (ErbB2)R.Inhib	TYKERB 250 MG TABLET #	
Antineoplastic - Epidermal Growth Factor Receptor (EGFR) - specific	ERLOTINIB HCL 100 MG TABLET #	
	ERLOTINIB HCL 150 MG TABLET #	
	ERLOTINIB HCL 25 MG TABLET #	
	EXKIVITY 40 MG CAPSULE #	
	TARCEVA 100 MG TABLET #	
	TARCEVA 150 MG TABLET #	
TARCEVA 25 MG TABLET #		
Antineoplastic - Epipodophyllotoxins	ETOPOSIDE 50 MG CAPSULE	
Antineoplastic - Estrogens	EMCYT 140 MG CAPSULE	
Antineoplastic - Exportin- 1 (XPO1) Inhibitors	XPOVIO 100 MG ONCE WEEKLY DOSE	
	XPOVIO 40 MG ONCE WEEKLY DOSE	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Exportin- 1 (XPO1) Inhibitors	XPOVIO 40 MG TWICE WEEKLY DOSE	
	XPOVIO 60 MG ONCE WEEKLY DOSE	
	XPOVIO 60 MG TWICE WEEKLY DOSE	
	XPOVIO 80 MG ONCE WEEKLY DOSE	
	XPOVIO 80 MG TWICE WEEKLY DOSE	
Antineoplastic - EZH2 Histone Methyltransferase (HMT) Inhibitor	TAZVERIK 200 MG TABLET	
Antineoplastic - Fibroblast Growth Factor Receptor (FGFR) Kinase Inhib	BALVERSA 3 MG TABLET #	
	BALVERSA 4 MG TABLET #	
	BALVERSA 5 MG TABLET #	
	TRUSELTIQ 100 MG DAILY DOSE PK #	
	TRUSELTIQ 125 MG DAILY DOSE PK #	
	TRUSELTIQ 50 MG DAILY DOSE PK #	
	TRUSELTIQ 75 MG DAILY DOSE PK #	
Antineoplastic - FMS-Like Tyrosine Kinase 3 (FLT3) Inhibitors	XOSPATA 40 MG TABLET #	
Antineoplastic - Gamma Secretase Inhibitors	OGSIVEO 50 MG TABLET #	
Antineoplastic - Hedgehog Pathway Inhibitor	DAURISMO 100 MG TABLET	
	DAURISMO 25 MG TABLET	
	ERIVEDGE 150 MG CAPSULE	
	ODOMZO 200 MG CAPSULE	
Antineoplastic - HIF-2-alpha Inhibitors	WELIREG 40 MG TABLET #	
Antineoplastic - Histone deacetylase (HDAC) inhibitors	ZOLINZA 100 MG CAPSULE	
Antineoplastic - Isocitrate Dehydrogenase 1 & 2 (IDH1 & IDH2) Inhibitors	VORANIGO 10 MG TABLET	
	VORANIGO 40 MG TABLET	
Antineoplastic - Isocitrate Dehydrogenase Inhibitors	IDHIFA 100 MG TABLET	
	IDHIFA 50 MG TABLET	
	REZLIDHIA 150 MG CAPSULE	
	TIBSOVO 250 MG TABLET	
Antineoplastic - Janus Kinase (JAK) Inhibitors	JAKAFI 10 MG TABLET	
	JAKAFI 15 MG TABLET	
	JAKAFI 20 MG TABLET	
	JAKAFI 25 MG TABLET	
	JAKAFI 5 MG TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Janus Kinase (JAK) Inhibitors	VONJO 100 MG CAPSULE #	
Antineoplastic - Janus Kinase (JAK), FMS-like Tyrosine Kinase (FLT) Inhibitor	INREBIC 100 MG CAPSULE #	
Antineoplastic - Kinase Inhibitors	GAVRETO 100 MG CAPSULE #	
	PEMAZYRE 13.5 MG TABLET #	
	PEMAZYRE 4.5 MG TABLET #	
	PEMAZYRE 9 MG TABLET #	
	QINLOCK 50 MG TABLET #	
	RETEVMO 40 MG CAPSULE #	
	RETEVMO 80 MG CAPSULE #	
	RETEVMO 80 MG CAPSULE #	
	TABRECTA 150 MG TABLET #	
	TABRECTA 200 MG TABLET #	
	TUKYSA 150 MG TABLET #	
	TUKYSA 150 MG TABLET #	
	TUKYSA 50 MG TABLET #	
	UKONIQ 200 MG TABLET #	
Antineoplastic - KRAS inhibitor	KRAZATI 200 MG TABLET	
	LUMAKRAS 120 MG TABLET	
	LUMAKRAS 240 MG TABLET	
	LUMAKRAS 320 MG TABLET	
Antineoplastic - LHRH (GnRH) Agonist Analog Pituitary Suppressants	ELIGARD 22.5 MG SYRINGE B	
	ELIGARD 22.5 MG SYRINGE KIT	
	ELIGARD 30 MG SYRINGE B	
	ELIGARD 30 MG SYRINGE KIT	
	ELIGARD 45 MG SYRINGE B	
	ELIGARD 45 MG SYRINGE KIT	
	ELIGARD 7.5 MG SYRINGE B	
	ELIGARD 7.5 MG SYRINGE KIT	
	LEUPROLIDE 2WK 1 MG/0.2 ML KIT	
	LEUPROLIDE DEPOT 22.5 MG VIAL	
	LUPRON DEPOT 22.5 MG 3MO KIT	
	LUPRON DEPOT 45 MG 6MO KIT	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - LHRH (GnRH) Agonist Analog Pituitary Suppressants	LUPRON DEPOT 7.5 MG KIT	
	LUPRON DEPOT-4 MONTH KIT	
	LUTRATE DEPOT 22.5 MG VIAL	
	TRELSTAR 22.5 MG VIAL	
	TRELSTAR DEPOT 3.75 MG VIAL	
	TRELSTAR LA 11.25 MG VIAL	
Antineoplastic - LHRH (GnRH) Antagonist Pituitary Suppressants	ORGOVYX 120 MG TABLET	
Antineoplastic - Mast Cell Stabilizers	CROMOLYN 100 MG/5 ML ORAL CONC	
	GASTROCROM 100 MG/5 ML CONC	
Antineoplastic - MEK1 and MEK2 Kinase I Antineoplastics	COTELLIC 20 MG TABLET #	
Antineoplastic - MEK1 and MEK2 Kinase Inhibitors	GOMEKLI 1 MG CAPSULE #	
	GOMEKLI 1 MG TABLET FOR SUSP #	
	GOMEKLI 2 MG CAPSULE #	
	KOSELUGO 10 MG CAPSULE #	
	KOSELUGO 25 MG CAPSULE #	
Antineoplastic - Menin Inhibitors	MEKTOVI 15 MG TABLET #	
	REVUFORJ 110 MG TABLET #	
Antineoplastic - mTOR Kinase Inhibitors	REVUFORJ 160 MG TABLET #	
	AFINITOR 10 MG TABLET	
	AFINITOR 2.5 MG TABLET	
	AFINITOR 5 MG TABLET	
	AFINITOR 7.5 MG TABLET	
	AFINITOR DISPERZ 2 MG TABLET	
	AFINITOR DISPERZ 3 MG TABLET	
	AFINITOR DISPERZ 5 MG TABLET	
	EVEROLIMUS 10 MG TABLET	
	EVEROLIMUS 2 MG TAB FOR SUSP	
	EVEROLIMUS 2.5 MG TABLET	
	EVEROLIMUS 3 MG TAB FOR SUSP	
	EVEROLIMUS 5 MG TAB FOR SUSP	
	EVEROLIMUS 5 MG TABLET	
EVEROLIMUS 7.5 MG TABLET		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - mTOR Kinase Inhibitors	TORPENZ 10 MG TABLET	
	TORPENZ 2.5 MG TABLET	
	TORPENZ 5 MG TABLET	
	TORPENZ 7.5 MG TABLET	
Antineoplastic - Multikinase Inhibitors	CABOMETYX 20 MG TABLET #	
	CABOMETYX 40 MG TABLET #	
	CABOMETYX 60 MG TABLET #	
	COMETRIQ 100 MG DAILY-DOSE PK #	
	COMETRIQ 140 MG DAILY-DOSE PK #	
	COMETRIQ 60 MG DAILY-DOSE PACK #	
	ICLUSIG 15 MG TABLET #	
	ICLUSIG 45 MG TABLET #	
	MEKINIST 0.5 MG TABLET #	
	MEKINIST 2 MG TABLET #	
	NEXAVAR 200 MG TABLET #	
	STIVARGA 40 MG TABLET #	
	TAFINLAR 50 MG CAPSULE #	
	TAFINLAR 75 MG CAPSULE #	
	TEPMETKO 225 MG TABLET #	
	VANFLYTA 17.7 MG TABLET #	
	VANFLYTA 26.5 MG TABLET #	
ZELBORAF 240 MG TABLET #		
Antineoplastic - onadotropin-Releasing Hormone (GnRH) Receptor Antagonist	CAMCEVI 42 MG SYRINGE	
Antineoplastic - Ornithine decarboxylase inhibitor	IWILFIN 192 MG TABLET #	
Antineoplastic - PI3K-alpha Inhibitors	ITOVEBI 3 MG TABLET #	
	ITOVEBI 9 MG TABLET #	
	PIQRAY 200 MG DAILY DOSE #	
	PIQRAY 250 MG DAILY DOSE #	
Antineoplastic - PI3K-delta Inhibitors	PIQRAY 300 MG DAILY DOSE #	
	ALIQOPA 60 MG VIAL #	
	COPIKTRA 15 MG CAPSULE #	
	COPIKTRA 25 MG CAPSULE #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - PI3K-delta Inhibitors	ZYDELIG 100 MG TABLET #	
	ZYDELIG 150 MG TABLET #	
Antineoplastic - Poly (ADP-ribose) polymerase (PARP) inhibitors	LYNPARZA 100 MG TABLET #	
	LYNPARZA 150 MG TABLET #	
	RUBRACA 200 MG TABLET #	
	RUBRACA 250 MG TABLET #	
	RUBRACA 300 MG TABLET #	
	TALZENNA 0.25 MG CAPSULE #	
	TALZENNA 1 MG CAPSULE #	
	ZEJULA 100 MG CAPSULE #	
	ZEJULA 200 MG TABLET #	
	ZEJULA 300 MG TABLET #	
Antineoplastic - Progestins	MEGESTROL 20 MG TABLET	
	MEGESTROL 40 MG TABLET	
Antineoplastic - Proteasome Enzyme Inhibitors	BORTEZOMIB 1 MG VIAL #	
	BORTEZOMIB 2.5 MG VIAL #	
	BORTEZOMIB 3.5 MG VIAL #	
	KYPROLIS 10 MG VIAL #	
	KYPROLIS 30 MG VIAL #	
	KYPROLIS 60 MG VIAL #	
	NINLARO 2.3 MG CAPSULE #	
	NINLARO 3 MG CAPSULE #	
	NINLARO 4 MG CAPSULE #	
VELCADE 3.5 MG VIAL #		
Antineoplastic - Protein-Tyrosine Kinase Inhibitors	ALECENSA 150 MG CAPSULE #	
	AYVAKIT 100 MG TABLET #	
	AYVAKIT 200 MG TABLET #	
	AYVAKIT 25 MG TABLET #	
	AYVAKIT 300 MG TABLET #	
	AYVAKIT 50 MG TABLET #	
	BOSULIF 100 MG TABLET #	
BOSULIF 400 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Protein-Tyrosine Kinase Inhibitors	BOSULIF 500 MG TABLET #	
	BRUKINSA 80 MG CAPSULE #	
	CAPRELSA 100 MG TABLET #	
	CAPRELSA 300 MG TABLET #	
	DASATINIB 100 MG TABLET #	
	DASATINIB 140 MG TABLET #	
	DASATINIB 20 MG TABLET #	
	DASATINIB 50 MG TABLET #	
	DASATINIB 70 MG TABLET #	
	DASATINIB 80 MG TABLET #	
	GLEEVEC 100 MG TABLET #	
	GLEEVEC 400 MG TABLET #	
	HERNEXEOS 60 MG TABLET #	
	IMATINIB MESYLATE 100 MG TAB #	
	IMATINIB MESYLATE 400 MG TAB #	
	IMKELDI 80 MG/ML SOLUTION #	
	INLYTA 1 MG TABLET #	
	INLYTA 5 MG TABLET #	
	LENVIMA 10 MG DAILY DOSE #	
	LENVIMA 12 MG DAILY DOSE #	
	LENVIMA 14 MG DAILY DOSE #	
	LENVIMA 18 MG DAILY DOSE #	
	LENVIMA 20 MG DAILY DOSE #	
	LENVIMA 24 MG DAILY DOSE #	
	LENVIMA 4 MG CAPSULE #	
	LENVIMA 8 MG DAILY DOSE #	
	QINLOCK 50 MG TABLET #	
	ROZLYTREK 100 MG CAPSULE #	
	ROZLYTREK 200 MG CAPSULE #	
	ROZLYTREK 50 MG PELLETT PACKET #	
	RYDAPT 25 MG CAPSULE #	
	SPRYCEL 100 MG TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Protein-Tyrosine Kinase Inhibitors	SPRYCEL 140 MG TABLET #	
	SPRYCEL 20 MG TABLET #	
	SPRYCEL 50 MG TABLET #	
	SPRYCEL 70 MG TABLET #	
	SPRYCEL 80 MG TABLET #	
	SUTENT 12.5 MG CAPSULE #	
	SUTENT 25 MG CAPSULE #	
	SUTENT 37.5 MG CAPSULE #	
	SUTENT 50 MG CAPSULE #	
	TASIGNA 150 MG CAPSULE #	
	TASIGNA 200 MG CAPSULE #	
	TASIGNA 50 MG CAPSULE #	
	TURALIO 125 MG CAPSULE #	
	TURALIO 200 MG CAPSULE #	
	VOTRIENT 200 MG TABLET #	
	XALKORI 200 MG CAPSULE #	
	XALKORI 250 MG CAPSULE #	
	ZYKADIA 150 MG CAPSULE #	
	ZYKADIA 150 MG TABLET #	
	Antineoplastic - RET Inhibitors	RETEVMO 120 MG TABLET #
RETEVMO 160 MG TABLET #		
RETEVMO 40 MG CAPSULE #		
RETEVMO 40 MG TABLET #		
RETEVMO 80 MG CAPSULE #		
RETEVMO 80 MG TABLET #		
Antineoplastic - Retinoids	TRETINOIN 10 MG CAPSULE	
Antineoplastic - Peginterferon alfa-2b-njft	BESREMI 500 MCG/ML SYRINGE	
Antineoplastic - Selective Estrogen Receptor Modulators (SERMs)	FARESTON 60 MG TABLET	
	ORSERDU 345 MG TABLET	
	ORSERDU 86 MG TABLET	
	SOLTAMOX 20 MG/10 ML SOLN	
	TAMOXIFEN 10 MG TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Selective Estrogen Receptor Modulators (SERMs)	TAMOXIFEN 20 MG TABLET	
	TOREMIFENE CITRATE 60 MG TAB	
Antineoplastic - Selective Retinoid X Receptor Agonists	BEXAROTENE 75 MG CAPSULE	
	TARGRETIN 75 MG CAPSULE	
Antineoplastic - Systemic Enzyme Inhibitor/Antiandrogen Combinations	AKEEGA 100-500 MG TABLET	
	AKEEGA 50-500 MG TABLET	
Antineoplastic - Systemic Enzyme Inhibitors	LYTGOBI 12 MG DAILY DOSE PACK #	
	LYTGOBI 16 MG DAILY DOSE PACK #	
	LYTGOBI 20 MG DAILY DOSE PACK #	
	ROMVIMZA 14 MG CAPSULE #	
	ROMVIMZA 20 MG CAPSULE #	
	ROMVIMZA 30 MG CAPSULE #	
Antineoplastic - Thalidomide Analogs	LENALIDOMIDE 10 MG CAPSULE	
	LENALIDOMIDE 15 MG CAPSULE	
	LENALIDOMIDE 2.5 MG CAPSULE	
	LENALIDOMIDE 20 MG CAPSULE	
	LENALIDOMIDE 25 MG CAPSULE	
	LENALIDOMIDE 5 MG CAPSULE	
	POMALYST 1 MG CAPSULE	
	POMALYST 2 MG CAPSULE	
	POMALYST 3 MG CAPSULE	
	POMALYST 4 MG CAPSULE	
	REVLIMID 10 MG CAPSULE	
	REVLIMID 15 MG CAPSULE	
	REVLIMID 2.5 MG CAPSULE	
	REVLIMID 20 MG CAPSULE	
	REVLIMID 25 MG CAPSULE	
Antineoplastic - Topoisomerase I Inhibitors	HYCAMTIN 0.25 MG CAPSULE	
	HYCAMTIN 1 MG CAPSULE	
Antineoplastic - Tropomyosin Receptor Kinase (TRK) Inhibitor	AUGTYRO 160 MG CAPSULE #	
	AUGTYRO 40 MG CAPSULE #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antineoplastic - Tropomyosin Receptor Kinase (TRK) Inhibitor	VITRAKVI 100 MG CAPSULE #	
	VITRAKVI 20 MG/ML SOLUTION #	
	VITRAKVI 25 MG CAPSULE #	
Anti-Obesity - Fat Absorption Decreasing Agents	ORLISTAT 120 MG CAPSULE	*PDL-P AGE PA QL
	XENICAL 120 MG CAPSULE	*PDL-P AGE PA QL
Anti-Obesity - Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists	Liraglutide 18 mg/3 ml pen (inner pack)	PDL-NP AGE PA QL
	Liraglutide 5-PAK 18 mg/ 3ml	PDL-NP AGE PA QL
	SAXENDA 18 MG/3 ML PEN	PDL-NP AGE PA QL
	WEGOVY 0.25 MG/0.5 ML PEN	PDL-NP AGE PA QL
	WEGOVY 0.5 MG/0.5 ML PEN	PDL-NP AGE PA QL
	WEGOVY 1 MG/0.5 ML PEN	PDL-NP AGE PA QL
	WEGOVY 1.7 MG/0.75 ML PEN	PDL-NP AGE PA QL
	WEGOVY 2.4 MG/0.75 ML PEN	PDL-NP AGE PA QL
Anti-Obesity - Incretin Mimetics Combination	ZEPBOUND 10 MG/0.5 ML PEN	*PDL-P AGE PA QL
	ZEPBOUND 10MG/DOSE(40MG/2.4ML)	*PDL-P AGE PA QL
	ZEPBOUND 12.5 MG/0.5 ML PEN	*PDL-P AGE PA QL
	ZEPBOUND 12.5MG/DOS(50MG/2.4ML)	*PDL-P AGE PA QL
	ZEPBOUND 15 MG/0.5 ML PEN	*PDL-P AGE PA QL
	ZEPBOUND 15MG/DOSE(60MG/2.4ML)	*PDL-P AGE PA QL
	ZEPBOUND 2.5 MG/0.5 ML PEN	*PDL-P AGE PA QL
	ZEPBOUND 2.5MG/DOS(10MG/2.4ML)	*PDL-P AGE PA QL
	ZEPBOUND 5 MG/0.5 ML PEN	*PDL-P AGE PA QL
	ZEPBOUND 5MG/DOSE (20MG/2.4ML)	*PDL-P AGE PA QL
	ZEPBOUND 7.5 MG/0.5 ML PEN	*PDL-P AGE PA QL
	ZEPBOUND 7.5MG/DOS(30MG/2.4ML)	*PDL-P AGE PA QL
Anti-Obesity - Melanocortin 4 Receptor Agonists	IMCIVREE 10 MG/ML VIAL #	
Antiparasitics	NITAZOXANIDE 500 MG TABLET	PDL-NP PA QL
Antiparkinson - Dopaminergic-Periph COMT-Dopa-decarboxylase Inhib Comb	CARBIDOPA-LEVODOPA 100 MG-ENTA	PDL-NP PA
	CARBIDOPA-LEVODOPA 125 MG-ENTA	PDL-NP PA
	CARBIDOPA-LEVODOPA 150 MG-ENTA	PDL-NP PA
	CARBIDOPA-LEVODOPA 200 MG-ENTA	PDL-NP PA
	CARBIDOPA-LEVODOPA 50 MG-ENTA	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antiparkinson - Dopaminergic-Periph COMT-Dopa-decarboxylase Inhib Comb	CARBIDOPA-LEVODOPA 75 MG-ENTA	PDL-NP PA
Antiparkinson - Dopaminerg-Peripheral Dopa-decarboxylase Inhibit Comb	CARBIDOPA-LEVO 10-100 MG ODT	PDL-NP PA
	CARBIDOPA-LEVO 25-100 MG ODT	PDL-NP PA
	CARBIDOPA-LEVO 25-250 MG ODT	PDL-NP PA
	Carbidopa-Levo ER 23.75-95 Cap	PDL-NP PA
	CARBIDOPA-LEVO ER 25-100 TAB	*PDL-P
	Carbidopa-Levo ER 36.25-145 Cap	PDL-NP PA
	Carbidopa-Levo ER 48.75-195 Cap	PDL-NP PA
	CARBIDOPA-LEVO ER 50-200 TAB	*PDL-P
	Carbidopa-Levo ER 61.25-245 Cap	PDL-NP PA
	CARBIDOPA-LEVODOPA 10-100 TAB	*PDL-P
	CARBIDOPA-LEVODOPA 25-100 TAB	*PDL-P
	CARBIDOPA-LEVODOPA 25-250 TAB	*PDL-P
	CREXONT ER 35 MG-140 MG CAP	PDL-NP AGE PA
	CREXONT ER 52.5 MG-210 MG CAP	PDL-NP AGE PA
	CREXONT ER 70 MG-280 MG CAP	PDL-NP AGE PA
	CREXONT ER 87.5 MG-350 MG CAP	PDL-NP AGE PA
	DHIVY 25-100 MG TABLET	PDL-NP PA
	DUOPA 4.63 MG-20 MG/ML SUSPENS	PDL-NP PA
	RYTARY ER 23.75 MG-95 MG CAP	PDL-NP PA
	RYTARY ER 36.25 MG-145 MG CAP	PDL-NP PA
	RYTARY ER 48.75 MG-195 MG CAP	PDL-NP PA
	RYTARY ER 61.25 MG-245 MG CAP	PDL-NP PA
	SINEMET 10-100 MG TABLET	PDL-NP PA
	SINEMET 25-100 MG TABLET	PDL-NP PA
	SINEMET 25-250 MG TABLET	PDL-NP PA
	VYALEV 120 MG-2,400 MG/10ML VL	PDL-NP AGE PA
Antiparkinson Adjuvant - Adenosine Receptor Antagonist	NOURIANZ 20 MG TABLET	PDL-NP PA
	NOURIANZ 40 MG TABLET	PDL-NP PA
Antiparkinson Adjuvant - Central/Peripheral COMT Inhibitors	TASMAR 100 MG TABLET	PDL-NP PA
	TOLCAPONE 100 MG TABLET	PDL-NP PA
Antiparkinson Adjuvant - Peripheral COMT Inhibitors	ENTACAPONE 200 MG TABLET	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antiparkinson Adjuvant - Peripheral COMT Inhibitors	ONGENTYS 25 MG CAPSULE	PDL-NP PA
	ONGENTYS 50 MG CAPSULE	PDL-NP PA
Antiparkinson Adjuvant - Peripheral Dopa-decarboxylase Inhibitors	CARBIDOPA 25 MG TABLET	PDL-NP PA
	LODOSYN 25 MG TABLET	PDL-NP PA
Antiparkinson Therapy - Anticholinergic Agents	BENZTROPINE MES 0.5 MG TAB #	
	BENZTROPINE MES 1 MG TABLET #	
	BENZTROPINE MES 2 MG TABLET #	
	TRIHEXYPHENIDYL 2 MG TABLET #	
	TRIHEXYPHENIDYL 2 MG/5 ML ELX #	
	TRIHEXYPHENIDYL 5 MG TABLET #	
Antiparkinson Therapy - Dopamine Precursors	INBRIJA 42 MG INHALATION CAP	PDL-NP PA
	INBRIJA 42 MG INHALATION CAP	PDL-NP PA
Antiparkinson Therapy - Ergot Alkaloids and Derivatives	BROMOCRIPTINE 2.5 MG TABLET	PDL-NP PA
	BROMOCRIPTINE 5 MG CAPSULE	PDL-NP PA
Antiparkinson Therapy - Monoamine Oxidase Inhibitor(MAO-B)	AZILECT 0.5 MG TABLET	PDL-NP AGE PA
	AZILECT 1 MG TABLET	PDL-NP AGE PA
	RASAGILINE MESYLATE 0.5 MG TAB	*PDL-P AGE PA
	RASAGILINE MESYLATE 1 MG TAB	*PDL-P AGE PA
	SELEGILINE HCL 5 MG CAPSULE	PDL-NP PA
	SELEGILINE HCL 5 MG TABLET	PDL-NP PA
	XADAGO 100 MG TABLET	PDL-NP PA
	XADAGO 50 MG TABLET	PDL-NP PA
	ZELAPAR 1.25 MG ODT TABLET	PDL-NP PA
Antiparkinson Therapy - Non-ergot Dopamine Agonist Agents	AMANTADINE 100 MG CAPSULE	*PDL-P
	AMANTADINE 100 MG TABLET	PDL-NP PA
	AMANTADINE 100 MG/10 ML CUP	*PDL-P
	AMANTADINE 50 MG/5 ML SOLUTION	*PDL-P
	GOCOVRI ER 137 MG CAPSULE	PDL-NP PA
	GOCOVRI ER 68.5 MG CAPSULE	PDL-NP PA
	NEUPRO 1 MG/24 HR PATCH	PDL-NP PA QL
	NEUPRO 2 MG/24 HR PATCH	PDL-NP PA QL
	NEUPRO 3 MG/24 HR PATCH	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antiparkinson Therapy - Non-ergot Dopamine Agonist Agents	NEUPRO 4 MG/24 HR PATCH	PDL-NP PA QL
	NEUPRO 6 MG/24 HR PATCH	PDL-NP PA QL
	NEUPRO 8 MG/24 HR PATCH	PDL-NP PA QL
	Onapgo 98 mg/20ml cartridge	PDL-NP AGE PA QL
	PRAMIPEXOLE 0.125 MG TABLET	*PDL-P
	PRAMIPEXOLE 0.25 MG TABLET	*PDL-P
	PRAMIPEXOLE 0.5 MG TABLET	*PDL-P
	PRAMIPEXOLE 0.75 MG TABLET	*PDL-P
	PRAMIPEXOLE 1 MG TABLET	*PDL-P
	PRAMIPEXOLE 1.5 MG TABLET	*PDL-P
	PRAMIPEXOLE ER 0.375 MG TABLET	PDL-NP PA
	PRAMIPEXOLE ER 0.75 MG TABLET	PDL-NP PA
	PRAMIPEXOLE ER 1.5 MG TABLET	PDL-NP PA
	PRAMIPEXOLE ER 2.25 MG TABLET	PDL-NP PA
	PRAMIPEXOLE ER 3 MG TABLET	PDL-NP PA
	PRAMIPEXOLE ER 3.75 MG TABLET	PDL-NP PA
	PRAMIPEXOLE ER 4.5 MG TABLET	PDL-NP PA
	ROPINIROLE HCL 0.25 MG TABLET	*PDL-P
	ROPINIROLE HCL 0.5 MG TABLET	*PDL-P
	ROPINIROLE HCL 1 MG TABLET	*PDL-P
	ROPINIROLE HCL 2 MG TABLET	*PDL-P
	ROPINIROLE HCL 3 MG TABLET	*PDL-P
	ROPINIROLE HCL 4 MG TABLET	*PDL-P
	ROPINIROLE HCL 5 MG TABLET	*PDL-P
	ROPINIROLE HCL ER 12 MG TABLET	PDL-NP PA
	ROPINIROLE HCL ER 2 MG TABLET	PDL-NP PA
ROPINIROLE HCL ER 4 MG TABLET	PDL-NP PA	
ROPINIROLE HCL ER 6 MG TABLET	PDL-NP PA	
ROPINIROLE HCL ER 8 MG TABLET	PDL-NP PA	
Anti-PCSK9 Monoclonal Antibodies	PRALUENT 150 MG/ML PEN	*PDL-P PA QL
	PRALUENT 75 MG/ML PEN	*PDL-P PA QL
	REPATHA 140 MG/ML SURECLICK	*PDL-P PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Anti-PCSK9 Monoclonal Antibodies	REPATHA 140 MG/ML SYRINGE	*PDL-P PA QL
	REPATHA 420 MG/3.5ML PUSHTRONX	*PDL-P PA QL
Antiporphyria Factors	PANHEMATIN 313 MG VIAL #	
Antiprotozoal Other	ATOVAQUONE 750 MG/5 ML SUSP	
Antiprotozoal-Antibacterial 1st Generation 2-methyl-5-nitroimidazole	FLAGYL 250 MG TABLET	PDL-NP PA
	FLAGYL 375 CAPSULE	PDL-NP PA
	FLAGYL 500 MG TABLET	PDL-NP PA
	METRONIDAZOLE 125 MG TABLET	PDL-NP PA
	METRONIDAZOLE 250 MG TABLET	*PDL-P
	METRONIDAZOLE 375 MG CAPSULE	PDL-NP PA
	METRONIDAZOLE 500 MG TABLET	*PDL-P
Antiprotozoal-Antibacterial 2nd Generation 2-methyl-5-nitroimidazole	TINIDAZOLE 250 MG TABLET	*PDL-P
	TINIDAZOLE 500 MG TABLET	*PDL-P
Antipsoriatic Agents - Interleukin 23 Inhibitors	ILUMYA 100 MG/ML SYRINGE	PDL-NP PA QL
	SKYRIZI 150 MG/ML PEN	PDL-NP PA QL
	SKYRIZI 150 MG/ML SYRINGE	PDL-NP PA QL
	SKYRIZI 180 MG/1.2 ML ON-BODY	PDL-NP PA QL
	SKYRIZI 360 MG/2.4 ML ON-BODY	PDL-NP PA QL
	TREMFYA 100 MG/ML INJECTOR	PDL-NP AGE PA QL
	TREMFYA 100 MG/ML PEN	PDL-NP AGE PA QL
	TREMFYA 100 MG/ML SYRINGE	PDL-NP AGE PA QL
	TREMFYA 200 MG/2 ML PEN	PDL-NP AGE PA QL
	TREMFYA 200 MG/2 ML SYRINGE	PDL-NP AGE PA QL
Antipsoriatic Agents - MC Antibody, Human Interleukin 12/23 Inhibitors	IMULDOSA 130 MG/26 ML VIAL	PDL-NP PA QL
	IMULDOSA 45 MG/0.5 ML SYRINGE	PDL-NP PA QL
	IMULDOSA 90 MG/ML SYRINGE	PDL-NP PA QL
	Otulfi 130mg/26ml vial	PDL-NP PA QL
	Otulfi 45mg/0.5ml Syringe	PDL-NP PA QL
	Otulfi 45mg/0.5ml Vial	PDL-NP PA QL
	Otulfi 90 mg/ml Syringe	PDL-NP PA QL
	Pyzchiva 130mg/26ml Vial	*PDL-P PA QL
	Pyzchiva 45mg/0.5ml Syringe	*PDL-P PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsoriatic Agents - MC Antibody, Human Interleukin 12/23 Inhibitors	Pyzchiva 45mg/0.5ml Vial	*PDL-P PA QL
	Pyzchiva 90mg/ml Syringe	*PDL-P PA QL
	Selarsdi 130mg/26ml Vial	PDL-NP PA QL
	Selarsdi 45mg/0.5ml Syringe	PDL-NP PA QL
	Selarsdi 45mg/0.5ml Vial	PDL-NP PA QL
	Selarsdi 90mg/ml Syringe	PDL-NP PA QL
	STELARA 130 MG/26 ML VIAL	PDL-NP PA QL
	STELARA 45 MG/0.5 ML SYRINGE	PDL-NP PA QL
	STELARA 45 MG/0.5 ML VIAL	PDL-NP PA QL
	STELARA 90 MG/ML SYRINGE	PDL-NP PA QL
	STEQEYMA 130 MG/26 ML VIAL	*PDL-P PA QL
	STEQEYMA 45 MG/0.5 ML SYRINGE	*PDL-P PA QL
	STEQEYMA 90 MG/ML SYRINGE	*PDL-P PA QL
	USTEKINUMAB 130 MG/26 ML VIAL	PDL-NP PA QL
	USTEKINUMAB 45 MG/0.5 ML VIAL	PDL-NP PA QL
	USTEKINUMAB 45MG/0.5ML SYRINGE	PDL-NP PA QL
	USTEKINUMAB 90 MG/ML SYRINGE	PDL-NP PA QL
	USTEKINUMAB-AAUZ 45 MG SYRINGE	PDL-NP PA QL
	USTEKINUMAB-AAUZ 90 MG/ML SYR	PDL-NP PA QL
	USTEKINUMAB-AEKN 45mg/0.5ml Syringe	PDL-NP PA QL
	USTEKINUMAB-AEKN 90mg/ml Syringe	PDL-NP PA QL
	USTEKINUMAB-TTWE 130MG/26ML VL	PDL-NP PA QL
	USTEKINUMAB-TTWE 45MG/0.5ML SY	PDL-NP PA QL
	USTEKINUMAB-TTWE 90 MG/ML SYR	PDL-NP PA QL
	YESINTEK 130 MG/26 ML VIAL	PDL-NP PA QL
	YESINTEK 45 MG/0.5 ML SYRINGE	PDL-NP PA QL
YESINTEK 45 MG/0.5 ML VIAL	PDL-NP PA QL	
YESINTEK 90 MG/ML SYRINGE	PDL-NP PA QL	
Antipsoriatic Agents - MC Antibody, Interleukin-17A Antagonist	COSENTYX 150 MG/ML SYRINGE	*PDL-P QL
	COSENTYX 300 MG DOSE-2 SYRINGE	*PDL-P QL
	COSENTYX 75 MG/0.5 ML SYRINGE	*PDL-P QL
	COSENTYX SENSOREADY 150 MG PEN	*PDL-P QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsoriatic Agents - MC Antibody, Interleukin-17A Antagonist	COSENTYX SNRDY 300MG DOSE-2PEN	*PDL-P QL
	COSENTYX UNOREADY 300 MG PEN	*PDL-P QL
	TALTZ 80 MG/ML AUTOINJ (3-PK)	PDL-NP PA QL
Antipsoriatic Agents, Systemic	SOTYKTU 6 MG TABLET	PDL-NP AGE PA QL
	TALTZ 20 MG/0.25 ML SYRINGE	PDL-NP PA QL
	TALTZ 40 MG/0.5 ML SYRINGE	PDL-NP PA QL
	TALTZ 80 MG/ML AUTOINJ	PDL-NP PA QL
	TALTZ 80 MG/ML AUTOINJ (2-PK)	PDL-NP PA QL
	TALTZ 80 MG/ML AUTOINJECTOR	PDL-NP PA QL
	TALTZ 80 MG/ML SYRINGE	PDL-NP PA QL
Antipsychotic - Atyp Dopamine-Serotonin Antag Dibenzo-Oxepino Pyrroles	SAPHRIS 10 MG TAB SUBLINGUAL #	
	SAPHRIS 2.5 MG TAB SUBLINGUAL #	
	SAPHRIS 5 MG TAB SUBLINGUAL #	
	SECUADO 3.8 MG/24 HR PATCH #	
	SECUADO 5.7 MG/24 HR PATCH #	
	SECUADO 7.6 MG/24 HR PATCH #	
Antipsychotic - Atyp Selective Serotonin 5-HT2A Inverse Agonists (SSIA)	NUPLAZID 10 MG TABLET #	
	NUPLAZID 34 MG CAPSULE #	
Antipsychotic - Atypical Dopamine Partial Agonist-Serotonin Mixed	ABILIFY 10 MG TABLET #	
	ABILIFY 15 MG TABLET #	
	ABILIFY 2 MG TABLET #	
	ABILIFY 20 MG TABLET #	
	ABILIFY 30 MG TABLET #	
	ABILIFY 5 MG TABLET #	
	ABILIFY ASIMTUFII 720 MG/2.4ML #	
	ABILIFY ASIMTUFII 720 MG/2.4ML #	
	ABILIFY ASIMTUFII 960 MG/3.2ML #	
	ABILIFY ASIMTUFII 960 MG/3.2ML #	
	ABILIFY MAINTENA ER 300 MG SYR #	
	ABILIFY MAINTENA ER 300 MG VL #	
	ABILIFY MAINTENA ER 400 MG SYR #	
	ABILIFY MAINTENA ER 400 MG VL #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsychotic - Atypical Dopamine Partial Agonist-Serotonin Mixed	ABILIFY MYCITE 10 MG KIT #	
	ABILIFY MYCITE 15 MG KIT #	
	ABILIFY MYCITE 2 MG KIT #	
	ABILIFY MYCITE 20 MG KIT #	
	ABILIFY MYCITE 30 MG KIT #	
	ABILIFY MYCITE 5 MG KIT #	
	ARIPIRAZOLE 1 MG/ML SOLUTION #	
	ARIPIRAZOLE 10 MG TABLET #	
	ARIPIRAZOLE 15 MG TABLET #	
	ARIPIRAZOLE 2 MG TABLET #	
	ARIPIRAZOLE 20 MG TABLET #	
	ARIPIRAZOLE 30 MG TABLET #	
	ARIPIRAZOLE 5 MG TABLET #	
	ARIPIRAZOLE ODT 10 MG TABLET #	
	ARIPIRAZOLE ODT 15 MG TABLET #	
	ARISTADA ER 1064 MG/3.9 ML SYR #	
	ARISTADA ER 441 MG/1.6 ML SYRN #	
	ARISTADA ER 662 MG/2.4 ML SYRN #	
	ARISTADA ER 882 MG/3.2 ML SYRN #	
	ARISTADA INITIO ER 675 MG/2.4 #	
	OPIPZA 10 MG FILM #	
	OPIPZA 2 MG FILM #	
	OPIPZA 5 MG FILM #	
	VRAYLAR 1.5 MG CAPSULE #	
	VRAYLAR 1.5 MG-3 MG PACK #	
	VRAYLAR 3 MG CAPSULE #	
	VRAYLAR 4.5 MG CAPSULE #	
VRAYLAR 6 MG CAPSULE #		
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisothiazolones	CAPLYTA 42 MG CAPSULE #	
	GEODON 20 MG CAPSULE #	
	GEODON 20 MG/ML VIAL #	
	GEODON 40 MG CAPSULE #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisothiazolones	GEODON 60 MG CAPSULE #	
	GEODON 80 MG CAPSULE #	
	LATUDA 120 MG TABLET #	
	LATUDA 20 MG TABLET #	
	LATUDA 40 MG TABLET #	
	LATUDA 60 MG TABLET #	
	LATUDA 80 MG TABLET #	
	LURASIDONE HCL 120 MG TABLET #	
	LURASIDONE HCL 20 MG TABLET #	
	LURASIDONE HCL 40 MG TABLET #	
	LURASIDONE HCL 60 MG TABLET #	
	LURASIDONE HCL 80 MG TABLET #	
	ZIPRASIDONE 20 MG/ML VIAL #	
	ZIPRASIDONE HCL 20 MG CAPSULE #	
	ZIPRASIDONE HCL 40 MG CAPSULE #	
	ZIPRASIDONE HCL 60 MG CAPSULE #	
	ZIPRASIDONE HCL 80 MG CAPSULE #	
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisoxazole Deriv	ERZOFRI 117 MG/0.75 ML SYRINGE #	
	ERZOFRI 156 MG/ML SYRINGE #	
	ERZOFRI 234 MG/1.5 ML SYRINGE #	
	ERZOFRI 351 MG/2.25 ML SYRINGE #	
	ERZOFRI 39 MG/0.25 ML SYRINGE #	
	ERZOFRI 78 MG/0.5 ML SYRINGE #	
	FANAPT 1 MG TABLET #	
	FANAPT 10 MG TABLET #	
	FANAPT 12 MG TABLET #	
	FANAPT 2 MG TABLET #	
	FANAPT 4 MG TABLET #	
	FANAPT 6 MG TABLET #	
	FANAPT 8 MG TABLET #	
	FANAPT TITRATION PACK #	
INVEGA ER 1.5 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisoxazole Deriv	INVEGA ER 3 MG TABLET #	
	INVEGA ER 6 MG TABLET #	
	INVEGA ER 9 MG TABLET #	
	INVEGA HAFYERA 1,092 MG/3.5 ML #	
	INVEGA HAFYERA 1,560 MG/5 ML #	
	INVEGA SUSTENNA 117 MG/0.75 ML #	
	INVEGA SUSTENNA 156 MG/ML SYRG #	
	INVEGA SUSTENNA 234 MG/1.5 ML #	
	INVEGA SUSTENNA 39 MG/0.25 ML #	
	INVEGA SUSTENNA 78 MG/0.5 ML #	
	INVEGA TRINZA 273 MG/0.875 ML #	
	INVEGA TRINZA 410 MG/1.315 ML #	
	INVEGA TRINZA 546 MG/1.75 ML #	
	INVEGA TRINZA 819 MG/2.625 ML #	
	PALIPERIDONE ER 1.5 MG TABLET #	
	PALIPERIDONE ER 3 MG TABLET #	
	PALIPERIDONE ER 6 MG TABLET #	
	PALIPERIDONE ER 9 MG TABLET #	
	PERSERIS ER 120 MG SYRINGE KIT #	
	PERSERIS ER 90 MG SYRINGE KIT #	
	RISPERDAL 0.5 MG TABLET #	
	RISPERDAL 1 MG TABLET #	
	RISPERDAL 1 MG/ML SOLUTION #	
	RISPERDAL 2 MG TABLET #	
	RISPERDAL 3 MG TABLET #	
	RISPERDAL 4 MG TABLET #	
	RISPERDAL CONSTA 12.5 MG VIAL #	
	RISPERDAL CONSTA 25 MG VIAL #	
	RISPERDAL CONSTA 37.5 MG VIAL #	
	RISPERDAL CONSTA 50 MG VIAL #	
RISPERIDONE 0.25 MG ODT #		
RISPERIDONE 0.25 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
 (See MPPL @ mi.primetherapeutics.com
 for coverage details)

AGE = Age Edit
 GENDER = Gender Edit
 ST = Step Therapy
 *= Over the Counter (OTC)
 *PDL-P = PDL Preferred
 PDL-NP = PDL Non-Preferred

PA = Prior Authorization
 QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisoxazole Deriv	RISPERIDONE 0.5 MG ODT #	
	RISPERIDONE 0.5 MG TABLET #	
	RISPERIDONE 1 MG ODT #	
	RISPERIDONE 1 MG TABLET #	
	RISPERIDONE 1 MG/ML SOLUTION #	
	RISPERIDONE 2 MG ODT #	
	RISPERIDONE 2 MG TABLET #	
	RISPERIDONE 3 MG ODT #	
	RISPERIDONE 3 MG TABLET #	
	RISPERIDONE 4 MG ODT #	
	RISPERIDONE 4 MG TABLET #	
	UZEDY ER 100 MG/0.28 ML SYRING #	
	UZEDY ER 125 MG/0.35 ML SYRING #	
	UZEDY ER 150 MG/0.42 ML SYRING #	
	UZEDY ER 200 MG/0.56 ML SYRING #	
	UZEDY ER 250 MG/0.7 ML SYRINGE #	
	UZEDY ER 50 MG/0.14 ML SYRINGE #	
	UZEDY ER 75 MG/0.21 ML SYRINGE #	
Antipsychotic - Atypical Dopamine-Serotonin Antag-Dibenzodiazepine Der	CLOZAPINE 100 MG TABLET #	
	CLOZAPINE 200 MG TABLET #	
	CLOZAPINE 25 MG TABLET #	
	CLOZAPINE 50 MG TABLET #	
	CLOZAPINE ODT 100 MG TABLET #	
	CLOZAPINE ODT 12.5 MG TABLET #	
	CLOZAPINE ODT 150 MG TABLET #	
	CLOZAPINE ODT 200 MG TABLET #	
	CLOZAPINE ODT 25 MG TABLET #	
	CLOZARIL 100 MG TABLET #	
	CLOZARIL 200 MG TABLET #	
	CLOZARIL 25 MG TABLET #	
	CLOZARIL 50 MG TABLET #	
VERSACLOZ 50 MG/ML SUSPENSION #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsychotic - Atypical Dopamine-Serotonin Antag-Dibenzothiazepine Der	QUETIAPINE ER 150 MG TABLET #	
	QUETIAPINE ER 200 MG TABLET #	
	QUETIAPINE ER 300 MG TABLET #	
	QUETIAPINE ER 400 MG TABLET #	
	QUETIAPINE ER 50 MG TABLET #	
	QUETIAPINE FUMARATE 100 MG TAB #	
	QUETIAPINE FUMARATE 200 MG TAB #	
	QUETIAPINE FUMARATE 25 MG TAB #	
	QUETIAPINE FUMARATE 300 MG TAB #	
	QUETIAPINE FUMARATE 400 MG TAB #	
	QUETIAPINE FUMARATE 50 MG TAB #	
	SEROQUEL 100 MG TABLET #	
	SEROQUEL 200 MG TABLET #	
	SEROQUEL 25 MG TABLET #	
	SEROQUEL 300 MG TABLET #	
	SEROQUEL 400 MG TABLET #	
	SEROQUEL 50 MG TABLET #	
	SEROQUEL XR 150 MG TABLET #	
	SEROQUEL XR 200 MG TABLET #	
	SEROQUEL XR 300 MG TABLET #	
SEROQUEL XR 400 MG TABLET #		
SEROQUEL XR 50 MG TABLET #		
SEROQUEL XR SAMPLE KIT #		
Antipsychotic - Atypical Dopamine-Serotonin Antag-Thienobenzodiazepines	OLANZAPINE 10 MG TABLET #	
	OLANZAPINE 10 MG VIAL #	
	OLANZAPINE 15 MG TABLET #	
	OLANZAPINE 2.5 MG TABLET #	
	OLANZAPINE 20 MG TABLET #	
	OLANZAPINE 5 MG TABLET #	
	OLANZAPINE 7.5 MG TABLET #	
	OLANZAPINE ODT 10 MG TABLET #	
OLANZAPINE ODT 15 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsychotic - Atypical Dopamine-Serotonin Antag-Thienobenzodiazepines	OLANZAPINE ODT 20 MG TABLET #	
	OLANZAPINE ODT 5 MG TABLET #	
	ZYPREXA 10 MG TABLET #	
	ZYPREXA 10 MG VIAL #	
	ZYPREXA 15 MG TABLET #	
	ZYPREXA 2.5 MG TABLET #	
	ZYPREXA 20 MG TABLET #	
	ZYPREXA 5 MG TABLET #	
	ZYPREXA 7.5 MG TABLET #	
	ZYPREXA RELPREVV 210 MG VL KIT #	
	ZYPREXA RELPREVV 300 MG VL KIT #	
	ZYPREXA RELPREVV 405 MG VL KIT #	
	ZYPREXA ZYDIS 10 MG TABLET #	
	ZYPREXA ZYDIS 15 MG TABLET #	
	ZYPREXA ZYDIS 20 MG TABLET #	
ZYPREXA ZYDIS 5 MG TABLET #		
Antipsychotic - Butyrophenone Derivatives	HALOPERIDOL 0.5 MG TABLET #	
	HALOPERIDOL 1 MG TABLET #	
	HALOPERIDOL 10 MG TABLET #	
	HALOPERIDOL 2 MG TABLET #	
	HALOPERIDOL 20 MG TABLET #	
	HALOPERIDOL 5 MG TABLET #	
Antipsychotic - Dibenzoxazepine Derivatives	LOXAPINE 10 MG CAPSULE #	
	LOXAPINE 25 MG CAPSULE #	
	LOXAPINE 5 MG CAPSULE #	
	LOXAPINE 50 MG CAPSULE #	
Antipsychotic - Dihydroindolones	MOLINDONE HCL 10 MG TABLET #	
	MOLINDONE HCL 25 MG TABLET #	
	MOLINDONE HCL 5 MG TABLET #	
Antipsychotic - Phenothiazines, Aliphatic	CHLORPROMAZINE 10 MG TABLET #	
	CHLORPROMAZINE 100 MG TABLET #	
	CHLORPROMAZINE 200 MG TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antipsychotic - Phenothiazines, Aliphatic	CHLORPROMAZINE 25 MG TABLET #	
	CHLORPROMAZINE 50 MG TABLET #	
Antipsychotic - Phenothiazines, Piperazine	FLUPHENAZINE 1 MG TABLET #	
	FLUPHENAZINE 10 MG TABLET #	
	FLUPHENAZINE 2.5 MG TABLET #	
	FLUPHENAZINE 2.5 MG/5 ML ELIX #	
	FLUPHENAZINE 5 MG TABLET #	
	FLUPHENAZINE 5 MG/ML CONC #	
	PERPHENAZINE 16 MG TABLET #	
	PERPHENAZINE 2 MG TABLET #	
	PERPHENAZINE 4 MG TABLET #	
	PERPHENAZINE 8 MG TABLET #	
	TRIFLUOPERAZINE 1 MG TABLET #	
	TRIFLUOPERAZINE 10 MG TABLET #	
	TRIFLUOPERAZINE 2 MG TABLET #	
	TRIFLUOPERAZINE 5 MG TABLET #	
Antipsychotic - Phenothiazines, Piperidine	THIORIDAZINE 10 MG TABLET #	
	THIORIDAZINE 100 MG TABLET #	
	THIORIDAZINE 25 MG TABLET #	
	THIORIDAZINE 50 MG TABLET #	
Antipsychotic - Thioxanthenes	THIOTHIXENE 1 MG CAPSULE #	
	THIOTHIXENE 10 MG CAPSULE #	
	THIOTHIXENE 2 MG CAPSULE #	
	THIOTHIXENE 5 MG CAPSULE #	
Antipsychotic-Atypical,D2 Receptor Partial Agonist-5HT Serotonin Mixed	REXULTI 0.25 MG TABLET #	
	REXULTI 0.5 MG TABLET #	
	REXULTI 1 MG TABLET #	
	REXULTI 2 MG TABLET #	
	REXULTI 3 MG TABLET #	
	REXULTI 4 MG TABLET #	
Antiretroviral - CCR5 Co-Receptor Antagonist	SELZENTRY 150 MG TABLET #	
	SELZENTRY 300 MG TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antiretroviral - HIV-1 Capsid Inhibitors	SUNLENCA 4- 300 MG TABLET #	
	SUNLENCA 5- 300 MG TABLET #	
	YEZTUGO 300 MG tablet #	
	YEZTUGO 463.5 MG/1.5 ML Vial #	
Antiretroviral - HIV-1 Fusion Inhibitors	FUZEON 90 MG VIAL #	
Antiretroviral - HIV-1 Integrase Strand Transfer Inhibitors	ISENTRESS 100 MG POWDER PACKET #	
	ISENTRESS 100 MG TABLET CHEW #	
	ISENTRESS 25 MG TABLET CHEW #	
	ISENTRESS 400 MG TABLET #	
	TIVICAY 50 MG TABLET #	
	TIVICAY PD 5 MG TAB FOR SUSP #	
	VITEKTA 150 MG TABLET #	
	VITEKTA 85 MG TABLET #	
	VOCABRIA 30 MG TABLET #	
Antiretroviral - Non-Nucleoside Reverse Transcriptase Inhib (NNRTI)	EDURANT 25 MG TABLET #	
	EFAVIRENZ 200 MG CAPSULE #	
	EFAVIRENZ 50 MG CAPSULE #	
	EFAVIRENZ 600 MG TABLET #	
	INTELENCE 100 MG TABLET #	
	INTELENCE 200 MG TABLET #	
	INTELENCE 25 MG TABLET #	
	NEVIRAPINE 200 MG TABLET #	
	NEVIRAPINE 50 MG/5 ML SUSP #	
	NEVIRAPINE ER 400 MG TABLET #	
	PIFELTRO 100 MG TABLET #	
	RESCRIPTOR 100 MG TABLET #	
	RESCRIPTOR 200 MG TABLET #	
	VIRAMUNE 200 MG TABLET #	
	VIRAMUNE 50 MG/5 ML SUSP #	
	VIRAMUNE XR 100 MG TABLET #	
VIRAMUNE XR 400 MG TABLET #		
Antiretroviral - Nucleoside & Nucleotide Analogs, Integrase Inhibitors	BIKTARVY 50-200-25 MG TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antiretroviral - Nucleoside & Nucleotide Analogs, Integrase Inhibitors	STRIBILD TABLET #	
	SYMTUZA 800-150-200-10 MG TAB #	
Antiretroviral - Nucleoside Reverse Transcriptase Inhibitors (NRTI)	ABACAVIR 300 MG TABLET #	
	DIDANOSINE DR 125 MG CAPSULE #	
	DIDANOSINE DR 200 MG CAPSULE #	
	DIDANOSINE DR 250 MG CAPSULE #	
	DIDANOSINE DR 400 MG CAPSULE #	
	EMTRIVA 10 MG/ML SOLUTION #	
	EMTRIVA 200 MG CAPSULE #	
	EPIVIR 10 MG/ML ORAL SOLN #	
	EPIVIR 150 MG TABLET #	
	EPIVIR 300 MG TABLET #	
	LAMIVUDINE 10 MG/ML ORAL SOLN #	
	LAMIVUDINE 150 MG TABLET #	
	LAMIVUDINE 300 MG TABLET #	
	RETROVIR 10 MG/ML SYRUP #	
	RETROVIR 100 MG CAPSULE #	
	RETROVIR 200 MG/20 ML VIAL #	
	STAVUDINE 1 MG/ML SOLUTION #	
	STAVUDINE 15 MG CAPSULE #	
	STAVUDINE 20 MG CAPSULE #	
	STAVUDINE 30 MG CAPSULE #	
	STAVUDINE 40 MG CAPSULE #	
	VIDEX 2 GM PEDIATRIC SOLN #	
	VIDEX 4 GM PEDIATRIC SOLN #	
	VIDEX EC 125 MG CAPSULE #	
	VIDEX EC 200 MG CAPSULE #	
	VIDEX EC 250 MG CAPSULE #	
	VIDEX EC 400 MG CAPSULE #	
ZERIT 1 MG/ML SOLUTION #		
ZERIT 15 MG CAPSULE #		
ZERIT 20 MG CAPSULE #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antiretroviral - Nucleoside Reverse Transcriptase Inhibitors (NRTI)	ZERIT 30 MG CAPSULE #	
	ZERIT 40 MG CAPSULE #	
	ZIAGEN 20 MG/ML SOLUTION #	
	ZIAGEN 300 MG TABLET #	
	ZIDOVUDINE 100 MG CAPSULE #	
	ZIDOVUDINE 300 MG TABLET #	
	ZIDOVUDINE 50 MG/5 ML SYRUP #	
Antiretroviral - Nucleotide Analog Reverse Transcriptase Inhibitors	VIREAD 150 MG TABLET #	
	VIREAD 200 MG TABLET #	
	VIREAD 250 MG TABLET #	
	VIREAD 300 MG TABLET #	
	VIREAD POWDER #	
Antiretroviral Combinations - NRTI's	ABACA VIR-LAMIVUDINE-ZIDOV TAB #	
	COMBIVIR TABLET #	
	DESCOVY 120-15 MG TABLET #	
	DESCOVY 200-25 MG TABLET #	
	EPZICOM TABLET #	
	LAMIVUDINE-ZIDOVUDINE TABLET #	
	TRIZIVIR TABLET #	
Antiretroviral Combinations - Nucleoside & Nucleotide Analog RTIs	TRUVADA 200 MG-300 MG TABLET #	
Antiretroviral Combinations - Nucleoside Analogs & Integrase Inhibitor	TRIUMEQ TABLET #	
Antiretroviral Combinations - Protease Inhibitors	KALETRA 100-25 MG TABLET #	
	KALETRA 200-50 MG TABLET #	
	KALETRA 400-100/5 ML ORAL SOLU #	
Antiretroviral-Integrase Inhibitor	APRETUDE ER 600 MG/3 ML VIAL #	
Antiretroviral-Integrase Inhibitor and NNRTI Combinations	CABENUVA ER 400 MG-600 MG SUSP #	
	CABENUVA ER 600 MG-900 MG SUSP #	
	JULUCA 50-25 MG TABLET #	
Antiretroviral-Integrase Inhibitor and NRTI Combinations	DOVATO 50-300 MG TABLET #	
Antiretroviral-Nucleoside& Nucleotide Analogs& Non-Nucleoside RTI Comb	ATRIPLA TABLET #	
	COMPLERA TABLET #	
	DELSTRIGO 100-300-300 MG TAB #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Antithyroid Agents, Thionamides - Imidazole Derivatives	METHIMAZOLE 10 MG TABLET	
	METHIMAZOLE 5 MG TABLET	
	TAPAZOLE 10 MG TABLET	
Antithyroid Agents, Thionamides - Thiouracil Derivatives	PROPYLTHIOURACIL 50 MG TABLET	
Antitubercular - D-alanine Analogs	CYCLOSERINE 250 MG CAPSULE	QL
Antitubercular - Diarylquinoline Antibiotics	SIRTURO 100 MG TABLET	PA
	SIRTURO 20 MG TABLET	PA
Antitubercular - Isonicotinic Acid Derivatives	ISONIAZID 100 MG TABLET	
	ISONIAZID 300 MG TABLET	
	ISONIAZID 50 MG/5 ML SOLUTION	AGE
Antitubercular - Niacinamide Derivatives	PYRAZINAMIDE 500 MG TABLET	
Antitubercular - Nitroimidazole Derivatives	PRETOMANID 200 MG TABLET	PA
Antitubercular - Rifamycin and Derivatives	PRIFTIN 150 MG TABLET	QL
	RIFABUTIN 150 MG CAPSULE	
	RIFAMPIN 150 MG CAPSULE	
	RIFAMPIN 300 MG CAPSULE	
Antitubercular Agents Other	ETHAMBUTOL HCL 100 MG TABLET	
	ETHAMBUTOL HCL 400 MG TABLET	
	TRECATOR 250 MG TABLET	
Antiviral Combinations	PAXLOVID 150-100 MG DOSE PACK	*PDL-P
	PAXLOVID 300/150-100MG(SEVERE)	*PDL-P
	PAXLOVID 300-100 MG DOSE PACK	*PDL-P
Antiviral Monoclonal Antibodies	BEYFORTUS 100 MG/ML SYRINGE	PA
	BEYFORTUS 50 MG/0.5 ML SYRINGE	PA
	SYNAGIS 100 MG/ML VIAL	PA
	SYNAGIS 50 MG/0.5 ML VIAL	PA
Antivirals, HIV-Specific, CD4 Attachment Inhibitor	RUKOBIA ER 600 MG TABLET #	
Appetite Stimulants - Progestin Hormone Type	MEGESTROL 625 MG/5 ML SUSP	PDL-NP PA
	MEGESTROL 800 MG/20 ML SUSP	*PDL-P
	MEGESTROL ACET 40 MG/ML SUSP	*PDL-P
	MEGESTROL ACET 400 MG/10 ML	*PDL-P
Artificial Tears and Lubricant Combinations	ARTIFICIAL TEARS DROPS *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Artificial Tears and Lubricant Combinations	ARTIFICIAL TEARS DROPS *	
	CVS NATURAL TEARS DROPS *	
	REFRESH LACRI-LUBE OINTMENT *	
	REFRESH P.M. OINTMENT *	
	SM LUBRICANT EYE DROPS *	
	SYSTANE 0.3-0.4% EYE DROPS *	
	SYSTANE GEL EYE DROPS *	
	SYSTANE ULTRA 0.4-0.3% EYE DRP *	
Artificial Tears and Lubricant Single Agents	CARBOXYMETHYLCELL 0.5% EYE DRP *	
	CARBOXYMETHYLCELL 1% EYE GEL	
	LUBRICATING PLUS 0.5% EYE DRPS *	
	POLYVINYL ALCOHL 1.4 % EYEDROP *	
	REFRESH LIQUIGEL 1% EYE DROPS *	
Asthma Therapy - 5-Lipoxygenase Inhibitors	ZILEUTON ER 600 MG TABLET	PDL-NP PA
	ZYFLO 600 MG FILMTAB	PDL-NP PA
Asthma Therapy - Glucocorticoids	ALVESCO 160 MCG INHALER	*PDL-P
	ALVESCO 80 MCG INHALER	*PDL-P
	ARMONAIR DIGIHALER 113 MCG	PDL-NP PA
	ARMONAIR DIGIHALER 232 MCG	PDL-NP PA
	ARMONAIR DIGIHALER 55 MCG	PDL-NP PA
	ARNUITY ELLIPTA 100 MCG INH	*PDL-P
	ARNUITY ELLIPTA 200 MCG INH	*PDL-P
	ARNUITY ELLIPTA 50 MCG INH	*PDL-P AGE
	ASMANEX HFA 100 MCG INHALER	*PDL-P QL
	ASMANEX HFA 200 MCG INHALER	*PDL-P QL
	ASMANEX HFA 50 MCG INHALER	*PDL-P AGE QL
	ASMANEX TWISTHALER 110 MCG #30	*PDL-P AGE QL
	ASMANEX TWISTHALER 220 MCG #14	*PDL-P QL
	ASMANEX TWISTHALER 220 MCG #30	*PDL-P QL
	ASMANEX TWISTHALER 220 MCG #60	*PDL-P QL
	ASMANEX TWISTHALR 220 MCG #120	*PDL-P QL
BUDESONIDE 0.25 MG/2 ML SUSP	*PDL-P AGE QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Asthma Therapy - Glucocorticoids	BUDESONIDE 0.5 MG/2 ML SUSP	*PDL-P AGE QL
	BUDESONIDE 1 MG/2 ML INH SUSP	*PDL-P AGE QL
	FLUTICASONE ELLIPTA 100MCG INH	PDL-NP PA
	FLUTICASONE ELLIPTA 200MCG INH	PDL-NP PA
	FLUTICASONE ELLIPTA 50 MCG INH	PDL-NP AGE PA
	FLUTICASONE PROP 100MCG DISKUS	PDL-NP PA
	FLUTICASONE PROP 250 MCG DISK	PDL-NP PA
	FLUTICASONE PROP 50 MCG DISKUS	PDL-NP PA
	FLUTICASONE PROP HFA 110 MCG	*PDL-P QL
	FLUTICASONE PROP HFA 220 MCG	*PDL-P QL
	FLUTICASONE PROP HFA 44 MCG	*PDL-P QL
	PULMICORT 0.25 MG/2 ML RESPUL	PDL-NP AGE PA QL
	PULMICORT 0.5 MG/2 ML RESPULE	PDL-NP AGE PA QL
	PULMICORT 1 MG/2 ML RESPULE	PDL-NP AGE PA QL
	PULMICORT 180 MCG FLEXHALER	*PDL-P QL
	PULMICORT 90 MCG FLEXHALER	*PDL-P QL
	QVAR REDIHALER 40 MCG	*PDL-P
	QVAR REDIHALER 80 MCG	*PDL-P
	Asthma Therapy - Interleukin-4 Rec. Antag Mab	DUPIXENT 100 MG/0.67 ML SYRING
DUPIXENT 200 MG/1.14 ML PEN		*PDL-P AGE PA
DUPIXENT 200 MG/1.14 ML SYRING		*PDL-P AGE PA
DUPIXENT 300 MG/2 ML PEN		*PDL-P AGE PA
DUPIXENT 300 MG/2 ML SYRINGE		*PDL-P AGE PA
Asthma Therapy - Leukotriene Receptor Antagonists	ACCOLATE 10 MG TABLET	PDL-NP PA
	ACCOLATE 20 MG TABLET	PDL-NP PA
	MONTELUKAST SOD 10 MG TABLET	*PDL-P
	MONTELUKAST SOD 4 MG GRANULES	PDL-NP AGE PA
	MONTELUKAST SOD 4 MG TAB CHEW	*PDL-P AGE
	MONTELUKAST SOD 5 MG TAB CHEW	*PDL-P AGE
	SINGULAIR 10 MG TABLET	PDL-NP PA
	SINGULAIR 4 MG GRANULES	PDL-NP AGE PA
SINGULAIR 4 MG TABLET CHEW	PDL-NP AGE PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Asthma Therapy - Leukotriene Receptor Antagonists	SINGULAIR 5 MG TABLET CHEW	PDL-NP AGE PA
	ZAFIRLUKAST 10 MG TABLET	PDL-NP PA
	ZAFIRLUKAST 20 MG TABLET	PDL-NP PA
Asthma Therapy - Monoclonal Antibodies to Immunoglobulin E (IgE)	XOLAIR 150 MG/ML AUTOINJECTOR	*PDL-P AGE PA
	XOLAIR 150 MG/ML SYRINGE	*PDL-P AGE PA
	XOLAIR 150 MG/ML SYRINGE	*PDL-P AGE PA
	XOLAIR 300 MG/2 ML AUTOINJECT	*PDL-P AGE PA
	XOLAIR 300 MG/2 ML SYRINGE	*PDL-P AGE PA
	XOLAIR 75 MG/0.5 ML AUTOINJECT	*PDL-P AGE PA
	XOLAIR 75 MG/0.5 ML SYRINGE	*PDL-P AGE PA
Asthma Therapy - Monoclonal Antibody -Interleukin-5 (IL-5) Antagonists	FASENRA PEN 30 MG/ML	*PDL-P AGE PA
	NUCALA 100 MG/ML AUTO-INJECTOR	PDL-NP AGE PA
	NUCALA 100 MG/ML SYRINGE	PDL-NP AGE PA
	NUCALA 40 MG/0.4 ML SYRINGE	PDL-NP AGE PA
Asthma Therapy - Thymic Stromal Lymphopoietin (TSLP) Antagonists	TEZSPIRE 210 MG/1.91 ML PEN	PDL-NP AGE PA
Asthma Therapy - Xanthines	THEOPHYLLINE 80 MG/15 ML CUP	
	THEOPHYLLINE 80 MG/15 ML SOLN	
	THEOPHYLLINE ER 100 MG TABLET	
	THEOPHYLLINE ER 200 MG TABLET	
	THEOPHYLLINE ER 300 MG TABLET	
	THEOPHYLLINE ER 400 MG TABLET	
	THEOPHYLLINE ER 450 MG TABLET	
	THEOPHYLLINE ER 600 MG TABLET	
Asthma/COPD - Phosphodiesterase-4 (PDE4) inhibitors	DALIRESP 250 MCG TABLET	PDL-NP PA
	DALIRESP 500 MCG TABLET	PDL-NP PA
	ROFLUMILAST 250 MCG TABLET	*PDL-P PA
	ROFLUMILAST 500 MCG TABLET	*PDL-P PA
Asthma/COPD - Anticholinergic Agents, Inhaled Long Acting	INCRUSE ELLIPTA 62.5 MCG INH	*PDL-P QL
	INCRUSE ELLIPTA 62.5 MCG INH	*PDL-P QL
	SPIRIVA HANDIHALER 18 MCG CAP	*PDL-P QL
	SPIRIVA HANDIHALER 18 MCG CAP	*PDL-P QL
	SPIRIVA HANDIHALER 18 MCG CAP	*PDL-P QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Asthma/COPD - Anticholinergic Agents, Inhaled Long Acting	SPIRIVA RESPIMAT 1.25 MCG INH	*PDL-P QL
	SPIRIVA RESPIMAT 2.5 MCG INH	*PDL-P QL
	TIOTROPIUM 18 MCG CAP-INHALER	PDL-NP PA QL
	TUDORZA PRESSAIR 400 MCG INHAL	PDL-NP PA
	YUPELRI 175 MCG/3 ML SOLUTION	PDL-NP PA
Asthma/COPD - Anticholinergic Agents, Inhaled Short Acting	ATROVENT 17 MCG HFA INHALER	*PDL-P QL
	IPRATROPIUM BR 0.02% SOLN	*PDL-P
Asthma/COPD - Beta 2-Adrenergic Agents, Inhaled, Ultra-Long Acting	STRIVERDI RESPIMAT INHAL SPRAY	PDL-NP PA
Asthma/COPD Therapy - Beta 2-Adrenergic Agents, Inhaled, Long Acting	ARFORMOTEROL 15 MCG/2 ML SOLN	PDL-NP PA
	BROVANA 15 MCG/2 ML SOLUTION	PDL-NP PA
	FORMOTEROL 20 MCG/2 ML NEB VL	PDL-NP PA
	PERFORMOMIST 20 MCG/2 ML SOLN	PDL-NP PA
	SEREVENT DISKUS 50 MCG	*PDL-P QL
	SEREVENT DISKUS 50 MCG	*PDL-P QL
Asthma/COPD Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting	ALBUTEROL 2.5 MG/0.5 ML SOL	*PDL-P
	ALBUTEROL HFA 90 MCG INHALER	*PDL-P QL
	ALBUTEROL HFA 90 MCG INHALER	*PDL-P QL
	ALBUTEROL HFA 90 MCG INHALER - PRASCO	PDL-NP PA QL
	ALBUTEROL SUL 0.63 MG/3 ML SOL	*PDL-P
	ALBUTEROL SUL 1.25 MG/3 ML SOL	*PDL-P
	ALBUTEROL SUL 2.5 MG/3 ML SOLN	*PDL-P
	LEVALBUTEROL 0.31 MG/3 ML SOL	PDL-NP PA
	LEVALBUTEROL 0.63 MG/3 ML SOL	PDL-NP PA
	LEVALBUTEROL 1.25 MG/3 ML SOL	PDL-NP PA
	LEVALBUTEROL CONC 1.25 MG/0.5	PDL-NP PA
	LEVALBUTEROL TAR HFA 45MCG INH	PDL-NP PA QL
	PROAIR DIGIHALER 90 MCG INHALR	PDL-NP PA QL
	PROAIR RESPICLICK 90 MCG INHLR	PDL-NP PA QL
	VENTOLIN HFA 90 MCG INHALER	*PDL-P QL
	VENTOLIN HFA 90 MCG INHALER	*PDL-P QL
	XOPENEX HFA 45 MCG INHALER	*PDL-P QL
Asthma/COPD Therapy - Beta Adrenergic Agents	TERBUTALINE SULFATE 2.5 MG TAB	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Asthma/COPD Therapy - Beta Adrenergic Agents	TERBUTALINE SULFATE 5 MG TAB	
Asthma/COPD Therapy - Beta Adrenergic-Anticholinergic Combinations	ANORO ELLIPTA 62.5-25 MCG INH	*PDL-P QL
	ANORO ELLIPTA 62.5-25 MCG INH	*PDL-P QL
	COMBIVENT RESPIMAT 20-100 MCG	*PDL-P QL
	DUAKLIR PRESSAIR 400-12MCG INH	PDL-NP PA
	IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	*PDL-P
	STIOLTO RESPIMAT INHALER (60)	*PDL-P QL
	UMECLIDINIUM-VILANTERO 62.5-25	PDL-NP PA QL
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	ADVAIR 100-50 DISKUS	*PDL-P QL
	ADVAIR 100-50 DISKUS	*PDL-P QL
	ADVAIR 250-50 DISKUS	*PDL-P QL
	ADVAIR 250-50 DISKUS	*PDL-P QL
	ADVAIR 500-50 DISKUS	*PDL-P QL
	ADVAIR 500-50 DISKUS	*PDL-P QL
	ADVAIR HFA 115-21 MCG INHALER	*PDL-P QL
	ADVAIR HFA 115-21 MCG INHALER	*PDL-P QL
	ADVAIR HFA 230-21 MCG INHALER	*PDL-P QL
	ADVAIR HFA 230-21 MCG INHALER	*PDL-P QL
	ADVAIR HFA 45-21 MCG INHALER	*PDL-P QL
	ADVAIR HFA 45-21 MCG INHALER	*PDL-P QL
	AIRDUO DIGIHALER 113-14 MCG	PDL-NP PA QL
	AIRDUO DIGIHALER 232-14 MCG	PDL-NP PA QL
	AIRDUO DIGIHALER 55-14 MCG	PDL-NP PA QL
	AIRDUO RESPICLICK 113-14 MCG	PDL-NP PA QL
	AIRDUO RESPICLICK 232-14 MCG	PDL-NP PA QL
	AIRDUO RESPICLICK 55-14 MCG	PDL-NP PA QL
	AIRSUPRA 90-80 MCG INHALER	PDL-NP PA QL
	BREO ELLIPTA 100-25 MCG INH	PDL-NP PA QL
BREO ELLIPTA 100-25 MCG INH	PDL-NP PA QL	
BREO ELLIPTA 200-25 MCG INH	PDL-NP PA QL	
BREO ELLIPTA 200-25 MCG INH	PDL-NP PA QL	
BREO ELLIPTA 50-25 MCG INHALER	PDL-NP AGE PA QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	BREYNA 160-4.5 MCG INHALER	PDL-NP PA QL
	BREYNA 80-4.5 MCG INHALER	PDL-NP PA QL
	BUDESONIDE-FORMOTEROL 160-4.5	PDL-NP PA QL
	BUDESONIDE-FORMOTEROL 80-4.5	PDL-NP PA QL
	DULERA 100 MCG-5 MCG INHALER	*PDL-P QL
	DULERA 100 MCG-5 MCG INHALER	*PDL-P QL
	DULERA 200 MCG-5 MCG INHALER	*PDL-P QL
	DULERA 200 MCG-5 MCG INHALER	*PDL-P QL
	DULERA 50 MCG-5 MCG INHALER	*PDL-P AGE QL
	FLUTICASONE-SALMETEROL 100-50	PDL-NP PA QL
	FLUTICASONE-SALMETEROL 113-14	PDL-NP PA QL
	FLUTICASONE-SALMETEROL 115-21	PDL-NP PA QL
	FLUTICASONE-SALMETEROL 230-21	PDL-NP PA QL
	FLUTICASONE-SALMETEROL 232-14	PDL-NP PA QL
	FLUTICASONE-SALMETEROL 250-50	PDL-NP PA QL
	FLUTICASONE-SALMETEROL 45-21	PDL-NP PA QL
	FLUTICASONE-SALMETEROL 500-50	PDL-NP PA QL
	FLUTICASONE-SALMETEROL 55-14	PDL-NP PA QL
	FLUTICASONE-VILANTEROL 100-25	PDL-NP PA QL
	FLUTICASONE-VILANTEROL 200-25	PDL-NP PA QL
	SYMBICORT 160-4.5 MCG INHALER	*PDL-P QL
	SYMBICORT 160-4.5 MCG INHALER	*PDL-P QL
	SYMBICORT 80-4.5 MCG INHALER	*PDL-P QL
	SYMBICORT 80-4.5 MCG INHALER	*PDL-P QL
	TRELEGY ELLIPTA 100-62.5-25	*PDL-P QL
	TRELEGY ELLIPTA 100-62.5-25	*PDL-P QL
	TRELEGY ELLIPTA 200-62.5-25	*PDL-P QL
	TRELEGY ELLIPTA 200-62.5-25	*PDL-P QL
	WIXELA 100-50 INHUB	PDL-NP PA QL
	WIXELA 250-50 INHUB	PDL-NP PA QL
	WIXELA 500-50 INHUB	PDL-NP PA QL
	Attention Deficit-Hyperact. Disorder (ADHD)- alpha-2 Receptor Agonist	CLONIDINE HCL ER 0.1 MG TABLET #

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Attention Deficit-Hyperact. Disorder (ADHD)- alpha-2 Receptor Agonist	GUANFACINE HCL ER 1 MG TABLET #	
	GUANFACINE HCL ER 1 MG TABLET #	
	GUANFACINE HCL ER 2 MG TABLET #	
	GUANFACINE HCL ER 2 MG TABLET #	
	GUANFACINE HCL ER 3 MG TABLET #	
	GUANFACINE HCL ER 3 MG TABLET #	
	GUANFACINE HCL ER 4 MG TABLET #	
	GUANFACINE HCL ER 4 MG TABLET #	
	INTUNIV ER 1 MG TABLET #	
	INTUNIV ER 2 MG TABLET #	
	INTUNIV ER 3 MG TABLET #	
	INTUNIV ER 4 MG TABLET #	
	ONYDA XR 0.1 MG/ML SUSPENSION #	
	Attention Deficit-Hyperactivity (ADHD) Therapy, Stimulant-Type	ADDERALL 10 MG TABLET #
ADDERALL 12.5 MG TABLET #		
ADDERALL 15 MG TABLET #		
ADDERALL 20 MG TABLET #		
ADDERALL 30 MG TABLET #		
ADDERALL 5 MG TABLET #		
ADDERALL 7.5 MG TABLET #		
ADDERALL XR 10 MG CAPSULE #		
ADDERALL XR 15 MG CAPSULE #		
ADDERALL XR 20 MG CAPSULE #		
ADDERALL XR 25 MG CAPSULE #		
ADDERALL XR 30 MG CAPSULE #		
ADDERALL XR 5 MG CAPSULE #		
ADHANSIA XR 25 MG CAPSULE #		
ADHANSIA XR 35 MG CAPSULE #		
ADHANSIA XR 45 MG CAPSULE #		
ADHANSIA XR 55 MG CAPSULE #		
ADHANSIA XR 70 MG CAPSULE #		
ADHANSIA XR 85 MG CAPSULE #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Attention Deficit-Hyperactivity (ADHD) Therapy, Stimulant-Type	APTENSIO XR 10 MG CAPSULE #	
	APTENSIO XR 15 MG CAPSULE #	
	APTENSIO XR 20 MG CAPSULE #	
	APTENSIO XR 30 MG CAPSULE #	
	APTENSIO XR 40 MG CAPSULE #	
	APTENSIO XR 50 MG CAPSULE #	
	APTENSIO XR 60 MG CAPSULE #	
	CONCERTA ER 18 MG TABLET #	
	CONCERTA ER 27 MG TABLET #	
	CONCERTA ER 36 MG TABLET #	
	CONCERTA ER 54 MG TABLET #	
	COTEMPLA XR-ODT 17.3 MG TABLET #	
	COTEMPLA XR-ODT 25.9 MG TABLET #	
	COTEMPLA XR-ODT 8.6 MG TABLET #	
	DAYTRANA 10 MG/9 HR PATCH #	
	DAYTRANA 15 MG/9 HR PATCH #	
	DAYTRANA 20 MG/9 HOUR PATCH #	
	DAYTRANA 30 MG/9 HOUR PATCH #	
	DEXMETHYLPHENIDATE 10 MG TAB #	
	DEXMETHYLPHENIDATE 2.5 MG TAB #	
	DEXMETHYLPHENIDATE 5 MG TAB #	
	DEXMETHYLPHENIDATE ER 10 MG CP #	
	DEXMETHYLPHENIDATE ER 15 MG CP #	
	DEXMETHYLPHENIDATE ER 20 MG CP #	
	DEXMETHYLPHENIDATE ER 25 MG CP #	
	DEXMETHYLPHENIDATE ER 30 MG CP #	
	DEXMETHYLPHENIDATE ER 35 MG CP #	
	DEXMETHYLPHENIDATE ER 40 MG CP #	
	DEXMETHYLPHENIDATE ER 5 MG CAP #	
	DEXTROAMP-AMPHET ER 10 MG CAP #	
	DEXTROAMP-AMPHET ER 15 MG CAP #	
DEXTROAMP-AMPHET ER 20 MG CAP #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
 (See MPPL @ mi.primetherapeutics.com
 for coverage details)

AGE = Age Edit
 GENDER = Gender Edit
 ST = Step Therapy
 *= Over the Counter (OTC)
 *PDL-P = PDL Preferred
 PDL-NP = PDL Non-Preferred

PA = Prior Authorization
 QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Attention Deficit-Hyperactivity (ADHD) Therapy, Stimulant-Type	DEXTROAMP-AMPHET ER 25 MG CAP #	
	DEXTROAMP-AMPHET ER 30 MG CAP #	
	DEXTROAMP-AMPHET ER 5 MG CAP #	
	DEXTROAMP-AMPHETAM 12.5 MG TAB #	
	DEXTROAMP-AMPHETAM 7.5 MG TAB #	
	DEXTROAMP-AMPHETAMIN 10 MG TAB #	
	DEXTROAMP-AMPHETAMIN 15 MG TAB #	
	DEXTROAMP-AMPHETAMIN 20 MG TAB #	
	DEXTROAMP-AMPHETAMIN 30 MG TAB #	
	DEXTROAMP-AMPHETAMINE 5 MG TAB #	
	FOCALIN 10 MG TABLET #	
	FOCALIN 2.5 MG TABLET #	
	FOCALIN 5 MG TABLET #	
	FOCALIN XR 10 MG CAPSULE #	
	FOCALIN XR 15 MG CAPSULE #	
	FOCALIN XR 20 MG CAPSULE #	
	FOCALIN XR 25 MG CAPSULE #	
	FOCALIN XR 30 MG CAPSULE #	
	FOCALIN XR 35 MG CAPSULE #	
	FOCALIN XR 40 MG CAPSULE #	
	FOCALIN XR 5 MG CAPSULE #	
	JORNAY PM 100 MG CAPSULE #	
	JORNAY PM 20 MG CAPSULE #	
	JORNAY PM 40 MG CAPSULE #	
	JORNAY PM 60 MG CAPSULE #	
	JORNAY PM 80 MG CAPSULE #	
	METHYLIN 10 MG/5 ML SOLUTION #	
	METHYLIN 5 MG/5 ML SOLUTION #	
	METHYLPHENIDATE 10 MG CHEW TAB #	
	METHYLPHENIDATE 10 MG TABLET #	
METHYLPHENIDATE 10 MG/5 ML SOL #		
METHYLPHENIDATE 2.5 MG CHEW TB #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Attention Deficit-Hyperactivity (ADHD) Therapy, Stimulant-Type	METHYLPHENIDATE 20 MG TABLET #	
	METHYLPHENIDATE 5 MG CHEW TAB #	
	METHYLPHENIDATE 5 MG TABLET #	
	METHYLPHENIDATE 5 MG/5 ML SOLN #	
	METHYLPHENIDATE CD 10 MG CAP #	
	METHYLPHENIDATE CD 20 MG CAP #	
	METHYLPHENIDATE CD 30 MG CAP #	
	METHYLPHENIDATE CD 40 MG CAP #	
	METHYLPHENIDATE CD 50 MG CAP #	
	METHYLPHENIDATE CD 60 MG CAP #	
	METHYLPHENIDATE ER 10 MG CAP #	
	METHYLPHENIDATE ER 10 MG TAB #	
	METHYLPHENIDATE ER 15 MG CAP #	
	METHYLPHENIDATE ER 18 MG TAB #	
	METHYLPHENIDATE ER 20 MG CAP #	
	METHYLPHENIDATE ER 20 MG TAB #	
	METHYLPHENIDATE ER 27 MG TAB #	
	METHYLPHENIDATE ER 30 MG CAP #	
	METHYLPHENIDATE ER 36 MG TAB #	
	METHYLPHENIDATE ER 40 MG CAP #	
	METHYLPHENIDATE ER 50 MG CAP #	
	METHYLPHENIDATE ER 54 MG TAB #	
	METHYLPHENIDATE ER 60 MG CAP #	
	METHYLPHENIDATE ER 72 MG TAB #	
	METHYLPHENIDATE ER(CD) 10MG CP #	
	METHYLPHENIDATE ER(CD) 20MG CP #	
	METHYLPHENIDATE ER(CD) 30MG CP #	
	METHYLPHENIDATE ER(CD) 40MG CP #	
	METHYLPHENIDATE ER(CD) 50MG CP #	
	METHYLPHENIDATE ER(CD) 60MG CP #	
METHYLPHENIDATE ER(LA) 10MG CP #		
METHYLPHENIDATE ER(LA) 20MG CP #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Attention Deficit-Hyperactivity (ADHD) Therapy, Stimulant-Type	METHYLPHENIDATE ER(LA) 30MG CP #	
	METHYLPHENIDATE ER(LA) 40MG CP #	
	METHYLPHENIDATE LA 10 MG CAP #	
	METHYLPHENIDATE LA 20 MG CAP #	
	METHYLPHENIDATE LA 30 MG CAP #	
	METHYLPHENIDATE LA 40 MG CAP #	
	METHYLPHENIDATE LA 60 MG CAP #	
	QUILLIVANT XR 25 MG/5 ML SUSP #	
	RELEXXII ER 72 MG TABLET #	
	RITALIN 10 MG TABLET #	
	RITALIN 20 MG TABLET #	
	RITALIN 5 MG TABLET #	
	RITALIN LA 10 MG CAPSULE #	
	RITALIN LA 20 MG CAPSULE #	
	RITALIN LA 30 MG CAPSULE #	
	RITALIN LA 40 MG CAPSULE #	
	VYVANSE 10 MG CAPSULE #	
	VYVANSE 10 MG CHEWABLE TABLET #	
	VYVANSE 20 MG CAPSULE #	
	VYVANSE 20 MG CHEWABLE TABLET #	
	VYVANSE 30 MG CAPSULE #	
	VYVANSE 30 MG CHEWABLE TABLET #	
	VYVANSE 40 MG CAPSULE #	
	VYVANSE 40 MG CHEWABLE TABLET #	
	VYVANSE 50 MG CAPSULE #	
	VYVANSE 50 MG CHEWABLE TABLET #	
	VYVANSE 60 MG CAPSULE #	
	VYVANSE 60 MG CHEWABLE TABLET #	
VYVANSE 70 MG CAPSULE #		
Attention Deficit-Hyperactivity Disorder (ADHD) Therapy, NRI-Type	ATOMOXETINE HCL 10 MG CAPSULE #	
	ATOMOXETINE HCL 100 MG CAPSULE #	
	ATOMOXETINE HCL 18 MG CAPSULE #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Attention Deficit-Hyperactivity Disorder (ADHD) Therapy, NRI-Type	ATOMOXETINE HCL 25 MG CAPSULE #	
	ATOMOXETINE HCL 40 MG CAPSULE #	
	ATOMOXETINE HCL 60 MG CAPSULE #	
	ATOMOXETINE HCL 80 MG CAPSULE #	
	STRATTERA 10 MG CAPSULE #	
	STRATTERA 100 MG CAPSULE #	
	STRATTERA 18 MG CAPSULE #	
	STRATTERA 25 MG CAPSULE #	
	STRATTERA 40 MG CAPSULE #	
	STRATTERA 60 MG CAPSULE #	
	STRATTERA 80 MG CAPSULE #	
AZAPIRONES	EXXUA ER 18.2 MG TAB (TITRATN) #	
	EXXUA ER 18.2 MG TABLET #	
	EXXUA ER 36.3 MG TABLET #	
	EXXUA ER 54.5 MG TABLET #	
	EXXUA ER 72.6 MG TABLET #	
B-Complex Vitamin Combinations	DIALYVITE 3,000 TABLET	
	DIALYVITE 800 PLUS D WAFER *	
	DIALYVITE 800 TABLET *	
	DIALYVITE 800-ULTRA D TABLET *	
	DIALYVITE 800-ZINC 15 MG TAB *	
	DIALYVITE 800-ZINC 50 MG TAB *	
	DIALYVITE SUPREME D TABLET	
	DIALYVITE TABLET	
	FULL SPECTRUM B WITH VIT C TAB *	
	KOBEE TABLET *	
	MYNEPHROCAPS SOFTGEL	
	NEPHRO-VITE TABLET *	
	PRORENAL MULTIVITAMIN TABLET *	
	RA BALANCED B-100 TABLET *	
RENAL CAPS SOFTGEL		
RENA-VITE TABLET *		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
B-Complex Vitamin Combinations	RENO CAPS SOFTGEL *	Covered for CSHCS Only
	RENO CAPS SOFTGEL *	Covered for CSHCS Only
	RENO CAPS SOFTGEL *	Covered for CSHCS Only
	SM VITAMIN B COMPLEX TABLET *	
	SM VITAMIN B-100 COMPLEX TAB *	
	STRESS FORMULA TABLET *	
	SUPER QUINTS B-50 TABLET *	
	TRIPHROCAPS SOFTGEL	
	VITAMIN B-100 COMPLEX TABLET *	
	VITAMIN B-50 COMPLEX TABLET *	
	WESCAPS CAPSULE	
B-Complex Vitamins	B-COMPLEX 100 INJECTION	
	B-COMPLEX WITH B12 TABLET *	
B-Complex Vitamins and Combinations	DIALYVITE WITH ZINC TABLET	
	NEPHPLEX RX TABLET	
Beta Blockers Cardiac Selective	ATENOLOL 100 MG TABLET	*PDL-P
	ATENOLOL 25 MG TABLET	*PDL-P
	ATENOLOL 50 MG TABLET	*PDL-P
	BETAXOLOL 10 MG TABLET	PDL-NP PA
	BETAXOLOL 20 MG TABLET	PDL-NP PA
	BISOPROLOL FUMARATE 10 MG TAB	*PDL-P
	BISOPROLOL FUMARATE 2.5 MG TAB	*PDL-P
	BISOPROLOL FUMARATE 5 MG TAB	*PDL-P
	BYSTOLIC 10 MG TABLET	PDL-NP PA
	BYSTOLIC 2.5 MG TABLET	PDL-NP PA
	BYSTOLIC 20 MG TABLET	PDL-NP PA
	BYSTOLIC 5 MG TABLET	PDL-NP PA
	KAPSPARGO SPRINKLE 100 MG CAP	PDL-NP PA
	KAPSPARGO SPRINKLE 200 MG CAP	PDL-NP PA
	KAPSPARGO SPRINKLE 25 MG CAP	PDL-NP PA
	KAPSPARGO SPRINKLE 50 MG CAP	PDL-NP PA
LOPRESSOR 100 MG TABLET	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Beta Blockers Cardiac Selective	LOPRESSOR 50 MG TABLET	PDL-NP PA
	METOPROLOL SUCC ER 100 MG TAB	*PDL-P
	METOPROLOL SUCC ER 200 MG TAB	*PDL-P
	METOPROLOL SUCC ER 25 MG TAB	*PDL-P
	METOPROLOL SUCC ER 50 MG TAB	*PDL-P
	METOPROLOL TARTRATE 100 MG TAB	*PDL-P
	METOPROLOL TARTRATE 25 MG TAB	*PDL-P
	METOPROLOL TARTRATE 37.5 MG TB	*PDL-P
	METOPROLOL TARTRATE 50 MG TAB	*PDL-P
	METOPROLOL TARTRATE 75 MG TAB	*PDL-P
	NEBIVOLOL 10 MG TABLET	*PDL-P
	NEBIVOLOL 2.5 MG TABLET	*PDL-P
	NEBIVOLOL 20 MG TABLET	*PDL-P
	NEBIVOLOL 5 MG TABLET	*PDL-P
	TENORMIN 100 MG TABLET	PDL-NP PA
	TENORMIN 25 MG TABLET	PDL-NP PA
	TENORMIN 50 MG TABLET	PDL-NP PA
	TOPROL XL 100 MG TABLET	PDL-NP PA
	TOPROL XL 200 MG TABLET	PDL-NP PA
	TOPROL XL 25 MG TABLET	PDL-NP PA
TOPROL XL 50 MG TABLET	PDL-NP PA	
Beta Blockers Cardiac Selective, Intrinsic Sympathomimetic Activity	ACEBUTOLOL 200 MG CAPSULE	PDL-NP PA
	ACEBUTOLOL 400 MG CAPSULE	PDL-NP PA
Beta Blockers Non-Cardiac Select., Intrinsic Sympathomimetic Activity	PINDOLOL 10 MG TABLET	PDL-NP PA
	PINDOLOL 5 MG TABLET	PDL-NP PA
Beta Blockers Non-Cardiac Selective	HEMANGEOL 4.28 MG/ML ORAL SOLN	*PDL-P AGE
	INDERAL LA 120 MG CAPSULE	PDL-NP PA
	INDERAL LA 160 MG CAPSULE	PDL-NP PA
	INDERAL LA 60 MG CAPSULE	PDL-NP PA
	INDERAL LA 80 MG CAPSULE	PDL-NP PA
	INDERAL XL 120 MG CAPSULE	PDL-NP PA
	INDERAL XL 80 MG CAPSULE	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Beta Blockers Non-Cardiac Selective	INNOPRAN XL 120 MG CAPSULE	PDL-NP PA
	INNOPRAN XL 80 MG CAPSULE	PDL-NP PA
	NADOLOL 20 MG TABLET	*PDL-P
	NADOLOL 40 MG TABLET	*PDL-P
	NADOLOL 80 MG TABLET	*PDL-P
	PROPRANOLOL 10 MG TABLET	*PDL-P
	PROPRANOLOL 20 MG TABLET	*PDL-P
	PROPRANOLOL 20 MG/5 ML SOLN	*PDL-P
	PROPRANOLOL 40 MG TABLET	*PDL-P
	PROPRANOLOL 40 MG/5 ML SOLN	*PDL-P
	PROPRANOLOL 60 MG TABLET	*PDL-P
	PROPRANOLOL 80 MG TABLET	*PDL-P
	PROPRANOLOL ER 120 MG CAPSULE	*PDL-P
	PROPRANOLOL ER 160 MG CAPSULE	*PDL-P
	PROPRANOLOL ER 60 MG CAPSULE	*PDL-P
	PROPRANOLOL ER 80 MG CAPSULE	*PDL-P
	TIMOLOL MALEATE 10 MG TABLET	PDL-NP PA
	TIMOLOL MALEATE 20 MG TABLET	PDL-NP PA
	TIMOLOL MALEATE 5 MG TABLET	PDL-NP PA
	Beta-Adrenergic and Anticholinergic Combo, Inhaled	BEVESPI AEROSPHERE INHALER
Bipolar Therapy Agents - Anticonvulsant Type	EQUETRO 100 MG CAPSULE #	
	EQUETRO 200 MG CAPSULE #	
	EQUETRO 300 MG CAPSULE #	
Bipolar Therapy Agents - Lithium	LITHIUM 8 MEQ/5 ML SOLUTION #	
	LITHIUM CARBONATE 150 MG CAP #	
	LITHIUM CARBONATE 300 MG CAP #	
	LITHIUM CARBONATE 300 MG TAB #	
	LITHIUM CARBONATE 600 MG CAP #	
	LITHIUM CARBONATE ER 300 MG TB #	
	LITHIUM CARBONATE ER 450 MG TB #	
	LITHOBID ER 300 MG TABLET #	
Bone Formation Stimulating Agents - Parathyroid Hormone-Type	BONSITY 560 MCG/2.24 ML PEN	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Bone Formation Stimulating Agents - Parathyroid Hormone-Type	FORTEO 600 MCG/2.4 ML PEN INJ	*PDL-P PA QL
	TERIPARATIDE 600 MCG/2.4ML PEN	PDL-NP PA
	TERIPARATIDE 620 MCG/2.48 ML	PDL-NP PA
	TERIPARATIDE 620 MCG/2.48 ML	PDL-NP PA
	TYMLOS 80 MCG DOSE PEN INJECTR	PDL-NP PA QL
Bone Resorption Inhibitors - Bisphosphonate and Vitamin D Combinations	FOSAMAX PLUS D 70 MG-2,800 IU	PDL-NP PA QL
	FOSAMAX PLUS D 70 MG-5,600 IU	PDL-NP PA QL
Bone Resorption Inhibitors - Bisphosphonates	ACTONEL 150 MG TABLET	PDL-NP PA
	ACTONEL 35 MG TABLET	PDL-NP PA QL
	ALENDRONATE SOD 70 MG/75 ML	PDL-NP PA
	ALENDRONATE SODIUM 10 MG TAB	*PDL-P
	ALENDRONATE SODIUM 35 MG TAB	*PDL-P QL
	ALENDRONATE SODIUM 5 MG TABLET	*PDL-P
	ALENDRONATE SODIUM 70 MG TAB	*PDL-P QL
	ATELVIA DR 35 MG TABLET	PDL-NP PA QL
	BINOSTO 70 MG EFFERVESCENT TAB	PDL-NP PA
	BONIVA 150 MG TABLET	PDL-NP PA QL
	FOSAMAX 70 MG TABLET	PDL-NP PA QL
	IBANDRONATE SODIUM 150 MG TAB	PDL-NP PA QL
	RISEDRONATE SOD DR 35 MG TAB	PDL-NP PA QL
	RISEDRONATE SODIUM 150 MG TAB	PDL-NP PA
	RISEDRONATE SODIUM 30 MG TAB	PDL-NP PA
	RISEDRONATE SODIUM 35 MG TAB	PDL-NP PA QL
RISEDRONATE SODIUM 5 MG TABLET	PDL-NP PA	
BPH Agent - 5-alpha Reductase Inhib. & alpha-1 Adrenoceptor Antag Comb	DUTASTERIDE-TAMSULOSIN 0.5-0.4	PDL-NP PA
C1 Esterase Inhibitor Agents	BERINERT 500 UNIT KIT #	
	BERINERT 500 UNIT VIAL #	
	CINRYZE 500 UNIT VIAL #	
	HAEGARDA 2,000 UNIT VIAL #	
	HAEGARDA 3,000 UNIT VIAL #	
	RUCONEST 2,100 UNIT VIAL #	
Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer	CINACALCET HCL 30 MG TABLET	PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer	CINACALCET HCL 60 MG TABLET	PA QL
	CINACALCET HCL 90 MG TABLET	PA QL
Calcitonins	CALCITONIN-SALMON 200 UNIT SPR	*PDL-P
Calcium Channel Blockers - Benzothiazepines	CARDIZEM 120 MG TABLET	PDL-NP PA
	CARDIZEM 30 MG TABLET	PDL-NP PA
	CARDIZEM 60 MG TABLET	PDL-NP PA
	CARDIZEM CD 120 MG CAPSULE	PDL-NP PA
	CARDIZEM CD 180 MG CAPSULE	PDL-NP PA
	CARDIZEM CD 240 MG CAPSULE	PDL-NP PA
	CARDIZEM CD 300 MG CAPSULE	PDL-NP PA
	CARDIZEM CD 360 MG CAPSULE	PDL-NP PA
	CARDIZEM LA 120 MG TABLET	PDL-NP PA
	CARDIZEM LA 180 MG TABLET	PDL-NP PA
	CARDIZEM LA 240 MG TABLET	PDL-NP PA
	CARDIZEM LA 300 MG TABLET	PDL-NP PA
	CARDIZEM LA 360 MG TABLET	PDL-NP PA
	CARDIZEM LA 420 MG TABLET	PDL-NP PA
	CARTIA XT 120 MG CAPSULE	*PDL-P
	CARTIA XT 180 MG CAPSULE	*PDL-P
	CARTIA XT 240 MG CAPSULE	*PDL-P
	CARTIA XT 300 MG CAPSULE	*PDL-P
	DILT XR 120 MG CAPSULE	*PDL-P
	DILT XR 180 MG CAPSULE	*PDL-P
	DILT XR 240 MG CAPSULE	*PDL-P
	DILTIAZEM 120 MG TABLET	*PDL-P
	DILTIAZEM 12HR ER 120 MG CAP	*PDL-P
	DILTIAZEM 12HR ER 60 MG CAP	*PDL-P
	DILTIAZEM 12HR ER 90 MG CAP	*PDL-P
	DILTIAZEM 24H ER(CD) 120 MG CP	*PDL-P
	DILTIAZEM 24H ER(CD) 180 MG CP	*PDL-P
DILTIAZEM 24H ER(CD) 240 MG CP	*PDL-P	
DILTIAZEM 24H ER(CD) 300 MG CP	*PDL-P	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Calcium Channel Blockers - Benzothiazepines	DILTIAZEM 24H ER(CD) 360 MG CP	*PDL-P
	DILTIAZEM 24H ER(LA) 120 MG TB	PDL-NP PA
	DILTIAZEM 24H ER(LA) 180 MG TB	PDL-NP PA
	DILTIAZEM 24H ER(LA) 240 MG TB	PDL-NP PA
	DILTIAZEM 24H ER(LA) 300 MG TB	PDL-NP PA
	DILTIAZEM 24H ER(LA) 360 MG TB	PDL-NP PA
	DILTIAZEM 24H ER(LA) 420 MG TB	PDL-NP PA
	DILTIAZEM 24HR ER 120 MG CAP	*PDL-P
	DILTIAZEM 24HR ER 180 MG CAP	*PDL-P
	DILTIAZEM 24HR ER 240 MG CAP	*PDL-P
	DILTIAZEM 24HR ER 300 MG CAP	*PDL-P
	DILTIAZEM 24HR ER 360 MG CAP	*PDL-P
	DILTIAZEM 24HR ER 420 MG CAP	*PDL-P
	DILTIAZEM 30 MG TABLET	*PDL-P
	DILTIAZEM 60 MG TABLET	*PDL-P
	DILTIAZEM 90 MG TABLET	*PDL-P
	MATZIM LA 180 MG TABLET	PDL-NP PA
	MATZIM LA 240 MG TABLET	PDL-NP PA
	MATZIM LA 300 MG TABLET	PDL-NP PA
	MATZIM LA 360 MG TABLET	PDL-NP PA
	MATZIM LA 420 MG TABLET	PDL-NP PA
	TAZTIA XT 120 MG CAPSULE	*PDL-P
	TAZTIA XT 180 MG CAPSULE	*PDL-P
	TAZTIA XT 240 MG CAPSULE	*PDL-P
	TAZTIA XT 300 MG CAPSULE	*PDL-P
	TAZTIA XT 360 MG CAPSULE	*PDL-P
	TIADYLT ER 120 MG CAPSULE	PDL-NP PA
	TIADYLT ER 180 MG CAPSULE	PDL-NP PA
	TIADYLT ER 240 MG CAPSULE	PDL-NP PA
	TIADYLT ER 300 MG CAPSULE	PDL-NP PA
	TIADYLT ER 360 MG CAPSULE	PDL-NP PA
	TIADYLT ER 420 MG CAPSULE	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Calcium Channel Blockers - Benzothiazepines	TIAZAC ER 120 MG CAPSULE	PDL-NP PA
	TIAZAC ER 180 MG CAPSULE	PDL-NP PA
	TIAZAC ER 240 MG CAPSULE	PDL-NP PA
	TIAZAC ER 300 MG CAPSULE	PDL-NP PA
	TIAZAC ER 360 MG CAPSULE	PDL-NP PA
	TIAZAC ER 420 MG CAPSULE	PDL-NP PA
Calcium Channel Blockers - Dihydropyridines	AMLODIPINE BESYLATE 10 MG TAB	*PDL-P
	AMLODIPINE BESYLATE 2.5 MG TAB	*PDL-P
	AMLODIPINE BESYLATE 5 MG TAB	*PDL-P
	FELODIPINE ER 10 MG TABLET	PDL-NP PA
	FELODIPINE ER 2.5 MG TABLET	PDL-NP PA
	FELODIPINE ER 5 MG TABLET	PDL-NP PA
	ISRADIPINE 2.5 MG CAPSULE	PDL-NP PA
	ISRADIPINE 5 MG CAPSULE	PDL-NP PA
	KATERZIA 1 MG/ML SUSPENSION	PDL-NP AGE PA
	LEVAMLODIPINE 2.5 MG TABLET	PDL-NP PA
	LEVAMLODIPINE MALEATE 5 MG TAB	PDL-NP PA
	NICARDIPINE 20 MG CAPSULE	PDL-NP PA
	NICARDIPINE 30 MG CAPSULE	PDL-NP PA
	NIFEDIPINE 10 MG CAPSULE	*PDL-P
	NIFEDIPINE 20 MG CAPSULE	*PDL-P
	NIFEDIPINE ER 30 MG TABLET	*PDL-P
	NIFEDIPINE ER 30 MG TABLET	*PDL-P
	NIFEDIPINE ER 60 MG TABLET	*PDL-P
	NIFEDIPINE ER 60 MG TABLET	*PDL-P
	NIFEDIPINE ER 90 MG TABLET	*PDL-P
NIFEDIPINE ER 90 MG TABLET	*PDL-P	
NISOLDIPINE ER 17 MG TABLET	PDL-NP PA	
NISOLDIPINE ER 20 MG TABLET	PDL-NP PA	
NISOLDIPINE ER 25.5 MG TABLET	PDL-NP PA	
NISOLDIPINE ER 30 MG TABLET	PDL-NP PA	
NISOLDIPINE ER 34 MG TABLET	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Calcium Channel Blockers - Dihydropyridines	NISOLDIPINE ER 40 MG TABLET	PDL-NP PA
	NISOLDIPINE ER 8.5 MG TABLET	PDL-NP PA
	NORLIQVA 1 MG/ML SOLUTION	*PDL-P AGE PA
	NORVASC 10 MG TABLET	PDL-NP PA
	NORVASC 2.5 MG TABLET	PDL-NP PA
	NORVASC 5 MG TABLET	PDL-NP PA
	PROCARDIA XL 30 MG TABLET	PDL-NP PA
	PROCARDIA XL 60 MG TABLET	PDL-NP PA
	PROCARDIA XL 90 MG TABLET	PDL-NP PA
	SULAR ER 17 MG TABLET	PDL-NP PA
	SULAR ER 34 MG TABLET	PDL-NP PA
	SULAR ER 8.5 MG TABLET	PDL-NP PA
Calcium Channel Blockers - Dihydropyridines - Cerebrovascular Specific	NIMODIPINE 30 MG CAPSULE	QL
Calcium Channel Blockers - Phenylalkylamines	VERAPAMIL 120 MG TABLET	*PDL-P
	VERAPAMIL 360 MG CAP PELLETT	PDL-NP PA
	VERAPAMIL 40 MG TABLET	*PDL-P
	VERAPAMIL 80 MG TABLET	*PDL-P
	VERAPAMIL ER 120 MG CAPSULE	PDL-NP PA
	VERAPAMIL ER 120 MG TABLET	*PDL-P
	VERAPAMIL ER 180 MG CAPSULE	PDL-NP PA
	VERAPAMIL ER 180 MG TABLET	*PDL-P
	VERAPAMIL ER 240 MG CAPSULE	PDL-NP PA
	VERAPAMIL ER 240 MG TABLET	*PDL-P
	VERAPAMIL ER PM 100 MG CAPSULE	PDL-NP PA
	VERAPAMIL ER PM 200 MG CAPSULE	PDL-NP PA
	VERAPAMIL ER PM 300 MG CAPSULE	PDL-NP PA
	VERAPAMIL SR 120 MG CAPSULE	PDL-NP PA
	VERAPAMIL SR 180 MG CAPSULE	PDL-NP PA
	VERAPAMIL SR 240 MG CAPSULE	PDL-NP PA
	VERELAN PM 100 MG CAP PELLETT	PDL-NP PA
VERELAN PM 200 MG CAP PELLETT	PDL-NP PA	
VERELAN PM 300 MG CAP PELLETT	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Cardiac Myosin Inhibitor	CAMZYOS 10 MG CAPSULE	AGE PA QL
	CAMZYOS 15 MG CAPSULE	AGE PA QL
	CAMZYOS 2.5 MG CAPSULE	AGE PA QL
	CAMZYOS 5 MG CAPSULE	AGE PA QL
Cardiac Selective Beta Blocker-Thiazide Diuretic & Related Comb.	ATENOLOL-CHLORTHALIDONE 100-25	*PDL-P
	ATENOLOL-CHLORTHALIDONE 50-25	*PDL-P
	BISOPROLOL-HCTZ 10-6.25 MG TAB	*PDL-P
	BISOPROLOL-HCTZ 2.5-6.25 MG TB	*PDL-P
	BISOPROLOL-HCTZ 5-6.25 MG TAB	*PDL-P
	METOPROLOL-HCTZ 100-25 MG TAB	PDL-NP PA
	METOPROLOL-HCTZ 100-50 MG TAB	PDL-NP PA
	METOPROLOL-HCTZ 50-25 MG TAB	PDL-NP PA
	TENORETIC 100 TABLET	PDL-NP PA
	TENORETIC 50 TABLET	PDL-NP PA
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents	AUVI-Q 0.1 MG AUTO-INJECTOR	PDL-NP PA QL
	AUVI-Q 0.15 MG AUTO-INJECTOR	PDL-NP PA QL
	AUVI-Q 0.3 MG AUTO-INJECTOR	PDL-NP PA QL
	EPINEPHRINE 0.15 MG AUTO-INJCT	*PDL-P QL
	EPINEPHRINE 0.15 MG AUTO-INJCT	*PDL-P QL
	EPINEPHRINE 0.15 MG AUTO-INJCT	*PDL-P QL
	EPINEPHRINE 0.3 MG AUTO-INJECT	*PDL-P QL
	EPINEPHRINE 0.3 MG AUTO-INJECT	*PDL-P QL
	EPINEPHRINE 0.3 MG AUTO-INJECT	*PDL-P QL
	EPIPEN 2-PAK 0.3 MG AUTO-INJCT	*PDL-P QL
	EPIPEN JR 0.15 MG AUTO-INJECTR	*PDL-P QL
	EPIPEN JR 2-PAK 0.15 MG INJCTR	*PDL-P QL
	NEFFY 1 MG/0.1 ML NASAL SPRAY	PDL-NP PA QL
	NEFFY 2 MG/0.1 ML NASAL SPRAY	PDL-NP PA QL
Cardiovascular Sympathomimetics	MIDODRINE HCL 10 MG TABLET	QL
	MIDODRINE HCL 2.5 MG TABLET	QL
	MIDODRINE HCL 5 MG TABLET	QL
Central Alpha-2 Agonists-Thiazide Diuretic & Related Comb.	METHYLDOPA-HCTZ 250-15 MG TAB	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Central Alpha-2 Agonists-Thiazide Diuretic & Related Comb.	METHYLDOPA-HCTZ 250-25 MG TAB	PDL-NP PA
Central Alpha-2 Receptor Agonists	CLONIDINE 0.1 MG/DAY PATCH	*PDL-P QL
	CLONIDINE 0.2 MG/DAY PATCH	*PDL-P QL
	CLONIDINE 0.3 MG/DAY PATCH	*PDL-P QL
	CLONIDINE HCL 0.1 MG TABLET	*PDL-P
	CLONIDINE HCL 0.1 MG TABLET	*PDL-P
	CLONIDINE HCL 0.2 MG TABLET	*PDL-P
	CLONIDINE HCL 0.2 MG TABLET	*PDL-P
	CLONIDINE HCL 0.3 MG TABLET	*PDL-P
	CLONIDINE HCL 0.3 MG TABLET	*PDL-P
	CLONIDINE HCL ER 0.17 MG TAB	*PDL-P
	GUANFACINE 1 MG TABLET	*PDL-P
	GUANFACINE 1 MG TABLET	*PDL-P
	GUANFACINE 2 MG TABLET	*PDL-P
	GUANFACINE 2 MG TABLET	*PDL-P
	METHYLDOPA 250 MG TABLET	*PDL-P
	METHYLDOPA 500 MG TABLET	*PDL-P
	NEXICLON XR 0.17 MG TABLET	*PDL-P
Cephalosporin Antibiotics - 1st Generation	CEFADROXIL 1 GM TABLET	PDL-NP PA QL
	CEFADROXIL 250 MG/5 ML SUSP	*PDL-P
	CEFADROXIL 500 MG CAPSULE	*PDL-P QL
	CEFADROXIL 500 MG/5 ML SUSP	*PDL-P
	CEPHALEXIN 125 MG/5 ML SUSP	*PDL-P
	CEPHALEXIN 250 MG CAPSULE	*PDL-P
	CEPHALEXIN 250 MG TABLET	*PDL-P
	CEPHALEXIN 250 MG/5 ML SUSP	*PDL-P
	CEPHALEXIN 500 MG CAPSULE	*PDL-P
	CEPHALEXIN 500 MG TABLET	*PDL-P
	CEPHALEXIN 750 MG CAPSULE	*PDL-P
Cephalosporin Antibiotics - 2nd Generation	CEFACTOR 125 MG/5 ML SUSP	PDL-NP PA
	CEFACTOR 250 MG CAPSULE	PDL-NP PA QL
	CEFACTOR 250 MG/5 ML SUSP	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Cephalosporin Antibiotics - 2nd Generation	CEFACLOR 375 MG/5 ML SUSPEN	PDL-NP PA
	CEFACLOR 500 MG CAPSULE	PDL-NP PA QL
	CEFACLOR ER 500 MG TABLET	PDL-NP PA QL
	CEFPROZIL 125 MG/5 ML SUSP	*PDL-P
	CEFPROZIL 250 MG TABLET	*PDL-P QL
	CEFPROZIL 250 MG/5 ML SUSP	*PDL-P
	CEFPROZIL 500 MG TABLET	*PDL-P QL
	CEFUROXIME AXETIL 250 MG TAB	*PDL-P QL
	CEFUROXIME AXETIL 500 MG TAB	*PDL-P QL
Cephalosporin Antibiotics - 3rd Generation	CEFDINIR 125 MG/5 ML SUSP	*PDL-P
	CEFDINIR 250 MG/5 ML SUSP	*PDL-P
	CEFDINIR 300 MG CAPSULE	*PDL-P QL
	CEFIXIME 100 MG/5 ML SUSP	PDL-NP PA
	CEFIXIME 200 MG/5 ML SUSP	PDL-NP PA
	CEFIXIME 400 MG CAPSULE	*PDL-P
	CEFPODOXIME 100 MG TABLET	PDL-NP PA QL
	CEFPODOXIME 100 MG/5 ML SUSP	PDL-NP PA
	CEFPODOXIME 200 MG TABLET	PDL-NP PA QL
CEFPODOXIME 50 MG/5 ML SUSP	PDL-NP PA	
Chelating Agents - Lead Poisoning	CHEMET 100 MG CAPSULE	
CMV Antiviral Agent - Nucleoside Analogs	PREVYMIS 120 MG PELLETT PACKET	
	PREVYMIS 20 MG PELLETT PACKET	
	PREVYMIS 240 MG TABLET	
	PREVYMIS 480 MG TABLET	
	VALGANCICLOVIR 450 MG TABLET	QL
CMV Antiviral Agent - pUL97 Kinase Inhibitor	LIVTENCITY 200 MG TABLET	
CNS Stimulant - Amphetamines	AMPHETAMINE ER 1.25 MG/ML SUSP #	
	AMPHETAMINE SULFATE 10 MG TAB #	
	AMPHETAMINE SULFATE 5 MG TAB #	
	DESOXYN 5 MG TABLET #	
	DEXEDRINE SPANSULE 10 MG #	
	DEXEDRINE SPANSULE 15 MG #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
CNS Stimulant - Amphetamines	DEXEDRINE SPANSULE 5 MG #	
	DEXTROAMPHETAMINE 10 MG TAB #	
	DEXTROAMPHETAMINE 5 MG TAB #	
	DEXTROAMPHETAMINE 5 MG/5 ML #	
	DEXTROAMPHETAMINE ER 10 MG CAP #	
	DEXTROAMPHETAMINE ER 15 MG CAP #	
	DEXTROAMPHETAMINE ER 5 MG CAP #	
	EVEKEO 10 MG TABLET #	
	EVEKEO 5 MG TABLET #	
	EVEKEO ODT 10 MG #	
	EVEKEO ODT 15 MG #	
	EVEKEO ODT 20 MG #	
	EVEKEO ODT 5 MG #	
	METHAMPHETAMINE 5 MG TABLET #	
	PROCENTRA 5 MG/5 ML SOLUTION #	
	ZENZEDI 10 MG TABLET #	
	ZENZEDI 15 MG TABLET #	
	ZENZEDI 2.5 MG TABLET #	
	ZENZEDI 20 MG TABLET #	
	ZENZEDI 30 MG TABLET #	
	ZENZEDI 5 MG TABLET #	
	ZENZEDI 7.5 MG TABLET #	
CNS Stimulant - Analeptics	CAFFEINE CIT 60 MG/3 ML ORAL	AGE
	DOPRAM 400 MG/20 ML VIAL #	
	DOXAPRAM HCL 20 MG/ML VIAL #	
CNS Stimulant Others	AMMONIA AROMATIC AMPUL * #	
	AMMONIA AROMATIC SPIRIT * #	
	AMMONIA INHALANT AMPULE * #	
Coagulation Factor X (Human)	COAGADEX 250 UNIT VIAL #	
	COAGADEX 500 UNIT VIAL #	
Colonic Acidifier (Ammonia Inhibitor)	ENULOSE 10 GM/15 ML SOLUTION #	
	GENERLAC 10 GM/15 ML SOLUTION #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Colonic Acidifier (Ammonia Inhibitor)	LACTULOSE 10 GM/15 ML SOLUTION #	
Complement 5a Receptor (C5aR) Antagonist	TAVNEOS 10 MG CAPSULE #	
	ZILBRYSQ 16.6 MG/0.416 ML SYRN #	
	ZILBRYSQ 23 MG/0.574 ML SYRING #	
	ZILBRYSQ 32.4 MG/0.81 ML SYRNG #	
Complement Factor B Inhibitors	FABHALTA 200 MG CAPSULE #	
Complement Factor D Inhibitors	VOYDEYA 100 MG TABLET #	
	VOYDEYA 150 MG DOSE TABLET #	
Complement Inhibitors	Empaveli 1,080 MG/20 VIAL #	
Contraceptive Injectable - Progestin	MEDROXYPROGESTERONE 150 MG/ML	QL
Contraceptive Oral - Biphasic	AZURETTE 28 DAY TABLET	
	DESOGESTR-ETH ESTRAD ETH ESTRA	
	PIMTREA 28 DAY TABLET	
Contraceptive Oral - Monophasic	ALYACEN 1-35 28 TABLET	
	APRI 28 DAY TABLET	
	AVIANE-28 TABLET	
	BLISOVI 24 FE TABLET	
	BLISOVI FE 1-20 TABLET	
	BRIELLYN TABLET	
	CRYSSELLE-28 TABLET	
	CYCLAFEM 1-35-28 TABLET	
	DASETTA 1-35-28 TABLET	
	DROSPIRENONE-EE 3-0.02 MG TAB	
	DROSPIRENONE-EE 3-0.03 MG TAB	
	ELINEST-28 TABLET	
	ENSKYCE 28 TABLET	
	ESTARYLLA 0.25-0.035 MG TABLET	
	ETHYNODIOL-ETH ESTRA 1MG-50MCG	
	FALMINA-28 TABLET	
	HAILEY FE 1-20 TABLET	
	INTROVALE 0.15-0.03 MG TABLET	
ISIBLOOM 28 DAY TABLET		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Contraceptive Oral - Monophasic	JULEBER 28 DAY TABLET	
	JUNEL 1 MG-20 MCG TABLET	
	JUNEL FE 1.5 MG-30 MCG TABLET	
	KELNOR 1-35 28 TABLET	
	KURVELO-28 TABLET	
	LARIN 1.5 MG-30 MCG TABLET	
	LARIN 21 1-20 TABLET	
	LARIN FE 1.5-30 TABLET	
	LARIN FE 1-20 TABLET	
	LEVONOR-ETH ESTRA 0.09-0.02 MG	
	LEVONOR-ETH ESTRAD 0.1-0.02 MG	
	LEVONOR-ETH ESTRAD 0.15-0.03	
	LEVONOR-ETH ESTRAD 0.15-0.03	
	LILLOW-28 TABLET	
	LOESTRIN FE 1.5-30 TABLET	
	LOW-OGESTREL-28 TABLET	
	MARLISSA-28 TABLET	
	MIBELAS 24 FE CHEWABLE TABLET	
	MICROGESTIN FE 1-20 TABLET	
	MILI 0.25-0.035 MG TABLET	
	MONO-LINYAH 28 TABLET	
	NIKKI 3 MG-0.02 MG TABLET	
	NORET-ESTR-FE 0.4-0.035(21)-75	
	NORETHIND-ETH ESTRAD 1-0.02 MG	
	NORETHIN-ESTRAD-FERR 1-0.02 MG	
	NORETHIN-ESTRA-FE 0.8-0.025 MG	
	NORG-ETHIN ESTRA 0.25-0.035 MG	
	NORTREL 0.5-35 TABLET	
	NORTREL 1-35 28 TABLET	
	ORTHO-NOVUM 1-35-28 TABLET	
	PHILITH 0.4-0.035 MG TABLET	
	PIRMELLA 1-35-28 TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Contraceptive Oral - Monophasic	PORTIA-28 TABLET	
	QUASENSE 0.15-0.03 MG TABLET	
	RECLIPSEN 28 DAY TABLET	
	SETLAKIN 0.15 MG-0.03 MG TAB	
	SPRINTEC 28 DAY TABLET	
	TARINA FE 1-20 TABLET	
	VESTURA 3 MG-0.02 MG TABLET	
	VYFEMLA 28 TABLET	
	WERA 0.5/0.035 MG 28 TABLET	
	ZOVIA 1-35 TABLET	
Contraceptive Oral - Progestin	CAMILA TABLET	
	DEBLITANE 0.35 MG TABLET	
	ERRIN 0.35 MG TABLET	
	HEATHER TABLET	
	JENCYCLA 0.35 MG TABLET	
	NORETHINDRONE 0.35 MG TABLET	
	OPIII 0.075 MG TABLET	
	OPIII 0.075 MG TABLET	
	OPIII 0.075 MG TABLET	
SHAROBEL 0.35 MG TABLET		
Contraceptive Oral - Triphasic	ALYACEN 7-7-7-28 TABLET	
	ARANELLE 28 TABLET	
	CAZIAN 28 DAY TABLET	
	CYCLAFEM 7-7-7-28 TABLET	
	DASETTA 7/7/7-28 TABLET	
	ENPRESSE-28 TABLET	
	LEENA 28 TABLET	
	LEVONEST-28 TABLET	
	MYZILRA-28 TABLET	
	NORG-EE 0.18-0.215-0.25/0.025	
NORG-EE 0.18-0.215-0.25/0.035		
PIRMELLA 7-7-7-28 TABLET		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Contraceptive Oral - Triphasic	TRI-LEGEST FE-28 DAY TABLET	
	TRI-LINYAH TABLET	
	TRI-LO-MARZIA TABLET	
	TRI-LO-SPRINTEC TABLET	
	TRI-SPRINTEC TABLET	
	TRIVORA-28 TABLET	
	TRI-VYLIBRA LO TABLET	
	VELIVET 28 DAY TABLET	
Contraceptive Transdermal Combinations	NORELGESTROM-EE 150-35 MCG/DAY	
	XULANE 150-35 MCG/DAY PATCH	
	ZAFEMY 150-35 MCG/DAY PATCH	
Contraceptives - Intravaginal, Systemic	ELURYNG VAGINAL RING	QL
	ETONOGESTREL-EE VAGINAL RING	QL
	HALOETTE VAGINAL RING	QL
COPD Therapy Agents	BREZTRI AEROSPHERE INHALER	PDL-NP PA QL
	BREZTRI AEROSPHERE INHALER	PDL-NP PA QL
Corticotropin-Releasing Factor Type 1 Receptor Antagonist	CRENESSITY 100 MG CAPSULE #	
	CRENESSITY 50 MG CAPSULE #	
	CRENESSITY 50 MG/ML SOLUTION #	
CXCR4 Chemokine Receptor Antagonists	XOLREMDI 100 MG CAPSULE #	
Cystic Fibrosis - Inhaled Osmotic Agents	BRONCHITOL 40 MG INHALE CAP	AGE PA QL
Cystic Fibrosis-Transmembrane Conductance Regulator (CFTR) Potentiator	KALYDECO 150 MG TABLET #	
	KALYDECO 25 MG GRANULES PACKET #	
	KALYDECO 50 MG GRANULES PACKET #	
	KALYDECO 75 MG GRANULES PACKET #	
Cystic Fib-Transmemb Conduct. Reg.(CFTR) Potentiator & Corrector Comb.	ALYFTREK 10-50-125 MG TABLET #	
	ALYFTREK 4-20-50 MG TABLET #	
	ORKAMBI 100 MG-125 MG TABLET #	
	ORKAMBI 100-125 MG GRANULE PKT #	
	ORKAMBI 150-188 MG GRANULE PKT #	
	ORKAMBI 200 MG-125 MG TABLET #	
	SYMDEKO 100/150 MG-150 MG TABS #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Cystic Fib-Transmemb Conduct. Reg.(CFTR) Potentiator & Corrector Comb.	TRIKAFTA 100/50/75 MG-150 MG #	
	TRIKAFTA 50-25-37.5 MG/75 MG #	
Cystinosis Therapy (Cystine Depleting Agents)	CYSTAGON 150 MG CAPSULE #	
	CYSTAGON 50 MG CAPSULE #	
	PROCYSBI DR 25 MG CAPSULE #	
	PROCYSBI DR 300 MG GRANULE PKT #	
	PROCYSBI DR 75 MG CAPSULE #	
	PROCYSBI DR 75 MG GRANULE PKT #	
Dental Product - Fluoride Preparations	DENTA 5000 PLUS CREAM	
	DENTA 5000 PLUS SENSITIV PASTE	
	DENTAGEL 1.1% GEL	
	FLUORIDE 0.25 MG TABLET CHEW	AGE QL
	FLUORIDE 0.5 MG TABLET CHEW	AGE QL
	FLUORIDE 1 MG TABLET CHEWABLE	AGE QL
	LUDENT FLUORIDE 0.25 MG TB CHW	AGE QL
	LUDENT FLUORIDE 0.5 MG TB CHEW	AGE QL
	LUDENT FLUORIDE 1 MG TAB CHEW	AGE QL
	SODIUM FLUORIDE 0.5 MG(1.1 MG)	AGE QL
	SODIUM FLUORIDE 0.5 MG/ML DROP	AGE QL
	SODIUM FLUORIDE 1 MG (2.2 MG)	AGE QL
	SODIUM FLUORIDE 1.1% GEL	
	SODIUM FLUORIDE 5000 PLUS CRM	
Dermatological - Antibacterial Aminoglycosides	GENTAMICIN 0.1% CREAM	
	GENTAMICIN 0.1% OINTMENT	
Dermatological - Antibacterial Mixtures	TRIPLE ANTIBIOTIC OINTMENT *	
	TRIPLE ANTIBIOTIC OINTMENT *	
Dermatological - Antibacterial Other	CENTANY 2% OINTMENT	PDL-NP PA
	CENTANY AT 2% OINTMENT KIT	PDL-NP PA
	MUPIROCIN 2% CREAM	PDL-NP PA
	MUPIROCIN 2% OINTMENT	*PDL-P
Dermatological - Antibacterial Polymyxins and Derivatives	BACITRACIN 500 UNIT/GM OINTMNT *	
	BACITRACIN 500 UNIT/GM OINTMNT *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Antibacterial Polymyxins and Derivatives	BACITRACIN ZN 500 UNIT/GM OINT *	
	BACITRACIN ZN 500 UNIT/GM OINT *	
	CVS BACITRACIN ZN 500 UNIT/GM *	
	EQL BACITRACIN ZN 500 UNIT/GM *	
	FIRST AID BACITRACIN OINTMENT *	
	HM BACITRACIN ZN 500 UNIT/GM *	
	QC BACITRACIN 500 UNIT/GM OINT *	
Dermatological - Antidermatitis	ZORYVE 0.05% CREAM	AGE PA
	ZORYVE 0.15% CREAM	AGE PA
Dermatological - Antifungal Allylamines	GNP TERBINAFINE 1% CREAM *	
	NAFTIFINE HCL 1% CREAM	PDL-NP PA
	NAFTIFINE HCL 1% GEL	PDL-NP PA
	NAFTIFINE HCL 2% CREAM	PDL-NP PA
	NAFTIN 1% GEL	PDL-NP PA
	NAFTIN 2% CREAM	PDL-NP PA
	NAFTIN 2% GEL	PDL-NP PA
	TERBINAFINE 1% CREAM *	
TERBINAFINE HCL 1% CREAM *		
Dermatological - Antifungal Amphoteric Polyene Macrolides	KLAYESTA 100,000 UNIT/GM POWD	*PDL-P
	NYAMYC 100,000 UNITS/GM POWDER	*PDL-P
	NYSTATIN 100,000 UNIT/GM CREAM	*PDL-P
	NYSTATIN 100,000 UNIT/GM OINT	*PDL-P
	NYSTATIN 100,000 UNIT/GM POWD	*PDL-P
	NYSTOP 100,000 UNIT/GM POWDER	*PDL-P
Dermatological - Antifungal Benzylamines	BUTENAFINE HCL 1% CREAM	PDL-NP PA
Dermatological - Antifungal Hydroxypyridinone	CICLODAN 0.77% CREAM	PDL-NP PA
	CICLODAN 0.77% CREAM KIT	PDL-NP PA
	CICLODAN 8% KIT	PDL-NP PA
	CICLODAN 8% SOLUTION	PDL-NP PA
	CICLOPIROX 0.77% CREAM	*PDL-P
	CICLOPIROX 0.77% GEL	PDL-NP PA
	CICLOPIROX 0.77% TOPICAL SUSP	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Antifungal Hydroxypyridinone	CICLOPIROX 1% SHAMPOO	PDL-NP PA
	CICLOPIROX 8% SOLUTION	*PDL-P
	CICLOPIROX 8% TREATMENT KIT	PDL-NP PA
	LOPROX 0.77% CREAM	PDL-NP PA
	LOPROX 0.77% CREAM KIT	PDL-NP PA
	LOPROX 0.77% SUSPENSION KIT	PDL-NP PA
	LOPROX 0.77% TOPICAL SUSP	PDL-NP PA
Dermatological - Antifungal Imidazole & Related Agents	ANTIFUNGAL 1% TOPICAL CREAM	*PDL-P
	CLOTRIMAZOLE 1% SOLUTION	PDL-NP PA
	CLOTRIMAZOLE 1% SOLUTION	*PDL-P
	CLOTRIMAZOLE 1% TOPICAL CREAM	*PDL-P
	ECONAZOLE NITRATE 1% CREAM	*PDL-P
	ERTACZO 2% CREAM	PDL-NP PA
	EXTINA 2% FOAM	PDL-NP PA
	KETOCONAZOLE 2% CREAM	*PDL-P
	KETOCONAZOLE 2% FOAM	PDL-NP PA
	KETOCONAZOLE 2% SHAMPOO	*PDL-P
	KETODAN 2% FOAM	PDL-NP PA
	KETODAN 2% FOAM KIT	PDL-NP PA
	LOTRIMIN AF 1% CREAM	PDL-NP PA
	LULICONAZOLE 1% CREAM	PDL-NP PA
	LUZU 1% CREAM	PDL-NP PA
	MICONAZOLE 2% TOPICAL CREAM	*PDL-P
	MICONAZOLE NITRATE 2% SOLUTION *	*PDL-P
	MICONAZOLE-ZINC-PETRO 0.25-15%	PDL-NP AGE PA
	MICOTRIN AC 1% TOPICAL CREAM	PDL-NP PA
	MYCOZYL AC 1% TOPICAL CREAM	PDL-NP PA
	OXICONAZOLE NITRATE 1% CREAM	PDL-NP PA
	OXISTAT 1% CREAM	PDL-NP PA
	OXISTAT 1% LOTION	PDL-NP PA
QC CLOTRIMAZOLE 1% TOP CREAM	*PDL-P	
SM ANTIFUNGAL 1% TOPICAL CREAM	*PDL-P	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Antifungal Imidazole & Related Agents	SM MICONAZOLE 2% TOPICAL CREAM	*PDL-P
	VUSION OINTMENT	PDL-NP AGE PA
Dermatological - Antifungal Oxaborole	TAVABOROLE 5% TOPICAL SOLUTION	PDL-NP AGE PA
Dermatological - Antifungal Thiocarbamate	ANTIFUNGAL 1% CREAM	*PDL-P
	ANTI-FUNGAL 1% POWDER	*PDL-P
	SM ANTIFUNGAL 1% CREAM	*PDL-P
	TOLNAFTATE 1% CREAM	*PDL-P
	TOLNAFTATE 1% POWDER	*PDL-P
Dermatological - Antifungal Triazole	JUBLIA 10% TOPICAL SOLUTION	PDL-NP AGE PA
Dermatological - Antifungal-Glucocorticoid Combinations	CLOTRIMAZOLE-BETAMETHASONE CRM	*PDL-P
	CLOTRIMAZOLE-BETAMETHASONE LOT	PDL-NP PA
	NYSTATIN-TRIAMCINOLONE CREAM	*PDL-P
	NYSTATIN-TRIAMCINOLONE OINTM	*PDL-P
Dermatological - Antineoplastic Alkylating Agents	VALCHLOR 0.016% GEL	
Dermatological - Antineoplastic Antimetabolites	CARAC 0.5% CREAM	
	EFUDEX 5% CREAM	
	FLUOROURACIL 0.5% CREAM	
	FLUOROURACIL 2% TOPICAL SOLN	
	FLUOROURACIL 5% CREAM	
	FLUOROURACIL 5% TOP SOLUTION	
Dermatological - Antineoplastic or Premalignant Lesions - NSAID's	DICLOFENAC SODIUM 3% GEL	
	SOLARAZE 3% GEL	
Dermatological - Antineoplastic Selective Retinoid X Receptor Agonist	BEXAROTENE 1% GEL	
	TARGRETIN 1% GEL	
Dermatological - Antipsoriatic Agents Systemic	BIMZELX 160 MG/ML AUTOINJECTOR	PDL-NP AGE PA QL
	BIMZELX 160 MG/ML SYRINGE	PDL-NP AGE PA QL
	BIMZELX 320 MG/2 ML AUTOINJECT	PDL-NP AGE PA QL
	BIMZELX 320 MG/2 ML SYRINGE	PDL-NP AGE PA QL
Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives	ACITRETIN 10 MG CAPSULE	PA QL
	ACITRETIN 17.5 MG CAPSULE	PA QL
	ACITRETIN 25 MG CAPSULE	PA QL
Dermatological - Antipsoriatic Agents Topical	BRYHALI 0.01% LOTION	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Antipsoriatic Agents Topical	CALCIPOTRIENE 0.005% CREAM	AGE PA QL
	CALCIPOTRIENE 0.005% OINTMENT	AGE PA QL
	CALCIPOTRIENE 0.005% SOLUTION	AGE PA QL
	CALCITRIOL 3 MCG/G OINTMENT	AGE PA QL
	HALOBETASOL PROP 0.05% FOAM	PDL-NP PA
	TAZAROTENE 0.05% CREAM	AGE PA QL
	TAZAROTENE 0.05% GEL	AGE PA QL
	TAZAROTENE 0.1% CREAM	AGE PA QL
	TAZAROTENE 0.1% GEL	AGE PA QL
	VTAMA 1% CREAM	AGE PA QL
	ZORYVE 0.3% CREAM	AGE PA
Dermatological - Antiseborrheic	SELENIUM SULFIDE 2.5% LOTION	
	ZORYVE 0.3% FOAM	AGE PA
Dermatological - Antiviral, Herpes	ACYCLOVIR 5% CREAM	*PDL-P
	ACYCLOVIR 5% OINTMENT	*PDL-P
	DENAVIR 1% CREAM	*PDL-P
	DOCOSANOL 10% CREAM *	
	PENCICLOVIR 1% CREAM	PDL-NP PA
	ZOVIRAX 5% CREAM	PDL-NP PA
	ZOVIRAX 5% OINTMENT	PDL-NP PA
Dermatological - Antiviral-Glucocorticoid Combinations	XERESE 5%-1% CREAM	PDL-NP PA
Dermatological - Burn Products Anti-infective	SILVER SULFADIAZINE 1% CREAM	
	SSD 1% CREAM	
Dermatological - Calcineurin Inhibitors	ELIDEL 1% CREAM	*PDL-P AGE PA QL
	HYFTOR 0.2% GEL	AGE PA QL
	PIMECROLIMUS 1% CREAM	*PDL-P AGE PA QL
	TACROLIMUS 0.03% OINTMENT	*PDL-P AGE PA QL
	TACROLIMUS 0.1% OINTMENT	*PDL-P AGE PA QL
Dermatological - Emollients	AMMONIUM LACTATE 12% CREAM	QL
	AMMONIUM LACTATE 12% CREAM *	QL
	AMMONIUM LACTATE 12% LOTION	QL
	AMMONIUM LACTATE 12% LOTION *	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Glucocorticoid	ALCLOMETASONE DIPR 0.05% OINT	PDL-NP PA
	ALCLOMETASONE DIPRO 0.05% CRM	PDL-NP PA
	AMCINONIDE 0.1% CREAM	PDL-NP PA
	ANTI-ITCH 1% CREAM	*PDL-P
	APEXICON E 0.05% CREAM	PDL-NP PA
	BESER 0.05% LOTION	PDL-NP PA
	BETAMETHASONE DP 0.05% CRM	*PDL-P
	BETAMETHASONE DP 0.05% LOT	*PDL-P
	BETAMETHASONE DP 0.05% OINT	*PDL-P
	BETAMETHASONE DP AUG 0.05% CRM	PDL-NP PA
	BETAMETHASONE DP AUG 0.05% GEL	PDL-NP PA
	BETAMETHASONE DP AUG 0.05% LOT	PDL-NP PA
	BETAMETHASONE DP AUG 0.05% OIN	PDL-NP PA
	BETAMETHASONE VA 0.1% CREAM	*PDL-P
	BETAMETHASONE VA 0.1% LOTION	*PDL-P
	BETAMETHASONE VALER 0.1% OINTM	*PDL-P
	BETAMETHASONE VALER 0.12% FOAM	PDL-NP PA
	CAPEX SHAMPOO	PDL-NP PA
	CLOBETASOL 0.025% CREAM	PDL-NP PA
	CLOBETASOL 0.05% CREAM	*PDL-P
	CLOBETASOL 0.05% GEL	PDL-NP PA
	CLOBETASOL 0.05% OINTMENT	*PDL-P
	CLOBETASOL 0.05% SHAMPOO	PDL-NP PA
	CLOBETASOL 0.05% SOLUTION	*PDL-P
	CLOBETASOL 0.05% TOPICAL LOTN	PDL-NP PA
	CLOBETASOL EMOLLIENT 0.05% CRM	PDL-NP PA
	CLOBETASOL EMOLLNT 0.05% FOAM	PDL-NP PA
	CLOBETASOL EMULSION 0.05% FOAM	PDL-NP PA
	CLOBETASOL PROP 0.05% FOAM	PDL-NP PA
	CLOBETASOL PROP 0.05% SPRAY	PDL-NP PA
	CLOBEX 0.05% SHAMPOO	PDL-NP PA
	CLOBEX 0.05% SPRAY	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Glucocorticoid	CLOCORTOLONE 0.1% CREAM PUMP	PDL-NP PA
	CLOCORTOLONE PIVALATE 0.1% CRM	PDL-NP PA
	CLODAN 0.05% SHAMPOO	PDL-NP PA
	DERMA-SMOOTHIE-FS BODY OIL	PDL-NP PA
	DERMA-SMOOTHIE-FS SCALP OIL	PDL-NP PA
	DESONIDE 0.05% CREAM	PDL-NP PA
	DESONIDE 0.05% LOTION	PDL-NP PA
	DESONIDE 0.05% OINTMENT	PDL-NP PA
	DESOXIMETASONE 0.05% CREAM	PDL-NP PA
	DESOXIMETASONE 0.05% GEL	PDL-NP PA
	DESOXIMETASONE 0.05% OINTMENT	PDL-NP PA
	DESOXIMETASONE 0.25% CREAM	PDL-NP PA
	DESOXIMETASONE 0.25% OINTMENT	PDL-NP PA
	DESOXIMETASONE 0.25% SPRAY	PDL-NP PA
	DIFLORASONE 0.05% CREAM	PDL-NP PA
	DIFLORASONE 0.05% OINTMENT	PDL-NP PA
	DIPROLENE 0.05% OINTMENT	PDL-NP PA
	FLUOCINOLONE 0.01% BODY OIL	PDL-NP PA
	FLUOCINOLONE 0.01% CREAM	PDL-NP PA
	FLUOCINOLONE 0.01% SCALP OIL	PDL-NP PA
	FLUOCINOLONE 0.01% SOLUTION	*PDL-P
	FLUOCINOLONE 0.025% CREAM	PDL-NP PA
	FLUOCINOLONE 0.025% OINTMENT	PDL-NP PA
	FLUOCINONIDE 0.05% CREAM	*PDL-P
	FLUOCINONIDE 0.05% GEL	*PDL-P
	FLUOCINONIDE 0.05% OINTMENT	*PDL-P
	FLUOCINONIDE 0.05% SOLUTION	*PDL-P
	FLUOCINONIDE 0.1% CREAM	*PDL-P
	FLUOCINONIDE-E 0.05% CREAM	PDL-NP PA
	FLURANDRENOLIDE 0.05% LOTION	PDL-NP PA
FLURANDRENOLIDE 0.05% OINTMENT	PDL-NP PA	
FLUTICASONE PROP 0.005% OINT	*PDL-P	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Glucocorticoid	FLUTICASONE PROP 0.05% CREAM	*PDL-P
	FLUTICASONE PROP 0.05% LOTION	PDL-NP PA
	GS ANTI-ITCH 1% CREAM	*PDL-P
	HALCINONIDE 0.1% CREAM	PDL-NP PA
	HALOBETASOL PROP 0.05% CREAM	*PDL-P
	HALOBETASOL PROP 0.05% OINTMNT	*PDL-P
	HALOG 0.1% CREAM	PDL-NP PA
	HALOG 0.1% OINTMENT	PDL-NP PA
	HALOG 0.1% SOLUTION	PDL-NP PA
	HM HYDROCORTISONE 1% CREAM	*PDL-P
	HYDROCORT BUTY 0.1% LIPO CREAM	PDL-NP PA
	HYDROCORTISONE 0.5% CREAM	*PDL-P
	HYDROCORTISONE 0.5% CREAM	*PDL-P
	HYDROCORTISONE 1% CREAM	*PDL-P
	HYDROCORTISONE 1% CREAM	*PDL-P
	HYDROCORTISONE 1% CREAM	*PDL-P
	HYDROCORTISONE 1% CREAM *	*PDL-P
	HYDROCORTISONE 1% OINTMENT	*PDL-P
	HYDROCORTISONE 1% OINTMENT	*PDL-P
	HYDROCORTISONE 1% OINTMENT	*PDL-P
	HYDROCORTISONE 2.5% CREAM	*PDL-P
	HYDROCORTISONE 2.5% LOTION	*PDL-P
	HYDROCORTISONE 2.5% OINTMENT	*PDL-P
	HYDROCORTISONE 2.5% SOLUTION	PDL-NP PA
	HYDROCORTISONE BUTY 0.1% CREAM	PDL-NP PA
	HYDROCORTISONE BUTYR 0.1% LOTN	PDL-NP PA
	HYDROCORTISONE BUTYR 0.1% OINT	PDL-NP PA
	HYDROCORTISONE BUTYR 0.1% SOLN	PDL-NP PA
	HYDROCORTISONE PLUS 1% CREAM	*PDL-P
	HYDROCORTISONE VAL 0.2% CREAM	PDL-NP PA
	HYDROCORTISONE VAL 0.2% OINTMT	PDL-NP PA
	IMPEKLO 0.05% LOTION	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Glucocorticoid	KENALOG 0.147 MG/GRAM SPRAY	PDL-NP PA
	LOCOID 0.1% LIPOCREAM	PDL-NP PA
	LOCOID 0.1% LOTION	PDL-NP PA
	MOMETASONE FUROATE 0.1% CREAM	*PDL-P
	MOMETASONE FUROATE 0.1% OINT	*PDL-P
	MOMETASONE FUROATE 0.1% SOLN	*PDL-P
	OLUX 0.05% FOAM	PDL-NP PA
	PANDEL 0.1% CREAM	PDL-NP PA
	PREDNICARBATE 0.1% CREAM	PDL-NP PA
	PREDNICARBATE 0.1% OINTMENT	PDL-NP PA
	QC ANTI-ITCH 1% CREAM	*PDL-P
	SM HYDROCORTISONE 1% OINTMENT	*PDL-P
	SYNALAR 0.01% SOLUTION	PDL-NP PA
	SYNALAR 0.025% CREAM	PDL-NP PA
	SYNALAR 0.025% OINTMENT	PDL-NP PA
	TEXACORT 2.5% SOLUTION	PDL-NP PA
	TOPICORT 0.05% CREAM	PDL-NP PA
	TOPICORT 0.05% GEL	PDL-NP PA
	TOPICORT 0.05% OINTMENT	PDL-NP PA
	TOPICORT 0.25% CREAM	PDL-NP PA
	TOPICORT 0.25% OINTMENT	PDL-NP PA
	TOPICORT 0.25% SPRAY	PDL-NP PA
	TOVET EMOLLIENT 0.05% FOAM	PDL-NP PA
	TRIAMCINOLONE 0.025% CREAM	*PDL-P
	TRIAMCINOLONE 0.025% LOTION	*PDL-P
	TRIAMCINOLONE 0.025% OINT	*PDL-P
	TRIAMCINOLONE 0.05% OINTMENT	*PDL-P
	TRIAMCINOLONE 0.1% CREAM	*PDL-P
	TRIAMCINOLONE 0.1% LOTION	*PDL-P
	TRIAMCINOLONE 0.1% OINTMENT	*PDL-P
TRIAMCINOLONE 0.147 MG/G SPRAY	PDL-NP PA	
TRIAMCINOLONE 0.5% CREAM	*PDL-P	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Dermatological - Glucocorticoid	TRIAMCINOLONE 0.5% OINTMENT	*PDL-P
	TRIDERM 0.1% CREAM	*PDL-P
	ULTRAVATE 0.05% LOTION	PDL-NP PA
	VANOS 0.1% CREAM	PDL-NP PA
Dermatological - Glucocorticoid-Emollient Combinations	HYDROCORTISONE-ALOE 1% CREAM	*PDL-P
	SM HYDROCORTISONE-ALOE 1% CRM	*PDL-P
	SYNALAR 0.025% CREAM KIT	PDL-NP PA
	SYNALAR 0.025% OINTMENT KIT	PDL-NP PA
Dermatological - Glucocorticoid-Skin Cleanser Combinations	CLODAN 0.05% KIT	PDL-NP PA
	SYNALAR TS 0.01% KIT	PDL-NP PA
Dermatological - Immunomodulator - Imidazoquinolinamines	IMIQUIMOD 5% CREAM PACKET	
Dermatological - Keratolytic-Antimitotic Single Agents	PODOFILOX 0.5% TOPICAL SOLN	
Dermatological - Local Anesthetic Combinations	BESER 0.05% KIT	PDL-NP PA
	LIDOCAINE-PRILOCAINE CREAM	QL
	TOVET 0.05% FOAM KIT	PDL-NP PA
Dermatological - NSAID Single Agents	DICLOFENAC 1.5% TOPICAL SOLN	*PDL-P
	DICLOFENAC 2% SOLUTION PUMP	PDL-NP PA
	DICLOFENAC EPOLAMINE 1.3% PTCH	PDL-NP PA QL
	DICLOFENAC SODIUM 1% GEL	*PDL-P
	DICLOFENAC SODIUM 1% GEL *	*PDL-P
	PENNSAID 2% PUMP	PDL-NP PA
	PENNSAID 2% SOLUTION PACKET	PDL-NP PA
Dermatological - Topical Local Anesthetic Amides	LIDOCAINE 3% CREAM	QL
	LIDOCAINE 5% OINTMENT	QL
	LIDOCAINE 5% PATCH	PA QL
	LIDOCAINE HCL 2% JELLY	
	LIDOCAINE PAIN RELIEF 4% PATCH *	QL
Digestive Enzyme Mixtures	CREON DR 12,000 UNIT CAPSULE	*PDL-P PA
	CREON DR 24,000 UNIT CAPSULE	*PDL-P PA
	CREON DR 3,000 UNIT CAPSULE	*PDL-P PA
	CREON DR 36,000 UNIT CAPSULE	*PDL-P PA
	CREON DR 6,000 UNIT CAPSULE	*PDL-P PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Digestive Enzyme Mixtures	DIGESTIVE ENZYMES CAPSULE #	
	DIGESTIVE ENZYMES TABLET #	
	ENZYMATIC DIGESTANT ER TABLET * #	
	PERTZYE DR 16,000 UNIT CAPSULE	PDL-NP PA
	PERTZYE DR 24,000 UNIT CAPSULE	PDL-NP PA
	PERTZYE DR 4,000 UNIT CAPSULE	PDL-NP PA
	PERTZYE DR 8,000 UNIT CAPSULE	PDL-NP PA
	VIOKACE 10,440-39,150 UNITS TB	PDL-NP PA
	VIOKACE 20,880-78,300 UNITS TB	PDL-NP PA
	ZENPEP DR 10,000 UNIT CAPSULE	*PDL-P PA
	ZENPEP DR 15,000 UNIT CAPSULE	*PDL-P PA
	ZENPEP DR 20,000 UNIT CAPSULE	*PDL-P PA
	ZENPEP DR 25,000 UNIT CAPSULE	*PDL-P PA
	ZENPEP DR 3,000 UNIT CAPSULE	*PDL-P PA
	ZENPEP DR 40,000 UNIT CAPSULE	*PDL-P PA
	ZENPEP DR 5,000 UNIT CAPSULE	*PDL-P PA
ZENPEP DR 60,000 UNIT CAPSULE	*PDL-P PA	
Digestive Enzymes	CVS DAIRY RELIEF 9,000 UNITS * #	
	CVS DAIRY RLF 9,000 UNITS CPLT * #	
	CVS LACTASE 3,000 UNIT CAPLET * #	
	CVS LACTASE ENZYME CAPLET * #	
	DAIRY DIGESTIVE AID 9,000 UNIT * #	
	DAIRY RELIEF 3,000 UNIT CAPLET * #	
	DAIRY RLF 9,000 UNIT TAB CHEW * #	
	ENZYMATIC DIGESTANT TABLET * #	
	ENZYME DIGEST CAPSULE * #	
	EQ DAIRY DIGESTIVE 9,000 UNIT * #	
	EQ DAIRY DIGESTIVE 9,000 UNIT * #	
	FAST ACTING LACTASE 9,000 UNIT * #	
	GNP DAIRY RELF 3,000 UNIT CPLT * #	
	GNP DAIRY RLF 9,000 UNIT CHEW * #	
	LAC-DOSE 3,000 UNIT CAPTAB * #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Digestive Enzymes	LACTAID FAST ACT 9,000 UNIT * #	
	LACTAID FAST ACT 9,000 UNITS * #	
	LACTASE 3,000 UNIT CAPLET * #	
	LACTASE FAST ACTING 9,000 UNIT * #	
	LACTOSE FAST ACTING 9,000 UNIT * #	
	LACTOSE FAST ACTING 9,000 UNIT * #	
	LACTOSE FAST ACTING RLF 9,000 * #	
	PUB DAIRY DIGESTIVE 9,000 UNIT * #	
	RA DAIRY AID 3,000 UNIT CAPLET * #	
	RA DAIRY RELIEF 9,000 UNIT * #	
	RA DAIRY RLF 9,000 UNIT CHEW * #	
	SM DAIRY DIGESTIVE CAPLET * #	
	SM ULTRA DAIRY DIGESTIVE CPLT * #	
	SUCRAID 8,500 UNITS/ML SOLN #	
	SUPERIOR DIGESTIVE ENZYME CAP #	
Digitalis Glycosides	DIGOXIN 0.125 MG TABLET	
	DIGOXIN 0.25 MG TABLET	
	DIGOXIN 125 MCG TABLET	
	DIGOXIN 250 MCG TABLET	
Direct Acting Vasodilators	HYDRALAZINE 10 MG TABLET	QL
	HYDRALAZINE 100 MG TABLET	QL
	HYDRALAZINE 20 MG/ML VIAL	
	HYDRALAZINE 20 MG/ML VIAL	
	HYDRALAZINE 20 MG/ML VIAL	Covered for CSHCS Only
	HYDRALAZINE 20 MG/ML VIAL	Covered for CSHCS Only
	HYDRALAZINE 20 MG/ML VIAL	
	HYDRALAZINE 20 MG/ML VIAL	
	HYDRALAZINE 20 MG/ML VIAL	Covered for CSHCS Only
	HYDRALAZINE 20 MG/ML VIAL	
	HYDRALAZINE 20 MG/ML VIAL	
	HYDRALAZINE 20 MG/ML VIAL	
	HYDRALAZINE 25 MG TABLET	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Direct Acting Vasodilators	HYDRALAZINE 50 MG TABLET	QL
	MINOXIDIL 10 MG TABLET	
	MINOXIDIL 2.5 MG TABLET	
Direct Factor Xa Inhibitors	ELIQUIS 2.5 MG TABLET	*PDL-P QL
	ELIQUIS 5 MG TABLET	*PDL-P QL
	ELIQUIS DVT-PE TREAT START 5MG	*PDL-P QL
	Rivaroxaban 1 MG/ML oral suspension	PDL-NP PA QL
	RIVAROXABAN 2.5 MG TABLET	PDL-NP PA QL
	SAVAYSA 15 MG TABLET	PDL-NP PA
	SAVAYSA 30 MG TABLET	PDL-NP PA
	SAVAYSA 60 MG TABLET	PDL-NP PA
	XARELTO 1 MG/ML SUSPENSION	*PDL-P QL
	XARELTO 10 MG TABLET	*PDL-P QL
	XARELTO 15 MG TABLET	*PDL-P QL
	XARELTO 2.5 MG TABLET	*PDL-P QL
	XARELTO 20 MG TABLET	*PDL-P QL
	XARELTO DVT-PE TREAT START 30D	*PDL-P QL
Diuretic - Aldosterone Receptor Antagonist, Non-selective	SPIRONOLACTONE 100 MG TABLET	QL
	SPIRONOLACTONE 25 MG TABLET	QL
	SPIRONOLACTONE 50 MG TABLET	QL
Diuretic - Carbonic Anhydrase Inhibitors	ACETAZOLAMIDE 125 MG TABLET	QL
	ACETAZOLAMIDE 250 MG TABLET	QL
	ACETAZOLAMIDE ER 500 MG CAP	QL
Diuretic - Loop	FUROSEMIDE 10 MG/ML SOLUTION	AGE
	FUROSEMIDE 20 MG TABLET	QL
	FUROSEMIDE 40 MG TABLET	QL
	FUROSEMIDE 40 MG/5 ML SOLN	AGE
	FUROSEMIDE 80 MG TABLET	QL
	TORSEMIDE 10 MG TABLET	QL
	TORSEMIDE 100 MG TABLET	QL
	TORSEMIDE 20 MG TABLET	QL
TORSEMIDE 5 MG TABLET	QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Diuretic - Potassium Sparing	AMILORIDE HCL 5 MG TABLET	QL
Diuretic - Potassium Sparing-Mineralocorticoid Receptor Antagonists	KERENDIA 10 MG TABLET	AGE PA QL
	KERENDIA 20 MG TABLET	AGE PA QL
	KERENDIA 40 MG TABLET	AGE PA QL
Diuretic - Potassium Sparing-Thiazide & Related Combinations	AMILORIDE HCL-HCTZ 5-50 MG TAB	QL
	SPIRONOLACTONE-HCTZ 25-25 TAB	QL
	TRIAMTERENE-HCTZ 37.5-25 MG CP	
	TRIAMTERENE-HCTZ 37.5-25 MG TB	
	TRIAMTERENE-HCTZ 75-50 MG TAB	
Diuretic - Selective Arginine Vasopressin V2 Receptor Antagonists	TOLVAPTAN 15 MG TABLET	AGE PA QL
	TOLVAPTAN 15 MG-15 MG TABLET	AGE PA QL
	TOLVAPTAN 30 MG TABLET	AGE PA QL
	TOLVAPTAN 30 MG-15 MG TABLET	AGE PA QL
	TOLVAPTAN 45 MG-15 MG TABLET	AGE PA QL
	TOLVAPTAN 60 MG-30 MG TABLET	AGE PA QL
	TOLVAPTAN 90 MG-30 MG TABLET	AGE PA QL
Diuretic - Thiazides and Related	CHLORTHALIDONE 25 MG TABLET	QL
	CHLORTHALIDONE 50 MG TABLET	QL
	DIURIL 250 MG/5 ML ORAL SUSP	AGE
	HYDROCHLOROTHIAZIDE 12.5 MG CP	
	HYDROCHLOROTHIAZIDE 12.5 MG TB	
	HYDROCHLOROTHIAZIDE 25 MG TAB	
	HYDROCHLOROTHIAZIDE 50 MG TAB	
	INDAPAMIDE 1.25 MG TABLET	QL
	INDAPAMIDE 2.5 MG TABLET	QL
	METOLAZONE 10 MG TABLET	QL
	METOLAZONE 2.5 MG TABLET	QL
	METOLAZONE 5 MG TABLET	QL
	DMARD - Antinflammatory, Select. costimulation modulator,T-cell Inhib.	ORENCIA 125 MG/ML SYRINGE
ORENCIA 50 MG/0.4 ML SYRINGE		PDL-NP PA QL
ORENCIA 87.5 MG/0.7 ML SYRINGE		PDL-NP PA QL
ORENCIA CLICKJECT 125 MG/ML		PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
DMARD - Interleukin-1 Receptor Antagonist (IL-1Ra)	KINERET 100 MG/0.67 ML SYRINGE #	
DMARD - Interleukin-6 (IL-6) Receptor Inhibitors, Monoclonal Antibody	ACTEMRA 162 MG/0.9 ML SYRINGE	PDL-NP AGE PA QL
	ACTEMRA ACTPEN 162 MG/0.9 ML	PDL-NP AGE PA QL
DMARD - Janus Kinase (JAK) Inhibitors	OLUMIANT 1 MG TABLET	PDL-NP PA QL
	OLUMIANT 2 MG TABLET	PDL-NP PA QL
	OLUMIANT 4 MG TABLET	PDL-NP PA QL
	RINVOQ ER 15 MG TABLET	PDL-NP PA QL
	RINVOQ ER 15 MG TABLET	PDL-NP PA QL
	RINVOQ ER 30 MG TABLET	PDL-NP PA QL
	RINVOQ ER 45 MG TABLET	PDL-NP PA QL
	RINVOQ LQ 1 MG/ML SOLUTION	PDL-NP PA QL
	XELJANZ 1 MG/ML SOLUTION	PDL-NP AGE PA QL
	XELJANZ 10 MG TABLET	PDL-NP AGE PA QL
	XELJANZ 5 MG TABLET	PDL-NP AGE PA QL
	XELJANZ XR 11 MG TABLET	PDL-NP AGE PA QL
	XELJANZ XR 22 MG TABLET	PDL-NP AGE PA QL
DMARD - Phosphodiesterase-4 (PDE4) Inhibitors	OTEZLA 10-20 MG STARTER 28 DAY	PDL-NP PA QL
	OTEZLA 10-20-30MG START 28 DAY	PDL-NP PA QL
	OTEZLA 20 MG TABLET	PDL-NP PA QL
	OTEZLA 30 MG TABLET	PDL-NP PA QL
	OTEZLA XR 75 MG TABLET	PDL-NP PA QL
	OTEZLA XR INITIATION PK 28 DAY	PDL-NP PA QL
DMARD - Pyrimidine Synthesis Inhibitors	LEFLUNOMIDE 10 MG TABLET	QL
	LEFLUNOMIDE 20 MG TABLET	QL
Eczema Agents, Interleukin-13 (IL-13) Inhibitors, MAB	ADBRY 150 MG/ML SYRINGE	*PDL-P PA QL
	ADBRY 300 MG/2 ML AUTOINJECTOR	*PDL-P PA QL
	EBGLYSS 250 MG/2 ML PEN	PDL-NP AGE PA QL
	EBGLYSS 250 MG/2 ML SYRINGE	PDL-NP AGE PA QL
Eczema Agents, Interleukin-13 (IL-13) Receptor Alpha Antagonist, MAB	NEMLUVIO 30 MG PEN	PDL-NP AGE PA QL
Eczema Agents, Janus Kinase (JAK) Inhibitors	CIBINQO 100 MG TABLET	PDL-NP AGE PA
	CIBINQO 200 MG TABLET	PDL-NP AGE PA
	CIBINQO 50 MG TABLET	PDL-NP AGE PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Eczema Agents, Janus Kinase (JAK) Inhibitors	OPZELURA 1.5% CREAM	PDL-NP AGE PA QL
Eczema Agents, Systemic, Interleukin-4 Rec. Antag Mab	DUPIXENT 100 MG/0.67 ML SYRINGE	*PDL-P AGE PA
	DUPIXENT 200 MG/1.14 ML PEN	*PDL-P AGE PA
	DUPIXENT 200 MG/1.14 ML SYRINGE	*PDL-P AGE PA
	DUPIXENT 300 MG/2 ML PEN	*PDL-P AGE PA
	DUPIXENT 300 MG/2 ML SYRINGE	*PDL-P AGE PA
Electrolyte Depleters - Ion Exchange Resin	KIONEX 15 GM/60 ML SUSPENSION	*PDL-P
	LOKELMA 10 GRAM POWDER PACKET	*PDL-P
	LOKELMA 5 GRAM POWDER PACKET	*PDL-P
	SOD POLYSTYREN SULF 15 G/60 ML	
	SODIUM POLYSTYRENE SULF POWDER	
	SPS 15 GM/60 ML SUSPENSION	*PDL-P
	SPS 30 GM/120 ML ENEMA SUSP	*PDL-P
	VELTASSA 1 GM POWDER PACKET	PDL-NP PA
	VELTASSA 16.8 GM POWDER PACKET	PDL-NP PA
	VELTASSA 25.2 GM POWDER PACKET	PDL-NP PA
VELTASSA 8.4 GM POWDER PACKET	PDL-NP PA	
Emergency Contraceptives	ECONTRA EZ 1.5 MG TABLET *	
	ELLA 30 MG TABLET	
	MY WAY 1.5 MG TABLET *	
	OPCICON ONE-STEP 1.5 MG TABLET *	
Endothelin Receptor Antagonists	TRYVIO 12.5 MG TABLET	AGE PA QL
Erythropoietins	ARANESP 10 MCG/0.4 ML SYRINGE	*PDL-P PA
	ARANESP 100 MCG/0.5 ML SYRINGE	*PDL-P PA
	ARANESP 100 MCG/ML VIAL	*PDL-P PA
	ARANESP 150 MCG/0.3 ML SYRINGE	*PDL-P PA
	ARANESP 200 MCG/0.4 ML SYRINGE	*PDL-P PA
	ARANESP 200 MCG/ML VIAL	*PDL-P PA
	ARANESP 25 MCG/0.42 ML SYRINGE	*PDL-P PA
	ARANESP 25 MCG/ML VIAL	*PDL-P PA
	ARANESP 300 MCG/0.6 ML SYRINGE	*PDL-P PA
ARANESP 40 MCG/0.4 ML SYRINGE	*PDL-P PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Erythropoietins	ARANESP 40 MCG/ML VIAL	*PDL-P PA
	ARANESP 500 MCG/1 ML SYRINGE	*PDL-P PA
	ARANESP 60 MCG/0.3 ML SYRINGE	*PDL-P PA
	ARANESP 60 MCG/ML VIAL	*PDL-P PA
	EPOGEN 10,000 UNITS/ML VIAL	*PDL-P PA
	EPOGEN 2,000 UNITS/ML VIAL	*PDL-P PA
	EPOGEN 20,000 UNITS/2 ML VIAL	*PDL-P PA
	EPOGEN 20,000 UNITS/ML VIAL	*PDL-P PA
	EPOGEN 3,000 UNITS/ML VIAL	*PDL-P PA
	EPOGEN 4,000 UNITS/ML VIAL	*PDL-P PA
	PROCRIT 10,000 UNITS/ML VIAL	PDL-NP PA
	PROCRIT 10,000 UNITS/ML VIAL	PDL-NP PA
	PROCRIT 2,000 UNITS/ML VIAL	PDL-NP PA
	PROCRIT 20,000 UNITS/ML VIAL	PDL-NP PA
	PROCRIT 3,000 UNITS/ML VIAL	PDL-NP PA
	PROCRIT 4,000 UNITS/ML VIAL	PDL-NP PA
	PROCRIT 40,000 UNITS/ML VIAL	PDL-NP PA
	RETACRIT 10,000 UNIT/ML VIAL	*PDL-P PA
	RETACRIT 2,000 UNIT/ML VIAL	*PDL-P PA
	RETACRIT 20,000 UNIT/2 ML VIAL	*PDL-P PA
	RETACRIT 20,000 UNIT/ML VIAL	*PDL-P PA
	RETACRIT 3,000 UNIT/ML VIAL	*PDL-P PA
RETACRIT 4,000 UNIT/ML VIAL	*PDL-P PA	
RETACRIT 40,000 UNIT/ML VIAL	*PDL-P PA	
Estrogen-Progestin	ESTRADIOL-NORETH 0.5-0.1 MG TB	AGE
	ESTRADIOL-NORETH 1-0.5 MG TAB	AGE
	NORETHIND-ETH ESTRAD 0.5-2.5	AGE QL
	NORETHIN-ETH ESTRAD 1 MG-5 MCG	AGE
	PREMPHASE 0.625-5 MG TABLET	AGE QL
	PREMPRO 0.3 MG-1.5 MG TABLET	AGE QL
	PREMPRO 0.45-1.5 MG TABLET	AGE QL
	PREMPRO 0.625-2.5 MG TABLET	AGE QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Estrogen-Progestin	PREMPRO 0.625-5 MG TABLET	AGE QL
Estrogens	DELESTROGEN 100 MG/5 ML VIAL	
	DELESTROGEN 200 MG/5 ML VIAL	
	DELESTROGEN 50 MG/5 ML VIAL	
	ESTRADIOL 0.025 MG PATCH(1/WK)	AGE QL
	ESTRADIOL 0.025 MG PATCH(2/WK)	AGE QL
	ESTRADIOL 0.0375MG PATCH(1/WK)	AGE QL
	ESTRADIOL 0.0375MG PATCH(2/WK)	AGE QL
	ESTRADIOL 0.05 MG PATCH (1/WK)	AGE QL
	ESTRADIOL 0.05 MG PATCH (2/WK)	AGE QL
	ESTRADIOL 0.06 MG PATCH (1/WK)	AGE QL
	ESTRADIOL 0.075 MG PATCH(1/WK)	AGE QL
	ESTRADIOL 0.075 MG PATCH(2/WK)	AGE QL
	ESTRADIOL 0.1 MG PATCH (1/WK)	AGE QL
	ESTRADIOL 0.1 MG PATCH (2/WK)	AGE QL
	ESTRADIOL 0.5 MG TABLET	AGE
	ESTRADIOL 1 MG TABLET	AGE
	ESTRADIOL 2 MG TABLET	AGE
	ESTRADIOL TDS 0.025 MG/DAY	AGE QL
	ESTRADIOL TDS 0.05 MG/DAY	AGE QL
	ESTRADIOL TDS 0.075 MG/DAY	AGE QL
	ESTRADIOL TDS 0.1 MG/DAY	AGE QL
	ESTRADIOL VALERATE 100 MG/5 ML	
	ESTRADIOL VALERATE 200 MG/5 ML	
	MENEST 0.3 MG TABLET	AGE
	MENEST 0.625 MG TABLET	AGE
	MENEST 1.25 MG TABLET	AGE
	MENEST 2.5 MG TABLET	AGE
	PREMARIN 0.3 MG TABLET	AGE QL
	PREMARIN 0.45 MG TABLET	AGE QL
	PREMARIN 0.625 MG TABLET	AGE QL
PREMARIN 0.9 MG TABLET	AGE QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Estrogens	PREMARIN 1.25 MG TABLET	AGE QL
Factor IX Complex (Prothrombin Complex Concentrate) Preparations	KCENTRA 1,000 UNIT VIAL #	
	KCENTRA 500 UNIT VIAL #	
Factor IX Preparations	ALPHANINE SD 1,000 UNITS VIAL #	
	ALPHANINE SD 1,500 UNITS VIAL #	
	ALPHANINE SD 500 UNITS VIAL #	
	ALPROLIX 1,000 UNIT NOMINAL #	
	ALPROLIX 2,000 UNIT NOMINAL #	
	ALPROLIX 250 UNIT NOMINAL #	
	ALPROLIX 3,000 UNIT NOMINAL #	
	ALPROLIX 4,000 UNIT NOMINAL #	
	ALPROLIX 500 UNIT NOMINAL #	
	BENEFIX 1,000 UNIT RANGE #	
	BENEFIX 2,000 UNIT RANGE #	
	BENEFIX 250 UNIT RANGE #	
	BENEFIX 3,000 UNIT RANGE #	
	BENEFIX 500 UNIT RANGE #	
	IDELVION 1,000 UNIT RANGE VIAL #	
	IDELVION 2,000 UNIT RANGE VIAL #	
	IDELVION 250 UNIT RANGE VIAL #	
	IDELVION 3,500 UNIT RANGE VIAL #	
	IDELVION 500 UNIT RANGE VIAL #	
	IXINITY 1,000 UNIT RANGE #	
	IXINITY 1,000 UNIT RANGE-2 VLS #	
	IXINITY 1,500 UNIT RANGE #	
	IXINITY 1,500 UNIT RANGE-2 VLS #	
	IXINITY 2,000 UNIT RANGE #	
	IXINITY 250 UNIT RANGE #	
	IXINITY 3,000 UNIT RANGE #	
	IXINITY 500 UNIT VIAL #	
MONONINE 1,000 UNIT VIAL #		
PROFILNINE 1,000 UNITS VIAL #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Factor IX Preparations	PROFILNINE 1,500 UNITS VIAL #	
	PROFILNINE 500 UNITS VIAL #	
	REBINYN 1,000 UNIT VIAL #	
	REBINYN 2,000 UNIT VIAL #	
	REBINYN 500 UNIT VIAL #	
	RIXUBIS 1,000 UNIT NOMINAL #	
	RIXUBIS 2,000 UNIT NOMINAL #	
	RIXUBIS 250 UNIT NOMINAL #	
	RIXUBIS 3,000 UNIT NOMINAL #	
	RIXUBIS 500 UNIT NOMINAL #	
Factor VII Preparations	NOVOSEVEN RT 1 MG VIAL #	
	NOVOSEVEN RT 2 MG VIAL #	
	NOVOSEVEN RT 5 MG VIAL #	
	NOVOSEVEN RT 8 MG VIAL #	
Factor VIII Preparations (AHF)	ADVATE 1,201-1,800 UNIT VIAL #	
	ADVATE 1,801-2,400 UNIT VIAL #	
	ADVATE 2,401-3,600 UNIT VIAL #	
	ADVATE 200-400 UNIT VIAL #	
	ADVATE 3,601-4,800 UNIT VIAL #	
	ADVATE 401-800 UNIT VIAL #	
	ADVATE 801-1,200 UNIT VIAL #	
	ADYNOVATE 1,251-2,500 UNIT VL #	
	ADYNOVATE 1,500 UNIT VIAL #	
	ADYNOVATE 200-400 UNIT VIAL #	
	ADYNOVATE 3,000 UNIT VIAL #	
	ADYNOVATE 401-800 UNIT VIAL #	
	ADYNOVATE 750 UNIT VIAL #	
	ADYNOVATE 801-1,250 UNIT VIAL #	
	AFSTYLA 1,000 UNIT VIAL #	
	AFSTYLA 1,500 UNIT RANGE VIAL #	
	AFSTYLA 2,000 UNIT VIAL #	
AFSTYLA 2,500 UNIT RANGE VIAL #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Factor VIII Preparations (AHF)	AFSTYLA 250 UNIT VIAL #	
	AFSTYLA 3,000 UNIT VIAL #	
	AFSTYLA 500 UNIT VIAL #	
	ALPHANATE 1,000-400 UNIT VIAL #	
	ALPHANATE 1,500-600 UNIT VIAL #	
	ALPHANATE 2,000-800 UNIT VIAL #	
	ALPHANATE 250-100 UNIT VIAL #	
	ALPHANATE 500-200 UNIT VIAL #	
	ELOCTATE 1,000 UNIT NOMINAL #	
	ELOCTATE 1,500 UNIT NOMINAL #	
	ELOCTATE 2,000 UNIT NOMINAL #	
	ELOCTATE 250 UNIT NOMINAL #	
	ELOCTATE 3,000 UNIT NOMINAL #	
	ELOCTATE 4,000 UNIT NOMINAL #	
	ELOCTATE 5,000 UNIT NOMINAL #	
	ELOCTATE 500 UNIT NOMINAL #	
	ELOCTATE 6,000 UNIT NOMINAL #	
	ELOCTATE 750 UNIT NOMINAL #	
	ESPEROCT 1,000 UNIT VIAL #	
	ESPEROCT 1,500 UNIT VIAL #	
	ESPEROCT 2,000 UNIT VIAL #	
	ESPEROCT 3,000 UNIT VIAL #	
	ESPEROCT 4,000 UNIT VIAL #	
	ESPEROCT 500 UNIT VIAL #	
	HELIXATE FS 1,000 UNIT VIAL #	
	HELIXATE FS 2,000 UNIT VIAL #	
	HELIXATE FS 250 UNIT VIAL #	
	HELIXATE FS 3,000 UNITS VIAL #	
	HELIXATE FS 500 UNIT VIAL #	
	HEMOPIL M 1,000 UNIT NOMINAL #	
	HEMOPIL M 1,700 UNIT NOMINAL #	
	HEMOPIL M 250 UNIT NOMINAL #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Factor VIII Preparations (AHF)	HEMOFIL M 500 UNIT NOMINAL #	
	HUMATE-P 1,200 UNIT VWF:RCO #	
	HUMATE-P 2,400 UNIT VWF:RCO #	
	HUMATE-P 600 UNIT VWF:RCO #	
	JIVI 1,000 UNIT VIAL #	
	JIVI 2,000 UNIT VIAL #	
	JIVI 3,000 UNIT VIAL #	
	JIVI 500 UNIT VIAL #	
	KOATE 1,000 UNIT VIAL #	
	KOATE 250 UNIT VIAL #	
	KOATE 500 UNIT VIAL #	
	KOGENATE FS 1,000 UNIT-BIOSET #	
	KOGENATE FS 1,000 UNITS VIAL #	
	KOGENATE FS 2,000 UNIT VIAL #	
	KOGENATE FS 2,000 UNIT-BIOSET #	
	KOGENATE FS 250 UNIT VIAL #	
	KOGENATE FS 250 UNIT VL-BIOSET #	
	KOGENATE FS 3,000 UNIT-BIOSET #	
	KOGENATE FS 3,000 UNITS VIAL #	
	KOGENATE FS 500 UNIT VIAL #	
	KOGENATE FS 500 UNIT VL-BIOSET #	
	KOVALTRY 1,000 UNIT VIAL #	
	KOVALTRY 2,000 UNIT VIAL #	
	KOVALTRY 250 UNIT VIAL #	
	KOVALTRY 3,000 UNIT VIAL #	
	KOVALTRY 500 UNIT VIAL #	
	NOVOEIGHT 1,000 UNIT VIAL #	
	NOVOEIGHT 1,500 UNIT VIAL #	
	NOVOEIGHT 2,000 UNIT VIAL #	
	NOVOEIGHT 250 UNIT VIAL #	
	NOVOEIGHT 3,000 UNIT VIAL #	
	NOVOEIGHT 500 UNIT VIAL #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Factor VIII Preparations (AHF)	NUWIQ 1,000 UNIT VIAL #	
	NUWIQ 2,000 UNIT VIAL #	
	NUWIQ 2,500 UNIT VIAL PACK #	
	NUWIQ 250 UNIT VIAL #	
	NUWIQ 3,000 UNIT VIAL PACK #	
	NUWIQ 4,000 UNIT VIAL PACK #	
	NUWIQ 500 UNIT VIAL #	
	OBIZUR 500 UNIT VIAL - 5 VIALS #	
	OBIZUR 500 UNIT VIAL #	
	OBIZUR 500 UNIT VIAL -10 VIALS #	
	RECOMBINATE 1,241-1,800 UNIT V #	
	RECOMBINATE 1,801-2,400 UNIT V #	
	RECOMBINATE 220-400 UNIT VIAL #	
	RECOMBINATE 401-800 UNIT VIAL #	
	RECOMBINATE 801-1,240 UNIT VL #	
	WILATE 1,000-1,000 UNIT VIAL #	
	WILATE 500-500 UNIT VIAL #	
	XYNTHA 1,000 UNIT KIT #	
	XYNTHA 2,000 UNIT KIT #	
	XYNTHA 250 UNIT KIT #	
	XYNTHA 500 UNIT KIT #	
	XYNTHA SOLOFUSE 1,000 UNIT KIT #	
	XYNTHA SOLOFUSE 2,000 UNIT KIT #	
XYNTHA SOLOFUSE 250 UNIT KIT #		
XYNTHA SOLOFUSE 3,000 UNIT KIT #		
XYNTHA SOLOFUSE 500 UNIT KIT #		
Factor VIII-Mimetic Agent, Monoclonal Antibody	ALHEMO 150 MG/1.5 ML PEN #	
	ALHEMO 300 MG/3 ML PEN #	
	ALHEMO 60 MG/1.5 ML PEN #	
	HEMLIBRA 105 MG/0.7 ML VIAL #	
	HEMLIBRA 150 MG/ML VIAL #	
	HEMLIBRA 30 MG/ML VIAL #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Factor VIII-Mimetic Agent, Monoclonal Antibody	HEMLIBRA 60 MG/0.4 ML VIAL #	
	HYMPAVZI 150 MG/ML PEN #	
Factor XII Inhibitors	ANDEMBRY 200 MG/1.2 ML AUTOIN #	
Factor XIII Preparations	CORIFACT KIT #	
	TRETTEN 2,500 UNIT VIAL #	
Fibromyalgia Agents - Serotonin-Norepinephrine Reuptake-Inhib (SNRIs)	SAVELLA 100 MG TABLET	*PDL-P
	SAVELLA 12.5 MG TABLET	*PDL-P
	SAVELLA 25 MG TABLET	*PDL-P
	SAVELLA 50 MG TABLET	*PDL-P
	SAVELLA TITRATION PACK	*PDL-P
Fluoroquinolone Antibiotics	AVELOX 400 MG TABLET	PDL-NP PA QL
	BAXDELA 450 MG TABLET	PDL-NP PA
	CIPRO 10% SUSPENSION	*PDL-P
	CIPRO 250 MG TABLET	PDL-NP PA QL
	CIPRO 5% SUSPENSION	*PDL-P
	CIPRO 500 MG TABLET	PDL-NP PA QL
	CIPROFLOXACIN 250 MG/5 ML SUSP	*PDL-P
	CIPROFLOXACIN 500 MG/5 ML SUSP	*PDL-P
	CIPROFLOXACIN HCL 250 MG TAB	*PDL-P QL
	CIPROFLOXACIN HCL 500 MG TAB	*PDL-P QL
	CIPROFLOXACIN HCL 750 MG TAB	*PDL-P QL
	LEVOFLOXACIN 25 MG/ML SOLUTION	*PDL-P
	LEVOFLOXACIN 250 MG TABLET	*PDL-P QL
	LEVOFLOXACIN 500 MG TABLET	*PDL-P QL
	LEVOFLOXACIN 750 MG TABLET	*PDL-P QL
	MOXIFLOXACIN HCL 400 MG TABLET	PDL-NP PA QL
	OFLOXACIN 300 MG TABLET	PDL-NP PA
	OFLOXACIN 400 MG TABLET	PDL-NP PA
	Gallstone Solubilizing (Litholysis) Agents	RELTONE 200 MG CAPSULE
RELTONE 400 MG CAPSULE		PDL-NP PA
URSO FORTE 500 MG TABLET		PDL-NP PA
URSODIOL 250 MG TABLET		*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Gallstone Solubilizing (Litholysis) Agents	URSODIOL 300 MG CAPSULE	*PDL-P
	URSODIOL 500 MG TABLET	*PDL-P
Gastric Acid Secretion Reducers - Histamine H2-Receptor Antagonists	CIMETIDINE 200 MG TABLET	
	CIMETIDINE 200 MG TABLET *	
	CIMETIDINE 300 MG TABLET	
	CIMETIDINE 300 MG/5 ML SOLN	
	CIMETIDINE 400 MG TABLET	
	CIMETIDINE 800 MG TABLET	
	FAMOTIDINE 10 MG TABLET *	
	FAMOTIDINE 20 MG TABLET	
	FAMOTIDINE 40 MG TABLET	
	FAMOTIDINE 40 MG/5 ML SUSP	AGE QL
	HM FAMOTIDINE 10 MG TABLET *	
	HM FAMOTIDINE 20 MG TABLET *	
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	ACID REDUCER DR 20 MG CAP	PDL-NP PA
	DEXILANT DR 30 MG CAPSULE	PDL-NP PA
	DEXILANT DR 60 MG CAPSULE	PDL-NP PA
	DEXLANSOPRAZOLE DR 30 MG CAP	PDL-NP PA
	DEXLANSOPRAZOLE DR 60 MG CAP	PDL-NP PA
	ESOMEPRAZOLE DR 10 MG PACKET	PDL-NP PA QL
	ESOMEPRAZOLE DR 2.5 MG PACKET	PDL-NP PA QL
	ESOMEPRAZOLE DR 20 MG PACKET	PDL-NP PA QL
	ESOMEPRAZOLE DR 40 MG PACKET	PDL-NP PA QL
	ESOMEPRAZOLE DR 5 MG PACKET	PDL-NP PA QL
	ESOMEPRAZOLE MAG DR 20 MG CAP	PDL-NP PA
	ESOMEPRAZOLE MAG DR 20 MG TAB	PDL-NP PA
	ESOMEPRAZOLE MAG DR 40 MG CAP	PDL-NP PA
	GS ESOMEPRAZOLE MAG DR 20 MG	PDL-NP PA
	GS LANSOPRAZOLE DR 15 MG CAP	PDL-NP PA
	GS OMEPRAZOLE DR 20 MG TABLET	PDL-NP PA
	LANSOPRAZOLE DR 15 MG CAPSULE	PDL-NP PA
	LANSOPRAZOLE DR 15 MG ODT	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	LANSOPRAZOLE DR 30 MG CAPSULE	PDL-NP PA
	LANSOPRAZOLE ODT 30 MG TABLET	PDL-NP PA
	NEXIUM DR 10 MG PACKET	*PDL-P QL
	NEXIUM DR 2.5 MG PACKET	*PDL-P QL
	NEXIUM DR 20 MG CAPSULE	PDL-NP PA
	NEXIUM DR 20 MG PACKET	*PDL-P QL
	NEXIUM DR 40 MG CAPSULE	PDL-NP PA
	NEXIUM DR 40 MG PACKET	*PDL-P QL
	NEXIUM DR 5 MG PACKET	*PDL-P QL
	OMEPRAZOLE DR 10 MG CAPSULE	*PDL-P QL
	OMEPRAZOLE DR 20 MG CAPSULE	*PDL-P QL
	OMEPRAZOLE DR 20 MG ODT	PDL-NP PA
	OMEPRAZOLE DR 20 MG TABLET	PDL-NP PA
	OMEPRAZOLE DR 40 MG CAPSULE	*PDL-P QL
	OMEPRAZOLE MAG DR 20 MG CAP	PDL-NP PA
	OMEPRAZOLE MAG DR 20 MG TABLET	PDL-NP PA
	OMEPRAZOLE MAG DR 20.6 MG CAP	PDL-NP PA
	PANTOPRAZOLE DR 40 MG SUSP PKT	PDL-NP PA QL
	PANTOPRAZOLE SOD DR 20 MG TAB	*PDL-P QL
	PANTOPRAZOLE SOD DR 40 MG TAB	*PDL-P QL
	PREVACID 24HR DR 15 MG CAPSULE *	PDL-NP PA
	PREVACID 30 MG SOLUTAB	PDL-NP PA
	PREVACID DR 15 MG SOLUTAB	PDL-NP PA
	PREVACID DR 30 MG CAPSULE	PDL-NP PA
	PRILOSEC DR 10 MG SUSPENSION	PDL-NP PA
	PRILOSEC DR 2.5 MG SUSPENSION	PDL-NP PA
	PROTONIX 40 MG SUSPENSION	*PDL-P QL
	PROTONIX DR 20 MG TABLET	PDL-NP PA QL
	PROTONIX DR 40 MG TABLET	PDL-NP PA QL
	QC OMEPRAZOLE MAG DR 20.6 MG	PDL-NP PA
RABEPRAZOLE SOD DR 20 MG TAB	PDL-NP PA	
SM ESOMEPRAZOLE MAG DR 20 MG	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	SM LANSOPRAZOLE DR 15 MG CAP	PDL-NP PA
Gastric Acid Secretion Reducing- Proton Pump Inhibitor & Antacid Comb.	KONVOMEK 2-84 MG/ML ORAL SUSP	PDL-NP PA
	OMEPRAZOLE-BICARB 20-1,100 CAP	PDL-NP PA
	OMEPRAZOLE-BICARB 20-1,680 PKT	PDL-NP PA
	OMEPRAZOLE-BICARB 40-1,100 CAP	PDL-NP PA
	OMEPRAZOLE-BICARB 40-1,680 PKT	PDL-NP PA
	ZEGERID 20 MG CAPSULE	PDL-NP PA
	ZEGERID 20 MG PACKET	PDL-NP PA
	ZEGERID 40 MG CAPSULE	PDL-NP PA
	ZEGERID 40 MG PACKET	PDL-NP PA
Gastric Mucosa - Cytoprotective Prostaglandin Analogs	MISOPROSTOL 100 MCG TABLET	QL
	MISOPROSTOL 200 MCG TABLET	QL
Gastrointestinal - Prokinetic Agents - 5-HT4 Receptor Agonists	MOTEGRITY 1 MG TABLET	PDL-NP PA
	MOTEGRITY 2 MG TABLET	PDL-NP PA
	PRUCALOPRIDE 1 MG TABLET	PDL-NP PA
	PRUCALOPRIDE 2 MG TABLET	PDL-NP PA
Gastrointestinal Antiflatulents	ANTI-GAS CAPSULE * #	
	BEANO MELTAWAYS * #	
	BEANO TABLET * #	
	BEANO TO GO TABLET * #	
	CVS GAS RELIEF 125 MG CHEW TAB *	
	CVS GAS RELIEF 80 MG TAB CHEW *	
	GAS RELIEF 125 MG CHEW TABLET *	
	GAS RELIEF 80 MG TABLET CHEW *	
	GAS RELIEF 80 TABLET CHEW *	
	GAS-X EX-STR 125 MG TAB CHEW *	
	HM GAS RELIEF 80 MG TAB CHEW *	
	INFANTS' GAS RLF 20 MG/0.3 ML *	
	MI-ACID GAS 80 MG TAB CHEW *	
	QC GAS RELIEF 125 MG TAB CHEW *	
	RA GAS RELIEF 125 MG TAB CHEW *	
	SIMETHICONE 125 MG TAB CHEW *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Gastrointestinal Antiflatulents	SIMETHICONE 80 MG TAB CHEW *	
	SM INF GAS RELIEF 20 MG/0.3 ML *	
Gastrointestinal Prokinetic Agents - D2 Antagonist/5-HT4 Agonists	METOCLOPRAMIDE 10 MG TABLET	
	METOCLOPRAMIDE 10 MG/10 ML SOL	
	METOCLOPRAMIDE 5 MG TABLET	
	METOCLOPRAMIDE 5 MG/5 ML SOLN	
General Anesthetic Adjuncts - Neuroleptic, Butyrophenone Derivative	DROPERIDOL 2.5 MG/ML AMPUL #	
	DROPERIDOL 2.5 MG/ML VIAL #	
General Inhalation Agents	HYPER-SAL 3.5% VIAL	Covered for CSHCS Only
	NEBUSAL 3% VIAL	Covered for CSHCS Only
	NEBUSAL 6% VIAL	Covered for CSHCS Only
	SODIUM CHLORIDE 3% VIAL	Covered for CSHCS Only
	SODIUM CHLORIDE 3% VIAL	Covered for CSHCS Only
	SODIUM CHLORIDE 3% VIAL	Covered for CSHCS Only
	SODIUM CHLORIDE 7% VIAL	Covered for CSHCS Only
	SODIUM CHLORIDE 7% VIAL	Covered for CSHCS Only
	SODIUM CHLORIDE 7% VIAL	Covered for CSHCS Only
	SODIUM CHLORIDE 7% VIAL	Covered for CSHCS Only
GI Antispasmodic - Belladonna Alkaloids	HYOSCYAMINE 0.125 MG ODT	AGE
	HYOSCYAMINE 0.125 MG TAB SL	AGE
	HYOSCYAMINE 0.125 MG/5 ML ELIX	AGE
	HYOSCYAMINE 0.125 MG/ML DROP	AGE
	HYOSCYAMINE ER 0.375 MG TAB	AGE
	HYOSCYAMINE SR 0.375 MG TAB	AGE
	HYOSCYAMINE SULF 0.125 MG TAB	AGE
	OSCIMIN SR 0.375 MG TABLET	AGE
GI Antispasmodic - Quaternary Ammonium Compounds	GLYCOPYRROLATE 1 MG TABLET	
	GLYCOPYRROLATE 2 MG TABLET	
GI Antispasmodic - Synthetic Tertiary Amines	DICYCLOMINE 10 MG CAPSULE	AGE
	DICYCLOMINE 10 MG/5 ML SOLN	AGE
	DICYCLOMINE 20 MG TABLET	AGE
Glucagon Analog Antihypoglycemic Agent	ZEGALOGUE 0.6 MG/0.6 ML SYRING	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Glucagon Analog Antihypoglycemic Agent	ZEGALOGUE 0.6 MG/0.6ML AUTOINJ	*PDL-P
Glucocorticoids	AGAMREE 40 MG/ML SUSPENSION	
	ALKINDI SPRINKLE 0.5 MG CAP	
	ALKINDI SPRINKLE 1 MG CAPSULE	
	ALKINDI SPRINKLE 2 MG CAPSULE	
	ALKINDI SPRINKLE 5 MG CAPSULE	
	CORTEF 10 MG TABLET	
	CORTEF 20 MG TABLET	
	CORTEF 5 MG TABLET	
	DEFLAZACORT 18 MG TABLET	
	DEFLAZACORT 30 MG TABLET	
	DEFLAZACORT 36 MG TABLET	
	DEFLAZACORT 6 MG TABLET	
	DEPO-MEDROL 20 MG/ML VIAL	
	DEPO-MEDROL 40 MG/ML VIAL	
	DEPO-MEDROL 80 MG/ML VIAL	
	DEXAMETHASONE 0.5 MG TABLET	
	DEXAMETHASONE 0.5 MG/5 ML ELX	
	DEXAMETHASONE 0.5 MG/5 ML LIQ	
	DEXAMETHASONE 0.75 MG TABLET	
	DEXAMETHASONE 1 MG TABLET	
	DEXAMETHASONE 1.5 MG TABLET	
	DEXAMETHASONE 10 DAY 1.5 MG TB	
	DEXAMETHASONE 10 MG/ML SYRING	
	DEXAMETHASONE 10 MG/ML VIAL	
	DEXAMETHASONE 100 MG/10 ML VL	
	DEXAMETHASONE 120 MG/30 ML VL	
	DEXAMETHASONE 13 DAY 1.5 MG TB	
	DEXAMETHASONE 2 MG TABLET	
	DEXAMETHASONE 20 MG/5 ML VIAL	
	DEXAMETHASONE 4 MG TABLET	
	DEXAMETHASONE 4 MG/ML SYRINGE	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Glucocorticoids	DEXAMETHASONE 4 MG/ML VIAL	
	DEXAMETHASONE 6 DAY 1.5 MG TAB	
	DEXAMETHASONE 6 MG TABLET	
	DEXAMETHASONE INTENSOL 1MG/1ML	
	EMFLAZA 18 MG TABLET	
	EMFLAZA 22.75 MG/ML ORAL SUSP	
	EMFLAZA 30 MG TABLET	
	EMFLAZA 36 MG TABLET	
	EMFLAZA 6 MG TABLET	
	HEMADY 20 MG TABLET	
	HYDROCORTISONE 10 MG TABLET	
	HYDROCORTISONE 20 MG TABLET	
	HYDROCORTISONE 5 MG TABLET	
	KENALOG-10 10 MG/ML VIAL	
	KENALOG-40 40 MG/ML VIAL	
	KHINDIVI 1 MG/ML SOLUTION	
	MEDROL 16 MG TABLET	
	MEDROL 2 MG TABLET	
	MEDROL 4 MG DOSEPAK	
	MEDROL 4 MG TABLET	
	MEDROL 8 MG TABLET	
	METHYLPREDNISOLONE 125 MG VIAL	
	METHYLPREDNISOLONE 16 MG TAB	
	METHYLPREDNISOLONE 32 MG TAB	
	METHYLPREDNISOLONE 4 MG DOSEPK	
	METHYLPREDNISOLONE 4 MG TABLET	
	METHYLPREDNISOLONE 40 MG VIAL	
	METHYLPREDNISOLONE 40 MG/ML VL	
	METHYLPREDNISOLONE 8 MG TAB	
	METHYLPREDNISOLONE 80 MG/ML VL	
	METHYLPREDNISOLONE SS 1 GM VL	
	MILLIPRED 5 MG TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Glucocorticoids	MILLIPRED DP 5 MG 12-DAY PACK	
	MILLIPRED DP 5 MG 6-DAY PACK	
	PREDNISOLONE 15 MG/5 ML SOLN	
	PREDNISOLONE 15 MG/5 ML SOLN	
	PREDNISOLONE 15MG/5ML SOLN CUP	
	PREDNISOLONE 20 MG/5 ML SOLN	
	PREDNISOLONE 5 MG/5 ML SOLN	
	PREDNISOLONE ODT 10 MG TABLET	
	PREDNISOLONE ODT 15 MG TABLET	
	PREDNISOLONE ODT 30 MG TABLET	
	PREDNISOLONE SOD PH 25 MG/5 ML	
	PREDNISON 1 MG TABLET	
	PREDNISON 10 MG TAB DOSE PACK	
	PREDNISON 10 MG TABLET	
	PREDNISON 2.5 MG TABLET	
	PREDNISON 20 MG TABLET	
	PREDNISON 5 MG TAB DOSE PACK	
	PREDNISON 5 MG TABLET	
	PREDNISON 5 MG/5 ML SOLUTION	
	PREDNISON 50 MG TABLET	
	PREDNISON INTENSOL 5 MG/ML	
	RAYOS DR 1 MG TABLET	
	RAYOS DR 2 MG TABLET	
	RAYOS DR 5 MG TABLET	
	SOLU-CORTEF 1,000 MG VIAL	
	SOLU-CORTEF 100 MG VIAL	
	SOLU-CORTEF 100 MG VIAL	
	SOLU-CORTEF 250 MG VIAL	
	SOLU-CORTEF 500 MG VIAL	
	SOLU-MEDROL 1 GM VIAL	
SOLU-MEDROL 1,000 MG VIAL		
SOLU-MEDROL 125 MG VIAL		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Glucocorticoids	SOLU-MEDROL 2,000 MG VIAL	
	SOLU-MEDROL 40 MG VIAL	
	SOLU-MEDROL 500 MG VIAL	
	SOLU-MEDROL 500 MG VIAL	
	TAPERDEX 12 DAY 1.5 MG TABLET	
	TAPERDEX 6 DAY 1.5 MG TABLET	
	TAPERDEX 7 DAY 1.5 MG TAB PACK	
	TRIAMCINOLONE ACET 40 MG/ML VL	
Glucocorticosteroids	EOHILIA 2 MG/10 ML STICK PACK	AGE PA QL
Glycopeptide Antibiotics	FIRVANQ 25 MG/ML SOLUTION	PDL-NP PA
	FIRVANQ 50 MG/ML SOLUTION	PDL-NP PA
	VANOCIN HCL 125 MG CAPSULE	PDL-NP PA
	VANOCIN HCL 250 MG CAPSULE	PDL-NP PA
	VANCOMYCIN 1 GM VIAL	
	VANCOMYCIN 25 MG/ML SOLUTION	*PDL-P
	VANCOMYCIN 50 MG/ML SOLUTION	*PDL-P
	VANCOMYCIN 500 MG VIAL	
	VANCOMYCIN 750 MG VIAL	
	VANCOMYCIN HCL 10 GM VIAL	
	VANCOMYCIN HCL 125 MG CAPSULE	*PDL-P
	VANCOMYCIN HCL 250 MG CAPSULE	*PDL-P
	VANCOMYCIN HCL 5 GM VIAL	
	VANCOMYCIN HCL 750 MG VIAL	
Glypromate (GPE) Analogs	DAYBUE 200 MG/ML SOLUTION #	
Gonadotropin Inhibitor Pituitary Suppressants	DANAZOL 100 MG CAPSULE	
	DANAZOL 200 MG CAPSULE	
	DANAZOL 50 MG CAPSULE	
Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Estrogen and Progesti	MYFEMBREE 40 MG-1 MG-0.5 MG TB	*PDL-P AGE PA QL
	ORIAHNN 300-1-0.5MG/300MG CAPS	*PDL-P AGE PA QL
Gout Acute Therapy - Antimitotics	COLCHICINE 0.6 MG CAPSULE	PDL-NP PA
	COLCHICINE 0.6 MG TABLET	*PDL-P
	COLCRYS 0.6 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Gout Acute Therapy - Antimitotics	GLOPERBA 0.6 MG/5 ML SOLUTION	PDL-NP PA
	MITIGARE 0.6 MG CAPSULE	PDL-NP PA
Gout and Hyperuricemia - Antimitotic-Uricosuric Combinations	PROBENECID-COLCHICINE TABLET	*PDL-P
Granulocyte Colony-Stimulating Factor (G-CSF)	FULPHILA 6 MG/0.6 ML SYRINGE	*PDL-P QL
	FYLNETRA 6 MG/0.6 ML SYRINGE	*PDL-P QL
	GRANIX 300 MCG/0.5 ML SAFE SYR	PDL-NP PA
	GRANIX 300 MCG/0.5 ML SYRINGE	PDL-NP PA
	GRANIX 300 MCG/ML VIAL	PDL-NP PA
	GRANIX 480 MCG/0.8 ML SAFE SYR	PDL-NP PA
	GRANIX 480 MCG/0.8 ML SYRINGE	PDL-NP PA
	GRANIX 480 MCG/1.6 ML VIAL	PDL-NP PA
	NEULASTA 6 MG/0.6 ML SYRINGE	PDL-NP PA QL
	NEULASTA ONPRO 6 MG/0.6 ML KIT	PDL-NP PA QL
	NEUPOGEN 300 MCG/0.5 ML SYR	*PDL-P
	NEUPOGEN 300 MCG/ML VIAL	*PDL-P
	NEUPOGEN 480 MCG/0.8 ML SYR	*PDL-P
	NEUPOGEN 480 MCG/1.6 ML VIAL	*PDL-P
	NIVESTYM 300 MCG/0.5 ML SYRING	PDL-NP PA
	NIVESTYM 300 MCG/ML VIAL	PDL-NP PA
	NIVESTYM 480 MCG/0.8 ML SYRING	PDL-NP PA
	NIVESTYM 480 MCG/1.6 ML VIAL	PDL-NP PA
	NYVEPRIA 6 MG/0.6 ML SYRINGE	PDL-NP PA QL
	RELEUKO 300 MCG/0.5 ML SYRINGE	PDL-NP PA
	RELEUKO 300 MCG/ML VIAL	PDL-NP PA
	RELEUKO 480 MCG/0.8 ML SYRINGE	PDL-NP PA
	RELEUKO 480 MCG/1.6 ML VIAL	PDL-NP PA
	STIMUFEND 6 MG/0.6 ML SYRINGE	PDL-NP PA QL
	UDENYCA 6 MG/0.6 ML AUTOINJECT	PDL-NP PA QL
	UDENYCA 6 MG/0.6 ML ONBODY	PDL-NP PA QL
	UDENYCA 6 MG/0.6 ML SYRINGE	PDL-NP PA QL
	ZARXIO 300 MCG/0.5 ML SYRINGE	PDL-NP PA QL
	ZARXIO 480 MCG/0.8 ML SYRINGE	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Granulocyte Colony-Stimulating Factor (G-CSF)	ZIEXTENZO 6 MG/0.6 ML SYRINGE	PDL-NP PA QL
Granulocyte-Macrophage Colony-Stimulating Factor (GM-CSF)	LEUKINE 250 MCG VIAL	PDL-NP PA
Growth Hormones	GENOTROPIN 12 MG CARTRIDGE	*PDL-P PA
	GENOTROPIN 5 MG CARTRIDGE	*PDL-P PA
	GENOTROPIN MINIQUICK 0.2 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 0.4 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 0.6 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 0.8 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 1 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 1.2 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 1.4 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 1.6 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 1.8 MG	*PDL-P PA
	GENOTROPIN MINIQUICK 2 MG	*PDL-P PA
	HUMATROPE 12 MG CARTRIDGE	PDL-NP PA
	HUMATROPE 24 MG CARTRIDGE	PDL-NP PA
	HUMATROPE 6 MG CARTRIDGE	PDL-NP PA
	NGENLA PEN 24 MG/1.2 ML	PDL-NP AGE PA
	NGENLA PEN 60 MG/1.2 ML	PDL-NP AGE PA
	NORDITROPIN FLEXPRO 10 MG/1.5	*PDL-P PA
	NORDITROPIN FLEXPRO 15 MG/1.5	*PDL-P PA
	NORDITROPIN FLEXPRO 30 MG/3 ML	*PDL-P PA
	NORDITROPIN FLEXPRO 5 MG/1.5	*PDL-P PA
	NUTROPIN AQ NUSPIN 10 INJECTOR	PDL-NP PA
	NUTROPIN AQ NUSPIN 20 INJECTOR	PDL-NP PA
	NUTROPIN AQ NUSPIN 5 INJECTOR	PDL-NP PA
	OMNITROPE 10 MG/1.5 ML CRTG	PDL-NP PA
	OMNITROPE 5 MG/1.5 ML CRTG	PDL-NP PA
	OMNITROPE 5.8 MG VIAL	PDL-NP PA
	SEROSTIM 4 MG VIAL	PDL-NP PA
SEROSTIM 5 MG VIAL	PDL-NP PA	
SEROSTIM 6 MG VIAL	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Growth Hormones	SKYTROFA 11 MG CARTRIDGE	PDL-NP PA
	SKYTROFA 13.3 MG CARTRIDGE	PDL-NP PA
	SKYTROFA 3 MG CARTRIDGE	PDL-NP PA
	SKYTROFA 3.6 MG CARTRIDGE	PDL-NP PA
	SKYTROFA 4.3 MG CARTRIDGE	PDL-NP PA
	SKYTROFA 5.2 MG CARTRIDGE	PDL-NP PA
	SKYTROFA 6.3 MG CARTRIDGE	PDL-NP PA
	SKYTROFA 7.6 MG CARTRIDGE	PDL-NP PA
	SKYTROFA 9.1 MG CARTRIDGE	PDL-NP PA
	SOGROYA 10 MG/1.5 ML PEN	PDL-NP PA QL
	SOGROYA 15 MG/1.5 ML PEN	PDL-NP PA QL
	SOGROYA 5 MG/1.5 ML PEN	PDL-NP PA QL
	ZOMACTON 10 MG VIAL	PDL-NP PA
	ZOMACTON 5 MG VIAL	PDL-NP PA
Heat Shock Protein (HSP) Modulating Agents	MIPLYFFA 124 MG CAPSULE #	
	MIPLYFFA 47 MG CAPSULE #	
	MIPLYFFA 62 MG CAPSULE #	
	MIPLYFFA 93 MG CAPSULE #	
Hematorheologic Agents	PENTOXIFYLLINE ER 400 MG TAB	
Hemostatic Systemic - Antifibrinolytic Agents	AMICAR 0.25 GRAM/ML ORAL SOLN #	
	AMINOCAPROIC ACID 0.25 GRAM/ML #	
	AMINOCAPROIC ACID 1,000 MG TAB #	
	AMINOCAPROIC ACID 5 G/20 ML VL #	
	AMINOCAPROIC ACID 500 MG TAB #	
	CYKLOKAPRON 1,000 MG/10 ML VL #	
	CYKLOKAPRON 100 MG/ML AMPUL #	
	FIBRYGA 1 GRAM RANGE VIAL #	
	LYSTEDA 650 MG TABLET #	
	RIASTAP VIAL #	
	TRANEXAMIC 1,000 MG/100ML-NACL #	
	TRANEXAMIC ACID 1,000 MG/10 ML #	
	TRANEXAMIC ACID 1,000 MG/10 ML #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Hemostatic Systemic - Antifibrinolytic Agents	TRANEXAMIC ACID 650 MG TABLET #	
Hemostatic Systemic- von Willebrand factor (vWF) Preparations	VONVENDI 1,300 UNIT VIAL #	
	VONVENDI 650 UNIT VIAL #	
Heparins	HEPARIN 40,000 UNITS/4 ML VIAL	
	HEPARIN 50,000 UNIT/10 ML VIAL	
	HEPARIN 50,000 UNITS/5 ML VIAL	
	HEPARIN SOD 10,000 UNIT/ML VL	
	HEPARIN SOD 5,000 UNIT/ML VIAL	
Hepatitis A Vaccine - Single Agents	HAVRIX 1,440 UNITS/ML SYRINGE	AGE QL
	HAVRIX 1,440 UNITS/ML VIAL	AGE QL
	HAVRIX 720 UNIT/0.5 ML SYRINGE	AGE QL
	HAVRIX 720 UNITS/0.5 ML VIAL	AGE QL
	VAQTA 25 UNITS/0.5 ML SYRINGE	AGE QL
	VAQTA 25 UNITS/0.5 ML VIAL	AGE QL
	VAQTA 50 UNITS/ML SYRINGE	AGE QL
	VAQTA 50 UNITS/ML VIAL	AGE QL
Hepatitis B Treatment- Nucleoside Analogs (Antiviral)	ENTECAVIR 0.5 MG TABLET	QL
	ENTECAVIR 1 MG TABLET	QL
	LAMIVUDINE HBV 100 MG TABLET	QL
	LAMIVUDINE HBV 100 MG TABLET	QL
	VEMLIDY 25 MG TABLET	AGE PA QL
Hepatitis B Treatment- Nucleotide Analogs (Antiviral)	ADEFOVIR DIPIVOXIL 10 MG TAB	QL
Hepatitis C - Interferons	PEGASYS 180 MCG/0.5 ML SYRINGE #	
	PEGASYS 180 MCG/ML VIAL #	
	PEGASYS PROCLICK 135 MCG/0.5 #	
	PEGINTRON 120 MCG KIT #	
	PEGINTRON 150 MCG KIT #	
	PEGINTRON 50 MCG KIT #	
	PEGINTRON 80 MCG KIT #	
	PEGINTRON REDIPEN 120 MCG #	
	PEGINTRON REDIPEN 120 MCG 4PK #	
PEGINTRON REDIPEN 150 MCG #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Hepatitis C - Interferons	PEGINTRON REDIPEN 50 MCG #	
	PEGINTRON REDIPEN 80 MCG #	
Hepatitis C - NS3/4A Serine Protease Inhibitors	OLYSIO 150 MG CAPSULE #	
Hepatitis C - NS5A Inhibitor and NS3/4A Protease Inhibitor Combination	MAVYRET 100-40 MG TABLET #	
	TECHNIVIE DOSE PACK #	
	ZEPATIER 50-100 MG TABLET #	
Hepatitis C - NS5A Replication Complex Inhibitors	DAKLINZA 30 MG TABLET #	
	DAKLINZA 60 MG TABLET #	
Hepatitis C - NS5A, NS3/4A Protease, Nucleo.NS5B Polymerase Inhib Comb	VOSEVI 400-100-100 MG TABLET #	
Hepatitis C - NS5B Polymerase and NS5A Inhibitor Combinations	EPCLUSA 400 MG-100 MG TABLET #	
	HARVONI 45-200 MG TABLET #	
	HARVONI 90-400 MG TABLET #	
	LEDIPASVIR-SOFOSBUVIR 90-400MG #	
	SOFOSBUVIR-VELPATASVIR 400-100 #	
Hepatitis C - Nucleos(t)ide Analog NS5B Polymerase Inhibitors	SOVALDI 200 MG TABLET #	
	SOVALDI 400 MG TABLET #	
Hepatitis C - Nucleoside Analogs	REBETOL 40 MG/ML SOLUTION #	
	RIBAVIRIN 200 MG CAPSULE #	
	RIBAVIRIN 200 MG TABLET #	
Herpes Antiviral Agent - Purine Analogs	ACYCLOVIR 200 MG CAPSULE	*PDL-P
	ACYCLOVIR 200 MG/5 ML SUSP	*PDL-P
	ACYCLOVIR 400 MG TABLET	*PDL-P
	ACYCLOVIR 800 MG TABLET	*PDL-P
	VALACYCLOVIR HCL 1 GRAM TABLET	*PDL-P
	VALACYCLOVIR HCL 500 MG TABLET	*PDL-P
	VALTREX 1 GM CAPLET	PDL-NP PA
	VALTREX 500 MG CAPLET	PDL-NP PA
Herpes Antiviral Agent - Thymidine Analogs	FAMCICLOVIR 125 MG TABLET	*PDL-P
	FAMCICLOVIR 250 MG TABLET	*PDL-P
	FAMCICLOVIR 500 MG TABLET	*PDL-P
Human Albumin	ALBUKED-25 VIAL #	
	ALBUKED-5 VIAL #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Human Albumin	ALBUMIN (HUMAN) 5% IV SOLUTION #	
	ALBUMINAR-25 IV SOLUTION #	
	ALBUMINEX 25% VIAL #	
	ALBUMINEX 5% VIAL #	
	ALBURX (HUMAN) 25% VIAL #	
	ALBURX (HUMAN) 5% VIAL #	
	ALBUTEIN 25% VIAL #	
	ALBUTEIN 5% VIAL #	
	BUMINATE 5% IV SOLUTION #	
	FLEXBUMIN 25% IV SOLUTION #	
	FLEXBUMIN 5% IV SOLUTION #	
	KEDBUMIN 25% VIAL #	
	PLASBUMIN-25 IV SOLUTION #	
	PLASBUMIN-5 IV SOLUTION #	
Human Insulins - Fixed Combinations	HUMULIN 70/30 KWIKPEN	*PDL-P QL
	HUMULIN 70-30 VIAL	*PDL-P QL
	NOVOLIN 70-30 100 UNIT/ML VIAL	PDL-NP PA QL
	NOVOLIN 70-30 FLEXPEN	PDL-NP PA QL
	RELION NOVOLIN 70-30 FLEXPEN	PDL-NP PA QL
	RELION NOVOLIN 70-30 VIAL	PDL-NP PA QL
Human Insulins - Intermediate Acting	HUMULIN N 100 UNIT/ML KWIKPEN	*PDL-P QL
	HUMULIN N 100 UNIT/ML VIAL	*PDL-P QL
	NOVOLIN N 100 UNIT/ML FLEXPEN	PDL-NP PA QL
	NOVOLIN N 100 UNIT/ML VIAL	PDL-NP PA QL
	NOVOLIN R 100 UNIT/ML FLEXPEN	PDL-NP PA QL
	RELION NOVOLIN N 100 UNIT/ML	PDL-NP PA QL
	RELION NOVOLIN N U-100 FLEXPEN	PDL-NP PA QL
	RELION NOVOLIN R U-100 FLEXPEN	PDL-NP PA QL
Human Insulins - Short Acting	HUMULIN R 100 UNIT/ML VIAL	*PDL-P QL
	HUMULIN R 500 UNIT/ML KWIKPEN	*PDL-P QL
	HUMULIN R 500 UNIT/ML VIAL	*PDL-P QL
	NOVOLIN R 100 UNIT/ML VIAL	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Human Insulins - Short Acting	RELION NOVOLIN R 100 UNIT/ML	PDL-NP PA QL
Human Monoclonal Antibody Complement (C5) Inhibitors	BKEMV 300 MG/30 ML VIAL #	
	EPYSQLI 300 MG/30 ML VIAL #	
	SOLIRIS 300 MG/30 ML VIAL #	
	ULTOMIRIS 300 MG/30 ML VIAL #	
Hyperpolarization-Activated Cyclic Nucleotide-Gated Channel Inhibitors	CORLANOR 5 MG/5 ML ORAL SOLN	PA
	IVABRADINE HCL 5 MG TABLET	PA
	IVABRADINE HCL 7.5 MG TABLET	PA
Hyperuricemia Therapy - Uricosurics	PROBENECID 500 MG TABLET	*PDL-P
Hyperuricemia Therapy - Xanthine Oxidase Inhibitors	ALLOPURINOL 100 MG TABLET	*PDL-P
	ALLOPURINOL 200 MG TABLET	*PDL-P
	ALLOPURINOL 300 MG TABLET	*PDL-P
	FEBUXOSTAT 40 MG TABLET	*PDL-P
	FEBUXOSTAT 80 MG TABLET	*PDL-P
	ULORIC 40 MG TABLET	PDL-NP PA
	ULORIC 80 MG TABLET	PDL-NP PA
	ZYLOPRIM 100 MG TABLET	PDL-NP PA
Hypnotics - Melatonin - Single Agents	MAXSLEEP JUNIOR 1 MG/ML LIQ *	Covered for CSHCS Only
	MELATONIN 1 MG/ML LIQUID *	Covered for CSHCS Only
Hypnotics - Melatonin M1/M2 Receptor Agonists	HETLIOZ 20 MG CAPSULE #	
	RAMELTEON 8 MG TABLET #	
	ROZEREM 8 MG TABLET #	
Hypoparathyroid Treatment - Parathyroid Hormone Analogs	YORVIPATH 168 MCG/0.56 ML PEN	AGE PA QL
	YORVIPATH 294 MCG/0.98 ML PEN	AGE PA QL
	YORVIPATH 420 MCG/1.4 ML PEN	AGE PA QL
Hypoxia Inducible Factor Prolyl Hydroxylase (HIF PH) Inhibitor	JESDUVROQ 1 MG TABLET	PDL-NP AGE PA
	JESDUVROQ 2 MG TABLET	PDL-NP AGE PA
	JESDUVROQ 4 MG TABLET	PDL-NP AGE PA
	JESDUVROQ 6 MG TABLET	PDL-NP AGE PA
	JESDUVROQ 8 MG TABLET	PDL-NP AGE PA
	VAFSEO 150 MG TABLET	PDL-NP AGE PA
	VAFSEO 300 MG TABLET	PDL-NP AGE PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
IBS Agent - Gastrointestinal Chloride Channel Activator Agents	AMITIZA 24 MCG CAPSULE	PDL-NP AGE PA QL
	AMITIZA 8 MCG CAPSULE	PDL-NP AGE PA QL
	LUBIPROSTONE 24 MCG CAPSULE	*PDL-P AGE QL
	LUBIPROSTONE 8 MCG CAPSULE	*PDL-P AGE QL
IBS Agent - Mixed Opioid Receptor Agonist and Antagonist	VIBERZI 100 MG TABLET	PDL-NP PA QL
	VIBERZI 75 MG TABLET	PDL-NP PA QL
IBS-C/CIC Agents, Guanylate Cyclase-C Agonist	LINZESS 145 MCG CAPSULE	*PDL-P AGE QL
	LINZESS 290 MCG CAPSULE	*PDL-P AGE QL
	LINZESS 72 MCG CAPSULE	*PDL-P AGE QL
	TRULANCE 3 MG TABLET	PDL-NP PA
Immunosuppressive - Calcineurin Inhibitors	ASTAGRAF XL 0.5 MG CAPSULE	
	ASTAGRAF XL 1 MG CAPSULE	
	ASTAGRAF XL 5 MG CAPSULE	
	CYCLOSPORINE 100 MG CAPSULE	
	CYCLOSPORINE 100 MG/ML SOLN	
	CYCLOSPORINE 25 MG CAPSULE	
	CYCLOSPORINE MODIFIED 100 MG	
	CYCLOSPORINE MODIFIED 25 MG	
	CYCLOSPORINE MODIFIED 50 MG	
	ENVARUS XR 0.75 MG TABLET	
	ENVARUS XR 1 MG TABLET	
	ENVARUS XR 4 MG TABLET	
	GENGRAF 100 MG CAPSULE	
	GENGRAF 100 MG/ML SOLUTION	
	GENGRAF 25 MG CAPSULE	
	NEORAL 100 MG GELATIN CAPSULE	
	NEORAL 100 MG/ML SOLUTION	
	NEORAL 25 MG GELATIN CAPSULE	
	PROGRAF 0.2 MG GRANULE PACKET	
	PROGRAF 0.5 MG CAPSULE	
PROGRAF 1 MG CAPSULE		
PROGRAF 1 MG GRANULE PACKET		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Immunosuppressive - Calcineurin Inhibitors	PROGRAF 5 MG CAPSULE	
	SANDIMMUNE 100 MG CAPSULE	
	SANDIMMUNE 100 MG/ML SOLN	
	SANDIMMUNE 25 MG CAPSULE	
	TACROLIMUS 0.5 MG CAPSULE (IR)	
	TACROLIMUS 1 MG CAPSULE (IR)	
	TACROLIMUS 5 MG CAPSULE (IR)	
Immunosuppressive - Inosine Monophosphate Dehydrogenase Inhibitors	CELLCEPT 200 MG/ML ORAL SUSP	
	CELLCEPT 250 MG CAPSULE	
	CELLCEPT 500 MG TABLET	
	MYCOPHENOLATE 200 MG/ML SUSP	
	MYCOPHENOLATE 250 MG CAPSULE	
	MYCOPHENOLATE 500 MG TABLET	
	MYCOPHENOLIC ACID DR 180 MG TB	
	MYCOPHENOLIC ACID DR 360 MG TB	
	MYFORTIC 180 MG TABLET	
MYFORTIC 360 MG TABLET		
Immunosuppressive - Mammalian Target of Rapamycin (mTOR) Inhibitors	EVEROLIMUS 0.25 MG TABLET	
	EVEROLIMUS 0.5 MG TABLET	
	EVEROLIMUS 0.75 MG TABLET	
	EVEROLIMUS 1 MG TABLET	
	RAPAMUNE 1 MG TABLET	
	RAPAMUNE 2 MG TABLET	
	SIROLIMUS 0.5 MG TABLET	
	SIROLIMUS 1 MG TABLET	
	SIROLIMUS 1 MG/ML SOLUTION	
	SIROLIMUS 2 MG TABLET	
	ZORTRESS 0.25 MG TABLET	
	ZORTRESS 0.5 MG TABLET	
	ZORTRESS 0.75 MG TABLET	
ZORTRESS 1 MG TABLET		
Immunosuppressive - Purine Analogs	AZASAN 100 MG TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Immunosuppressive - Purine Analogs	AZASAN 75 MG TABLET	
	AZATHIOPRINE 100 MG TABLET	
	AZATHIOPRINE 50 MG TABLET	
	AZATHIOPRINE 75 MG TABLET	
	IMURAN 50 MG TABLET	
Indirect Factor Xa Inhibitors	ARIXTRA 10 MG/0.8 ML SYRINGE	PDL-NP PA
	ARIXTRA 2.5 MG/0.5 ML SYRINGE	PDL-NP PA
	ARIXTRA 5 MG/0.4 ML SYRINGE	PDL-NP PA
	ARIXTRA 7.5 MG/0.6 ML SYRINGE	PDL-NP PA
	FONDAPARINUX 10 MG/0.8 ML SYR	PDL-NP PA
	FONDAPARINUX 2.5 MG/0.5 ML SYR	PDL-NP PA
	FONDAPARINUX 5 MG/0.4 ML SYR	PDL-NP PA
Inflammatory Bowel Agent - Aminosalicylates and Related Agents	FONDAPARINUX 7.5 MG/0.6 ML SYR	PDL-NP PA
	AZULFIDINE 500 MG TABLET	PDL-NP PA
	AZULFIDINE ENTAB 500 MG	PDL-NP PA
	BALSALAZIDE DISODIUM 750 MG CP	PDL-NP PA
	COLAZAL 750 MG CAPSULE	PDL-NP PA
	DELZICOL DR 400 MG CAPSULE	PDL-NP PA
	DIPENTUM 250 MG CAPSULE	PDL-NP PA
	LIALDA DR 1.2 GM TABLET	PDL-NP PA
	MESALAMINE 4 GM/60 ML ENEMA	
	MESALAMINE 800 MG DR TABLET	PDL-NP PA
	MESALAMINE DR 1.2 GM TABLET	*PDL-P
	MESALAMINE DR 400 MG CAPSULE	PDL-NP PA
	MESALAMINE ER 0.375 GRAM CAP	PDL-NP PA
	MESALAMINE ER 500 MG CAPSULE	PDL-NP PA
	PENTASA 250 MG CAPSULE	*PDL-P
	PENTASA 500 MG CAPSULE	*PDL-P
SULFASALAZINE 500 MG TABLET	*PDL-P	
SULFASALAZINE DR 500 MG TAB	*PDL-P	
Inflammatory Bowel Agent - Glucocorticoids	BUDESONIDE EC 3 MG CAPSULE	PA QL
	BUDESONIDE ER 9 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Inflammatory Bowel Agent - Glucocorticoids	UCERIS 9 MG ER TABLET	PDL-NP PA
Inflammatory Bowel Agent - Integrin Receptor Antagonist, MC Antibody	ENTYVIO 108 MG/0.68 ML PEN	PDL-NP PA QL
	ENTYVIO 300 MG VIAL	PDL-NP PA
Inflammatory Bowel Agent - Sphingosine 1-phosphate receptor modulator	VELSIPITY 2 MG TABLET	PDL-NP AGE PA QL
Inflammatory Bowel Agent - Tumor Necrosis Factor Alpha Blockers	CIMZIA 200 MG VIAL KIT	PDL-NP PA QL
	CIMZIA 2X200 MG/ML SYRINGE KIT	PDL-NP PA QL
	CIMZIA 2X200 MG/ML(X3)START KT	PDL-NP PA QL
	ZYMFENTRA 120 MG/ML PEN KIT	PDL-NP AGE PA QL
	ZYMFENTRA 120 MG/ML PEN KIT (2 Pack)	PDL-NP AGE PA QL
	ZYMFENTRA 120 MG/ML SYRINGE KT	PDL-NP AGE PA
Influenza Antiviral Agents - Neuraminidase Inhibitors	OSELTAMIVIR 6 MG/ML SUSPENSION	*PDL-P QL
	OSELTAMIVIR PHOS 30 MG CAPSULE	*PDL-P QL
	OSELTAMIVIR PHOS 45 MG CAPSULE	*PDL-P QL
	OSELTAMIVIR PHOS 75 MG CAPSULE	*PDL-P QL
	RELENZA 5 MG DISKHALER	*PDL-P QL
	TAMIFLU 30 MG CAPSULE	PDL-NP PA QL
	TAMIFLU 45 MG CAPSULE	PDL-NP PA QL
	TAMIFLU 6 MG/ML SUSPENSION	PDL-NP PA QL
Influenza Antiviral Agents - PA Endonuclease Inhibitor	XOFLUZA 40 MG TABLET	PDL-NP PA
	XOFLUZA 80 MG TABLET	PDL-NP PA
Influenza-A Antiviral Agents	FLUMADINE 100 MG TABLET	PDL-NP PA
	RIMANTADINE HCL 100 MG TABLET	*PDL-P
Insulin Analogs - Fixed Combinations	HUMALOG MIX 50-50 KWIKPEN	*PDL-P QL
	HUMALOG MIX 75-25 KWIKPEN	PDL-NP PA QL
	HUMALOG MIX 75-25 VIAL	*PDL-P QL
	INSULIN ASPART PRO MIX70-30 PN	*PDL-P QL
	INSULIN ASPART PRO MIX70-30 VL	*PDL-P QL
	INSULIN LISPRO MIX 75-25 KWKPN	*PDL-P QL
	NOVOLOG MIX 70-30 FLEXPEN	PDL-NP PA QL
Insulin Analogs - Long Acting	NOVOLOG MIX 70-30 VIAL	PDL-NP PA QL
	BASAGLAR 100 UNIT/ML KWIKPEN	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Insulin Analogs - Long Acting	BASAGLAR TEMPO PEN 100 UNIT/ML	PDL-NP PA QL
	INSULIN DEGLUDEC 100 UNIT/ML	PDL-NP PA QL
	INSULIN DEGLUDEC PEN (U-100)	PDL-NP PA QL
	INSULIN DEGLUDEC PEN (U-200)	PDL-NP PA QL
	INSULIN GLARGINE MAX SOLO U300	PDL-NP PA QL
	INSULIN GLARGINE SOLOSTAR U300	PDL-NP PA QL
	INSULIN GLARGINE-YFGN U100 PEN	PDL-NP PA QL
	INSULIN GLARGINE-YFGN U100 VL	PDL-NP PA QL
	LANTUS 100 UNIT/ML VIAL	*PDL-P QL
	LANTUS SOLOSTAR 100 UNIT/ML	*PDL-P QL
	LEVEMIR 100 UNIT/ML VIAL	*PDL-P QL
	LEVEMIR FLEXPEN 100 UNIT/ML	*PDL-P QL
	LEVEMIR FLEXTOUCH 100 UNIT/ML	*PDL-P QL
	REZVOGLAR 100 UNIT/ML KWIKPEN	PDL-NP PA QL
	SEMGLEE (YFGN) 100 UNIT/ML PEN	PDL-NP PA QL
	SEMGLEE (YFGN) 100 UNIT/ML VL	PDL-NP PA QL
	TOUJEO MAX SOLOSTR 300 UNIT/ML	PDL-NP PA QL
	TOUJEO SOLOSTAR 300 UNIT/ML	PDL-NP PA QL
	TRESIBA 100 UNIT/ML VIAL	PDL-NP PA QL
	TRESIBA FLEXTOUCH 100 UNIT/ML	PDL-NP PA QL
TRESIBA FLEXTOUCH 200 UNIT/ML	PDL-NP PA QL	
Insulin Analogs - Rapid Acting	ADMELOG 100 UNIT/ML VIAL	PDL-NP PA QL
	ADMELOG SOLOSTAR 100 UNIT/ML	PDL-NP PA QL
	AFREZZA 12 UNIT CARTRIDGE	PDL-NP PA QL
	AFREZZA 4 UNIT CARTRIDGE	PDL-NP PA QL
	AFREZZA 4 UNIT/8 UNIT/12 UNIT	PDL-NP PA QL
	AFREZZA 8 UNIT CARTRIDGE	PDL-NP PA QL
	AFREZZA 90-4 UNIT / 90-8 UNIT	PDL-NP PA QL
	AFREZZA 90-8 UNIT / 90-12 UNIT	PDL-NP PA QL
	APIDRA 100 UNIT/ML VIAL	PDL-NP PA QL
	APIDRA SOLOSTAR 100 UNIT/ML	PDL-NP PA QL
FIASP 100 UNIT/ML FLEXTOUCH	PDL-NP PA QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Insulin Analogs - Rapid Acting	FIASP 100 UNIT/ML VIAL	PDL-NP PA QL
	FIASP PENFILL 100 UNIT/ML CART	PDL-NP PA QL
	FIASP PUMPCART 100 UNIT/ML	PDL-NP PA QL
	HUMALOG 100 UNIT/ML CARTRIDGE	*PDL-P QL
	HUMALOG 100 UNIT/ML KWIKPEN	*PDL-P QL
	HUMALOG 100 UNIT/ML VIAL	*PDL-P QL
	HUMALOG 200 UNIT/ML KWIKPEN	PDL-NP PA QL
	HUMALOG JR 100 UNIT/ML KWIKPEN	*PDL-P QL
	HUMALOG TEMPO PEN 100 UNIT/ML	*PDL-P QL
	INSULIN ASPART 100 UNIT/ML CRT	*PDL-P QL
	INSULIN ASPART 100 UNIT/ML PEN	*PDL-P QL
	INSULIN ASPART 100 UNIT/ML VL	*PDL-P QL
	INSULIN LISPRO 100 UNIT/ML PEN	*PDL-P QL
	INSULIN LISPRO 100 UNIT/ML VL	*PDL-P QL
	INSULIN LISPRO JR 100 UNIT/ML	*PDL-P QL
	LYUMJEV 100 UNIT/ML KWIKPEN	PDL-NP PA QL
	LYUMJEV 100 UNIT/ML VIAL	PDL-NP PA QL
	LYUMJEV 200 UNIT/ML KWIKPEN	PDL-NP PA QL
	LYUMJEV TEMPO PEN 100 UNIT/ML	PDL-NP PA QL
	MERILOG 100 UNIT/ML VIAL	PDL-NP PA QL
	MERILOG SOLOSTAR 100 UNIT/ML	PDL-NP PA QL
	NOVOLOG 100 UNIT/ML FLEXPEN	PDL-NP PA QL
	NOVOLOG 100 UNIT/ML VIAL	PDL-NP PA QL
NOVOLOG PENFILL 100 UNIT/ML	PDL-NP PA QL	
Insulin Response Enhancers - Biguanides	GLUMETZA ER 1,000 MG TABLET	PDL-NP PA
	GLUMETZA ER 500 MG TABLET	PDL-NP PA
	METFORMIN ER 1,000 MG GASTR-TB	PDL-NP PA
	METFORMIN ER 1,000 MG OSM-TAB	PDL-NP PA
	METFORMIN ER 500 MG GASTRC-TB	PDL-NP PA
	METFORMIN ER 500 MG OSMOTIC TB	PDL-NP PA
	METFORMIN HCL 1,000 MG TABLET	*PDL-P
	METFORMIN HCL 500 MG TABLET	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Insulin Response Enhancers - Biguanides	METFORMIN HCL 500 MG/5 ML SOLN	PDL-NP PA
	METFORMIN HCL 625 MG TABLET	PDL-NP PA
	METFORMIN HCL 750 MG TABLET	PDL-NP PA
	METFORMIN HCL 850 MG TABLET	*PDL-P
	METFORMIN HCL ER 500 MG TABLET	*PDL-P
	METFORMIN HCL ER 750 MG TABLET	*PDL-P
	RIOMET 500 MG/5 ML SOLUTION	PDL-NP PA
	RIOMET ER 500 MG/5 ML SUSP	PDL-NP PA
Insulin Response Enhancers - Thiazolidinediones (PPAR-gamma agonists)	ACTOS 15 MG TABLET	PDL-NP PA
	ACTOS 30 MG TABLET	PDL-NP PA
	ACTOS 45 MG TABLET	PDL-NP PA
	PIOGLITAZONE HCL 15 MG TABLET	*PDL-P
	PIOGLITAZONE HCL 30 MG TABLET	*PDL-P
	PIOGLITAZONE HCL 45 MG TABLET	*PDL-P
Interleukin 6 (IL-6) Receptor Inhibitors	TYENNE 162 MG/0.9 ML AUTOINJCT	PDL-NP AGE PA QL
	TYENNE 162 MG/0.9 ML SYRINGE	PDL-NP AGE PA QL
Interleukin Antagonists	OMVOH 100 MG/ML PEN	PDL-NP AGE PA QL
	OMVOH 100 MG/ML SYRINGE	PDL-NP AGE PA QL
	OMVOH 300 MG DOSE - 2 PENS	PDL-NP AGE PA QL
	OMVOH 300 MG DOSE - 2 SYRINGES	PDL-NP AGE PA QL
Interleukin-6 (IL-6) Receptor Inhibitors	ENSPRYNG 120 MG/ML SYRINGE	AGE PA QL
	KEVZARA 150 MG/1.14 ML PEN INJ	PDL-NP PA QL
	KEVZARA 150 MG/1.14 ML SYRINGE	PDL-NP PA QL
	KEVZARA 200 MG/1.14 ML PEN INJ	PDL-NP PA QL
	KEVZARA 200 MG/1.14 ML SYRINGE	PDL-NP PA QL
Interstitial Cystitis Agents	ELMIRON 100 MG CAPSULE	PA QL
Intestinal Flora Modifiers	CULTURELLE 10B CELL CAPSULE *	Covered for CSHCS Only
	CULTURELLE HLTH-WELL 15B CELL *	Covered for CSHCS Only
	CULTURELLE HLTH-WELL 15B CELL *	Covered for CSHCS Only
	CULTURELLE HLTH-WELL 15B CELL *	Covered for CSHCS Only
	CULTURELLE HLTH-WELL 15B CELL *	Covered for CSHCS Only
Irritable Bowel Syndrome (IBS) Agents	ALOSETRON HCL 0.5 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Irritable Bowel Syndrome (IBS) Agents	ALOSETRON HCL 1 MG TABLET	PDL-NP PA
	IBSRELA 50 MG TABLET	PDL-NP AGE PA QL
	LOTRONEX 0.5 MG TABLET	PDL-NP PA
	LOTRONEX 1 MG TABLET	PDL-NP PA
Kinase Inhibitors Combination	AVMAPKI-FAKZYNJA CO-PACK #	
Laxative - Lubricant	CVS MINERAL OIL ENEMA *	
	FLEET MINERAL OIL ENEMA *	
	FT READY TO USE MIN OIL ENEMA *	
	GNP MINERAL OIL ENEMA *	
	HM READY TO USE MIN OIL ENEMA *	
	READY TO USE ENEMA *	
	SM READY TO USE ENEMA *	Covered for CSHCS Only
Laxative - Saline and Osmotic	CITRATE OF MAGNESIA SOLN *	
	CITROMA SOLUTION *	
	CLEARLAX POWDER *	
	CVS CITRATE OF MAGNESIA SOLN *	
	CVS MAGNESIUM CITRATE SOLN *	
	CVS MILK OF MAGNESIA SUSP *	
	EQ MAGNESIUM CITRATE SOLUTION *	
	EQ MILK OF MAGNESIA SUSPENSION *	
	GNP CITRATE OF MAGNESIA SOLN *	
	GNP MILK OF MAGNESIA SUSP *	
	HM MAGNESIUM CITRATE SOLUTION *	
	HM MILK OF MAGNESIA SUSPENSION *	
	LACTULOSE 10 GM/15 ML SOLUTION	
	LACTULOSE 10 GM/15 ML SOLUTION	
	LACTULOSE 10 GM/15 ML SOLUTION	
	LACTULOSE 10 GM/15 ML SOLUTION	
	MAGNESIUM CITRATE SOLUTION *	
	MILK OF MAGNESIA SUSPENSION *	
	PHILLIPS' MILK OF MAGNESIA *	
	POLYETHYLENE GLYCOL 3350 POWD *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Laxative - Saline and Osmotic	PUB MILK OF MAGNESIA SUSP *	
	QC MAGNESIUM CITRATE SOLUTION *	
	QC MILK OF MAGNESIA SUSPENSION *	
	RA CITRATE OF MAGNESIA SOLN *	
	RA MILK OF MAGNESIA SUSPENSION *	
	SM MAGNESIUM CITRATE SOLUTION *	
	SM MILK OF MAGNESIA SUSPENSION *	
Laxative - Saline/Osmotic Mixtures	CVS ENEMA DISPOSABLE *	
	ENEMA READY TO USE *	
	ENEMA READY TO USE *	
	ENEMA READY TO USE *	
	ENEMA READY-TO-USE *	
	EQL ENEMA READY TO USE *	
	FLEET ENEMA *	Covered for CSHCS Only
	FLEET ENEMA *	Covered for CSHCS Only
	FLEET ENEMA *	Covered for CSHCS Only
	FLEET ENEMA *	
	FT ENEMA READY TO USE *	
	FT ENEMA READY TO USE TWIN PAK *	
	GNP ENEMA READY TO USE *	
	HM ENEMA READY TO USE *	
	HM ENEMA READY TO USE TWIN PAK *	
	PEDIATRIC ENEMA *	
	PEG 3350 ELECTROLYTE SOLN	
	PEG 3350-ELECTROLYTE SOLUTION	
	PEG-3350 AND ELECTROLYTES SOLN	
	PEG-3350 WITH FLAVOR PACKS SOL	
	QC ENEMA READY TO USE	
	QC ENEMA READY TO USE TWIN PAK	
	QC READY TO USE ENEMA *	
RA ENEMA TWIN PACK *		
RA SALINE ENEMA *		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Laxative - Saline/Osmotic Mixtures	SM ENEMA READY TO USE	Covered for CSHCS Only
	SM ENEMA READY TO USE *	
	SM ENEMA READY TO USE TWIN PAK	Covered for CSHCS Only
	SOD SUL-POTASS SUL-MAG SUL SOL	QL
Laxative - Stimulant	BISACODYL 10 MG SUPPOSITORY *	
	BISACODYL EC 5 MG TABLET *	
	CORRECTOL 5 MG TABLET *	
	CVS LAXATIVE PILLS *	
	EQ MAX STR LAXATIVE PILLS *	
	EX-LAX MAXIMUM STR 25 MG TAB *	
	GENTLE LAXATIVE 5 MG TABLET *	
	GENTLE LAXATIVE EC 5 MG TABLET *	
	GNP LAXATIVE 25 MG PILL *	
	LAXATIVE 15 MG PILLS *	
	LAXATIVE 25 MG PILLS *	
	LAXATIVE 5 MG TABLET *	
	LAXATIVE FEMININE 5 MG TAB *	
	NATURAL LAXATIVE TABLET *	
	RA LAXATIVE 25 MG PILL *	
	RA WOMEN'S LAXATIVE TABLET *	
	SENNA 8.6 MG SOFTGEL *	
	SENNA 8.6 MG TABLET *	
	SENNA 8.8 MG/5 ML SYRUP *	
	SENNA-TIME 8.6 MG TABLET *	
	SENOKOT 8.6 MG TABLET *	
	SENOKOT EXTRA STR 17.2 MG TAB *	
	SM LAXATIVE TABLET *	
SM WOMAN'S LAXATIVE 5 MG TAB *		
WOMANS LAXATIVE TABLET *		
WOMAN'S LAXATIVE TABLET *		
WOMEN'S LAXATIVE 5 MG TABLET *		
Laxative - Stimulant & Surfactant Combinations	SENEXON-S 50-8.6 MG TABLET *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Laxative - Stimulant & Surfactant Combinations	SENNA PLUS TABLET *	
	SENNA-S TABLET *	
	SENNA-TIME S TABLET *	
	SENNOSIDES-DOCUSATE SODIUM TAB *	
	SEKOKOT-S TABLET *	
	STIMULANT LAXATIVE PLUS TABLET *	
Laxative - Surfactant	COLACE CLEAR 50 MG SOFTGEL *	
	CVS STOOL SOFTENER 50 MG SFTGL *	
	DOCU LIQUID 50 MG/5 ML *	
	DOCUPRENE 100 MG TABLET *	
	DOCUSATE CAL 240 MG CAPSULE *	
	DOCUSATE CAL 240 MG SOFTGEL *	
	DOCUSATE SODIUM 100 MG SOFTGEL *	
	DOCUSATE SODIUM 100 MG TAB *	
	DOCUSATE SODIUM 100 MG TABLET *	
	DOCUSATE SODIUM 250 MG SOFTGEL *	
	DOCUSATE SODIUM 50 MG/5 ML LIQ *	
	DOCUSATE SODIUM MINI ENEMA *	
	DOCUSOL PLUS MINI-ENEMA *	Covered for CSHCS Only
	ENEMEEZ MINI ENEMA *	Covered for CSHCS Only
	ENEMEEZ MINI ENEMA *	Covered for CSHCS Only
	ENEMEEZ MINI ENEMA *	Covered for CSHCS Only
	ENEMEEZ MINI ENEMA *	Covered for CSHCS Only
	ENEMEEZ PLUS MINI ENEMA *	
	ENEMEEZ PLUS MINI ENEMA *	
	PROMOLAXIN 100 MG TABLET *	
STOOL SOFTENER 100 MG TABLET *		
Leptin Hormone Analogs	MYALEPT 11.3 MG (5 MG/ML) VIAL #	
LHRH (GnRH) Antagonists	ORLISSA 150 MG TABLET	*PDL-P AGE PA QL
	ORLISSA 200 MG TABLET	*PDL-P AGE PA QL
Lincosamide Antibiotics	CLINDAMYCIN (PEDI) 75 MG/5 ML	AGE
	CLINDAMYCIN HCL 150 MG CAPSULE	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Lincosamide Antibiotics	CLINDAMYCIN HCL 300 MG CAPSULE	
	CLINDAMYCIN HCL 75 MG CAPSULE	
Low Molecular Weight Heparins	ENOXAPARIN 100 MG/ML SYRINGE	*PDL-P
	ENOXAPARIN 120 MG/0.8 ML SYR	*PDL-P
	ENOXAPARIN 150 MG/ML SYRINGE	*PDL-P
	ENOXAPARIN 30 MG/0.3 ML SYR	*PDL-P
	ENOXAPARIN 300 MG/3 ML VIAL	*PDL-P
	ENOXAPARIN 40 MG/0.4 ML SYR	*PDL-P
	ENOXAPARIN 60 MG/0.6 ML SYR	*PDL-P
	ENOXAPARIN 80 MG/0.8 ML SYR	*PDL-P
	FRAGMIN 10,000 UNIT/4 ML VIAL	PDL-NP PA
	FRAGMIN 10,000 UNIT/ML SYRINGE	PDL-NP PA
	FRAGMIN 12,500 UNIT/0.5 ML SYR	PDL-NP PA
	FRAGMIN 15,000 UNIT/0.6 ML SYR	PDL-NP PA
	FRAGMIN 18,000 UNIT/0.72 ML	PDL-NP PA
	FRAGMIN 2,500 UNIT/0.2 ML SYR	PDL-NP PA
	FRAGMIN 5,000 UNIT/0.2 ML SYR	PDL-NP PA
	FRAGMIN 7,500 UNIT/0.3 ML SYR	PDL-NP PA
	FRAGMIN 95,000 UNIT/3.8 ML VL	PDL-NP PA
	LOVENOX 100 MG/ML SYRINGE	PDL-NP PA
	LOVENOX 120 MG/0.8 ML SYRINGE	PDL-NP PA
	LOVENOX 150 MG/ML SYRINGE	PDL-NP PA
	LOVENOX 30 MG/0.3 ML SYRINGE	PDL-NP PA
	LOVENOX 300 MG/3 ML VIAL	PDL-NP PA
	LOVENOX 40 MG/0.4 ML SYRINGE	PDL-NP PA
LOVENOX 60 MG/0.6 ML SYRINGE	PDL-NP PA	
LOVENOX 80 MG/0.8 ML SYRINGE	PDL-NP PA	
Luteal Phase Supporting, Progesterone-type	CRINONE 8% GEL	PDL-NP PA
Macrolides	AZITHROMYCIN 1 GM PWD PACKET	*PDL-P QL
	AZITHROMYCIN 100 MG/5 ML SUSP	*PDL-P
	AZITHROMYCIN 200 MG/5 ML SUSP	*PDL-P
	AZITHROMYCIN 250 MG TABLET	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Macrolides	AZITHROMYCIN 500 MG TABLET	*PDL-P QL
	AZITHROMYCIN 600 MG TABLET	*PDL-P QL
	CLARITHROMYCIN 125 MG/5 ML SUS	*PDL-P
	CLARITHROMYCIN 250 MG TABLET	*PDL-P QL
	CLARITHROMYCIN 250 MG/5 ML SUS	*PDL-P
	CLARITHROMYCIN 500 MG TABLET	*PDL-P QL
	CLARITHROMYCIN ER 500 MG TAB	PDL-NP PA
	DIFICID 200 MG TABLET	*PDL-P
	DIFICID 40 MG/ML SUSPENSION	PDL-NP AGE PA
	E.E.S. 200 MG/5 ML SUSPENSION	PDL-NP PA
	E.E.S. 400 MG TABLET	PDL-NP PA
	ERYPED 200 MG/5 ML SUSPENSION	PDL-NP PA
	ERYPED 400 MG/5 ML SUSPENSION	PDL-NP PA
	ERY-TAB DR 250 MG TABLET	PDL-NP PA
	ERY-TAB DR 333 MG TABLET	PDL-NP PA
	ERY-TAB DR 500 MG TABLET	PDL-NP PA
	ERYTHROCIN 250 MG FILMTAB	*PDL-P
	ERYTHROMYCIN 200 MG/5 ML SUSP	*PDL-P
	ERYTHROMYCIN 250 MG FILMTAB	PDL-NP PA
	ERYTHROMYCIN 400 MG/5 ML SUSP	PDL-NP PA
	ERYTHROMYCIN 500 MG FILMTAB	PDL-NP PA
	ERYTHROMYCIN DR 250 MG CAP	PDL-NP PA
	ERYTHROMYCIN DR 250 MG CAP	PDL-NP PA
	ERYTHROMYCIN DR 250 MG TABLET	PDL-NP PA
	ERYTHROMYCIN DR 333 MG TABLET	PDL-NP PA
	ERYTHROMYCIN DR 500 MG TABLET	PDL-NP PA
	ERYTHROMYCIN ES 400 MG TAB	*PDL-P
	FIDAXOMICIN 200 MG TABLET	PDL-NP PA
	ZITHROMAX 1 GM POWDER PACKET	PDL-NP PA QL
	ZITHROMAX 100 MG/5 ML SUSP	PDL-NP PA
	ZITHROMAX 200 MG/5 ML SUSP	PDL-NP PA
	ZITHROMAX 250 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Macrolides	ZITHROMAX 250 MG Z-PAK TABLET	PDL-NP PA
	ZITHROMAX 500 MG TABLET	PDL-NP PA QL
	ZITHROMAX TRI-PAK 500 MG TAB	PDL-NP PA QL
Medical Supplies & DME - Cervical Cap	FEMCAP 22 MM CERVICAL CAP	
	FEMCAP 26 MM CERVICAL CAP	
	FEMCAP 30 MM CERVICAL CAP	
Medical Supplies & DME - Diaphragms	CAYA CONTOURED DIAPHRAGM	
	WIDE SEAL DIAPHRAGM 60MM	
	WIDE SEAL DIAPHRAGM 65MM	
	WIDE SEAL DIAPHRAGM 70MM	
	WIDE SEAL DIAPHRAGM 75MM	
	WIDE SEAL DIAPHRAGM 80MM	
	WIDE SEAL DIAPHRAGM 85MM	
	WIDE SEAL DIAPHRAGM 90MM	
	WIDE SEAL DIAPHRAGM 95MM	
Medical Supplies & DME - Female Condoms	FC2 FEMALE CONDOM	QL
Medical Supplies & DME - Male Condoms	AIMSCO LATEX CONDOM	QL
	CONDOMS LUBRICATED	QL
	FANTASY CONDOM	QL
	KIMONO CONDOMS	QL
	KIMONO MAXX CONDOM	QL
	KIMONO MICROTHIN AQUA LUBE	QL
	KIMONO MICROTHIN CONDOM	QL
	KIMONO MICROTHIN LARGE CONDOM	QL
	KIMONO TEXTURED CONDOM	QL
	TRUSTEX CONDOM	QL
	TRUSTEX CONDOM	QL
	TRUSTEX LATEX CONDOM	QL
	TRUSTEX-RIA CONDOM	QL
	TRUSTEX-RIA CONDOM	QL
Medical Supplies & DME - Peak Flow Meters	AIRZONE PEAK FLOW METER	QL
	ASSESS PEAK FLOW METER	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Medical Supplies & DME - Peak Flow Meters	ASTHMA CHECK PEAK FLOW MTR	QL
	ASTHMAMENTOR PEAK FLOW MTR	QL
	IN-CHECK NASAL WITH MASK	QL
	IN-CHECK ORAL FLOW METER	QL
	MICROLIFE PEAK FLOW METER	QL
	MINI WRIGHT PEAK FLOW METER	QL
	MINI-WRIGHT PEAK FLOW METER	QL
	PEAK-AIR PEAK FLOW METER	QL
	PERSONAL BEST PEAK FLOW MTR	QL
	PIKO 1 FLOW METER	QL
	POCKET PEAK FLOW METER	QL
	TRUZONE PEAK FLOW METER	QL
	Medical Supplies & DME - Respiratory Therapy Supplies	ACE AEROSOL CLOUD ENHANCER
AEROCHAMBER MINI		QL
AEROCHAMBER MV HOLD CHAMBER		QL
AEROCHAMBER PLUS FLOW-VU		QL
AEROCHAMBER PLUS FLOW-VU LARGE		QL
AEROCHAMBER PLUS FLOW-VU MED		QL
AEROCHAMBER PLUS FLOW-VU SMALL		QL
AEROCHAMBER Z-STAT PLUS LARGE		QL
AEROCHAMBER Z-STAT PLUS W-FLOW		QL
AEROCHAMBER Z-STAT PLUS-MED		QL
AEROCHAMBER Z-STAT PLUS-SMALL		QL
AEROTRACH HOLDING CHAMBER		QL
BREATHERITE MDI SPACER		QL
BREATHRITE VALVED MDI CHAMBER		QL
BREATHRITE VALVED MDI SPACER		QL
CLEVER CHOICE CHAMBER-LRG MASK		QL
COMPACT SPACE CHAMBER PLUS		QL
COMPACT SPACE CHAMBER-LRG MASK		QL
COMPACT SPACE CHAMBER-MED MASK		QL
COMPACT SPACE CHAMBER-SM MASK		QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Medical Supplies & DME - Respiratory Therapy Supplies	EASIVENT HOLDING CHAMBER	QL
	EASIVENT MASK-LARGE	QL
	EASIVENT MASK-MEDIUM	QL
	EASIVENT MASK-SMALL	QL
	INSPIRACHAMBER	QL
	INSPIRACHAMBER WITH MASK-MED	QL
	INSPIRACHAMBER WITH MASK-SMALL	QL
	LITEAIRE MDI CHAMBER	QL
	LITETOUCH LARGE MASK	QL
	LITETOUCH MEDIUM MASK	QL
	LITETOUCH SMALL MASK	QL
	MICROCHAMBER	QL
	MICROSPACER FOR AEROSOL DEVICE	QL
	ONE WAY VALVED MOUTHPIECE	QL
	OPTICHAMBER ADULT MASK-LARGE	QL
	OPTICHAMBER DIAMOND VHC	QL
	OPTICHAMBER DIAMOND-LARGE MASK	QL
	OPTICHAMBER DIAMOND-MED MASK	QL
	OPTICHAMBER DIAMOND-SMALL MASK	QL
	PANDA MASK LARGE	QL
	PANDA MASK MEDIUM	QL
	PANDA MASK SMALL	QL
	PEDIATRIC MEDIUM MASK	QL
	PEDIATRIC MOUTHPIECE	QL
	PEDIATRIC PANDA MASK	QL
	PEDIATRIC SMALL MASK	QL
	POCKET CHAMBER	QL
	PRIMEAIRE CHAMBER	QL
	PRO COMFORT SPACER-ADULT MASK	QL
	PRO COMFORT SPACER-CHILD MASK	QL
	PROCARE SPACER WITH ADULT MASK	QL
	PROCARE SPACER WITH CHILD MASK	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Medical Supplies & DME - Respiratory Therapy Supplies	PROCHAMBER HOLDING CHAMBER	QL
	RITEFLO SPACER	QL
	SIDESTREAM PEDIATRIC FACE MASK	QL
	SILICONE MASK-INFANT	QL
	SILICONE MASK-PEDIATRIC	QL
	SPACE CHAMBER PLUS	QL
	VORTEX ADULT MASK	QL
	VORTEX FROG CHILD MASK	QL
	VORTEX HOLDING CHAMBER	QL
	VORTEX LADYBUG TODDLER MASK	QL
	VORTEX VHC FROG CHILD MASK	QL
	VORTEX VHC LADYBUG TODDLER MSK	QL
Menopausal Symptoms Suppressant-SSRI Antidepressant Type	BRISDELLE 7.5 MG CAPSULE #	
Metabolic Disease Enzyme Replacement, Fabry's Disease	FABRAZYME 35 MG VIAL #	
	FABRAZYME 5 MG VIAL #	
Metabolic Disease Enzyme Replacement, Gaucher's Disease	CEREZYME 400 UNITS VIAL #	
	ELELYSO 200 UNITS VIAL #	
	VPRIV 400 UNITS VIAL #	
Metabolic Disease Enzyme Replacement, Hypophosphatasia	STRENSIQ 18 MG/0.45 ML VIAL #	
	STRENSIQ 28 MG/0.7 ML VIAL #	
	STRENSIQ 40 MG/ML VIAL #	
	STRENSIQ 80 MG/0.8 ML VIAL #	
Metabolic Disease Enzyme Replacement, Mucopolysaccharidosis	ALDURAZYME 2.9 MG/5 ML VIAL #	
	ELAPRASE 6 MG/3 ML VIAL #	
	MEPSEVII 10 MG/5 ML VIAL #	
	NAGLAZYME 5 MG/5 ML VIAL #	
	VIMIZIM 5 MG/5 ML VIAL #	
Metabolic Disease Enzyme Replacement, Pompe Disease	LUMIZYME 50 MG VIAL #	
Metabolic Dx Enzyme Replacement, Severe Combined Immune Deficiency	ADAGEN 250 UNITS/ML VIAL #	
	REVCovi 2.4 MG/1.5 ML VIAL #	
Metabolic Modifier - Carnitine Replenisher Agents	CARNITOR 1 GM/5 ML VIAL #	
	CARNITOR 100 MG/ML ORAL SOLN #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Metabolic Modifier - Carnitine Replenisher Agents	CARNITOR 330 MG TABLET #	
	CARNITOR SF 100 MG/ML ORAL SOL #	
	LEVOCARNITINE 1 G/10 ML SOLN #	
	LEVOCARNITINE 330 MG TABLET #	
Metabolic Modifier - Gaucher's Disease, Type-1, Substrate Reduction Tx	CERDELGA 84 MG CAPSULE #	
	MIGLUSTAT 100 MG CAPSULE #	
	ZAVESCA 100 MG CAPSULE #	
Metabolic Modifier - Hereditary Tyrosinemia Treatment Agents	NITISINONE 10 MG CAPSULE #	
	NITISINONE 2 MG CAPSULE #	
	NITISINONE 5 MG CAPSULE #	
	NITYR 10 MG TABLET #	
	NITYR 2 MG TABLET #	
	NITYR 5 MG TABLET #	
	ORFADIN 10 MG CAPSULE #	
	ORFADIN 2 MG CAPSULE #	
	ORFADIN 20 MG CAPSULE #	
	ORFADIN 4 MG/ML SUSPENSION #	
	ORFADIN 5 MG CAPSULE #	
Metabolic Modifier - Homocystinuria Treatment Agents	CYSTADANE 1 GRAM/1.7 ML POWDER #	
Metabolic Modifier - Urea Cycle Disorder Agents-Conjugating agents	AMMONUL 10%-10% VIAL #	
	BUPHENYL 500 MG TABLET #	
	BUPHENYL POWDER #	
	GLYCEROL PHENYLBUT 1.1 GRAM/ML #	
	PHEBURANE PELLETT #	
	RAVICTI 1.1 GRAM/ML LIQUID #	
	SOD PHENYLACET-SOD BENZOATE VL #	
	SODIUM PHENYLBUTYRATE 500MG TB #	
SODIUM PHENYLBUTYRATE POWDER #		
Metabolic Modifier-Carbamoyl Phosphate Synthetase 1 (CPS 1) activator	CARBAGLU 200 MG DISPER TABLET #	
	CARGLUMIC ACID 200 MG TAB SUSP #	
Metabolic Modifiers - GAA Deficiency Treatment - Agents	OPFOLDA 65 MG CAPSULE #	
Methotrexate Rescue Agents	LEUCOVORIN CALCIUM 10 MG TAB	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Methotrexate Rescue Agents	LEUCOVORIN CALCIUM 15 MG TAB	
	LEUCOVORIN CALCIUM 25 MG TAB	
	LEUCOVORIN CALCIUM 5 MG TAB	
Migraine Products - Cyclooxygenase 2 (COX-2) Inhibitors	ELYXYB 120 MG/4.8 ML SOLUTION	PDL-NP AGE PA QL
Migraine Therapy - Calcitonin Gene-Related Peptide Antagonist	NURTEC ODT 75 MG TABLET	*PDL-P AGE PA QL
Migraine Therapy - Calcitonin Gene-Related Peptide Inhibitors	AIMOVIG 140 MG/ML AUTOINJECTOR	*PDL-P AGE PA QL
	AIMOVIG 70 MG/ML AUTOINJECTOR	*PDL-P AGE PA QL
	AJOVY 225 MG/1.5 ML AUTOINJECT	*PDL-P AGE PA QL
	AJOVY 225 MG/1.5 ML AUTOINJECT	*PDL-P AGE PA QL
	AJOVY 225 MG/1.5 ML SYRINGE	*PDL-P AGE PA QL
	EMGALITY 120 MG/ML PEN	*PDL-P AGE PA QL
	EMGALITY 120 MG/ML SYRINGE	*PDL-P AGE PA QL
	EMGALITY 300 MG (100 MG X3SYR)	*PDL-P AGE PA QL
	NURTEC ODT 75 MG TABLET	*PDL-P AGE PA QL
Migraine Therapy - CGRP Receptor Blockers (gepants)	QULIPTA 10 MG TABLET	*PDL-P AGE PA QL
	QULIPTA 30 MG TABLET	*PDL-P AGE PA QL
	QULIPTA 60 MG TABLET	*PDL-P AGE PA QL
	UBRELVY 100 MG TABLET	*PDL-P AGE PA QL
	UBRELVY 50 MG TABLET	*PDL-P AGE PA QL
	ZAVZPRET 10 MG NASAL SPRAY	PDL-NP AGE PA QL
Migraine Therapy - Selective Serotonin Agonists 5-HT(1)	ALMOTRIPTAN MALATE 12.5 MG TAB	PDL-NP PA QL
	ALMOTRIPTAN MALATE 6.25 MG TAB	PDL-NP PA QL
	ELETRIPTAN HBR 20 MG TABLET	PDL-NP PA QL
	ELETRIPTAN HBR 40 MG TABLET	PDL-NP PA QL
	FROVA 2.5 MG TABLET	PDL-NP PA QL
	FROVATRIPTAN SUCC 2.5 MG TAB	PDL-NP PA QL
	IMITREX 100 MG TABLET	PDL-NP PA QL
	IMITREX 25 MG TABLET	PDL-NP PA QL
	IMITREX 4 MG/0.5 ML CARTRIDGES	PDL-NP PA QL
	IMITREX 4 MG/0.5 ML PEN INJECT	PDL-NP PA QL
	IMITREX 50 MG TABLET	PDL-NP PA QL
	IMITREX 6 MG/0.5 ML CARTRIDGES	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Migraine Therapy - Selective Serotonin Agonists 5-HT(1)	IMITREX 6 MG/0.5 ML PEN INJECT	PDL-NP PA QL
	IMITREX 6 MG/0.5 ML VIAL	PDL-NP PA QL
	MAXALT 10 MG TABLET	PDL-NP PA QL
	MAXALT MLT 10 MG TABLET	PDL-NP PA QL
	NARATRIPTAN HCL 1 MG TABLET	PDL-NP PA QL
	NARATRIPTAN HCL 2.5 MG TABLET	PDL-NP PA QL
	RELPAX 20 MG TABLET	PDL-NP PA QL
	RELPAX 40 MG TABLET	PDL-NP PA QL
	REYVOW 100 MG TABLET	PDL-NP AGE PA QL
	REYVOW 50 MG TABLET	PDL-NP AGE PA QL
	RIZATRIPTAN 10 MG ODT	*PDL-P QL
	RIZATRIPTAN 10 MG TABLET	*PDL-P QL
	RIZATRIPTAN 5 MG ODT	*PDL-P QL
	RIZATRIPTAN 5 MG TABLET	*PDL-P QL
	SUMATRIPTAN 20 MG NASAL SPRAY	*PDL-P QL
	SUMATRIPTAN 4 MG/0.5 ML CART	*PDL-P QL
	SUMATRIPTAN 4 MG/0.5 ML INJECT	*PDL-P QL
	SUMATRIPTAN 5 MG NASAL SPRAY	*PDL-P QL
	SUMATRIPTAN 6 MG/0.5 ML CART	*PDL-P QL
	SUMATRIPTAN 6 MG/0.5 ML VIAL	*PDL-P QL
	SUMATRIPTAN 6 MG/0.5ML AUTOINJ	*PDL-P QL
	SUMATRIPTAN SUCC 100 MG TABLET	*PDL-P QL
	SUMATRIPTAN SUCC 25 MG TABLET	*PDL-P QL
	SUMATRIPTAN SUCC 50 MG TABLET	*PDL-P QL
	Symbravo 10 mg-20mg Tablet	PDL-NP PA QL
	TOSYMRA 10 MG NASAL SPRAY	PDL-NP PA QL
	ZOLMITRIPTAN 2.5 MG NASAL SPRY	PDL-NP PA
	ZOLMITRIPTAN 2.5 MG ODT	PDL-NP PA QL
	ZOLMITRIPTAN 2.5 MG TABLET	PDL-NP PA QL
	ZOLMITRIPTAN 5 MG NASAL SPRAY	PDL-NP PA
	ZOLMITRIPTAN 5 MG ODT	PDL-NP PA QL
	ZOLMITRIPTAN 5 MG TABLET	PDL-NP PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Migraine Therapy - Selective Serotonin Agonists 5-HT(1)	ZOMIG 2.5 MG NASAL SPRAY	PDL-NP PA
	ZOMIG 2.5 MG TABLET	PDL-NP PA QL
	ZOMIG 5 MG NASAL SPRAY	PDL-NP PA
	ZOMIG 5 MG TABLET	PDL-NP PA QL
Migraine Therapy - Serotonin Agonist 5-HT(1) and NSAID Comb.	SUMATRIPTAN-NAPROXEN 85-500 MG	PDL-NP PA
Mineralocorticoids	FLUDROCORTISONE 0.1 MG TABLET	
Minerals & Electrolytes - Calcium Replacement	CALCIUM 500 MG TABLET *	
	CALCIUM 600 MG TABLET *	
	CALCIUM CARB 1,250 MG/5 ML SUS *	
	CALCIUM CITRATE 250 MG CAPLET *	Covered for CSHCS Only
	CALCIUM CITRATE 250 MG TABLET *	Covered for CSHCS Only
	CALCIUM CITRATE 250 MG TABLET *	Covered for CSHCS Only
	CALCIUM CITRATE 250 MG TABLET *	Covered for CSHCS Only
	CALCIUM GLUC 1,000 MG/10 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 1,000 MG/10 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 1,000 MG/10 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 1,000 MG/10 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 1,000 MG/10 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 10,000 MG/100 ML	Covered for CSHCS Only
	CALCIUM GLUC 5,000 MG/50 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 5,000 MG/50 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 5,000 MG/50 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 5,000 MG/50 ML VL	Covered for CSHCS Only
	CALCIUM GLUC 5,000 MG/50 ML VL	Covered for CSHCS Only
CALCIUM GLUC 5,000 MG/50 ML VL	Covered for CSHCS Only	
OYSTER SHELL CALCIUM 500 MG TB *		
VITAMIN D3 25 MCG TABLET *	Covered for CSHCS Only	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Minerals & Electrolytes - Calcium Replacement/Vitamin D Combinations	CALCIUM + VITAMIN D TABLET *	
	CALCIUM 250+D TABLET *	
	CALCIUM 250+D TABLET *	
	CALCIUM 500 + D TABLET *	
	CALCIUM 500 + VIT D 200 CAPLET *	
	CALCIUM 500 + VIT D 200 TABLET *	
	CALCIUM 500 + VIT D3 400 TAB *	
	CALCIUM 500 + VIT D3 400 TAB *	
	CALCIUM 600 + VIT D TABLET *	
	CALCIUM 600-VIT D3 800 TABLET *	
	CALCIUM CITRATE - VIT D3 TAB *	
	CALCIUM CITRATE-VIT D CAPLET *	
	CALCIUM CITRATE-VIT D3 CAPLET *	
	CALCIUM CITRATE-VIT D3 TABLET *	
	CITRACAL + D MAXIMUM CAPLET *	
	EQ CALCIUM 500 + VIT D 400 TAB *	
	EQ CALCIUM CITRATE+D TABLET *	
	GNP CALCIUM 500 + VIT D3 TAB *	
	GNP CALCIUM 600 + VIT D3 TAB *	
	HM CALCIUM CITRATE-VIT D CPLT *	
	OS-CAL 500+D3 CAPLET *	
	OYSTER SHELL 250 MG + VIT D TB *	
	OYSTER SHELL 500-VIT D3 200 TB *	
	OYSTER SHELL CALCIUM + D TAB *	
	OYSTER SHELL CALCIUM-VIT D TAB *	
	OYSTER SHELL CALCIUM-VIT D TAB *	
	OYSTER SHELL+D 250 MG TABLET *	
	OYSTERCAL-D 500 MG-400 UNIT TB *	
	RA CALCIUM CITRATE - VIT D TAB *	
	SM CALCIUM 500 + VIT D 400 TAB *	
	SM CALCIUM 500 + VIT D 400 TAB *	
SM CALCIUM 500-VIT D3 200 CPLT *		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Minerals & Electrolytes - Calcium Replacement/Vitamin D Combinations	SV CALCIUM CITRATE-VIT D3 TAB *	
Minerals & Electrolytes - Iron	CHILD FERROUS SULFATE 15 MG/ML *	AGE
	CVS IRON 27 MG TABLET *	
	CVS IRON 65 MG TABLET *	
	FE C PLUS TABLET *	AGE
	FERATE 27 MG TABLET *	
	FERATE 27 MG TABLET *	
	FERGON 27 MG TABLET *	
	FEROSUL 220 MG/5 ML ELIXIR *	AGE
	FEROSUL 325 MG TABLET *	
	FERRO-TIME 325 MG TABLET *	
	FERROUS GLUCONATE 324 MG TAB *	
	FERROUS SULF 15 MG IRON/ML DRP *	AGE
	FERROUS SULF 15 MG IRON/ML DRP *	Covered for CSHCS Only
	FERROUS SULF 220 MG/5 ML ELIX *	AGE
	FERROUS SULF 300 MG/5 ML LIQ *	AGE
	FERROUS SULF 44 MG IRON/5ML LQ *	AGE
	FERROUS SULF EC 324 MG TABLET *	
	FERROUS SULF EC 325 MG TABLET *	
	FERROUS SULFATE 325 MG TABLET *	
	GNP IRON 45 MG TABLET *	
	GNP IRON 65 MG TABLET *	
	INFANT IRON 15 MG/ML DROP *	Covered for CSHCS Only
	INFANT IRON 15 MG/ML DROP *	Covered for CSHCS Only
	INFANT IRON 15 MG/ML DROP *	Covered for CSHCS Only
	IRON 45 MG TABLET *	
	IRON 65 MG TABLET *	
	PEDIA IRON 15 MG/ML DROP *	Covered for CSHCS Only
	PEDIATRIC FE-VITE 15 MG/ML DRP *	Covered for CSHCS Only
	RA IRON 65 MG TABLET *	
	RA SLOW RELEASE IRON 45 MG TAB *	
	SLOW RELEASE IRON 45 MG TABLET *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Minerals & Electrolytes - Iron	SV IRON 65 MG TABLET *	
Minerals & Electrolytes - Iron Combinations	NEPHRON FA TABLET	Covered for CSHCS Only
Minerals & Electrolytes - Magnesium	CVS MAGNESIUM 500 MG TABLET *	
	MAGNESIUM 500 MG TABLET *	
	MAGNESIUM CHELATED 100 MG TAB *	Covered for CSHCS Only
	MAGNESIUM CHELATED 100 MG TAB *	Covered for CSHCS Only
	MAGNESIUM CHELATED 100 MG TAB *	Covered for CSHCS Only
	MAGNESIUM CHL 200 MG/ML VIAL	
	MAGNESIUM CITRATE 100 MG TAB *	Covered for CSHCS Only
	MAGNESIUM GLUC 500 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM GLUC 500 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM GLUCONATE TABLET *	Covered for CSHCS Only
	MAGNESIUM GLUCONATE TABLET *	Covered for CSHCS Only
	MAGNESIUM GLYCINATE 100 MG CAP	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 400 MG TABLET *	
	MAGNESIUM OXIDE 400 MG TABLET *	
	MAGNESIUM OXIDE 400 MG TABLET *	Covered for CSHCS Only
	MAGNESIUM OXIDE 420 MG TABLET *	
	MAGNESIUM OXIDE 440 MG TABLET	Covered for CSHCS Only

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Minerals & Electrolytes - Magnesium	MAGNESIUM OXIDE 500 MG TABLET *	
	MAGNESIUM SULFATE 50% VIAL	
	PHILLIPS 500 MG CAPLET *	
	PUREVITA VITAMIN D3 25 MCG TAB *	Covered for CSHCS Only
	SLOWMAG MUSCLE RECOVERY GUMMY *	Covered for CSHCS Only
	TRUE MAGNESIUM OXIDE 400 MG TB *	
	TRUE MAGNESIUM OXIDE 500 MG TB *	Covered for CSHCS Only
	TRUE VITAMIN E 180 MG CAPSULE *	Covered for CSHCS Only
	TRUE VITAMIN E 90 MG CAPSULE *	Covered for CSHCS Only
	VITAMIN D3 25 MCG TABLET *	Covered for CSHCS Only
	VITAMIN E 180 MG SOFTGEL *	Covered for CSHCS Only
	WELL MAGNESIUM OXIDE 400 MG TB *	
Minerals & Electrolytes - Magnesium Combinations	BEELITH TABLET *	
Minerals & Electrolytes - Oral Electrolytes	ORALYTE SOLUTION *	
	PEDIALYTE SOLUTION *	
	SM PEDIATRIC ELECTROLYTE SOLN *	
Minerals & Electrolytes - Phosphate	GLYCOPHOS VIAL	
	PHOS-NAK PACKET	Covered for CSHCS Only
	PHOSPHOROUS POWDER PACKET *	Covered for CSHCS Only
	PHOSPHORUS-SODIUM-POTASSIUM *	Covered for CSHCS Only
	POTASSIUM PHOSP 45 MMOL/15 ML	
	SODIUM PHOSPHATE 15 MMOL/5 ML	Covered for CSHCS Only
	SODIUM PHOSPHATE 15 MMOL/5 ML	Covered for CSHCS Only
	SODIUM PHOSPHATE 15 MMOL/5 ML	Covered for CSHCS Only
	SODIUM PHOSPHATE 150 MMOL/50ML	Covered for CSHCS Only
	SODIUM PHOSPHATE 150 MMOL/50ML	Covered for CSHCS Only
	SODIUM PHOSPHATE 45 MMOL/15 ML	Covered for CSHCS Only
	SODIUM PHOSPHATE 45 MMOL/15 ML	Covered for CSHCS Only
	SODIUM-POTASSIUM-PHOS POWDER *	Covered for CSHCS Only
Minerals & Electrolytes - Potassium, Oral	KLOR-CON-EF 25 MEQ TAB EFF	
	POTASSIUM CL ER 10 MEQ CAPSULE	
	POTASSIUM CL ER 10 MEQ TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Minerals & Electrolytes - Potassium, Oral	POTASSIUM CL ER 10 MEQ TABLET	
	POTASSIUM CL ER 20 MEQ TABLET	
	POTASSIUM CL ER 20 MEQ TABLET	
	POTASSIUM CL ER 8 MEQ CAPSULE	
	POTASSIUM CL ER 8 MEQ TABLET	
Minerals & Electrolytes - Sodium	SODIUM CHLORIDE 1 GM TABLET *	Covered for CSHCS Only
	SODIUM CHLORIDE 1 GM TABLET *	Covered for CSHCS Only
	SODIUM CHLORIDE 1 GM TABLET *	Covered for CSHCS Only
Minerals & Electrolytes - Zinc	ORAZINC 110 MG TABLET *	Covered for CSHCS Only
	ORAZINC 220 MG CAPSULE *	Covered for CSHCS Only
	ZINC 50 MG TABLET *	Covered for CSHCS Only
	ZINC 50 MG TABLET *	Covered for CSHCS Only
	ZINC GLUCONATE 100 MG TABLET *	Covered for CSHCS Only
	ZINC GLUCONATE 100 MG TABLET *	Covered for CSHCS Only
	ZINC SULFATE 220 MG (50MG) CAP *	Covered for CSHCS Only
	ZINC SULFATE 220 MG (50MG) CAP *	Covered for CSHCS Only
	ZINC SULFATE 220 MG CAPSULE *	Covered for CSHCS Only
	ZINC SULFATE 220 MG CAPSULE *	Covered for CSHCS Only
	ZINC SULFATE 50 MG (220 MG) TB *	Covered for CSHCS Only
ZINC-220 CAPSULE *	Covered for CSHCS Only	
Miotics - Cholinesterase Inhibitors	PHOSPHOLINE IODIDE 0.125% DROP	
Miotics - Direct Acting	PILOCARPINE 1% EYE DROPS	
	PILOCARPINE 2% EYE DROPS	
	PILOCARPINE 4% EYE DROPS	
Modified C-type Natriuretic Peptide (CNP)	VOXZOGO 0.4 MG VIAL #	
	VOXZOGO 0.56 MG VIAL #	
	VOXZOGO 1.2 MG VIAL #	
Monobactam Antibiotics	CAYSTON 75 MG INHAL SOLUTION	*PDL-P
Mouth and Throat - Antifungals	CLOTRIMAZOLE 10 MG TROCHE	*PDL-P
	NYSTATIN 100,000 UNIT/ML SUSP	*PDL-P
	NYSTATIN 500,000 UNIT/5 ML CUP	*PDL-P
	NYSTATIN 500,000 UNIT/5 ML SUS	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Mouth and Throat - Antiseptics	CHLORHEXIDINE 0.12% RINSE	
Mouth and Throat - Glucocorticoids	TRIAMCINOLONE 0.1% PASTE	QL
Mouth and Throat - Local Anesthetic Amides	LIDOCAINE 2% VISCOUS SOLN	
Mouth and Throat - Saliva Stimulants	PILOCARPINE HCL 5 MG TABLET	
	PILOCARPINE HCL 7.5 MG TABLET	
Movement Disorder Therapy - Huntington's Disease	AUSTEDO 12 MG TABLET	AGE PA QL
	AUSTEDO 6 MG TABLET	AGE PA QL
	AUSTEDO 9 MG TABLET	AGE PA QL
	AUSTEDO XR 12 MG TABLET	AGE PA QL
	AUSTEDO XR 18 MG TABLET	AGE PA QL
	AUSTEDO XR 24 MG TABLET	AGE PA QL
	AUSTEDO XR 30 MG TABLET	AGE PA QL
	AUSTEDO XR 36 MG TABLET	AGE PA QL
	AUSTEDO XR 42 MG TABLET	AGE PA QL
	AUSTEDO XR 48 MG TABLET	AGE PA QL
	AUSTEDO XR 6 MG TABLET	AGE PA QL
	AUSTEDO XR TITR(12-18-24-30MG)	AGE PA QL
Movement Disorder Therapy - Restless Legs Syndrome	HORIZANT ER 300 MG TABLET	*PDL-P
	HORIZANT ER 600 MG TABLET	*PDL-P
Movement Disorder Therapy - Tardive Dyskinesia	INGREZZA 40 MG CAPSULE	AGE PA QL
	INGREZZA 40 MG SPRINKLES CAP	AGE PA QL
	INGREZZA 60 MG CAPSULE	AGE PA QL
	INGREZZA 60 MG SPRINKLES CAP	AGE PA QL
	INGREZZA 80 MG CAPSULE	AGE PA QL
	INGREZZA 80 MG SPRINKLES CAP	AGE PA QL
	INGREZZA INITIATION PACK	AGE PA QL
Mucolytics	ACETYLCYSTEINE 10% VIAL	
	ACETYLCYSTEINE 20% VIAL	
	PULMOZYME 1 MG/ML AMPUL	PA QL
Multiple Sclerosis Agent - CD20-Directed Cytolytic Antibody	KESIMPTA 20 MG/0.4 ML PEN	*PDL-P
Multiple Sclerosis Agent - Interferons	AVONEX PEN 30 MCG/0.5 ML KIT	*PDL-P
	AVONEX PREFILLED SYR 30 MCG KT	*PDL-P QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Multiple Sclerosis Agent - Interferons	BETASERON 0.3 MG KIT	*PDL-P
	BETASERON 0.3 MG VIAL	*PDL-P
	PLEGRIDY 125 MCG/0.5 ML PEN	PDL-NP PA
	PLEGRIDY 125 MCG/0.5 ML SYRINGE	PDL-NP PA
	PLEGRIDY 125 MCG/0.5 ML SYRINGE	PDL-NP PA
	PLEGRIDY PEN INJ STARTER PACK	PDL-NP PA
	PLEGRIDY SYRINGE STARTER PACK	PDL-NP PA
	REBIF 22 MCG/0.5 ML SYRINGE	PDL-NP PA
	REBIF 44 MCG/0.5 ML SYRINGE	PDL-NP PA QL
	REBIF REBIDOSE 22 MCG/0.5 ML	PDL-NP PA
	REBIF REBIDOSE 44 MCG/0.5 ML	PDL-NP PA
	REBIF REBIDOSE TITRATION PACK	PDL-NP PA
	REBIF TITRATION PACK	PDL-NP PA
Multiple Sclerosis Agent - Others	BAFIERTAM DR 95 MG CAPSULE	PDL-NP PA QL
	COPAXONE 20 MG/ML SYRINGE	*PDL-P
	COPAXONE 40 MG/ML SYRINGE	PDL-NP PA
	DIMETHYL FUMARATE 30D START PK	*PDL-P
	DIMETHYL FUMARATE DR 120 MG CP	*PDL-P
	DIMETHYL FUMARATE DR 240 MG CP	*PDL-P
	GLATIRAMER 20 MG/ML SYRINGE	PDL-NP PA
	GLATIRAMER 40 MG/ML SYRINGE	PDL-NP PA
	GLATOPA 20 MG/ML SYRINGE	PDL-NP PA
	GLATOPA 40 MG/ML SYRINGE	PDL-NP PA
	TECFIDERA DR 120 MG CAPSULE	PDL-NP PA
	TECFIDERA DR 240 MG CAPSULE	PDL-NP PA
	TECFIDERA STARTER PACK	PDL-NP PA
VUMERITY DR 231 MG CAPSULE	PDL-NP PA	
Multiple Sclerosis Agent - Potassium Channel Blocker	DALFAMPRIDINE ER 10 MG TABLET	AGE PA QL
	FIRDAPSE 10 MG TABLET #	
Multiple Sclerosis Agent - Purine Nucleoside Analogs	CLADRIBINE 10 MG X 10 TAB PK	PDL-NP PA
	CLADRIBINE 10 MG X 4 TABLET PK	PDL-NP PA
	CLADRIBINE 10 MG X 5 TABLET PK	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Multiple Sclerosis Agent - Purine Nucleoside Analogs	CLADRIBINE 10 MG X 6 TABLET PK	PDL-NP PA
	CLADRIBINE 10 MG X 7 TABLET PK	PDL-NP PA
	CLADRIBINE 10 MG X 8 TABLET PK	PDL-NP PA
	CLADRIBINE 10 MG X 9 TABLET PK	PDL-NP PA
	MAVENCLAD 10 MG X 10 TABLET PK	PDL-NP PA
	MAVENCLAD 10 MG X 4 TABLET PK	PDL-NP PA
	MAVENCLAD 10 MG X 5 TABLET PK	PDL-NP PA
	MAVENCLAD 10 MG X 6 TABLET PK	PDL-NP PA
	MAVENCLAD 10 MG X 7 TABLET PK	PDL-NP PA
	MAVENCLAD 10 MG X 8 TABLET PK	PDL-NP PA
	MAVENCLAD 10 MG X 9 TABLET PK	PDL-NP PA
Multiple Sclerosis Agent - Pyrimidine Synthesis Inhibitors	AUBAGIO 14 MG TABLET	PDL-NP PA
	AUBAGIO 7 MG TABLET	PDL-NP PA
	TERIFLUNOMIDE 14 MG TABLET	*PDL-P
	TERIFLUNOMIDE 7 MG TABLET	*PDL-P
Multiple Sclerosis Agent - Sphingosine 1-phosphate receptor modulator	FINGOLIMOD 0.5 MG CAPSULE	*PDL-P
	GILENYA 0.25 MG CAPSULE	PDL-NP PA
	GILENYA 0.5 MG CAPSULE	PDL-NP PA
	MAYZENT 0.25 MG STARTER PACK	PDL-NP PA
	MAYZENT 0.25 MG TABLET	PDL-NP PA
	MAYZENT 0.25MG START-1MG MAINT	PDL-NP PA
	MAYZENT 1 MG TABLET	PDL-NP PA
	MAYZENT 2 MG TABLET	PDL-NP PA
	PONVORY 14-DAY STARTER PACK	PDL-NP AGE PA
	PONVORY 20 MG TABLET	PDL-NP AGE PA
	TASCENSO ODT 0.25 MG TABLET	PDL-NP AGE PA
	TASCENSO ODT 0.5 MG TABLET	PDL-NP AGE PA
	ZEPOSIA 0.92 MG CAPSULE	PDL-NP AGE PA
ZEPOSIA STARTER KIT (28-DAY)	PDL-NP AGE PA	
ZEPOSIA STARTER PACK (7-DAY)	PDL-NP AGE PA	
Multiple Vitamins and Mineral Combinations	A THRU Z SELECT 50+ FORMULA TB *	
	A THRU Z SELECT MEN 50+ TABLET *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Multiple Vitamins and Mineral Combinations	A THRU Z SELECT MULTIVIT TAB *	
	A THRU Z SELECT TABLET *	
	ABC PLUS TABLET *	
	BACMIN CAPLET	
	CENTRUM SILVER WOMEN TABLET *	
	CENTURY ADULTS 50+ TABLET *	
	CENTURY TABLET *	
	CENTURY ULTIMATE MEN'S TABLET *	
	CENTURY ULTIMATE WOMEN'S TAB *	
	CERTAVITE SENIOR TABLET *	
	CERTAVITE SR-ANTIOXIDANT TAB *	
	CVS SPECTRAVITE ULTRA MEN TAB *	
	CVS SPECTRAVITE ULTRA MEN'S TB *	
	CVS SPECTRAVITE WOMEN'S TABLET *	
	DIALYVITE 5000 TABLET	
	EQ COMPLETE MULTIVITAMIN TAB *	
	GNP CENTURY MATURE TABLET *	
	GNP MEGA MULTI FOR MEN TABLET *	
	GNP MEGA MULTI FOR WOMEN TAB *	
	GNP ONE DAILY TABLET *	
	GNP THERAPEUTIC-M CAPLET *	
	HM COMPLETE 50+ TABLET *	
	HM ULTIMATE MEN'S COMPLETE TAB *	
	HM ULTIMATE WOMEN'S 50+ TABLET *	
	ICAPS MV TABLET *	
	MEGA MULTI FOR MEN TABLET *	
	MEGA MULTI FOR WOMEN TAB *	
	ONE DAILY FOR MEN TABLET *	
	ONE DAILY MEN'S HEALTH TABLET *	
	ONE DAILY TABLET *	
ONE-A-DAY TEEN ADVANTAGE TAB *		
PRORENAL QD SOFTGEL *		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Multiple Vitamins and Mineral Combinations	QC MEN'S DAILY MULTIVIT-MIN TB *	
	RA CENTRAL-VITE WOMEN'S TABLET *	
	SENTRY SENIOR TABLET *	
	SM COMPLETE 50+ TABLET *	
	SM COMPLETE SENIOR FORMULA TAB *	
	SM ULTIMATE MEN'S COMPLETE TAB *	
	SM ULTIMATE WOMEN'S 50+ TABLET *	
	SUPER THERA VITE M TABLET *	
	TAB-A-VITE MULTIVIT WITH IRON *	
	THERA M PLUS TABLET *	
	THERA-M CAPLET *	
	THERA-M TABLET *	
	THERAPEUTIC-M CAPLET *	
	V-C FORTE CAPSULE	
	VIC-FORTE CAPSULE	
VITAMIN AND MINERALS TABLET *		
Multivitamin Preparations	DEKAS ESSENTIAL CAPSULE *	Covered for CSHCS Only
	DEKAS ESSENTIAL LIQUID *	Covered for CSHCS Only
	DEKAS PLUS CHEWABLE TABLET *	Covered for CSHCS Only
	DEKAS PLUS SOFTGEL *	Covered for CSHCS Only
Multivitamins	A THRU Z ADVANCED FORMULA TAB *	
	CENTRUM ADULTS TABLET *	
	CENTURY TABLET *	
	CENTURY ULTIMATE WOMEN'S TAB *	
	CEROVITE ADVANCED FORM TAB *	
	CERTAVITE-ANTIOXIDANT TABLET *	
	CVS SPECTRAVITE ADVANCED TAB *	
	CVS SPECTRAVITE ULTRA WOMEN TB *	
	DAILY MULTIPLE TABLET *	
	DAILY MULTIVITAMIN-IRON TABLET *	
	DAILY VIT FORMULA + IRON TAB *	
	DAILY-VITE TABLET *	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Multivitamins	EQ COMPLETE MULTIVITAMIN TAB *	
	ESSENTIA TABLET *	
	GNP ONE DAILY MEN'S 50+ TABLET *	
	HM COMPLETE MULTI-VIT-MINERAL *	
	MULTI COMPLETE-IRON TABLET *	
	MULTI-DAY PLUS IRON TABLET *	
	MULTI-VITAMIN DAILY TABLET *	
	ONCOVITE TABLET *	
	ONE DAILY ESSENTIAL TABLET *	
	ONE DAILY FOR MEN 50+ ADV TAB *	
	ONE DAILY MEN'S 50+ TABLET *	
	ONE DAILY MULTIVITAMIN-IRON TB *	
	ONE DAILY PLUS IRON TABLET *	
	ONE-A-DAY TEEN ADVANTAGE TAB *	
	QUINTABS TABLET *	
	RA CENTRAL-VITE TABLET *	
	RA ONE DAILY WOMEN'S TABLET *	
	SENTRY TABLET *	
	SM COMPLETE MULTI-VIT-MINERAL *	
	TAB-A-VITE TABLET *	
	THERA CAPLET *	
THERA TABLET *		
THERA-TABS TABLET *		
THEREMS TABLET *		
TM-DAILY VITE TABLET *		
YELETS TABLET *		
Mu-Opioid Receptor Antagonists, Peripherally-Acting	MOVANTIK 12.5 MG TABLET	PDL-NP PA
	MOVANTIK 25 MG TABLET	PDL-NP PA
	RELISTOR 12 MG/0.6 ML SYRINGE	PDL-NP PA
	RELISTOR 12 MG/0.6 ML VIAL	PDL-NP PA
	RELISTOR 150 MG TABLET	PDL-NP PA
	RELISTOR 8 MG/0.4 ML SYRINGE	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Mu-Opioid Receptor Antagonists, Peripherally-Acting	SYMPROIC 0.2 MG TABLET	PDL-NP PA
Muscular Dystrophy - Histone Deacetylase Inhibitors	DUVYZAT 8.86 MG/ML ORAL SUSP #	
Narcolepsy & Cataplexy Therapy Agents - Sedative-Type	SODIUM OXYBATE 0.5 G/ML SOLN	AGE PA QL
	XYWAV 0.5 GM/ML ORAL SOLUTION	AGE PA QL
Narcolepsy Therapy Agents - Dopamine and NE Reuptake Inhibitor (DNRI)	SUNOSI 150 MG TABLET #	
	SUNOSI 75 MG TABLET #	
Narcolepsy Therapy Agents - H3-Receptor Antagonist/Inverse Agonist	WAKIX 17.8 MG TABLET #	
	WAKIX 4.45 MG TABLET #	
Narcolepsy Therapy Agents - Non-Sympathomimetic	MODAFINIL 100 MG TABLET #	
	MODAFINIL 200 MG TABLET #	
	NUVIGIL 150 MG TABLET #	
	NUVIGIL 200 MG TABLET #	
	NUVIGIL 250 MG TABLET #	
	NUVIGIL 50 MG TABLET #	
	PROVIGIL 100 MG TABLET #	
Narcotic Antagonists	PROVIGIL 200 MG TABLET #	
	KLOXXADO 8 MG NASAL SPRAY	QL
	NALOXONE 0.4 MG/ML VIAL	
	NALOXONE 2 MG/2 ML SYRINGE	
	NALOXONE 4 MG/10 ML VIAL	
	NALOXONE HCL 4 MG NASAL SPRAY	
	NALOXONE HCL 4 MG NASAL SPRAY	
	NALTREXONE 50 MG TABLET #	
	NARCAN 4 MG NASAL SPRAY	
	NARCAN 4 MG NASAL SPRAY *	
	OPVEE 2.7 MG NASAL SPRAY	QL
	REXTOVY 4 MG NASAL SPRAY	
	ZIMHI 5 MG/0.5 ML SYRINGE	QL
Nasal Anticholinergics	IPRATROPIUM 0.03% SPRAY	*PDL-P
	IPRATROPIUM 0.06% SPRAY	*PDL-P
Nasal Antihistamine and Anti-inflammatory Steroid Combinations	AZELASTIN-FLUTIC 137-50MCG SPR	PDL-NP PA
	AZELASTIN-FLUTIC 137-50MCG SPR	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Nasal Antihistamine and Anti-inflammatory Steroid Combinations	DYMISTA NASAL SPRAY	PDL-NP PA
	DYMISTA NASAL SPRAY	PDL-NP PA
Nasal Antihistamines	AZELASTINE 0.1% (137 MCG) SPRY	*PDL-P
	AZELASTINE 0.15% NASAL SPRAY	*PDL-P
	OLOPATADINE 665 MCG NASAL SPRY	PDL-NP PA
	RYALTRIS 665-25 MCG SPRAY	PDL-NP PA
Nasal Corticosteroids	24H NASAL ALLERGY 55 MCG SPRAY	PDL-NP PA
	ALLERGY RELIEF 50 MCG SPRAY	PDL-NP PA
	BECONASE AQ 0.042% SPRAY	PDL-NP PA
	BUDESONIDE 32 MCG NASAL SPRAY	PDL-NP PA
	CHILD FLONASE ALLER RLF 50 MCG	PDL-NP PA
	FLUNISOLIDE 0.025% SPRAY	PDL-NP PA
	FLUTICASONE PROP 50 MCG SPRAY	*PDL-P
	GS NASAL ALLERGY 24HR SPRAY	PDL-NP PA
	MOMETASONE FUROATE 50 MCG SPRY	PDL-NP PA
	MOMETASONE FUROATE 50 MCG SPRY	PDL-NP PA
	NASAL ALLERGY 24HR SPRAY	PDL-NP PA
	NASONEX 24HR ALLERGY 50MCG SPR *	PDL-NP PA
	OMNARIS 50 MCG NASAL SPRAY	PDL-NP PA
	QC ALLERGY RELIEF 50 MCG SPRAY	PDL-NP PA
	QNASL 80 MCG NASAL SPRAY	PDL-NP PA
	QNASL CHILDREN'S 40 MCG SPRAY	PDL-NP PA
	RYALTRIS 665-25 MCG SPRAY	PDL-NP PA
	SM ALLERGY RELIEF 50 MCG SPRAY	PDL-NP PA
	TRIAMCINOLONE 55 MCG NASAL SPR	PDL-NP PA
	XHANCE 93 MCG NASAL SPRAY	PDL-NP PA
ZETONNA 37 MCG NASAL SPRAY	PDL-NP PA	
Nasal Mast Cell Stabilizers	CROMOLYN SODIUM NASAL SPRAY *	
	NASALCROM 5.2 MG NASAL SPRAY *	
Neuroactive Steroid GABA-A Receptor Modulator	ZTALMY 50 MG/ML SUSPENSION #	
Neuropathic Agents	LYRICA CR 165 MG TABLET #	
	LYRICA CR 330 MG TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Neuropathic Agents	LYRICA CR 82.5 MG TABLET #	
NMDA Receptor Antagonist and NDRI Comb	AUVELITY ER 45-105 MG TABLET #	
Non-Cardiac Selective Beta Blocker-Thiazide Diuretic & Related Comb.	PROPRANOLOL-HCTZ 40-25 MG TAB	PDL-NP PA
	PROPRANOLOL-HCTZ 80-25 MG TAB	PDL-NP PA
Non-Systemic Ileal Bile Acid Transport Inhibitor	BYLVAY 1,200 MCG CAPSULE #	
	BYLVAY 200 MCG PELLETT #	
	BYLVAY 400 MCG CAPSULE #	
	BYLVAY 600 MCG PELLETT #	
	LIVMARLI 9.5 MG/ML ORAL SOLN #	
NSAID Analgesic & Histamine H2 Receptor Antagonist Combinations	IBUPROFEN-FAMOTIDIN 800-26.6MG	PDL-NP PA
NSAID Analgesic & Prostaglandin Analog Combinations	ARTHROTEC 50 MG-200 MCG TAB	PDL-NP PA
	ARTHROTEC 75 MG-200 MCG TAB	PDL-NP PA
	DICLOFENAC-MISOPROST 50-0.2 MG	PDL-NP PA
	DICLOFENAC-MISOPROST 50-0.2 MG	PDL-NP PA
	DICLOFENAC-MISOPROST 75-0.2 MG	PDL-NP PA
	DICLOFENAC-MISOPROST 75-0.2 MG	PDL-NP PA
NSAID Analgesic & Proton Pump Inhibitor Combinations	NAPROXEN-ESOMEPRAZ DR 375-20MG	PDL-NP PA
	NAPROXEN-ESOMEPRAZ DR 500-20MG	PDL-NP PA
	VIMOVO DR 500-20 MG TABLET	PDL-NP PA
NSAID Analgesic and Non-Salicylate Analgesic Combination	GS DUAL ACTION PAIN 250-125 MG *	PDL-NP PA
NSAID Analgesic, Cyclooxygenase-2 (COX-2) Selective Inhibitors	CELEBREX 100 MG CAPSULE	PDL-NP PA QL
	CELEBREX 200 MG CAPSULE	PDL-NP PA QL
	CELEBREX 400 MG CAPSULE	PDL-NP PA QL
	CELEBREX 50 MG CAPSULE	PDL-NP PA QL
	CELECOXIB 100 MG CAPSULE	*PDL-P QL
	CELECOXIB 200 MG CAPSULE	*PDL-P QL
	CELECOXIB 400 MG CAPSULE	*PDL-P QL
	CELECOXIB 50 MG CAPSULE	*PDL-P QL
NSAID Analgesics (COX Non-Specific) - Anthranilic Acid Derivatives	MECLOFENAMATE 100 MG CAPSULE	PDL-NP PA
	MECLOFENAMATE 50 MG CAPSULE	PDL-NP PA
	MEFENAMIC ACID 250 MG CAPSULE	PDL-NP PA
NSAID Analgesics (COX Non-Specific) - Other	KETOROLAC 10 MG TABLET	*PDL-P QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
NSAID Analgesics (COX Non-Specific) - Other	NABUMETONE 500 MG TABLET	*PDL-P
	NABUMETONE 750 MG TABLET	*PDL-P
	RELAFEN DS 1,000 MG TABLET	PDL-NP PA
	SULINDAC 150 MG TABLET	*PDL-P
	SULINDAC 200 MG TABLET	*PDL-P
	TOLECTIN 600 MG TABLET	PDL-NP PA
	TOLMETIN SODIUM 400 MG CAP	PDL-NP PA
	TOLMETIN SODIUM 600 MG TAB	PDL-NP PA
NSAID Analgesics (COX Non-Specific) - Oxicam Derivatives	FELDENE 10 MG CAPSULE	PDL-NP PA
	MELOXICAM 10 MG CAPSULE	PDL-NP PA
	MELOXICAM 15 MG TABLET	*PDL-P
	MELOXICAM 5 MG CAPSULE	PDL-NP PA
	MELOXICAM 7.5 MG TABLET	*PDL-P
	PIROXICAM 10 MG CAPSULE	PDL-NP PA
	PIROXICAM 20 MG CAPSULE	PDL-NP PA
NSAID Analgesics (COX Non-Specific) - Phenylacetic Acid Derivatives	DICLOFENAC POT 25 MG TABLET	PDL-NP PA
	DICLOFENAC POT 50 MG TABLET	PDL-NP PA
	DICLOFENAC POTASSIUM 25 MG CAP	PDL-NP PA
	DICLOFENAC SOD DR 25 MG TAB	*PDL-P
	DICLOFENAC SOD DR 50 MG TAB	*PDL-P
	DICLOFENAC SOD DR 75 MG TAB	*PDL-P
	DICLOFENAC SOD EC 25 MG TAB	*PDL-P
	DICLOFENAC SOD EC 50 MG TAB	*PDL-P
	DICLOFENAC SOD EC 75 MG TAB	*PDL-P
	DICLOFENAC SOD ER 100 MG TAB	PDL-NP PA
	LOFENA 25 MG TABLET	PDL-NP PA
NSAID Analgesics (COX Non-Specific) - Propionic Acid Derivatives	ALL DAY PAIN RLF 220 MG CAPLET	*PDL-P
	ALL DAY RELIEF 220 MG CAPLET	*PDL-P
	ALL DAY RELIEF 220 MG TABLET	*PDL-P
	DAYPRO 600 MG CAPLET	PDL-NP PA
	FENOPROFEN 400 MG CAPSULE	PDL-NP PA
	FENOPROFEN 600 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
NSAID Analgesics (COX Non-Specific) - Propionic Acid Derivatives	FLURBIPROFEN 100 MG TABLET	PDL-NP PA
	GNP IBUPROFEN 100 MG CHEW TAB	*PDL-P
	GS CHILD IBUPROFEN 100 MG/5 ML	*PDL-P
	GS CHILD IBUPROFEN 100 MG/5 ML	*PDL-P
	GS IBUPROFEN 200 MG CAPLET	*PDL-P
	GS IBUPROFEN 200 MG CAPLET	*PDL-P
	GS IBUPROFEN 200 MG TABLET	*PDL-P
	GS IBUPROFEN 200 MG TABLET	*PDL-P
	GS NAPROXEN SOD 220 MG CAPLET	*PDL-P
	GS NAPROXEN SOD 220 MG TABLET	*PDL-P
	HM IBUPROFEN 200 MG SOFTGEL	*PDL-P
	IBU 400 MG TABLET	*PDL-P
	IBU 600 MG TABLET	*PDL-P
	IBU 800 MG TABLET	*PDL-P
	IBU-200 200 MG TABLET	*PDL-P
	IBUPROFEN 100 MG/5 ML SUSP	*PDL-P
	IBUPROFEN 200 MG CAPSULE	*PDL-P
	IBUPROFEN 200 MG SOFTGEL	*PDL-P
	IBUPROFEN 200 MG/10ML SUSP CUP	*PDL-P
	IBUPROFEN 300 MG TABLET	PDL-NP PA
	IBUPROFEN 400 MG TABLET	*PDL-P
	IBUPROFEN 600 MG TABLET	*PDL-P
	IBUPROFEN 800 MG TABLET	*PDL-P
	IBUPROFEN JR STR 100 MG TB CHW	*PDL-P
	INFANT IBUPROFEN 50 MG/1.25 ML	*PDL-P
	KETOPROFEN 50 MG CAPSULE	PDL-NP PA
	KETOPROFEN 75 MG CAPSULE	PDL-NP PA
	KETOPROFEN ER 200 MG CAPSULE	PDL-NP PA
	KIPROFEN 25 MG CAPSULE	PDL-NP PA
	NALFON 400 MG CAPSULE	PDL-NP PA
	NALFON 600 MG TABLET	PDL-NP PA
	NAPRELAN CR 375 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
NSAID Analgesics (COX Non-Specific) - Propionic Acid Derivatives	NAPRELAN CR 500 MG TABLET	PDL-NP PA
	NAPRELAN CR 750 MG TABLET	PDL-NP PA
	NAPROSYN 125 MG/5 ML SUSPEN	PDL-NP PA
	NAPROXEN 125 MG/5 ML SUSPEN	PDL-NP PA
	NAPROXEN 250 MG TABLET	*PDL-P
	NAPROXEN 375 MG TABLET	*PDL-P
	NAPROXEN 500 MG TABLET	*PDL-P
	NAPROXEN DR 375 MG TABLET	PDL-NP PA
	NAPROXEN DR 375 MG TABLET	PDL-NP PA
	NAPROXEN DR 500 MG TABLET	PDL-NP PA
	NAPROXEN DR 500 MG TABLET	PDL-NP PA
	NAPROXEN SOD CR 375 MG TABLET	PDL-NP PA
	NAPROXEN SOD CR 500 MG TABLET	PDL-NP PA
	NAPROXEN SOD ER 375 MG TABLET	PDL-NP PA
	NAPROXEN SOD ER 500 MG TABLET	PDL-NP PA
	NAPROXEN SODIUM 220 MG CAPLET	*PDL-P
	NAPROXEN SODIUM 220 MG CAPSULE	*PDL-P
	NAPROXEN SODIUM 220 MG TABLET	*PDL-P
	NAPROXEN SODIUM 275 MG TAB	PDL-NP PA
	NAPROXEN SODIUM 550 MG TAB	PDL-NP PA
	OXAPROZIN 600 MG CAPLET	PDL-NP PA
	OXAPROZIN 600 MG TABLET	PDL-NP PA
	QC IBUPROFEN 200 MG CAPLET	*PDL-P
	QC IBUPROFEN 200 MG TABLET	*PDL-P
	SM IBUPROFEN 200 MG CAPLET	*PDL-P
	SM IBUPROFEN 200 MG SOFTGEL	*PDL-P
SM IBUPROFEN 200 MG TABLET	*PDL-P	
SM IBUPROFEN IB 100 MG CHEW TB	*PDL-P	
SM INFANT IBUPROFEN SUSP DROP	*PDL-P	
SM NAPROXEN SOD 220 MG CAPLET	*PDL-P	
NSAID Analgesics, (COX Non-specific) - Indole Acetic Acid Derivatives	ETODOLAC 200 MG CAPSULE	PDL-NP PA
	ETODOLAC 300 MG CAPSULE	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
NSAID Analgesics, (COX Non-specific) - Indole Acetic Acid Derivatives	ETODOLAC 400 MG TABLET	PDL-NP PA
	ETODOLAC 500 MG TABLET	PDL-NP PA
	ETODOLAC ER 400 MG TABLET	PDL-NP PA
	ETODOLAC ER 500 MG TABLET	PDL-NP PA
	ETODOLAC ER 600 MG TABLET	PDL-NP PA
	INDOMETHACIN 25 MG CAPSULE	*PDL-P
	INDOMETHACIN 25 MG/5 ML SUSP	PDL-NP PA
	INDOMETHACIN 50 MG CAPSULE	*PDL-P
	INDOMETHACIN ER 75 MG CAPSULE	PDL-NP PA
Nuclear Factor Erythroid 2-REL. Factor 2 Activator	SKYCLARYS 50 MG CAPSULE #	
Ophthalmic - Adrenergic-Carbonic Anhydrase Inhibitor Combinations	SIMBRINZA 1%-0.2% EYE DROPS	*PDL-P
Ophthalmic - Antibacterial-Glucocorticoid Combinations	NEO-BACIT-POLY-HC EYE OINTMENT	
	NEOMYC-POLYM-DEXAMET EYE OINTM	
	NEOMYC-POLYM-DEXAMETH EYE DROP	
	SULF-PRED 10-0.23% EYE DROPS	
	SULF-PRED 10-0.25% EYE DROPS	
	TOBRAMYCIN-DEXAMETH OPHTH SUSP	
Ophthalmic - Anticholinergics	ATROPINE 1% EYE DROPS	
	ATROPINE 1% EYE OINTMENT	
	CYCLOPENTOLATE 1% EYE DROPS	
	CYCLOPENTOLATE HCL 2% DROPS	
	TROPICAMIDE 0.5% EYE DROPS	
	TROPICAMIDE 1% EYE DROPS	
Ophthalmic - Antihistamine-Decongestant Combinations	CVS EYE ALLERGY RELIEF EYE DRP *	
	EYE ALLERGY RELIEF DROPS *	
	NAPHCON-A EYE DROPS *	
	VISINE-A EYE ALLERGY DROPS *	
Ophthalmic - Antihistamines	ALAWAY 0.025% EYE DROPS	*PDL-P
	ALCAFTADINE 0.25% EYE DROP	PDL-NP PA
	AZELASTINE HCL 0.05% DROPS	*PDL-P
	BEPOTASTINE 1.5% EYE DROP	PDL-NP PA
	BEPREVE 1.5% EYE DROPS	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Ophthalmic - Antihistamines	CHILD'S ALAWAY 0.025% EYE DROP	*PDL-P
	EPINASTINE HCL 0.05% EYE DROPS	PDL-NP PA
	EYE ITCH RELIEF 0.025% DROPS	*PDL-P
	KETOTIFEN FUM 0.025% EYE DROPS	*PDL-P
	KETOTIFEN FUM 0.035% EYE DROPS	*PDL-P
	LASTACAPT ONCE DAILY 0.25% DRP	PDL-NP PA
	OLOPATADINE HCL 0.1% EYE DROPS	*PDL-P
	OLOPATADINE HCL 0.1% EYE DROPS	PDL-NP PA
	OLOPATADINE HCL 0.2% EYE DROP	*PDL-P
	OLOPATADINE HCL 0.2% EYE DROP	PDL-NP PA
	PATADAY ONCE DAILY 0.2% DROPS	PDL-NP PA
	PATADAY ONCE DAILY 0.7% DROPS	PDL-NP PA
	PATADAY TWICE DAILY 0.1% DROPS	PDL-NP PA
	ZADITOR 0.025% (0.035%) DROPS	PDL-NP PA
	ZERVIATE 0.24% EYE DROP	PDL-NP PA
Ophthalmic - Anti-inflammatory, Glucocorticoids	ALREX 0.2% EYE DROPS	PDL-NP PA
	DEXAMETHASONE 0.1% EYE DROP	
	EYSUVIS 0.25% EYE DROPS	PDL-NP PA QL
	FLUOROMETHOLONE 0.1% EYE DROP	QL
	LOTEPREDNOL ETABONATE 0.2% DRP	PDL-NP PA
	PREDNISOLONE AC 1% EYE DROP	
Ophthalmic - Anti-inflammatory, Immunomodulators	PREDNISOLONE SOD 1% EYE DROP	
	CEQUA 0.09% SOLUTION	PDL-NP PA QL
	CYCLOSPORINE 0.05% EYE EMULS	PDL-NP PA QL
	RESTASIS 0.05% EYE EMULSION	*PDL-P QL
	RESTASIS MULTIDOSE 0.05% EYE	PDL-NP PA QL
	VERKAZIA 0.1% EYE EMULSION	PDL-NP AGE PA QL
Ophthalmic - Anti-inflammatory, NSAIDs	VEVYE 0.1% EYE DROP	PDL-NP AGE PA QL
	ACULAR 0.5% EYE DROPS	PDL-NP PA
	ACULAR LS 0.4% OPHTH SOL	PDL-NP PA
	ACUVAIL 0.45% OPHTH SOLUTION	PDL-NP PA
	BROMFENAC SOD 0.075% EYE DROP	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Ophthalmic - Anti-inflammatory, NSAIDs	BROMFENAC SODIUM 0.07% EYE DRP	PDL-NP PA
	BROMFENAC SODIUM 0.09% EYE DRP	PDL-NP PA
	BROMSITE 0.075% EYE DROPS	PDL-NP PA
	DICLOFENAC 0.1% EYE DROPS	*PDL-P
	FLURBIPROFEN 0.03% EYE DROP	*PDL-P
	ILEVRO 0.3% OPHTH DROPS	PDL-NP PA
	KETOROLAC 0.4% OPHTH SOLUTION	PDL-NP PA
	KETOROLAC 0.5% OPHTH SOLUTION	*PDL-P
	NEVANAC 0.1% EYE DROP	PDL-NP PA
	PROLENSA 0.07% EYE DROPS	PDL-NP PA
Ophthalmic - Beta blockers-Adrenergic Combinations	BRIMONIDINE-TIMOLOL 0.2%-0.5%	PDL-NP PA
	COMBIGAN 0.2%-0.5% EYE DROPS	*PDL-P
Ophthalmic - Beta blockers-Carbonic Anhydrase Inhibitor Combinations	COSOPT EYE DROPS	PDL-NP PA
	COSOPT PF EYE DROPS	PDL-NP PA
	DORZOLAMIDE-TIMOLOL 2%-0.5%	PDL-NP PA
	DORZOLAMIDE-TIMOLOL EYE DROPS	*PDL-P
Ophthalmic - Carbonic Anhydrase Inhibitors	AZOPT 1% EYE DROPS	PDL-NP PA
	BRINZOLAMIDE 1% EYE DROPS	*PDL-P
	DORZOLAMIDE HCL 2% EYE DROPS	*PDL-P
Ophthalmic - Decongestants	PHENYLEPHRINE 2.5% EYE DROP	
Ophthalmic - Human Nerve Growth Factor (hNGF)	OXERVATE 0.002% EYE DROP	AGE PA QL
Ophthalmic - Hyperosmolar Agents	CVS SODIUM CHLORIDE 5% OINT *	
	SODIUM CHLORIDE 5% EYE DROP *	
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-blockers	BETAXOLOL HCL 0.5% EYE DROP	PDL-NP PA
	BETIMOL 0.25% EYE DROPS	PDL-NP PA
	BETIMOL 0.5% EYE DROPS	PDL-NP PA
	BETOPTIC S 0.25% EYE DROP	*PDL-P
	CARTEOLOL HCL 1% EYE DROPS	*PDL-P
	ISTALOL 0.5% EYE DROPS	PDL-NP PA
	LEVOBUNOLOL 0.5% EYE DROPS	PDL-NP PA
	TIMOLOL 0.25% GEL-SOLUTION	*PDL-P
	TIMOLOL 0.5% EYE DROP	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-blockers	TIMOLOL 0.5% EYE DROPS	PDL-NP PA
	TIMOLOL 0.5% GEL-SOLUTION	*PDL-P
	TIMOLOL 0.5% GFS GEL-SOLUTION	*PDL-P
	TIMOLOL MALEATE 0.25% EYE DROP	PDL-NP PA
	TIMOLOL MALEATE 0.25% EYE DROP	*PDL-P
	TIMOLOL MALEATE 0.5% EYE DROP	PDL-NP PA
	TIMOLOL MALEATE 0.5% EYE DROPS	*PDL-P
	TIMOPTIC 0.25% OCUDOSE DROP	PDL-NP PA
	TIMOPTIC 0.5% OCUDOSE DROP	PDL-NP PA
	TIMOPTIC-XE 0.25% EYE GEL-SOLN	PDL-NP PA
	TIMOPTIC-XE 0.5% GEL-SOLUTION	PDL-NP PA
Ophthalmic - Local Anesthetic Esters	PROPARACAINE 0.5% EYE DROPS	
Ophthalmic - Mast Cell Stabilizers	ALOMIDE 0.1% EYE DROPS	PDL-NP PA
	CROMOLYN 4% EYE DROPS	*PDL-P
Ophthalmic - Rho Kinase Inhibitor and Prostaglandin Analog Combination	ROCKLATAN 0.02%-0.005% EYE DRP	*PDL-P
Ophthalmic - selective cholinergic agonist	TYRVAYA 0.03 MG NASAL SPRAY	PDL-NP PA QL
Ophthalmic Antibacterial Mixtures	BACITRACIN-POLYMYXIN EYE OINT	
	NEOMYC-BACIT-POLYMIX EYE OINT	
	NEOMYC-POLYM-GRAMICID EYE DROP	
	POLYMYXIN B-TMP EYE DROPS	
Ophthalmic Antibiotic - Aminoglycosides	GENTAMICIN 0.3% EYE DROP	
	TOBRAMYCIN 0.3% EYE DROP	
Ophthalmic Antibiotic - Dehydropeptidase Inhibitors	BACITRACIN 500 UNIT/GM OPHTH	
Ophthalmic Antibiotic - Fluoroquinolones	BESIFLOXACIN 0.6% EYE DROP	PDL-NP PA
	BESIVANCE 0.6% SUSP	PDL-NP PA
	CILOXAN 0.3% OINTMENT	PDL-NP PA
	CIPROFLOXACIN 0.3% EYE DROP	*PDL-P
	GATIFLOXACIN 0.5% EYE DROPS	PDL-NP PA
	LEVOFLOXACIN 0.5% EYE DROP	PDL-NP PA
	MOXIFLOXACIN 0.5% EYE DROPS	*PDL-P
	MOXIFLOXACIN 0.5% EYE DRP-VISC	PDL-NP PA
	OCUFLOX 0.3% EYE DROPS	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Ophthalmic Antibiotic - Fluoroquinolones	OFLOXACIN 0.3% EYE DROPS	*PDL-P
	VIGAMOX 0.5% EYE DROPS	PDL-NP PA
Ophthalmic Antibiotic - Macrolides	AZASITE 1% EYE DROPS	PDL-NP PA
	ERYTHROMYCIN 0.5% EYE OINTMENT	*PDL-P
Ophthalmic Antibiotic - Sulfonamides	SULFACETAMIDE 10% EYE DROPS	
	SULFACETAMIDE 10% EYE OINTMENT	
Ophthalmic Anti-Inflammatory Immunomodulator-Type	XIIDRA 5% EYE DROPS	*PDL-P QL
Ophthalmic Others	MIEBO 100% EYE DROP	PDL-NP AGE PA QL
	TRYPTYR 0.003% EYE DROP	PDL-NP PA QL
Ophthalmic-Intraocular Press. Reducing, Sel. Alpha Adrenergic Agonists	ALPHAGAN P 0.1% DROPS	PDL-NP PA
	ALPHAGAN P 0.15% EYE DROPS	PDL-NP PA
	APRACLONIDINE HCL 0.5% DROPS	*PDL-P
	BRIMONIDINE 0.2% EYE DROP	*PDL-P
	BRIMONIDINE TARTRATE 0.1% DROP	PDL-NP PA
	BRIMONIDINE TARTRATE 0.15% DRP	PDL-NP PA
	IOPIDINE 1% EYE DROPS	PDL-NP PA
Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs	BIMATOPROST 0.03% EYE DROPS	PDL-NP PA
	IYUZEH 0.005% EYE DROP	PDL-NP PA
	LATANOPROST 0.005% EYE DROPS	*PDL-P
	LUMIGAN 0.01% EYE DROPS	PDL-NP PA
	TAFLOPROST 0.0015% EYE DROP	PDL-NP PA
	TRAVATAN Z 0.004% EYE DROP	PDL-NP PA
	TRAVOPROST 0.004% EYE DROP	PDL-NP PA
	VYZULTA 0.024% OPHTH SOLUTION	PDL-NP PA
	XALATAN 0.005% EYE DROPS	PDL-NP PA
	XELPROS 0.005% EYE DROP	PDL-NP PA
	ZIOPTAN 0.0015% EYE DROPS	PDL-NP PA
Ophthalmic-Intraocular Pressure Reducing Agents, Rho Kinase Inhibitors	RHOPRESSA 0.02% OPHTH SOLUTION	*PDL-P
Otic - Anti-infective-Glucocorticoid Combinations	CIPRO HC OTIC SUSPENSION	PDL-NP PA
	CIPROFLOXACIN-HYDROCORT 0.2-1%	PDL-NP PA
	CIPROFLOX-DEXAMETH OTIC SUSP	*PDL-P
	NEOMYCIN-POLYMYXIN-HC EAR SOLN	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Otic - Anti-infective-Glucocorticoid Combinations	NEOMYCIN-POLYMYXIN-HC EAR SUSP	*PDL-P
Otic - Anti-infectives other	ACETIC ACID 2% EAR SOLUTION	
Otic - Fluoroquinolones	CIPROFLOXACIN 0.2% OTIC SOLN	PDL-NP PA
	OFLOXACIN 0.3% EAR DROPS	*PDL-P
Otic - Fluoroquinolones -Combination	CIPROFLOX-FLUOCINLN 0.3-0.025%	PDL-NP PA
Otic - Glucocorticoids	HYDROCORTISON-ACETIC ACID SOLN	
Overactive Bladder Agents - Beta -3 Adrenergic Receptor Agonist	GEMTESA 75 MG TABLET	PDL-NP PA
	MIRABEGRON ER 25 MG TABLET	PDL-NP PA
	MIRABEGRON ER 50 MG TABLET	PDL-NP PA
	MYRBETRIQ ER 25 MG TABLET	*PDL-P
	MYRBETRIQ ER 50 MG TABLET	*PDL-P
	MYRBETRIQ ER 8 MG/ML SUSP	*PDL-P
Oxalosis Agent - Oxalate Inhibitor, siRNA Based	RIVFLOZA 128 MG/0.8 ML SYRINGE #	
	RIVFLOZA 160 MG/ML SYRINGE #	
	RIVFLOZA 80 MG/0.5 ML VIAL #	
Oxazolidinone Antibiotics	LINEZOLID 100 MG/5 ML SUSP	PDL-NP PA
	LINEZOLID 600 MG TABLET	*PDL-P QL
	SIVEXTRO 200 MG TABLET	PDL-NP PA QL
	ZYVOX 100 MG/5 ML SUSPENSION	PDL-NP PA
	ZYVOX 600 MG TABLET	PDL-NP PA QL
Oxytocic - Ergot Alkaloids	METHYLERGONOVINE 0.2 MG TABLET	AGE QL
PAH Agents - Activin Signaling Inhibitor	WINREVAIR 45 MG ONE-VIAL KIT	PDL-NP AGE PA
	WINREVAIR 45 MG TWO-VIAL KIT	PDL-NP AGE PA
	WINREVAIR 60 MG ONE-VIAL KIT	PDL-NP AGE PA
	WINREVAIR 60 MG TWO-VIAL KIT	PDL-NP AGE PA
PAH Agents - Selective Prostacyclin Receptor (IP) Agonists	UPTRAVI 1,000 MCG TABLET	*PDL-P PA
	UPTRAVI 1,200 MCG TABLET	*PDL-P PA
	UPTRAVI 1,400 MCG TABLET	*PDL-P PA
	UPTRAVI 1,600 MCG TABLET	*PDL-P PA
	UPTRAVI 200 MCG TABLET	*PDL-P PA
	UPTRAVI 200-800 TITRATION PACK	*PDL-P PA
	UPTRAVI 400 MCG TABLET	*PDL-P PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
PAH Agents - Selective Prostacyclin Receptor (IP) Agonists	UPTRAVI 600 MCG TABLET	*PDL-P PA
	UPTRAVI 800 MCG TABLET	*PDL-P PA
PDE Inhibitor-Endothelin Receptor Antagonist Comb-Two Ingred	OPSYNVI 10-20 MG TABLET	PDL-NP AGE PA QL
	OPSYNVI 10-40 MG TABLET	PDL-NP AGE PA QL
Pediatric Vitamin Preparations	DEKAS PLUS LIQUID *	Covered for CSHCS Only
	MVW COMPLETE FORM MULTIVI SFGL *	Covered for CSHCS Only
	MVW COMPLETE FORMUL D3000 CHEW *	Covered for CSHCS Only
	MVW COMPLETE FORMUL D3000 CHEW *	Covered for CSHCS Only
	MVW COMPLETE FORMUL D5000 SFGL *	Covered for CSHCS Only
Pediatric Vitamins	COMPLETE FORMULATION PEDIATRIC *	Covered for CSHCS Only
	MVW COMPLETE FORM MULTIVI SFGL *	Covered for CSHCS Only
	MVW COMPLETE FORM MULTIVIT CHW *	Covered for CSHCS Only
	MVW COMPLETE FORM MULTIVIT CHW *	Covered for CSHCS Only
	MVW COMPLETE FORM MULTIVIT CHW *	Covered for CSHCS Only
	MVW COMPLETE FORMUL D3000 SFGL *	Covered for CSHCS Only
	NANO VM 1-3 POWDER *	Covered for CSHCS Only
Pediatric Vitamins and Mineral Combinations	NANOVM 9-18 POWDER *	Covered for CSHCS Only
	NANOVM T-F POWDER *	Covered for CSHCS Only
Pediatric Vitamins with Fluoride Combinations	MULTI-VIT W-FLUOR 0.25 MG/ML	AGE QL
	MULTIVIT-FLUOR 0.25 MG TAB CHW	AGE QL
	MULTIVIT-FLUOR 0.25 MG/ML DROP	AGE QL
	MULTIVIT-FLUOR 0.5 MG TAB CHEW	AGE QL
	MULTIVIT-FLUOR 0.5 MG/ML DROP	AGE QL
	MULTIVIT-FLUORIDE 1 MG TAB CHW	AGE QL
	MULTIVIT-FLUOR-IRON 0.25 MG/ML	AGE QL
	MULTIVIT-IRON-FL 0.25 MG/ML	AGE QL
	TRI-VIT-FLUOR 0.25 MG/ML DROP	AGE QL
	TRI-VIT-FLUOR 0.5 MG/ML DROP	AGE QL
Penicillin Antibiotic - Natural	PENICILLIN VK 125 MG/5 ML SOLN	
	PENICILLIN VK 250 MG TABLET	
	PENICILLIN VK 250 MG/5 ML SOLN	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Penicillin Antibiotic - Natural	PENICILLIN VK 500 MG TABLET	
Penicillin Antibiotic - Penicillinase-resistant	DICLOXACILLIN 250 MG CAPSULE	
	DICLOXACILLIN 500 MG CAPSULE	
Peptic Ulcer - Gastric Lumen Adherent Cytoprotectives	SUCRALFATE 1 GM TABLET	QL
Peptic Ulcer - Treatment of H. Pylori: Antibiotic-Bismuth Combinations	BISMUTH-METRO-TETR 140-125-125	PDL-NP PA
	PYLERA CAPSULE	*PDL-P
Peptic Ulcer - Treatment of H. Pylori: PCAB Combinations - Three Ingredient	VOQUEZNA TRIPLE PAK	PDL-NP PA
Peptic Ulcer - Treatment of H. Pylori: PCAB Combinations - Two Ingredient	VOQUEZNA DUAL PAK	PDL-NP PA
Peptic Ulcer-Treatment H. Pylori - Proton Pump Inhibitor & Antibiotics	LANSOPRAZOL-AMOXICIL-CLARITHRO	PDL-NP PA QL
	OMECLAMOX-PAK COMBO PACK	PDL-NP PA
	TALICIA DR 10-250-12.5 MG CAP	PDL-NP PA
Periodontal Product - Tetracycline-Type, Collagenase Inhibitors	DOXYCYCLINE HYCLATE 20 MG TAB	
Peripheral Alpha-1 Receptor Blockers	CARDURA 1 MG TABLET	PDL-NP PA
	CARDURA 2 MG TABLET	PDL-NP PA
	CARDURA 4 MG TABLET	PDL-NP PA
	CARDURA 8 MG TABLET	PDL-NP PA
	CARDURA XL 4 MG TABLET	PDL-NP PA
	CARDURA XL 8 MG TABLET	PDL-NP PA
	DOXAZOSIN MESYLATE 1 MG TAB	*PDL-P
	DOXAZOSIN MESYLATE 2 MG TAB	*PDL-P
	DOXAZOSIN MESYLATE 4 MG TAB	*PDL-P
	DOXAZOSIN MESYLATE 8 MG TAB	*PDL-P
	PRAZOSIN 1 MG CAPSULE	*PDL-P
	PRAZOSIN 2 MG CAPSULE	*PDL-P
	PRAZOSIN 5 MG CAPSULE	*PDL-P
	TERAZOSIN 1 MG CAPSULE	*PDL-P
	TERAZOSIN 10 MG CAPSULE	*PDL-P
	TERAZOSIN 2 MG CAPSULE	*PDL-P
	TERAZOSIN 5 MG CAPSULE	*PDL-P
	Pharmaceutical Adjuvant - Inhalation Vehicles	HYPER-SAL 7% VIAL
PULMOSAL 7% VIAL		Covered for CSHCS Only
SODIUM CHLORIDE 0.9% INHAL VL		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Pharmaceutical Adjuvant - Inhalation Vehicles	SODIUM CHLORIDE 7% VIAL	Covered for CSHCS Only
Pharmacoenhancer - Cytochrome P450 Inhibitors	TYBOST 150 MG TABLET #	
Pharmacological Chaperone Tx - alpha-galactosidase A enzyme stabilizer	GALAFOLD 123 MG CAPSULE #	
Phenylketonuria(PKU) Tx Agents - Cofactor of Phenylalanine Hydroxylase	KUVAN 100 MG POWDER PACKET #	
	KUVAN 100 MG TABLET #	
	KUVAN 500 MG POWDER PACKET #	
Phosphate Binders	AURYXIA 210 MG TABLET	PDL-NP PA
	CALCIUM ACETATE 667 MG CAPSULE	*PDL-P PA
	CALCIUM ACETATE 667 MG GELCAP	*PDL-P PA
	CALCIUM ACETATE 667 MG TABLET	*PDL-P PA
	FERRIC CITRATE 210 MG TABLET	PDL-NP PA
	FOSRENOL 1,000 MG POWDER PACK	PDL-NP PA
	FOSRENOL 1,000 MG TABLET CHEW	PDL-NP PA
	FOSRENOL 500 MG TABLET CHEW	PDL-NP PA
	FOSRENOL 750 MG POWDER PACKET	PDL-NP PA
	FOSRENOL 750 MG TABLET CHEW	PDL-NP PA
	LANTHANUM CARB 1,000 MG TB CHW	PDL-NP PA
	LANTHANUM CARB 500 MG TAB CHEW	PDL-NP PA
	LANTHANUM CARB 750 MG TAB CHEW	PDL-NP PA
	REVELA 0.8 GM POWDER PACKET	PDL-NP PA
	REVELA 2.4 GM POWDER PACKET	PDL-NP PA
	REVELA 800 MG TABLET	PDL-NP PA
	SEVELAMER 0.8 GM POWDER PACKET	PDL-NP PA
	SEVELAMER 2.4 GM POWDER PACKET	PDL-NP PA
	SEVELAMER CARBONATE 800 MG TAB	*PDL-P PA
	SEVELAMER HCL 400 MG TABLET	PDL-NP PA
	SEVELAMER HCL 800 MG TABLET	PDL-NP PA
	VELPHORO 500 MG CHEWABLE TAB	PDL-NP PA
XPHOZAH 20 MG TABLET	PDL-NP PA	
XPHOZAH 30 MG TABLET	PDL-NP PA	
Phosphodiesterase (PDE) Inhibitors	OHTUVAYRE 3 MG/2.5ML INHAL SUS	AGE PA QL
PIK3CA-Related Overgrowth Spectrum (PROS) Agents	VIJOICE 125 MG TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
PIK3CA-Related Overgrowth Spectrum (PROS) Agents	VIJOICE 250 MG DAILY DOSE PACK #	
	VIJOICE 50 MG TABLET #	
Plasma Fractions	OCTAPLAS BLOOD GROUP A IV BAG #	
	OCTAPLAS BLOOD GROUP AB IV BAG #	
	OCTAPLAS BLOOD GROUP B IV BAG #	
	OCTAPLAS BLOOD GROUP O IV BAG #	
	PLASMANATE 5% IV SOLUTION #	
Plasma Kallikrein Inhibitor Agents	EKTERLY 300 MG TABLET #	
	KALBITOR 10 MG/ML VIAL #	
	ORLADEYO 108 MG PELLETT PACKET #	
	ORLADEYO 110 MG CAPSULE #	
	ORLADEYO 132 MG PELLETT PACKET #	
	ORLADEYO 150 MG CAPSULE #	
	ORLADEYO 72 MG PELLETT PACKET #	
	ORLADEYO 96 MG PELLETT PACKET #	
Plasma Proteins Which Facilitate Anticoagulation	ATRYN 1,750 UNIT VIAL #	
	THROMBATE III 500 UNITS VIAL #	
Platelet Aggregation Inhib - Cyclopentyl-triazolo-pyrimidines (CPTPs)	BRILINTA 60 MG TABLET	*PDL-P
	BRILINTA 90 MG TABLET	*PDL-P
	TICAGRELOR 60 MG TABLET	PDL-NP PA
	TICAGRELOR 90 MG TABLET	PDL-NP PA
Platelet Aggregation Inhib - PDEsterase & Adenosine deaminase Inhibitor	DIPYRIDAMOLE 25 MG TABLET	PDL-NP PA
	DIPYRIDAMOLE 50 MG TABLET	PDL-NP PA
	DIPYRIDAMOLE 75 MG TABLET	PDL-NP PA
Platelet Aggregation Inhibitor Combinations	ASPIRIN-DIPYRIDAM ER 25-200 MG	PDL-NP PA
Platelet Aggregation Inhibitors - Phosphodiesterase III Inhibitors	CILOSTAZOL 100 MG TABLET	QL
	CILOSTAZOL 50 MG TABLET	QL
Platelet Aggregation Inhibitors - Quinazoline Agents	ANAGRELIDE HCL 0.5 MG CAPSULE	
	ANAGRELIDE HCL 1 MG CAPSULE	
Platelet Aggregation Inhibitors - Salicylates	ASPIRIN 81 MG CHEWABLE TABLET *	QL
	ASPIRIN EC 81 MG TABLET *	QL
	BAYER ASPIRIN 81 MG CHEW TAB *	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Platelet Aggregation Inhibitors - Salicylates	EQ ASPIRIN 81 MG CHEWABLE TAB *	QL
	GS ASPIRIN 81 MG CHEWABLE TAB *	QL
	HM ASPIRIN EC 81 MG TABLET *	QL
	KRO ASPIRIN 81 MG CHEWABLE TAB *	QL
	PUB ASPIRIN 81 MG CHEWABLE TAB *	QL
	RA ASPIRIN 81 MG CHEWABLE TAB *	QL
	SM ASPIRIN EC 81 MG TABLET *	QL
Platelet Aggregation Inhibitors - Thienopyridine Agents	CLOPIDOGREL 300 MG TABLET	*PDL-P QL
	CLOPIDOGREL 75 MG TABLET	*PDL-P QL
	EFFIENT 10 MG TABLET	PDL-NP AGE PA
	EFFIENT 5 MG TABLET	PDL-NP AGE PA
	PLAVIX 75 MG TABLET	PDL-NP PA QL
	PRASUGREL 10 MG TABLET	*PDL-P AGE
	PRASUGREL 5 MG TABLET	*PDL-P AGE
Postherpetic Neuralgia Agents	GABAPENTIN ER 300 MG TABLET	*PDL-P
	GABAPENTIN ER 600 MG TABLET	*PDL-P
	GABARONE 100 MG TABLET #	
	GABARONE 400 MG TABLET #	
	GRALISE ER 300 MG TABLET	*PDL-P
	GRALISE ER 450 MG TABLET	*PDL-P
	GRALISE ER 600 MG TABLET	*PDL-P
	GRALISE ER 750 MG TABLET	*PDL-P
	GRALISE ER 900 MG TABLET	*PDL-P
PPI - Potassium-Competitive Acid Blockers (P-CAB)	VOQUEZNA 10 MG TABLET	AGE PA QL
	VOQUEZNA 20 MG TABLET	AGE PA QL
Prenatal Vitamins and Minerals	CLASSIC PRENATAL TABLET *	AGE GENDER QL
	COMPLETE NATAL DHA	AGE QL
	COMPLETENATE TABLET CHEW	AGE GENDER QL
	HM PRENATAL TABLET *	AGE GENDER QL
	MARNATAL-F CAPSULE	AGE QL
	M-NATAL PLUS TABLET *	AGE GENDER QL
	NEO-VITAL RX TABLET	AGE QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Prenatal Vitamins and Minerals	NESTABS ABC PRENATAL COMBO PK	AGE QL
	NESTABS TABLET	AGE GENDER QL
	NEWGEN TABLET	AGE GENDER QL
	OB COMPLETE PREMIER TABLET	AGE QL
	OB COMPLETE WITH DHA SOFTGEL	AGE QL
	ONE NATAL RX PRENATAL TABLET	AGE QL
	PNV PRENATAL PLUS MULTIVIT TAB	AGE GENDER QL
	PNV-DHA SOFTGEL	AGE QL
	PNV-SELECT TABLET	AGE QL
	PRENATAL PLUS TABLET	AGE GENDER QL
	PRENATAL PLUS VITAMIN-MINERAL	AGE QL
	PRENATAL TABLET *	AGE GENDER QL
	PRENATAL VITAMIN PLUS LOW IRON	AGE GENDER QL
	PRENATAL VITAMINS TABLET *	AGE GENDER QL
	PRENATE STAR TABLET	AGE QL
	PREPLUS CA-FE 27 MG-FA 1 MG TB	AGE GENDER QL
	PROVIDA OB CAPSULE	AGE QL
	QC PRENATAL TABLET *	AGE GENDER QL
	SELECT-OB + DHA PACK	AGE QL
	SELECT-OB CHEWABLE CAPLET	AGE QL
	SELECT-OB CHEWABLE CAPLET	AGE QL
	SE-NATAL 19 CHEWABLE TABLET	AGE QL
	SE-NATAL-19 TABLET	AGE GENDER QL
	SM PRENATAL TABLET *	AGE GENDER QL
	SV PRENATAL TABLET *	AGE GENDER QL
	THRIVITE RX TABLET *	AGE GENDER QL
	TRICARE PRENATAL TABLET	AGE GENDER QL
	TRINATAL RX 1 TABLET	AGE GENDER QL
	VINATE ONE TABLET	AGE GENDER QL
	VITAFOL FE PLUS SOFTGEL	AGE QL
VITAFOL GUMMIES	AGE QL	
VITAFOL ULTRA SOFTGEL	AGE QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Prenatal Vitamins and Minerals	VITAFOL-OB CAPLET	AGE QL
	VITAFOL-OB+DHA COMBO PACK	AGE QL
	VITAFOL-ONE CAPSULE	AGE QL
	VOL-PLUS TABLET *	AGE GENDER QL
	WESNATAL DHA COMPLETE	AGE QL
	WESNATE DHA SOFTGEL	AGE QL
	WESTAB PLUS TABLET *	AGE GENDER QL
	ZATEAN-PN DHA CAPSULE	AGE QL
Prenatal Vitamins without Iron	PRENATE ENHANCE SOFTGEL	AGE QL
	WESCAP-PN DHA CAPSULE	AGE QL
	WESTGEL DHA SOFTGEL	AGE QL
Progeria Syndrome Treatment Agents - Farnyltransferase Inhibitor	ZOKINVY 50 MG CAPSULE #	
	ZOKINVY 75 MG CAPSULE #	
Progestins	MEDROXYPROGESTERONE 10 MG TAB	*PDL-P
	MEDROXYPROGESTERONE 2.5 MG TAB	*PDL-P
	MEDROXYPROGESTERONE 5 MG TAB	*PDL-P
	NORETHINDRONE 5 MG TABLET	*PDL-P
	PROGESTERONE 100 MG CAPSULE	*PDL-P
	PROGESTERONE 200 MG CAPSULE	*PDL-P
	PROGESTERONE 500 MG/10 ML VIAL	PDL-NP PA
	PROMETRIUM 100 MG CAPSULE	PDL-NP PA
	PROMETRIUM 200 MG CAPSULE	PDL-NP PA
	PROVERA 10 MG TABLET	PDL-NP PA
	PROVERA 2.5 MG TABLET	PDL-NP PA
	PROVERA 5 MG TABLET	PDL-NP PA
Progestins - Antineoplastic	HYDROXYPROGESTERONE 1.25 G/5ML	
Prolactin Inhibitor - Ergot Derivative Dopamine Receptor Agonists	CABERGOLINE 0.5 MG TABLET	
Prostatic Hypertrophy Agent - alpha-1-Adrenoceptor Antagonists	ALFUZOSIN HCL ER 10 MG TABLET	*PDL-P
	FLOMAX 0.4 MG CAPSULE	PDL-NP PA
	RAPAFLO 4 MG CAPSULE	PDL-NP PA
	RAPAFLO 8 MG CAPSULE	PDL-NP PA
	SILODOSIN 4 MG CAPSULE	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Prostatic Hypertrophy Agent - alpha-1-Adrenoceptor Antagonists	SILODOSIN 8 MG CAPSULE	PDL-NP PA
	TAMSULOSIN HCL 0.4 MG CAPSULE	*PDL-P
	TEZRULY 1 MG/ML SOLUTION	PDL-NP AGE PA QL
Prostatic Hypertrophy Agent - Type I & II 5-alpha Reductase Inhibitors	AVODART 0.5 MG SOFTGEL	PDL-NP PA
	DUTASTERIDE 0.5 MG CAPSULE	*PDL-P
Prostatic Hypertrophy Agent - Type II 5-alpha Reductase Inhibitors	FINASTERIDE 5 MG TABLET	*PDL-P
	PROSCAR 5 MG TABLET	PDL-NP PA
Protease Inhibitors (Non-Peptidic) Antiretroviral	APTIVUS 100 MG/ML SOLUTION #	
	APTIVUS 250 MG CAPSULE #	
	PREZCOBIX 800 MG-150 MG TABLET #	
	PREZISTA 100 MG/ML SUSPENSION #	
	PREZISTA 150 MG TABLET #	
	PREZISTA 400 MG TABLET #	
	PREZISTA 600 MG TABLET #	
	PREZISTA 75 MG TABLET #	
Protease Inhibitors (Peptidic) Antiretroviral	PREZISTA 800 MG TABLET #	
	CRIXIVAN 200 MG CAPSULE #	
	CRIXIVAN 400 MG CAPSULE #	
	EVOTAZ 300 MG-150 MG TABLET #	
	INVIRASE 200 MG CAPSULE #	
	INVIRASE 500 MG TABLET #	
	LEXIVA 50 MG/ML SUSPENSION #	
	LEXIVA 700 MG TABLET #	
	NORVIR 100 MG SOFTGEL CAP #	
	NORVIR 100 MG TABLET #	
	NORVIR 80 MG/ML SOLUTION #	
	REYATAZ 150 MG CAPSULE #	
	REYATAZ 200 MG CAPSULE #	
	REYATAZ 300 MG CAPSULE #	
REYATAZ 50 MG POWDER PACKET #		
VIRACEPT 250 MG TABLET #		
VIRACEPT 625 MG TABLET #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Protein C Preparations	CEPROTIN 400-600 UNITS VIAL #	
	CEPROTIN 800-1,200 UNITS VIAL #	
Pulmonary Antihypertensive Agents - Endothelin Receptor Antagonists	AMBRISENTAN 10 MG TABLET	*PDL-P PA
	AMBRISENTAN 5 MG TABLET	*PDL-P PA
	BOSENTAN 125 MG TABLET	PDL-NP PA
	BOSENTAN 32 MG TABLET FOR SUSP	PDL-NP PA
	BOSENTAN 62.5 MG TABLET	PDL-NP PA
	LETAIRIS 10 MG TABLET	PDL-NP PA
	LETAIRIS 5 MG TABLET	PDL-NP PA
	OPSUMIT 10 MG TABLET	*PDL-P PA
	TRACLEER 125 MG TABLET	*PDL-P PA
	TRACLEER 32 MG TABLET FOR SUSP	PDL-NP PA
	TRACLEER 62.5 MG TABLET	*PDL-P PA
	YUTREPIA 106 MCG INHAL CAP	PDL-NP PA
	YUTREPIA 26.5 MCG INHAL CAP	PDL-NP PA
	YUTREPIA 53 MCG INHAL CAP	PDL-NP PA
	YUTREPIA 79.5 MCG INHAL CAP	PDL-NP PA
Pulmonary Antihypertensive Agents - Prostacyclin-type	ORENITRAM ER 0.125 MG TABLET	PDL-NP PA
	ORENITRAM ER 0.25 MG TABLET	PDL-NP PA
	ORENITRAM ER 1 MG TABLET	PDL-NP PA
	ORENITRAM ER 2.5 MG TABLET	PDL-NP PA
	ORENITRAM ER 5 MG TABLET	PDL-NP PA
	ORENITRAM MONTH 1 TITRATION KT	PDL-NP PA
	ORENITRAM MONTH 2 TITRATION KT	PDL-NP PA
	ORENITRAM MONTH 3 TITRATION KT	PDL-NP PA
	TYVASO 1.74 MG/2.9 ML SOLUTION	*PDL-P PA
	TYVASO DPI 16 MCG CARTRIDGE	PDL-NP PA
	TYVASO DPI 16-32 MCG TITR KIT	PDL-NP PA
	TYVASO DPI 16-32-48 MCG TITRAT	PDL-NP PA
	TYVASO DPI 32 MCG CARTRIDGE	PDL-NP PA
	TYVASO DPI 32-48 MCG MAINT KIT	PDL-NP PA
TYVASO DPI 48 MCG CARTRIDGE	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Pulmonary Antihypertensive Agents - Prostacyclin-type	TYVASO DPI 64 MCG CARTRIDGE	PDL-NP PA
	TYVASO INHALATION REFILL KIT	*PDL-P PA
	TYVASO INHALATION STARTER KIT	*PDL-P PA
	TYVASO INSTITUTIONAL START KIT	*PDL-P PA
	VENTAVIS 10 MCG/1 ML SOLUTION	*PDL-P PA
	VENTAVIS 20 MCG/1 ML SOLUTION	*PDL-P PA
Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhib.	ADCIRCA 20 MG TABLET	PDL-NP PA
	ALYQ 20 MG TABLET	*PDL-P PA
	LIQREV 10 MG/ML ORAL SUSP	PDL-NP PA
	REVATIO 10 MG/ML ORAL SUSP	PDL-NP PA
	REVATIO 20 MG TABLET	PDL-NP PA
	SILDENAFIL 10 MG/ML ORAL SUSP	*PDL-P PA
	SILDENAFIL 20 MG TABLET	*PDL-P PA
	TADALAFIL 20 MG TABLET	*PDL-P PA
TADLIQ 20 MG/5 ML SUSPENSION	PDL-NP AGE PA	
Pulmonary Antihypertensive Agents-Soluble Guanylate Cyclase Stimulator	ADEMPAS 0.5 MG TABLET	*PDL-P PA
	ADEMPAS 1 MG TABLET	*PDL-P PA
	ADEMPAS 1.5 MG TABLET	*PDL-P PA
	ADEMPAS 2 MG TABLET	*PDL-P PA
	ADEMPAS 2.5 MG TABLET	*PDL-P PA
Pyruvate Kinase Activator	PYRUKYND 20 MG TABLET #	
	PYRUKYND 20-5 MG TAPER PACK #	
	PYRUKYND 5 MG TABLET #	
	PYRUKYND 5 MG TAPER PACK #	
	PYRUKYND 50 MG TABLET #	
	PYRUKYND 50 MG TAPER PACK #	
	PYRUKYND 50-20 MG TAPER PACK #	
Renin Inhibitor, Direct	ALISKIREN 150 MG TABLET	PDL-NP PA
	ALISKIREN 300 MG TABLET	PDL-NP PA
	TEKTURNA 150 MG TABLET	PDL-NP PA
	TEKTURNA 300 MG TABLET	PDL-NP PA
Retinoic Acid Receptor (RAR) Agonists	SOHONOS 1 MG CAPSULE #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Retinoic Acid Receptor (RAR) Agonists	SOHONOS 1.5 MG CAPSULE #	
	SOHONOS 10 MG CAPSULE #	
	SOHONOS 2.5 MG CAPSULE #	
	SOHONOS 5 MG CAPSULE #	
RHO Kinase Inhibitor	REZUROCK 200 MG TABLET	
Rifamycins and Related Derivative Antibiotics	AEMCOLO DR 194 MG TABLET	PDL-NP AGE PA QL
RSV Pre-Fusion F A&B Vaccine Recomb Reconstituted Solution	AEROCHAMBER PLUS W-FLOWSIGNAL	QL
RSV Pre-Fusion F3 Protein (RSVPreF3) Vac Recomb Adjuvanted	AREXVY VIAL KIT	AGE QL
Salicylate Analgesic and Sedative Combinations	BUTALBITAL-ASA-CAFFEINE CAP	AGE QL
Salicylate Analgesics	ASPIRIN 300 MG SUPPOSITORY *	
	ASPIRIN 325 MG TABLET *	AGE QL
	ASPIRIN EC 325 MG TABLET *	AGE QL
	DIFLUNISAL 500 MG TABLET	PDL-NP PA
	DOLOBID 250 MG TABLET	PDL-NP PA
	DOLOBID 375 MG TABLET	PDL-NP PA
	GNP ASPIRIN 325 MG TABLET *	AGE QL
	QC ASPIRIN EC 325 MG TABLET *	AGE QL
	RA ASPIRIN EC 325 MG TABLET *	AGE QL
Salicylate Analgesics, Buffered	BUFFERIN 325 MG TABLET *	AGE
	TRI-BUFFERED ASPIRIN 325 MG *	AGE
	TRI-BUFFERED ASPIRIN 325 MG TB *	AGE
Scabicide & Pediculicide Combinations	FT LICE KILLING SHAMPOO *	QL
	GNP LICE KILLING SHAMPOO *	QL
	LICE KILLING SHAMPOO *	QL
	SB LICE KILLING SHAMPOO *	QL
Scabicide & Pediculicide Single Agents	GNP LICE TREATMENT 1% CRM RINS *	QL
	IVERMECTIN 0.5% LOTION	AGE
	LICE TREATMENT 1% CREME RINSE *	QL
	MALATHION 0.5% LOTION	AGE QL
	NIX 1% CREME RINSE LIQUID *	QL
	PERMETHRIN 5% CREAM	QL
RA LICE TREATMENT 1% CRM RINSE *	QL	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Scabicide & Pediculicide Single Agents	SM LICE KILLING SHAMPOO *	QL
	SM LICE TREATMENT 1% CRM RINSE *	QL
	SPINOSAD 0.9% TOPICAL SUSP	AGE QL
Sedative-Hypnotic - Antihistamines	ALKA-SELTZER PLUS ALLERGY TAB * #	
	COMPOZ 25 MG GELCAP * #	
	CVS NIGHTTIME SLEEP AID CAPLET * #	
	DIPHENHYDRAMINE 25 MG CAPLET * #	
	EQ NIGHTTIME SLEEP AID 50 MG * #	
	EQ SLEEP AID 25 MG TABLET * #	
	EQL NIGHTTIME SLEEP AID CAPLET * #	
	EQL SLEEP AID 25 MG TABLET * #	
	EQL SLEEP AID 50 MG SOFTGEL * #	
	GNP NIGHTTIME SLEEP AID CAPLET * #	
	GNP NIGHTTIME SLEEP AID CPLT * #	
	NIGHTTIME SLEEP AID 25 MG CPLT * #	
	NIGHTTIME SLEEP AID CPLT * #	
	NYTOL 25 MG QUICKCAPS CAPLET * #	
	QC NIGHTTIME SLEEP 25 MG TAB * #	
	QC SLEEP AID 50 MG SOFTGEL * #	
	RA NIGHTTIME SLEEP AID CPLT * #	
	RA NIGHTTIME SLEEP GEL * #	
	RA SLEEP AID 25 MG CAPLET * #	
	RA SLEEP TABLET * #	
	RA SLEEP-AID SOFTGEL * #	
	SIMPLY SLEEP 25 MG CAPLET * #	
	SLEEP AID 25 MG CAPLET * #	
	SLEEP AID TABLET * #	
	SLEEP II 25 MG TABLET * #	
	SLEEP TABS 25 MG TABLET * #	
	SLEEP TIME 50 MG/30 ML LIQUID * #	
SLEEPING 50 MG CAPSULE * #		
SM SLEEP AID NIGHT TIME CAPLET * #		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Sedative-Hypnotic - Antihistamines	SM SLEEP AID SOFTGEL * #	
	UNISOM 25 MG SLEEPTABS * #	
	UNISOM SLEEP AID 25 MG TABLET * #	
	WAL-SLEEP Z 25 MG SOFTGEL * #	
	WAL-SOM 50 MG SOFTGEL * #	
	ZZZQUIL 25 MG LIQUICAP * #	
Sedative-Hypnotic - Barbiturates	AMYTAL SODIUM 0.5 GRAM VIAL #	
	BUTISOL SODIUM 30 MG TABLET #	
	NEMBUTAL SODIUM 50 MG/ML VIAL #	
	SECONAL SODIUM 100 MG CAPSULE #	
Sedative-Hypnotic - Benzodiazepines	ESTAZOLAM 1 MG TABLET #	
	ESTAZOLAM 2 MG TABLET #	
	FLURAZEPAM 15 MG CAPSULE #	
	FLURAZEPAM 30 MG CAPSULE #	
	HALCION 0.25 MG TABLET #	
	RESTORIL 15 MG CAPSULE #	
	RESTORIL 22.5 MG CAPSULE #	
	RESTORIL 30 MG CAPSULE #	
	RESTORIL 7.5 MG CAPSULE #	
	TEMAZEPAM 15 MG CAPSULE #	
	TEMAZEPAM 22.5 MG CAPSULE #	
	TEMAZEPAM 30 MG CAPSULE #	
	TEMAZEPAM 7.5 MG CAPSULE #	
	TRIAZOLAM 0.125 MG TABLET #	
TRIAZOLAM 0.25 MG TABLET #		
Sedative-Hypnotic - GABA-Receptor Modulators	AMBIEN 10 MG TABLET #	
	AMBIEN 5 MG TABLET #	
	AMBIEN CR 12.5 MG TABLET #	
	AMBIEN CR 6.25 MG TABLET #	
	DAYVIGO 10 MG TABLET #	
	EDLUAR 10 MG SL TABLET #	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Sedative-Hypnotic - GABA-Receptor Modulators	EDLUAR 5 MG SL TABLET #	
	ESZOPICLONE 1 MG TABLET #	
	ESZOPICLONE 2 MG TABLET #	
	ESZOPICLONE 3 MG TABLET #	
	LUNESTA 1 MG TABLET #	
	LUNESTA 2 MG TABLET #	
	LUNESTA 3 MG TABLET #	
	ZALEPLON 10 MG CAPSULE #	
	ZALEPLON 5 MG CAPSULE #	
	ZOLPIDEM TART 1.75 MG TAB SL #	
	ZOLPIDEM TART 3.5 MG TABLET SL #	
	ZOLPIDEM TART ER 12.5 MG TAB #	
	ZOLPIDEM TART ER 6.25 MG TAB #	
	ZOLPIDEM TARTRATE 10 MG TABLET #	
	ZOLPIDEM TARTRATE 5 MG TABLET #	
Sedative-Hypnotic - Orexin Receptor Antagonist	BELSOMRA 10 MG TABLET #	
	BELSOMRA 15 MG TABLET #	
	BELSOMRA 20 MG TABLET #	
	BELSOMRA 5 MG TABLET #	
Sedative-Hypnotic - Selective Alpha2-Adrenoreceptor Agonists	DEXMEDETOMIDINE 200 MCG/2 ML #	
	PRECEDEX 200 MCG/2 ML VIAL #	
	PRECEDEX 200 MCG/50 ML INJECT #	
	PRECEDEX 400 MCG/100 ML INJECT #	
	PRECEDEX 80 MCG/20 ML INJECT #	
Sedative-Hypnotic - Tricyclic Antidepressant Type	DOXEPIN HCL 3 MG TABLET #	
	DOXEPIN HCL 6 MG TABLET #	
Selective Estrogen Receptor Modulators (SERMs)	EVISTA 60 MG TABLET	PDL-NP PA
	RALOXIFENE HCL 60 MG TABLET	*PDL-P
Sickle Cell Anemia Agents	DROXIA 200 MG CAPSULE	
	DROXIA 300 MG CAPSULE	
	DROXIA 400 MG CAPSULE	
	L-GLUTAMINE 5 GRAM POWDER PKT	AGE PA QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Sickle Cell Anemia Agents	SIKLOS 1,000 MG TABLET	AGE
	SIKLOS 100 MG TABLET	AGE
	XROMI 100 MG/ML SOLUTION	
Skeletal Muscle Relaxant - Analgesic Salicylate Combinations	NORGESIC FORTE 50-770-60 MG TB	PDL-NP PA
Skeletal Muscle Relaxant - Central Muscle Relaxants	AMRIX ER 15 MG CAPSULE	PDL-NP PA
	AMRIX ER 30 MG CAPSULE	PDL-NP PA
	BACLOFEN 10 MG TABLET	*PDL-P
	BACLOFEN 15 MG TABLET	*PDL-P
	BACLOFEN 20 MG TABLET	*PDL-P
	BACLOFEN 25 MG/5 ML SUSPENSION	PDL-NP PA
	BACLOFEN 5 MG TABLET	*PDL-P
	BACLOFEN 5 MG/5 ML SOLUTION	*PDL-P PA
	CHLORZOXAZONE 250 MG TABLET	PDL-NP PA
	CHLORZOXAZONE 375 MG TABLET	PDL-NP PA
	CHLORZOXAZONE 500 MG TABLET	PDL-NP PA
	CHLORZOXAZONE 750 MG TABLET	PDL-NP PA
	CYCLOBENZAPRINE 10 MG TABLET	*PDL-P
	CYCLOBENZAPRINE 5 MG TABLET	*PDL-P
	CYCLOBENZAPRINE 7.5 MG TABLET	*PDL-P
	CYCLOBENZAPRINE ER 15 MG CAP	PDL-NP PA
	CYCLOBENZAPRINE ER 30 MG CAP	PDL-NP PA
	FEXMID 7.5 MG TABLET	PDL-NP PA
	FLEQSUVY 25 MG/5 ML SUSPENSION	PDL-NP PA
	LORZONE 375 MG TABLET	PDL-NP PA
	LORZONE 750 MG TABLET	PDL-NP PA
	LYVISPAH 10 MG GRANULE PACKET	PDL-NP PA
	LYVISPAH 20 MG GRANULE PACKET	PDL-NP PA
LYVISPAH 5 MG GRANULE PACKET	PDL-NP PA	
METAXALONE 400 MG TABLET	PDL-NP PA	
METAXALONE 640 MG TABLET	PDL-NP PA	
METAXALONE 800 MG TABLET	PDL-NP PA	
METHOCARBAMOL 1,000 MG TABLET	PDL-NP PA	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Skeletal Muscle Relaxant - Central Muscle Relaxants	METHOCARBAMOL 500 MG TABLET	*PDL-P
	METHOCARBAMOL 750 MG TABLET	*PDL-P
	NORGESIC 25-385-30 MG TABLET	PDL-NP PA
	ORPHENADRINE ER 100 MG TABLET	*PDL-P
	ORPHENADRIN-ASA-CAF 25-385-30MG	PDL-NP PA
	TANLOR 1,000 MG TABLET	PDL-NP PA
	TIZANIDINE HCL 2 MG CAPSULE	PDL-NP PA
	TIZANIDINE HCL 2 MG TABLET	*PDL-P
	TIZANIDINE HCL 4 MG CAPSULE	PDL-NP PA
	TIZANIDINE HCL 4 MG TABLET	*PDL-P
	TIZANIDINE HCL 6 MG CAPSULE	PDL-NP PA
	ZANAFLEX 2 MG CAPSULE	PDL-NP PA
	ZANAFLEX 4 MG CAPSULE	PDL-NP PA
	ZANAFLEX 4 MG TABLET	PDL-NP PA
	ZANAFLEX 6 MG CAPSULE	PDL-NP PA
Skeletal Muscle Relaxant - Direct Muscle Relaxants	DANTRIUM 25 MG CAPSULE	PDL-NP PA
	DANTROLENE SODIUM 100 MG CAP	PDL-NP PA
	DANTROLENE SODIUM 25 MG CAP	PDL-NP PA
	DANTROLENE SODIUM 50 MG CAP	PDL-NP PA
Smoking Deterrents - NE & Dopamine Reuptake Inhibitor (NDRI)-Type	BUPROPION HCL SR 150 MG TABLET	QL
Smoking Deterrents - Nicotine-Type	CVS NICOTINE 14 MG/24HR PATCH *	QL
	EQ NICOTINE 14 MG/24HR PATCH *	QL
	EQ NICOTINE 2 MG LOZENGE *	QL
	EQ NICOTINE 4 MG LOZENGE *	QL
	EQ NICOTINE 7 MG/24HR PATCH *	QL
	GNP NICOTINE 2 MG LOZENGE *	QL
	GNP NICOTINE 2 MG MINI LOZENGE *	QL
	GNP NICOTINE 4 MG CHEWING GUM *	QL
	GNP NICOTINE 4 MG MINI LOZENGE *	QL
	HM NICOTINE 2 MG LOZENGE *	QL
	KRO NICOTINE 2 MG LOZENGE *	QL
	KRO NICOTINE 4 MG LOZENGE *	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Smoking Deterrents - Nicotine-Type	NICOTINE 14 MG/24HR PATCH *	QL
	NICOTINE 2 MG CHEWING GUM *	QL
	NICOTINE 2 MG LOZENGE *	QL
	NICOTINE 2 MG MINI LOZENGE *	QL
	NICOTINE 21 MG/24HR PATCH *	QL
	NICOTINE 4 MG CHEWING GUM *	QL
	NICOTINE 4 MG LOZENGE *	QL
	NICOTINE 4 MG MINI LOZENGE *	QL
	NICOTINE 7 MG/24HR PATCH *	QL
	NICOTINE TRANSDERMAL SYSTEM *	QL
	NICOTROL CARTRIDGE INHALER	QL
	NICOTROL NS 10 MG/ML SPRAY	QL
	RA NICOTINE 14 MG/24HR PATCH *	QL
	RA NICOTINE 2 MG LOZENGE *	QL
	SM NICOTINE 14 MG/24HR PATCH *	QL
	SM NICOTINE 2 MG CHEWING GUM *	QL
	SM NICOTINE 2 MG LOZENGE *	QL
	SM NICOTINE 21 MG/24HR PATCH *	QL
	SM NICOTINE 4 MG LOZENGE *	QL
	SW NICOTINE 2 MG LOZENGE *	QL
Smoking Deterrents - Nicotinic Receptor Partial Agonist, alpha4beta2	CHANTIX 1 MG CONT MONTH BOX	QL
	VARENICLINE 0.5 MG TABLET	QL
	VARENICLINE 1 MG TABLET	QL
	VARENICLINE STARTING MONTH BOX	QL
Soluble Guanylate Cyclase Stimulator	VERQUVO 10 MG TABLET	AGE PA QL
	VERQUVO 2.5 MG TABLET	AGE PA QL
	VERQUVO 5 MG TABLET	AGE PA QL
Somatostatic Agents	OCTREOTIDE 1,000 MCG/ML VIAL	PA
	OCTREOTIDE ACET 100 MCG/ML VL	PA
	OCTREOTIDE ACET 200 MCG/ML VL	PA
	OCTREOTIDE ACET 50 MCG/ML VIAL	PA
Spermicides	PHEXXI 1.8-1-0.4% VAGINAL GEL	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Sphingosine 1-phosphate (S1P) receptor modulator	ZEPOSIA 0.92 MG CAPSULE	PDL-NP AGE PA
	ZEPOSIA STARTER KIT (28-DAY)	PDL-NP AGE PA
	ZEPOSIA STARTER PACK (7-DAY)	PDL-NP AGE PA
Survival of motor neuron 2 (SMN2) splicing modifier	EVRYSDI 5 MG TABLET #	
	EVRYSDI 60 MG/80 ML(0.75MG/ML) #	
Tetracycline Antibiotics	DOXYCYCLINE 25 MG/5 ML SUSP	
	DOXYCYCLINE HYCLATE 100 MG TAB	
	DOXYCYCLINE HYCLATE 50 MG CAP	
	DOXYCYCLINE MONO 100 MG CAP	
	DOXYCYCLINE MONO 100 MG TABLET	
	DOXYCYCLINE MONO 50 MG CAP	
	DOXYCYCLINE MONO 50 MG TABLET	
	MINOCYCLINE 100 MG CAPSULE	
	MINOCYCLINE 50 MG CAPSULE	
	MINOCYCLINE 75 MG CAPSULE	
Therapy for Drooling- primary or secondary sialorrhea-Anticholinergic	GLYCOPYRROLATE 1 MG/5 ML SOLN	AGE
Thrombin Inhibitor - Selective Direct & Reversible	DABIGATRAN ETEXILATE 110 MG CP	*PDL-P QL
	DABIGATRAN ETEXILATE 150 MG	*PDL-P QL
	DABIGATRAN ETEXILATE 75 CAP	*PDL-P QL
	PRADAXA 110 MG CAPSULE	PDL-NP PA QL
	PRADAXA 110 MG PELLET PACK	PDL-NP AGE PA
	PRADAXA 150 MG CAPSULE	PDL-NP PA QL
	PRADAXA 150 MG PELLET PACK	PDL-NP AGE PA
	PRADAXA 20 MG PELLET PACK	PDL-NP AGE PA
	PRADAXA 30 MG PELLET PACK	PDL-NP AGE PA
	PRADAXA 40 MG PELLET PACK	PDL-NP AGE PA
	PRADAXA 50 MG PELLET PACK	PDL-NP AGE PA
PRADAXA 75 MG CAPSULE	PDL-NP PA QL	
Thyroid Hormones - Animal Source (Porcine)	ADTHYZA 130 MG TABLET	
	ADTHYZA 16.25 MG TABLET	
	ADTHYZA 32.5 MG TABLET	
	ADTHYZA 65 MG TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Thyroid Hormones - Animal Source (Porcine)	ADTHYZA 97.5 MG TABLET	
	ARMOUR THYROID 120 MG TABLET	
	ARMOUR THYROID 15 MG TABLET	
	ARMOUR THYROID 180 MG TABLET	
	ARMOUR THYROID 240 MG TABLET	
	ARMOUR THYROID 30 MG TABLET	
	ARMOUR THYROID 300 MG TABLET	
	ARMOUR THYROID 60 MG TABLET	
	ARMOUR THYROID 90 MG TABLET	
	NP THYROID 120 MG TABLET	
	NP THYROID 15 MG TABLET	
	NP THYROID 30 MG TABLET	
	NP THYROID 60 MG TABLET	
	NP THYROID 90 MG TABLET	
Thyroid Hormones - Synthetic T3 (Triiodothyronine)	CYTOMEL 25 MCG TABLET	
	CYTOMEL 5 MCG TABLET	
	CYTOMEL 50 MCG TABLET	
	LIOETHYRONINE SOD 25 MCG TAB	
	LIOETHYRONINE SOD 5 MCG TAB	
	LIOETHYRONINE SOD 50 MCG TAB	
Thyroid Hormones - Synthetic T4 (Thyroxine)	ERMEZA 150 MCG/5 ML SOLUTION	
	LEVOTHYROXINE 100 MCG TABLET	
	LEVOTHYROXINE 112 MCG TABLET	
	LEVOTHYROXINE 125 MCG TABLET	
	LEVOTHYROXINE 137 MCG TABLET	
	LEVOTHYROXINE 150 MCG TABLET	
	LEVOTHYROXINE 175 MCG TABLET	
	LEVOTHYROXINE 200 MCG TABLET	
	LEVOTHYROXINE 25 MCG TABLET	
	LEVOTHYROXINE 300 MCG TABLET	
	LEVOTHYROXINE 50 MCG TABLET	
LEVOTHYROXINE 75 MCG TABLET		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Thyroid Hormones - Synthetic T4 (Thyroxine)	LEVOTHYROXINE 88 MCG TABLET	
	LEVOXYL 100 MCG TABLET	
	LEVOXYL 112 MCG TABLET	
	LEVOXYL 125 MCG TABLET	
	LEVOXYL 137 MCG TABLET	
	LEVOXYL 150 MCG TABLET	
	LEVOXYL 175 MCG TABLET	
	LEVOXYL 200 MCG TABLET	
	LEVOXYL 25 MCG TABLET	
	LEVOXYL 50 MCG TABLET	
	LEVOXYL 75 MCG TABLET	
	LEVOXYL 88 MCG TABLET	
	SYNTHROID 100 MCG TABLET	
	SYNTHROID 112 MCG TABLET	
	SYNTHROID 125 MCG TABLET	
	SYNTHROID 137 MCG TABLET	
	SYNTHROID 150 MCG TABLET	
	SYNTHROID 175 MCG TABLET	
	SYNTHROID 200 MCG TABLET	
	SYNTHROID 25 MCG TABLET	
	SYNTHROID 300 MCG TABLET	
	SYNTHROID 50 MCG TABLET	
	SYNTHROID 75 MCG TABLET	
	SYNTHROID 88 MCG TABLET	
	THYQUIDITY 100 MCG/5 ML SOLN	
	UNITHROID 100 MCG TABLET	
	UNITHROID 112 MCG TABLET	
	UNITHROID 125 MCG TABLET	
	UNITHROID 137 MCG TABLET	
	UNITHROID 150 MCG TABLET	
	UNITHROID 175 MCG TABLET	
	UNITHROID 200 MCG TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Thyroid Hormones - Synthetic T4 (Thyroxine)	UNITHROID 25 MCG TABLET	
	UNITHROID 300 MCG TABLET	
	UNITHROID 50 MCG TABLET	
	UNITHROID 75 MCG TABLET	
	UNITHROID 88 MCG TABLET	
Topical Anti-infectives - Quinolone	XEPI 1% CREAM	PDL-NP PA QL
Topical Anti-Inflam., Phosphodiesterase-4 (PDE4) Inhib	EUCRISA 2% OINTMENT	*PDL-P AGE PA QL
TX For Attention Deficit-Hyperact(ADHD)/Narcolepsy	QUILLICHEW ER 20 MG CHEW TAB #	
	QUILLICHEW ER 30 MG CHEW TAB #	
	QUILLICHEW ER 40 MG CHEW TAB #	
Urinary Acidifier - Bacterial Urease Inhibitor	LITHOSTAT 250 MG TABLET #	
Urinary Acidifier - Phosphates	K-PHOS #2 TABLET	
	K-PHOS ORIGINAL TABLET	
Urinary Alkalinizer - Citrates	POTASSIUM CIT-CITRIC ACID SOLN	
	POTASSIUM CITRATE ER 10 MEQ TB	
	POTASSIUM CITRATE ER 15 MEQ TB	
	POTASSIUM CITRATE ER 5 MEQ TAB	
	SOD CITRATE-CITRIC ACID SOLN	
Urinary Analgesics	PHENAZOPYRIDINE 100 MG TAB	
	PHENAZOPYRIDINE 200 MG TAB	
Urinary Antibacterial - Methenamine & Salts	METHENAMINE HIPPI 1 GM TABLET	
	METHENAMINE MAND 1 GM TABLET	
	METHENAMINE MD 500 MG TABLET	
Urinary Antibacterial - Nitrofurantoin Derivatives	NITROFURANTOIN MCR 100 MG CAP	AGE QL
	NITROFURANTOIN MCR 50 MG CAP	AGE QL
	NITROFURANTOIN MONO-MCR 100 MG	AGE QL
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)	DARIFENACIN ER 15 MG TABLET	PDL-NP PA
	DARIFENACIN ER 7.5 MG TABLET	PDL-NP PA
	SOLIFENACIN 10 MG TABLET	*PDL-P
	SOLIFENACIN 5 MG TABLET	*PDL-P
	VESICARE 10 MG TABLET	PDL-NP PA
	VESICARE 5 MG TABLET	PDL-NP PA

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)	VESICARE LS 5 MG/5 ML SUSP	PDL-NP PA
Urinary Antispasmodic - Smooth Muscle Relaxants	DETROL 1 MG TABLET	PDL-NP PA
	DETROL 2 MG TABLET	PDL-NP PA
	DETROL LA 2 MG CAPSULE	PDL-NP PA
	DETROL LA 4 MG CAPSULE	PDL-NP PA
	DITROPAN XL 10 MG TABLET	PDL-NP PA
	DITROPAN XL 5 MG TABLET	PDL-NP PA
	FESOTERODINE ER 4 MG TABLET	*PDL-P
	FESOTERODINE ER 8 MG TABLET	*PDL-P
	FLAVOXATE HCL 100 MG TABLET	PDL-NP PA
	OXYBUTYNIN 2.5 MG TABLET	*PDL-P
	OXYBUTYNIN 5 MG TABLET	*PDL-P
	OXYBUTYNIN 5 MG/5 ML SOLUTION	*PDL-P
	OXYBUTYNIN 5 MG/5 ML SYRUP	*PDL-P
	OXYBUTYNIN CL ER 10 MG TABLET	*PDL-P
	OXYBUTYNIN CL ER 15 MG TABLET	*PDL-P
	OXYBUTYNIN CL ER 5 MG TABLET	*PDL-P
	OXYTROL 3.9 MG/24HR PATCH	PDL-NP PA
	OXYTROL FOR WOMEN 3.9 MG/24HR *	
	TOLTERODINE TART ER 2 MG CAP	*PDL-P
	TOLTERODINE TART ER 4 MG CAP	*PDL-P
	TOLTERODINE TARTRATE 1 MG TAB	*PDL-P
	TOLTERODINE TARTRATE 2 MG TAB	*PDL-P
	TOVIAZ ER 4 MG TABLET	PDL-NP PA
	TOVIAZ ER 8 MG TABLET	PDL-NP PA
	TROSPIUM CHLORIDE 20 MG TABLET	*PDL-P
	TROSPIUM CHLORIDE ER 60 MG CAP	PDL-NP PA
Urinary Retention Therapy - Parasympathomimetic Agents	BETHANECHOL 10 MG TABLET	QL
	BETHANECHOL 25 MG TABLET	QL
	BETHANECHOL 5 MG TABLET	QL
	BETHANECHOL 50 MG TABLET	QL
Urinary Tract Protective Agents used in conjunction with Chemotherapy	MESNA 400 MG TABLET	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Urinary Tract Protective Agents used in conjunction with Chemotherapy	MESNEX 400 MG TABLET	
Vaginal Antibacterial - Lincosamides	CLEOCIN 100 MG VAGINAL OVULE	*PDL-P
	CLEOCIN 2% VAGINAL CREAM	PDL-NP PA
	CLINDAMYCIN 2% VAGINAL CREAM	*PDL-P
	CLINDESSE 2% VAGINAL CREAM	*PDL-P
	XACIATO 2% VAGINAL GEL	PDL-NP AGE PA
Vaginal Antifungal - Imidazoles	CLOTRIMAZOLE 1% VAGINAL CREAM *	GENDER
	CLOTRIMAZOLE 1% VAGINAL CREAM *	GENDER
	CLOTRIMAZOLE 3 2% CREAM *	GENDER
	CLOTRIMAZOLE-3 CREAM *	GENDER
	CLOTRIMAZOLE-7 CREAM *	GENDER
	GS MICONAZOLE 3 COMBO PACK *	GENDER
	MICONAZOLE 3 COMBO PACK *	GENDER
	MICONAZOLE 7 100 MG VAG SUPP *	GENDER
	MICONAZOLE 7 CREAM *	GENDER
	MONISTAT 3 COMBO PACK *	GENDER
	MONISTAT 3 COMBO PACK *	GENDER
	MONISTAT 7 CREAM *	GENDER
	PUB MICONAZOLE3DAY COMBO PACK *	GENDER
	RA CLOTRIMAZOLE 1% CREAM *	GENDER
	RA MICONAZOLE 3 COMBO PACK *	GENDER
	SM 3-DAY VAGINAL CREAM *	GENDER
	SM CLOTRIMAZOLE 1% CREAM *	GENDER
	SM MICONAZOLE 3 COMBO PACK *	GENDER
	SM MICONAZOLE 3 COMBO PACK *	GENDER
	SM MICONAZOLE 7 100 MG VAG SUP *	GENDER
	SM MICONAZOLE 7 CREAM *	GENDER
Vaginal Antifungal - Triazoles	TERCONAZOLE 0.4% CREAM	GENDER
	TERCONAZOLE 0.8% CREAM	GENDER
Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives	METRONIDAZOLE VAGINAL 0.75% GL	*PDL-P
	METRONIDAZOLE VAGINAL 1.3% GEL	PDL-NP PA
	NUVESSA VAGINAL 1.3% GEL	*PDL-P

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives	VANDAZOLE VAGINAL 0.75% GEL	PDL-NP PA
Vaginal Estrogens	ESTRADIOL 0.01% CREAM	GENDER QL
	ESTRADIOL 10 MCG VAGINAL INSRT	
	VAGIFEM 10 MCG VAGINAL TAB	
	YUVAFEM 10 MCG VAGINAL INSERT	
Vaginal Progestins	CRINONE 4% GEL	PDL-NP PA
Vascular Endothelial Growth Factor (VEGF) Inhibitors	FRUZAQLA 1 MG CAPSULE #	
	FRUZAQLA 5 MG CAPSULE #	
Vitamins - A	BETA CAROTENE 7,500 MCG SFGL *	Covered for CSHCS Only
	BETA CAROTENE 7,500 MCG SFGL *	Covered for CSHCS Only
	BETA-CAROTENE 25,000 UNIT SFGL *	Covered for CSHCS Only
	BETA-CAROTENE 25,000 UNIT SFGL *	Covered for CSHCS Only
	VITAMIN A 10,000 UNIT SOFTGEL *	Covered for CSHCS Only
	VITAMIN A 3,000 MCG SOFTGEL *	Covered for CSHCS Only
Vitamins - B Preparation Combinations	FABB TABLET	
	FOLBIC TABLET	
	FOLTABS 800 TABLET *	
	NIVA-FOL TABLET	Covered for CSHCS Only
	VIRT-GARD TABLET *	
	WESTAB MAX TABLET *	
	WESTAB ONE TABLET *	
Vitamins - B-12, Cyanocobalamin and derivatives	CYANOCOBALAMIN 1,000 MCG/ML VL	
Vitamins - B-2, Riboflavin and Derivatives	CVS VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	RIBOFLAVIN 100 MG TABLET *	Covered for CSHCS Only
	RIBOFLAVIN 50 MG TABLET *	Covered for CSHCS Only
	TRUE VITAMIN B2 100 MG TABLET *	Covered for CSHCS Only
	TRUE VITAMIN B2 100 MG TABLET *	Covered for CSHCS Only
	TRUE VITAMIN B2 25 MG TABLET *	Covered for CSHCS Only
	TRUE VITAMIN B2 50 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Vitamins - B-2, Riboflavin and Derivatives	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 100 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 25 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 25 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 25 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 50 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 50 MG TABLET *	Covered for CSHCS Only
	VITAMIN B-2 50 MG TABLET *	Covered for CSHCS Only
	WELL VITAMIN B2 100 MG TABLET *	Covered for CSHCS Only
Vitamins - B-3, Niacin and Derivatives	NIACINAMIDE 500 MG TABLET *	
Vitamins - Biotin	BIOTIN 5,000 MCG TABLET *	
Vitamins - C, Ascorbic Acid and Derivatives	VITAMIN C 500 MG TABLET *	Covered for CSHCS Only
	VITAMIN C 500 MG TABLET *	Covered for CSHCS Only
	VITAMIN C 500 MG TABLET *	Covered for CSHCS Only
	VITAMIN C 500 MG TABLET *	Covered for CSHCS Only
	VITAMIN C 500 MG TABLET *	Covered for CSHCS Only
Vitamins - D Derivatives	CALCIDOL DROPS *	Covered for CSHCS Only
	CALCITRIOL 0.25 MCG CAPSULE	QL
	CALCITRIOL 0.5 MCG CAPSULE	QL
	CALCITRIOL 1 MCG/ML SOLUTION	AGE
	CVS VITAMIN D3 50 MCG SOFTGEL *	
	CVS VITAMIN D3 50 MCG SOFTGEL *	
	CVS VITAMIN D3 50 MCG TABLET *	Covered for CSHCS Only
	D3-50 50,000 UNIT CAPSULE *	
	DIALYVITE VIT D3 50,000 UNIT *	
EQL VITAMIN D3 50 MCG SOFTGEL *		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Vitamins - D Derivatives	ERGOCALCIFEROL 200 MCG/ML DROP *	Covered for CSHCS Only
	ERGOCALCIFEROL 200 MCG/ML DROP *	Covered for CSHCS Only
	ERGOCALCIFEROL 8,000 UNITS/ML *	Covered for CSHCS Only
	GNP VITAMIN D 1,000 UNIT TAB *	
	INFANT VITAMIN D 10 MCG/ML DRP *	
	PEDIATRIC D-VITE 10 MCG/ML LIQ *	
	RA VITAMIN D3 1,000 UNIT TAB *	
	TRUE VITAMIN D3 50 MCG CAPSULE *	
	TRUE VITAMIN D3 50 MCG CAPSULE *	
	TRUE VITAMIN D3 50 MCG TABLET *	Covered for CSHCS Only
	VITAL-D RX TABLET	
	VITAMIN D2 1.25MG(50,000 UNIT)	
	VITAMIN D3 1,000 UNIT SOFTGEL *	
	VITAMIN D3 1,000 UNIT TABLET *	Covered for CSHCS Only
	VITAMIN D3 10 MCG/ML DROP *	Covered for CSHCS Only
	VITAMIN D3 10 MCG/ML LIQUID *	
	VITAMIN D3 10,000 UNIT TABLET *	Covered for CSHCS Only
	VITAMIN D3 2,000 UNIT SOFTGEL *	
	VITAMIN D3 2,000 UNIT SOFTGEL *	
	VITAMIN D3 2,000 UNIT SOFTGEL *	
	VITAMIN D3 2,000 UNIT SOFTGEL *	
	VITAMIN D3 2,000 UNIT SOFTGEL *	
	VITAMIN D3 2,000 UNIT SOFTGEL *	
	VITAMIN D3 25 MCG TABLET *	Covered for CSHCS Only
	VITAMIN D3 25 MCG TABLET *	Covered for CSHCS Only
	VITAMIN D3 25 MCG TABLET *	Covered for CSHCS Only
	VITAMIN D3 25 MCG TABLET *	Covered for CSHCS Only
	VITAMIN D3 400 UNIT/ML LIQUID *	
	VITAMIN D3 5,000 UNIT SOFTGEL *	
	VITAMIN D3 5,000 UNIT TABLET *	
	VITAMIN D3 50 MCG CAPSULE *	
VITAMIN D3 50 MCG CAPSULE *		

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Vitamins - D Derivatives	VITAMIN D3 50 MCG SOFTGEL *	
	VITAMIN D3 50 MCG SOFTGEL *	Covered for CSHCS Only
	VITAMIN D3 50 MCG SOFTGEL *	Covered for CSHCS Only
	VITAMIN D3 50 MCG SOFTGEL *	
	VITAMIN D3 50 MCG SOFTGEL *	Covered for CSHCS Only
	VITAMIN D3 50 MCG SOFTGEL *	Covered for CSHCS Only
	VITAMIN D3 50 MCG SOFTGEL *	
	VITAMIN D3 50 MCG SOFTGEL *	Covered for CSHCS Only
	VITAMIN D3 50 MCG TABLET	Covered for CSHCS Only
	VITAMIN D3 50 MCG TABLET *	Covered for CSHCS Only
	VITAMIN D3 50 MCG TABLET *	Covered for CSHCS Only
	VITAMIN D3 50 MCG TABLET *	Covered for CSHCS Only
	VITAMIN D3 50 MCG TABLET *	
	VITAMIN D3 50 MCG TABLET *	Covered for CSHCS Only
	VITAMIN D3 50,000 UNIT CAPSULE *	
	WELL VITAMIN D3 50 MCG SOFTGEL *	
Vitamins - E	CVS VITAMIN E 400 UNIT CAPSULE *	
	EQL VITAMIN E 400 UNIT SOFTGEL *	
	FNP VITAMIN E 200 UNIT TABLET *	Covered for CSHCS Only
	FNP VITAMIN E 200 UNIT TABLET *	Covered for CSHCS Only
	FNP VITAMIN E 200 UNIT TABLET *	Covered for CSHCS Only
	FNP VITAMIN E 200 UNIT TABLET *	Covered for CSHCS Only
	FNP VITAMIN E 400 UNIT TABLET *	Covered for CSHCS Only
	FNP VITAMIN E 400 UNIT TABLET *	Covered for CSHCS Only
	FNP VITAMIN E 400 UNIT TABLET *	Covered for CSHCS Only
	FNP VITAMIN E 400 UNIT TABLET *	Covered for CSHCS Only
	FNP VITAMIN E LIQUID *	Covered for CSHCS Only
	GNP VITAMIN E 400 UNIT SOFTGEL *	
	HM VITAMIN E 400 UNIT SOFTGEL *	
	RA VITAMIN E 400 UNIT SOFTGEL *	
	SM VITAMIN E 400 UNIT CAPSULE *	
	TRUE VITAMIN E 450 MG CAPSULE	

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation

Drug Class	Drug Name	Utilization Management
Vitamins - E	TRUE VITAMIN E 450 MG CAPSULE *	
	VITAMIN E 100 UNIT TABLET *	Covered for CSHCS Only
	VITAMIN E 100 UNIT TABLET *	Covered for CSHCS Only
	VITAMIN E 15 UNIT/0.3 ML DROP *	
	VITAMIN E 180 MG SOFTGEL *	Covered for CSHCS Only
	VITAMIN E 180MG(400 UNIT) SFGL *	Covered for CSHCS Only
	VITAMIN E 400 UNIT CAPSULE *	
	VITAMIN E 450 MG SOFTGEL *	Covered for CSHCS Only
	VITAMIN E 450 MG SOFTGEL *	
	WELL VITAMIN E 450 MG CAPSULE *	
Vitamins - Folic Acid and Derivatives	FOLIC ACID 0.4 MG TABLET *	QL
	FOLIC ACID 0.8 MG TABLET *	
	FOLIC ACID 1 MG TABLET	
	FOLIC ACID 1,000 MCG TABLET *	
Vitamins - K, Phytonadione and Derivatives	PHYTONADIONE 5 MG TABLET	QL

See individual health plan formulary for more details

= Carved Out- Bill Fee-For-Service Medicaid
(See MPPL @ mi.primetherapeutics.com
for coverage details)

AGE = Age Edit
GENDER = Gender Edit
ST = Step Therapy
*= Over the Counter (OTC)
*PDL-P = PDL Preferred
PDL-NP = PDL Non-Preferred

PA = Prior Authorization
QL = Quantity Limitation