

CMSP DRUG FORMULARY

Administered by MedImpact

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INTRODUCTION

Foreword

Members with the CMSP Standard Benefit are eligible for covered prescriptions without a copayment after meeting a monthly share of cost (SOC). CMSP members who additionally have coverage under the CMSP Primary Care Benefit should use their CMSP Primary Care Benefit (CMSP-PCB) as the primary pharmacy benefit.

The below table describes CMSP prescription coverage:

	CMSP Primary Care Benefit	CMSP Standard Benefit
When to use the benefit	<ul style="list-style-type: none"> Primary benefit for CMSP Aid Codes 89 and 50 	<ul style="list-style-type: none"> Primary benefit for CMSP Aid Code 88 Secondary benefit for CMSP Aid Code 89 and 50. Use when CMSP Primary Care Benefit does not provide coverage (e.g., prescription cost exceeds maximum cost of \$500/claim, drug is excluded from Primary Care Benefit, or patient exceeds \$1500 maximum benefit per CMSP-PCB enrollment period).
Patient out-of-pocket cost	<ul style="list-style-type: none"> \$5 copayment per prescription No monthly share of cost requirement 	<ul style="list-style-type: none"> Monthly share of cost must be met before prescription coverage No copayment per prescription
Benefit maximums	<ul style="list-style-type: none"> \$500 per prescription claim \$1500 maximum benefit per CMSP-PCB enrollment period 	<ul style="list-style-type: none"> None
Drug exclusions	<ul style="list-style-type: none"> Specialty drugs excluded. See “<i>Prescription Coverage of Select Drug Classes</i>” section of the CMSP Primary Care Benefit formulary for additional information about excluded drugs. 	<ul style="list-style-type: none"> Specialty drugs generally covered. See “<i>Prescription Coverage of Select Drug Classes</i>” section of the CMSP Standard Benefit formulary for additional information about excluded drugs.

This document represents the efforts of MedImpact and the County Medical Services Program (CMSP) Governing Board to provide physicians and pharmacists with a method to evaluate the various drug products available under the CMSP Standard Benefit. The medical treatment of patients is frequently related to the practical application of drug therapy. Due to the vast availability of medication treatment modalities, a reasonable program of drug product selection and drug usage must be developed. The goal of the CMSP Standard Benefit Drug Formulary is to enhance the ability of physicians and pharmacists participating in CMSP to provide optimal cost-effective drug therapy for CMSP members.

The development, maintenance, and improvement of the CMSP Standard Benefit Drug Formulary is evolutionary and requires on-going oversight. This is accomplished by a pharmacy and therapeutics review process conducted by a panel of physicians and pharmacists. The CMSP Standard Benefit Drug Formulary is a continuously reviewed and revised list of drug products that reflects the consensus clinical opinion of the panel. Using this Formulary, you are encouraged to review the information and provide input and comments to the CMSP Governing Board.

CMSP uses the following criteria in the evaluation of product selection for the CMSP Standard Benefit Drug Formulary:

- The drug product must demonstrate unequivocal safety for medical use.
- The drug product must be efficacious and be medically necessary for the treatment, maintenance or prophylaxis of the medical condition.
- The drug product must demonstrate therapeutic marker outcomes accepted by the medical community.
- The drug product must be accepted for use by the medical community.
- The drug product should have a favorable cost ratio for the treatment of the medical condition.

How to Use the Drug Formulary

The Standard Benefit Drug Formulary is a list of covered and preferred drug agents for CMSP members. All products are listed by their generic names and most common proprietary (branded) name. The Standard Benefit Drug Formulary may be accessed by using the index, both by generic and proprietary name (in small capital letters) and by therapeutic drug category. Any product not found in this Formulary listing, or any Formulary updates published by the CMSP Governing Board shall be considered a Non-Formulary Drug.

Coverage Limitations

The Standard Benefit Drug Formulary does not provide information regarding the specific coverage or limitations an individual member may have. CMSP members may have specific limitations, such as share of cost, which are not reflected in this Drug Formulary. This Drug Formulary contains only FDA-approved outpatient drugs for eligible members and does not apply to non-FDA approved drugs or medications used in inpatient settings. If a CMSP member has any specific questions regarding coverage, they should contact the CMSP Governing Board at (916) 649-2631 for further explanation of benefits.

CMSP members are not eligible to receive prescription drug services outside of California and the designated board state areas of Oregon, Nevada and Arizona.

Generic Substitution

When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated. The brand names listed are for reference use only and do not denote coverage, unless specifically noted. Greater economy is realized through the use of generic equivalents. This policy is not meant to preclude or supplant any state statutes that may exist. All drugs that are or become available generically are subject to review by the CMSP pharmacy and therapeutics review process.

CMSP approves such multisource drugs for addition to the maximum allowable cost (MAC) list based on the following criteria:

- A minimum of one "A" rated source of the product.
- An FDA Rating for generic equivalency.
- Review by CMSP Governing Board for efficacy and safety.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy or where blood level maintenance is crucial will not be subject to substitution. These products are:

- ◇ Coumadin
- ◇ Dilantin
- ◇ Lanoxin
- ◇ Premarin
- ◇ Neoral Oral Solution
- ◇ Synthroid

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products. If a physician determines that there is a documented medical need for the brand equivalent, a request for coverage may be made using the medication request process.

Experimental Drugs

The experimental nature or use of drug products will be determined by CMSP using current medical literature. Any drug product or use of an existing product that is determined to be experimental will be excluded from coverage.

Prior Authorization

Drug products that are listed as Prior Authorization (PA) required require approval when the member presents a prescription to a network pharmacy. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

If the request does not meet the criteria established by CMSP, the request will be denied and alternative therapy may be recommended. Each request will be reviewed on individual patient need and approval may be given if a documented medical need exists.

Request Process for Non-Formulary Agents

Coverage for non-formulary agents may be requested in advance by physicians. When a CMSP member gives a prescription order for a non-formulary drug to a pharmacist, the pharmacist should notify the physician and member of the nonformulary status. The physician, pharmacist or member may then call MedImpact at (800) 788-2949 to initiate the medical exception process. To obtain coverage, the prescribing physician may:

- A. Fax a completed Medication Request Form (MRF) to MedImpact at (858) 790-7100, or
- B. Contact MedImpact at (800) 788-2949 and provide all necessary information requested.

The following general criteria are used for approval.

- 1) The use of CMSP Standard Benefit Formulary Drug Products is contraindicated in the patient.
- 2) The patient has failed an appropriate trial of Formulary or related agents.
- 3) The choices available in the CMSP Standard Benefit Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
- 4) The use of a CMSP Standard Benefit Formulary Drug may provoke an underlying condition, which would be detrimental to patient care.

CMSP recognizes that not all medical needs can be met with agents listed in this document and encourages inquires about optional therapies.

Step Care Agents

Drug products defined as step care will undergo an electronic pre-authorization process per CMSP guidelines, which requires a trial of first-line drug(s) before a Step Care drug will be covered at the formulary brand level. If recommended guidelines for first-line therapy are not met, then the Step Care drug may be subject to review through the prior authorization process.

Quantity Limits

Limitations on quantity may be placed on certain products due to safety, therapeutic or cost-effectiveness considerations. Prescriptions for such agents exceeding the quantity limit (QL) will be subject to the prior authorization process.

Appeals Process

Prior authorization and medical exception requests are evaluated based on medical necessity and safety as described. In the event of denial, providers or CMSP members may request a formal appeal verbally or in writing within sixty (60) days of denial notification. To request an appeal, call (800) 788-2949 or send your written appeal request to the following address:

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court, San Diego, CA 92131
Attention: Appeals Coordinator
or
Fax (858) 790-6060

Formulary Process and Communication

The CMSP Standard Benefit Drug Formulary is a tool to promote cost-effective prescription drug use. While every attempt has been made to create a document that meets all therapeutic needs, the art of medicine makes this a formidable task. CMSP welcomes input on the formulary from physicians and pharmacists providing services to CMSP clients. Suggestions and comments should be submitted to the CMSP Governing Board at the following address:

CMSP Governing Board
ATTN: Pharmacy and Therapeutics Panel
1545 River Park Drive, Suite 435
Sacramento, CA 95815
(916) 649-2631

Prescription Coverage of Select Drug Classes

Drug Class	CMSP Primary Care Benefit	CMSP Standard Benefit Coverage
HIV Antiretroviral Agents	<p>Antiretroviral drugs are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> Antiretroviral agents for the treatment of HIV are not covered unless the member is ineligible for the AIDS Drug Assistance Program (ADAP). Evidence of ADAP ineligibility for antiretroviral coverage is required. Contact ADAP at (844) 421-7050 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for antiretroviral coverage. This form can be obtained on the CMSP website: https://cmspcounties.org. Pre-exposure prophylaxis (PrEP) is not a covered benefit. It may be available through the manufacturer's patient assistance program. Additional information about drug company patient assistance programs is available on the internet at https://medicineassistancetool.org.</p>	<p>Antiretroviral agents for the treatment of HIV are not covered unless the member is ineligible for the AIDS Drug Assistance Program (ADAP).</p> <p>Evidence of ADAP ineligibility for antiretroviral coverage is required. Contact ADAP at (844) 421-7050 for more information.</p> <p>A Record of Denied Program Eligibility form must be completed and submitted to CMSP for antiretroviral coverage. This form can be obtained on the CMSP website: https://cmspcounties.org.</p> <p>Pre-exposure prophylaxis (PrEP) is not a covered benefit. It may be available through the manufacturer's patient assistance program. Additional information about drug company patient assistance programs is available on the internet at https://medicineassistancetool.org.</p>
Contraceptives	<p>Contraceptives are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> Contraceptives are not covered unless the member is not eligible for Family PACT. Evidence of Family PACT ineligibility for contraceptive coverage is required. Contact Family PACT at (800) 942-1054 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for contraceptive coverage. This form can be obtained on the CMSP website: https://cmspcounties.org.</p>	<p>Contraceptives are not covered unless the member is not eligible for Family PACT.</p> <p>Evidence of Family PACT ineligibility for contraceptive coverage is required. Contact Family PACT at (800) 942-1054 for more information.</p> <p>A Record of Denied Program Eligibility form must be completed and submitted to CMSP for contraceptive coverage. This form can be obtained on the CMSP website: https://cmspcounties.org.</p>
Cystic Fibrosis Agents: Kalydeco, Orkambi, Symdeko, Trikafta	<p>Specialty drugs are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> Cystic Fibrosis therapies otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP (916) 552-9105 opt 2 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: https://cmspcounties.org.</p>	<p>Cystic Fibrosis therapies otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP.</p> <p>Evidence of GHPP ineligibility is required. Contact GHPP at (916) 552-9105 opt 2 for more information.</p> <p>A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: https://cmspcounties.org.</p>

<p>Hemophilia Agents</p>	<p>Specialty drugs are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> Hemophilia products otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP at (916) 552-9105 opt 2 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: https://cmspcounties.org.</p>	<p>Hemophilia products otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP.</p> <p>Evidence of GHPP ineligibility is required. Contact GHPP at (916) 552-9105 opt 2 for more information.</p> <p>A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: https://cmspcounties.org.</p>
<p>Hepatitis C: Ribavirin and Pegylated Interferons</p>	<p>Specialty drugs are excluded under the CMSP Primary Care Benefit.</p> <p><u>For patients who also have the CMSP Standard Benefit:</u> These agents are not a covered benefit unless the member is ineligible for the drug manufacturer's patient assistance program and clinical prior authorization requirements are met. Evidence of ineligibility for the drug manufacturers' patient assistance program must be completed by the manufacturer and submitted to MedImpact.</p>	<p>These agents are not a covered benefit unless the member is ineligible for the drug manufacturer's patient assistance program and clinical prior authorization requirements are met.</p> <p>Evidence of ineligibility for the drug manufacturers' patient assistance program must be completed by the manufacturer and submitted to MedImpact.</p>
<p>Hepatitis C: Harvoni, Sovaldi, Viekira Pak, Zepatier, Epclusa, Mavyret, Vosevi</p>	<p>These agents are not a covered benefit. These agents may be available through the manufacturers' patient assistance program. Additional information about drug company patient assistance programs is available on the internet at https://medicineassistancetool.org.</p>	<p>These agents are not a covered benefit. These agents may be available through the manufacturers' patient assistance program. Additional information about drug company patient assistance programs is available on the internet at https://medicineassistancetool.org.</p>

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CENTRAL NERVOUS SYSTEM AGENTS

Analgesic and Anti-Inflammatory Agents

Non-Steroidal Anti-Inflammatory Agents

FIRST LINE AGENTS

Aspirin	ASPIRIN
Aspirin EC	ECOTRIN
Celecoxib	CELEBREX
Diclofenac Sodium	VOLTAREN
Etodolac	LODINE
Ibuprofen	MOTRIN (INCLUDES OTC)
Indomethacin	INDOCIN
Ketoprofen	ORUVAIL, 200MG STRENGTH NON-FORMULARY
Indomethacin, Sustained Release	INDOCIN SR
Meloxicam Tablets	MOBIC (TABLETS ONLY), SUSPENSION NON-FORMULARY
Nabumetone	RELAFEN
Naproxen	NAPROSYN
Naproxen Sodium	ANAPROX
	ANAPROX DS
Salsalate	DISALCID
Sulindac	CLINORIL
Piroxicam	FELDENE

SECOND LINE AGENTS

SE	Etodolac Extended Release	LODINE XL, STEP THERAPY , RESTRICTED TO A TRIAL OF 2 UNRESTRICTED NSAIDS IN THE PAST 90 DAYS
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Miscellaneous Arthritis Agents

Leflunomide	ARAVA
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Migraine Agents

	APAP/Dichloralphenazone/Isomethep	MIDRIN
	Butalbital/APAP/Caffeine	ESGIC
		ESGIC PLUS
		FIORICET
	Butalbital/Aspirin/Caffeine (Tablets Only)	FIORINAL
	Ergotamine/Caffeine	CAFERGOT
QL	Naratriptan	AMERGE, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Rizatriptan	MAXALT, MAXALT MLT, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
QL	Sumatriptan	IMITREX, LIMITED TO 4 INJECTIONS, 9 TABLETS, OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH, SUMAVEL NON-FORMULARY
SE, QL	Eletriptan	RELPAK, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS/MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
SE, QL	Zolmitriptan	ZOMIG, ZOMIG ZMT STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF SUMATRIPTAN IN THE PAST 120 DAYS, LIMITED TO 9 TABLETS OR 6 NASAL UNITS PER MONTH, ONLY 1 RX FOR ANY TRIPTAN/MONTH
PA, QL	Dihydroergotamine	MIGRANAL, PA REQ , LIMITED TO 1 KIT (4 TREATMENTS) PER MONTH

Opiate Agonists

QL	Acetaminophen/Codeine	TYLENOL #2, #3, #4, LIMITED TO #240/MONTH OR 960ML/MONTH ; ORAL SUSPENSION AND VOPAC NON-FORMULARY
QL	Acetaminophen/Hydrocodone	NORCO 5/325, LIMITED TO #240/MONTH
QL		NORCO 7.5/325, LIMITED TO #180/MONTH
QL		NORCO 10/325, LIMITED TO #150/MONTH
		ALL OTHER HYDROCODONE/APAP STRENGTHS NON-FORMULARY
QL	Butalbital/APAP/Caffeine/Codeine	FIORICET/CODEINE, LIMITED TO #180/MONTH
QL	Butalbital/Aspirin/Caffeine/Codeine	FIORINAL/CODEINE, LIMITED TO #180/MONTH
QL	Codeine/Aspirin	EMPIRIN #2, #3, #4, LIMITED TO #240/MONTH
QL	Hydromorphone	DILAUDID, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine	MSIR, LIMITED TO #240/MONTH OR 960ML/MONTH
QL	Morphine SR	MS CONTIN/ORAMORPH SR, LIMITED TO #120/MONTH
QL	Oxycodone	OXYIR, LIMITED TO #240/MONTH
QL	Oxycodone	OXYFAST, LIMITED TO #960ML/MONTH
QL	Oxycodone/Acetaminophen	PERCOCET, LIMITED TO #240/MONTH; MAGNACET AND PRIMALEV NON-FORMULARY
QL		TYLOX, LIMITED TO #240/MONTH
QL	Oxycodone/Aspirin	PERCODAN, LIMITED TO #240/MONTH
PA, QL	Oxycodone	OXYCONTIN, PA REQ , LIMITED TO #60/MONTH

Narcotic Withdrawal Therapy Agents

Naloxone Spray and Syringes NARCAN; **EVZIO NON-FORMULARY**

Opiate Antagonists

Naltrexone REVIA

Miscellaneous Analgesics

	Acetaminophen	TYLENOL
	Tramadol	ULTRAM ; ULTRAM ER NON-FORMULARY
PA, QL	Butorphanol NS	STADOL NS, PA REQ , LIMITED TO 2 BOTTLES/MONTH

Miscellaneous Central Nervous System Agents

Donepezil ARICEPT

Anticonvulsant Agents

Barbiturate Anticonvulsants

Mephobarbital
Phenobarbital
Primidone
MEBARAL
PHENOBARBITAL
MYSOLINE

Benzodiazepine Anticonvulsants

QL	Clonazepam	KLONOPIN, LIMITED TO #90/MONTH; RAPDIS TABLETS NON-FORMULARY
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Hydantoin Anticonvulsants

Phenytoin
DILANTIN, PHENYTEK

Miscellaneous Anticonvulsants

Carbamazepine
Carbamazepine Extended Release
TEGRETOL; **EQUETRO NON-FORMULARY**
TEGRETOL XR

Divalproex Sodium
Divalproex Sodium Extended Release
DEPAKOTE
DEPAKOTE ER
Gabapentin
NEURONTIN
Levetiracetam
KEPPRA
Oxcarbazepine
TRILEPTAL
Tiagabine
GABITRIL
Valproic Acid
DEPAKENE
Zonisamide
ZONEGRAN

QL	Lamotrigine	LAMICTAL, LIMITED TO #60/MONTH FOR 100MG AND 150MG, #180/MONTH FOR 25MG
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QL	Topiramate	TOPAMAX, LIMITED TO #90/MONTH FOR 25MG, 50MG AND 100MG STRENGTHS
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Antiparkinsonian Agents

Amantadine	SYMMETREL
Benzotropine Mesylate	COGENTIN
Bromocriptine	PARLODEL
Carbidopa/Levodopa	SINEMET; PARCOPA NON-FORMULARY
Carbidopa/Levodopa CR	SINEMET CR
Pramipexole	MIRAPEX
Ropinirole	REQUIP; REQUIP XL NON-FORMULARY
Selegiline	SELEGILINE, ZELAPAR AND EMSAM NON-FORMULARY
Trihexyphenidyl	ARTANE

Muscle Relaxant Agents

Skeletal Muscle Relaxants

QL	Baclofen	LIORESAL
	Carisoprodol	SOMA, LIMITED TO #120/MONTH; 250 STRENGTH NON-FORMULARY
	Chlorzoxazone	PARAFON DSC
	Cyclobenzaprine	FLEXERIL
	Dantrolene Sodium	DANTRIUUM
	Methocarbamol	ROBAXIN
	Orphenadrine Citrate	NORFLEX
	Orphenadrine/Aspirin/Caffeine	NORGESIC

Psychotherapeutic Agents

Tricyclic Antidepressant Agents

Amitriptyline	ELAVIL
Amoxapine	ASENDIN
Desipramine	NORPRAMIN
Doxepin	SINEQUAN
Imipramine	TOFRANIL, TOFRANIL PM NON-FORMULARY
Maprotiline	LUDIOMIL
Nortriptyline	PAMELOR
Protriptyline	VIVACTIL

S.S.R.I. Agents

Citalopram	CELEXA
Fluoxetine Capsules	PROZAC CAPSULES (10MG, 20MG ONLY), TABLETS NON-FORMULARY
Fluvoxamine	LUVOX
Paroxetine	PAXIL
Sertraline	ZOLOFT

S.N.R.I. Agents

QL	Duloxetine	CYMBALTA , LIMITED TO #60/MONTH
QL	Venlafaxine	EFFEXOR, LIMITED TO #60/MONTH IF DOSE ≤ 200MG/DAY, LIMITED TO #90/MONTH OF DOSE > 200MG/DAY
QL	Venlafaxine Extended Release	EFFEXOR XR, LIMITED TO #30/MONTH VENLAFAXINE EXTENDED RELEASE TABLETS NON-FORMULARY

M.A.O. Inhibitor Agents

Phenelzine	NARDIL
Tranylcypromine	PARNATE

Miscellaneous Antidepressant Agents

	Bupropion	WELLBUTRIN, APLENZIN NON-FORMULARY
	Bupropion SR	WELLBUTRIN SR, APLENZIN NON-FORMULARY
	Bupropion XL	WELLBUTRIN XL, APLENZIN NON-FORMULARY
	Clomipramine	ANAFRANIL
	Mirtazapine	REMERON TAB, SOLTABS AND 7.5MG TABLETS NON-FORMULARY
	Trazodone	DESYREL
MD, QL	Nefazodone	SERZONE, RESTRICTED TO PSYCHIATRY, LIMITED TO #60/MONTH

Antimanic Agents

	Lithium Carbonate	ESKALITH LITHOBID
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Benzodiazepines

QL	Alprazolam	XANAX, LIMITED TO #90/MONTH; XANAX XR, NIRAVAM, AND ALPRAZOLAM INTENSOL NON-FORMULARY
QL	Clorazepate	TRANXENE, LIMITED TO #90/MONTH
QL	Chlordiazepoxide	LIBRIUM, LIMITED TO #90/MONTH
QL	Diazepam	VALIUM, LIMITED TO #90/MONTH, DIASTAT NON-FORMULARY
QL	Flurazepam	DALMANE, LIMITED TO #30/MONTH
QL	Lorazepam	ATIVAN, LIMITED TO #90/MONTH; LORAZEPAM ORAL CONCENTRATE NON-FORMULARY
QL	Temazepam	RESTORIL, LIMITED TO #30/MONTH; 22.5MG STRENGTH NON-FORMULARY
QL	Triazolam	HALCION, LIMITED TO #30/MONTH

Antipsychotic Agents

QL	Asenapine	SAPHRIS, LIMITED TO #60 PER MONTH
QL	Aripiprazole	ABILIFY, LIMITED TO #30 PER MONTH DISCMELTS NON-FORMULARY
	Chlorpromazine	THORAZINE
	Clozapine	CLOZARIL
	Fluphenazine	PROLIXIN
	Haloperidol	HALDOL, HALDOL DECANOATE-VIALS ONLY
	Loxapine	LOXITANE
	Molindone	MOBAN
QL	Olanzapine	ZYPREXA, LIMITED TO #60/MONTH
QL		ZYPREXA ZYDIS, LIMITED TO #60/MONTH
		ZYPREXA INJECTION
		ZYPREXA RELPREVV
	Perphenazine	TRILAFON
	Pimozide	ORAP
QL	Quetiapine	SEROQUEL, LIMITED TO #90/MONTH, 25MG STRENGTH NON-FORMULARY. 25MG STRENGTH NOT COVERED FOR INSOMNIA, SUBMIT PA FOR OTHER INDICATIONS.
QL	Risperidone	RISPERDAL, LIMITED TO #60/MONTH
	Thioridazine	MELLARIL
	Thiothixene	NAVANE
QL	Trifluoperazine	STELAZINE
QL	Ziprasidone	GEODON, LIMITED TO #60/MONTH

Antipsychotic/SSRI Combination Agents

QL	Olanzapine/Fluoxetine HCl	SYMBYAX, LIMITED TO #30/MONTH
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Miscellaneous Anxiolytics, Sedatives, and Hypnotics

	Buspirone	BUSPAR 7.5MG STRENGTH NON-FORMULARY
	Chloral Hydrate	NOCTEC

QL	Hydroxyzine Hydroxyzine Pamoate Promethazine Zolpidem	ATARAX VISTARIL PHENERGAN AMBIEN, LIMITED TO #14/MONTH, AMBIEN CR AND EDLUAR NON-FORMULARY
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CARDIOVASCULAR/BLOOD AGENTS

Antiarrhythmic Agents

Antidysrhythmic Drug Agents

Amiodarone	CORDARONE; 100MG STRENGTH NON-FORMULARY
Disopyramide	NORPACE
Disopyramide CR	NORPACE CR
Flecainide	TAMBOCOR
Mexiletine	MEXITIL
Procainamide	PRONESTYL
Procainamide SR	PROCAN SR
	PROCANBID
Propafenone	RYTHMOL
Quinidine Gluconate	QUINAGLUTE
Quinidine Polygalacturonate	CARDIOQUIN
Quinidine Sulfate	CIN-QUIN
Quinidine Sulfate SR	QUINIDEX
Sotalol	BETAPACE

Antihypertensive Agents

Alpha-Adrenergic Antagonist Antihypertensive Agents

Reserpine	SERPASIL
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Beta-Adrenergic Antagonist Agents

Atenolol	TENORMIN
Metoprolol Succinate	TOPROL XL
Metoprolol Tartrate	LOPRESSOR
Nadolol	CORGARD
Pindolol	VISKEN
Propranolol	INDERAL
Propranolol LA	INDERAL LA

Combination Alpha-Beta Antagonist Agents

Carvedilol	COREG; COREG CR NON-FORMULARY
Labetalol	NORMODYNE
	TRANDATE

Angiotensin Converting Enzyme Inhibitor Agents

Benazepril	LOTENSIN
Captopril	CAPOTEN
Enalapril	VASOTEC
Lisinopril	PRINIVIL
	ZESTRIL

Angiotensin Receptor Blocker Agents

SE, QL	Irbesartan	AVAPRO
	Losartan	COZAAR
	Telmisartan	MICARDIS
	Olmesartan	BENICAR, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

SE, QL

Valsartan

DIOVAN, **STEP THERAPY**, LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

Calcium Channel Blocking Agents

Amlodipine
Diltiazem
Diltiazem SR
Diltiazem CD
Felodipine
Nifedipine, Sustained Release
Verapamil
Verapamil LA Tablets
Verapamil SR Capsules

NORVASC, LIMITED TO #30/MONTH
CARDIZEM
CARDIZEM SR; **CARDIZEM LA NON-FORMULARY**
CARTIA XT
PLENDIL, LIMITED TO #30/MONTH
ADALAT CC
CALAN
CALAN SR; **COVERA-HS NON-FORMULARY**
VERELAN

Centrally Acting Antihypertensive Agents

Clonidine
Guanfacine
Methyldopa

CATAPRES
TENEX
ALDOMET

Combination Antihypertensive Agents

Atenolol/Chlorthalidone
Benazepril/HCTZ
Bisoprolol/HCTZ
Captopril/HCTZ
Enalapril/HCTZ
Lisinopril/HCTZ

TENORETIC
LOTENSIN HCT
ZIAC
CAPOZIDE
VASORETIC
ZESTORETIC
PRINZIDE

SE, QL

Losartan/HCTZ
Olmesartan/HCTZ

HYZAAR,
BENICAR HCT, **STEP THERAPY**, LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

SE, QL

Valsartan/HCTZ

DIOVAN HCT, **STEP THERAPY**, LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF LOSARTAN OR LOSARTAN/HCTZ IN THE PAST 90 DAYS

Drugs for Pheochromocytoma

PA

Phenoxybenzamine

DIBENZYLINE, **PA REQUIRED**

Potassium-Sparing Diuretics

Spironolactone
Spironolactone/HCTZ
Triamterene
Triamterene 37.5mg/HCTZ 25mg
Triamterene 37.5mg/HCTZ 25mg
Triamterene 75mg/HCTZ 50mg

ALDACTONE
ALDACTAZIDE
DYRENIUM
DYAZIDE
DYAZIDE
MAXZIDE 50

Loop Diuretics

Bumetanide
Furosemide

BUMEX
LASIX

Thiazide and Related Diuretics

Chlorthalidone
Hydrochlorothiazide (HCTZ)
Indapamide
Metolazone

HYGROTON
HYDRODIURIL
LOZOL
ZAROXOLYN

Vasodilator Antihypertensive Agents

Doxazosin Mesylate
Hydralazine
Minoxidil
Prazosin
Terazosin

CARDURA; **CARDURAL XL NON-FORMULARY**
APRESOLINE
LONITEN
MINIPRESS
HYTRIN

Antilipemic Agents

Atorvastatin	LIPITOR
Cholestyramine/Aspartame	QUESTRAN LIGHT
Cholestyramine/Sucrose	QUESTRAN
Gemfibrozil	LOPID
Lovastatin	MEVACOR
Niacin	NIACIN
Pravastatin	PRAVACHOL
Niacin, Delayed Release	NIASPAN
Niacin/Lovastatin	ADVICOR
Simvastatin	ZOCOR, 80MG STRENGTH RESTRICTED TO PRIOR USE OF 80MG DUE TO MYOPATHY RISK; ALL OTHER STRENGTHS FORMULARY

Blood Agents

Coagulants and Anticoagulants

QL	Enoxaparin	LOVENOX, LIMITED TO #20/FILL TIMES 3
	Warfarin Sodium	COUMADIN

Hemophilia Agents

Hemophilia products otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP at (916) 552-9105 opt 2 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: <https://cmspcounties.org>.

Hemorheologic Agents

Pentoxifylline	TRENTAL
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Cardiac Glycoside Agents

Digoxin	LANOXIN; LANOXICAPS NON-FORMULARY
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Antiplatelet Agents

Cilostazole	PLETAL
Clopidogrel	PLAVIX
Dipyridamole	persantine
Pasugrel	EFFIENT

Vasodilating Agents

Isosorbide Dinitrate	ISORDIL; CHEW TABLETS NON-FORMULARY
Isosorbide Dinitrate SR	DILATRATE SR
Isosorbide Mononitrate	ISOSORBIDE MONONITRATE
Isosorbide Dinitrate ER	ISOSORBIDE MONONITRATE
Nitroglycerin Ointment	NITROL
Nitroglycerin Patches	NITRO-DUR
Nitroglycerin Spray	NITROLINGUAL SPRAY
Nitroglycerin Sublingual	NITROSTAT SL
SE	IMDUR, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ISOSORBIDE DINITRATE OR ISOSORBIDE DINITRATE SR IN THE PAST 90 DAYS

GASTROINTESTINAL AGENTS

Antidiarrheal Agents

Attapulgite	PAREPECTOLIN
Bismuth Subsalicylate	PEPTO BISMOL
Diphenoxylate/Atropine	LOMOTIL
Kaolin/Pectin	KAOPECTATE
Loperamide	IMODIUM

Antiemetic Agents

Meclizine	ANTIVERT
Metoclopramide	REGLAN
Ondansetron ODT Tablets	ZOFRAN ODT
Ondansetron Tablets	ZOFRAN TABLETS
Ondansetron Solution	ZOFRAN SOLUTION
Prochlorperazine Maleate	COMPAZINE
	COMPAZINE SPANSULES NOT COVERED
Promethazine	PHENERGAN
Trimethobenzamide	TIGAN

Antimuscarinic/Antispasmodic Agents

Belladonna/Phenobarbital (Extentabs, Capsules Not Covered)	DONNATAL
Chlordiazepoxide/Clidinium	CHLORDIAZEPOXIDE/CLIDINIUM
Dicyclomine	BENTYL
Hyoscyamine Sulfate	LEVBID
	LEVSIN
	LEVSIN SL

Antiulcer/Antipeptic Agents

Antacid Mg OH/Al OH	MAALOX, TC
Antacid Mg OH/Al OH/Simethicone	MYLANTA I, II
Lansoprazole 15mg OTC	PREVACID 24HR, LEGEND LANSOPRAZOLE NON-FORMULARY
Misoprostol	CYTOTEC
Omeprazole 20mg and 40mg	PRILOSEC 20MG AND 40MG, OTHER STRENGTHS NON-FORMULARY
Omeprazole Magnesium	PRILOSEC OTC
Pantoprazole Tablets	PROTONIX
Simethicone	MYLICON
Sucralfate	CARAFATE

Bowel Evacuant Agents

QL	Bowel Evacuation Prep Kits	FLEET PREP KIT 1, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR FLEET PREP KIT 2, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR FLEET PREP KIT 3, LIMITED TO #2 KITS/MONTH AND 4 FILLS PER YEAR
QL	Enema	FLEET ENEMA, LIMITED TO #2 ENEMAS/MONTH AND 4 FILLS PER YEAR

QL	Oral Colon Lavage Solution Oral Saline Laxative	COLYTE FLEET PHOSPHO-SODA, LIMITED TO #2 BOTTLES/MONTH AND 4 FILLS PER YEAR
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Digestive Enzymes

Amylase/Lipase/Protease	PANCRELIPASE 5,000
Amylase/Lipase/Protease	CREON
Amylase/Lipase/Protease	PANCREAZE

Gallstone Solubilizing Agents

Ursodiol	ACTIGALL
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Gastrointestinal Stimulant Agents

Metoclopramide	REGLAN
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H₂ Antagonist Agents

Cimetidine	TAGAMET
Famotidine	PEPCID
Ranitidine	ZANTAC (TABLETS ONLY)

Laxative Agents

QL	Bisacodyl Suppositories	DULCOLAX, LIMITED TO #30/MONTH
	Docusate Sodium Capsules	COLACE
QL	Lactulose	CEPHULAC, LIMITED TO 4L/MONTH
QL		CHRONULAC, LIMITED TO 4L/MONTH
	Sennosides	SENNA

Miscellaneous Gastrointestinal Supplies

Ostomy Supplies

Miscellaneous Gastrointestinal Agents

	Mesalamine	DELZICOL
		ROWASA
	Olsalazine	DIPENTUM
	Sulfasalazine	AZULFIDINE
PA	Budesonide	ENTOCORT EC, PA REQ

ANTI-INFECTIVE AGENTS

Amebicides

Metronidazole	FLAGYL; FLAGYL ER NON-FORMULARY
Iodoquinol (Diiodohydroxyquin)	YODOXIN

Anthelmintic Agents

Albendazole	ALBENZA
Furazolidone	FUROXONE
Mebendazole	VERMOX
Praziquantel	BILTRICIDE

Antibiotic Agents

Aminoglycosides

Neomycin Sulfate

MYCIFRADIN

Cephalosporins

Cefaclor

CECLOR

Cefadroxil

DURICEF

Cefdinir

OMNICEF

QL

Cefixime

SUPRAX, LIMITED TO #1 X 400MG/FILL

Cefuroxime Tablets

CEFTIN

Cephalexin

KEFLEX; **750MG STRENGTH NON-FORMULARY**

Macrolide Antibiotic Agents

QL

Azithromycin

ZITHROMAX, LIMITED TO A 5-DAY SUPPLY; **ZMAX NON-FORMULARY**

Erythromycin Base

ERY-TAB

PCE

ERYPED SUSPENSION

Erythromycin Stearate

ERYTHROCIN

Erythromycin Ethylsuccinate

EES

Erythromycin/Sulfisoxazole

PEDIAZOLE

PA

Clarithromycin

BIAXIN, **PA REQ**

Miscellaneous Antibiotic Agents

Clindamycin

CLEOCIN

Metronidazole

FLAGYL

Penicillins

Amoxicillin

AMOXIL

TRIMOX

Amoxicillin/Potassium Clavulanate

AUGMENTIN

Ampicillin

PRINCIPEN

Dicloxacillin

DYNAPEN

Penicillin VK (125mg Tablets Not Covered)

PEN VK

Quinolones

QL

Ciprofloxacin tablets

CIPRO TABLETS ONLY, LIMITED TO 21-DAY SUPPLY; **CIPRO XR AND PROQUIN XR NONFORMULARY**

QL

Moxifloxacin

AVELOX, LIMITED TO 21-DAY SUPPLY

Sulfonamide Agents

Erythromycin/Sulfisoxazole

PEDIAZOLE

Sulfamethoxazole/Trimethoprim (SMZ/TMP)

BACTRIM

SEPTRA

Sulfisoxazole

GANTRISIN

Sulfadiazine

SULFADIAZINE

Trimethoprim

TRIMPEX

Tetracyclines

Doxycycline

VIBRAMYCIN

VIBRA-TABS

DORYX, PERIOSTAT, AND ORACEA NON-FORMULARY

Minocycline

MINOCIN

Tetracycline

ACHROMYCIN V

SUMYCIN

Antifungal Agents

Clotrimazole

MYCELEX TROCHE

Fluconazole

DIFLUCAN

Griseofulvin Ultramicrosized	GRIS-PEG
Ketoconazole	FULVICIN P/G
Nystatin (Oral Powder Not Covered)	NIZORAL
Terbinafine Tablets	MYCOSTATIN
	LAMISIL TABLETS

Antimalarial Agents

Atovaquone/Proguanil	MALARONE
Chloroquine Phosphate	CHLOROQUINE PHOSPHATE
Hydroxychloroquine	PLAQUENIL
Iodoquinol	YODOXIN
Mefloquine	LARIAM
Primaquine	PRIMAQUINE
Pyrimethamine	DARAPRIM
Quinine (260mg Not Covered)	QUININE

Antituberculosis Agents

Ethambutol	MYAMBUTOL
Isoniazid	ISONIAZID
Pyrazinamide	PYRAZINAMIDE
Rifabutin	MYCOBUTIN
Rifampin	RIFADIN

Anti-Ulcer Eradication Agents

QL	Amoxicillin/Clarithromycin/Lansoprazole	PREVPAC, LIMITED TO 14-DAY SUPPLY/YEAR
QL	Tetracycline/Bismuth/Metronidazole	HELIDAC, LIMITED TO 14-DAY SUPPLY/YEAR

Hepatitis C Antiviral Agents

PA	Ribavirin	COPEGUS, REBETOL, PA REQ
PA	Peginterferon Alfa 2b	PEG-INTRON, PA REQ , PEGASYS NON-FORMULARY

Other Hepatitis C agents are not a covered benefit for CMSP members. These agents may be available through the manufacturers' patient assistance program. Additional information about drug company patient assistance programs is available on the internet at <http://https://medicineassistancetool.org/>.

HIV Antiretroviral Agents

CMSP requires evidence of ADAP ineligibility for antiretroviral coverage for the treatment of HIV infection. Contact ADAP (844) 421-7050 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for antiretroviral coverage. This form can be obtained on the CMSP website: <https://cmspcounties.org>

Pre-exposure prophylaxis (PrEP) is not a covered benefit. It may be available through the manufacturer's patient assistance program. Additional information about drug company patient assistance programs is available on the internet at <https://medicineassistancetool.org>.

Other Antiviral Agents

Amantadine	SYMMETREL
Acyclovir Oral	ZOVIRAX ORAL
Osetamivir	TAMIFLU, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER TAMIFLU OR RELENZA PER 6 MONTHS
Rimantadine	FLUMADINE
Zanamivir	RELENZA, QTY LIMITED TO A 5-DAY COURSE OF TREATMENT OF EITHER RELENZA OR TAMIFLU PER 6 MONTHS

SE	Valacyclovir Famciclovir	VALTREX FAMVIR, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ACYCLOVIR IN THE PAST 90 DAYS
	Nirmatrelvir/Ritonavir Molnupiravir Tecovirimat Oral	PAXLOVID (EUA) LAGEVRIO (EUA) TPOXX (NATIONAL STOCKPILE)

Leprostatic Agents

Clofazimine Dapsone	LAMPRENE DAPSONE; ACZONE NON-FORMULARY
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ANTINEOPLASTIC, IMMUNOMODULATOR, BLOOD COLONY STIMULATING FACTOR AND IMMUNOSUPPRESSANT AGENTS

Antineoplastic Agents

PA	Altretamine Anastrozole Bexarotene Bicalutamide Busulfan Capecitabine Chlorambucil Cyclophosphamide Estramustine Etoposide Flutamide Hydroxyurea Imatinib Letrozole Levamisole Lomustine Megestrol Melphalan Mercaptopurine Methotrexate Mitotane Nilutamide Procarbazine Tamoxifen Citrate Testolactone Thioguanine Tretinoin	HEXALEN ARIMIDEX TARGRETIN CASODEX MYLERAN XELODA LEUKERAN CYTOXAN EMCYT VEPESID EULEXIN HYDREA GLEEVEC, PA REQ FEMARA ERGAMISOL CEENU MEGACE ALKERAN PURINETHOL RHEUMATREX LYSODREN NILANDRON MATULANE NOLVADEX TESLAC THIOGUANINE VESANOID
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Blood Colony Stimulating Factors

PA	Darbepoetin	ARANESP, PA REQ
PA	Erythropoietin	EPOGEN, PA REQ
PA		PROCRIT, PA REQ
PA	Filgrastim	NEUPOGEN, PA REQ
PA	Oprelvekin	NEUMEGA, PA REQ
PA	Pegfilgrastim	NEULASTA, PA REQ

PA Sargramostim LEUKINE, PA REQ

Multiple Sclerosis Agents

PA Glatiramer COPAXONE, PA REQ
PA Interferon Beta 1a AVONEX, PA REQ
PA REBIF, PA REQ
PA Interferon Beta 1b BETASERON, PA REQ

Miscellaneous Agents

PA Adalimumab HUMIRA, PA REQ
PA Anakinra KINERET, PA REQ
PA Etanercept ENBREL, PA REQ
PA Interferon Alfa 2a ROFERON A, PA REQ
PA Interferon Alfa 2b INTRON A, PA REQ
PA Interferon Alfa N3 ALFERON N, PA REQ
PA Interferon Alfacon 1 INFERGEN, PA REQ
PA Interferon Gamma 1b ACTIMMUNE, PA REQ
PA Leuprolide LUPRON, PA REQ

Immunosuppressant Agents

Azathioprine IMURAN; AZASAN NON-FORMULARY
Cyclosporine NEORAL
Leucovorin SANDIMMUNE
Mycophenolate Mofetil WELLCOVORIN
Sirolimus CELLCEPT ; MYFORTIC NON-FORMULARY
Tacrolimus (Oral only) RAPAMUNE
PROGRAF

RESPIRATORY/ENT AGENTS

Antihistamine Agents

Single Entity Alkylamine Agents

Chlorpheniramine CHLORTRIMETON
Dexchlorpheniramine POLARAMINE

Single Entity Ethanolamine Agents

Cyproheptadine PERIACTIN
Diphenhydramine BENADRYL

Non-Sedating Single Entity Agents

Cetirizine, OTC CETIRIZINE, OTC
Fexofenadine FEXOFENADINE
Loratadine, OTC LORATADINE, OTC

Miscellaneous Antihistamine Agents

Hydroxyzine ATARAX
Hydroxyzine Pamoate VISTARIL
Promethazine PHENERGAN

Antihistamine/Decongestant Combination Agents

Antihistamine/Decongestant Agents

Bromphen/Pseudoephedrine BROMFED
BROMFED PD
Guaifenesin/Pseudoephedrine GUAIFED-PD
Pseudoephedrine/Chlorpheniramine DECONAMINE SR

Antitussive Agents

Non-Narcotic Antitussive Agents

Benzonatate	TESSALON
Dextromethorphan	TUSSIN PEDIATRIC
Promethazine/Dextromethorphan	PHENERGAN W/DEXTROMETHORPHAN

Narcotic Antitussive Agents

Codeine/Chlorpheniramine/ Pseudoephedrine	NOVAHISTINE DH
Guaifenesin/Codeine	ROBITUSSIN A-C
Guaifenesin/Codeine/Pseudoephedrine	NOVAHISTINE EXPECTORANT ROBITUSSIN DAC
Phenylephrine/Hydrocodone/ Chlorpheniramine	HISTUSSIN HC ENDAL-HD
Promethazine/Codeine	PHENERGAN/CODEINE
Promethazine/Phenylephrine/Codeine	PHENERGAN VC/CODEINE
Terpin Hydrate/Codeine	TERPIN HYDRATE/CODEINE
Tripolidine/Pseudoephedrine/Codeine	ACTIFED/CODEINE

Decongestants

Pseudoephedrine	SUDAFED
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Asthma/COPD Agents

Inhaled Sympathomimetic (Adrenergic) Agents

QL	Albuterol HFA	PROVENTIL HFA , LIMITED TO #2 INHALERS/MONTH, PROAIR HFA, VENTOLIN HFA, AND XOPENEX HFA NON-FORMULARY.
QL	Albuterol/Ipratropium	COMBIVENT RESPIMAT, LIMITED TO #1 INHALER/MONTH
QL	Formoterol	FORADIL, LIMITED TO #60/MONTH
QL	Ipratropium	ATROVENT HFA
QL	Pirbuterol Acetate	MAXAIR, LIMITED TO #2 INHALERS/MONTH MAXAIR AUTOHALER, LIMITED TO #2 INHALERS/MONTH
QL	Salmeterol	SEREVENT, LIMITED TO #1 INHALER/MONTH OR #60 BLISTERS/MONTH
SE, QL	Mometasone/Formoterol	DULERA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF ORAL INHALED STEROID (IF ASTHMA), ANTICHOLINERGIC, OR ANTICHOLINERGIC/LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH
SE, QL	Salmeterol/Fluticasone	ADVAIR DISKUS 250/50 STRENGTH ONLY, STEP THERAPY , RESTRICTED TO COPD AFTER A TRIAL ANTICHOLINERGIC OR LABA IN THE PAST 90 DAYS, LIMITED TO #1 INHALER/MONTH

Oral Sympathomimetic (Adrenergic) Agents

Albuterol	PROVENTIL
Albuterol E.R.	PROVENTIL REPETABS VOLMAX
Metaproterenol Oral	ALUPENT
Terbutaline Sulfate	BRETHINE BRICANYL

Inhaled Oral Corticosteroid Agents

QL	Beclomethasone Inhaler	QVAR REDIHALER, LIMITED TO #2 INHALERS/MONTH
QL	Mometasone Inhaler	ASMANEX, LIMITED TO #2 INHALERS/MONTH

Leukotriene Receptor Antagonists

QL	Montelukast	SINGULAIR, LIMITED TO #30/MONTH
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Respiratory Smooth Muscle Relaxant Agents

Aminophylline 150mg/5ml	
Aminophylline Suppositories	
Theophylline, 80mg/15cc (Alcohol Free)	SLO-PHYLLIN 80

Theophylline
Theophylline, Sustained Release

SLO-PHYLLIN
THEO-DUR, SLO-BID, UNIPHYL

Cystic Fibrosis Therapy

Cystic Fibrosis therapy otherwise available through the Genetically Handicapped Persons Program (GHPP) program are not a covered benefit unless the member is not eligible for GHPP. Evidence of GHPP ineligibility is required. Contact GHPP at (916) 552-9105 opt 2 for more information. A Record of Denied Program Eligibility form must be completed and submitted to CMSP for medication coverage. This form can be obtained on the CMSP website: <https://cmspcounties.org>.

Expectorant Agents

Guaifenesin	ROBITUSSIN
Guaifenesin/Dextromethorphan	ROBITUSSIN DM
Guaifenesin/Phenylephrine	ENDAL
Guaifenesin/Pseudoephedrine	ZEPHREX LA
Phenylephrine/Promethazine	PHENERGAN VC
Phenylephrine/Guaifenesin	RESCON GC
Potassium Iodide	SSKI

Mucolytic Agents

Acetylcysteine	MUCOMYST
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Eye, Ear, Nose and Throat (EENT) Preparations

Ophthalmic Antibiotic Agents

Bacitracin	BACITRACIN
Dexamethasone/Polymyxin/Neomycin	MAXITROL
Erythromycin Base	ILOTYCIN
Gentamicin	GARAMYCIN
Gentamicin/Prednisolone	PRED-G
Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN OPHTHALMIC
Neomycin/Gramicidin/Polymyxin	NEOSPORIN OPHTHALMIC
Ofloxacin	OCUFLOX
Polymixin B Sulfate/TMP	POLYTRIM
Tobramycin	TOBREX

Ophthalmic Anti-Inflammatory Agents, Corticosteroid

Fluorometholone	EFLONE
	FML
	FML FORTE
Prednisolone Acetate	PRED MILD OPHTHALMIC
	PRED FORTE
Prednisolone Phosphate	INFLAMASE
	INFLAMASE FORTE

Ophthalmic Anti-Inflammatory Agents, NSAIDs

Flurbiprofen Sodium	OCUFEN
Diclofenac Sodium	VOLTAREN
Ketorolac Tromethamine	ACULAR

Ophthalmic Antiviral Agents

Trifluridine Ophthalmic Solution	VIROPTIC
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Ophthalmic Beta Blockers

Levobunolol	BETAGAN
Timolol	TIMOPTIC

Ophthalmic Miotic Agents

Brimonidine

Dorzolamide
Dorzolamide/Timolol
Echothiophate Iodide
Pilocarpine

Ophthalmic Mydriatic Agents

Atropine Sulfate
Dipivefrin
Tropicamide

Ophthalmic Sulfonamide Agents

Sulfacetamide

Sulfacetamide 10%/Prednisolone 0.2%
Sulfacetamide 10%/Prednisolone 0.5%

Miscellaneous Ophthalmic Agents

Ketotifen
Latanoprost
Naphazoline
Naphazoline/Pheniramine

Otic Anti-Infective Agents

Acetic Acid
Acetic Acid 2%
Acetic Acid 2%/Hydrocortisone 1%
Hydrocortisone/Neomycin/Polymyxin
Ofloxacin

Miscellaneous Otic Agents

Benzocaine/Antipyrine
Carbamide Peroxide/Glycerin

ALPHAGAN
ALPHAGAN P
TRUSOPT
COSOPT
PHOSPHOLINE IODIDE
PILOCAR
OCUSERT NOT COVERED

ISOPTO ATROPINE
PROPINE
MYDRIACYL

BLEPH-10
SODIUM SULAMYD
BLEPHAMIDE
METIMYD

ZADITOR OTC, ALAWAY
XALATAN
ALBALON
NAPHCON-A

VOSOL
DOMEBORO
VOSOL HC
CORTISPORIN
FLOXIN OTIC

AURALGAN
DEBROX

Inhaled/Oral EENT Agents

Inhaled Nasal Agents

Fluticasone, Nasal
Triamcinolone, Nasal
Ipratropium, Nasal

QL

Carbonic Anhydrase Inhibitor Agents

Acetazolamide
Acetazolamide SA
Methazolamide

Local Anesthetic Agents

Benzocaine/Antipyrine Otic
Lidocaine Solution
Lidocaine, Viscous
Triamcinolone 0.1% in Orabase

FLONASE
NASACORT
ATROVENT, LIMITED TO #2 DEVICES/MONTH

DIAMOX
DIAMOX SEQUELS
NEPTAZANE

AURALGAN
XYLOCAINE
VISCIOUS XYLOCAINE
KENALOG IN ORABASE

Miscellaneous EENT Agents

Carbachol
Chlorhexidine Gluconate
Cromolyn Ophthalmic Solution
Epinephrine Injection
Optichamber
Sodium Chloride for Inhalation
Triethanolamine

QL

ISOPTO CARBACHOL
PERIDEX
CROLOM
EPIPEN
OPTICHAMBER, LIMITED TO #2/YEAR
GENERIC
CERUMENEX

DIABETES AND THYROID AGENTS

Oral Diabetes Agents

Sulfonylureas

Glipizide	GLUCOTROL
Glipizide L.A.	GLUCOTROL XL
Glyburide	DIABETA, GLYNASE
	MICRONASE
Glimepiride	AMARYL
Chlorpropamide	DIABINESE
Tolazamide	TOLINASE
Tolbutamide	ORINASE

Non-Sulfonylureas

	Acarbose	PRECOSE
	Metformin	GLUCOPHAGE
	Metformin ER	GLUCOPHAGE XR
	Pioglitazone	ACTOS
SE, QL	Alogliptin	NESINA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH
SE, QL	Sitagliptin	JANUVIA, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN IN THE PAST 365 DAYS , LIMITED TO 30 TABLETS/MONTH

Combination Diabetes Agents

	Glipizide/Metformin	METAGLIP
SE, QL	Glyburide/Metformin	GLUCOVANCE
	Alogliptin/Metformin	KAZANO, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR ALOGLIPTIN IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH
SE, QL	Sitagliptin/Metformin	JANUMET, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 60 TABLETS/MONTH
SE, QL	Sitagliptin/Metformin Extended Release	JANUMET XR, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF METFORMIN OR JANUVIA IN THE PAST 365 DAYS, LIMITED TO 30 TABLETS/MONTH EXCEPT JANUMET XR 50-1000, WHICH IS LIMITED TO 60 TABLETS/MONTH

Insulin Agents

Rapid-Acting Insulins

Insulin Lispro	INSULIN LISPRO VIAL & KWIKPEN U-100
Insulin Lispro Protamine/Insulin Lispro	INSULIN LISPRO PROTAMINE MIX 75-25 PEN; HUMALOG MIX 75-25 VIAL; HUMALOG MIX 50-50 VIAL & KWIKPEN

Insulin Aspart
Insulin Aspart Protamine/Insulin Aspart

Regular Insulins

Insulin Regular
Insulin NPH
Insulin NPH/ Insulin Regular

Long-Acting Insulins

Insulin Glargine
Insulin Glargine-AGLR
Insulin Glargine-YFGN

NOVOLOG VIAL & FLEXPEN
INSULIN ASPART PROTAMINE/INSULIN ASPART MIX 70-30
VIAL, NOVOLOG MIX 70-30 VIAL & FLEXPEN

HUMULIN R VIAL
HUMULIN N VIAL & KWIKPEN
HUMULIN MIX 70-30 VIAL & KWIKPEN

INSULIN GLARGINE VIAL, LANTUS VIAL & SOLOSTAR PEN
REZVOGLAR KWIKPEN
INSULIN GLARGINE-YFGN VIAL & PEN

Miscellaneous Diabetes Agents

Glucagon

GLUCAGON

Thyroid Agents

Levothyroxine
Liotrix
Liothyronine
Thyroid, Desiccated

LEVOTHROID
THYROLAR
CYTOMEL
ARMOUR THYROID
LEVOXYL
SYNTHROID

Antithyroid Agents

Methimazole
Propylthiouracil

TAPAZOLE
PROPYLTHIOURACIL

HORMONE AGENTS

Oral Adrenal Corticosteroid Agents

Cortisone Acetate
Dexamethasone
Fludrocortisone Acetate
Hydrocortisone Oral
Methylprednisolone
Prednisone

Prednisolone

CORTONE
DECADRON
FLORINEF
CORTEF
MEDROL
DELTASONE
ORASONE
MEDROL DOSEPAK
PEDIAPRED
PRELONE

Androgen Agents

Danazol
Fluoxymesterone
Methyltestosterone

DANOCRINE
HALOTESTIN
ANDROID
METANDREN

Bone Resorption Inhibitors

QL	Alendronate	FOSAMAX, 70MG AND 35MG LIMITED TO #4/MONTH; 5MG, 10MG, AND 40MG LIMITED TO #30/MONTH; SOLUTION LIMITED TO #300ML/MONTH FOSAMAX PLUS D NONFORMULARY
PA	Calcitonin	MIACALCIN NS, PA REQ

Parathyroid Hormone

PA, QL	Teriparatide	FORTEO, PA REQ , LIMITED TO 1 PEN/MONTH
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Estrogen Agents

	Conjugated Estrogens	PREMARIN
	Conjugated Estrogens, Vaginal	PREMARIN VAGINAL CREAM
	Estradiol	ESTRACE
	Estradiol Patches	ALORA CLIMARA ESTRADERM VIVELLE VIVELLE DOT
	Estrogen/Medroxyprogesterone	PREMPRO, PREMPRO LOW DOSE PREMPHASE
SE	Esterified Estrogens/Methyltestosterone	ESTRATEST, ESTRATEST HS
	Estradiol/Vaginal Ring	ESTRING, STEP THERAPY , RESTRICTED TO USE AFTER A TRIAL OF PREMARIN VAGINAL CREAM IN THE PAST 90 DAYS

Estrogen Agonist-Antagonists

	Raloxifene	EVISTA
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Oral Contraceptive Agents

CMSP requires evidence of Family PACT ineligibility for contraceptive coverage. Contact Family PACT at (800) 942-1054 for more information. A Record of Denied Program Eligibility form must be completed and submitted to MedImpact for contraceptive coverage. This form can be obtained on the CMSP website: <https://cmspcounties.org>.

Oxytocic Agents

	Ergonovine Maleate	ERGOTRATE
	Methylergonovine Maleate	METHERGINE

Pituitary Agents

	Desmopressin	DDAVP
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Progestin Agents

	Medroxyprogesterone	CYCRIN PROVERA
	Norethindrone Acetate	AYGESTIN NORLUTATE

GENITOURINARY AGENTS

Urinary Anti-Infective Agents

Meth/Me Blue/PA/Salol/ATP/Hyos	URISED
Nitrofurantoin (Tablets, Suspension Only)	FURADANTIN
Trimethoprim	TRIMPEX

Urinary Anti-Spasmotic Agents

Pentosan	ELMIRON
Phenazopyridine	PYRIDIUM

Genitourinary Smooth Muscle Relaxant Agents

	Belladonna/Methylene Blue	URISED
	Oxybutynin	DITROPAN
		DITROPAN XL NOT COVERED
ST, QL	Tolterodine	DETROL, STEP THERAPY , LIMITED TO #60/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS
ST, QL		DETROL LA, STEP THERAPY , LIMITED TO #30/MONTH, RESTRICTED TO USE AFTER A TRIAL OF OXYBUTININ IN THE PAST 90 DAYS

Parasympathomimetic (Cholinergic) Agents

Bethanechol	URECHOLINE
Neostigmine	PROSTIGMIN
Pyridostigmine	MESTINON

TOPICAL/MUCOUS MEMBRANE AGENTS

Keratolytic Agents

Anthralin	DRITHOCREME
	DRITHO-SCALP
Podofilox	CONDYLOX

Miscellaneous Skin/Mucous Membrane Agents

	Aluminum Acetate	BURROWS SOLUTION
	Aluminum Chloride Hexahydrate	DRYSOL
	Benzoyl Peroxide, OTC Generic	BENZOYL PEROXIDE, OTC GENERIC
	Calamine	CALAMINE LOTION
	Calcipotriene	DOVONEX
	Fluorouracil	EFUDEX
	Hydrocortisone 1% Rectal	PROCTOCORT
	Masoprocol	ACTINEX
PA	Becaplermin	REGANEX, PA REQ
PA	Isotretinoin	ACCUTANE, PA REQ

Topical Antibiotic Agents

Bacitracin	BACITRACIN
Bacitracin/Polymixin/Neomycin	NEOSPORIN
Clindamycin Solution	CLEOCIN T
Erythromycin Topical	ERYGEL
	EMGEL
	T-STAT
Erythromycin/Benzoyl Peroxide	BENZAMYCIN
Gentamicin Sulfate	GARAMYCIN
Mupirocin	BACTROBAN
Silver Sulfadiazine	SILVADENE

Topical Antifungal Agents

Clotrimazole	LOTRIMIN
Clotrimazole/Betamethasone	LOTRISONE
Ciclopirox	LOPROX
Ketoconazole	NIZORAL
Miconazole Nitrate	MONISTAT-DERM
Nystatin	MYCOSTATIN
Terbinafine	LAMISIL
Tolnaftate	TINACTIN
Triamcinolone/Nystatin	MYCOLOG II

Vaginal Antifungal Agents

Butoconazole	FEMSTAT
Clotrimazole Cream/Vaginal Tablets	MYCELEX
	MYCELEX G
Nystatin	MYCOSTATIN
Miconazole Cream/Vaginal Tablets	MONISTAT
	MONISTAT 3
Triple Sulfa Cream	SULTRIN
Tioconazole	VAGISTAT-1

Vaginal Anti-Infective Agents

Metronidazole	METROGEL-VAGINAL
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Topical Contraceptive Agents

CMSP requires evidence of Family PACT ineligibility for contraceptive coverage. Contact Family PACT at (800) 942-1054 for more information. A Record of Denied Program Eligibility form must be completed and submitted to MedImpact for contraceptive coverage. This form can be obtained on the CMSP website: <https://cmspcounties.org>.

Topical Anti-Inflammatory Agents

LOW POTENCY	
Fluocinolone 0.025%	SYNALAR
Desonide	TRIDESILON
Hydrocortisone	HYTONE
Hydrocortisone Enema	CORTENEMA
Hydrocortisone Acetate	CORTIFOAM
Hydrocortisone/Pramoxine	PROCTOCREAM-HC

MEDIUM POTENCY

Betamethasone Dipropionate

Betamethasone Valerate 0.01%

Betamethasone Valerate 0.1%

Desoximetasone Cream/Gel 0.05%

Flurandrenolide

Hydrocortisone Valerate

Mometasone Furoate Cream

Triamcinolone

DIPROSONE

MAXIVATE

VALISONE REDUCED STRENGTH

VALISONE

TOPICORT LP

CORDRAN

WESTCORT

ELOCON

ARISTOCORT

ARISTOCORT A NOT COVERED

KENALOG

HIGH POTENCY

Betamethasone Dipropionate

Desoximetasone 0.25%

Fluocinonide

Fluocinolone Acetonide 0.2%

VERY HIGH POTENCY

Augmented Betamethasone

Dipropionate

Clobetasol Cream, Gel, Solution,

Ointment

Diflorasone Diacetate

DIPROLENE

TOPICORT

LIDEX

LIDEX E

SYNALAR

DIPROLENE AF

TEMOVATE

FLORONE

FLORONE-E

PSORCON

Topical Antipruritic and Local Anesthetic Agents

Lidocaine (Viscous and Spray Only)

Pramoxine/Hydrocortisone

Pramoxine

Pimecrolimus

Tacrolimus

PA

PA

XYLOCAINE

PROCTOFOAM HC

EPIFOAM

ELIDEL, **PA REQ**PROTOPIC, **PA REQ*****Topical Antiviral Agents***

Acyclovir Topical

ZOVIRAX OINTMENT

Topical Miscellaneous Anti-Infective Agents

Selenium Sulfide 2.5%

Sulfacetamide Lotion

EXSEL

SELSUN

SEBIZON

Scabicide/Pediculicide Agents

Crotamiton

Malathion

Permethrin

EURAX

OVIDE

ELIMITE

NIX

MISCELLANEOUS/UNCLASSIFIED AGENTS***Electrolyte Agents*****Miscellaneous Agents**

Calcium Acetate

PHOS LO

Calcium Carbonate
Magnesium Oxide, OTC Generic

TUMS
MAGNESIUM OXIDE, OTC GENERIC

Potassium Agents

Potassium Chloride 8mEq
Potassium Chloride
Potassium Chloride 10mEq
Potassium Chloride

MICRO-K

KAON-CL 10
K-DUR
MICRO-K 10

Potassium Chloride 20mEq
Potassium Chloride

K-DUR

Potassium Chloride Effervescent Tablets
Potassium Chloride Tablets
Potassium Chloride Tablets

K-LYTE
K-LYTE CL DS

Potassium Chloride Powders
Potassium Chloride Powder

K-LOR

Potassium Chloride Liquids
Potassium Chloride Liquid

KAON-CL

Potassium-Removing Resins
Sodium Polystyrene Sulfonate

KAYEXALATE

Heavy Metal Antagonist Agents

Penicillamine

CUPRIMINE

Vitamin Agents

Vitamin B-Complex Agents

Cyanocobalamin
Folic Acid
Niacin
Pyridoxine
Thiamine

VITAMIN B₁₂ (ORAL FORMULATIONS ONLY)
FOLIC ACID
NIACIN
VITAMIN B₆
VITAMIN B₁

Vitamin D

Calcitriol
Ergocalciferol

ROCALTROL
DRISDOL

Vitamin K Activity Agents

Phytonadione

MEPHYTON

Iron Agents

Ferrous Sulfate (Tablets, Liquid, Drops)

FEOSOL

Diagnostic Testing

Blood Glucose Supplies

QL Alcohol Swabs
Blood Glucose Monitoring Control
Solution
QL Blood Glucose Test Strips

LIMITED TO 200/MONTH
BLOOD GLUCOSE MONITORING CONTROL SOLUTION, **ROCHE PRODUCTS (E.G., ACCU-CHEK) ONLY**
BLOOD GLUCOSE TEST STRIPS, **ROCHE STRIPS (E.G., ACCU-CHEK) ONLY**, LIMITED TO 100 STRIPS/MONTH FOR MEMBERS THAT ARE DIET-CONTROLLED OR ON ORAL AGENTS. MEMBERS ON INSULIN LIMITED TO 150 STRIPS/MONTH. LARGER QUANTITIES AVAILABLE VIA PRIOR AUTHORIZATION
GLUCOMETERS, **ROCHE METERS (E.G., ACCU-CHEK) ONLY**

Glucometers
Lancets

Alcohol And Smoking Deterrent Agents

PA Bupropion SR ZYBAN, **PA REQ**
Disulfiram ANTABUSE
PA Nicotine NICORETTE GUM, **PA REQ**
PA NICOTINE PATCH, **PA REQ** (OTC PATCHES ONLY)
PA NICOTROL NASAL SPRAY, **PA REQ**

Gout Agents

QL Allopurinol ZYLOPRIM
Colchicine COLCRYS, LIMITED TO 1 TABLET/DAY. PATIENTS WHO FAIL 1 TABLET/DAY MAY RECEIVE 2 TABLETS/DAY.
Probenecid BENEMID

Vaccinations

Immunizations covered at zero cost share to members for *routine* use or with shared clinical decision-making as defined by the Centers for Disease Control and Prevention (CDC), or the Advisory Committee on Immunization Practices (ACIP) recommended immunizations for all persons for the vaccines listed below.

QL, Age	Influenza	FLUBLOK, AGE ≥ 18 YO, LIMITED TO 1 DOSE/180 DAYS FLUZONE HIGH DOSE AND FLUAD, AGE ≥ 65 YO, LIMITED TO 1 DOSE/180 DAYS
QL, Age	COVID-19	COMIRNATY, NOVAVAX, SPIKEVAX, AGE ≥ 18 YO, LIMITED TO 1/FILL
QL, Age	Human Papillomavirus	GARDASIL 9, AGE 18-45 YO, LIMITED TO 3 DOSES/365 DAYS
QL, Age	Hepatitis A	VAQTA, HAVRIX, AGE ≥ 18 YO, LIMITED TO 2 DOSES/365 DAYS
QL, Age	Hepatitis B	ENGERIX-B ADULT, AGE ≥ 18 YO, LIMITED TO 4 DOSES/365 DAYS HEPLISAV-B, AGE ≥ 18 YO, LIMITED TO 2 DOSES/365 DAYS PREHEVBRIO, RECOMBIVAX HB, AGE ≥ 18 YO, LIMITED TO 3 DOSES/365 DAYS
QL, Age	Hepatitis B/Hepatitis A Combo	TWINRIX, AGE ≥ 18 YO, LIMITED TO 4 DOSES/365 DAYS
QL, Age	Measles, Mumps, Rubella	MMR, PRIORIX, AGE ≥ 18 YO, LIMITED TO 2 DOSES/365 DAYS
QL, Age	Meningococcal Serogroup B	BEXSERO, AGE 18-25 YO, LIMITED TO 2 DOSES/365 DAYS TRUMENBA, AGE 18-25 YO, LIMITED TO 3 DOSES/365 DAYS
QL, Age	Meningococcal Quadrivalent Conjugate	MENACWY [MENVEO, MENQUADFI], AGE 18-23 YO, LIMITED TO 1 DOSE/365 DAYS
QL, Age	Meningococcal ACWY-B	PENBRAYA, AGE 18-25 YO, LIMITED TO 2 DOSES/365 DAYS
QL, Age	Pneumococcal 15-Valent Conjugate	VAXNEUVANCE, AGE ≥ 65 YO, LIMITED TO 1 DOSE/365 DAYS
	Pneumococcal 20-Valent Conjugate	PREVNAR 20, AGE ≥ 65 YO, LIMITED TO 1 DOSE/365 DAYS
	Pneumococcal polysaccharide	PNEUMOVAX 23, AGE ≥ 65 YO, LIMITED TO 1 DOSE/365 DAYS
QL, Age	Poliovirus	IPOL, AGE ≥ 18 YO, LIMITED TO 3 DOSES/365 DAYS
QL, Age	Respiratory Syncytial Virus (RSV)	ABRYSVO, AREXVY, AGE ≥ 65 YO, LIMITED TO 1 DOSE/365 DAYS (FOR ABRYSVO ONLY: IF AGE < 60 YO AND PREGNANT, LIMITED TO 1 DOSE/365 DAYS)
QL, Age	Tetanus, Diphtheria, Pertussis Tetanus, Diphtheria	TDAP, AGE ≥ 18 YO, LIMITED TO 1 DOSE/365 DAYS TD, AGE ≥ 18 YO, LIMITED TO 1 DOSE/365 DAYS
QL, Age	Varicella	VARIVAX, AGE ≥ 18 YO, LIMITED TO 2 DOSES/365 DAYS
QL, Age	Zoster Vaccines, Recombinant	SHINGRIX, AGE ≥ 50 YO, LIMITED TO 2 DOSES/365 DAYS

Other Medical Supplies

Limited medical supplies are available through the pharmacy benefit. For additional information, contact MedImpact at (800) 788-2949. The following exceptions should be noted:

- Durable medical equipment (e.g., wheelchairs, walkers, canes, crutches) are filled through the medical benefit. CMSP does not provide coverage for contraceptive medical supplies (e.g., diaphragms, cervical caps, condoms) unless the member is ineligible for Family PACT. Call Family PACT (800) 942-1054. If ineligible, call MedImpact at (800) 788-2949.

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