CMSP COUNTY MEDICAL SERVICES PROGRAM

CMSP DRUG FORMULARY

Administered by MedImpact

October 2024

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	• Primary benefit for CMSP Aid Codes 89 and 50	• 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	• $5 copayment per prescription • No monthly share of cost requirement	• Monthly share of cost must be met before prescription coverage • No copayment per prescription
Benefit maximums	• $500 per prescription claim • $1500 maximum benefit per CMSP-PCB enrollment period	• None
Drug exclusions	• Specialty drugs excluded. • See "*Prescription Coverage of Select Drug Classes*" section of the CMSP Primary Care Benefit formulary for additional information about excluded drugs.	• Specialty drugs generally covered. See "*Prescription Coverage of Select Drug Classes*" 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	Antiretroviral drugs are excluded under the CMSP Primary Care Benefit. For patients who also have the CMSP Standard Benefit: 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.	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.
Contraceptives	Contraceptives are excluded under the CMSP Primary Care Benefit. For patients who also have the CMSP Standard Benefit: 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.	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.
Cystic Fibrosis Agents: Kalydeco, Orkambi, Symdeko, Trikafta	Specialty drugs are excluded under the CMSP Primary Care Benefit. For patients who also have the CMSP Standard Benefit: 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.	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 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.

Hemophilia Agents	Specialty drugs are excluded under the CMSP Primary Care Benefit. For patients who also have the CMSP Standard Benefit: 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.	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.
Hepatitis C: Ribavirin and Pegylated Interferons	Specialty drugs are excluded under the CMSP Primary Care Benefit. For patients who also have the CMSP Standard Benefit: 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.	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.
Hepatitis C: Harvoni, Sovaldi, Viekira Pak, Zepatier, Epclusa, Mavyret, Vosevi	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.	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.

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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

Miscellaneous Arthritis Agents

	Leflunomide	ARAVA

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	RELPAX, **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	MEBARAL
	Phenobarbital	PHENOBARBITAL
	Primidone	MYSOLINE

Benzodiazepine Anticonvulsants

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

Hydantoin Anticonvulsants

	Phenytoin	DILANTIN, PHENYTEK

Miscellaneous Anticonvulsants

	Carbamazepine	TEGRETOL; **EQUETRO NON-FORMULARY**
	Carbamazepine Extended Release	TEGRETOL XR
	Divalproex Sodium	DEPAKOTE
	Divalproex Sodium Extended Release	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

QL	Topiramate	TOPAMAX, LIMITED TO #90/MONTH FOR 25MG, 50MG AND 100MG STRENGTHS

Antiparkinsonian Agents

	Amantadine	SYMMETREL
	Benztropine 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

	Baclofen	LIORESAL
QL	Carisoprodol	SOMA, LIMITED TO #120/MONTH; **250 STRENGTH NON-FORMULARY**
	Chlorzoxazone	PARAFON DSC
	Cyclobenzaprine	FLEXERIL
	Dantrolene Sodium	DANTRIUM
	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

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
	Trifluoperazine	STELAZINE
QL	Ziprasidone	GEODON, LIMITED TO #60/MONTH

Antipsychotic/SSRI Combination Agents

QL	Olanzapine/Fluoxetine HCl	SYMBYAX, LIMITED TO #30/MONTH

Miscellaneous Anxiolytics, Sedatives, and Hypnotics

	Buspirone	BUSPAR
		7.5MG STRENGTH NON-FORMULARY
	Chloral Hydrate	NOCTEC

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

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

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

	Irbesartan	AVAPRO
	Losartan	COZAAR
	Telmisartan	MICARDIS
SE, QL	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	NORVASC, LIMITED TO #30/MONTH
	Diltiazem	CARDIZEM
	Diltiazem SR	CARDIZEM SR; **CARDIZEM LA NON-FORMULARY**
	Diltiazem CD	CARTIA XT
	Felodipine	PLENDIL, LIMITED TO #30/MONTH
	Nifedipine, Sustained Release	ADALAT CC
	Verapamil	CALAN
	Verapamil LA Tablets	CALAN SR; **COVERA-HS NON-FORMULARY**
	Verapamil SR Capsules	VERELAN
	Centrally Acting Antihypertensive Agents	
	Clonidine	CATAPRES
	Guanfacine	TENEX
	Methyldopa	ALDOMET
	Combination Antihypertensive Agents	
	Atenolol/Chlorthalidone	TENORETIC
	Benazepril/HCTZ	LOTENSIN HCT
	Bisoprolol/HCTZ	ZIAC
	Captopril/HCTZ	CAPOZIDE
	Enalapril/HCTZ	VASORETIC
	Lisinopril/HCTZ	ZESTORETIC PRINZIDE
	Losartan/HCTZ	HYZAAR,
SE, QL	Olmesartan/HCTZ	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	ALDACTONE
	Spironolactone/HCTZ	ALDACTAZIDE
	Triamterene	DYRENIUM
	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
	Triamterene 37.5mg/HCTZ 25mg	DYAZIDE
	Triamterene 75mg/HCTZ 50mg	MAXZIDE 50
	Loop Diuretics	
	Bumetanide	BUMEX
	Furosemide	LASIX
	Thiazide and Related Diuretics	
	Chlorthalidone	HYGROTON
	Hydrochlorothiazide (HCTZ)	HYDRODIURIL
	Indapamide	LOZOL
	Metolazone	ZAROXOLYN
	Vasodilator Antihypertensive Agents	
	Doxazosin Mesylate	CARDURA; **CARDURAL XL NON-FORMULARY**
	Hydralazine	APRESOLINE
	Minoxidil	LONITEN
	Prazosin	MINIPRESS
	Terazosin	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

Cardiac Glycoside Agents

	Digoxin	LANOXIN; **LANOXICAPS NON-FORMULARY**

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	Isosorbide Mononitrate	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

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

Digestive Enzymes

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

Gallstone Solubilizing Agents

	Ursodiol	ACTIGALL

Gastrointestinal Stimulant Agents

	Metoclopramide	REGLAN

H_2 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

Antihelmintic 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 FULVICIN P/G
	Ketoconazole	NIZORAL
	Nystatin (Oral Powder Not Covered)	MYCOSTATIN
	Terbinafine Tablets	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
	Oseltamivir	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**

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

Leprostatic Agents

	Clofazimine	LAMPRENE
	Dapsone	DAPSONE; **ACZONE NON-FORMULARY**

ANTINEOPLASTIC, IMMUNOMODULATOR, BLOOD COLONY STIMULATING FACTOR AND IMMUNOSUPPRESSANT AGENTS

Antineoplastic Agents

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

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
		SANDIMMUNE
	Leucovorin	WELLCOVORIN
	Mycophenolate Mofetil	CELLCEPT ; **MYFORTIC NON-FORMULARY**
	Sirolimus	RAPAMUNE
	Tacrolimus (Oral only)	PROGRAF

RESPIRATORY/EENT 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
	Triprolidine/Pseudoephedrine/Codeine	ACTIFED/CODEINE

Decongestants

	Pseudoephedrine	SUDAFED

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
	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

Respiratory Smooth Muscle Relaxant Agents

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

Theophylline	SLO-PHYLLIN
Theophylline, Sustained Release	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

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

Ophthalmic Beta Blockers

Levobunolol	BETAGAN
Timolol	TIMOPTIC

Ophthalmic Miotic Agents

	Brimonidine	ALPHAGAN
		ALPHAGAN P
	Dorzolamide	TRUSOPT
	Dorzolamide/Timolol	COSOPT
	Echothiophate Iodide	PHOSPHOLINE IODIDE
	Pilocarpine	PILOCAR
		OCUSERT NOT COVERED
Ophthalmic Mydriatic Agents		
	Atropine Sulfate	ISOPTO ATROPINE
	Dipivefrin	PROPINE
	Tropicamide	MYDRIACYL
Ophthalmic Sulfonamide Agents		
	Sulfacetamide	BLEPH-10
		SODIUM SULAMYD
	Sulfacetamide 10%/Prednisolone 0.2%	BLEPHAMIDE
	Sulfacetamide 10%/Prednisolone 0.5%	METIMYD
Miscellaneous Ophthalmic Agents		
	Ketotifen	ZADITOR OTC, ALAWAY
	Latanoprost	XALATAN
	Naphazoline	ALBALON
	Naphazoline/Pheniramine	NAPHCON-A
Otic Anti-Infective Agents		
	Acetic Acid	VOSOL
	Acetic Acid 2%	DOMEBORO
	Acetic Acid 2%/Hydrocortisone 1%	VOSOL HC
	Hydrocortisone/Neomycin/Polymyxin	CORTISPORIN
	Ofloxacin	FLOXIN OTIC
Miscellaneous Otic Agents		
	Benzocaine/Antipyrine	AURALGAN
	Carbamide Peroxide/Glycerin	DEBROX

Inhaled/Oral EENT Agents

Inhaled Nasal Agents		
	Fluticasone, Nasal	FLONASE
	Triamcinolone, Nasal	NASACORT
QL	Ipratropium, Nasal	ATROVENT, LIMITED TO #2 DEVICES/MONTH
Carbonic Anhydrase Inhibitor Agents		
	Acetazolamide	DIAMOX
	Acetazolamide SA	DIAMOX SEQUELS
	Methazolamide	NEPTAZANE
Local Anesthetic Agents		
	Benzocaine/Antipyrine Otic	AURALGAN
	Lidocaine Solution	XYLOCAINE
	Lidocaine, Viscous	VISCOUS XYLOCAINE
	Triamcinolone 0.1% in Orabase	KENALOG IN ORABASE

Miscellaneous EENT Agents

	Carbachol	ISOPTO CARBACHOL
	Chlorhexidine Gluconate	PERIDEX
	Cromolyn Ophthalmic Solution	CROLOM
	Epinephrine Injection	EPIPEN
QL	Optichamber	OPTICHAMBER, LIMITED TO #2/YEAR
	Sodium Chloride for Inhalation	GENERIC
	Triethanolamine	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
	Glyburide/Metformin	GLUCOVANCE
SE, QL	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	NOVOLOG VIAL & FLEXPEN
Insulin Aspart Protamine/Insulin Aspart	INSULIN ASPART PROTAMINE/INSULIN ASPART MIX 70-30 VIAL, NOVOLOG MIX 70-30 VIAL & FLEXPEN

Regular Insulins

Insulin Regular	HUMULIN R VIAL
Insulin NPH	HUMULIN N VIAL & KWIKPEN
Insulin NPH/ Insulin Regular	HUMULIN MIX 70-30 VIAL & KWIKPEN

Long-Acting Insulins

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

Miscellaneous Diabetes Agents

Glucagon	GLUCAGON

Thyroid Agents

Levothyroxine	LEVOTHROID
Liotrix	THYROLAR
Liothyronine	CYTOMEL
Thyroid, Desiccated	ARMOUR THYROID
	LEVOXYL
	SYNTHROID

Antithyroid Agents

Methimazole	TAPAZOLE
Propylthiouracil	PROPYLTHIOURACIL

HORMONE AGENTS

Oral Adrenal Corticosteroid Agents

Cortisone Acetate	CORTONE
Dexamethasone	DECADRON
Fludrocortisone Acetate	FLORINEF
Hydrocortisone Oral	CORTEF
Methylprednisolone	MEDROL
Prednisone	DELTASONE
	ORASONE
	MEDROL DOSEPAK
Prednisolone	PEDIAPRED
	PRELONE

Androgen Agents

Danazol	DANOCRINE
Fluoxymesterone	HALOTESTIN
Methyltestosterone	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

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
	Esterified Estrogens/Methyltestosterone	ESTRATEST, ESTRATEST HS
SE	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

Oral Contraceptive Agents

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Oxytocic Agents

	Ergonovine Maleate	ERGOTRATE
	Methylergonovine Maleate	METHERGINE

Pituitary Agents

	Desmopressin	DDAVP

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-Spasmodic 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	REGRANEX, **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

Topical Contraceptive Agents

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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	DIPROSONE
		MAXIVATE
	Betamethasone Valerate 0.01%	VALISONE REDUCED STRENGTH
	Betamethasone Valerate 0.1%	VALISONE
	Desoximetasone Cream/Gel 0.05%	TOPICORT LP
	Flurandrenolide	CORDRAN
	Hydrocortisone Valerate	WESTCORT
	Mometasone Furoate Cream	ELOCON
	Triamcinolone	ARISTOCORT
		ARISTOCORT A NOT COVERED
		KENALOG
	HIGH POTENCY	
	Betamethasone Dipropionate	DIPROLENE
	Desoximetasone 0.25%	TOPICORT
	Fluocinonide	LIDEX
		LIDEX E
	Fluocinolone Acetonide 0.2%	SYNALAR
	VERY HIGH POTENCY	
	Augmented Betamethasone Dipropionate	DIPROLENE AF
	Clobetasol Cream, Gel, Solution, Ointment	TEMOVATE
	Diflorasone Diacetate	FLORONE
		FLORONE-E
		PSORCON

Topical Antipruritic and Local Anesthetic Agents

	Lidocaine (Viscous and Spray Only)	XYLOCAINE
	Pramoxine/Hydrocortisone	PROCTOFOAM HC
	Pramoxine	EPIFOAM
PA	Pimecrolimus	ELIDEL, **PA REQ**
PA	Tacrolimus	PROTOPIC, **PA REQ**

Topical Antiviral Agents

	Acyclovir Topical	ZOVIRAX OINTMENT

Topical Miscellaneous Anti-Infective Agents

	Selenium Sulfide 2.5%	EXSEL
		SELSUN
	Sulfacetamide Lotion	SEBIZON

Scabicide/Pediculicide Agents

	Crotamiton	EURAX
	Malathion	OVIDE
	Permethrin	ELIMITE
		NIX

MISCELLANEOUS/UNCLASSIFIED AGENTS

Electrolyte Agents

Miscellaneous Agents

	Calcium Acetate	PHOS LO

Calcium Carbonate	TUMS
Magnesium Oxide, OTC Generic	MAGNESIUM OXIDE, OTC GENERIC

Potassium Agents

Potassium Chloride 8mEq	
Potassium Chloride	MICRO-K
Potassium Chloride 10mEq	
Potassium Chloride	KAON-CL 10 K-DUR MICRO-K 10
Potassium Chloride 20mEq	
Potassium Chloride	K-DUR
Potassium Chloride Effervescent Tablets	
Potassium Chloride Tablets	K-LYTE
Potassium Chloride Tablets	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	VITAMIN B_{12} (ORAL FORMULATIONS ONLY)
	Folic Acid	FOLIC ACID
	Niacin	NIACIN
	Pyridoxine	VITAMIN B_6
	Thiamine	VITAMIN B_1

Vitamin D

	Calcitriol	ROCALTROL
	Ergocalciferol	DRISDOL

Vitamin K Activity Agents

	Phytonadione	MEPHYTON

Iron Agents

	Ferrous Sulfate (Tablets, Liquid, Drops)	FEOSOL

Diagnostic Testing

Blood Glucose Supplies

QL	Alcohol Swabs	LIMITED TO 200/MONTH
	Blood Glucose Monitoring Control Solution	BLOOD GLUCOSE MONITORING CONTROL SOLUTION, **ROCHE PRODUCTS (E.G., ACCU-CHEK) ONLY**
QL	Blood Glucose Test Strips	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	GLUCOMETERS, **ROCHE METERS (E.G., ACCU-CHEK) ONLY**
	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

	Allopurinol	ZYLOPRIM
QL	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	TDAP, AGE ≥ 18 YO, LIMITED TO 1 DOSE/365 DAYS
	Tetanus, Diphtheria	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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