Abridged Formulary 2026

(Partial List of Covered Drugs or “Drug List”)

County of Orange Medicare Prescription Drug Plan (PDP)
Administered by Optum Rx®
Effective January 1, 2026 – December 31, 2026

Optum Rx Member Services
This is not a complete list of drugs covered by our plan. For a complete listing or other questions about this document, please contact Member Services. This call is free.

optumrx.com

Toll-free **1-800-908-9097,** TTY **711**
24 hours a day, 7 days a week

Optum Rx®

This Abridged Formulary was last updated: 08/06/2025
Formulary ID 26047
S8841_26_MC-DS10_COO_C

January 1, 2026 - December 31, 2026

Please read:

This document contains information about some of the drugs we cover.

This document includes a shortened Drug List (formulary) for our plan which is current as of August 6, 2025. For a complete updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

For existing members: This formulary has changed since last year. Please review this document to make sure it still contains the drugs you take.

When this drug list refers to "we," "us," or "our," it means Optum Rx. When it refers to "plan" or "our plan," it means County of Orange Medicare Prescription Drug Plan.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2027.

What you pay for vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

What you pay for insulin - You will not pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

What Is the County of Orange Medicare Prescription Drug Plan abridged formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by County of Orange Medicare Prescription Drug Plan with the help of Optum Rx and a team of healthcare providers, which includes drugs believed to be a necessary part of a quality treatment program.

This plan will usually cover the drugs listed in our formulary as long as:

- The drug is medically necessary.
- The prescription is filled at an Optum Rx network pharmacy, and
- Other plan rules are followed.

This document is a shortened formulary and includes only some of the drugs covered by this plan. For a complete listing of all prescription drugs covered please contact us at 1-800-908-9097, TTY 711 or visit **optumrx.com**.

Can the formulary (drug list) change?

Most changes in drug coverage happen on January 1, but the following changes may happen during the plan year:

- Add or remove drugs on the formulary during the year.
- Move them to different tiers, or
- Add new restrictions.

We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: **optumrx.com**.

Changes that can affect you this year: In the cases below, you will be impacted by coverage changes during the plan year:

- **Immediate substitutions of certain new versions of brand-name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand-name drug or original biological product on our formulary, but immediately move it to a different tier or add new restrictions.

  We can make these immediate changes only if we are adding a new generic version of a brand-name drug or adding certain new biosimilar versions of an original biological product that was already on the formulary (for example, adding a replaceable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

  If you are currently taking the brand-name drug or original biological product, we may not tell you in advance before we make an immediate change. But we will provide you with information about the specific change(s) we have made.

  If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the drug that is being changed. For more information, see the section below titled “How do I request an exception to the County of Orange Medicare Prescription Drug Plan’s formulary?”

  Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

- **Drugs removed from the market.** If a drug is removed from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be removed for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** Here are some other reasons for drug coverage changes:
  - **Adding new drugs:**
    - Adding a new generic drug to replace a brand-name drug.
    - Adding a new biosimilar to replace an original biological product**.**
  - **Changing drug guidelines:**
    - Adding new rules to a drug.
    - Moving a drug to a higher cost-sharing tier, or
    - Both adding rules and moving a drug to a higher cost-sharing tier after adding a new drug.
  - **Removing drugs:**
    - Removing a brand-name drug when adding a generic equivalent.
    - Removing an original biological product when adding a biosimilar.
  - **Applying new rules:**
    - Adding new rules to the brand-name drug or original biological product.
    - Moving the brand-name drug or original biological product to a different cost-sharing tier, or
    - Both adding new rules and moving the drug to a different cost-sharing tier.

We must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the drug you have been taking. The notice we send you will also include information on how to request an exception. You can also find information in the "How do I request an exception to the County of Orange Medicare Prescription Drug Plan's formulary?" section below.

Changes that will not impact you if you are currently taking the drug. Usually, if you are taking a drug on our 2026 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2026 plan year except as described above. This means these drugs will remain available at the same cost-sharing tier and there will be no new restrictions for the rest of the plan year. You will not get direct notices about changes that do not impact you. Starting on January 1 of next year, these changes may impact you. It is important to look at the formulary for the new plan year for any changes to drugs you may take.

This formulary is current as of August 6, 2025. To get updated information about the drugs covered by County of Orange Medicare Prescription Drug Plan please contact us at 1-800-908-9097, TTY 711.

You may also visit our website for the most up-to-date information at **optumrx.com** > *Member tools* > *Drug pricing and information*.

How do I use the formulary?

There are 2 ways to find your drug within the formulary:

- **Medical condition**

  The formulary begins on page 9. The drugs in this formulary are grouped into categories based on the type of medical condition(s) they are used to treat. For example, drugs used for a heart condition are listed under the category "Cardiovascular Agents." If you know what your drug is used for, look for the category name in the list that begins on page 9. Then, look under the category name for your drug.

- **Alphabetical listing**

  If you are not sure what category to look under, you should look for your drug in the Index that begins on page 25. The Index provides an alphabetical list of all drugs in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Our plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs work just as well as and usually cost less than brand-name drugs There are generics available for many brand-name drugs. Generic drugs usually can be substituted for the brand-name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

When we refer to drugs on the formulary, it can mean either a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Depending on state laws, you may or may not need a new prescription for some biosimilars.

For discussion of drug types, please see the Evidence of Coverage, Chapter 3, Section 3.1, "The 'Drug List' tells which Part D drugs are covered.

Are there any restrictions on my coverage?

Some covered drugs may have requirements or limits on coverage. These requirements and limits may include:

Prior authorization (PA)	You or your prescriber may need to get prior authorization for certain drugs. This means you will need to get approval from Optum Rx before you fill your prescriptions. If you do not get approval, the drug may not be covered.
Quantity limits (QL)	For certain drugs, there is a limit on the amount of the drug we will cover. This may be in addition to a standard 1-month or 3-month supply.
Step therapy (ST)	In some cases, it is required that you first try certain drugs to treat your medical condition before we will cover another drug for it. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

To find out if your drug has any additional requirements or limits, look in the formulary that begins on page 9. You can also find more information at **optumrx.com** or by calling us at 1-800-908-9097, TTY 711.

You can ask Optum Rx to make an exception to these restrictions or limits, or for a list of other similar drugs that may treat your health condition. See the section “How do I request an exception to the County of Orange Medicare Prescription Drug Plan’s formulary?” on page 6 for additional information.

What are over-the-counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. County of Orange Medicare Prescription Drug Plan pays for certain OTC drugs. The cost to County of Orange Medicare Prescription Drug Plan of these OTC drugs will not count toward your total Part D drug costs.

What if my drug is not on the formulary?

If your drug is not in this formulary (list of covered drugs), you should first contact Optum Rx at 1-800-908-9097 , TTY 711 or visit **optumrx.com** and ask if your drug is covered. This document includes only a short list of covered drugs, so we may cover your medication. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If your drug is not covered, you have 2 options:

- You can ask Optum Rx for a list of similar drugs that are covered. When you receive the list, show it to your prescriber and ask them to prescribe a similar drug that is covered.
- You can ask Optum Rx to make an exception and cover your drug. See below for information about how to request an exception.

This plan offers supplemental coverage on some prescription drugs not normally covered under Medicare Part D and/or Part B. If you have any questions about your supplemental coverage, you can call Optum Rx toll free at 1-800-908-9097, TTY 711.

How do I request an exception to the County of Orange Medicare Prescription Drug Plan's formulary?

You can ask Optum Rx to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make:

- You can ask us to cover a drug even if it is not on our formulary. If approved, the drug will be covered at a cost share set by the plan. You may not ask us to provide the drug at a lower cost level.
- If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
- You can ask us to cover a formulary drug at a lower cost level if the drug is not in the high-cost tier. If approved, this would lower the amount you must pay for your drug.

Note: If we approve your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will approve your exception request if the alternative drug is on the plan's formulary or if the restrictions are not effective and could cause harm.

You or your prescriber should contact Optum Rx for an initial coverage decision for a formulary, tier, or usage restriction exception. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.**

Generally, we must make our decision within 72 hours of getting your prescriber's statement. You can request an expedited (fast) decision if you or your prescriber believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is approved, we must give you a decision no later than 24 hours after we get your prescriber's statement.

What can I do if my drug is not on the formulary or has a restriction?

As a member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but your ability to get your drug is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your prescriber about the following:

- About requesting a coverage decision to show that you meet the criteria for approval,
- Switching to an alternative drug that we cover, or
- Requesting a formulary exception so that we'll cover the drug you take.

While you talk to your prescriber to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs not on our formulary, or if your ability to get your drugs is limited, we will cover up to a 30-day supply when you go to a network pharmacy. We will not provide more coverage for these drugs after your first 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply. If coverage is not approved, after you first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover up to a 31-day emergency supply of that drug while you ask for a formulary exception.

If you are a current member with a level-of-care change and you need a drug that is not on our formulary, or if your ability to get your drugs is limited, we will cover up to a 31-day supply for a short time while you seek a formulary exception. If you are in the process of applying for an exception, we will consider allowing continued coverage until a decision is made.

For more information

For more detailed information about your County of Orange Medicare Prescription Drug Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials. If you have questions about the plan, please call Optum Rx at 1-800-908-9097 , TTY 711 or visit **optumrx.com**.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week. You may also visit medicare.gov.

County of Orange Medicare Prescription Drug Plan Formulary

The formulary below provides coverage information about some of the drugs covered by County of Orange Medicare Prescription Drug Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 25.

Remember: This is only a short list of covered drugs. If your prescription is not in this short list, please contact us at 1-800-908-9097, TTY 711.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., COZAAR), and generic drugs are listed in lower-case italics (e.g., *atenolol*). The following abbreviations listed in the "Requirements/Limits" column let you know if there are any special requirements for coverage of your drug.

Requirements/Limits	Helpful Tips
B/D	This prescription drug has a Part B versus Part D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending upon the conditions. Information may need to be submitted describing the use and setting of the drug to make the determination.
NDS	Non-extended days' supply. This prescription drug is not available for an extended days' supply.
PA	Prior authorization. Our plan requires you or your physician to get prior authorization for certain drugs. This means you will need to get approval from Optum Rx before you fill your prescriptions. If you do not get approval, your drug may not be covered.
QL	Quantity limit. For certain drugs, our plan limits the amount of the drug we will cover. This may be in addition to a standard one-month or three-month supply.
ST	Step therapy. In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Nonsteroidal Anti-inflammatory Drugs		
CELEBREX CAPSULE 100MG, 200MG, 400MG, 50MG	3	QL(60 EA per 30 days)
celecoxib capsule 100mg, 200mg, 400mg, 50mg	1	QL(60 EA per 30 days)
diclofenac sodium dr tablet delayed release 25mg, 50mg, 75mg	1	
ibuprofen tablet 300mg, 400mg, 600mg, 800mg	1	
ibu tablet 400mg, 600mg, 800mg	1	
meloxicam tablet 15mg, 7.5mg	1	
naproxen tablet 250mg, 375mg, 500mg	1	
Opioid Analgesics, Long-acting		
morphine sulfate er tablet extended release 100mg, 15mg, 200mg, 30mg, 60mg	1	NDS
MS CONTIN TABLET EXTENDED RELEASE 15MG, 30MG	3	NDS
MS CONTIN TABLET EXTENDED RELEASE 100MG, 200MG, 60MG	4	NDS
Opioid Analgesics, Short-acting		
acetaminophen/codeine phosphate tablet 300mg; 60mg	1	NDS
acetaminophen/codeine tablet 300mg; 15mg, 300mg; 30mg	1	NDS
endocet tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	1	NDS
hydrocodone bitartrate/acetaminophen tablet 300mg; 10mg, 300mg; 5mg, 300mg; 7.5mg, 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg	1	NDS
hydrocodone/acetaminophen tablet 325mg; 7.5mg	1	NDS
NALOCET TABLET 300MG; 2.5MG	4	NDS
OXAYDO TABLET 5MG, 7.5MG	4	NDS
OXYCODONE AND ACETAMINOPHEN TABLET 300MG; 7.5MG	4	NDS
oxycodone hydrochloride tablet 10mg, 15mg, 20mg, 30mg, 5mg	1	NDS
OXYCODONE/ACETAMINOPHEN TABLET 300MG; 10MG, 300MG; 2.5MG, 300MG; 5MG	4	NDS
oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	1	NDS
PERCOCET TABLET 325MG; 2.5MG	3	NDS
PERCOCET TABLET 325MG; 10MG, 325MG; 5MG, 325MG; 7.5MG	4	NDS
PROLATE TABLET 300MG; 10MG, 300MG; 5MG, 300MG; 7.5MG	4	NDS
ROXICODONE TABLET 15MG	3	NDS
ROXICODONE TABLET 30MG	4	NDS
tramadol hydrochloride tablet 100mg, 25mg, 50mg, 75mg	1	NDS

Drug Name	Drug Tier	Requirements/Limits
Anesthetics		
Local Anesthetics		
lidocaine ointment 5%	1	QL(150 GM per 30 days); PA
lidocaine patch 5%	1	PA
LIDOCAN PATCH 5%	3	PA
LIDODERM PATCH 5%	3	PA
premium lidocaine ointment 5%	1	QL(150 GM per 30 days); PA
TRIDACAINE III PATCH 5%	3	PA
TRIDACAINE II PATCH 5%	3	PA
TRIDACAINE PATCH 5%	3	PA
ZTLIDO PATCH 1.8%	3	QL(90 EA per 30 days); PA
Anti-Addiction/Substance Abuse Treatment Agents		
Alcohol Deterrents/Anti-craving		
naltrexone hydrochloride tablet 50mg	1	
Antibacterials		
Antibacterials, Other		
clindamycin hcl capsule 300mg	1	
clindamycin hydrochloride capsule 150mg, 300mg, 75mg	1	
methenamine hippurate tablet 1gm	1	
metronidazole tablet 125mg, 250mg, 500mg	1	
nitrofurantoin monohydrate/macrocrystals capsule 100mg	1	
nitrofurantoin monohydrate capsule 100mg	1	
Beta-lactam, Cephalosporins		
cefadroxil capsule 500mg	1	
cefdinir capsule 300mg	1	
cefpodoxime proxetil tablet 100mg, 200mg	1	
cefuroxime axetil tablet 250mg, 500mg	1	
cephalexin capsule 250mg, 500mg, 750mg	1	
Beta-lactam, Penicillins		
amoxicillin/clavulanate potassium tablet 250mg; 125mg, 500mg; 125mg, 875mg; 125mg	1	
amoxicillin capsule 250mg, 500mg	1	
amoxicillin tablet 500mg, 875mg	1	
Macrolides		
azithromycin tablet 250mg, 500mg, 600mg	1	
Quinolones		
ciprofloxacin hcl tablet 750mg	1	
ciprofloxacin hydrochloride tablet 250mg, 500mg	1	
levofloxacin tablet 250mg, 500mg, 750mg	1	
Sulfonamides		
sulfamethoxazole/trimethoprim ds tablet 800mg; 160mg	1	
sulfamethoxazole/trimethoprim tablet 400mg; 80mg	1	
Tetracyclines		
doxycycline hyclate capsule 100mg, 50mg	1	

Drug Name	Drug Tier	Requirements/Limits
doxycycline hyclate tablet 100mg, 150mg, 75mg	1	
doxycycline monohydrate capsule 100mg, 50mg, 75mg	1	
doxycycline monohydrate tablet 100mg, 150mg, 50mg, 75mg	1	
Anticonvulsants		
Anticonvulsants, Other		
KEPPRA TABLET 500MG	3	
KEPPRA TABLET 1000MG, 750MG	4	
LAMICTAL TABLET 100MG, 150MG, 200MG, 25MG	4	
lamotrigine tablet 100mg, 150mg, 200mg, 25mg	1	
levetiracetam tablet 1000mg, 250mg, 500mg, 750mg	1	
roweepra tablet 500mg	1	
subvenite tablet 100mg, 150mg, 200mg, 25mg	1	
TOPAMAX TABLET 50MG	3	
TOPAMAX TABLET 100MG, 200MG	4	
topiramate tablet 100mg, 200mg, 25mg, 50mg	1	
Gamma-aminobutyric Acid (GABA) Modulating Agents		
clonazepam tablet 2mg	1	QL(300 EA per 30 days)
clonazepam tablet 0.5mg, 1mg	1	QL(90 EA per 30 days)
gabapentin capsule 400mg	1	QL(270 EA per 30 days)
gabapentin capsule 100mg, 300mg	1	QL(360 EA per 30 days)
gabapentin tablet 800mg	1	QL(150 EA per 30 days)
gabapentin tablet 600mg	1	QL(180 EA per 30 days)
GABARONE TABLET 400MG	4	QL(270 EA per 30 days); ST
GABARONE TABLET 100MG	4	QL(540 EA per 30 days); ST
KLONOPIN TABLET 2MG	3	QL(300 EA per 30 days)
KLONOPIN TABLET 0.5MG, 1MG	3	QL(90 EA per 30 days)
LYRICA CAPSULE 300MG	3	QL(60 EA per 30 days)
LYRICA CAPSULE 100MG, 150MG, 200MG, 225MG, 25MG, 50MG, 75MG	3	QL(90 EA per 30 days)
MYSOLINE TABLET 250MG, 50MG	4	
NEURONTIN CAPSULE 400MG	3	QL(270 EA per 30 days)
NEURONTIN CAPSULE 100MG, 300MG	3	QL(360 EA per 30 days)
NEURONTIN TABLET 800MG	4	QL(150 EA per 30 days)
NEURONTIN TABLET 600MG	4	QL(180 EA per 30 days)
pregabalin capsule 300mg	1	QL(60 EA per 30 days)
pregabalin capsule 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg	1	QL(90 EA per 30 days)
primidone tablet 125mg, 250mg, 50mg	1	
Antidementia Agents		
Cholinesterase Inhibitors		
donepezil hcl tablet 10mg, 23mg	1	
donepezil hydrochloride tablet 5mg	1	
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
memantine hcl titration pak tablet 0	1	

Drug Name	Drug Tier	Requirements/Limits
memantine hydrochloride tablet 10mg, 5mg	1	
Antidepressants		
Antidepressants, Other		
bupropion hydrochloride er (sr) tablet extended release 12 hour 150mg, 200mg	1	QL(60 EA per 30 days)
bupropion hydrochloride er (sr) tablet extended release 12 hour 100mg	1	QL(90 EA per 30 days)
bupropion hydrochloride er (xl) tablet extended release 24 hour 300mg	1	QL(30 EA per 30 days)
bupropion hydrochloride er (xl) tablet extended release 24 hour 150mg	1	QL(90 EA per 30 days)
mirtazapine tablet 15mg, 30mg, 45mg, 7.5mg	1	
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 150MG, 200MG	3	QL(60 EA per 30 days)
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 100MG	3	QL(90 EA per 30 days)
WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 300MG	4	QL(30 EA per 30 days)
WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 150MG	4	QL(90 EA per 30 days)
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor		
citalopram hydrobromide tablet 10mg, 20mg, 40mg	1	
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 20MG, 60MG	3	QL(60 EA per 30 days)
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 30MG	3	QL(90 EA per 30 days)
duloxetine hydrochloride dr capsule delayed release particles 20mg, 60mg	1	QL(60 EA per 30 days)
duloxetine hydrochloride dr capsule delayed release particles 30mg, 40mg	1	QL(90 EA per 30 days)
escitalopram oxalate tablet 10mg, 20mg, 5mg	1	
fluoxetine hydrochloride capsule 10mg, 20mg, 40mg	1	
paroxetine hcl tablet 30mg, 40mg	1	
paroxetine hydrochloride tablet 10mg, 20mg	1	
PAXIL TABLET 10MG, 20MG, 30MG, 40MG	3	
PROZAC CAPSULE 20MG	3	
PROZAC CAPSULE 40MG	4	
sertraline hcl tablet 50mg	1	
sertraline hydrochloride tablet 100mg, 25mg	1	
trazodone hydrochloride tablet 100mg, 150mg, 50mg	1	
venlafaxine hydrochloride er capsule extended release 24 hour 150mg, 37.5mg, 75mg	1	
Tricyclics		

Drug Name	Drug Tier	Requirements/Limits
nortriptyline hcl capsule 25mg, 75mg	1	
nortriptyline hydrochloride capsule 10mg, 50mg	1	
PAMELOR CAPSULE 10MG, 25MG, 50MG, 75MG	4	
Antiemetics		
Antiemetics, Other		
ANTIVERT TABLET 50MG	3	
meclizine hcl tablet 12.5mg, 25mg	1	
meclizine hydrochloride tablet 25mg, 50mg	1	
Emetogenic Therapy Adjuncts		
ondansetron hcl tablet 24mg	1	QL(14 EA per 28 days); B/D
ondansetron hydrochloride tablet 4mg, 8mg	1	B/D
ondansetron odt tablet disintegrating 16mg, 4mg, 8mg	1	B/D
Antifungals		
Antifungals		
DIFLUCAN TABLET 200MG	4	
fluconazole tablet 100mg, 150mg, 200mg, 50mg	1	
ketoconazole cream 2%	1	QL(90 GM per 30 days)
ketoconazole shampoo 2%	1	
klayesta powder 100000unit/gm	1	QL(120 GM per 30 days)
nyamyc powder 100000unit/gm	1	QL(120 GM per 30 days)
nystatin cream 100000unit/gm	1	
nystatin powder 100000unit/gm	1	QL(120 GM per 30 days)
nystatin suspension 100000unit/ml	1	
nystop powder 100000unit/gm	1	QL(120 GM per 30 days)
terbinafine hcl tablet 250mg	1	QL(84 EA per 180 days)
Antigout Agents		
Antigout Agents		
allopurinol tablet 100mg, 200mg, 300mg	1	
colchicine tablet 0.6mg	1	
Antimigraine Agents		
Serotonin (5-HT) Receptor Agonist		
IMITREX TABLET 100MG, 25MG, 50MG	3	QL(9 EA per 30 days)
sumatriptan succinate tablet 100mg, 25mg, 50mg	1	QL(9 EA per 30 days)
Antineoplastics		
Antiandrogens		
abiraterone acetate tablet 250mg	1	PA
abiraterone acetate tablet 500mg	4	PA
abirtega tablet 250mg	1	PA
ZYTIGA TABLET 250MG, 500MG	4	PA
Aromatase Inhibitors, 3rd Generation		
anastrozole tablet 1mg	1	
ARIMIDEX TABLET 1MG	3	
letrozole tablet 2.5mg	1	
Antiparasitics		

Drug Name	Drug Tier	Requirements/Limits
Antiprotozoals		
hydroxychloroquine sulfate tablet 100mg, 200mg, 300mg, 400mg	1	
PLAQUENIL TABLET 200MG	3	
SOVUNA TABLET 200MG, 300MG	3	ST
Antiparkinson Agents		
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa/levodopa tablet 10mg; 100mg, 25mg; 100mg, 25mg; 250mg	1	
DHIVY TABLET 25MG; 100MG	3	ST
Antipsychotics		
2nd Generation/Atypical		
ABILIFY TABLET 10MG, 15MG, 20MG, 2MG, 30MG, 5MG	4	QL(30 EA per 30 days)
aripiprazole tablet 10mg, 15mg, 20mg, 2mg, 30mg, 5mg	1	QL(30 EA per 30 days)
olanzapine tablet 10mg, 15mg, 2.5mg, 20mg, 5mg, 7.5mg	1	QL(30 EA per 30 days)
quetiapine fumarate tablet 300mg, 400mg	1	QL(60 EA per 30 days)
quetiapine fumarate tablet 100mg, 150mg, 200mg, 25mg, 50mg	1	QL(90 EA per 30 days)
SEROQUEL TABLET 300MG, 400MG	3	QL(60 EA per 30 days)
SEROQUEL TABLET 100MG, 200MG, 25MG, 50MG	3	QL(90 EA per 30 days)
ZYPREXA TABLET 10MG, 2.5MG, 5MG, 7.5MG	3	QL(30 EA per 30 days)
ZYPREXA TABLET 15MG, 20MG	4	QL(30 EA per 30 days)
Antispasticity Agents		
Antispasticity Agents		
baclofen tablet 10mg, 15mg, 20mg, 5mg	1	
tizanidine hcl tablet 2mg	1	
tizanidine hydrochloride tablet 4mg	1	
Antivirals		
Antiherpetic Agents		
acyclovir tablet 400mg, 800mg	1	
SITAVIG TABLET 50MG	3	QL(2 EA per 30 days)
valacyclovir hydrochloride tablet 1gm, 500mg	1	QL(120 EA per 30 days)
VALTREX TABLET 1GM, 500MG	3	QL(120 EA per 30 days)
Antiviral, Coronavirus Agents		
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	2	QL(11 EA per 5 days); (300mg-100mg Day 1; 150mg-100mg Days 2-5 Pak)
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	2	QL(20 EA per 5 days); (150mg-100mg Pak)
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	2	QL(30 EA per 5 days); (300mg-100mg Pak)
Anxiolytics		

Drug Name	Drug Tier	Requirements/Limits
Anxiolytics, Other		
buspirone hcl tablet 15mg	1	
buspirone hydrochloride tablet 10mg, 30mg, 5mg, 7.5mg	1	
Benzodiazepines		
alprazolam tablet 0.25mg, 0.5mg, 1mg	1	QL(120 EA per 30 days)
alprazolam tablet 2mg	1	QL(150 EA per 30 days)
ATIVAN TABLET 2MG	4	QL(150 EA per 30 days)
ATIVAN TABLET 0.5MG, 1MG	4	QL(90 EA per 30 days)
diazepam tablet 10mg	1	QL(120 EA per 30 days)
diazepam tablet 5mg	1	QL(240 EA per 30 days)
diazepam tablet 2mg	1	QL(300 EA per 30 days)
lorazepam tablet 2mg	1	QL(150 EA per 30 days)
lorazepam tablet 0.5mg, 1mg	1	QL(90 EA per 30 days)
VALIUM TABLET 10MG	3	QL(120 EA per 30 days)
VALIUM TABLET 5MG	3	QL(240 EA per 30 days)
VALIUM TABLET 2MG	3	QL(300 EA per 30 days)
XANAX TABLET 0.25MG, 0.5MG, 1MG	3	QL(120 EA per 30 days)
XANAX TABLET 2MG	3	QL(150 EA per 30 days)
Blood Glucose Regulators		
Antidiabetic Agents		
glimepiride tablet 1mg, 2mg, 4mg	1	
glipizide er tablet extended release 24 hour 10mg, 2.5mg, 5mg	1	
glipizide xl tablet extended release 24 hour 10mg, 2.5mg, 5mg	1	
glipizide tablet 10mg, 2.5mg, 5mg	1	
GLUMETZA TABLET EXTENDED RELEASE 24 HOUR 500MG	3	PA
GLUMETZA TABLET EXTENDED RELEASE 24 HOUR 1000MG	4	PA
JANUVIA TABLET 100MG, 25MG, 50MG	2	QL(30 EA per 30 days)
metformin hydrochloride er tablet extended release 24 hour 1000mg, 500mg, 750mg	1	
metformin hydrochloride er tablet extended release 24 hour 1000mg, 500mg	1	PA
metformin hydrochloride tablet 1000mg, 500mg, 850mg	1	
metformin hydrochloride tablet 625mg, 750mg	4	PA
MOUNJARO INJECTION 10MG/0.5ML, 12.5MG/0.5ML, 15MG/0.5ML, 2.5MG/0.5ML, 5MG/0.5ML, 7.5MG/0.5ML	2	QL(2 ML per 28 days); PA
OZEMPIC INJECTION 2MG/3ML, 4MG/3ML, 8MG/3ML	2	QL(3 ML per 28 days); PA
pioglitazone hcl tablet 45mg	1	
pioglitazone hydrochloride tablet 15mg, 30mg	1	
TRULICITY INJECTION 0.75MG/0.5ML, 1.5MG/0.5ML, 3MG/0.5ML, 4.5MG/0.5ML	2	QL(2 ML per 28 days); PA
Insulins		
ADMELOG SOLOSTAR INJECTION 100UNIT/ML	3	ST

Drug Name	Drug Tier	Requirements/Limits
ADMELOG INJECTION 100UNIT/ML	3	ST
BASAGLAR KWIKPEN INJECTION 100UNIT/ML	3	ST
BASAGLAR TEMPO PEN INJECTION 100UNIT/ML	3	ST
HUMALOG JUNIOR KWIKPEN INJECTION 100UNIT/ML	2	
HUMALOG KWIKPEN INJECTION 100UNIT/ML, 200UNIT/ML	2	
HUMALOG INJECTION 100UNIT/ML	2	
HUMULIN R U-500 (CONCENTRATED) INJECTION 500UNIT/ML	2	
INSULIN LISPRO INJECTION 100UNIT/ML	2	
LANTUS SOLOSTAR INJECTION 100UNIT/ML	2	
TOUJEO MAX SOLOSTAR INJECTION 300UNIT/ML	2	
TOUJEO SOLOSTAR INJECTION 300UNIT/ML	2	
Blood Products and Modifiers		
Anticoagulants		
dabigatran etexilate capsule 110mg, 150mg, 75mg	1	QL(60 EA per 30 days)
ELIQUIS TABLET 2.5MG	2	QL(60 EA per 30 days)
ELIQUIS TABLET 5MG	2	QL(90 EA per 30 days)
jantoven tablet 10mg, 1mg, 2.5mg, 2mg, 3mg, 4mg, 5mg, 6mg, 7.5mg	1	
rivaroxaban tablet 2.5mg	2	QL(360 EA per 30 days)
warfarin sodium tablet 10mg, 1mg, 2.5mg, 2mg, 3mg, 4mg, 5mg, 6mg, 7.5mg	1	
XARELTO TABLET 10MG, 20MG	2	QL(30 EA per 30 days)
XARELTO TABLET 2.5MG	2	QL(360 EA per 30 days)
XARELTO TABLET 15MG	2	QL(60 EA per 30 days)
Platelet Modifying Agents		
clopidogrel tablet 300mg, 75mg	1	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine hydrochloride tablet 0.1mg, 0.2mg, 0.3mg	1	
midodrine hydrochloride tablet 10mg, 2.5mg, 5mg	1	
Angiotensin II Receptor Antagonists		
losartan potassium tablet 100mg, 25mg, 50mg	1	
olmesartan medoxomil tablet 20mg, 40mg, 5mg	1	
valsartan tablet 160mg, 320mg, 40mg, 80mg	1	
Angiotensin-converting Enzyme (ACE) Inhibitors		
lisinopril tablet 10mg, 2.5mg, 20mg, 30mg, 40mg, 5mg	1	
Antiarrhythmics		
amiodarone hydrochloride tablet 100mg, 200mg, 400mg	1	
digoxin tablet 125mcg, 250mcg, 62.5mcg	1	
flecainide acetate tablet 100mg, 150mg, 50mg	1	
PACERONE TABLET 100MG, 200MG, 400MG	1	
Beta-adrenergic Blocking Agents		

Drug Name	Drug Tier	Requirements/Limits
atenolol tablet 100mg, 25mg, 50mg	1	
bisoprolol fumarate tablet 10mg, 2.5mg, 5mg	1	
carvedilol tablet 12.5mg, 25mg, 3.125mg, 6.25mg	1	
metoprolol succinate er tablet extended release 24 hour 100mg, 200mg, 25mg, 50mg	1	
metoprolol tartrate tablet 100mg, 25mg, 37.5mg, 50mg, 75mg	1	
propranolol hcl tablet 40mg	1	
propranolol hydrochloride tablet 10mg, 20mg, 60mg, 80mg	1	
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate tablet 10mg, 2.5mg, 5mg	1	
nifedipine er tablet extended release 24 hour 30mg, 60mg, 90mg	1	
Calcium Channel Blocking Agents, Nondihydropyridines		
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 120MG, 180MG	3	
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 240MG, 300MG, 360MG	4	
cartia xt capsule extended release 24 hour 120mg, 180mg, 240mg, 300mg	1	
diltiazem hcl cd capsule extended release 24 hour 360mg	1	
diltiazem hydrochloride er capsule extended release 24 hour 120mg, 180mg, 240mg, 300mg, 360mg	1	
Cardiovascular Agents, Other		
ENTRESTO TABLET 24MG; 26MG, 49MG; 51MG, 97MG; 103MG	2	QL(60 EA per 30 days)
lisinopril/hydrochlorothiazide tablet 12.5mg; 10mg, 12.5mg; 20mg, 25mg; 20mg	1	
losartan potassium/hydrochlorothiazide tablet 12.5mg; 100mg, 12.5mg; 50mg, 25mg; 100mg	1	
triamterene/hydrochlorothiazide capsule 25mg; 37.5mg	1	
triamterene/hydrochlorothiazide tablet 25mg; 37.5mg, 50mg; 75mg	1	
Diuretics, Loop		
bumetanide tablet 0.5mg, 1mg, 2mg	1	
furosemide tablet 20mg, 40mg, 80mg	1	
SOAANZ TABLET 20MG, 40MG, 60MG	3	ST
torsemide tablet 100mg, 10mg, 20mg, 5mg	1	
Diuretics, Thiazide		
chlorthalidone tablet 25mg, 50mg	1	
HEMICLOR TABLET 12.5MG	3	
hydrochlorothiazide capsule 12.5mg	1	
hydrochlorothiazide tablet 12.5mg, 25mg, 50mg	1	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate tablet 120mg, 145mg, 160mg, 40mg, 48mg, 54mg	1	

Drug Name	Drug Tier	Requirements/Limits
FENOGLIDE TABLET 120MG	3	
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin calcium tablet 10mg, 20mg, 40mg, 80mg	1	
lovastatin tablet 10mg, 20mg, 40mg	1	
pravastatin sodium tablet 10mg, 20mg, 40mg, 80mg	1	
rosuvastatin calcium tablet 10mg, 20mg, 40mg, 5mg	1	
simvastatin tablet 10mg, 20mg, 40mg, 5mg, 80mg	1	
Dyslipidemics, Other		
ezetimibe tablet 10mg	1	
LOVAZA CAPSULE 375MG; 465MG; 1GM	3	
omega-3-acid ethyl esters capsule 375mg; 465mg; 1gm	1	
REPATHA SURECLICK INJECTION 140MG/ML	2	QL(3 ML per 28 days); PA
Mineralocorticoid Receptor Antagonists		
spironolactone tablet 100mg, 25mg, 50mg	1	
Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)		
DAPAGLIFLOZIN PROPANEDIOL TABLET 10MG, 5MG	2	QL(30 EA per 30 days)
FARXIGA TABLET 10MG, 5MG	2	QL(30 EA per 30 days)
JARDIANCE TABLET 10MG, 25MG	2	QL(30 EA per 30 days)
Vasodilators, Direct-acting Arterial/Venous		
isosorbide mononitrate er tablet extended release 24 hour 120mg, 30mg, 60mg	1	
nitroglycerin tablet sublingual 0.3mg, 0.4mg, 0.6mg	1	
Vasodilators, Direct-acting Arterial		
hydralazine hydrochloride tablet 100mg, 10mg, 25mg, 50mg	1	
minoxidil tablet 10mg, 2.5mg	1	
Dental and Oral Agents		
Dental and Oral Agents		
chlorhexidine gluconate solution 0.12%	1	
doxycycline hyclate tablet 20mg	1	
periogard solution 0.12%	1	
Dermatological Agents		
Acne and Rosacea Agents		
metronidazole gel 0.75%, 1%	1	
Dermatitis and Pruritus Agents		
clobetasol propionate cream 0.05%	1	
clobetasol propionate ointment 0.05%	1	
clobetasol propionate solution 0.05%	1	
hydrocortisone cream 1%, 2.5%	1	
hydrocortisone ointment 2.5%	1	
hydrocortisone ointment 1%	1	QL(100 GM per 30 days)
IMPOYZ CREAM 0.025%	4	
tacrolimus ointment 0.03%, 0.1%	1	
triamcinolone acetonide cream 0.025%, 0.1%, 0.5%	1	
triamcinolone acetonide ointment 0.025%, 0.1%, 0.5%	1	

Drug Name	Drug Tier	Requirements/Limits
Dermatological Agents, Other		
CARAC CREAM 0.5%	4	
clotrimazole/betamethasone dipropionate cream 0.05%; 1%	1	QL(90 GM per 30 days)
EFUDEX CREAM 5%	3	QL(40 GM per 30 days)
FLUOROURACIL CREAM 0.5%	4	
fluorouracil cream 5%	1	QL(40 GM per 30 days)
Topical Anti-infectives		
ciclodan solution 8%	1	PA
ciclopirox nail lacquer solution 8%	1	PA
mupirocin ointment 2%	1	QL(110 GM per 30 days)
Electrolytes/Minerals/Metals/Vitamins		
Electrolyte/Mineral Replacement		
klor-con 10 tablet extended release 10meq	1	
klor-con 8 tablet extended release 8meq	1	
klor-con m10 tablet extended release 10meq	1	
klor-con m15 tablet extended release 15meq	1	
klor-con m20 tablet extended release 20meq	1	
potassium chloride er capsule extended release 10meq, 8meq	1	
potassium chloride er tablet extended release 10meq, 15meq, 20meq, 8meq	1	
Gastrointestinal Agents		
Anti-Constipation Agents		
constulose solution 10gm/15ml	1	
lactulose solution 10gm/15ml	1	
Antispasmodics, Gastrointestinal		
dicyclomine hydrochloride capsule 10mg	1	
Gastrointestinal Agents, Other		
gavilyte-c solution reconstituted 240gm; 2.98gm; 6.72gm; 5.84gm; 22.72gm	1	
gavilyte-g solution reconstituted 236gm; 2.97gm; 6.74gm; 5.86gm; 22.74gm	1	
peg-3350/electrolytes solution reconstituted 236gm; 2.97gm; 6.74gm; 5.86gm; 22.74gm	1	
Histamine2 (H2) Receptor Antagonists		
famotidine tablet 20mg, 40mg	1	
PEPCID TABLET 40MG	3	
Protectants		
sucralfate tablet 1gm	1	
Proton Pump Inhibitors		
esomeprazole magnesium capsule delayed release 20mg, 40mg	3	QL(60 EA per 30 days)
lansoprazole capsule delayed release 15mg, 30mg	1	QL(60 EA per 30 days)
NEXIUM CAPSULE DELAYED RELEASE 20MG, 40MG	3	QL(60 EA per 30 days)
omeprazole dr capsule delayed release 10mg, 40mg	1	QL(60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
omeprazole capsule delayed release 20mg, 40mg	1	QL(60 EA per 30 days)
pantoprazole sodium tablet delayed release 20mg, 40mg	1	QL(60 EA per 30 days)
PREVACID CAPSULE DELAYED RELEASE 30MG	3	QL(60 EA per 30 days)
PROTONIX TABLET DELAYED RELEASE 20MG, 40MG	3	QL(60 EA per 30 days)
Genitourinary Agents		
Antispasmodics, Urinary		
GEMTESA TABLET 75MG	3	
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR 25MG, 50MG	2	
oxybutynin chloride er tablet extended release 24 hour 10mg, 15mg, 5mg	1	
oxybutynin chloride tablet 2.5mg, 5mg	1	
solifenacin succinate tablet 10mg, 5mg	1	
trospium chloride tablet 20mg	1	
VESICARE TABLET 10MG, 5MG	3	
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er tablet extended release 24 hour 10mg	1	
CIALIS TABLET 5MG	3	QL(30 EA per 30 days); PA
dutasteride capsule 0.5mg	1	
finasteride tablet 5mg	1	
tadalafil tablet 2.5mg, 5mg	1	QL(30 EA per 30 days); PA
tamsulosin hydrochloride capsule 0.4mg	1	
terazosin hcl capsule 10mg, 1mg, 5mg	1	
terazosin hydrochloride capsule 2mg	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
dexamethasone tablet 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg	1	
methylprednisolone dose pack tablet therapy pack 4mg	1	
prednisone tablet 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
Androgens		
ANDROGEL PUMP GEL 1.62%	3	PA
DEPO-TESTOSTERONE INJECTION 100MG/ML, 200MG/ML	3	PA
FORTESTA GEL 10MG/ACT	3	PA
NATESTO GEL 5.5MG/ACT	3	PA
TESTIM GEL 1%	3	PA
testosterone cypionate injection 100mg/ml, 200mg/ml	1	PA
testosterone pump gel 1.62%	1	PA
testosterone pump gel 1%	2	PA
testosterone gel 10mg/act, 20.25mg/1.25gm, 40.5mg/2.5gm	1	PA
testosterone gel 25mg/2.5gm, 50mg/5gm	2	PA

Drug Name	Drug Tier	Requirements/Limits
VOGELXO PUMP GEL 1%	3	PA
VOGELXO GEL 50MG/5GM	3	PA
Estrogens		
estradiol cream 0.1mg/gm	1	
estradiol tablet 10mcg	1	
yuvafem tablet 10mcg	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
euthyrox tablet 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 25mcg, 50mcg, 75mcg, 88mcg	3	
levo-t tablet 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 25mcg, 300mcg, 50mcg, 75mcg, 88mcg	3	
levothyroxine sodium tablet 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 25mcg, 300mcg, 50mcg, 75mcg, 88mcg	1	
levoxyl tablet 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 25mcg, 50mcg, 75mcg, 88mcg	1	
SYNTHROID TABLET 100MCG, 112MCG, 125MCG, 137MCG, 150MCG, 175MCG, 200MCG, 25MCG, 300MCG, 50MCG, 75MCG, 88MCG	3	
unithroid tablet 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 25mcg, 300mcg, 50mcg, 75mcg, 88mcg	1	
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
methimazole tablet 10mg, 5mg	1	
Immunological Agents		
Immunological Agents, Other		
DUPIXENT INJECTION 200MG/1.14ML	4	QL(4.56 ML per 28 days); PA
DUPIXENT INJECTION 300MG/2ML	4	QL(8 ML per 28 days); PA
Immunosuppressants		
methotrexate sodium tablet 2.5mg	1	
Vaccines		
AREXVY INJECTION 120MCG/0.5ML	1	QL(1 EA per 999 days)
BOOSTRIX INJECTION 2.5LF/0.5ML; 18.5MCG/0.5ML; 5LF/0.5ML	1	
SHINGRIX INJECTION 50MCG/0.5ML	1	
Inflammatory Bowel Disease Agents		
Glucocorticoids		
ANUSOL-HC CREAM 2.5%	3	
hydrocortisone cream 1%, 2.5%	1	
procto-med hc cream 2.5%	1	
PROCTOSOL HC CREAM 2.5%	1	
PROCTOZONE-HC CREAM 2.5%	1	
Metabolic Bone Disease Agents		

Drug Name	Drug Tier	Requirements/Limits
Metabolic Bone Disease Agents		
alendronate sodium tablet 10mg, 35mg	1	
alendronate sodium tablet 70mg	1	QL(4 EA per 28 days)
calcitriol capsule 0.25mcg, 0.5mcg	1	
FOSAMAX TABLET 70MG	3	QL(4 EA per 28 days)
ibandronate sodium tablet 150mg	1	QL(1 EA per 28 days)
Ophthalmic Agents		
Ophthalmic Agents, Other		
cyclosporine emulsion 0.05%	2	
dorzolamide hcl/timolol maleate solution 22.3mg/ml; 6.8mg/ml	1	
dorzolamide hydrochloride/timolol maleate pf solution 2%; 0.5%	1	
neomycin/polymyxin/dexamethasone ointment 0.1%; 3.5mg/gm; 10000unit/gm	1	
neomycin/polymyxin/dexamethasone suspension 0.1%; 3.5mg/ml; 10000unit/ml	1	
polymyxin b sulfate/trimethoprim sulfate solution 10000unit/ml; 0.1%	1	
RESTASIS MULTIDOSE EMULSION 0.05%	2	
RESTASIS EMULSION 0.05%	2	
VERKAZIA EMULSION 0.1%	4	QL(120 EA per 30 days); PA
Ophthalmic Anti-Infectives		
erythromycin ointment 5mg/gm	1	
moxifloxacin hydrochloride solution 0.5%	1	
ofloxacin solution 0.3%	1	
Ophthalmic Anti-inflammatories		
ACUVAIL SOLUTION 0.45%	3	ST
ketorolac tromethamine solution 0.4%, 0.5%	1	
PRED MILD SUSPENSION 0.12%	2	
prednisolone acetate suspension 1%	1	
Ophthalmic Beta-Adrenergic Blocking Agents		
timolol maleate solution 0.25%, 0.5%	1	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
brimonidine tartrate solution 0.1%, 0.15%, 0.2%	1	
dorzolamide hydrochloride solution 2%	1	
Ophthalmic Prostaglandin and Prostamide Analogs		
bimatoprost solution 0.03%	1	QL(5 ML per 30 days)
IYUZEH SOLUTION 0.005%	3	ST
latanoprost solution 0.005%	1	
LUMIGAN SOLUTION 0.01%	2	QL(2.5 ML per 25 days)
Respiratory Tract/Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
fluticasone propionate suspension 50mcg/act	1	

Drug Name	Drug Tier	Requirements/Limits
Antihistamines		
azelastine hcl solution 0.15%	1	QL(60 ML per 30 days)
azelastine hydrochloride solution 0.1%, 0.15%	1	QL(60 ML per 30 days)
hydroxyzine hcl tablet 50mg	1	
hydroxyzine hydrochloride tablet 10mg, 25mg	1	
levocetirizine dihydrochloride tablet 5mg	1	
Antileukotrienes		
montelukast sodium tablet 10mg	1	
Bronchodilators, Anticholinergic		
ipratropium bromide solution 0.03%, 0.06%	1	
SPIRIVA RESPIMAT AEROSOL SOLUTION 2.5MCG/ACT	2	
SPIRIVA RESPIMAT AEROSOL SOLUTION 1.25MCG/ACT	2	QL(8 GM per 30 days)
Bronchodilators, Sympathomimetic		
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(13.4 GM per 30 days); (6.7GM Package Size)
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(17 GM per 30 days); (8.5GM Package Size)
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(48 GM per 30 days); (18GM Package Size)
PROVENTIL HFA AEROSOL SOLUTION 108MCG/ACT	3	QL(13.4 GM per 30 days)
VENTOLIN HFA AEROSOL SOLUTION 108MCG/ACT	3	QL(48 GM per 30 days); ST
Respiratory Tract Agents, Other		
ADVAIR DISKUS AEROSOL POWDER BREATH ACTIVATED 100MCG/ACT; 50MCG/ACT, 250MCG/ACT; 50MCG/ACT, 500MCG/ACT; 50MCG/ACT	3	QL(60 EA per 30 days)
AIRDUO RESPICLICK 113/14 AEROSOL POWDER BREATH ACTIVATED 113MCG/ACT; 14MCG/ACT	3	QL(1 EA per 30 days)
AIRDUO RESPICLICK 232/14 AEROSOL POWDER BREATH ACTIVATED 232MCG/ACT; 14MCG/ACT	3	QL(1 EA per 30 days)
AIRDUO RESPICLICK 55/14 AEROSOL POWDER BREATH ACTIVATED 55MCG/ACT; 14MCG/ACT	3	QL(1 EA per 30 days)
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100MCG/ACT; 25MCG/ACT, 200MCG/INH; 25MCG/INH, 50MCG/INH; 25MCG/INH	2	QL(60 EA per 30 days)
breyna aerosol 160mcg/act; 4.5mcg/act, 80mcg/act; 4.5mcg/act	3	QL(10.3 GM per 30 days)
BREZTRI AEROSPHERE AEROSOL 160MCG/ACT; 4.8MCG/ACT; 9MCG/ACT	2	QL(23.6 GM per 28 days)
fluticasone propionate/salmeterol diskus aerosol powder breath activated 100mcg/act; 50mcg/act, 250mcg/act; 50mcg/act, 500mcg/act; 50mcg/act	1	QL(60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FLUTICASONE PROPIONATE/SALMETEROL AEROSOL POWDER BREATH ACTIVATED 113MCG/ACT; 14MCG/ACT, 232MCG/ACT; 14MCG/ACT, 55MCG/ACT; 14MCG/ACT	3	QL(1 EA per 30 days)
fluticasone propionate/salmeterol aerosol powder breath activated 500mcg/act; 50mcg/act	1	QL(60 EA per 30 days)
STIOLTO RESPIMAT AEROSOL SOLUTION 2.5MCG/ACT; 2.5MCG/ACT	3	QL(24 GM per 30 days); ST
TRELEGY ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100MCG/ACT; 62.5MCG/ACT; 25MCG/ACT, 200MCG/INH; 62.5MCG/INH; 25MCG/INH	2	QL(60 EA per 30 days)
wixela inhub aerosol powder breath activated 100mcg/act; 50mcg/act, 250mcg/act; 50mcg/act, 500mcg/act; 50mcg/act	1	QL(60 EA per 30 days)
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
cyclobenzaprine hydrochloride tablet 10mg, 5mg, 7.5mg	1	PA
FEXMID TABLET 7.5MG	3	PA
methocarbamol tablet 500mg, 750mg	1	
methocarbamol tablet 1000mg	4	
Sleep Disorder Agents		
Sleep Promoting Agents		
AMBIEN TABLET 10MG, 5MG	3	QL(30 EA per 30 days)
RESTORIL CAPSULE 15MG, 22.5MG, 30MG, 7.5MG	3	QL(30 EA per 30 days)
temazepam capsule 15mg, 22.5mg, 30mg, 7.5mg	1	QL(30 EA per 30 days)
zolpidem tartrate tablet 10mg, 5mg	1	QL(30 EA per 30 days)

Index of Drugs

Formulary ID: 26047, Version: 7, Effective Date: 01/01/2026
Last Updated: 08/06/2025

NOTICE OF NONDISCRIMINATION

OptumRx®, Inc. complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member ID card. (TTY **711**).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Optum Civil Rights Coordinator
1 Optum Circle
Eden Prairie, MN 55344
Optum_Civil_Rights@optum.com

If you need help filing a complaint, call the toll-free number **1-888-445-8745.** (TTY **711**).

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

Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf

Phone: **1-800-368-1019, 1-800-537-7697** (TDD)

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at hhs.gov/ocr/complaints/index.html.

This notice is available at optum.com/en/language-assistance-nondiscrimination.html.

This information is available in other formats like large print. To ask for another format, please call the telephone number listed on your member plan ID card.

Notice of Availability of Language Assistance Services and Alternate Formats

ATTENTION: Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card. TTY:**711**

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro. TTY: **711**

ملاحظة: إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃ
និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។
ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

请注意：如果您说**中文 (Chinese)**，我们可以为您提供免费语言协助服务以及大字印刷本等其他格式的免费通信。请致电您的会员身份卡上的免付费电话号码。

請注意：如果您說**中文 (Chinese)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

ATTENTION: Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, muaj cov kev pab cuam txhais lus thiab muaj kev sib txuas lus pab dawb ua lwm hom ntawv, xws li luam ua ntawv loj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

ATENSION: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

ATTENZIONE: se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイアルにお電話ください。

알림 사항: 한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

BAA'ÁKONÍNÍZIN: **Diné (Navajo)** saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó náánáłahgo át'éego bee hadadilyaa bee ahxił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nitł'izí bee nééhoziní bąąh t'áá hiik'eh bee hane'í námboo bee hodíilnih.

توجه: اگر به زبان **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ВНИМАНИЕ! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

FIIRO GAAR AH: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Ka wac lambarka wicitaanka bilaashka ah kaarkaaga aqoonsiga xubinta.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

LƯU Ý: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.

This abridged formulary was updated on August 6 2025, and is not complete list of drugs covered by our plan.

This is not a complete list of drugs covered by our plan. For a complete listing or if you have other questions, please contact:

Optum Rx Member Services

Phone (toll-free):	**1-800-908-9097**
TTY users:	**711**
Hours of operation:	24 hours a day, 7 days a week
Website:	**optumrx.com**

Optum Rx®

Optum Rx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum® company — a leading provider of integrated health services. Learn more at optumrx.com.

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County of Orange
Abridged Formulary