DOCTORS
HEALTHCARE PLANS, INC.

FORMULARY

List of Covered Drugs

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

This formulary was updated on 12/1/2021. For more recent information or other questions, please contact Doctors HealthCare Plans Member Services Department at (786) 460-3427 or toll-free at (833) 342-7463 or, for TTY users, dial 711, Monday through Sunday 8AM to 8PM ET, or visit us online at: www.doctorshcp.com.

FORMULARIO

Lista de medicamentos cubiertos

LEA LO SIGUIENTE: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

Este formulario se actualizó el 01 de diciembre de 2021. Para obtener información más reciente o si tiene otras preguntas, comuníquese con Doctors HealthCare Plans Departamento de Servicios al Asociado al (786) 460-3427 o al número de teléfono gratuito (833) 342-7463. Los usuarios de TTY deben llamar al 711, lunes a domingo 8AM hasta 8PM ET, o visite www.doctorshcp.com.

H4140_RXDRUGLIST2021_C | DHCPFORMULARY_21389_v36

2021

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

When this drug list (formulary) refers to "we," "us", or "our," it means Doctors HealthCare Plans, Inc. When it refers to "plan" or "our plan," it means Doctors HealthCare Plans, Inc. .

This document includes a list of the drugs (formulary) for our plan which is current as of 12/01/2021. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2021, and from time to time during the year.

What is the Doctors HealthCare Plans, Inc. Formulary?

A formulary is a list of covered drugs selected by the Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Doctors HealthCare Plans network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage (EOC).

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later 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 brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Doctors HealthCare Plans, Inc. Formulary?"

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently

on the formulary; or add new restrictions to the brand name drug or move it to a different cost sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Doctors HealthCare Plans, Inc. Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 12/01/2021. To get updated information about the drugs covered by the Plan, please contact us. Our contact information appears on the front and back cover pages.

If any other type of approved formulary change (non-maintenance change) is made during the year, we will notify you by sending you a list of these changes.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 19. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat 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 number 19. 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 159. The Index provides an alphabetical list of all of the drugs included 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?

The 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 cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Doctors HealthCare Plans requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from the Plan before you fill your prescriptions. If you don't get approval, we may not cover the drug.

- **Quantity Limits:** For certain drugs, Doctors HealthCare Plans limits the amount of the drug that the Plan will cover. For example, the Plan provides 30 capsules per prescription for *temazepam*. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Doctors HealthCare Plans 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, the Plan 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.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 19. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted on line documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask us 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 Doctors HealthCare Plans, Inc. formulary?" on page 6 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that we do not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by the Plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by us.

- You can ask the Plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Doctors HealthCare Plans, Inc. Formulary?

You can ask us 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, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- **You can ask us to cover a formulary drug at a lower cost-sharing level (if this drug is not on the specialty tier).** If approved this would lower the amount you must pay for your drug.

- **You can ask us to waive coverage restrictions or limits on your drug.** For example, for certain drugs, the Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing 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 it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor 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 that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your 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 a 31-day emergency supply of that drug while you pursue a formulary exception.

Members experiencing a level of care change may access a refill upon admission or discharge to a long term care (LTC) facility. Members in need of a one-time Transition Fill, or who are prescribed a Non-Formulary drug as a result of a level of care change, can be placed in transition via manual override at point of sale or by contacting Doctors HealthCare Plans for an override. The plan may provide an extension of the Transition Period, on a case-by-case basis, to the extent that a Member's exception request or appeal has not been processed by the end of the minimum Transition Period and until such time that a transition has been made (either through a switch to a formulary drug or a decision on an exception request).

For more information

For more detailed information about your Plans prescription drug coverage, please review your Evidence of Coverage (EOC) and other plan materials.

If you have questions about Doctors HealthCare Plans, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit http://www.medicare.gov.

Our Formulary

The formulary below provides coverage information about the drugs covered by the Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 159.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., JANUVIA) and generic drugs are listed in lower-case italics (e.g., *metformin*).

The information in the Requirements/Limits column tells you if the Plan has any special requirements for coverage of your drug.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 786-460-3427 o 833-342-7463 (TTY: 711).

Cost-Sharing for a one-month supply of a covered Part D prescription drug during the Initial Coverage Stage

Miami-Dade County

	Tier 1 Preferred Generics	Tier 2 Generics	Tier 3 Preferred Brands	Tier 4 Non-Preferred Drugs	Tier 5 Specialty
DrMax HMO-POS H4140-001	**$0**	**$0**	**$0**	**$45***	**33%***
DrPlus HMO-POS SNP H4140-002	**$0**	**$0**	**$0**	**$35***	**33%***
DrCare HMO-POS SNP H4140-003	**$0**	**$0**	**$10***	**$40***	**33%***
DrExtra HMO-POS SNP H4140-004	**$0**	**$0**	**$10***	**$40***	**33%***
DrValue HMO-POS H4140-005	**$0**	**$0**	**$45***	**$90***	**33%***
DrFirst HMO-POS H4140-006	**$0**	**$0**	**25%***	**25%***	**25%***
DrChoice HMO-POS H4140-007	**$0**	**$0**	**25%***	**25%***	**25%***

One-month cost shares are the same for Network Retail Pharmacy, Mail-Order Pharmacy and Long-Term Care Pharmacy.
Tier 1 and 2 drugs are covered through the Coverage Gap.
Excluded drugs are covered at $0 cost sharing throughout the year.
A long-term supply is not available for drugs in Tier 5 - Specialty Tier.
DrFirst and DrChoice have a Part D Deductible of $445* for drugs in Tiers 3-5 only.
***Important**: You may pay $0.00-$9.20 per prescription. The amount you pay depends on your Part D prescription and your low-income subsidy (LIS) coverage. Please refer to your Evidence of Coverage (EOC) for more information about this coverage and your LIS Rider for the specific amount you will pay.

12/01/2021

Legend

Generic drugs are shown in lowercase italic (e.g., *metformin*). Brand-name drugs are shown in capital letters (e.g., JANUVIA).

The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. 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.

LEGEND	
TIER	**NAME**
1	Preferred Generics
2	Generics
3	Preferred Brands
4	Non-Preferred Drugs
5	Specialty

SYMBOL	NAME	DESCRIPTION
ED	Excluded Drugs	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
PA	Prior Authorization	The process of obtaining approval for certain prescriptions before benefits will be approved. You, your doctor or other network provider will need to request prior authorization before you fill the prescription.
PA – Part B vs D Determination	Prior Authorization - Part BvsD Determination	This drug may be covered under either your Part D prescription drug benefits or as a Part B drug under your medical benefits, as determined by Medicare.
PA – FOR NEW STARTS ONLY	Prior Authorization – For New Starts Only	Prior Authorization applies to New Starts only. The process of obtaining approval for certain prescriptions before benefits will be approved. You, your doctor or other network provider will need to request prior authorization before you fill the prescription.
QL	Quantity Limits	Restricts the frequency, amount or dosage of medication for which you can obtain benefits each time you get a prescription filled (most often set on a monthly basis).
ST	Step Therapy	The process of first trying a certain drug or drugs to determine if that drug or those drugs will treat your medical condition before your plan will cover another drug for that condition.

Nota para los asociados actuales: este Formulario ha cambiado con respecto al año pasado. Revise este documento para asegurarse de que aún contiene los medicamentos que toma.

Cuando esta Lista de medicamentos (Formulario) menciona “nosotros”, “nos” o “nuestro”, hace referencia a Doctors HealthCare Plans, Inc. Cuando dice “plan” o “nuestro plan”, hace referencia a Doctors HealthCare Plans, Inc.

Este documento incluye una lista de los medicamentos (Formulario) de nuestro plan, la cual está en vigencia desde el 12/01/2021. Para obtener un formulario actualizado, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y la portada posterior.

Generalmente, debe concurrir a las farmacias de la red para usar el beneficio de medicamentos con receta. Los beneficios, el formulario, la red de farmacias o los copagos/el coseguro pueden cambiar el 1 de enero de 2021 y periódicamente durante el año.

¿Qué es el Formulario de Doctors HealthCare Plans, Inc.?

Un Formulario es una lista de medicamentos cubiertos seleccionados por el Plan con la colaboración de un equipo de proveedores de atención médica, que representa los tratamientos con receta que se considera que son parte necesaria de un programa de tratamiento de calidad. Normalmente, el Plan cubrirá los medicamentos incluidos en el formulario, siempre que el medicamento sea médicamente necesario, el medicamento con receta se obtenga en una farmacia de la red de Doctors HealthCare Plans y se cumpla con otras normas del Plan. Para obtener más información sobre cómo obtener sus medicamentos con receta, consulte la Evidencia de cobertura (EOC).

¿Puede cambiar el Formulario (lista de medicamentos)?

La mayoría de los cambios en la cobertura de los medicamentos ocurren el 1 de enero, pero nosotros podríamos agregar o quitar medicamentos de la Lista de medicamentos durante el año, moverlos a diferentes niveles de costo compartido o agregar nuevas restricciones. Debemos seguir las normas de Medicare al hacer estos cambios.

Cambios que pueden afectarlo este año: en los casos a continuación, usted se verá afectado por los cambios de cobertura durante el año:

- **Nuevos medicamentos genéricos.** Podemos eliminar inmediatamente un medicamento de marca de nuestra Lista de medicamentos si lo reemplazamos con un nuevo medicamento genérico que aparecerá en el mismo nivel de costo compartido o en un nivel de costo compartido más bajo y con las mismas restricciones o menos. Además, cuando agreguemos el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de medicamentos, pero inmediatamente moverlo a un nivel de costo compartido diferente o agregar nuevas restricciones. Si actualmente está tomando ese medicamento de marca, quizás no le informemos con antelación antes de que realicemos el cambio, pero más adelante le proporcionaremos información sobre los cambios específicos que hemos realizado.
    - Si realizamos un cambio, usted o la persona autorizada a dar recetas pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento de marca para usted. En el aviso que le proporcionamos también se incluirá información sobre cómo solicitar una excepción, y usted también puede encontrar información en la sección a continuación titulada “¿Cómo puedo solicitar que se haga una excepción al Formulario de Doctors HealthCare Plans, Inc. ?”.

- **Medicamentos retirados del mercado.** Si la Administración de Drogas y Alimentos considera que un medicamento de nuestro Formulario es inseguro o el fabricante del medicamento lo retira del mercado, eliminaremos de inmediato dicho medicamento de nuestro Formulario y les notificaremos a los asociados que toman el medicamento en cuestión.

- **Otros cambios.** Podemos hacer otros cambios que afectan a los asociados que actualmente toman un medicamento. Por ejemplo, podemos agregar un medicamento genérico que no es nuevo en el mercado para reemplazar un medicamento de marca que actualmente se encuentre en el Formulario o agregar nuevas restricciones al medicamento de marca o moverlo a un nivel de costo compartido diferente o ambas cosas. O bien, podemos hacer cambios en función de las nuevas pautas clínicas. Si retiramos medicamentos de nuestro Formulario, o agregamos autorizaciones previas, restricciones de límite de cantidad o de tratamiento escalonado en un medicamento o si pasamos un medicamento a un nivel superior de costo compartido, debemos notificarles a los asociados afectados por el cambio al menos 30 días antes de que entre en vigencia dicho cambio, o cuando el asociado solicite un resurtido del medicamento, momento en el cual el asociado recibirá un suministro del medicamento para 30 días.
    - Si realizamos estos otros cambios, usted o la persona autorizada a dar recetas pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento de marca para usted. En el aviso que le proporcionamos también se incluirá información sobre cómo solicitar una excepción, y usted también puede encontrar información en la sección a continuación titulada "¿Cómo puedo solicitar que se haga una excepción al Formulario de Doctors HealthCare Plans, Inc.?".

Cambios que no lo afectarán si actualmente toma el medicamento. En general, si usted toma un medicamento de nuestro Formulario para 2021 que estaba cubierto al comienzo del año, nosotros no discontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2021, excepto como se describe anteriormente. Esto significa que, por el resto del año de cobertura, estos medicamentos continuarán disponibles al mismo costo compartido y sin nuevas restricciones para aquellos asociados que estén tomándolos. No recibirá un aviso directo este año sobre cambios que no lo afectan. Sin embargo, dichos cambios lo afectarían a partir del 1 de enero del año siguiente, y es importante que verifique la Lista de medicamentos del nuevo año de beneficios por cualquier cambio en los medicamentos.

El Formulario adjunto es vigente a partir del 12/01/2021. Para recibir información actualizada sobre los medicamentos cubiertos por el Plan, comuníquese con nosotros. Nuestra información de contacto aparece en las páginas de la portada y la portada posterior.

Si se realiza cualquier otro tipo de cambio en el formulario aprobado (que no sea de mantenimiento) durante el año, lo notificaremos enviándole una lista de dichos cambios o un formulario actualizado.

¿Cómo utilizo el Formulario?

Hay dos formas para encontrar su medicamento dentro del Formulario:

Afección médica

El Formulario comienza en la página 19. Los medicamentos de este Formulario están agrupados en categorías según el tipo de afección médica para cuyo tratamiento se los emplea. Por ejemplo, los medicamentos utilizados para tratar una afección cardíaca se enumeran dentro de la categoría Cardiovascular Agents. Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que empieza en la página 19. Luego, busque su medicamento debajo del nombre de la categoría.

Listado alfabético

Si no está seguro de qué categoría consultar, debe buscar su medicamento en el Índice que comienza en la página 159. El Índice proporciona una lista alfabética de todos los medicamentos incluidos en este documento. En el Índice, están tanto los medicamentos de marca como los genéricos. Busque en el Índice y encuentre su medicamento. Junto a su medicamento, verá el número de página donde puede encontrar información acerca de la cobertura. Vaya a la página que figura en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

El Plan cubre tanto los medicamentos de marca como los genéricos. Un medicamento genérico está aprobado por la Administración de Drogas y Alimentos (FDA) dado que se considera que tiene el mismo ingrediente activo que el medicamento de marca. Normalmente, los medicamentos genéricos cuestan menos que los de marca.

¿Hay alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos o límites adicionales de cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** Doctors HealthCare Plans exige que usted [o su médico] obtenga una autorización previa para determinados medicamentos. Esto significa que necesitará contar con la aprobación de el Plan antes de obtener sus medicamentos con receta. Si no consigue la autorización, es posible que el Plan no cubra el medicamento.

- **Límites de cantidad:** para ciertos medicamentos, Doctors HealthCare Plans limita la cantidad del medicamento que cubrirá. Por ejemplo, el Plan proporciona 30 cápsulas por receta para temazepam . Esto puede ser complementario a un suministro estándar para un mes o tres meses.

- **Tratamiento escalonado:** en algunos casos, Doctors HealthCare Plans requiere que usted primero pruebe ciertos medicamentos para tratar su afección médica antes de que cubramos otro medicamento para esa enfermedad. Por ejemplo, si el medicamento A y el medicamento B tratan su afección médica, es posible que el Plan no cubra el medicamento B a menos que usted pruebe primero el medicamento A. Si el medicamento A no funciona para usted, entonces el Plan cubrirá el medicamento B.

Para averiguar si su medicamento tiene requisitos o límites adicionales, consulte el Formulario que empieza en la página 19. También puede obtener más información sobre las restricciones que se aplican a medicamentos cubiertos específicos en nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y tratamiento escalonado. También puede pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y la portada posterior.

Puede pedirle a nosotros que haga una excepción a estas restricciones o límites, o puede solicitarle una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección “¿Cómo puedo solicitar que se haga una excepción al Formulario de Doctors HealthCare Plans, Inc..?” en la página 14 para obtener información acerca de cómo solicitar una excepción.

12/01/2021

¿Qué pasa si mi medicamento no está en el Formulario?

Si el medicamento que toma no está incluido en este Formulario (lista de medicamentos cubiertos), primero debe comunicarse con el Departamento de Servicios al Asociado y preguntar si su medicamento está cubierto.

Si resulta que el Plan no cubre el medicamento que toma, tiene dos alternativas:

- Puede pedir al Departamento de Servicios al Asociado una lista de medicamentos similares que estén cubiertos por el Plan. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por nosotros.

- Puede solicitar que el Plan haga una excepción y cubra su medicamento. Consulte a continuación para obtener información sobre cómo solicitar una excepción.

¿Cómo puedo solicitar que se haga una excepción al Formulario de Doctors HealthCare Plans, Inc.?

Puede solicitarle al Plan que haga una excepción a nuestras normas de cobertura. Hay varios tipos de excepciones que puede solicitarnos.

- Puede pedirnos que cubramos un medicamento, incluso si no está en nuestro Formulario. Si se aprueba, este medicamento estará cubierto a un nivel de costo compartido predeterminado, y usted no podrá pedirnos que le brindemos el medicamento a un nivel de costo compartido menor.

- Puede pedirnos que cubramos un medicamento del Formulario a un nivel de costo compartido menor (si este medicamento no está incluido en el nivel de medicamentos especializados). Si se aprueba, esto reduciría el monto que usted debe pagar por su medicamento.
- Puede pedirnos que no apliquemos restricciones o límites de cobertura para su medicamento. Por ejemplo, para ciertos medicamentos, el Plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que hagamos una excepción al límite y cubramos una cantidad mayor.

Por lo general, el Plan solo aprobará su pedido de excepción si los medicamentos alternativos incluidos en el Formulario del plan, el medicamento de menor costo compartido o las restricciones de uso adicionales no fueran tan efectivos para tratar su afección o pudieran causarle efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión inicial de cobertura para una excepción al Formulario, o a la restricción de uso. **Cuando solicita una excepción al Formulario, o a la restricción de uso, debe presentar una declaración de su médico o de la persona autorizada a dar recetas que respalde su solicitud.** Por lo general, debemos tomar una decisión dentro de las 72 horas a partir de la fecha de haber recibido la declaración que respalda su solicitud por parte de la persona autorizada a dar recetas. Puede solicitar una excepción acelerada (rápida) si usted o su médico consideran que esperar 72 horas para la toma de la decisión podría perjudicar gravemente su salud. Si se le concede el trámite rápido de la excepción, debemos comunicarle nuestra decisión a más tardar dentro de las 24 horas después de haber recibido la declaración de respaldo de su médico o de otra persona autorizada a dar recetas.

¿Qué debo hacer antes de hablar con mi médico sobre el cambio de los medicamentos que tomo o la solicitud de una excepción?

Como asociado nuevo o permanente de nuestro plan, es posible que esté tomando medicamentos que no están incluidos en el Formulario. También es posible que esté tomando un medicamento incluido en el Formulario, pero su capacidad de conseguirlo sea limitada. Por ejemplo, puede necesitar nuestra autorización previa antes de poder obtener su medicamento con receta. Debe consultar con su médico para decidir si debe cambiar su medicamento por uno apropiado que nosotros cubramos o solicitar una excepción al formulario para que le cubramos el medicamento que toma. Mientras evalúa con su médico el procedimiento adecuado para seguir en su caso, podemos cubrir su medicamento, en ciertos casos, durante los primeros 90 días en que usted sea asociado de nuestro plan.

Para cada uno de los medicamentos que no estén incluidos en el Formulario, o si su capacidad para conseguir los medicamentos es limitada, cubriremos un suministro temporal para 30 días. Si su receta está indicada para menos días, permitiremos que realice resurtidos por un máximo de hasta 30 días del medicamento. Después del primer suministro para 30 días, no seguiremos pagando estos medicamentos, incluso si ha sido asociado del plan durante menos de 90 días.

Si es residente de un centro de atención a largo plazo y necesita un medicamento que no está en el Formulario o si su capacidad para conseguir los medicamentos es limitada, pero ya pasaron los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia del medicamento para 31 días mientras solicita la excepción al formulario.

Los asociados que están experimentando un cambio en el nivel de atención pueden acceder a un reabastecimiento luego de la admisión o la dada de alta de un centro de atención a largo plazo. Los asociados con necesidad de un reabastecimiento de transición única o aquel que le han formulado un medicamento que no es de receta como resultado de un cambio en el nivel de atención, pueden ser puestos en transición por medio de una anulación manual en punto de venta o comunicándose con Doctors HealthCare Plans. El plan puede proporcionar una extensión al período de transición, según el caso, en la medida en que la solicitud de excepción o apelación de un asociado no haya sido procesada al final del período mínimo de transición y hasta el momento en que la transición se haya realizado (ya sea mediante el cambio a un medicamento recetado o a la decisión de un pedido de excepción).

Para obtener más información

Para obtener información más detallada sobre la cobertura para medicamentos con receta de Doctors HealthCare Plans, consulte la Evidencia de cobertura y otra documentación del plan.

Si tiene alguna pregunta sobre Doctors HealthCare Plans, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y la portada posterior.

Si tiene preguntas generales sobre su cobertura para medicamentos con receta de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. O visite http://www.medicare.gov.

12/01/2021

Formulario de Doctors HealthCare Plans

El formulario a continuación proporciona información acerca de la cobertura de los medicamentos cubiertos por Doctors HealthCare Plans. Si tiene alguna dificultad para encontrar el medicamento que toma en la lista, consulte el Índice que comienza en la página 159.

La primera columna de la tabla menciona el nombre del medicamento. Los medicamentos de marca están en letra mayúscula (por ejemplo, JANUVIA), y los medicamentos genéricos están en letra minúscula y cursiva (por ejemplo, *metformin*).

La información incluida en la columna de Requisitos/límites indica si Doctors HealthCare Plans tiene algún requisito especial para la cobertura del medicamento.

Distribución de costos por un suministro de un mes de un medicamento recetado y cubierto de la Parte D durante la Etapa de Cobertura Inicial

Condado de Miami-Dade

	Nivel 1 Medicamentos genéricos preferidos	Nivel 2 Medicamentos genéricos	Nivel 3 Medicamentos de marca preferidos	Nivel 4 Medicamentos no preferidos	Nivel 5 Medicamentos especializados
DrMax HMO-POS H4140-001	**$0**	**$0**	**$0**	**$45***	**33%***
DrPlus HMO-POS SNP H4140-002	**$0**	**$0**	**$0**	**$35***	**33%***
DrCare HMO-POS SNP H4140-003	**$0**	**$0**	**$10***	**$40***	**33%***
DrExtra HMO-POS SNP H4140-004	**$0**	**$0**	**$10***	**$40***	**33%***
DrValue HMO-POS H4140-005	**$0**	**$0**	**$45***	**$90***	**33%***
DrFirst HMO-POS H4140-006	**$0**	**$0**	**25%***	**25%***	**25%***
DrChoice HMO-POS H4140-007	**$0**	**$0**	**25%***	**25%***	**25%***

Farmacia de la red, Farmacia de venta por correo y Farmacia de centro de atención a largo plazo tienen el mismo distribución de costos.

Los medicamentos en el Nivel 1 y 2 están cubiertos durante el período sin cobertura.

Los medicamentos excluidos tienen cobertura con una distribución de costos de $0 durante todo el año.

No hay disponible un suministro a largo plazo para medicamentos en el Nivel 5 - Nivel de medicamentos especializados

DrFirst y DrChoice tienen un deducible bajo la parte D de $445* por medicamentos en Niveles 3 – 5 solamente.

***Importante**: Usted puede pagar $0.00-$9.20 por receta. El monto que paga se determina por la receta de la Parte D cubierta y su cobertura de subsidio por bajos ingresos (LIS). Para obtener información más detallada acerca de la cobertura para medicamentos, lea su Evidencia de cobertura (EOC) y consulte su LIS Rider para conocer el monto específico que paga.

12/01/2021

Leyenda

Los medicamentos genéricos figuran en letra minúscula y cursiva (por ej., *metformin*). Los medicamentos de marca figuran en letra mayúscula (por ej., JANUVIA).

El Índice brinda una lista alfabética de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca como los medicamentos genéricos se enumeran en el Índice. Encuentre su medicamento. Al lado de su medicamento verá el número de página en la que puede encontrar información de cobertura. Vaya a la página que se enumera en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

LEYENDA	
NIVEL	**NOMBRE**
1	Genéricos preferidos
2	Genéricos
3	Medicamentos de marca preferidos
4	Medicamentos no preferidos
5	Medicamentos especializados

SÍMBOLO	NOMBRE	DESCRIPCIÓN
ED	Medicamento Excluido	Este medicamento con receta por lo general no está cubierto en un plan de medicamentos con receta de Medicare. El monto que paga cuando obtiene uno de estos medicamentos con receta no se tiene en cuenta en sus costos totales de medicamentos (es decir, el monto que usted paga no lo ayuda a calificar para la cobertura en situaciones catastróficas). Además, si recibe ayuda adicional para pagar sus medicamentos con receta, no recibirá ninguna ayuda adicional para pagar este medicamento.
PA	Autorización previa	El proceso de obtener la aprobación para determinadas recetas antes de aprobar los beneficios. Usted, su médico u otro proveedor de la red necesitarán solicitar autorización previa antes de abastecer la receta.
PA - Part B vs D Determination	Autorización previa – Parte B vs D Determinación	Este medicamento puede estar cubierto por los beneficios para los medicamentos recetados de la Parte D o como un medicamento de la Parte B bajo sus beneficios médicos, según lo determine Medicare.
PA – FOR NEW STARTS ONLY	Autorización previa - Sólo para nuevos inicios	La autorización previa sólo se aplica a los inicios nuevos. El proceso de obtener la aprobación para determinadas recetas antes de aprobar los beneficios. Usted, su médico u otro proveedor de la red necesitarán solicitar autorización previa antes de abastecer la receta.
QL	Límites de cantidad	Limita la frecuencia, cantidad o dosis de medicamento para la cual puede obtener beneficios cada vez que se le abastezca una receta (generalmente una vez por mes).
ST	Terapia escalonada	El proceso de probar por primera vez determinado medicamento o medicamentos para determinar si el o los mismos tratarán su afección médica antes de que su plan cubra otro medicamento para dicha afección.

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANALGESICS		
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
celecoxib	2	QL (60 PER 30 DAYS)
diclofenac epolamine	3	PA, QL (60 PER 30 DAYS)
diclofenac pot 50 mg tablet	1	
diclofenac sodium (dr 25 mg tab, dr 50 mg tab, dr 75 mg tab, ec 25 mg tab, ec 50 mg tab, ec 75 mg tab)	1	
diclofenac sodium er	1	
diclofenac sodium-misoprostol	4	
diflunisal	2	
ec-naproxen	1	
etodolac (200 mg capsule, 300 mg capsule, 400 mg tablet, 500 mg tablet)	2	
etodolac er	4	
flurbiprofen	2	
ibu	1	
ibuprofen (400 mg tablet, 600 mg tablet, 800 mg tablet)	1	
indomethacin (25 mg capsule, 50 mg capsule)	2	
indomethacin er	4	
ketoprofen er 200 mg capsule	4	
ketoprofen (25 mg capsule, 75 mg capsule)	2	
ketorolac 10 mg tablet	1	QL (20 PER 30 OVER TIME)
ketorolac tromethamine (15 mg/ml vial, 30 mg/ml carpuject, 30 mg/ml vial, 60 mg/2 ml carpuject)	2	

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
meclofenamate sodium	4	
mefenamic acid	4	
meloxicam (7.5 mg tablet, 15 mg tablet)	1	
nabumetone	2	
naproxen 125 mg/5 ml suspen	2	
naproxen (250 mg tablet, 375 mg tablet, dr 375 mg tablet, 500 mg kit, 500 mg tablet, dr 500 mg tablet)	1	
naproxen sodium (275 mg tab, 550 mg tab)	2	
oxaprozin	2	
PENNSAID (PUMP, SOLUTION PACKET)	5	PA, QL (224 PER 30 DAYS)
piroxicam	2	
salsalate	1	
sulindac	1	
tolmetin sodium (200 mg tab, 400 mg cap)	2	
tolmetin sodium 600 mg tab	4	
OPIOID ANALGESICS, LONG-ACTING		
EMBEDA (ER 20-0.8 MG CAPSULE, ER 30-1.2 MG CAPSULE, ER 50-2 MG CAPSULE, ER 60-2.4 MG CAPSULE)	3	
EMBEDA (ER 80-3.2 MG CAPSULE, ER 100-4 MG CAPSULE)	5	
fentanyl (12 mcg/hr patch, 25 mcg/hr patch, 50 mcg/hr patch)	2	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
fentanyl (37.5 mcg/hr patch, 75 mcg/hr patch, 100 mcg/hr patch)	4	
fentanyl (62.5 mcg/hr patch, 87.5 mcg/hr patch)	5	
hydrocodone bitartrate er (er 10 mg capsule, er 15 mg capsule, er 20 mg capsule, er 30 mg capsule, er 40 mg capsule, er 50 mg capsule)	4	
hydrocodone bitartrate er (er 100 mg tablet, er 120 mg tablet)	5	
hydrocodone bitartrate er (er 20 mg tablet, er 30 mg tablet, er 40 mg tablet, er 60 mg tablet, er 80 mg tablet)	3	
hydromorphone er	4	
levorphanol tartrate	5	
methadone hcl (5 mg/5 ml solution, hcl 5 mg tablet, 10 mg/5 ml solution, hcl 10 mg tablet, hcl 10 mg/ml syringe)	2	
methadone hcl (10 mg/ml vial, 200 mg/20 ml vl)	4	
morphine sulfate er (er 30 mg cap, er 40 mg cap, er 60 mg cap)	4	QL (30 PER 30 DAYS)
morphine sulfate er 100 mg cap	5	
morphine sulfate er (er 10 mg cap, er 20 mg cap, er 45 mg cap, er 50 mg cap, er 75 mg cap, er 80 mg cap, er 90 mg cap, er 120 mg cap)	4	
morphine sulfate er (er 15 mg tablet, er 30 mg tablet, er 60 mg tablet, er 100 mg tablet, er 200 mg tablet)	2	

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
oxymorphone hcl er	4	
tramadol hcl er (er 100 mg tablet, er 200 mg tablet, er 300 mg tablet, hcl er 100 mg tablet, hcl er 200 mg tablet, hcl er 300 mg tablet)	2	
OPIOID ANALGESICS, SHORT-ACTING		
ABSTRAL	5	PA
acetaminophen-codeine (acetamin-codein 300-30 mg/12.5, acetaminop-codeine 120-12 mg/5, acetaminophen-cod #2 tablet, acetaminophen-cod #3 tablet, acetaminophen-cod #4 tablet)	1	
asa-butalb-caffeine-codeine	2	
ascomp with codeine	4	
butalb-acetamin-caf-cod 50-300	2	
butalbital compound-codeine	2	
butorphanol 10 mg/ml spray	2	
codeine sulfate	2	
endocet (5-325 tablet, 7.5-325 mg tablet, 10-325 mg tablet)	2	
fentanyl citrate (cit 1,200 mcg, citrate 600 mcg, citrate 800 mcg)	5	PA
fentanyl citrate otfc 200 mcg	4	PA
fentanyl citrate otfc 400 mcg	4	PA, QL (120 PER 30 DAYS)
hydrocodone-acetaminophen (5-325 mg, 7.5-325, 10-325 mg)	1	

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
hydrocodone-acetaminophen (hydrocodone-acetamin 2.5-108/5, hydrocodone-acetamin 2.5-325, hydrocodone-acetamin 5-217/10, hydrocodone-acetamin 5-300 mg, hydrocodone-acetamin 7.5-300, hydrocodone-acetamin 10-300 mg, hydrocodone-acetamn 7.5-325/15)	2	
hydrocodone-ibuprofen	2	
hydromorphone hcl (1 mg/ml solution, 1 mg/ml vial, 2 mg tablet, 2 mg/ml carpujct, 2 mg/ml isecure, 2 mg/ml syringe, 2 mg/ml vial, hcl 2 mg/ml amp, 4 mg tablet, 4 mg/ml vial, 5 mg/5 ml soln, 10 mg/ml ampule, 10 mg/ml vial, 50 mg/5 ml amp, 50 mg/5 ml vial, 500 mg/50 ml vl)	2	
hydromorphone 8 mg tablet	2	QL (180 PER 30 DAYS)
lorcet	2	
lorcet hd	2	
lorcet plus	2	
morphine sulfate (5 mg/ml syringe, sulf 10 mg/5 ml soln, sulf 20 mg/5 ml soln, sulf 100 mg/5 ml conc, sulfate ir 15 mg tab, sulfate ir 30 mg tab)	2	
morphine sulfate (2 mg/ml carpuject, 2 mg/ml isecure syr, 2 mg/ml syringe, 4 mg/ml carpuject, 4 mg/ml isecure syr, 4 mg/ml syringe, 8 mg/ml carpuject, 8 mg/ml isecure syrng, 8 mg/ml syringe, 10 mg/ml carpuject, 10 mg/ml isecure syrg, 10 mg/ml syringe)	4	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
nalbuphine hcl (10 mg/ml ampul, 20 mg/ml ampul, 100 mg/10 ml vial, 200 mg/10 ml vial)	4	
naloxone 0.4 mg/ml carpuject	2	
oxycodone hcl ((ir) 5 mg cap, (ir) 10 mg tab, (ir) 20 mg tab)	2	QL (180 PER 30 DAYS)
oxycodone hcl 100 mg/5 ml conc	4	
oxycodone hcl ((ir) 5 mg tablet, 5 mg/5 ml soln, (ir) 15 mg tab, (ir) 30 mg tab)	2	
oxycodone hcl-aspirin	2	
oxycodone hcl-ibuprofen	2	
oxycodone-acetaminophen (oxycodone-acetaminophen 5-325, oxycodone-acetaminophen 10-325, oxycodone-acetaminophn 2.5-325, oxycodone-acetaminophn 7.5-325)	2	
oxymorphone hcl	4	
tramadol hcl	1	
tramadol hcl-acetaminophen	2	
vicodin	2	
vicodin hp	2	
ANESTHETICS		
LOCAL ANESTHETICS		
amiodarone hcl (150 mg/3 ml vial, 450 mg/9 ml vial, 900 mg/18 ml vial)	2	
lidocaine 5% patch	4	PA
lidocaine 5% ointment	4	PA, QL (120 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
lidocaine hcl (jel urojet ac, jelly, jelly uro-jet)	2	QL (30 PER 30 DAYS)
lidocaine hcl 4% solution	2	QL (50 PER 30 DAYS)
lidocaine hcl (0.5% vial, 2% 100 mg/5 ml, 2% 40 mg/2 ml, 2% 40 mg/2 ml vl, 2% ampul, 2% vial)	2	
lidocaine hcl viscous	1	
lidocaine-prilocaine	2	QL (30 PER 30 DAYS)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
acamprosate calcium	2	
disulfiram	2	
VIVITROL	5	
OPIOID DEPENDENCE TREATMENTS		
buprenorphine hcl (0.3 mg/ml crpjct, 0.3 mg/ml vial)	4	
buprenorphine hcl (2 mg tablet, 8 mg tablet)	2	
buprenorphine-nalox 12-3mg flm	2	QL (60 PER 30 DAYS)
buprenorphine-nalox 4-1mg film	2	QL (180 PER 30 DAYS)
buprenorphine-naloxone (2-0.5mg fm, 2-0.5mg tb)	2	QL (360 PER 30 DAYS)
buprenorphine-naloxone (8-2 mg tab, 8-2mg film)	2	QL (90 PER 30 DAYS)
butorphanol tartrate (1 mg/ml vial, 2 mg/ml vial, 4 mg/2 ml vial)	4	
naltrexone hcl	2	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
OPIOID REVERSAL AGENTS		
naloxone 2 mg auto-injector	3	QL (0.8 PER 30 DAYS)
naloxone hcl (0.4 mg/ml vial, 2 mg/2 ml syringe, 4 mg/10 ml vial)	2	
NARCAN	3	
SMOKING CESSATION AGENTS		
bupropion hcl sr 150 mg tablet	2	QL (60 PER 30 DAYS)
CHANTIX (0.5 MG TABLET, 1 MG CONT MONTH BOX, 1 MG TABLET, STARTING MONTH BOX)	4	QL (504 PER 365 OVER TIME)
NICOTROL	4	QL (2688 PER 365 OVER TIME)
NICOTROL NS	4	QL (360 PER 365 OVER TIME)
varenicline tartrate	4	QL (504 PER 365 OVER TIME)
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin sulf 500 mg/2 ml vial	2	
ARIKAYCE	5	PA
gentak	1	
gentamicin 0.3% eye drop	1	
gentamicin sulfate (0.1% cream, 0.1% ointment, 10 mg/ml vial, 80 mg/2 ml vial, 800 mg/20 ml vial)	2	
gentamicin sulfate in ns (iso 100 mg/100 ml, isoton 60 mg/50 ml, isoton 80 mg/100 ml, isoton 80 mg/50 ml)	2	
neomycin sulfate	2	

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
neomycin-polymyxin b (40 mg/ml amp, 40 mg/ml vl)	2	
paromomycin sulfate	2	
streptomycin sulfate	4	
tobramycin 0.3% eye drop	1	
tobramycin 10 mg/ml vial	2	
tobramycin sulfate (1.2 gm vial, 1.2 gram/30 ml vial, 40 mg/ml vial, 80 mg/2 ml vial, 1,200 mg/30 ml vial)	4	
TOBREX 0.3% EYE OINTMENT	4	
ANTIBACTERIALS, OTHER		
baciim	2	
bacitracin (500 unit/gm ophth, 50,000 unit vial)	2	
BACTROBAN NASAL	4	
CLEOCIN 100 MG VAGINAL OVULE	4	
clindamycin (pediatric)	2	
clindamycin hcl	2	
clindamycin phosphate 1% foam	4	
clindamycin phosphate (ph gel, phosphate gel)	3	
clindamycin phosphate (ph 1% solution, 2% vaginal cream, ph 9 g/60 ml vial, 300 mg/2 ml addvan, ph 300 mg/2 ml vl, ph 600 mg/4 ml vl, ph 900 mg/6 ml vl, phos 1% pledget, phosp 1% lotion)	2	
clindamycin phosphate-d5w	2	
colistimethate	4	

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
CORTISPORIN (CREAM, OINTMENT)	4	
DALVANCE	5	
daptomycin	5	
fosfomycin tromethamine	4	
KIMYRSA	5	
linezolid 100 mg/5 ml susp	4	PA, QL (1800 PER 30 DAYS)
linezolid 600 mg tablet	4	PA, QL (56 PER 28 DAYS)
linezolid-d5w	4	
mafenide acetate	2	
methenamine hippurate	2	
methenamine mandelate	4	
metronidazole (top 1% gel pump, topical 0.75% gl, topical 1% gel, vaginal 0.75% gl)	4	
metronidazole (0.75% cream, 0.75% lotion, 250 mg tablet, 375 mg capsule, 500 mg/100 ml)	2	
metronidazole 500 mg tablet	1	
mupirocin 2% cream	4	
mupirocin 2% ointment	2	
neomycin-bacitracin-poly-hc	2	
neomycin-poly-hc eye drops	2	
nitrofurantoin mcr 100 mg cap	1	QL (360 PER 365 OVER TIME)
nitrofurantoin mcr 25 mg cap	1	QL (1440 PER 365 OVER TIME)
nitrofurantoin mcr 50 mg cap	1	QL (720 PER 365 OVER TIME)
nitrofurantoin 25 mg/5 ml susp	4	
nitrofurantoin mono-macro	1	QL (180 PER 365 OVER TIME)
ORBACTIV	5	

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
polymyxin b sulfate	2	
silver sulfadiazine	3	
SIVEXTRO (200 MG TABLET, 200 MG VIAL)	5	QL (6 PER 30 DAYS)
SULFAMYLON 8.5% CREAM	4	
SYNERCID	5	
tigecycline	5	
trimethoprim	1	
vancomycin hcl 125 mg capsule	4	PA
vancomycin hcl 250 mg capsule	5	PA
vancomycin 250 mg/5 ml soln	2	PA
vancomycin hcl (1 gm add-van vial, 1 gm vial, hcl 10 gm vial, hcl 100 gm smartpak, hcl 250 mg vial, 500 mg add-van vial, 500 mg vial, 750 mg add-van vial, hcl 750 mg vial)	2	
XIFAXAN	5	PA
BETA-LACTAM, CEPHALOSPORINS		
AVYCAZ	5	
cefaclor (125 mg/5 ml susp, 250 mg capsule, 250 mg/5 ml susp, 375 mg/5 ml suspen)	1	
cefaclor er	1	
cefadroxil (1 gm tablet, 250 mg/5 ml susp, 500 mg capsule, 500 mg/5 ml susp)	2	
cefazolin sodium (1 gm add-van vial, 1 gm vial, 10 gm vial, 20 gm bulk vial, sod 100 gm bulk bag, sod 300 gm bulk bag, 500 mg vial)	2	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
cefdinir (125 mg/5 ml susp, 250 mg/5 ml susp, 300 mg capsule)	2	
cefepime hcl (1 gm vial, 2 gram vial)	2	
cefixime 400 mg capsule	1	
cefixime (100 mg/5 ml susp, 200 mg/5 ml susp)	4	
cefotaxime sodium	2	
cefotetan (1 gm vial, 2 gm vial)	2	
cefoxitin	2	
cefpodoxime proxetil (50 mg/5 ml susp, 100 mg tablet, 100 mg/5 ml susp, 200 mg tablet)	4	
cefprozil (125 mg/5 ml susp, 250 mg tablet, 250 mg/5 ml susp, 500 mg tablet)	2	
ceftazidime (1 gm vial, 2 gm vial, 6 gm vial)	2	
ceftriaxone (1 gm add-vant vial, 1 gm vial, 2 gm add vial, 2 gm vial, 10 gm vial, 100 gram bulk bag, 250 mg vial, 500 mg vial)	2	
cefuroxime	2	
cefuroxime sodium	2	
cephalexin (250 mg capsule, 500 mg capsule, 750 mg capsule)	1	
cephalexin (125 mg/5 ml susp, 250 mg tablet, 250 mg/5 ml susp, 500 mg tablet)	2	
SUPRAX (100 MG TABLET CHEWABLE, 200 MG TABLET CHEWABLE, 500 MG/5 ML SUSPENSION)	3	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
tazicef (1 gm add-vantage vial, 1 gram vial, 2 gm add-vantage vial, 2 gram vial, 6 gram vial)	3	
TEFLARO	5	
BETA-LACTAM, OTHER		
aztreonam 1 gm vial	4	
chloramphenicol sod succinate	4	
ertapenem	4	
imipenem-cilastatin sodium	4	
lincomycin hcl	2	
meropenem	2	
BETA-LACTAM, PENICILLINS		
amoxicillin (125 mg tab chew, 125 mg/5 ml susp, 200 mg/5 ml susp, 250 mg capsule, 250 mg tab chew, 250 mg/5 ml susp, 400 mg/5 ml susp, 500 mg capsule, 500 mg tablet, 875 mg tablet)	1	
amoxicillin-clavulanate pot er	2	
amoxicillin-clavulanate potass (200-28.5 mg tab chew, 200-28.5 mg/5 ml sus, 250-125 mg tablet, 250-62.5 mg/5 ml sus, 400-57 mg tab chew, 400-57 mg/5 ml susp, 500-125 mg tablet, 600-42.9 mg/5 ml sus, 875-125 mg tablet)	2	
ampicillin sodium (1 gm add-vantage vl, 1 gm vial, 10 gm bottle, 10 gm vial, 125 mg vial)	2	
ampicillin trihydrate	1	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ampicillin-sulbactam (ampicillin-sulb 1.5 g add vial, ampicillin-sulb 3 gm add vial, ampicillin-sulbactam 1.5 gm vl, ampicillin-sulbactam 3 gm vial, ampicillin-sulbactam 15 gm vl)	2	
AUGMENTIN 125-31.25 MG/5 ML	4	
BICILLIN C-R	4	
BICILLIN L-A	4	
dicloxacillin sodium	1	
nafcillin sodium (1 gm add-van vial, 1 gm vial, 2 gm add-vant vial, 2 gm vial, 10 gm bulk vial)	4	
oxacillin 10 gm vial	5	
oxacillin sodium (1 gm add-vantage vl, 1 gm vial, 2 gm add-vantage vl, 2 gm vial)	4	
penicillin g potassium	2	
penicillin g sodium	2	
penicillin gk-iso-osm dextrose (pen g 2 million unit/50 ml, pen g 3 million unit/50 ml)	4	
penicillin v potassium (125 mg/5 ml soln, 250 mg tablet, 250 mg/5 ml soln, 500 mg tablet)	1	
piperacillin-tazobactam (piperacil-tazo 2.25 gm add vl, piperacil-tazo 3.375 gm add vl, piperacil-tazo 4.5 gm add vial, piperacil-tazobact 2.25 gm vl, piperacil-tazobact 3.375 gm vl, piperacil-tazobact 4.5 gm vial, piperacil-tazobact 13.5 gm vl, piperacil-tazobact 40.5 gram)	2	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
MACROLIDES		
AZASITE	4	
azithromycin (250 mg tablet, 500 mg tablet, 600 mg tablet)	1	
azithromycin (1 gm pwd packet, 100 mg/5 ml susp, 200 mg/5 ml susp, 500 mg add-van vl, i.v. 500 mg vial)	2	
clarithromycin (125 mg/5 ml sus, 250 mg tablet, 250 mg/5 ml sus, 500 mg tablet)	2	
clarithromycin er	2	
DIFICID (40 MG/ML SUSPENSION, 200 MG TABLET)	5	
ery	2	
ERYTHROCIN LACTOBIONATE (500 MG ADDVAN VIAL, LACT 500 MG VIAL)	4	
ERYTHROCIN STEARATE	4	
erythromycin (0.5% eye ointment, dr 250 mg tablet, dr 333 mg tablet, dr 500 mg tablet)	1	
erythromycin (2% gel, 2% solution, dr 250 mg cap)	2	
erythromycin (250 mg, 500 mg)	4	
erythromycin 400 mg/5 ml susp	5	
erythromycin ethylsuccinate (200 mg/5 ml susp, es 400 mg tab)	2	
QUINOLONES		
BESIVANCE	4	
CILOXAN 0.3% OINTMENT	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ciprofloxacin	2	
ciprofloxacin er	2	
ciprofloxacin hcl (0.3% eye drop, hcl 100 mg tab, hcl 250 mg tab, hcl 500 mg tab, hcl 750 mg tab)	1	
ciprofloxacin 200 mg/100ml-d5w	2	
gatifloxacin	2	
levofloxacin 0.5% eye drops	2	
levofloxacin (250 mg tablet, 500 mg tablet, 750 mg tablet)	1	
levofloxacin (25 mg/ml solution, 500 mg/20 ml vial, 750 mg/30 ml vial)	4	
levofloxacin-d5w (500 mg/100, 750 mg/150)	2	
moxifloxacin 0.5% eye drops	2	
moxifloxacin 400 mg/250 ml bag	4	
moxifloxacin hcl	2	
ofloxacin 0.3% eye drops	1	
ofloxacin (0.3% ear drops, 300 mg tablet, 400 mg tablet)	2	
XEPI	4	
SULFONAMIDES		
sulfacetamide sodium (drops, ointment)	2	
sulfacetamide sodium (sod top susp, sodium lotn)	4	
sulfadiazine	2	
sulfamethoxazole-tmp susp	2	
sulfamethoxazole-trimethoprim (ds tablet, ss tablet)	1	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
sulfamethoxazole-tmp iv vial	4	
TETRACYCLINES		
ARESTIN	5	
demeclocycline hcl	2	
doxy 100	2	
doxycycline hyclate (50 mg tablet, hyclate 50 mg cap, hyclate 100 mg cap, hyclate 100 mg tab)	1	
doxycycline hyclate 20 mg tab	2	
doxycycline hyclate (dr 50 mg tab, dr 75 mg tab, dr 100 mg tab, dr 150 mg tab, dr 200 mg tab)	4	
doxycycline monohydrate (50 mg cap, 100 mg cap, 150 mg cap)	1	
doxycycline monohydrate (25 mg/5 ml susp, mono 50 mg tablet, mono 100 mg tablet, mono 150 mg tablet)	2	
doxycycline monohydrate (75 mg capsule, 75 mg tablet)	4	
minocycline hcl (50 mg capsule, 75 mg capsule, 100 mg capsule)	2	
minocycline hcl (50 mg tablet, 75 mg tablet, 100 mg tablet)	4	
NUZYRA (150 MG TABLET, 150 MG TABLET-7 DAY, 150 MG-7 DAY WITH LOAD)	5	PA, QL (30 PER 14 DAYS)
NUZYRA 100 MG VIAL	5	PA, QL (15 PER 14 DAYS)
okebo	4	
tetracycline hcl	2	
VIBRAMYCIN 50 MG/5 ML SYRUP	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANTICANCER AGENTS		
AYVAKIT (25 MG TABLET, 50 MG TABLET)	5	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
RUBRACA 250 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
APTIOM	5	ST
BRIVIACT (10 MG TABLET, 10 MG/ML ORAL SOLN, 25 MG TABLET, 50 MG TABLET, 75 MG TABLET, 100 MG TABLET)	5	
BRIVIACT 50 MG/5 ML VIAL	4	
DIACOMIT (250 MG CAPSULE, 250 MG POWDER PACKET)	5	PA - FOR NEW STARTS ONLY, QL (360 PER 30 DAYS)
DIACOMIT (500 MG CAPSULE, 500 MG POWDER PACKET)	5	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
EPIDIOLEX	5	PA - FOR NEW STARTS ONLY
FINTEPLA	5	PA - FOR NEW STARTS ONLY, QL (360 PER 30 DAYS)
FYCOMPA (0.5 MG/ML ORAL SUSP, 2 MG TABLET, 6 MG TABLET, 12 MG TABLET)	4	
FYCOMPA (4 MG TABLET, 8 MG TABLET, 10 MG TABLET)	5	
levetiracetam (100 mg/ml soln, 500 mg/5 ml soln, 1000 mg/10 ml)	2	
levetiracetam (250 mg tablet, 500 mg tablet, 750 mg tablet, 1,000 mg tablet)	1	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
levetiracetam 500 mg/5 ml vial	4	
levetiracetam er	2	
levetiracetam-nacl (500 mg/100, 1,000mg/100)	4	
NAYZILAM	5	PA - FOR NEW STARTS ONLY, QL (10 PER 30 DAYS)
roweepra 500 mg tablet	1	
roweepra xr	2	
SPRITAM	4	
XCOPRI (50-100 MG PAK, 150-200 MG PK)	5	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS)
XCOPRI 12.5-25 MG TITRATION PK	4	PA - FOR NEW STARTS ONLY, QL (28 PER 28 DAYS)
XCOPRI (150 MG TABLET, 200 MG TABLET)	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
XCOPRI (250 MG DAILY PACK, 350 MG DAILY PACK)	5	PA - FOR NEW STARTS ONLY, QL (56 PER 28 DAYS)
XCOPRI 100 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
XCOPRI 50 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS)
CALCIUM CHANNEL MODIFYING AGENTS		
CELONTIN	4	
ethosuximide (250 mg capsule, 250 mg/5 ml soln)	2	
pregabalin (25 mg capsule, 50 mg capsule, 75 mg capsule, 100 mg capsule, 150 mg capsule, 200 mg capsule, 225 mg capsule)	1	QL (90 PER 30 DAYS)
pregabalin 300 mg capsule	1	QL (60 PER 30 DAYS)
pregabalin 20 mg/ml solution	1	QL (900 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
zonisamide	2	
GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS		
clobazam (2.5 mg/ml suspension, 10 mg tablet)	4	
clobazam 20 mg tablet	3	
clonazepam (0.5 mg tablet, 1 mg tablet, 2 mg tablet)	1	
clonazepam (0.125 mg dis tab, 0.125 mg odt, 0.25 mg odt, 0.5 mg dis tablet, 0.5 mg odt, 1 mg dis tablet, 1 mg odt)	2	QL (90 PER 30 DAYS)
clonazepam 2 mg odt	2	QL (300 PER 30 DAYS)
diazepam (2.5 mg gel sys, 10 mg gel syst, 20 mg gel syst)	4	
divalproex sodium (dr 125 mg cap sprnk, dr 125 mg cp(sprnk))	1	
divalproex sodium (dr 125 mg tab, dr 250 mg tab, dr 500 mg tab)	2	
divalproex sodium er	2	
gabapentin (100 mg capsule, 300 mg capsule)	1	QL (360 PER 30 DAYS)
gabapentin 400 mg capsule	1	QL (270 PER 30 DAYS)
gabapentin (250 mg/5 ml soln, 300 mg/6 ml soln)	2	QL (2160 PER 30 DAYS)
gabapentin 600 mg tablet	1	QL (180 PER 30 DAYS)
gabapentin 800 mg tablet	1	QL (150 PER 30 DAYS)
phenobarbital (15 mg tablet, 16.2 mg tablet, 20 mg/5 ml elix, 20 mg/5 ml soln, 30 mg tablet, 30 mg/7.5 ml sol, 32.4 mg tablet, 60 mg tablet, 60 mg/15 ml soln, 64.8 mg tablet, 97.2 mg tablet, 100 mg tablet)	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
primidone	2	
SYMPAZAN	5	
tiagabine hcl	4	
valproate sodium	4	
valproic acid (250 mg capsule, 250 mg/5 ml soln, 500 mg/10 ml sol)	2	
VALTOCO	5	QL (20 PER 30 DAYS)
vigabatrin (500 mg powder packt, 500 mg tablet)	5	PA - FOR NEW STARTS ONLY
vigadrone	5	PA - FOR NEW STARTS ONLY
GLUTAMATE REDUCING AGENTS		
felbamate 600 mg/5 ml susp	5	
felbamate (400 mg tablet, 600 mg tablet)	4	
lamotrigine (25 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet)	1	
lamotrigine (5 mg disper tablet, 25 mg disper tab)	2	
lamotrigine er	4	
lamotrigine odt (odt 25 mg tablet, odt 50 mg tablet, odt 100 mg tablet)	4	
topiramate (15 mg cap, 25 mg cap)	2	
topiramate (25 mg tablet, 50 mg tablet, 100 mg tablet, 200 mg tablet)	1	
SODIUM CHANNEL AGENTS		
carbamazepine (100 mg tab chew, 100 mg/5 ml susp, 200 mg/10ml susp)	2	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
carbamazepine 200 mg tablet	1	
carbamazepine er (er 100 mg cap, er 100 mg tablet, er 200 mg cap, er 200 mg tablet, er 300 mg cap, er 400 mg tablet)	2	
DILANTIN (30 MG CAPSULE, 50 MG INFATAB, 100 MG CAPSULE)	4	
DILANTIN-125	4	
epitol	2	
fosphenytoin 100 mg pe/2 ml vl	2	
oxcarbazepine 300 mg/5 ml susp	4	
oxcarbazepine (150 mg tablet, 300 mg tablet, 600 mg tablet)	2	
PEGANONE	4	
phenytoin (50 mg infatab, 50 mg infatab chew, 50 mg tablet chew, 100 mg/4 ml susp, 125 mg/5 ml susp)	2	
phenytoin sodium (50 mg/ml ampul, 50 mg/ml vial, 100 mg/2 ml vial, 250 mg/5 ml vial)	4	
phenytoin sodium extended	2	
rufinamide 40 mg/ml suspension	5	
rufinamide (200 mg tablet, 400 mg tablet)	4	
TEGRETOL (100 MG/5 ML SUSP, 200 MG TABLET)	4	
TEGRETOL XR	4	
VIMPAT (10 MG/ML SOLUTION, 50 MG TABLET, 100 MG TABLET, 150 MG TABLET, 200 MG TABLET, 200 MG/20 ML VIAL)	4	

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANTIDEMENTIA AGENTS		
CHOLINESTERASE INHIBITORS		
donepezil hcl (5 mg tablet, 10 mg tablet)	1	
donepezil hcl 23 mg tablet	2	
donepezil hcl odt	1	
galantamine er	2	
galantamine hbr	2	
galantamine hydrobromide	4	
rivastigmine (1.5 mg capsule, 3 mg capsule, 4.5 mg capsule, 6 mg capsule)	2	
rivastigmine (4.6 mg/24hr patch, 9.5 mg/24hr patch, 13.3 mg/24hr ptch)	4	
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
memantine hcl (2 mg/ml solution, 5 mg tablet, 10 mg tablet)	2	PA
memantine 5-10 mg titration pk	3	PA
memantine hcl er	3	PA, QL (30 PER 30 DAYS)
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
APLENZIN	5	ST, QL (30 PER 30 DAYS)
bupropion hcl	1	
bupropion hcl sr (sr 100 mg tablet, sr 200 mg tablet)	1	QL (90 PER 30 DAYS)
bupropion hcl sr 150mg tablet	2	QL (60 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
bupropion hcl xl 150 mg tablet	2	QL (90 PER 30 DAYS)
bupropion hcl xl 300 mg tablet	2	QL (30 PER 30 DAYS)
bupropion hcl xl 450 mg tablet	4	QL (30 PER 30 DAYS)
mirtazapine 15 mg tablet	1	
mirtazapine (7.5 mg tablet, 15 mg odt, 30 mg odt, 30 mg tablet, 45 mg odt, 45 mg tablet)	2	
SPRAVATO (56 MG PACK, 84 MG PACK)	5	PA - FOR NEW STARTS ONLY
MONOAMINE OXIDASE INHIBITORS		
EMSAM	5	ST, QL (30 PER 30 DAYS)
MARPLAN	4	
phenelzine sulfate	2	
tranylcypromine sulfate	4	
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR		
citalopram hbr (10 mg/5 ml soln, 20 mg/10 ml sol)	2	
citalopram hbr (10 mg tablet, 20 mg tablet, 40 mg tablet)	1	
desvenlafaxine er 100 mg tab	4	ST, QL (120 PER 30 DAYS)
desvenlafaxine er 50 mg tab	4	ST, QL (30 PER 30 DAYS)
desvenlafaxine succinate er (er 25 mg, er 50 mg)	4	ST, QL (30 PER 30 DAYS)
desvenlafaxine succnt er 100mg	4	ST, QL (120 PER 30 DAYS)
DRIZALMA SPRINKLE (DR 20 MG CAP, DR 60 MG CAP)	4	QL (60 PER 30 DAYS)
DRIZALMA SPRINKLE (DR 30 MG CAP, DR 40 MG CAP)	4	QL (90 PER 30 DAYS)
duloxetine hcl (dr 20 mg cap, dr 60 mg cap)	2	QL (60 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
duloxetine hcl dr 30 mg cap	2	QL (90 PER 30 DAYS)
duloxetine hcl dr 40 mg cap	4	QL (90 PER 30 DAYS)
escitalopram oxalate (5 mg tablet, oxalate 5 mg/5 ml, 10 mg tablet, 20 mg tablet)	1	
FETZIMA 20-40 MG TITRATION PAK	4	ST, QL (56 PER 365 OVER TIME)
FETZIMA (ER 20 MG CAPSULE, ER 40 MG CAPSULE, ER 80 MG CAPSULE, ER 120 MG CAPSULE)	4	ST, QL (30 PER 30 DAYS)
fluoxetine dr	4	ST, QL (4 PER 28 DAYS)
fluoxetine hcl (10 mg capsule, 20 mg capsule, 40 mg capsule)	1	
fluoxetine hcl (hcl 10 mg tablet, 20 mg/5 ml solution, hcl 20 mg tablet)	2	
fluvoxamine maleate	2	
fluvoxamine maleate er	4	ST, QL (60 PER 30 DAYS)
maprotiline hcl	2	
nefazodone hcl	2	
olanzapine-fluoxetine hcl (3-25 mg, 6-25 mg)	4	QL (90 PER 30 DAYS)
olanzapine-fluoxetine hcl (6-50 mg, 12-25 mg, 12-50 mg)	4	QL (30 PER 30 DAYS)
paroxetine cr	3	
paroxetine er	3	
paroxetine hcl (10 mg tablet, 20 mg tablet, 30 mg tablet, 40 mg tablet)	1	
paroxetine mesylate	4	QL (30 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
PAXIL 10 MG/5 ML SUSPENSION	4	
PEXEVA (10 MG TABLET, 20 MG TABLET, 40 MG TABLET)	4	QL (30 PER 30 DAYS)
PEXEVA 30 MG TABLET	4	QL (60 PER 30 DAYS)
sertraline 20 mg/ml oral conc	2	
sertraline hcl (25 mg tablet, 50 mg tablet, 100 mg tablet)	1	
trazodone 300 mg tablet	2	
trazodone hcl (50 mg tablet, 100 mg tablet, 150 mg tablet)	1	
TRINTELLIX	4	ST, QL (30 PER 30 DAYS)
venlafaxine hcl	1	
venlafaxine hcl er (er 37.5 mg cap, er 75 mg cap)	1	
venlafaxine hcl er (er 150 mg cap, er 150 mg tab, er 225 mg tab)	3	
venlafaxine hcl er (er 37.5 mg tab, er 75 mg tab)	2	
VIIBRYD 10-20 MG STARTER PACK	4	ST, QL (60 PER 365 OVER TIME)
VIIBRYD (10 MG TABLET, 20 MG TABLET, 40 MG TABLET)	4	ST, QL (30 PER 30 DAYS)
TRICYCLICS		
amitriptyline hcl	2	
amoxapine	2	
chlordiazepoxide-amitriptyline	2	
clomipramine hcl	4	
desipramine hcl	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
doxepin hcl (10 mg capsule, 10 mg/ml oral conc, 25 mg capsule, 50 mg capsule, 75 mg capsule, 100 mg capsule, 150 mg capsule)	1	
imipramine hcl	1	
imipramine pamoate	4	
nortriptyline hcl (10 mg cap, 25 mg cap, 50 mg cap, 75 mg cap)	1	
nortriptyline 10 mg/5 ml soln	2	
perphenazine-amitriptyline	2	
protriptyline hcl	2	
trimipramine maleate	4	
ANTIEMETICS		
ANTIEMETICS, OTHER		
compro	4	
doxylamine succ-pyridoxine hcl	4	
meclizine hcl (12.5 mg tablet, 25 mg tablet)	1	
MOTEGRITY	4	PA, QL (30 PER 30 DAYS)
phenadoz	4	
prochlorperazine edisylate	4	
prochlorperazine maleate	1	
prochlorperazine supp	2	
promethazine hcl (25 mg/ml ampul, 25 mg/ml vial, 50 mg/ml ampul, 50 mg/ml vial)	4	
promethazine hcl (12.5 mg suppos, 25 mg suppository, 50 mg suppository)	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
promethazine hcl (6.25 mg/5 ml soln, 6.25 mg/5 ml syrp, 12.5 mg tablet, 25 mg tablet, 50 mg tablet)	1	
promethegan 25 mg suppository	4	
promethegan 50 mg suppository	2	
scopolamine	4	QL (10 PER 30 DAYS)
trimethobenzamide hcl	2	PA - Part B vs D Determination
EMETOGENIC THERAPY ADJUNCTS		
aprepitant 125-80-80 mg pack	2	PA - Part B vs D Determination, QL (6 PER 30 OVER TIME)
aprepitant 125 mg capsule	2	PA - Part B vs D Determination, QL (2 PER 30 OVER TIME)
aprepitant 40 mg capsule	2	PA - Part B vs D Determination, QL (1 PER 30 OVER TIME)
aprepitant 80 mg capsule	2	PA - Part B vs D Determination, QL (8 PER 30 OVER TIME)
dronabinol	4	PA, QL (60 PER 30 OVER TIME)
EMEND 125 MG POWDER PACKET	4	PA - Part B vs D Determination, QL (6 PER 30 OVER TIME)
granisetron hcl 1 mg tablet	2	PA - Part B vs D Determination, QL (30 PER 30 OVER TIME)
granisetron hcl (0.1 mg/ml vial, 1 mg/ml vial, 4 mg/4 ml vial)	2	
ondansetron 4 mg/5 ml solution	2	PA - Part B vs D Determination, QL (450 PER 30 DAYS)
ondansetron hcl (4 mg tablet, 8 mg tablet)	2	PA - Part B vs D Determination
ondansetron hcl 24 mg tablet	2	PA - Part B vs D Determination, QL (14 PER 28 OVER TIME)
ondansetron hcl (4 mg/2 ml isecure, hcl 4 mg/2 ml amp, hcl 4 mg/2 ml syr, hcl 4 mg/2 ml vial)	2	QL (240 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ondansetron odt	1	PA - Part B vs D Determination
palonosetron hcl (0.25 mg/5 ml vial, hcl 0.25 mg/5 ml)	4	
SANCUSO	5	QL (2 PER 30 OVER TIME)
ANTIFUNGALS		
ABELCET	5	PA - Part B vs D Determination
AMBISOME	5	PA - Part B vs D Determination
amphotericin b	4	PA - Part B vs D Determination
caspofungin acetate	5	
ciclopirox (0.77% cream, 0.77% gel, 0.77% topical susp, 1% shampoo, 8% solution)	2	
clotrimazole 1% topical cream	1	
clotrimazole 10 mg troche	2	
CRESEMBA (186 MG CAPSULE, 372 MG VIAL)	5	
econazole nitrate	4	
ERAXIS(WATER DIL) 100 MG VIAL	5	
ERAXIS(WATER DIL) 50 MG VIAL	4	
fluconazole (10 mg/ml susp, 40 mg/ml susp, 50 mg tablet, 100 mg tablet, 200 mg tablet)	2	
fluconazole 150 mg tablet	1	
fluconazole-nacl (200 mg/100 ml, 400 mg/200 ml)	2	
flucytosine	5	
griseofulvin 125 mg/5 ml susp	2	
griseofulvin micro 500 mg tab	4	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
griseofulvin ultramicrosize	4	
gynazole 1	4	
itraconazole (10 mg/ml solution, 100 mg capsule)	4	PA
ketoconazole (2% cream, 200 mg tablet)	2	
ketoconazole 2% foam	4	
ketoconazole 2% shampoo	1	
micafungin 100 mg vial	5	
micafungin 50 mg vial	4	
miconazole 3 200 mg vag supp	2	
naftifine hcl (1% cream, 1% gel, 2% cream)	4	
NAFTIN 2% GEL	4	
NATACYN	4	
nyamyc	2	
nystatin (100,000 unit/ml susp, 500,000 unit/5 ml sus)	1	
nystatin (100,000 unit/gm cream, 100,000 unit/gm oint, 100,000 unit/gm powd, 500,000 unit oral tab)	2	
nystatin-triamcinolone (cream, ointm)	2	
nystop	2	
ONMEL	5	PA
oxiconazole nitrate	5	
posaconazole (dr 100 mg tablet, 200 mg/5 ml susp)	5	PA
terbinafine hcl	1	QL (84 PER 180 OVER TIME)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
terconazole (0.4% cream, 0.8% cream, 80 mg suppository)	2	
voriconazole 40 mg/ml susp	5	
voriconazole (50 mg tablet, 200 mg tablet, 200 mg vial)	4	
ANTIGOUT AGENTS		
allopurinol	1	
colchicine 0.6 mg tablet	2	
febuxostat	3	ST
probenecid	2	
probenecid-colchicine	2	
ANTIMIGRAINE AGENTS		
ANTIMIGRAINE AGENTS, OTHER		
AIMOVIG AUTOINJECTOR	4	PA, QL (1 PER 30 DAYS)
AIMOVIG AUTOINJECTOR (2 PACK)	4	PA, QL (2 PER 30 DAYS)
AJOVY AUTOINJECTOR	4	PA, QL (1.5 PER 30 DAYS)
AJOVY SYRINGE	4	PA, QL (1.5 PER 30 DAYS)
EMGALITY PEN	4	PA, QL (2 PER 30 DAYS)
EMGALITY 120 MG/ML SYRINGE	4	PA, QL (2 PER 30 DAYS)
EMGALITY SYRINGE (100 MG/ML SYR(1 OF 3), 300 MG (100 MG X3SYR))	4	PA, QL (3 PER 30 DAYS)
UBRELVY 100 MG TABLET	5	PA, QL (16 PER 30 DAYS)
UBRELVY 50 MG TABLET	5	PA, QL (32 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ERGOT ALKALOIDS		
dihydroergotamine 1 mg/ml amp	5	
dihydroergotamine 4 mg/ml spry	5	QL (8 PER 30 OVER TIME)
ergotamine-caffeine	2	
migergot	4	
SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS		
almotriptan malate	4	QL (12 PER 30 OVER TIME)
frovatriptan succinate	4	QL (12 PER 30 OVER TIME)
naratriptan hcl	2	QL (9 PER 30 OVER TIME)
rizatriptan (5 mg odt, 5 mg tablet, 10 mg odt, 10 mg tablet)	2	QL (18 PER 30 OVER TIME)
sumatriptan	4	QL (12 PER 30 OVER TIME)
sumatriptan succinate (4 mg/0.5 ml cart, 4 mg/0.5 ml inject)	4	QL (8 PER 30 OVER TIME)
sumatriptan 6 mg/0.5 ml syrng	4	QL (15 PER 30 OVER TIME)
sumatriptan succinate (25 mg tablet, 50 mg tablet, 100 mg tablet)	1	QL (9 PER 30 OVER TIME)
sumatriptan succinate (6 mg/0.5 ml cart, 6 mg/0.5 ml inject, 6 mg/0.5 ml vial)	4	QL (5 PER 30 OVER TIME)
zolmitriptan 2.5 mg nasal spry	4	QL (18 PER 30 OVER TIME)
zolmitriptan 5 mg nasal spray	4	QL (12 PER 30 OVER TIME)
zolmitriptan (2.5 mg tablet, 5 mg tablet)	3	QL (12 PER 30 OVER TIME)
zolmitriptan 2.5 mg odt	3	QL (12 PER 30 OVER TIME)
zolmitriptan 5 mg odt	3	QL (9 PER 30 OVER TIME)
ZOMIG 2.5 MG NASAL SPRAY	4	QL (18 PER 30 OVER TIME)
ZOMIG 5 MG NASAL SPRAY	4	QL (12 PER 30 OVER TIME)

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
guanidine hcl	4	
pyridostigmine 60 mg/5 ml soln	5	
pyridostigmine bromide (30 mg tablet, 60 mg tablet)	2	
pyridostigmine bromide er	4	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
dapsone (25 mg tablet, 100 mg tablet)	2	
rifabutin	2	
ANTITUBERCULARS		
CAPASTAT SULFATE	4	
ethambutol hcl	2	
isoniazid (50 mg/5 ml solution, 100 mg/ml vial)	4	
isoniazid (100 mg tablet, 300 mg tablet)	1	
PASER	4	
PRETOMANID	4	PA, QL (30 PER 30 DAYS)
PRIFTIN	4	
pyrazinamide	2	
rifampin (150 mg capsule, 300 mg capsule)	2	
rifampin iv 600 mg vial	4	
RIFATER	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
SIRTURO	5	
TRECATOR	4	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
busulfan	5	
carmustine	5	
cyclophosphamide (25 mg capsule, 25 mg tablet, 50 mg capsule, 50 mg tablet)	3	PA - Part B vs D Determination
dacarbazine 200 mg vial	2	
ifosfamide 1 gm vial	4	
KISQALI FEMARA 200 MG CO-PACK	5	PA - FOR NEW STARTS ONLY, QL (49 PER 28 OVER TIME)
KISQALI FEMARA 400 MG CO-PACK	5	PA - FOR NEW STARTS ONLY, QL (70 PER 28 OVER TIME)
KISQALI FEMARA 600 MG CO-PACK	5	PA - FOR NEW STARTS ONLY, QL (91 PER 28 DAYS)
LEUKERAN	4	
MATULANE	5	
melphalan hcl	5	
oxaliplatin 100 mg/20 ml vial	4	
PEPAXTO	5	PA - FOR NEW STARTS ONLY
thiotepa 15 mg vial	5	
TREANDA 100 MG VIAL	5	PA - Part B vs D Determination
VALCHLOR	5	PA - FOR NEW STARTS ONLY
YONDELIS	5	
ZANOSAR	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANTIANDROGENS		
abiraterone acetate	5	PA - FOR NEW STARTS ONLY
bicalutamide	2	
ERLEADA	3	QL (120 PER 30 DAYS)
flutamide	2	
nilutamide	5	
NUBEQA	5	PA - FOR NEW STARTS ONLY
XTANDI (40 MG CAPSULE, 40 MG TABLET, 80 MG TABLET)	5	PA - FOR NEW STARTS ONLY
YONSA	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
ANTIANGIOGENIC AGENTS		
FOTIVDA	5	PA - FOR NEW STARTS ONLY, QL (21 PER 28 DAYS)
POMALYST	5	PA - FOR NEW STARTS ONLY
REVLIMID	5	PA - FOR NEW STARTS ONLY
THALOMID	5	PA - FOR NEW STARTS ONLY
ANTIESTROGENS/MODIFIERS		
EMCYT	5	
fulvestrant	5	
SOLTAMOX	4	
tamoxifen citrate	2	
toremifene citrate	5	
ANTIMETABOLITES		
adrucil 500 mg/10 ml vial	2	
ALIMTA 500 MG VIAL	5	
ARRANON	5	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
cladribine	5	
clofarabine	5	
cytarabine (20 mg/ml vial, 1000 mg/50 ml vial)	2	
DROXIA	4	
fluorouracil (1 gram/20 ml vial, 2.5 gram/50 ml vl, 5 gram/100 ml vl, 500 mg/10 ml vial)	2	PA - Part B vs D Determination
FOLOTYN 40 MG/2 ML VIAL	5	PA - FOR NEW STARTS ONLY
gemcitabine hcl 1 gram vial	4	
hydroxyurea	2	
LONSURF 15 MG-6.14 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (100 PER 28 DAYS)
LONSURF 20 MG-8.19 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (80 PER 28 DAYS)
mercaptopurine	2	
NIPENT	5	
PURIXAN	5	
TABLOID	4	
VYXEOS	5	
ANTINEOPLASTICS, OTHER		
ABRAXANE	5	
ARZERRA 1,000 MG/50 ML VIAL	5	PA
ARZERRA 100 MG/5 ML VIAL	5	PA - FOR NEW STARTS ONLY
AVASTIN	5	PA - FOR NEW STARTS ONLY
AYVAKIT (100 MG TABLET, 200 MG TABLET, 300 MG TABLET)	5	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
azacitidine	5	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
BALVERSA	5	
BAVENCIO	5	
BELEODAQ	5	PA - FOR NEW STARTS ONLY
BLENREP	5	PA - FOR NEW STARTS ONLY
bleomycin sulfate 30 unit vial	2	
BREYANZI	5	PA - FOR NEW STARTS ONLY
BREYANZI CD4 COMPONENT	5	PA - FOR NEW STARTS ONLY
BREYANZI CD8 COMPONENT	5	PA - FOR NEW STARTS ONLY
carboplatin (50 mg/5 ml vial, 150 mg vial, 150 mg/15 ml vial, 450 mg/45 ml vial, 600 mg/60 ml vial)	2	
cisplatin (50 mg/50 ml vial, 100 mg/100 ml vial, 200 mg/200 ml vial)	2	
COPIKTRA	5	PA - FOR NEW STARTS ONLY
COTELLIC	5	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
CYRAMZA	5	PA - FOR NEW STARTS ONLY
dactinomycin	5	
DARZALEX	5	PA - FOR NEW STARTS ONLY
DARZALEX FASPRO	5	PA - FOR NEW STARTS ONLY
daunorubicin hcl (20 mg vial, 20 mg/4 ml vial, 50 mg/10 ml vial)	4	
decitabine	5	PA - FOR NEW STARTS ONLY
dexrazoxane 250 mg vial	5	
docetaxel (20 mg/2 ml vial, 20 mg/ml vial, 80 mg/4 ml vial, 80 mg/8 ml vial, 160 mg/16 ml vial, 160 mg/8 ml vial)	5	
doxorubicin 50 mg/25 ml vial	2	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
doxorubicin hcl liposome	5	
ELITEK	5	
EMPLICITI	5	PA - FOR NEW STARTS ONLY
ENHERTU	5	PA - FOR NEW STARTS ONLY
epirubicin 200 mg/100 ml vial	2	
ERBITUX 100 MG/50 ML VIAL	5	PA - FOR NEW STARTS ONLY
ERWINAZE	5	
FARYDAK (10 MG CAPSULE, 15 MG CAPSULE, 20 MG CAPSULE)	5	PA - FOR NEW STARTS ONLY, QL (6 PER 21 OVER TIME)
fludarabine 50 mg vial	4	
HALAVEN	5	PA - FOR NEW STARTS ONLY
HERCEPTIN	5	PA - FOR NEW STARTS ONLY
HERCEPTIN HYLECTA	5	PA - FOR NEW STARTS ONLY
IBRANCE (75 MG CAPSULE, 75 MG TABLET, 100 MG CAPSULE, 100 MG TABLET, 125 MG CAPSULE, 125 MG TABLET)	5	PA - FOR NEW STARTS ONLY
idarubicin hcl	5	
IDHIFA	5	QL (30 PER 30 DAYS)
IMFINZI	5	PA - FOR NEW STARTS ONLY
IMLYGIC 1 MILLION PFU/ML VIAL	4	PA - FOR NEW STARTS ONLY
INQOVI	5	PA - FOR NEW STARTS ONLY, QL (5 PER 28 DAYS)
irinotecan hcl 100 mg/5 ml vl	4	
JEVTANA	5	PA - FOR NEW STARTS ONLY
KADCYLA 100 MG VIAL	5	PA - FOR NEW STARTS ONLY
KANJINTI 150 MG VIAL	5	PA - FOR NEW STARTS ONLY

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
KEYTRUDA	5	PA - FOR NEW STARTS ONLY
KISQALI	5	PA - FOR NEW STARTS ONLY, QL (63 PER 28 OVER TIME)
KOSELUGO	5	PA - FOR NEW STARTS ONLY
LARTRUVO	5	PA - FOR NEW STARTS ONLY
leucovorin calcium (5 mg tab, 10 mg tab, 15 mg tab, 25 mg tab)	2	
leucovorin calcium (50 mg vial, 100 mg vial, 200 mg vial, 350 mg vial, 500 mg vl)	4	
levoleucovorin calcium (50 mg vial, 175 mg/17.5 ml, 250 mg/25 ml vl)	5	
LORBRENA	5	PA - FOR NEW STARTS ONLY
LYNPARZA	5	PA - FOR NEW STARTS ONLY
mitomycin (5 mg vial, 40 mg vial)	5	
mitoxantrone hcl	2	PA - FOR NEW STARTS ONLY
MONJUVI	5	PA - FOR NEW STARTS ONLY
MYLOTARG	5	
NINLARO	5	PA - FOR NEW STARTS ONLY
OGIVRI 150 MG VIAL	5	PA - FOR NEW STARTS ONLY
ONCASPAR	5	PA - FOR NEW STARTS ONLY
OPDIVO (40 MG/4 ML VIAL, 100 MG/10 ML VIAL, 240 MG/24 ML VIAL)	5	PA - FOR NEW STARTS ONLY
paclitaxel	2	
PADCEV	5	PA - FOR NEW STARTS ONLY
PEMAZYRE	5	PA - FOR NEW STARTS ONLY, QL (14 PER 21 DAYS)
PERJETA	5	PA - FOR NEW STARTS ONLY

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
PHESGO	5	PA - FOR NEW STARTS ONLY
POLIVY 140 MG VIAL	5	PA - FOR NEW STARTS ONLY
PORTRAZZA	5	PA - FOR NEW STARTS ONLY
PROLEUKIN	5	
QINLOCK	5	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
RETEVMO	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
RIABNI	5	PA - FOR NEW STARTS ONLY
RITUXAN	5	PA - FOR NEW STARTS ONLY
romidepsin (10 mg kit, 10 mg vial)	5	PA - FOR NEW STARTS ONLY
RUBRACA (200 MG TABLET, 300 MG TABLET)	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
RUXIENCE	5	PA - FOR NEW STARTS ONLY
RYDAPT	5	PA - FOR NEW STARTS ONLY, QL (224 PER 28 DAYS)
SARCLISA	5	PA - FOR NEW STARTS ONLY
SYLATRON	5	PA - FOR NEW STARTS ONLY
SYLVANT 100 MG VIAL	5	PA
SYNRIBO	5	PA - FOR NEW STARTS ONLY
TABRECTA	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
TAZVERIK	5	PA - FOR NEW STARTS ONLY
TECENTRIQ 1,200 MG/20 ML VIAL	5	
TRAZIMERA 420 MG VIAL	5	PA - FOR NEW STARTS ONLY
TRODELVY	5	PA - FOR NEW STARTS ONLY
TRUSELTIQ	5	PA - FOR NEW STARTS ONLY
TRUXIMA	5	PA - FOR NEW STARTS ONLY

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
TUKYSA	5	PA - FOR NEW STARTS ONLY
TURALIO	5	PA - FOR NEW STARTS ONLY
VECTIBIX 100 MG/5 ML VIAL	5	
VELCADE	5	PA - FOR NEW STARTS ONLY
VERZENIO	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
vinblastine sulfate	2	
vincasar pfs 1 mg/ml vial	2	
vincristine 1 mg/ml vial	2	
vinorelbine 50 mg/5 ml vial	2	
XPOVIO	5	PA - FOR NEW STARTS ONLY
YERVOY 50 MG/10 ML VIAL	5	PA - FOR NEW STARTS ONLY
ZALTRAP 100 MG/4 ML VIAL	5	PA - FOR NEW STARTS ONLY
ZEJULA	5	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
ZEPZELCA	5	PA - FOR NEW STARTS ONLY
ZIRABEV	5	PA - FOR NEW STARTS ONLY
ZOLINZA	5	PA - FOR NEW STARTS ONLY
AROMATASE INHIBITORS, 3RD GENERATION		
anastrozole	1	
exemestane	3	
letrozole	1	
Antineoplastics, other		
GAVRETO	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
IMLYGIC 100 MILLION PFU/ML VL	5	PA - FOR NEW STARTS ONLY
LUMAKRAS	5	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ONUREG	5	PA - FOR NEW STARTS ONLY, QL (14 PER 28 DAYS)
ENZYME INHIBITORS		
ETOPOPHOS	5	
etoposide (100 mg/5 ml vial, 500 mg/25 ml vial, 1,000 mg/50 ml vial)	2	
KYPROLIS	5	PA - FOR NEW STARTS ONLY
PIQRAY	5	
TALZENNA	5	PA - FOR NEW STARTS ONLY
toposar	2	
topotecan hcl 4 mg vial	5	
ZYDELIG	5	PA - FOR NEW STARTS ONLY
MOLECULAR TARGET INHIBITORS		
AFINITOR 10 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
AFINITOR DISPERZ	5	PA - FOR NEW STARTS ONLY
ALECENSA	5	PA - FOR NEW STARTS ONLY, QL (240 PER 30 DAYS)
ALIQOPA	5	
ALUNBRIG 90 MG-180 MG TAB PACK	3	PA - FOR NEW STARTS ONLY, QL (60 PER 365 OVER TIME)
ALUNBRIG (90 MG TABLET, 180 MG TABLET)	3	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ALUNBRIG 30 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (180 PER 30 DAYS)
BOSULIF	5	PA - FOR NEW STARTS ONLY
BRAFTOVI	5	PA - FOR NEW STARTS ONLY
BRUKINSA	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
CABOMETYX	5	PA - FOR NEW STARTS ONLY
CALQUENCE	5	QL (60 PER 30 DAYS)
CAPRELSA 100 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
CAPRELSA 300 MG TABLET	5	PA - FOR NEW STARTS ONLY
COMETRIQ	5	PA - FOR NEW STARTS ONLY
DAURISMO 100 MG TABLET	5	PA - FOR NEW STARTS ONLY
DAURISMO 25 MG TABLET	3	PA - FOR NEW STARTS ONLY
ERIVEDGE	5	PA - FOR NEW STARTS ONLY
erlotinib hcl (100 mg tablet, 150 mg tablet)	5	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
erlotinib hcl 25 mg tablet	5	PA - FOR NEW STARTS ONLY, QL (90 PER 30 DAYS)
everolimus (2.5 mg tablet, 5 mg tablet, 7.5 mg tablet)	5	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
GILOTRIF	5	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ICLUSIG (10 MG TABLET, 15 MG TABLET)	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
ICLUSIG 30 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
ICLUSIG 45 MG TABLET	5	PA - FOR NEW STARTS ONLY
imatinib mesylate	5	PA - FOR NEW STARTS ONLY
IMBRUVICA (70 MG CAPSULE, 140 MG CAPSULE, 140 MG TABLET, 280 MG TABLET, 420 MG TABLET, 560 MG TABLET)	5	PA - FOR NEW STARTS ONLY
INLYTA	5	PA - FOR NEW STARTS ONLY
INREBIC	5	PA - FOR NEW STARTS ONLY
IRESSA	5	PA - FOR NEW STARTS ONLY
JAKAFI	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
lapatinib	5	PA - FOR NEW STARTS ONLY
LENVIMA	5	PA - FOR NEW STARTS ONLY
MEKINIST	5	PA - FOR NEW STARTS ONLY
MEKTOVI	5	PA - FOR NEW STARTS ONLY
NERLYNX	5	QL (180 PER 30 DAYS)
NEXAVAR	5	PA - FOR NEW STARTS ONLY
ODOMZO	5	PA - FOR NEW STARTS ONLY
ROZLYTREK	5	PA - FOR NEW STARTS ONLY
SPRYCEL	5	PA - FOR NEW STARTS ONLY
STIVARGA	5	PA - FOR NEW STARTS ONLY
sunitinib malate	5	PA - FOR NEW STARTS ONLY
TAFINLAR	5	PA - FOR NEW STARTS ONLY
TAGRISSO	5	PA - FOR NEW STARTS ONLY, QL (30 PER 30 DAYS)
TASIGNA	5	PA - FOR NEW STARTS ONLY
temsirolimus	5	
TEPMETKO	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
TIBSOVO	5	PA - FOR NEW STARTS ONLY
UKONIQ	5	PA - FOR NEW STARTS ONLY, QL (120 PER 30 DAYS)
VENCLEXTA (10 MG TAB (10MG X 2), 10 MG TABLET, 50 MG TABLET)	3	PA - FOR NEW STARTS ONLY
VENCLEXTA 100 MG TABLET	5	PA - FOR NEW STARTS ONLY
VENCLEXTA STARTING PACK	5	PA - FOR NEW STARTS ONLY
VITRAKVI (20 MG/ML SOLUTION, 25 MG CAPSULE, 100 MG CAPSULE)	5	PA - FOR NEW STARTS ONLY
VIZIMPRO	5	PA - FOR NEW STARTS ONLY

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Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
VOTRIENT	5	PA - FOR NEW STARTS ONLY
WELIREG	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
XALKORI	5	PA - FOR NEW STARTS ONLY
XOSPATA	5	PA - FOR NEW STARTS ONLY
ZELBORAF	5	PA - FOR NEW STARTS ONLY
ZYKADIA (150 MG CAPSULE, 150 MG TABLET)	5	PA - FOR NEW STARTS ONLY
MONOCLONAL ANTIBODY/ANTIBODY-DRUG CONJUGATE		
DANYELZA	5	PA - FOR NEW STARTS ONLY
JEMPERLI	5	PA - FOR NEW STARTS ONLY
LIBTAYO	5	PA - FOR NEW STARTS ONLY
RYBREVANT	5	PA - FOR NEW STARTS ONLY
ZYNLONTA	5	PA - FOR NEW STARTS ONLY
RETINOIDS		
bexarotene	5	PA - FOR NEW STARTS ONLY
PANRETIN	5	
TARGRETIN 1% GEL	5	PA - FOR NEW STARTS ONLY
tretinoin 10 mg capsule	5	
TREATMENT ADJUNCTS		
mesna	2	
MESNEX 400 MG TABLET	5	
ANTIPARASITICS		
ANTHELMINTICS		
albendazole	5	
ivermectin 3 mg tablet	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
praziquantel	1	
ANTIPROTOZOALS		
atovaquone	5	
atovaquone-proguanil hcl	2	
chloroquine phosphate	2	
COARTEM	4	
hydroxychloroquine 200 mg tab	1	
IMPAVIDO	5	PA, QL (84 PER 28 DAYS)
mefloquine hcl	2	
nitazoxanide	5	
pentamidine 300 mg vial	4	
pentamidine 300 mg inhal powdr	3	PA - Part B vs D Determination
primaquine	4	
pyrimethamine	5	PA
quinine sulfate	2	PA
tinidazole	2	
PEDICULICIDES/SCABICIDES		
EURAX 10% CREAM	4	
ivermectin 0.5% lotion	4	
lindane	4	
malathion	4	
permethrin	2	
SKLICE	4	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
benztropine mesylate (2 mg/2 ml ampule, 2 mg/2 ml vial)	2	
benztropine mesylate (0.5 mg tab, 1 mg tablet, 2 mg tablet)	1	
trihexyphenidyl 2 mg/5 ml soln	2	
trihexyphenidyl hcl (2 mg tablet, 5 mg tablet)	1	
ANTIPARKINSON AGENTS, OTHER		
entacapone	3	
INBRIJA	5	PA, QL (300 PER 30 DAYS)
NOURIANZ	5	PA
ONGENTYS	4	PA
OSMOLEX ER 322 MG DAILY DOSE	4	QL (60 PER 30 DAYS)
tolcapone	5	
DOPAMINE AGONISTS		
APOKYN	5	PA, QL (60 PER 30 DAYS)
bromocriptine mesylate (2.5 mg tablet, 5 mg capsule)	4	
KYNMOBI (10 MG FILM, 15 MG FILM, 20 MG FILM, 25 MG FILM, 30 MG FILM)	5	PA, QL (150 PER 30 DAYS)
NEUPRO	4	ST
pramipexole dihydrochloride	2	
ropinirole er	3	
ropinirole hcl	1	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
DOPAMINE PRECURSORS/L- AMINO ACID DECARBOXYLASE INHIBITORS		
carbidopa	5	
carbidopa-levodopa (carbidopa-levo 10-100 mg odt, carbidopa-levo 25-250 mg odt, carbidopa-levodopa 10-100 tab, carbidopa-levodopa 25-100 tab, carbidopa-levodopa 25-250 tab)	2	
carbidopa-levodopa er	2	
carbidopa-levodopa-entacapone	4	
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
rasagiline mesylate	3	
selegiline hcl (5 mg capsule, 5 mg tablet)	2	
ZELAPAR	5	
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
chlorpromazine hcl (25 mg/ml amp, 25 mg/ml ampule, 50 mg/2 ml amp)	2	
chlorpromazine hcl (10 mg tablet, 25 mg tablet, 30 mg/ml conc, 50 mg tablet, 100 mg tablet, 100 mg/ml conc, 200 mg tablet)	4	
fluphenazine decanoate	3	
fluphenazine hcl (1 mg tablet, 2.5 mg tablet, 2.5 mg/5 ml elix, 2.5 mg/ml vial, 5 mg tablet, 5 mg/ml conc, 10 mg tablet)	3	
haloperidol	1	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
haloperidol decanoate (dec 50 mg/ml vial, dec 100 mg/ml amp, dec 100 mg/ml vial, dec 250 mg/5 ml vl, dec 500 mg/5 ml vl, decan 50 mg/ml amp)	1	
haloperidol decanoate 100	1	
haloperidol lactate (2 mg/ml conc, 5 mg/ml ampul, 5 mg/ml syring, 5 mg/ml vial, 10 mg/5 ml cup, 50 mg/10 ml vl)	1	
loxapine	2	
molindone hcl	2	
perphenazine	2	
pimozide	4	
thioridazine hcl	1	
thiothixene	2	
trifluoperazine hcl	2	
2ND GENERATION/ATYPICAL		
ABILIFY MAINTENA (ER 300 MG SYR, ER 300 MG VL, ER 400 MG SYR, ER 400 MG VL)	5	
aripiprazole 1 mg/ml solution	4	QL (750 PER 30 DAYS)
aripiprazole (10 mg tablet, 30 mg tablet)	4	QL (30 PER 30 DAYS)
aripiprazole (2 mg tablet, 5 mg tablet, 15 mg tablet, 20 mg tablet)	4	QL (60 PER 30 DAYS)
aripiprazole odt	4	QL (60 PER 30 DAYS)
ARISTADA (ER 441 MG/1.6 ML SYRN, ER 662 MG/2.4 ML SYRN, ER 882 MG/3.2 ML SYRN)	5	
ARISTADA ER 1064 MG/3.9 ML SYR	5	QL (3.9 PER 56 OVER TIME)

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ARISTADA INITIO	5	
asenapine maleate	4	QL (60 PER 30 DAYS)
CAPLYTA	5	ST, QL (30 PER 30 DAYS)
FANAPT TITRATION PACK	4	ST, QL (8 PER 180 OVER TIME)
FANAPT (1 MG TABLET, 2 MG TABLET, 4 MG TABLET)	4	ST, QL (60 PER 30 DAYS)
FANAPT (6 MG TABLET, 8 MG TABLET, 10 MG TABLET, 12 MG TABLET)	5	ST, QL (60 PER 30 DAYS)
INVEGA SUSTENNA (78 MG/0.5 ML, 117 MG/0.75 ML, 156 MG/ML SYRG, 234 MG/1.5 ML)	5	
INVEGA SUSTENNA 39 MG/0.25 ML	4	
INVEGA TRINZA	5	
LATUDA (20 MG TABLET, 40 MG TABLET, 60 MG TABLET, 120 MG TABLET)	5	QL (30 PER 30 DAYS)
LATUDA 80 MG TABLET	5	QL (60 PER 30 DAYS)
NUPLAZID (10 MG TABLET, 34 MG CAPSULE)	5	PA - FOR NEW STARTS ONLY
NUPLAZID 17 MG TABLET	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
olanzapine (2.5 mg tablet, 5 mg tablet, 7.5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet)	1	QL (30 PER 30 DAYS)
olanzapine 10 mg vial	2	
olanzapine odt	4	QL (30 PER 30 DAYS)
paliperidone er (er 1.5 mg tablet, er 3 mg tablet)	4	QL (30 PER 30 DAYS)
paliperidone er 6 mg tablet	4	QL (60 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
paliperidone er 9 mg tablet	5	QL (30 PER 30 DAYS)
PERSERIS	5	
quetiapine fumarate (25 mg tab, 50 mg tab, 100 mg tab, 200 mg tab)	2	QL (90 PER 30 DAYS)
quetiapine fumarate (300 mg tab, 400 mg tab)	2	QL (60 PER 30 DAYS)
quetiapine er 200 mg tablet	2	QL (90 PER 30 DAYS)
quetiapine fumarate er (er 50 mg tablet, er 150 mg tablet, er 300 mg tablet, er 400 mg tablet)	2	QL (60 PER 30 DAYS)
REXULTI	5	QL (30 PER 30 DAYS)
RISPERDAL CONSTA (12.5 MG VIAL, 25 MG VIAL)	4	
RISPERDAL CONSTA (37.5 MG VIAL, 50 MG VIAL)	5	
risperidone 1 mg/ml solution	2	QL (240 PER 30 DAYS)
risperidone (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 3 mg tablet, 4 mg tablet)	1	QL (60 PER 30 DAYS)
risperidone odt	2	QL (60 PER 30 DAYS)
SECUADO	5	ST, QL (30 PER 30 DAYS)
VRAYLAR 1.5 MG-3 MG PACK	4	ST, QL (14 PER 365 OVER TIME)
VRAYLAR (1.5 MG CAPSULE, 3 MG CAPSULE, 4.5 MG CAPSULE, 6 MG CAPSULE)	5	ST, QL (30 PER 30 DAYS)
ziprasidone hcl	2	QL (60 PER 30 DAYS)
ziprasidone mesylate	4	QL (60 PER 30 DAYS)
ZYPREXA RELPREVV (210 MG VIAL, 210 MG VL KIT)	4	
ZYPREXA RELPREVV (300 MG VIAL, 300 MG VL KIT, 405 MG VIAL, 405 MG VL KIT)	5	QL (2 PER 28 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
TREATMENT-RESISTANT		
clozapine (25 mg tablet, 100 mg tablet)	2	QL (270 PER 30 DAYS)
clozapine 200 mg tablet	2	QL (120 PER 30 DAYS)
clozapine 50 mg tablet	2	QL (180 PER 30 DAYS)
clozapine odt (odt 25 mg tablet, odt 100 mg tablet)	4	QL (270 PER 30 DAYS)
clozapine odt 12.5 mg tablet	4	QL (90 PER 30 DAYS)
clozapine odt 150 mg tablet	4	QL (180 PER 30 DAYS)
clozapine odt 200 mg tablet	5	QL (120 PER 30 DAYS)
VERSACLOZ	5	QL (540 PER 30 DAYS)
ANTISPASTICITY AGENTS		
baclofen (5 mg tablet, 10 mg tablet)	1	
baclofen 20 mg tablet	2	
baclofen 40 mg/20 ml vial	5	
BOTOX	4	PA
dantrolene sodium (25 mg cap, 50 mg cap, 100 mg cap)	2	
LIORESAL INTRATHECAL (10 MG/5 ML AMPULE, 10 MG/5 ML K, 40 MG/20 ML AMPULE, 40 MG/20 ML K)	5	
LIORESAL IT 0.05 MG/1 ML AMP	4	
tizanidine hcl (2 mg tablet, 4 mg tablet)	1	
XEOMIN 50 UNIT VIAL	4	PA

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
cidofovir	5	
ganciclovir 500 mg vial	2	
valganciclovir hcl (hcl 50 mg/ml, 450 mg tablet)	5	
ZIRGAN	4	
ANTI-HEPATITIS B (HBV) AGENTS		
adefovir dipivoxil	5	
BARACLUDE 0.05 MG/ML SOLUTION	4	QL (600 PER 30 DAYS)
entecavir	4	QL (30 PER 30 DAYS)
EPIVIR HBV 25 MG/5 ML SOLN	4	
INTRON A (10 MILLION UNITS VIL, 18 MILLION UNIT/3 ML, 50 MILLION UNITS VIL)	5	PA - FOR NEW STARTS ONLY
lamivudine 100 mg tablet	3	
lamivudine hbv	3	
ANTI-HEPATITIS C (HCV) AGENTS, DIRECT ACTING AGENTS		
ledipasvir-sofosbuvir	5	PA, QL (168 PER 365 OVER TIME)
sofosbuvir-velpatasvir	5	PA, QL (84 PER 365 OVER TIME)
SOVALDI 400 MG TABLET	5	PA, QL (336 PER 365 OVER TIME)
VOSEVI	5	PA
ANTI-HEPATITIS C (HCV) AGENTS, OTHER		
PEGASYS (180 MCG/0.5 ML SYRINGE, 180 MCG/ML VIAL)	5	PA

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
PEGASYS PROCLICK	5	PA
ribavirin 200 mg capsule	2	
ribavirin 200 mg tablet	4	
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY	5	QL (30 PER 30 DAYS)
DOVATO	5	
GENVOYA	5	QL (30 PER 30 DAYS)
ISENTRESS (25 MG TABLET CHEW, 100 MG POWDER PACKET, 100 MG TABLET CHEW, 400 MG TABLET)	3	
STRIBILD	5	QL (30 PER 30 DAYS)
TIVICAY (25 MG TABLET, 50 MG TABLET)	5	
TIVICAY 10 MG TABLET	4	
TRIUMEQ	5	QL (30 PER 30 DAYS)
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
COMPLERA	5	QL (30 PER 30 DAYS)
DELSTRIGO	5	
EDURANT	5	
efavirenz 50 mg capsule	4	
efavirenz (200 mg capsule, 600 mg tablet)	5	
efavirenz-emtric-tenofov disop	5	QL (30 PER 30 DAYS)
efavirenz-lamivu-tenofov disop	5	QL (30 PER 30 DAYS)
etravirine	5	
INTELENCE 25 MG TABLET	4	
nevirapine 50 mg/5 ml susp	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
nevirapine 200 mg tablet	2	
nevirapine er	4	
ODEFSEY	5	QL (30 PER 30 DAYS)
PIFELTRO	5	
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir 20 mg/ml solution	2	
abacavir 300 mg tablet	4	
abacavir-lamivudine	4	QL (30 PER 30 DAYS)
abacavir-lamivudine-zidovudine	5	QL (60 PER 30 DAYS)
CIMDUO	5	
DESCOVY	5	QL (30 PER 30 DAYS)
didanosine (dr 125 mg capsule, dr 250 mg capsule, dr 400 mg capsule)	2	
didanosine dr 200 mg capsule	2	QL (60 PER 30 DAYS)
emtricitabine	4	
emtricitabine-tenofovir disop	5	QL (30 PER 30 DAYS)
EMTRIVA 10 MG/ML SOLUTION	4	
JULUCA	5	QL (30 PER 30 DAYS)
lamivudine (10 mg/ml oral soln, 150 mg tablet)	2	
lamivudine 300 mg tablet	4	
lamivudine-zidovudine	4	QL (60 PER 30 DAYS)
RETROVIR 200 MG/20 ML VIAL	4	
stavudine	2	
TEMIXYS	5	QL (30 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
tenofovir disoproxil fumarate	3	
VIDEX	4	
VIREAD (150 MG TABLET, 200 MG TABLET, 250 MG TABLET, POWDER)	5	
zidovudine (50 mg/5 ml syrup, 100 mg capsule, 300 mg tablet)	2	
ANTI-HIV AGENTS, OTHER		
FUZEON	5	QL (60 PER 30 DAYS)
ISENTRESS HD	3	QL (60 PER 30 DAYS)
RUKOBIA	5	QL (60 PER 30 DAYS)
SELZENTRY 20 MG/ML ORAL SOLN	2	
SELZENTRY (25 MG TABLET, 75 MG TABLET, 150 MG TABLET, 300 MG TABLET)	3	
TROGARZO	5	
TYBOST	3	
ANTI-HIV AGENTS, PROTEASE INHIBITORS		
APTIVUS (100 MG/ML SOLUTION, 250 MG CAPSULE)	5	
atazanavir sulfate	3	
CRIXIVAN	3	
EVOTAZ	5	QL (30 PER 30 DAYS)
fosamprenavir calcium	5	
INVIRASE	5	
LEXIVA 50 MG/ML SUSPENSION	4	
lopinavir-ritonavir 80-20mg/ml	2	
lopinavir-ritonavr 100-25mg tb	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
lopinavir-ritonavr 200-50mg tb	5	
NORVIR (80 MG/ML SOLUTION, 100 MG POWDER PACKET)	4	
PREZCOBIX	5	QL (30 PER 30 DAYS)
PREZISTA (100 MG/ML SUSPENSION, 600 MG TABLET, 800 MG TABLET)	5	
PREZISTA (75 MG TABLET, 150 MG TABLET)	4	
REYATAZ 50 MG POWDER PACKET	5	
ritonavir	3	
SYMTUZA	5	
VIRACEPT	5	
ANTI-INFLUENZA AGENTS		
amantadine (50 mg/5 ml solution, 100 mg/10 ml soln)	1	
amantadine (100 mg capsule, 100 mg tablet)	2	
GOCOVRI	5	PA
oseltamivir phos 75 mg capsule	2	QL (110 PER 365 OVER TIME)
oseltamivir phosphate (30 mg capsule, 45 mg capsule)	2	QL (180 PER 365 OVER TIME)
oseltamivir 6 mg/ml suspension	2	QL (2250 PER 365 OVER TIME)
OSMOLEX ER (ER 129 MG TABLET, ER 193 MG TABLET, ER 258 MG TABLET)	4	PA
RELENZA	4	QL (240 PER 365 OVER TIME)
rimantadine hcl	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANTIHERPETIC AGENTS		
acyclovir 5% cream	5	
acyclovir 5% ointment	4	
acyclovir 200 mg/5 ml susp	2	
acyclovir (200 mg capsule, 400 mg tablet, 800 mg tablet)	1	
acyclovir sodium (500 mg/10 ml vial, 1,000 mg/20 ml vial)	4	PA - Part B vs D Determination
DENAVIR	5	
famciclovir	2	
trifluridine	2	
valacyclovir	2	QL (120 PER 30 DAYS)
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
CABENUVA	5	
TIVICAY PD	3	QL (180 PER 30 DAYS)
VOCABRIA	5	QL (30 PER 30 DAYS)
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
buspirone hcl	1	
hydroxyzine pamoate	1	
BENZODIAZEPINES		
alprazolam (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet)	1	QL (120 PER 30 DAYS)
alprazolam 2 mg tablet	1	QL (150 PER 30 DAYS)
alprazolam er (er 0.5 mg tablet, er 1 mg tablet)	2	QL (30 PER 30 DAYS)
alprazolam er 2 mg tablet	2	QL (150 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
alprazolam er 3 mg tablet	2	QL (90 PER 30 DAYS)
alprazolam intensol	2	
alprazolam odt (odt 0.25 mg tab, odt 0.5 mg tab, odt 1 mg tab)	2	QL (120 PER 30 DAYS)
alprazolam odt 2 mg tab	2	QL (150 PER 30 DAYS)
alprazolam xr (0.5 mg tablet, 1 mg tablet)	2	QL (30 PER 30 DAYS)
alprazolam xr 2 mg tablet	2	QL (150 PER 30 DAYS)
alprazolam xr 3 mg tablet	2	QL (90 PER 30 DAYS)
chlordiazepoxide 10 mg capsule	2	QL (900 PER 30 DAYS)
chlordiazepoxide 25 mg capsule	2	QL (360 PER 30 DAYS)
chlordiazepoxide 5 mg capsule	2	QL (120 PER 30 DAYS)
clorazepate 15 mg tablet	2	QL (180 PER 30 DAYS)
clorazepate 3.75 mg tablet	2	
clorazepate 7.5 mg tablet	2	QL (360 PER 30 DAYS)
diazepam (2 mg tablet, 5 mg tablet, 5 mg/5 ml solution, 5 mg/ml oral conc, 10 mg tablet)	2	
lorazepam 2 mg/ml oral concent	2	
lorazepam (0.5 mg tablet, 1 mg tablet)	1	QL (90 PER 30 DAYS)
lorazepam 2 mg tablet	1	QL (150 PER 30 DAYS)
lorazepam intensol	2	
oxazepam	2	QL (120 PER 30 DAYS)
temazepam	1	QL (30 PER 30 DAYS)
BIPOLAR AGENTS		
MOOD STABILIZERS		
EQUETRO	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
lithium	3	
lithium carbonate (150 mg cap, 300 mg cap, 300 mg tab, 600 mg cap)	1	
lithium carbonate er	1	
BLOOD GLUCOSE REGULATORS		
ANTIDIABETIC AGENTS		
acarbose	1	
ACTOPLUS MET XR 15-1,000 MG TB	4	QL (60 PER 30 DAYS)
ACTOPLUS MET XR 30-1,000 MG TB	4	QL (45 PER 30 DAYS)
AVANDIA 2 MG TABLET	4	QL (120 PER 30 DAYS)
AVANDIA 4 MG TABLET	4	QL (60 PER 30 DAYS)
BYDUREON BCISE	4	QL (3.4 PER 28 DAYS)
BYDUREON PEN	4	QL (4 PER 28 DAYS)
BYETTA 10 MCG DOSE PEN INJ	4	QL (2.4 PER 30 DAYS)
BYETTA 5 MCG DOSE PEN INJ	4	QL (1.2 PER 30 DAYS)
caretouch pen needle 29g 12mm	1	QL (200 PER 30 DAYS)
comfort touch pen needle (pen ndl 33g 6mm, pen ndl 33gx4mm, pen ndl 33gx5mm)	1	QL (200 PER 30 DAYS)
CYCLOSET	4	
droplet pen needle (pen needle 29gx1/2", pen needle 31gx3/16", pen needle 31gx5/16", pen needle 32gx5/32")	1	QL (200 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
easy touch insulin syringe (syr 0.5ml 27g12.7mm, syr 0.5ml 28g12.7mm, syr 0.5ml 29g12.7mm, syr 1 ml 27g 12.7mm, syr 1 ml 28g 12.7mm, syr 1 ml 29g 12.7mm)	1	QL (200 PER 30 DAYS)
easy touch safety pen needle (easy touch pen ndl 29g 8mm, easy touch pen ndl 30g 8mm, easytouch pen ndl 30g 6mm)	1	QL (200 PER 30 DAYS)
FARXIGA	3	QL (30 PER 30 DAYS)
glimepiride 1 mg tablet	1	QL (240 PER 30 DAYS)
glimepiride 2 mg tablet	1	QL (120 PER 30 DAYS)
glimepiride 4 mg tablet	1	QL (60 PER 30 DAYS)
glipizide 10 mg tablet	1	QL (120 PER 30 DAYS)
glipizide 5 mg tablet	1	QL (240 PER 30 DAYS)
glipizide er 10 mg tablet	1	QL (60 PER 30 DAYS)
glipizide er 2.5 mg tablet	1	QL (240 PER 30 DAYS)
glipizide er 5 mg tablet	1	QL (120 PER 30 DAYS)
glipizide xl 10 mg tablet	1	QL (60 PER 30 DAYS)
glipizide xl 2.5 mg tablet	1	QL (240 PER 30 DAYS)
glipizide xl 5 mg tablet	1	QL (120 PER 30 DAYS)
glipizide-metformin (2.5-500 mg, 5-500 mg)	1	QL (120 PER 30 DAYS)
glipizide-metformin 2.5-250 mg	1	QL (240 PER 30 DAYS)
glyburide 1.25 mg tablet	2	QL (480 PER 30 DAYS)
glyburide 2.5 mg tablet	2	QL (240 PER 30 DAYS)
glyburide 5 mg tablet	2	QL (120 PER 30 DAYS)
glyburide micro 1.5 mg tab	2	QL (240 PER 30 DAYS)
glyburide micro 3 mg tablet	2	QL (120 PER 30 DAYS)

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Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
glyburide micro 6 mg tablet	2	QL (60 PER 30 DAYS)
glyburid-metformin 1.25-250 mg	2	QL (240 PER 30 DAYS)
glyburide-metformin hcl (2.5-500 mg, 5-500 mg)	2	QL (120 PER 30 DAYS)
incontrol pen needle	1	QL (200 PER 30 DAYS)
INSULIN PEN NEEDLE	1	QL (200 PER 30 DAYS)
insulin syringe (ins syr 0.3 ml 8mmx31g(1/2), ins syr uf 0.3ml 12.7mmx30g, ins syr uf 0.5ml 12.7mmx30g, ins syrn uf 1 ml 12.7mmx30g, ins syrng uf 0.3 ml 8mmx31g, ins syrng uf 0.5 ml 8mmx31g, insulin syr uf 1 ml 8mmx31g)	1	QL (200 PER 30 DAYS)
INSULIN SYRINGE (DISP) U-100 0.3 ML	1	QL (200 PER 30 DAYS)
INSULIN SYRINGE (DISP) U-100 1 ML	1	QL (200 PER 30 DAYS)
INSULIN SYRINGE (DISP) U-100 1/2 ML	1	QL (200 PER 30 DAYS)
INVOKAMET (150-1,000 MG TABLET, 150-500 MG TABLET)	3	QL (60 PER 30 DAYS)
INVOKAMET 50-500 MG TABLET	3	QL (120 PER 30 DAYS)
INVOKAMET XR (50-1,000 MG TAB, 50-500 MG TABLET, 150-500 MG TABLET)	3	QL (60 PER 30 DAYS)
INVOKANA 100 MG TABLET	3	QL (90 PER 30 DAYS)
INVOKANA 300 MG TABLET	3	QL (30 PER 30 DAYS)
JANUMET	3	QL (60 PER 30 DAYS)
JANUMET XR (50-1,000 MG TABLET, 50-500 MG TABLET)	3	QL (60 PER 30 DAYS)
JANUMET XR 100-1,000 MG TABLET	3	QL (30 PER 30 DAYS)

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
JANUVIA	3	
JARDIANCE 10 MG TABLET	3	QL (60 PER 30 DAYS)
JARDIANCE 25 MG TABLET	3	QL (30 PER 30 DAYS)
JENTADUETO	3	QL (60 PER 30 DAYS)
JENTADUETO XR 2.5 MG-1,000 MG	3	QL (60 PER 30 DAYS)
JENTADUETO XR 5 MG-1,000 MG TB	3	QL (30 PER 30 DAYS)
KOMBIGLYZE XR (5-1,000 MG TAB, 5-500 MG TABLET)	4	QL (30 PER 30 DAYS)
KOMBIGLYZE XR 2.5-1,000 MG TAB	4	QL (60 PER 30 DAYS)
metformin er 500 mg gastrc-tb	5	QL (120 PER 30 DAYS)
metformin er 500 mg osmotic tb	4	
metformin hcl 500 mg/5 ml soln	4	QL (765 PER 30 DAYS)
metformin hcl 1,000 mg tablet	1	QL (60 PER 30 DAYS)
metformin hcl 500 mg tablet	1	QL (150 PER 30 DAYS)
metformin hcl 850 mg tablet	1	QL (90 PER 30 DAYS)
metformin hcl er 500 mg tablet	1	QL (120 PER 30 DAYS)
metformin hcl er 750 mg tablet	1	QL (60 PER 30 DAYS)
miglitol	4	
nateglinide	1	
NEEDLES, INSULIN DISP., SAFETY	1	QL (200 PER 30 DAYS)
ONGLYZA 2.5 MG TABLET	4	QL (60 PER 30 DAYS)
ONGLYZA 5 MG TABLET	4	QL (30 PER 30 DAYS)
OZEMPIC (1 MG/DOSE (2 MG/1.5ML), 1 MG/DOSE (4 MG/3 ML))	3	QL (3 PER 28 DAYS)
OZEMPIC 0.25-0.5 MG/DOSE PEN	3	QL (1.5 PER 28 DAYS)

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
pen needle (pen needle 33g 4mm, relion pen needle 31g 6mm, relion pen needle 31gx5/16", relion pen needle 32gx5/32")	1	QL (200 PER 30 DAYS)
pioglitazone hcl 15 mg tablet	1	QL (60 PER 30 DAYS)
pioglitazone hcl 30 mg tablet	1	QL (45 PER 30 DAYS)
pioglitazone hcl 45 mg tablet	1	QL (30 PER 30 DAYS)
pioglitazone-glimepiride	3	QL (45 PER 30 DAYS)
pioglitazone-metformin	2	QL (90 PER 30 DAYS)
pip pen needle	1	QL (200 PER 30 DAYS)
repaglinide	1	
repaglinide-metformin hcl	2	QL (150 PER 30 DAYS)
RYBELSUS	3	QL (30 PER 30 DAYS)
securesafe pen needle	1	
sure comfort safety pen needle	1	QL (200 PER 30 DAYS)
SYMLINPEN 120	5	PA
SYMLINPEN 60	5	PA
SYNJARDY (5-1,000 MG TABLET, 12.5-1,000 MG TABLET)	3	QL (60 PER 30 DAYS)
SYNJARDY (5-500 MG TABLET, 12.5-500 MG TABLET)	3	QL (120 PER 30 DAYS)
SYNJARDY XR (5-1,000 MG TABLET, 10-1,000 MG TABLET, 12.5-1,000 MG TAB)	3	QL (60 PER 30 DAYS)
SYNJARDY XR 25-1,000 MG TABLET	3	QL (30 PER 30 DAYS)
tolazamide 250 mg tablet	1	QL (240 PER 30 DAYS)
tolazamide 500 mg tablet	1	QL (120 PER 30 DAYS)
tolbutamide	1	QL (180 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
TRADJENTA	3	QL (30 PER 30 DAYS)
TRIJARDY XR (10-5-1,000 MG TAB, 25-5-1,000 MG TAB)	3	QL (30 PER 30 DAYS)
TRIJARDY XR (5-2.5-1,000 MG TAB, 12.5-2.5-1,000 MG)	3	QL (60 PER 30 DAYS)
true comfort pen needle (pen ndl 31g 8mm, pen ndl 32g 5mm)	1	QL (200 PER 30 DAYS)
TRULICITY	3	QL (2 PER 28 DAYS)
ulticare pen needle (gnp pen ndl, hm pen needle)	1	QL (200 PER 30 DAYS)
ulticare safety pen needle	1	
ultiguard safe 1ml 30g 12.7mm	1	QL (200 PER 30 DAYS), CB (200 / 30 day(s))
ultiguard safepack-insulin syr (safe0.3ml 30g 12.7mm, safe0.5ml 30g 12.7mm, safepack 1ml 31g 8mm, safepk 0.3ml 31g 8mm, safepk 0.5ml 31g 8mm)	1	QL (200 PER 30 DAYS)
ultra flo insulin syringe (0.3ml 30g 1/2" (1/2), 0.3ml 30g 5/16"(1/2), 0.3ml 31g 5/16"(1/2), syr 0.3 ml 30g 5/16", syr 0.3 ml 31g 5/16", syr 0.5 ml 29g 1/2")	1	QL (200 PER 30 DAYS)
ultra flo pen needle (pen needle 31g 5mm, pen needle 31g 8mm, pen needle 32g 4mm, pen needle 33g 4mm)	1	QL (200 PER 30 DAYS)
unifine pen needle	1	QL (200 PER 30 DAYS)
unifine pentips (31g 6mm, 31g 8mm, 31gx3/16", 32gx5/32")	1	QL (200 PER 30 DAYS)
unifine pentips plus	1	QL (200 PER 30 DAYS)
veo insulin syringe	1	QL (200 PER 30 DAYS)
VICTOZA 2-PAK	3	QL (9 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
VICTOZA 3-PAK	3	QL (9 PER 30 DAYS)
XIGDUO XR (10 MG-1,000 MG TAB, 10 MG-500 MG TABLET)	3	QL (30 PER 30 DAYS)
XIGDUO XR (2.5 MG-1,000 MG TAB, 5 MG-1,000 MG TABLET, 5 MG-500 MG TABLET)	3	QL (60 PER 30 DAYS)
GLYCEMIC AGENTS		
diazoxide	5	
GLUCAGEN	4	
glucagon emergency kit (1 mg kit, kit)	3	
INSULINS		
ADMELOG	3	
ADMELOG SOLOSTAR	3	
BASAGLAR KWIKPEN U-100	3	
HUMALOG KWIKPEN U-200	3	
HUMALOG MIX 50-50	3	
HUMALOG MIX 50-50 KWIKPEN	3	
HUMALOG MIX 75-25	3	
HUMULIN 70-30	3	
HUMULIN 70/30 KWIKPEN	3	
HUMULIN N	3	
HUMULIN N KWIKPEN	3	
HUMULIN R	3	
HUMULIN R U-500	3	
HUMULIN R U-500 KWIKPEN	3	
INSULIN ASPART	3	

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
INSULIN ASPART FLEXPEN	3	
INSULIN ASPART PENFILL	3	
INSULIN ASPART PROT MIX 70-30 (MIX70-30 PN, MIX70-30 VL)	3	
INSULIN LISPRO	3	
INSULIN LISPRO JUNIOR KWIKPEN	3	
INSULIN LISPRO KWIKPEN U-100	3	
INSULIN LISPRO PROTAMINE MIX	3	
LANTUS	3	
LANTUS SOLOSTAR	3	
LEVEMIR	3	
LEVEMIR FLEXTOUCH	3	
NOVOLIN 70-30	4	ST
NOVOLIN 70-30 FLEXPEN	4	ST
NOVOLIN N	4	ST
NOVOLIN N FLEXPEN	4	ST
NOVOLIN R	4	ST
NOVOLIN R FLEXPEN	4	ST
TOUJEO MAX SOLOSTAR	3	
TOUJEO SOLOSTAR	3	
TRESIBA	3	
TRESIBA FLEXTOUCH U-100	3	
TRESIBA FLEXTOUCH U-200	3	

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS		
ANTICOAGULANTS		
argatroban	5	
argatroban-0.9% nacl	5	
COUMADIN	4	
ELIQUIS DVT-PE TREAT START 5MG	3	QL (148 PER 365 OVER TIME)
ELIQUIS 2.5 MG TABLET	3	QL (60 PER 30 DAYS)
ELIQUIS 5 MG TABLET	3	QL (90 PER 30 DAYS)
enoxaparin 30 mg/0.3 ml syr	4	QL (10.5 PER 90 OVER TIME)
enoxaparin 40 mg/0.4 ml syr	4	QL (14 PER 90 OVER TIME)
enoxaparin 60 mg/0.6 ml syr	4	QL (21 PER 90 OVER TIME)
enoxaparin sodium (100 mg/ml syringe, 150 mg/ml syringe)	4	QL (35 PER 90 OVER TIME)
enoxaparin sodium (80 mg/0.8 ml syr, 120 mg/0.8 ml syr)	4	QL (28 PER 90 OVER TIME)
enoxaparin 300 mg/3 ml vial	4	QL (105 PER 90 OVER TIME)
fondaparinux 10 mg/0.8 ml syr	5	QL (28 PER 90 OVER TIME)
fondaparinux 2.5 mg/0.5 ml syr	4	QL (17.5 PER 90 OVER TIME)
fondaparinux 5 mg/0.4 ml syr	5	QL (14 PER 90 OVER TIME)
fondaparinux 7.5 mg/0.6 ml syr	5	QL (21 PER 90 OVER TIME)
FRAGMIN (2,500 UNIT/0.2 ML SYR, 5,000 UNIT/0.2 ML SYR)	4	
FRAGMIN (7,500 UNIT/0.3 ML SYR, 10,000 UNIT/ML SYRINGE, 12,500 UNIT/0.5 ML SYR, 15,000 UNIT/0.6 ML SYR, 18,000 UNIT/0.72 ML, 95,000 UNIT/3.8 ML VL)	5	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
heparin sodium (sod 1,000 unit/ml vial, sod 5,000 unit/ml vial, 10,000 unit/10 ml vial, sod 20,000 unit/ml vl, 30,000 unit/30 ml vial, 50,000 unit/10 ml vial)	2	PA - Part B vs D Determination
heparin sodium (sod 10,000 unit/ml vl, 40,000 unit/4 ml vial, 50,000 unit/5 ml vial)	2	
heparin 25,000 unit/500-1/2 ns	2	
heparin sodium-d5w (20,000 unit/500, 25,000 unit/250)	2	
jantoven	1	
PRADAXA	4	QL (60 PER 30 DAYS)
warfarin sodium	1	
XARELTO DVT-PE TREAT START 30D	3	QL (102 PER 365 OVER TIME)
XARELTO (10 MG TABLET, 20 MG TABLET)	3	QL (30 PER 30 DAYS)
XARELTO (2.5 MG TABLET, 15 MG TABLET)	3	QL (60 PER 30 DAYS)
BLOOD FORMATION MODIFIERS		
anagrelide hcl	2	
ARANESP (10 MCG/0.4 ML SYRINGE, 25 MCG/0.42 ML SYRING, 25 MCG/ML VIAL, 40 MCG/0.4 ML SYRINGE, 40 MCG/ML VIAL, 60 MCG/0.3 ML SYRINGE)	4	PA
ARANESP (60 MCG/ML VIAL, 100 MCG/0.5 ML SYRINGE, 100 MCG/ML VIAL, 150 MCG/0.3 ML SYRINGE, 200 MCG/0.4 ML SYRINGE, 200 MCG/ML VIAL, 300 MCG/0.6 ML SYRINGE, 300 MCG/ML VIAL, 500 MCG/1 ML SYRINGE)	5	PA

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
CABLIVI (11 MG KIT, 11 MG VIAL)	5	PA
DOPTELET (10 TAB PK) 20 MG TAB	5	PA, QL (10 PER 30 DAYS)
DOPTELET (15 TAB PK) 20 MG TAB	5	PA, QL (15 PER 30 DAYS)
DOPTELET (30 TAB PK) 20 MG TAB	5	PA, QL (60 PER 30 DAYS)
FULPHILA	5	PA
GRANIX (300 MCG/0.5 ML SAFE SYR, 300 MCG/0.5 ML SYRINGE, 300 MCG/ML VIAL, 480 MCG/0.8 ML SAFE SYR, 480 MCG/0.8 ML SYRINGE, 480 MCG/1.6 ML VIAL)	5	PA
LEUKINE	5	PA
MOZOBIL	5	PA, QL (38.4 PER 365 OVER TIME)
NEULASTA	5	PA
NEULASTA ONPRO	5	PA
NEUPOGEN (300 MCG/0.5 ML SYR, 300 MCG/ML VIAL, 480 MCG/0.8 ML SYR, 480 MCG/1.6 ML VIAL)	5	PA
NIVESTYM (300 MCG/0.5 ML SYRING, 300 MCG/ML VIAL, 480 MCG/0.8 ML SYRING, 480 MCG/1.6 ML VIAL)	5	PA
PROCRIT (2,000 UNITS/ML VIAL, 3,000 UNITS/ML VIAL, 4,000 UNITS/ML VIAL, 10,000 UNITS/ML VIAL)	4	PA
PROCRIT (20,000 UNITS/ML VIAL, 40,000 UNITS/ML VIAL)	5	PA
PROMACTA (12.5 MG TABLET, 25 MG TABLET, 50 MG TABLET, 75 MG TABLET)	5	PA

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
REBLOZYL	5	PA
RETACRIT (2,000 UNIT/ML VIAL, 3,000 UNIT/ML VIAL, 4,000 UNIT/ML VIAL, 10,000 UNIT/ML VIAL, 20,000 UNIT/2 ML VIAL, 20,000 UNIT/ML VIAL)	4	PA, QL (14 PER 30 DAYS)
RETACRIT 40,000 UNIT/ML VIAL	5	PA, QL (14 PER 30 DAYS)
UDENYCA	5	PA
ZARXIO	5	PA
ZIEXTENZO	5	PA
HEMOSTASIS AGENTS		
tranexamic acid 1,000 mg/10 ml	2	
tranexamic acid 650 mg tablet	1	
PLATELET MODIFYING AGENTS		
ADAKVEO	5	PA
aspirin-dipyridamole er	4	
BRILINTA	3	
cilostazol	1	
clopidogrel	1	
prasugrel hcl	2	QL (30 PER 30 DAYS)
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
clonidine	3	
clonidine hcl (0.1 mg tablet, 0.2 mg tablet, 0.3 mg tablet)	1	
guanfacine hcl	4	
LUCEMYRA	5	PA, QL (224 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
methyldopa	2	
methyldopa-hydrochlorothiazide	2	
methyldopate hcl	4	
midodrine hcl	3	
ALPHA-ADRENERGIC BLOCKING AGENTS		
phenoxybenzamine hcl	5	
prazosin hcl	2	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan cilexetil	1	
candesartan-hydrochlorothiazid	1	
EDARBI	4	
EDARBYCLOR	4	
irbesartan	1	
irbesartan-hydrochlorothiazide	1	
losartan potassium	1	
losartan-hydrochlorothiazide	1	
olmesartan medoxomil	2	
olmesartan-hydrochlorothiazide	2	
telmisartan	1	
telmisartan-hydrochlorothiazid	1	
valsartan	1	
valsartan-hydrochlorothiazide	1	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
benazepril hcl	1	
benazepril-hydrochlorothiazide	1	
captopril	1	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
captopril-hydrochlorothiazide	1	
enalapril maleate (2.5 mg tab, 5 mg tablet, 10 mg tab, 20 mg tab)	1	
enalapril-hydrochlorothiazide	1	
fosinopril sodium	1	
fosinopril-hydrochlorothiazide	1	
lisinopril	1	
lisinopril-hydrochlorothiazide	1	
moexipril hcl	1	
perindopril erbumine	1	
quinapril hcl	1	
quinapril-hydrochlorothiazide	1	
ramipril	1	
trandolapril	1	
trandolapril-verapamil er (er 1-240 mg, er 2-240 mg, er 4-240 mg)	1	
ANTIARRHYTHMICS		
amiodarone hcl (100 mg tablet, 200 mg tablet, 400 mg tablet)	1	
disopyramide phosphate	2	
dofetilide	4	
flecainide acetate	2	
mexiletine hcl	3	
MULTAQ	3	
procainamide hcl	4	
propafenone hcl	2	
propafenone hcl er	4	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
quinidine gluconate (80 mg/ml vial, er 324 mg tab)	4	
quinidine sulfate	2	
sorine	2	
sotalol (120 mg tablet, 160 mg tablet, 240 mg tablet)	2	
sotalol 80 mg tablet	1	
sotalol af	2	
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol hcl	1	
atenolol	1	
atenolol-chlorthalidone	1	
betaxolol hcl (10 mg tablet, 20 mg tablet)	2	
bisoprolol fumarate	2	
bisoprolol-hydrochlorothiazide	1	
carvedilol	1	
carvedilol er	3	
labetalol hcl (100 mg tablet, 200 mg tablet, 300 mg tablet)	2	
labetalol hcl (20 mg/4 ml vial, 100 mg/20 ml vl, 200 mg/40 ml vl)	1	
metoprolol succinate	2	
metoprolol tartrate (5 mg/5 ml carpuject, tart 5 mg/5 ml amp, tart 5 mg/5 ml vial, tartrate 25 mg tab, tartrate 37.5 mg tb, tartrate 50 mg tab, tartrate 75 mg tab, tartrate 100 mg tab)	1	
metoprolol-hydrochlorothiazide	2	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
nadolol	2	
nadolol-bendroflumethiazide	2	
nebivolol hcl	3	
pindolol	2	
propranolol hcl (10 mg tablet, 20 mg tablet, 20 mg/5 ml soln, 40 mg tablet, 40 mg/5 ml soln, 60 mg tablet, 80 mg tablet)	2	
propranolol 1 mg/ml vial	4	
propranolol hcl er	2	
propranolol-hydrochlorothiazid	2	
timolol maleate (5 mg tablet, 10 mg tablet, 20 mg tablet)	2	
CALCIUM CHANNEL BLOCKING AGENTS		
amlodipine besylate	1	
amlodipine besylate-benazepril	1	
amlodipine-atorvastatin (2.5-10 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg, 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg)	3	
amlodipine-olmesartan	2	
amlodipine-valsartan	1	
amlodipine-valsartan-hctz (10-160-12.5mg, 10-320-25 mg)	3	
amlodipine-valsartan-hctz (5-160-12.5 mg, 5-160-25 mg)	2	
CARDIZEM LA 120 MG TABLET	4	
cartia xt	2	
dilt-xr	2	
diltiazem 12hr er	2	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
diltiazem 24hr er (24hr er 120 mg cap, 24hr er 180 mg cap, 24hr er 240 mg cap, 24hr er 300 mg cap, 24hr er 420 mg cap)	2	
diltiazem 24hr er 360 mg cap	3	
diltiazem 24h er(cd) 360 mg cp	3	
diltiazem 24hr er (cd) (24h er(cd) 120 mg cp, 24h er(cd) 180 mg cp, 24h er(cd) 240 mg cp, 24h er(cd) 300 mg cp)	2	
diltiazem 24hr er (la)	2	
diltiazem 24hr er (xr)	2	
diltiazem hcl (30 mg tablet, 60 mg tablet, 90 mg tablet, 120 mg tablet)	1	
diltiazem hcl (25 mg/5 ml vial, 50 mg/10 ml vial, 100 mg add-van vial, 125 mg/25 ml vial)	4	
felodipine er	2	
isradipine	4	
matzim la	4	
nicardipine hcl (25 mg/10 ml ampule, 25 mg/10 ml vial)	4	
nicardipine hcl (20 mg capsule, 30 mg capsule)	3	
nifedipine er	2	
nimodipine	4	
nisoldipine	4	
olmesartan-amlodipine-hctz	3	
taztia xt	2	
telmisartan-amlodipine	2	
tiadylt er	1	

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
verapamil er (er 120 mg capsule, er 180 mg capsule, er 240 mg capsule)	2	
verapamil er (er 120 mg tablet, er 180 mg tablet, er 240 mg tablet)	1	
verapamil er pm	4	
verapamil hcl (5 mg/2 ml ampul, 5 mg/2 ml vial, 10 mg/4 ml vial)	2	
verapamil hcl (40 mg tablet, 80 mg tablet, 120 mg tablet)	1	
verapamil sr (sr 120 mg capsule, sr 180 mg capsule, sr 240 mg capsule)	2	
verapamil sr 360 mg capsule	3	
CARDIOVASCULAR AGENTS, OTHER		
acetazolamide	2	
acetazolamide er	3	
aliskiren	2	
amlodipine-atorvast 2.5-20 mg	3	
amlod-valsa-hctz 10-160-25 mg	3	
CORLANOR 5 MG/5 ML ORAL SOLN	4	PA
CORLANOR (5 MG TABLET, 7.5 MG TABLET)	4	PA, QL (60 PER 30 DAYS)
digitek 125 mcg tablet	1	QL (30 PER 30 DAYS)
digitek 250 mcg tablet	1	
digox 125 mcg tablet	2	QL (30 PER 30 DAYS)
digox 250 mcg tablet	1	
digoxin 0.05 mg/ml solution	2	
digoxin (0.25 mg/ml syringe, 500 mcg/2 ml ampule)	4	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
digoxin (0.125 mg tablet, 125 mcg tablet)	1	QL (30 PER 30 DAYS)
digoxin (0.25 mg tablet, 250 mcg tablet)	1	
ENTRESTO	3	QL (60 PER 30 DAYS)
EVKEEZA 1,200 MG/8 ML VIAL	5	PA, QL (8 PER 28 DAYS)
EVKEEZA 345 MG/2.3 ML VIAL	5	PA, QL (4.6 PER 28 DAYS)
LANOXIN 187.5 MCG TABLET	4	QL (30 PER 30 DAYS)
LANOXIN 62.5 MCG TABLET	4	
metyrosine	5	
NORTHERA	5	PA
pentoxifylline	1	
PRALUENT PEN	4	PA, QL (2 PER 28 DAYS)
ranolazine er	3	
REPATHA PUSHTRONEX	4	PA, QL (3.5 PER 28 DAYS)
REPATHA SURECLICK	4	PA, QL (3 PER 28 DAYS)
REPATHA SYRINGE	4	PA, QL (3 PER 28 DAYS)
TEKTURNA HCT	4	
DIURETICS, CARBONIC ANHYDRASE INHIBITORS		
acetazolamide sodium	2	
DIURETICS, LOOP		
bumetanide (0.5 mg tablet, 1 mg tablet, 2 mg tablet)	1	
bumetanide (0.25 mg/ml vial, 1 mg/4 ml vial, 2.5 mg/10 ml vial)	2	
ethacrynic acid	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
furosemide (10 mg/ml solution, 20 mg tablet, 20 mg/2 ml vial, 40 mg tablet, 40 mg/4 ml syringe, 40 mg/4 ml vial, 40 mg/5 ml soln, 80 mg tablet, 100 mg/10 ml syring, 100 mg/10 ml vial)	1	
torsemide	1	
DIURETICS, POTASSIUM-SPARING		
ALDACTAZIDE 50-50 TABLET	4	
amiloride hcl	2	
amiloride-hydrochlorothiazide	1	
eplerenone	2	
spironolactone	1	
spironolactone-hctz	2	
triamterene	2	
triamterene-hydrochlorothiazid (37.5-25 mg cp, 37.5-25 mg tb, 75-50 mg tab)	1	
DIURETICS, THIAZIDE		
chlorothiazide	2	
chlorothiazide sodium	4	
chlorthalidone	1	
DIURIL	4	
hydrochlorothiazide (12.5 mg cp, 12.5 mg tb, 25 mg tab, 50 mg tab)	1	
indapamide	1	
methyclothiazide	2	
metolazone	2	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
fenofibrate (43 mg capsule, 50 mg capsule, 130 mg capsule, 145 mg tablet, 150 mg capsule, 200 mg capsule)	2	
fenofibrate (48 mg tablet, 54 mg tablet, 67 mg capsule, 134 mg capsule, 160 mg tablet)	1	
fenofibrate 40 mg tablet	4	
fenofibric acid (35 mg tablet, dr 45 mg cap, 105 mg tablet, dr 135 mg cap)	2	
gemfibrozil	1	
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
atorvastatin calcium	1	
fluvastatin er	4	
fluvastatin sodium	4	
LIVALO	4	ST
lovastatin	1	
pravastatin sodium	1	
rosuvastatin calcium	1	
simvastatin (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet, 80 mg tablet)	1	
DYSLIPIDEMICS, OTHER		
cholestyramine (packet, powder)	2	
cholestyramine light (packet, powder)	2	
colesevelam hcl (hcl 3.75 g packet, 625 mg tablet)	4	
colestipol hcl (1 gm tablet, granules, granules packet)	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ezetimibe	2	
ezetimibe-simvastatin	3	
icosapent ethyl	4	
JUXTAPID	5	PA, QL (30 PER 30 DAYS)
NEXLETOL	4	PA, QL (30 PER 30 DAYS)
NEXLIZET	4	PA, QL (30 PER 30 DAYS)
niacin er (er 750 mg tablet, er 1,000 mg tablet)	4	
niacin er 500 mg tablet	2	
niacor	2	
omega-3 acid ethyl esters	2	
prevalite (packet, powder)	2	
VASCEPA	4	
VASODILATORS, DIRECT-ACTING ARTERIAL		
hydralazine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 100 mg tablet)	1	
hydralazine 20 mg/ml vial	4	
minoxidil (2.5 mg tablet, 10 mg tablet)	2	
VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS		
BIDIL	3	
isosorbide dinitrate	2	
isosorbide dinitrate er	2	
isosorbide mononitrate	1	
isosorbide mononitrate er	1	
minitran	2	
NITRO-BID	3	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
NITRO-DUR (0.3 MG/HR PATCH, 0.8 MG/HR PATCH)	4	
nitroglycerin 400 mcg spray	3	
nitroglycerin (0.3 mg tablet, 0.4 mg tablet)	1	
nitroglycerin 0.6 mg tablet sl	2	
nitroglycerin 5 mg/ml vial	4	
nitroglycerin patch	2	
VERQUVO	4	PA, QL (30 PER 30 DAYS)
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
dextroamphetamine 5 mg/5 ml	4	PA
dextroamphetamine 10 mg tab	2	PA, QL (180 PER 30 DAYS)
dextroamphetamine 5 mg tab	2	PA, QL (90 PER 30 DAYS)
dextroamphetamine er 10 mg cap	4	PA, QL (180 PER 30 DAYS)
dextroamphetamine er 15 mg cap	4	PA, QL (120 PER 30 DAYS)
dextroamphetamine er 5 mg cap	4	PA, QL (60 PER 30 DAYS)
dextroamphetamine-amphet er	4	PA, QL (30 PER 30 DAYS)
dextroamphetamine-amphetamine	2	QL (90 PER 30 DAYS)
VYVANSE (10 MG CAPSULE, 20 MG CAPSULE, 30 MG CAPSULE, 40 MG CAPSULE, 50 MG CAPSULE, 60 MG CAPSULE, 70 MG CAPSULE)	4	QL (30 PER 30 DAYS)
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
atomoxetine hcl (10 mg capsule, 18 mg capsule)	2	QL (60 PER 30 DAYS)

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
atomoxetine hcl (25 mg capsule, 40 mg capsule, 60 mg capsule, 100 mg capsule)	4	QL (60 PER 30 DAYS)
atomoxetine hcl 80 mg capsule	4	QL (30 PER 30 DAYS)
clonidine hcl er	4	
dexmethylphenidate hcl	2	PA, QL (60 PER 30 DAYS)
dexmethylphenidate er 20 mg cp	4	PA, QL (60 PER 30 DAYS)
dexmethylphenidate hcl er (er 10 mg cp, er 15 mg cp, er 25 mg cp, er 30 mg cp, er 35 mg cp, er 40 mg cp)	4	PA, QL (30 PER 30 DAYS)
guanfacine hcl er	4	
methylphenidate er (er 10 mg cap, er 15 mg cap, er 18 mg tab, er 20 mg cap, er 27 mg tab, er 30 mg cap, er 40 mg cap, er 50 mg cap, er 54 mg tab, er 60 mg cap)	4	PA, QL (30 PER 30 DAYS)
methylphenidate er 36 mg tab	4	PA, QL (60 PER 30 DAYS)
methylphenidate er 10 mg tab	4	PA, QL (180 PER 30 DAYS)
methylphenidate er 20 mg tab	4	PA, QL (90 PER 30 DAYS)
methylphenidate er(la) 30mg cp	4	PA, QL (30 PER 30 DAYS)
methylphenidate hcl (5 mg/5 ml soln, 10 mg/5 ml sol)	4	PA
methylphenidate 10 mg chew tab	4	PA, QL (180 PER 30 DAYS)
methylphenidate hcl (2.5 mg chew tb, 5 mg chew tab)	4	PA, QL (90 PER 30 DAYS)
methylphenidate hcl (5 mg tablet, 10 mg tablet, 20 mg tablet)	2	PA, QL (90 PER 30 DAYS)
methylphenidate hcl cd	4	PA, QL (30 PER 30 DAYS)
methylphenidate hcl er (cd)	4	PA, QL (30 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
methylphenidate la (30 mg cap, 60 mg cap)	4	PA, QL (30 PER 30 DAYS)
CENTRAL NERVOUS SYSTEM, OTHER		
AUSTEDO 12 MG TABLET	5	PA, QL (120 PER 30 DAYS)
AUSTEDO 6 MG TABLET	5	PA, QL (240 PER 30 DAYS)
AUSTEDO 9 MG TABLET	5	PA, QL (180 PER 30 DAYS)
butalb-acetamin-caff 50-325-40	1	QL (360 PER 30 DAYS)
butalbital-asa-caffeine cap	1	
INGREZZA	5	PA, QL (30 PER 30 DAYS)
INGREZZA INITIATION PACK	5	PA, QL (28 PER 28 DAYS)
NUEDEXTA	4	PA
riluzole	2	PA
tencon	4	QL (360 PER 30 DAYS)
tetrabenazine	5	PA
TIGLUTIK	4	
VYNDAMAX	5	PA, QL (30 PER 30 DAYS)
VYNDAQEL	5	PA, QL (120 PER 30 DAYS)
FIBROMYALGIA AGENTS		
SAVELLA TITRATION PACK	3	QL (110 PER 365 OVER TIME)
SAVELLA (12.5 MG TABLET, 25 MG TABLET, 50 MG TABLET, 100 MG TABLET)	3	QL (60 PER 30 DAYS)
MULTIPLE SCLEROSIS AGENTS		
AUBAGIO	5	PA, QL (30 PER 30 DAYS)
AVONEX (30 MCG VIAL KIT, PREFILLED SYR 30 MCG KT)	5	PA, QL (4 PER 28 DAYS)
AVONEX PEN	5	PA, QL (4 PER 28 DAYS)
BETASERON (0.3 MG KIT, 0.3 MG VIAL)	5	PA, QL (15 PER 30 DAYS)

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
dalfampridine er	5	PA, QL (60 PER 30 DAYS)
dimethyl fumarate (dr 120 mg cp, dr 240 mg cp)	5	PA, QL (60 PER 30 DAYS)
dimethyl fumarate 30d start pk	5	PA, QL (120 PER 365 OVER TIME)
FIRDAPSE	5	PA, QL (240 PER 30 DAYS)
GILENYA	5	PA, QL (30 PER 30 DAYS)
glatiramer 20 mg/ml syringe	5	PA, QL (30 PER 30 DAYS)
glatiramer 40 mg/ml syringe	5	PA, QL (12 PER 28 DAYS)
glatopa 20 mg/ml syringe	5	PA, QL (30 PER 30 DAYS)
glatopa 40 mg/ml syringe	5	PA, QL (12 PER 28 DAYS)
MAYZENT 0.25 MG STARTER PACK	5	PA, QL (12 PER 30 DAYS)
MAYZENT (0.25 MG TABLET, 2 MG TABLET)	5	PA
OCREVUS	5	PA
PLEGRIDY 125 MCG/0.5 ML SYRING	5	PA, QL (1 PER 28 DAYS)
PLEGRIDY 125 MCG/0.5 ML PEN	5	PA, QL (1 PER 28 DAYS)
PLEGRIDY PEN INJ STARTER PACK	5	PA, QL (2 PER 365 OVER TIME)
REBIF (22 MCG/0.5 ML SYRINGE, 44 MCG/0.5 ML SYRINGE)	5	PA, QL (6 PER 28 DAYS)
REBIF TITRATION PACK	5	PA, QL (8.4 PER 365 OVER TIME)
REBIF REBIDOSE (22 MCG/0.5 ML, 44 MCG/0.5 ML)	5	PA, QL (6 PER 28 DAYS)
REBIF REBIDOSE TITRATION PACK	5	PA, QL (8.4 PER 365 OVER TIME)
TYSABRI	5	PA

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
VUMERITY	5	PA, QL (120 PER 30 DAYS)
DENTAL AND ORAL AGENTS		
cevimeline hcl	4	
chlorhexidine 0.12% rinse	1	
KEPIVANCE	5	
pilocarpine hcl (5 mg tablet, 7.5 mg tablet)	2	
triamcinolone 0.1% paste	2	
DERMATOLOGICAL AGENTS		
acitretin	5	
adapalene (0.1% cream, 0.1% gel, 0.1% solution, 0.3% gel, 0.3% gel pump)	2	PA
ammonium lactate (cream, lotion)	2	
azelaic acid	4	
calcipotriene (cream, ointment, solution)	3	
calcipotriene-betamethasone	5	QL (400 PER 30 DAYS)
calcipotriene-betamethasone dp	4	QL (400 PER 28 DAYS)
calcitriol 3 mcg/g ointment	4	
claravis	4	PA
clindamycin phos-benzoyl perox (pero 1.2-2.5%, perox 1.2-5%)	4	
clindamycin phos-tretinoin	4	PA
clindamycin-benzoyl peroxide (clindamycin-benzoyl 1-5%, clindamycin-bnz 1-5% pmp)	4	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
clotrimazole-betamethasone (crm, lot)	2	
CONDYLOX	4	
COSENTYX (2 SYRINGES)	5	PA
COSENTYX PEN	5	PA
COSENTYX PEN (2 PENS)	5	PA
COSENTYX SYRINGE	5	PA
diclofenac 1.5% topical soln	1	QL (300 PER 30 DAYS)
diclofenac sodium 1% gel	2	QL (1000 PER 30 DAYS)
diclofenac sodium 3% gel	4	PA
doxepin 5% cream	5	PA, QL (90 PER 30 DAYS)
DUOBRII	5	PA, QL (200 PER 30 DAYS)
erythromycin-benzoyl peroxide	2	
FINACEA 15% FOAM	4	
fluorouracil 0.5% cream	5	
fluorouracil (2% topical soln, 5% cream, 5% topical soln)	2	
imiquimod (cream, cream pump)	5	
imiquimod 5% cream packet	2	
isotretinoin	3	PA
methoxsalen	5	
MIRVASO (GEL, GEL PUMP)	4	PA
myorisan	4	PA
PICATO	5	
pimecrolimus	4	
podofilox	2	
RECTIV	4	
REGRANEX	5	PA

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
SANTYL	4	
selenium sulfide	1	
SILIQ	5	PA
SKYRIZI 150 MG/ML SYRINGE	5	PA
SKYRIZI (2 SYRINGES) KIT	5	PA
SKYRIZI PEN	5	PA
STELARA (45 MG/0.5 ML SYRINGE, 90 MG/ML SYRINGE)	5	PA
tacrolimus (0.03%, 0.1%)	4	PA
TALTZ AUTOINJECTOR	5	PA
TALTZ AUTOINJECTOR (2 PACK)	5	PA
TALTZ AUTOINJECTOR (3 PACK)	5	PA
TALTZ SYRINGE	5	PA
tazarotene 0.1% cream	3	PA
TAZORAC 0.05% CREAM	4	PA
TAZORAC (0.05% GEL, 0.1% GEL)	4	PA, QL (100 PER 30 DAYS)
tretinoin (0.01% gel, 0.025% cream, 0.025% gel, 0.05% cream, 0.05% gel, 0.1% cream)	4	PA
tretinoin microsphere (gel 0.04% pump, gel 0.04% tube, gel 0.1% pump, gel 0.1% tube)	4	PA
VEREGEN	5	
zenatane	4	PA
ZYCLARA (2.5% CREAM PUMP, 3.75% CREAM, 3.75% CREAM PUMP)	5	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/MINERAL REPLACEMENT		
AMINOSYN II WITH ELECTROLYTES	4	
AMINOSYN WITH ELECTROLYTES	4	PA - Part B vs D Determination
CARBAGLU	5	
CLINIMIX (4.25%-10% SOLUTION, 4.25%-20% SOLUTION, 4.25%-25% SOLUTION, 4.25%-5% SOLUTION, 5%-15% SOLUTION, 5%-25% SOLUTION)	4	PA - Part B vs D Determination
CLINIMIX E (2.75%-10% SOLUTION, 2.75%-5% SOLUTION, 4.25%-10% SOLUTION, 4.25%-25% SOLUTION, 4.25%-5% SOLUTION, 5%-15% SOLUTION, 5%-20% SOLUTION, 5%-25% SOLUTION)	4	PA - Part B vs D Determination
dextrose 10%-0.2% nacl	2	
dextrose 10%-0.45% nacl	2	
dextrose 2.5%-0.45% nacl	2	
dextrose 5%-0.2% nacl	2	
dextrose 5%-0.2% nacl-kcl	2	
dextrose 5%-0.225% nacl	2	
dextrose 5%-0.225% nacl-kcl	2	
dextrose 5%-0.3% nacl	2	
dextrose 5%-0.3% nacl-kcl	2	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
dextrose 5%-0.33% nacl	2	
dextrose 5%-0.45% nacl	2	
dextrose 5%-0.45% nacl-kcl	2	
dextrose 5%-0.9% nacl	2	
dextrose 5%-1/2ns-kcl	2	
dextrose 5%-ns-kcl	2	
dextrose 5%-potassium chloride (20 meq/l in solution, 40 meq in solution)	2	
dextrose in lactated ringers	2	
dextrose in water (5%-water 100 ml, 5%-water 50 ml, 5%-water iv soln, 5%-water vial, 10%-water iv solution)	1	
glucose in water	1	
IONOSOL MB-DEXTROSE 5%	4	
ISOLYTE P WITH DEXTROSE	4	
ISOLYTE S IV SOLUTION-EXCEL	4	
klor-con	4	
klor-con m10	2	
KLOR-CON M15	3	
klor-con m20	2	
lactated ringers injection	2	
magnesium sulfate (syringe, vial)	2	
NORMOSOL-M AND DEXTROSE	4	
NORMOSOL-R	4	
NORMOSOL-R AND DEXTROSE	1	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
PLASMA-LYTE 148	4	
PLASMA-LYTE A PH 7.4	4	
potassium chloride (2 meq/ml conc, er 8 meq tablet, 10 meq/100 ml sol, 10 meq/5 ml conc, er 10 meq capsule, er 10 meq tablet, 20 meq packet, 20 meq/10 ml conc, 20 meq/100 ml sol, 40 meq/100 ml sol, 40 meq/20 ml conc, 60 meq/30 ml conc)	1	
potassium chloride (10% (20 meq/15ml), 10% (40 meq/30ml), 20% (40 meq/15ml))	3	
potassium chloride (er 8 capsule, er 15 tablet, er 20 tablet)	2	
kcl 20 meq in d5w-lact ringer	2	
potassium chloride proamp	1	
potassium chloride-0.9% nacl	2	
potassium chloride-nacl	2	
potassium chloride-water	1	
potassium citrate er	2	
PROCALAMINE	4	PA - Part B vs D Determination

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
sodium chloride (saline 0.45% soln-excel con, sodium chloride 0.45% soln, sodium chloride 0.9% 100 ml, sodium chloride 0.9% 1,000 ml, sodium chloride 0.9% 250 ml, sodium chloride 0.9% 50 ml, sodium chloride 0.9% 500 ml, sodium chloride 0.9% sol-excel, sodium chloride 0.9% soln, sodium chloride 0.9% solution, sodium chloride 3% iv soln, sodium chloride 5% iv soln, sodium chloride 50 meq/20 ml, sodium chloride 100 meq/40 ml)	1	
sodium chloride-water	1	
SODIUM FLUORIDE 2.2 MG (FLUORIDE ION 1 MG) ORAL TABLET	2	
sodium lactate	2	
TPN ELECTROLYTES	4	
ELECTROLYTE/MINERAL/METAL MODIFIERS		
clovique	5	PA, QL (240 PER 30 DAYS)
deferasirox (90 mg tablet, 125 mg tb for susp, 180 mg tablet, 250 mg tb for susp, 360 mg tablet, 500 mg tb for susp)	5	PA
deferiprone	5	PA
FERRIPROX (100 MG/ML SOLUTION, 1,000 MG TABLET)	5	PA
FERRIPROX (2 TIMES A DAY)	5	PA
FERRIPROX (3 TIMES A DAY)	5	PA
JYNARQUE (15 MG TABLET, 15 MG-15 MG TABLET, 30 MG TABLET, 30 MG-15 MG TABLET, 45 MG-15 MG TABLET, 60 MG-30 MG TABLET, 90 MG-30 MG TABLET)	5	PA

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
kionex	4	
penicillamine (250 mg capsule, 250 mg tablet)	5	
SAMSCA 15 MG TABLET	5	QL (60 PER 30 DAYS)
sodium polystyrene sulfonate (sod polystyren sulf 15 g/60 ml, sps 15 gm/60 ml suspension, sps 30 gm/120 ml enema, sps 50 gm/200 ml enema)	4	
sodium polystyrene sulf powder	2	
SPS (15 GM/60 ML SUSPENSION, 30 GM/120 ML ENEMA SUSP)	4	
tolvaptan	5	QL (60 PER 30 DAYS)
trientine hcl	5	PA, QL (240 PER 30 DAYS)
PHOSPHATE BINDERS		
AURYXIA	5	PA
calcium acetate (667 mg capsule, 667 mg gelcap, 667 mg tablet)	1	
FOSRENOL (750 MG POWDER PACKET, 1,000 MG POWDER PACK)	5	
lanthanum carbonate	5	
PHOSLYRA	4	
sevelamer 0.8 gm powder packet	5	QL (180 PER 30 DAYS)
sevelamer 2.4 gm powder packet	5	QL (90 PER 30 DAYS)
sevelamer carbonate 800 mg tab	4	
sevelamer hcl	4	
VELPHORO	5	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
VITAMINS		
cyanocobalamin injection (b-12)	1	QL (10 PER 30 DAYS)
DERMACINRX PRENATRIX	2	
DERMACINRX PRENATRYL	2	
DOJOLVI	5	PA
folic acid (1 mg tablet, 1,000 mcg tablet)	1	
NEONATAL COMPLETE	2	
NEONATAL PLUS	2	
NEONATAL-DHA	2	
PNV TABS 20-1	2	
PREGEN DHA	2	
PRENATAL VITAMINS	2	
vinacal b	2	
vitamin d2 1.25mg(50,000 unit)	1	QL (4 PER 28 DAYS)
westab plus	2	
zingiber	2	
GASTROINTESTINAL AGENTS		
ANTISPASMODICS, GASTROINTESTINAL		
CUVPOSA	4	
dicyclomine hcl (10 mg capsule, 10 mg/5 ml soln, 20 mg tablet, 20 mg/2 ml ampul, 20 mg/2 ml vial)	1	
glycopyrrolate (1 mg tablet, 2 mg tablet)	2	
glycopyrrolate (0.2 mg/ml vial, 0.4 mg/2 ml vl, 1 mg/5 ml vial, 4 mg/20 ml vial)	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
methscopolamine bromide	4	
GASTROINTESTINAL AGENTS, OTHER		
CHENODAL	5	
CHOLBAM	5	PA
cromolyn 100 mg/5 ml oral conc	3	
diphenoxylate-atropine (diphenoxylat-atrop 2.5-0.025/5, diphenoxylate-atrop 2.5-0.025)	1	
GATTEX	5	PA
lansoprazol-amoxicil-clarithro	4	
loperamide 2 mg capsule	2	
metoclopramide hcl (5 mg tablet, 5 mg/5 ml soln, 10 mg tablet, 10 mg/10 ml sol)	1	
metoclopramide 10 mg/2 ml vial	2	
metoclopramide hcl odt	3	
MOVANTIK	3	QL (30 PER 30 DAYS)
OCALIVA	5	PA, QL (30 PER 30 DAYS)
PYLERA	5	
RELISTOR 8 MG/0.4 ML SYRINGE	5	PA, QL (12 PER 30 DAYS)
RELISTOR (12 MG/0.6 ML SYRINGE, 12 MG/0.6 ML VIAL)	5	PA, QL (18 PER 30 DAYS)
ursodiol (250 mg tablet, 300 mg capsule, 500 mg tablet)	3	
XERMELO	5	PA
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
cimetidine (300 mg tablet, 300 mg/5 ml soln, 400 mg tablet, 400 mg/6.67 ml soln, 800 mg tablet)	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
famotidine (20 mg piggyback, 20 mg tablet, 40 mg tablet)	1	
famotidine 40 mg/5 ml susp	4	
famotidine 20 mg/2 ml vial	2	
nizatidine 150 mg capsule	2	
nizatidine 300 mg capsule	1	
nizatidine 15 mg/ml solution	4	
ranitidine hcl 50 mg/2 ml vial	2	
IRRITABLE BOWEL SYNDROME AGENTS		
alosetron hcl	5	PA
AMITIZA	3	QL (60 PER 30 DAYS)
LINZESS	3	QL (30 PER 30 DAYS)
lubiprostone	3	QL (60 PER 30 DAYS)
LAXATIVES		
constulose	2	
enulose	1	
gavilyte-c	1	
gavilyte-g	1	
gavilyte-n	2	
generlac	1	
GOLYTELY PACKET	4	
KRISTALOSE 20 GM PACKET	4	
lactulose (10 gm packet, 10 gm/15 ml solution, 20 gm/30 ml solution)	2	
MOVIPREP	3	
peg 3350-electrolyte	2	
peg-3350 and electrolytes	1	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
peg3350-sod sul-nacl-kcl-asb-c	2	
PREPOPIK	4	
SUPREP	3	
trilyte with flavor packets	2	
PROTECTANTS		
misoprostol	2	
sucralfate 1 gm/10 ml susp	4	
sucralfate 1 gm tablet	2	
PROTON PUMP INHIBITORS		
DEXILANT	4	QL (30 PER 30 DAYS)
esomeprazole magnesium (dr 20 mg cap, dr 40 mg cap)	2	QL (30 PER 30 DAYS)
esomeprazole magnesium (dr 10 mg packet, dr 20 mg packet, dr 40 mg packet)	3	QL (30 PER 30 DAYS)
esomeprazole sodium	2	
lansoprazole (dr 15 mg capsule, dr 30 mg capsule)	2	QL (30 PER 30 DAYS)
NEXIUM (DR 2.5 MG PACKET, DR 5 MG PACKET)	3	QL (30 PER 30 DAYS)
omeprazole (dr 10 mg capsule, dr 20 mg capsule)	1	QL (60 PER 30 DAYS)
omeprazole dr 40 mg capsule	1	QL (30 PER 30 DAYS)
pantoprazole sodium (dr 20 mg tab, dr 40 mg tab)	1	QL (30 PER 30 DAYS)
pantoprazole sodium 40 mg vial	2	
rabeprazole sod dr 20 mg tab	2	QL (30 PER 30 DAYS)
GENETIC OR ENZYME DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
ADAGEN	5	PA

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ALDURAZYME	5	PA
CERDELGA	5	PA
CEREZYME	5	PA
CREON (DR 3,000 UNIT CAPSULE, DR 6,000 UNIT CAPSULE, DR 12,000 UNIT CAPSULE)	3	
CREON DR 24,000 UNIT CAPSULE	4	
CREON DR 36,000 UNIT CAPSULE	5	
CYSTADANE	5	
CYSTAGON	4	
ELAPRASE	5	PA
EXONDYS-51	5	PA
FABRAZYME 35 MG VIAL	5	PA
GALAFOLD	5	PA
GIVLAARI	5	PA, QL (2 PER 30 DAYS)
KANUMA	5	PA
LUMIZYME	5	PA
miglustat	5	PA
NAGLAZYME	5	PA
nitisinone	5	
NITYR	5	
ORFADIN 4 MG/ML SUSPENSION	5	
OXLUMO	5	PA
PALYNZIQ	5	PA
PROCYSBI (DR 25 MG CAPSULE, DR 75 MG CAPSULE, DR 75 MG GRANULE PKT, DR 300 MG GRANULE PKT)	5	PA

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Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
RAVICTI	5	PA
sapropterin dihydrochloride (100 mg powder pkt, 100 mg tablet, 500 mg powder pkt)	5	PA
sodium phenylbutyrate (500mg tb, powder)	5	
STRENSIQ	5	PA
SUCRAID	5	
TEGSEDI	5	PA - FOR NEW STARTS ONLY, QL (6 PER 30 DAYS)
VPRIV	5	PA
ZENPEP (DR 15,000 UNIT CAPSULE, DR 25,000 UNIT CAPSULE)	4	
ZENPEP (DR 20,000 UNIT CAPSULE, DR 40,000 UNIT CAPSULE)	5	
ZENPEP (DR 3,000 UNIT CAPSULE, DR 5,000 UNIT CAPSULE, DR 10,000 UNIT CAPSULE)	3	
ZOKINVY	5	PA
GENITOURINARY AGENTS		
ANTISPASMODICS, URINARY		
darifenacin er	4	
flavoxate hcl	2	
GELNIQUE (GEL PUMP, GEL SACHET)	4	ST
MYRBETRIQ (ER 25 MG TABLET, ER 50 MG TABLET)	3	
oxybutynin chloride (5 mg tablet, 5 mg/5 ml syrup)	1	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
oxybutynin chloride er	2	
solifenacin succinate	1	
tolterodine tartrate	3	
tolterodine tartrate er	3	
TOVIAZ	4	ST
trospium chloride	2	
trospium chloride er	2	
BENIGN PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl er	1	
CARDURA XL	4	
doxazosin mesylate	1	
dutasteride	4	
dutasteride-tamsulosin	4	
finasteride 5 mg tablet	1	
silodosin	2	
tadalafil 5 mg tablet	4	PA, QL (30 PER 30 DAYS)
tamsulosin hcl	1	
terazosin hcl	1	
GENITOURINARY AGENTS, OTHER		
bethanechol chloride	2	
ELMIRON	4	
phenazopyridine hcl	4	
sildenafil citrate (25 mg tablet, 50 mg tablet, 100 mg tablet)	1	QL (4 PER 30 OVER TIME)
tadalafil (10 mg tablet, 20 mg tablet)	1	QL (4 PER 30 OVER TIME)
THIOLA EC	5	PA

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
tiopronin	5	PA
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
a-hydrocort	4	
alclometasone dipropionate (dipr oint, dipro crm)	2	
amcinonide (cream, lotion, ointment)	4	
apexicon e	4	
betamethasone diprop augmented (crm, gel, lot, oin)	2	
betamethasone dipropionate (crm, lot, oint)	2	
betamethasone valerate (va cream, va lotion, valer ointm)	2	
betamethasone valer 0.12% foam	4	
CAPEX SHAMPOO	4	
clobetasol emollient (emollient crm, emollnt foam)	4	
clobetasol emulsion	4	
clobetasol propionate (cream, gel, ointment, prop foam, prop spray, shampoo, topical lotn)	4	
clobetasol 0.05% solution	2	
clodan	4	
colocort	2	
CORDRAN 4 MCG/SQ CM TAPE LARGE	4	
cortisone acetate	2	
DEPO-MEDROL 20 MG/ML VIAL	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
DERMA-SMOOTHE-FS SCALP OIL	2	
desonide (gel, lotion)	4	
desonide (cream, ointment)	2	
desoximetasone (0.05% cream, 0.05% gel, 0.05% ointment, 0.25% cream, 0.25% ointment, 0.25% spray)	4	
desrx	4	
dexamethasone (0.5 mg/5 ml elx, 0.5 mg/5 ml liq, 6 day 1.5 mg tab, 10 day 1.5 mg tb, 13 day 1.5 mg tb)	2	
dexamethasone (0.5 mg tablet, 0.75 mg tablet, 1 mg tablet, 1.5 mg tablet, 2 mg tablet, 4 mg tablet, 6 mg tablet)	1	
dexamethasone intensol	2	
dexamethasone sodium phosphate (4 mg/ml syringe, 4 mg/ml vial, 10 mg/ml vial, 20 mg/5 ml vial, 100 mg/10 ml vl, 120 mg/30 ml vl)	1	
fludrocortisone acetate	2	
fluocinolone acetonide (0.01% cream, 0.01% solution, 0.025% cream, 0.025% ointment)	2	
fluocinolone 0.01% body oil	4	
fluocinonide 0.1% cream	1	
fluocinonide 0.05% gel	4	
fluocinonide (cream, ointment, solution)	2	
fluocinonide-e	2	
flurandrenolide (cream, lotion, ointment)	4	

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Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
fluticasone propionate (0.005% oint, 0.05% cream, 0.05% lotion)	2	
halobetasol propionate (cream, ointmnt)	2	
hydrocortisone (2.5% cream, 2.5% lotion, 2.5% ointment, 5 mg tablet, 10 mg tablet, 20 mg tablet, 100 mg/60 ml)	1	
hydrocortisone butyrate (hydrocort buty lipid crm, hydrocort buty lipo cream, hydrocortisone butyr oint, hydrocortisone butyr soln)	4	
hydrocortisone butyr 0.1% lotn	1	
hydrocortisone valerate (cream, ointmt)	4	
ISTURISA 1 MG TABLET	5	PA, QL (240 PER 30 DAYS)
ISTURISA 10 MG TABLET	5	PA, QL (180 PER 30 DAYS)
ISTURISA 5 MG TABLET	5	PA, QL (60 PER 30 DAYS)
methylprednisolone (4 mg dosepk, 4 mg tablet)	1	
methylprednisolone (8 mg tab, 16 mg tab, 32 mg tab)	2	
methylprednisolone acetate	2	
methylprednisolone sodium succ (40 mg vl, 125 mg)	2	
methylprednisolone ss 1 gm vl	4	
millipred	4	
mometasone furoate (cream, oint, soln)	1	
PANDEL	5	
prednicarbate (cream, ointment)	2	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
prednisolone	2	
prednisolone sodium phosphate (5 mg/5 ml soln, 10 mg/5 ml soln, 15 mg/5 ml soln, 20 mg/5 ml soln, sod ph 25 mg/5 ml)	2	
prednisone (1 mg tablet, 2.5 mg tablet, 5 mg tab dose pack, 5 mg tablet, 5 mg/5 ml solution, 10 mg tab dose pack, 10 mg tablet, 20 mg tablet, 50 mg tablet)	1	
PROMACTA (12.5 MG SUSPEN PACKET, 25 MG SUSPENSION PCKT)	5	PA
SOLU-CORTEF (100 MG, 250 MG)	4	
SOLU-MEDROL 2,000 MG VIAL	4	
triamcinolone acetonide (0.025% cream, 0.025% lotion, 0.025% oint, 0.05% ointment, 0.1% cream, 0.1% lotion, 0.1% ointment, 0.5% cream, 0.5% ointment)	1	
triamcinolone acetonide (0.147 mg/g spray, acet 40 mg/ml vl, acet 40mg/ml vl, acet 200 mg/5 ml, acet 400 mg/10ml)	4	
triderm 0.5% cream	1	
tritocin	1	
UCERIS 2 MG RECTAL FOAM	4	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
ACTHAR	5	PA
CHORIONIC GONADOTROPIN	4	PA

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
desmopressin acetate (0.01% solution, 0.01% spray, acetate 0.1 mg tb, acetate 0.2 mg tb, 10 mcg/0.1 ml spr)	2	
EGRIFTA	5	PA, QL (60 PER 30 DAYS)
EGRIFTA SV	5	PA, QL (60 PER 30 DAYS)
GENOTROPIN (MINIQUICK 0.4 MG, MINIQUICK 0.6 MG, MINIQUICK 0.8 MG, MINIQUICK 1 MG, MINIQUICK 1.2 MG, MINIQUICK 1.4 MG, MINIQUICK 1.6 MG, MINIQUICK 1.8 MG, MINIQUICK 2 MG, 5 MG CARTRIDGE, 12 MG CARTRIDGE)	5	PA
GENOTROPIN MINIQUICK 0.2 MG	4	PA
HUMATROPE (5 MG VIAL, 6 MG CARTRIDGE, 12 MG CARTRIDGE, 24 MG CARTRIDGE)	5	PA
INCRELEX	5	
NORDITROPIN FLEXPRO	5	PA
NUTROPIN AQ NUSPIN	5	PA
OMNITROPE (5 MG/1.5 ML, 10 MG/1.5 ML)	5	PA
SAIZEN	5	PA
SAIZEN-SAIZENPREP	5	PA
SEROSTIM	5	PA
STIMATE	5	
ZOMACTON 10 MG VIAL	5	PA
ZOMACTON 5 MG VIAL	4	PA
ZORBTIVE	5	PA

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PROSTAGLANDINS)		
KORLYM	5	PA, QL (120 PER 30 DAYS)
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ANABOLIC STEROIDS		
ANADROL-50	5	PA
oxandrolone 10 mg tablet	3	PA, QL (60 PER 30 DAYS)
oxandrolone 2.5 mg tablet	3	PA, QL (240 PER 30 DAYS)
ANDROGENS		
ANDRODERM	3	
danazol	2	
methyltestosterone	5	PA
NATESTO	5	PA, QL (21.96 PER 30 DAYS)
testosterone ((2.5 g) pkt, gel pump)	4	QL (150 PER 30 DAYS)
testosterone (1% (25mg/2.5g) pk, 1% (50 mg/5 g) pk, 12.5 mg/1.25 gram, 50 mg/5 gram gel, 50 mg/5 gram pkt)	3	QL (300 PER 30 DAYS)
testosterone 1.62%(1.25 g) pkt	4	QL (112.5 PER 30 DAYS)
testosterone cypionate	2	
testosterone enanthate	2	
ESTROGENS		
alyacen 1-35 28 tablet	2	
amabelz	4	
amethia	2	QL (91 PER 91 DAYS)

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
amethia lo	2	
apri	2	
aranelle	2	
ashlyna	2	QL (91 PER 91 DAYS)
aubra	2	
aubra eq	2	
aviane	2	
balziva	2	
bekyree	2	
BIJUVA	4	
blisovi 24 fe	2	
blisovi fe	2	
briellyn	2	
camrese lo	2	QL (91 PER 91 DAYS)
caziant	2	
CLIMARA PRO	4	
COMBIPATCH	4	
cryselle	2	
cyclafem	2	
DEPO-ESTRADIOL	4	
desogestr-eth estrad eth estra	2	
drosp-ee-levomef 3-0.02-0.451	2	
drospirenone-ee 3-0.03 mg tab	2	
emoquette	2	
enpresse	2	
estradiol 0.01% cream	2	
estradiol (0.5 mg tablet, 1 mg tablet, 2 mg tablet)	1	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
estradiol (once weekly)	2	
estradiol (twice weekly)	2	
estradiol valerate	2	
estradiol-norethindrone acetat	1	
ESTRING	4	QL (1 PER 90 OVER TIME)
ESTROGEL	3	
etonogestrel-ethinyl estradiol	2	
falmina	2	
FEMRING	4	QL (1 PER 90 OVER TIME)
femynor	2	
fyavolv	4	
gianvi	2	
hailey 24 fe	4	
introvale	2	QL (91 PER 91 DAYS)
jinteli	1	
juleber	2	
junel 1 mg-20 mcg tablet	2	
junel fe	2	
junel fe 24	2	
kaitlib fe	2	
kariva	2	
kelnor 1-35	2	
larin	2	
larin fe	2	
larissia	2	
leena	2	
lessina	2	

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
levonest	2	
levonorgestrel-eth estradiol (0.1-0.02 mg, 0.15-0.03, triphasic)	2	
levora-28	2	
LO LOESTRIN FE	4	
loryna	2	
low-ogestrel	2	
lutera	2	
marlissa	2	
melodetta 24 fe	4	
MENEST (0.3 MG TABLET, 0.625 MG TABLET, 1.25 MG TABLET)	4	
microgestin	2	
microgestin fe	2	
mimvey	4	
mimvey lo	4	
mononessa	2	
necon	2	
nikki	2	
norethin-eth estra-ferrous fum	2	
norethind-eth estrad 1-0.02 mg	2	
norethindron-ethinyl estradiol (norethin-eth 1 mg-5 mcg, norethind-eth 0.5-2.5)	4	
norethindrone-e.estradiol-iron (1-0.02(24)-75 chw, 1-0.02(24)-75 tab)	2	
norgestimate-ethinyl estradiol	2	
nortrel (0.5-35-28 tablet, 1-35 28 tablet, 7-7-7-28 tablet)	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ocella	2	
ogestrel	2	
orsythia	2	
pimtrea	2	
pirmella (1-35 28 tablet, 1-35-28 tablet)	2	
portia	2	
PREMARIN (0.3 MG TABLET, 0.45 MG TABLET, 0.625 MG TABLET, 0.9 MG TABLET, 1.25 MG TABLET, VAGINAL CREAM-APPL)	4	
PREMPHASE	4	
PREMPRO	4	
previfem	2	
quasense	2	
reclipsen	2	
setlakin	2	QL (91 PER 91 DAYS)
sprintec	2	
sronyx	2	
tarina fe	2	
tarina fe 1-20 eq	2	
tri-legest fe	2	
tri-lo-estarylla	2	
tri-lo-sprintec	2	
tri-previfem	2	
tri-sprintec	2	
trivora-28	2	
velivet	2	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
vienva	2	
vyfemla	2	
wymzya fe	2	
xulane	4	
yuvafem	4	
zarah	2	
zovia 1-35	2	
zovia 1-35e	2	
PROGESTINS		
camila	2	
CRINONE	4	PA
deblitane	2	
DEPO-PROVERA 400 MG/ML VIAL	4	QL (10 PER 28 DAYS)
DEPO-SUBQ PROVERA 104	4	QL (0.65 PER 90 OVER TIME)
errin	2	
hydroxyprogesterone caproate (hydroxyprogest 250 mg/ml vial, hydroxyprogesterone 1.25 g/5ml)	5	PA
jolivette	2	
lyza	2	
medroxyprogesterone acetate (2.5 mg tab, 5 mg tab, 10 mg tab)	1	
medroxyprogesterone 150 mg/ml	2	QL (1 PER 90 OVER TIME)
megestrol 625 mg/5 ml susp	4	PA - FOR NEW STARTS ONLY
megestrol acetate (40 mg/ml susp, 400 mg/10 ml)	3	PA - FOR NEW STARTS ONLY

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
megestrol acetate (20 mg tablet, 40 mg tablet)	1	
nora-be	2	
norethindrone	2	
norethindrone ac (lupaneta)	2	
norethindrone acetate	2	
progesterone (100 mg capsule, 200 mg capsule)	2	
sharobel	2	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
OSPHENA	3	
raloxifene hcl	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
ARMOUR THYROID	4	
EUTHYROX	1	
levothyroxine	4	
levothyroxine sodium (25 mcg tablet, 50 mcg tablet, 75 mcg tablet, 88 mcg tablet, 100 mcg tablet, 112 mcg tablet, 125 mcg tablet, 137 mcg tablet, 150 mcg tablet, 175 mcg tablet, 200 mcg tablet, 300 mcg tablet)	1	
LEVOXYL	3	
liothyronine sodium (5 mcg tab, 25 mcg tab, 50 mcg tab)	2	
liothyronine sod 10 mcg/ml vl	4	
SYNTHROID	3	
THYROLAR-1	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
THYROLAR-1/2	4	
THYROLAR-1/4	4	
THYROLAR-2	4	
THYROLAR-3	4	
TIROSINT (13 MCG CAPSULE, 25 MCG CAPSULE, 50 MCG CAPSULE, 75 MCG CAPSULE, 88 MCG CAPSULE, 100 MCG CAPSULE, 112 MCG CAPSULE, 125 MCG CAPSULE, 137 MCG CAPSULE, 150 MCG CAPSULE)	4	
TIROSINT-SOL	4	
UNITHROID	4	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
LYSODREN	3	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
cabergoline	2	
desmopressin acetate (ac 4 mcg/ml ampul, ac 4 mcg/ml vial, 40 mcg/10 ml vial)	4	
ELIGARD (22.5 MG SYRINGE B, 22.5 MG SYRINGE KIT)	4	PA - FOR NEW STARTS ONLY, QL (1 PER 84 OVER TIME)
ELIGARD (30 MG SYRINGE B, 30 MG SYRINGE KIT)	4	PA - FOR NEW STARTS ONLY, QL (1 PER 112 OVER TIME)
ELIGARD (45 MG SYRINGE B, 45 MG SYRINGE KIT)	4	PA - FOR NEW STARTS ONLY, QL (1 PER 168 OVER TIME)
ELIGARD (7.5 MG SYRINGE B, 7.5 MG SYRINGE KIT)	4	PA - FOR NEW STARTS ONLY, QL (1 PER 28 OVER TIME)
FIRMAGON (2 X 120 MG KIT, 120 MG VIAL)	5	PA - FOR NEW STARTS ONLY, QL (4 PER 365 OVER TIME)

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
FIRMAGON 80 MG KIT	4	PA - FOR NEW STARTS ONLY, QL (1 PER 28 OVER TIME)
leuprolide acetate (14 mg/2.8 ml kt, 14 mg/2.8 ml vl)	3	PA - FOR NEW STARTS ONLY
LUPANETA PK 11.25-5 MG 3MO KIT	5	PA, QL (1 PER 84 DAYS)
LUPANETA PK 3.75-5 MG 1MO KIT	5	PA, QL (1 PER 28 DAYS)
LUPRON DEPOT (11.25 MG 3MO KIT, 22.5 MG 3MO KIT)	5	PA - FOR NEW STARTS ONLY, QL (1 PER 84 OVER TIME)
LUPRON DEPOT (3.75 MG KIT, 7.5 MG KIT)	5	PA - FOR NEW STARTS ONLY, QL (1 PER 28 OVER TIME)
LUPRON DEPOT 45 MG 6MO KIT	5	PA - FOR NEW STARTS ONLY, QL (1 PER 168 OVER TIME)
LUPRON DEPOT-4 MONTH KIT	5	PA - FOR NEW STARTS ONLY, QL (1 PER 112 OVER TIME)
LUPRON DEPO 11.25MG (LUPANETA)	5	PA - FOR NEW STARTS ONLY, QL (1 PER 84 OVER TIME)
LUPRON DEPOT 3.75MG (LUPANETA)	5	PA - FOR NEW STARTS ONLY, QL (1 PER 28 OVER TIME)
LUPRON DEPOT-PED (11.25 MG KIT, 15 MG KIT)	5	PA, QL (1 PER 28 OVER TIME)
LUPRON DEPOT-PED 7.5 MG KIT	5	PA - FOR NEW STARTS ONLY, QL (1 PER 28 OVER TIME)
LUPRON DEPOT-PED 11.25 MG 3MO	5	PA - FOR NEW STARTS ONLY, QL (1 PER 84 OVER TIME)
LUPRON DEPOT-PED 30 MG 3MO KIT	5	PA, QL (1 PER 1112 OVER TIME)
octreotide acetate (acet 0.05 mg/ml vl, acet 50 mcg/ml amp, acet 50 mcg/ml vial, acet 100 mcg/ml amp, acet 100 mcg/ml vl, acet 200 mcg/ml vl, acet 500 mcg/ml amp, acet 500 mcg/ml vl, 1,000 mcg/5 ml vial)	4	PA

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ORGOVYX	5	PA - FOR NEW STARTS ONLY, QL (33 PER 30 DAYS)
SANDOSTATIN LAR DEPOT	5	PA
SIGNIFOR	5	PA, QL (60 PER 30 DAYS)
SIGNIFOR LAR (20 MG KIT, 20 MG VIAL, 40 MG KIT, 40 MG VIAL, 60 MG KIT, 60 MG VIAL)	5	QL (1 PER 28 DAYS)
SOMATULINE DEPOT (60 MG/0.2 ML, 90 MG/0.3 ML)	5	PA
SOMATULINE DEPOT 120 MG/0.5 ML	5	PA - FOR NEW STARTS ONLY
SOMAVERT	5	PA
SYNAREL	5	
TRELSTAR 11.25 MG VIAL	5	PA - FOR NEW STARTS ONLY, QL (1 PER 84 OVER TIME)
TRELSTAR 22.5 MG VIAL	5	PA - FOR NEW STARTS ONLY, QL (1 PER 168 OVER TIME)
TRELSTAR 3.75 MG VIAL	5	PA - FOR NEW STARTS ONLY, QL (1 PER 28 OVER TIME)
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
ANTITHYROID AGENTS		
methimazole	1	
propylthiouracil	2	
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
BERINERT (500 UNIT KIT, 500 UNIT VIAL)	5	PA
CINRYZE	5	PA

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
icatibant	5	PA
RUCONEST	5	PA
IMMUNE SUPPRESSANTS		
ASTAGRAF XL (0.5 MG CAPSULE, 1 MG CAPSULE)	4	PA - Part B vs D Determination
ASTAGRAF XL 5 MG CAPSULE	5	PA - Part B vs D Determination
AZASAN	4	PA - Part B vs D Determination
azathioprine 50 mg tablet	2	PA - Part B vs D Determination
azathioprine sodium	2	
BAQSIMI	4	
BENLYSTA (120 MG VIAL, 200 MG/ML AUTOINJECT, 200 MG/ML SYRINGE, 400 MG VIAL)	5	PA
CIMZIA (2X200 MG/ML SYRINGE KIT, 2X200 MG/ML(X3)START KT, 200 MG VIAL KIT)	5	PA
cyclosporine (25 mg capsule, 100 mg capsule, 250 mg/5 ml ampul)	2	PA - Part B vs D Determination
cyclosporine modified (25 mg, 50 mg, 100 mg, 100mg/ml)	2	PA - Part B vs D Determination
DUPIXENT PEN (200 MG/1.14 ML PEN, 300 MG/2 ML PEN)	5	PA
DUPIXENT SYRINGE (200 MG/1.14 ML SYRING, 300 MG/2 ML SYRINGE)	5	PA
ENBREL (25 MG KIT, 25 MG/0.5 ML SYRINGE, 25 MG/0.5 ML VIAL, 50 MG/ML SYRINGE)	5	PA
ENBREL MINI	5	PA

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ENBREL SURECLICK	5	PA
everolimus (0.5 mg tablet, 0.75 mg tablet)	5	PA - FOR NEW STARTS ONLY
everolimus 0.25 mg tablet	4	PA - FOR NEW STARTS ONLY
gengraf (25 mg capsule, 100 mg capsule, 100 mg/ml solution)	2	PA - Part B vs D Determination
HUMIRA	5	PA
HUMIRA PEDIATRIC CROHN'S	5	PA
HUMIRA PEN	5	PA
HUMIRA PEN CROHN'S-UC-HS	5	PA
HUMIRA PEN PSOR-UVEITS-ADOL HS	5	PA
HUMIRA(CF)	5	PA
HUMIRA(CF) PEDIATRIC CROHN'S	5	PA
HUMIRA(CF) PEN (HUMIRA(CF) PEN 40 MG/0.4 ML, HUMIRA(CF) PEN 80 MG/0.8 ML)	5	PA
HUMIRA(CF) PEN CROHN'S-UC-HS	5	PA
HUMIRA(CF) PEN PSOR-UV-ADOL HS	5	PA
INFLECTRA	5	PA
KEVZARA (150 MG/1.14 ML PEN INJ, 150 MG/1.14 ML SYRINGE, 200 MG/1.14 ML PEN INJ, 200 MG/1.14 ML SYRINGE)	5	PA
KINERET	5	PA
methotrexate sodium	1	
mycophenolate 200 mg/ml susp	5	PA - Part B vs D Determination

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Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
mycophenolate mofetil (250 mg capsule, 500 mg tablet, 500 mg vial)	2	PA - Part B vs D Determination
mycophenolic acid	4	PA - Part B vs D Determination
NULOJIX	5	PA - FOR NEW STARTS ONLY
ORENCIA (50 MG/0.4 ML SYRINGE, 87.5 MG/0.7 ML SYRINGE, 125 MG/ML SYRINGE, 250 MG VIAL)	5	PA
ORENCIA CLICKJECT	5	PA, QL (4 PER 28 DAYS)
PROGRAF 5 MG/ML AMPULE	4	PA - Part B vs D Determination
PROGRAF (0.2 MG GRANULE PACKET, 1 MG GRANULE PACKET)	5	PA - Part B vs D Determination
RENFLEXIS	5	PA
REZUROCK	5	PA - FOR NEW STARTS ONLY, QL (60 PER 30 DAYS)
SIMPONI (50 MG/0.5 ML PEN INJEC, 50 MG/0.5 ML SYRINGE, 100 MG/ML PEN INJECTOR, 100 MG/ML SYRINGE)	5	PA
SIMPONI ARIA	5	PA
sirolimus (1 mg/ml solution, 2 mg tablet)	5	PA - Part B vs D Determination
sirolimus (0.5 mg tablet, 1 mg tablet)	4	PA - Part B vs D Determination
tacrolimus (0.5 mg capsule (ir), 1 mg capsule (ir))	2	PA - Part B vs D Determination
tacrolimus 5 mg capsule (ir)	4	PA - Part B vs D Determination
TREXALL	4	
XATMEP	4	
ZORTRESS 1 MG TABLET	5	PA - FOR NEW STARTS ONLY

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
IMMUNIZING AGENTS, PASSIVE		
ATGAM	5	
BIVIGAM	5	PA
FLEBOGAMMA DIF 10% VIAL	5	PA
GAMASTAN S-D	3	PA
GAMMAGARD LIQUID	5	PA
GAMMAGARD S-D	5	PA
GAMMAKED (1 GRAM/10 ML VIAL, 5 GRAM/50 ML VIAL, 10 GRAM/100 ML VIAL, 20 GRAM/200 ML VIAL)	5	PA
GAMMAPLEX (5 GRAM/100 ML VIAL, 10 GRAM/200 ML VIAL, 20 GRAM/400 ML VIAL)	5	PA
GAMUNEX-C	5	PA
HIZENTRA (1 GRAM/5 ML SYRINGE, 1 GRAM/5 ML VIAL, 2 GRAM/10 ML SYRINGE, 2 GRAM/10 ML VIAL, 4 GRAM/20 ML SYRINGE, 4 GRAM/20 ML VIAL, 10 GRAM/50 ML VIAL)	5	PA
HYPERRAB S-D	3	
IMOGAM RABIES-HT	3	
OCTAGAM	5	PA
ODACTRA	4	PA, QL (30 PER 30 DAYS)
PANZYGA	5	PA
PRIVIGEN	5	PA
SYNAGIS 50 MG/0.5 ML VIAL	5	PA
THYMOGLOBULIN	5	
VARIZIG	3	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
IMMUNOMODULATORS		
ACTEMRA 162 MG/0.9 ML SYRINGE	5	PA, QL (3.6 PER 28 DAYS)
ACTEMRA (80 MG/4 ML VIAL, 200 MG/10 ML VIAL, 400 MG/20 ML VIAL)	5	PA
ACTEMRA ACTPEN	5	PA, QL (3.6 PER 28 DAYS)
ACTIMMUNE	5	PA - FOR NEW STARTS ONLY
ARCALYST	5	PA
GRASTEK	4	PA, QL (30 PER 30 DAYS)
ILARIS	5	PA, QL (2 PER 28 DAYS)
leflunomide	2	
OLUMIANT	5	PA
OTEZLA (28 DAY STARTER PACK, 30 MG TABLET)	5	PA
RIDAURA	5	
SIMULECT 20 MG VIAL	5	
STELARA 130 MG/26 ML VIAL	5	PA
TAVALISSE	5	PA
XELJANZ (1 MG/ML SOLUTION, 5 MG TABLET, 10 MG TABLET)	5	PA
XELJANZ XR	5	PA
Immune Suppressants		
HUMIRA(CF) PEN PEDIATRIC UC	5	PA
LUPKYNIS	5	PA
methotrexate (1 gm vial, 2.5 mg tablet, 50 mg/2 ml vial, 250 mg/10 ml vial)	1	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
RASUVO 10 MG/0.2 ML AUTOINJ	4	PA, QL (0.8 PER 28 DAYS)
RASUVO 12.5 MG/0.25 ML AUTOINJ	4	PA, QL (1 PER 28 DAYS)
RASUVO 15 MG/0.3 ML AUTOINJ	4	PA, QL (1.2 PER 28 DAYS)
RASUVO 17.5 MG/0.35 ML AUTOINJ	4	PA, QL (1.4 PER 28 DAYS)
RASUVO 20 MG/0.4 ML AUTOINJ	4	PA, QL (1.6 PER 28 DAYS)
RASUVO 22.5 MG/0.45 ML AUTOINJ	4	PA, QL (1.8 PER 28 DAYS)
RASUVO 25 MG/0.5 ML AUTOINJ	4	PA, QL (2 PER 28 DAYS)
RASUVO 30 MG/0.6 ML AUTOINJ	4	PA, QL (2.4 PER 28 DAYS)
RASUVO 7.5 MG/0.15 ML AUTOINJ	4	PA, QL (0.6 PER 28 DAYS)
REDITREX 10 MG/0.4 ML SYRINGE	4	PA, QL (1.6 PER 28 DAYS)
REDITREX 12.5 MG/0.5 ML SYRING	4	PA, QL (2 PER 28 DAYS)
REDITREX 15 MG/0.6 ML SYRINGE	4	PA, QL (2.4 PER 28 DAYS)
REDITREX 17.5 MG/0.7 ML SYRING	4	PA, QL (2.8 PER 28 DAYS)
REDITREX 20 MG/0.8 ML SYRINGE	4	PA, QL (3.2 PER 28 DAYS)
REDITREX 22.5 MG/0.9 ML SYRING	4	PA, QL (3.6 PER 28 DAYS)
REDITREX 25 MG/ML SYRINGE	4	PA, QL (4 PER 28 DAYS)
REDITREX 7.5 MG/0.3 ML SYRINGE	4	PA, QL (1.2 PER 28 DAYS)

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Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
VACCINES		
ACTHIB	3	
ADACEL TDAP (SYRINGE, VIAL)	3	
BCG VACCINE (TICE STRAIN)	4	
BEXSERO	3	
BOOSTRIX TDAP (SYRINGE, VIAL)	3	
DAPTACEL DTAP	3	
DIPHTHERIA-TETANUS TOXOIDS-PED	3	
ENGERIX-B 20 MCG/ML SYRN	3	PA - Part B vs D Determination
ENGERIX-B PEDIATRIC-ADOLESCENT	3	PA - Part B vs D Determination
GARDASIL 9 (9 SYRINGE, 9 VIAL)	3	
HAVRIX (720 UNIT/0.5 ML SYRINGE, 720 UNITS/0.5 ML VIAL, 1,440 UNITS/ML SYRINGE, 1,440 UNITS/ML VIAL)	3	
HIBERIX	3	
IMOVAX RABIES VACCINE	3	PA - Part B vs D Determination
INFANRIX DTAP (SYRINGE, VIAL)	3	
IPOL	3	
IXIARO	3	
KINRIX (TIP-LOK SYRINGE, VIAL)	3	
M-M-R II VACCINE	3	
MENACTRA	3	

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
MENQUADFI	3	
MENVEO A-C-Y-W-135-DIP	3	
PEDIARIX	3	
PEDVAXHIB	3	
PENTACEL ACTHIB COMPONENT	3	
PROQUAD	3	
QUADRACEL DTAP-IPV	3	
RABAVERT	3	PA - Part B vs D Determination
RECOMBIVAX HB (5 MCG/0.5 ML SYR, 10 MCG/ML SYR, 10 MCG/ML VIAL, 40 MCG/ML VIAL)	3	PA - Part B vs D Determination
ROTARIX	3	
ROTATEQ	3	
SHINGRIX	3	
TDVAX	3	
TENIVAC SYRINGE	3	
TRUMENBA	3	
TWINRIX	3	
TYPHIM VI (25 MCG/0.5 ML AL, 25 MCG/0.5 ML SYRNG)	3	
VAQTA (25 UNITS/0.5 ML SYRINGE, 25 UNITS/0.5 ML VIAL, 50 UNITS/ML SYRINGE, 50 UNITS/ML VIAL)	3	
VARIVAX VACCINE	3	
YF-VAX	3	
ZOSTAVAX	3	

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		
balsalazide disodium	2	
DIPENTUM	5	
mesalamine 4 gm/60 ml enema	4	QL (1800 PER 30 DAYS)
mesalamine 4 gm/60 ml kit	4	QL (4 PER 30 DAYS)
mesalamine 1,000 mg supp	5	
mesalamine dr 1.2 gm tablet	3	QL (120 PER 30 DAYS)
mesalamine dr	4	QL (180 PER 30 DAYS)
mesalamine er	4	QL (240 PER 30 DAYS)
PENTASA	4	
sulfasalazine	2	
sulfasalazine dr	2	
GLUCOCORTICOIDS		
budesonide ec	4	
budesonide er	5	ST
procto-med hc	2	
procto-pak	2	
proctosol-hc	2	
proctozone-hc	2	
METABOLIC BONE DISEASE AGENTS		
alendronate sod 70 mg/75 ml	2	
alendronate sodium (5 mg tablet, 10 mg tab, 35 mg tab, 40 mg tab)	1	
alendronate sodium 70 mg tab	1	QL (4 PER 28 DAYS)

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
BINOSTO	4	QL (4 PER 28 DAYS)
calcitonin-salmon 200 units sp	2	QL (3.7 PER 30 DAYS)
calcitriol (1 mcg/ml ampul, 1 mcg/ml solution)	2	
calcitriol (0.25 mcg capsule, 0.5 mcg capsule)	1	
cinacalcet hcl	5	PA - Part B vs D Determination
doxercalciferol (0.5 mcg cap, 1 mcg capsule, 2.5 mcg cap, 4 mcg/2 ml vl)	4	
etidronate disodium	2	
ibandronate sodium 150 mg tab	2	QL (1 PER 28 DAYS)
ibandronate 3 mg/3 ml vial	2	
MIACALCIN	5	PA - Part B vs D Determination
NATPARA	5	PA, QL (2 PER 28 DAYS)
pamidronate disodium (30 mg/10 ml vial, 60 mg/10 ml vial, 90 mg/10 ml vial)	2	PA - Part B vs D Determination
paricalcitol (1 mcg capsule, 2 mcg capsule, 4 mcg capsule)	2	PA - Part B vs D Determination
paricalcitol (2 mcg/ml vial, 5 mcg/ml vial, 10 mcg/2 ml vial)	4	
PROLIA	4	PA, QL (1 PER 180 DAYS)
RAYALDEE	5	PA, QL (60 PER 30 DAYS)
risedronate sodium (5 mg tablet, 30 mg tab)	3	
risedronate sodium 150 mg tab	3	QL (1 PER 28 DAYS)
risedronate sodium 35 mg tab	3	QL (4 PER 28 DAYS)
risedronate sodium dr	2	QL (4 PER 28 DAYS)
TERIPARATIDE	5	PA

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
TYMLOS	5	PA
XGEVA	5	PA
zoledronic acid 4 mg/100 ml	5	
zoledronic acid 5 mg/100 ml	4	PA
zoledronic acid (4 mg vial, 4 mg/5 ml vial)	4	
MISCELLANEOUS THERAPEUTIC AGENTS		
alcohol prep pads (70%, advocate 70%, pharm choice, saps 70%)	1	
alcohol 70% swabs	1	
AMINOSYN II (7% IV SOLUTION, 10% IV SOLUTION)	4	PA - Part B vs D Determination
AMINOSYN-HBC	4	PA - Part B vs D Determination
AMINOSYN-PF	4	PA - Part B vs D Determination
AMINOSYN-RF	4	PA - Part B vs D Determination
FREAMINE HBC	4	PA - Part B vs D Determination
GAUZE PADS & DRESSINGS - PADS 2 X 2	1	
HEPATAMINE	4	PA - Part B vs D Determination
INTRALIPID 20% IV FAT EMUL	4	PA - Part B vs D Determination
ISOPROPYL ALCOHOL 0.7 ML/ML MEDICATED PAD	1	
KEVEYIS	5	PA, QL (120 PER 30 DAYS)
lactated ringers irrigation	2	
levocarnitine (1 g/10 ml soln, 330 mg tablet)	2	
MYALEPT	5	PA
NEPHRAMINE	4	PA - Part B vs D Determination

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
NUTRILIPID	4	PA - Part B vs D Determination
omnipod 5 pack pod	4	PA, QL (15 PER 30 DAYS), CB (Capped Benefit)
omnipod starter kit	4	PA, QL (1 PER 365 OVER TIME), CB (Capped Benefit)
omnipod dash 5 pack pod	4	PA, QL (15 PER 30 DAYS), CB (Capped Benefit)
PHYSIOLYTE	4	
PHYSIOSOL	4	
PREMASOL 10% IV SOLUTION	4	PA - Part B vs D Determination
PREMASOL 6% IV SOLUTION	4	
PROSOL	4	PA - Part B vs D Determination
sodium chloride (irrig, irrig., prcss sol)	3	
TRAVASOL	4	PA - Part B vs D Determination
TROPHAMINE 10% IV SOLUTION	4	PA - Part B vs D Determination
true comfort pro alcohol pads	1	
v-go 20	4	PA, QL (30 PER 30 DAYS)
v-go 30	4	PA, QL (30 PER 30 DAYS)
v-go 40	4	PA, QL (30 PER 30 DAYS)
vgo 20	4	PA, QL (30 PER 30 DAYS)
vgo 30	4	PA, QL (30 PER 30 DAYS)
vgo 40	4	PA, QL (30 PER 30 DAYS)
sterile water for irrigation	1	
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
ak-poly-bac	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
atropine 1% eye drops	2	
bacitracin-polymyxin	2	
BEOVU	5	PA
CEQUA	4	QL (60 PER 30 DAYS)
CYSTARAN	5	PA, QL (60 PER 28 OVER TIME)
EMADINE	4	
EYLEA 2 MG/0.05 ML SYRINGE	5	PA
EYLEA 2 MG/0.05 ML VIAL	5	PA, QL (1.2 PER 365 OVER TIME)
LACRISERT	4	
LUCENTIS (0.3 MG/0.05 ML SYRING, 0.3 MG/0.05 ML VIAL, 0.5 MG/0.05 ML SYRING, 0.5 MG/0.05 ML VIAL)	5	PA, QL (1.2 PER 365 OVER TIME)
neomycin-bacitracin-polymyxin	2	
neomycin-polymyxin-gramicidin	2	
OXERVATE	5	PA, QL (60 PER 30 DAYS)
polymyxin b sul-trimethoprim	1	
proparacaine hcl	2	
RESTASIS	3	
RESTASIS MULTIDOSE	3	
TEPEZZA	5	PA
VISUDYNE	5	PA
XIIDRA	4	PA, QL (60 PER 30 DAYS)
OPHTHALMIC ANTI-ALLERGY AGENTS		
ALOCRIL	4	
azelastine hcl 0.05% drops	2	
bepotastine besilate	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
cromolyn 4% eye drops	1	
epinastine hcl	2	
LASTACAFT	4	
olopatadine hcl (0.1% drops, 0.2% drop)	2	
PAZEO	3	
OPHTHALMIC ANTI-INFLAMMATORIES		
ALOMIDE	4	
ALREX	3	
BLEPHAMIDE	4	
BLEPHAMIDE S.O.P.	4	
bromfenac sodium	4	
dexamethasone 0.1% eye drop	2	
diclofenac 0.1% eye drops	1	
difluprednate	3	
FLAREX	3	
fluorometholone	2	
flurbiprofen sodium	1	
FML FORTE	3	
FML S.O.P.	3	
ILEVRO	3	QL (6 PER 30 OVER TIME)
ketorolac tromethamine (0.4% solution, 0.5% solution)	2	
LOTEMAX 0.5% EYE OINTMENT	4	QL (14 PER 365 OVER TIME)
loteprednol 0.5% ophthalmc gel	4	QL (20 PER 365 OVER TIME)
loteprednol etabonate 0.5% drp	2	
MAXIDEX	3	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
neomycin-polymyxin-dexameth (neomyc-polym-dexamet ointm, neomyc-polym-dexameth drop)	2	
NEVANAC	3	QL (6 PER 30 OVER TIME)
PRED MILD	3	
PRED-G (1% DROPS, S.O.P. OINTMENT)	4	
prednisolone acetate	2	
prednisolone sod 1% eye drop	2	
PROLENSA	4	QL (12 PER 365 OVER TIME)
sulfacetamide-prednisolone	2	
TOBRADEX EYE OINTMENT	4	
TOBRADEX ST	4	
tobramycin-dexamethasone	2	
ZYLET	4	
OPHTHALMIC ANTIGLAUCOMA AGENTS		
ALPHAGAN P 0.1% DROPS	3	
apraclonidine hcl	2	
AZOPT	3	
betaxolol hcl 0.5% eye drop	2	
BETIMOL	4	
BETOPTIC S	4	
brimonidine 0.2% eye drop	1	
brimonidine tartrate 0.15% drp	4	
brinzolamide	3	
carteolol hcl	1	
dorzolamide hcl	2	
dorzolamide-timolol (2%-0.5%, eye drops)	2	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
IOPIDINE 1% EYE DROPS	4	
levobunolol hcl	1	
methazolamide	3	
metipranolol	2	
PHOSPHOLINE IODIDE	4	
pilocarpine hcl (1% drops, 2% drops, 4% drops)	2	
SIMBRINZA	4	
timolol maleate (0.25% drop, 0.5% drop, 0.5% drops)	1	
timolol maleate (0.25% gel-solution, 0.25% gfs gel-solution, 0.5% eye drop, 0.5% gel-solution, 0.5% gfs gel-solution)	4	
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
bimatoprost 0.03% eye drops	2	
COMBIGAN	3	
DURYSTA	5	PA
latanoprost 0.005% eye drops	1	
LUMIGAN	3	
travoprost	1	
OTIC AGENTS		
acetic acid 2% ear solution	2	
CIPRO HC	4	
CIPRODEX	3	
ciprofloxacin 0.2% otic soln	2	
ciprofloxacin-dexamethasone	3	
COLY-MYCIN S	4	

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
DERMOTIC	2	
hydrocortisone-acetic acid	2	
neomycin-polymyxin-hc ear susp	2	
neomycin-polymyxin-hydrocort	2	
RESPIRATORY TRACT/PULMONARY AGENTS		
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
ARNUITY ELLIPTA	3	QL (30 PER 30 DAYS)
ASMANEX (TWISTHALER 110 MCG #30, TWISTHALER 220 MCG #30, TWISTHALER 220 MCG #60, TWISTHALR 220 MCG #120)	3	QL (1 PER 30 DAYS)
ASMANEX HFA	3	QL (26 PER 30 DAYS)
budesonide (0.25 mg/2 ml susp, 0.5 mg/2 ml susp, 1 mg/2 ml inh susp)	4	PA - Part B vs D Determination, QL (120 PER 30 DAYS)
FLOVENT 250 MCG DISKUS	3	QL (240 PER 30 DAYS)
FLOVENT DISKUS (50 MCG, 100 MCG)	3	QL (60 PER 30 DAYS)
FLOVENT HFA (HFA 110 MCG INHALER, HFA 220 MCG INHALER)	3	QL (24 PER 30 DAYS)
FLOVENT HFA 44 MCG INHALER	3	QL (21.2 PER 30 DAYS)
flunisolide	1	QL (50 PER 30 DAYS)
fluticasone prop 50 mcg spray	1	
mometasone furoate 50 mcg spry	4	QL (34 PER 30 DAYS)
QVAR REDIHALER	3	QL (21.2 PER 30 DAYS)

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DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
ANTIHISTAMINES		
azelastine hcl (0.1% (137 mcg) spry, 0.15% nasal spray)	2	QL (60 PER 30 DAYS)
azelastine-fluticasone	3	
cetirizine hcl (1 mg/ml soln, 1 mg/ml syrup)	1	
cyproheptadine hcl (2 mg/5 ml soln, 2 mg/5 ml syrup, 4 mg tablet, 4 mg/10 ml syrp)	2	
desloratadine 5 mg tablet	2	
diphenhydramine 50 mg/ml vial	2	
hydroxyzine hcl (10 mg/5 ml soln, 10 mg/5 ml syrup, 50 mg/25 ml syrup)	2	
hydroxyzine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet)	1	
hydroxyzine hcl (25 mg/ml vial, 50 mg/ml vial, 100 mg/2 ml vial, 500 mg/10 ml vial)	4	
levocetirizine 5 mg tablet	2	
olopatadine 665 mcg nasal spry	4	QL (30.5 PER 30 DAYS)
ANTILEUKOTRIENES		
montelukast sodium (4 mg granules, 4 mg tab chew, 5 mg tab chew)	2	
montelukast sod 10 mg tablet	1	
zafirlukast	2	
zileuton er	5	
ZYFLO	5	ST

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA	4	QL (25.8 PER 30 DAYS)
COMBIVENT RESPIMAT	3	QL (8 PER 30 DAYS)
INCRUSE ELLIPTA	4	ST, QL (30 PER 30 DAYS)
ipratropium br 0.02% soln	1	PA - Part B vs D Determination, QL (312.5 PER 30 DAYS)
ipratropium bromide (0.03% spray, 0.06% spray)	2	
ipratropium-albuterol	2	PA - Part B vs D Determination, QL (540 PER 30 DAYS)
SPIRIVA	3	QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT	3	QL (4 PER 30 DAYS)
BRONCHODILATORS, SYMPATHOMIMETIC		
ADRENALIN	4	
albuterol hfa 90 mcg inhaler (generic proair hfa)	2	QL (17 PER 30 DAYS)
albuterol hfa 90 mcg inhaler (generic proventil hfa)	2	QL (14 PER 30 DAYS)
albuterol hfa 90 mcg inhaler (generic ventolin hfa)	2	QL (36 PER 30 DAYS)
albuterol sulfate (2.5 mg/0.5 ml sol, 5 mg/ml solution, 15 mg/3 ml solution, 20 mg/4 ml solution, 100 mg/20 ml soln)	2	PA - Part B vs D Determination, QL (100 PER 30 DAYS)
albuterol sulf 2 mg/5 ml syrup	2	
albuterol sulfate (2 mg tab, 4 mg tab, er 4 mg tab, er 8 mg tab)	3	
albuterol sul 0.63 mg/3 ml sol	2	PA - Part B vs D Determination, QL (375 PER 30 DAYS)
albuterol sul 1.25 mg/3 ml sol	1	PA - Part B vs D Determination, QL (375 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
albuterol sul 2.5 mg/3 ml soln	1	PA - Part B vs D Determination, QL (525 PER 30 DAYS)
albuterol sulfate hfa	2	QL (17 PER 30 DAYS)
arformoterol tartrate	5	PA - Part B vs D Determination, QL (120 PER 30 DAYS)
epinephrine (0.15 mg auto-injct, 0.3 mg auto-inject)	3	
EPIPEN	4	
EPIPEN 2-PAK	4	
EPIPEN JR	4	
EPIPEN JR 2-PAK	4	
formoterol fumarate	4	PA - Part B vs D Determination, QL (120 PER 30 DAYS)
levalbuterol concentrate	4	PA - Part B vs D Determination, QL (90 PER 30 DAYS)
levalbuterol 1.25 mg/3 ml sol	4	PA - Part B vs D Determination, QL (90 PER 30 DAYS)
levalbuterol hcl (0.31 mg/3 ml sol, 0.63 mg/3 ml sol)	4	PA - Part B vs D Determination, QL (540 PER 30 DAYS)
levalbuterol tartrate hfa	2	QL (30 PER 30 DAYS)
metaproterenol sulfate (10 mg tablet, 10 mg/5 ml syr, 20 mg tablet)	4	
PROAIR RESPICLICK	4	QL (2 PER 30 DAYS)
SEREVENT DISKUS	3	QL (60 PER 30 DAYS)
terbutaline sulfate (2.5 mg tab, 5 mg tab)	4	
terbutaline sulf 1 mg/ml vial	5	
CYSTIC FIBROSIS AGENTS		
BETHKIS	5	PA - Part B vs D Determination
BRONCHITOL	5	PA

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
CAYSTON	5	PA
KALYDECO (25 MG GRANULES PACKET, 50 MG GRANULES PACKET, 75 MG GRANULES PACKET, 150 MG TABLET)	5	PA
ORKAMBI (100-125 MG GRANULE PKT, 150-188 MG GRANULE PKT)	5	PA
ORKAMBI (100 MG TABLET, 200 MG TABLET)	5	PA, QL (112 PER 28 DAYS)
PULMOZYME	5	PA
TOBI PODHALER	5	QL (224 PER 56 OVER TIME)
tobramycin (300 mg/4 ml, 300 mg/5 ml)	5	PA - Part B vs D Determination
TRIKAFTA	5	PA
MAST CELL STABILIZERS		
cromolyn 20 mg/2 ml neb soln	2	PA - Part B vs D Determination
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
aminophylline 250 mg/10 ml vl	2	
DALIRESP	4	PA
theophylline (80 mg/15 ml soln, er 400 mg tablet, er 600 mg tablet)	2	
theophylline anhydrous	2	
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS	5	PA, QL (90 PER 30 DAYS)
alyq	5	PA, QL (60 PER 30 DAYS)
ambrisentan	5	PA, QL (30 PER 30 DAYS)
bosentan	5	PA, QL (60 PER 30 DAYS)

You can find information on what the symbols and abbreviations on this table mean by going to page numbers 8 and 9.
Puede encontrar información sobre lo que significan los símbolos y las abreviaturas de esta tabla en las páginas 17 y 18.

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
OPSUMIT	5	PA, QL (30 PER 30 DAYS)
ORENITRAM ER (ER 0.25 MG TABLET, ER 1 MG TABLET, ER 2.5 MG TABLET, ER 5 MG TABLET)	5	PA
ORENITRAM ER 0.125 MG TABLET	4	PA
sildenafil 10 mg/ml oral susp	5	PA
sildenafil 20 mg tablet	2	PA, QL (180 PER 30 DAYS)
sildenafil 10 mg/12.5 ml vial	5	PA, QL (2250 PER 30 DAYS)
tadalafil 20mg (generic adcirca)	5	PA, QL (60 PER 30 DAYS)
treprostinil	5	PA
UPTRAVI 200-800 TITRATION PACK	5	PA, QL (400 PER 365 OVER TIME)
UPTRAVI (200 MCG TABLET, 400 MCG TABLET, 600 MCG TABLET, 800 MCG TABLET, 1,000 MCG TABLET, 1,200 MCG TABLET, 1,400 MCG TABLET, 1,600 MCG TABLET)	5	PA, QL (60 PER 30 DAYS)
UPTRAVI 1,800 MCG VIAL	5	PA
VENTAVIS	5	PA, QL (270 PER 30 DAYS)
PULMONARY FIBROSIS AGENTS		
ESBRIET 267 MG TABLET	5	PA, QL (180 PER 30 DAYS)
OFEV	5	PA
RESPIRATORY TRACT AGENTS, OTHER		
acetylcysteine (10% vial, 20% vial)	2	PA - Part B vs D Determination
ADVAIR HFA	3	QL (24 PER 30 DAYS)
ANORO ELLIPTA	3	QL (60 PER 30 DAYS)
ARALAST NP	5	PA

Doctors HealthCare Plans, Inc. (List of Covered Drugs/Lista de medicamentos cubiertos)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
benzonatate (100 mg capsule, perle 100 mg cap, 200 mg capsule)	1	
BREO ELLIPTA	3	QL (60 PER 30 DAYS)
budesonide-formoterol 160-4.5	3	QL (12 PER 30 DAYS)
budesonide-formoterol 80-4.5	3	QL (13.8 PER 30 DAYS)
DULERA	4	ST, QL (13 PER 30 DAYS)
ESBRIET 267 MG CAPSULE	5	PA, QL (270 PER 30 DAYS)
ESBRIET 801 MG TABLET	5	PA, QL (90 PER 30 DAYS)
fluticasone-salmeterol (55-14, 113-14, 232-14)	3	
fluticasone-salmeterol (100-50, 250-50, 500-50)	3	QL (60 PER 30 DAYS)
GLASSIA	5	PA
NUCALA (100 MG/ML AUTO-INJECTOR, 100 MG/ML POWDER VIAL, 100 MG/ML SYRINGE)	5	PA, QL (3 PER 28 DAYS)
PROLASTIN C	5	PA
promethazine vc	2	
promethazine-phenylephrine	2	
STIOLTO RESPIMAT	3	QL (4 PER 30 DAYS)
TRELEGY ELLIPTA	3	QL (60 PER 30 DAYS)
wixela inhub	4	QL (60 PER 30 DAYS)
XOLAIR (75 MG/0.5 ML SYRINGE, 150 MG/1.2 ML POWDER VL, 150 MG/ML SYRINGE)	5	PA
ZEMAIRA	5	PA

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
SKELETAL MUSCLE RELAXANTS		
carisoprodol 350 mg tablet	4	
chlorzoxazone (375 mg tablet, 500 mg tablet, 750 mg tablet)	1	
cyclobenzaprine hcl (5 mg tablet, 10 mg tablet)	2	
orphenadrine citrate	2	
orphenadrine citrate er	1	
SLEEP DISORDER AGENTS		
GABA RECEPTOR MODULATORS		
eszopiclone	1	
zaleplon 10 mg capsule	1	QL (60 PER 30 DAYS)
zaleplon 5 mg capsule	1	QL (30 PER 30 DAYS)
zolpidem tartrate (5 mg tablet, 10 mg tablet)	1	QL (30 PER 30 DAYS)
zolpidem tartrate (1.75 mg tab, 3.5 mg tablet)	4	QL (30 PER 30 DAYS)
zolpidem tartrate er	4	QL (60 PER 30 DAYS)
SLEEP DISORDERS, OTHER		
armodafinil (150 mg tablet, 200 mg tablet, 250 mg tablet)	4	PA, QL (30 PER 30 DAYS)
armodafinil 50 mg tablet	4	PA, QL (60 PER 30 DAYS)
doxepin hcl (3 mg tablet, 6 mg tablet)	1	QL (30 PER 30 DAYS)
HETLIOZ	5	PA, QL (30 PER 30 DAYS)
modafinil	3	PA, QL (30 PER 30 DAYS)
ramelteon	4	QL (30 PER 30 DAYS)

DRUG NAME NOMBRE DEL MEDICAMENTO	DRUG TIER NIVEL DE MEDICAMENTO	REQUIREMENTS/LIMITS REQUISITOS/ LIMITES
XYREM	5	PA, QL (540 PER 30 DAYS)
null		
ANTIVIRALS, MISCELLANEOUS		
PREVYMIS (240 MG TABLET, 480 MG TABLET)	5	PA, QL (30 PER 30 DAYS)
PREVYMIS 240 MG/12 ML VIAL	5	PA, QL (360 PER 30 DAYS)
PREVYMIS 480 MG/24 ML VIAL	5	PA, QL (720 PER 30 DAYS)

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DOCTORS
HEALTHCARE PLANS, INC.

This formulary was updated on 12/01/2021. For more recent information or other questions, please contact Doctors HealthCare Plans Member Services Department at (786) 460-3427 or toll-free at (833) 342-7463 or, for TTY users, dial 711, Monday through Sunday 8AM to 8PM ET, or visit us online at: www.doctorshcp.com.

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